

# **1 INTRODUCING PHOBIAS, CHANGE, TRANSITION, PROGRESSION AND ENERGY PSYCHOLOGY**

## **1.1. What do phobias have to do with change, transition and progression?**

Walsch (2009) explains a life -changing event as "Change is the shifting of any circumstance, situation, or condition, physical or nonphysical, in such a way that the original is rendered not merely different from what it was, but altered so radically as to make it utterly unrecognizable and impossible to return to anything resembling its former state." (p.16). He suggests that when everything in your life changes, change everything, physical and non-physical like your emotions, thoughts, and perceptions (Walsch, 2009). Change has been with us, is with us, and will be with us – always. As we note how nature changes - seasons, weather, solar and lunar cycles, so also do we realize changes within us, in our emotional worlds, thought patterns, reality perceptions, our bodies, in the world of technology, in our careers, and our economy. According to Benor (2004), psychotherapeutic discoveries reveal that human habits are hard to change because people are inclined to view themselves in certain ways and therefore act in accordance with these familiar and therefore comfortable perceptions. Gallo (2012) adds that when people try to create change, they also create resistance. Not only are people comfortable with their behaviours, but friends and family also anticipate certain behaviours which can get in the way of changing old habits of perception and behaviour, even when the change is for the better. Therefore people tend to resist behavioural changes and habitual changes, not only in themselves, but in others as well (Benor, 2004). The homeodynamic theory of Psychoneuroimmunology assumes that “the optimum adaptive environment for living systems is not homeostasis but rather a continual flux of changes” which makes change an indispensable ingredient for optimum human

functioning as it makes it possible for a person to adapt to new and/or threatening provocations as well as observing and correcting maladaptive functioning (Rider, 1992, p. 1). Not only will change always be with us, but the pace of change is increasing and therefore it is healthy to view that "all change is for your own good" (Walsch, 2009, p. 163). This is especially evident when we look at the changes in technology. No one is using a phone or computer they bought ten, or even five years ago. We cannot get away from *change*, which Webster (2001, p. 344) defines as "to become different, to become altered, modified, anything that is or may be substituted for another" and the Oxford online dictionary describes as "move from one to another" and "an act or process through which something becomes different".

"Because no living system can be completely stable for long, it undergoes various shifts, transitions, or changes through *fluctuations*." (Johanson, 2009, p. 164) and because "life is a self-sustaining system", we need to adapt to change to remain functional (Walsch, 2009, p. 163). In my Energy Psychology (a "branch of psychology that studies the effects of energy systems, such as the acupuncture meridians, chakras and morphic resonance on emotions and behavior" (Gallo, 2005, p. 227) and includes therapies that use both energetic interventions and psychological approaches simultaneously (Radcliff, *n.d.*) ) practice, I have found numerous distresses that can cause enough fluctuations or instabilities in a system to drive a person to enter therapy. The majority of my clients come to me because they cannot progress with a situation in their lives that was created by a change and which sometimes also required a transition. If the change was a divorce, they cannot, for example, *transition* ("change from one position, state, stage, subject, concept to another" (Webster, 2001, p. 2010), from being married to being a single person. Other examples of change where a transition might be needed are a separation/ a break up, loss or change of a job, retirement, moving, immigration, protracted illness, surgery, or loss of a loved one through death. The

person wants to feel better, get advice, follow the advice, get a new perspective and move on from where they are – they want to change and experience progression. They often find that they cannot do any of these. My question would be why can't they? Loebenstein, (2006) says when there is a lot of anxiety around change and transition, and it is difficult or hard for the person to move forward in his/her life, the presence of a phobia is likely. If a *phobia* is “an exaggerated, irrational emotional (and physical) reaction that is out of proportion with what is happening in reality” and an “extreme black and white statement of the worst things the client's unconscious mind and body can imagine” (Swack, 2007b, Phobia section, p. 9 & 10), “an extreme or irrational fear of or aversion to something” (Oxford online dictionary, *n.d.*) and “a persistent, irrational fear of a specific object, activity, or situation that leads to a compelling desire to avoid it” (Webster, 2001, p. 1455), it will create a crises for the client. Fourie (2006) mentioned that phobic behaviours are often rooted in a person's interpersonal and intrapersonal lives. With this in mind, there might be a link between change and phobias. Traditionally, phobias have been thought of as irrational fears toward common objects or events, such as the number thirteen, water, or heights (Plotnik & Kouyoumdjian, 2011). However, recent anecdotal evidence and research has shown that phobias can be toward more innocuous events, such as life changes, life transitions and progression toward goals (Swack, 2007b). Wade's (1990) research, for example, leaned more towards the abstract and less tangible when he researched the effectiveness of an **E**nergy **P**sychology (EP) phobia intervention, the Callahan Phobia Treatment Techniques, on self-esteem, self-acceptance and self-concept. Both EP and the Callahan Phobia Treatment will be discussed in chapter two.

I started to reflect on the possibility to see if change and/or transition can create phobia(s) which are interfering with progression towards a client's goal(s) and/or intentions and if these phobias might be phobias of change and/or transition and/ or progression.

The focus of this study is not only to resolve phobias, but to detect and resolve phobias as subtle as a phobia of change (metathesiophobia or tropophobia) and/or transition and/ or progression with an EP method, the HBLU™ simple phobia protocol (Appendix L). “**H**ealing from the **B**ody **L**evel **U**p (HBLU™) is a holistic psychotherapeutic system that simultaneously addresses the somatic, psychological, and spiritual aspects of an issue. It is a method [not a technique] in which the client uses muscle testing to formulate a goal, identify what is interfering with reaching the goal, and select the best intervention for clearing interference. When the interference pattern clears, it does so on the client’s conscious and unconscious mind, body, and soul levels as confirmed by muscle testing and measurable behavioural results. This method for tailoring each healing session to the individual allows for specificity and reproducibility” (Gallo, 2002, p. 59).

These more subtle phobias might not have a “specific panic trigger” like you would have with specific phobias such as a phobia of spiders (arachnophobia) (Bener, Ghuloum & Dafeeah, 2011, p. 141) and are therefore less obvious and less easy to detect because the symptoms are generally not directly and prominently related to or associated with a phobia. This does not mean that the person might not have a phobia. A person can have a range of distinct responses to factors in their external and internal environment (that were linked or present during the time of the phobic imprint) and have certain symptoms, like being unable to move ahead from the change in their life or transition into a new identity (for example, a recent retiree), and be unaware that they have a phobia as they don’t realize that they are actually avoiding the very thing that they fear, changing into a new identity (Shapiro & Forrest, 1997). These phobias will be referred to as subtle phobias in this study. *Subtle* is defined in the Webster’s II New College dictionary (2001, p. 1100) as “not immediately clear, difficult to detect” and gives a good description of what is meant by more subtle phobias (for example phobias of change) in this study.

I found a lack of research and critical reading on phobias which are not specific or social. I could also not find any literature on the correlation between phobias and change, transition and progression and associated treatments. I believe that my research will contribute to filling the gap as far as exploring the interconnectedness of change, transition, progression and phobias goes and the consequential effect it has on a person. This study will further test whether the HBLU™ simple phobia treatment is effective for 1) detecting and 2) relieving subtle phobias, such as phobias of change, transition and progression, in ten participants.

In this chapter the motivation for relieving individuals of subtle phobias of change, transition and or progression with an Energy Psychology method, HBLU™, will be discussed. The history and development of EP and HBLU™ will be delineated and the research objectives and research question will also be addressed in this chapter.

## **1.2. Reasons for relieving individuals of subtle phobias**

Not only are phobias the most common anxiety disorder in childhood (Bener et al., 2011), but it is also one of the most common disorders for which people seek treatment (Fourie, 2006). If phobias are not treated, they can become chronic and reduce a person's quality of life (Bener et al., 2011). With my new thought processes and perspectives about the face of phobias, I started to think that subtle phobias are a relevant aspect to address in the high stress world we live in with all its uncertainties and constant, fast changes and required transitions.

In my career as an Energy Psychology Practitioner, I am faced with clients who have unfortunate incidents happening in their lives and they need help moving from an undesired state, situation and/or self-perception to a more desirable state, situation and/or self-perception. I realized that many new clients, or regular clients who were faced with new

situations would use words and phrases such as “stuck”, “inability to move forward” and “I know what to do, but cannot do it”, “anxious”, “stressed”, “I cannot think straight” and “I cannot focus”. These indicators can be linked to a phobia because when someone experiences a physical or emotional traumatic shock, during their unfortunate incident, they go into the fight/flight/freeze reflex, and the memory of this reaction (together with all environmental associations - possible phobic stimuli) remains frozen in the body and a phobic conditioned response can be the result. This phobic reaction (for example the inability to move forward) can be set off by any associated trigger (phobic stimulus) in the environment (Colman, 2006; Shapiro & Forrest, 1997; Swack, 2007b; Swack, 2008). As a phobic reaction is a conditioned physical reaction/reflex, we cannot control it consciously (Swack, 2001a). Callahan confirms this with his views that the interaction between the energy system and mental disturbance in the associated thought field (the energetic field of thoughts) is the fundamental and primary cause for distress, rather than the developmental and cognitive aspects (Gallo, 2005). The phobic person is aware of the irrationality of the fear, but cannot rationalize him/ herself out of it (Salas, 2001; Swack, 2007b). When Bener et al. (2011) mention that “phobic disorders cause severe impairment and excessive distress” (p. 140) and that phobias can disrupt relationships and cause severe anxiety and depression, and Salas (2001) states that high anxiety and physiological reactions such as increased heart rate, increased shallow chest breathing and sweaty hands as noticeable phobic reactions, it further confirms the symptoms I see in my clients as phobias. I observe these symptoms in my clients through the issues they present and through their language, behaviour and physiological reactions.

Apart from observing the above mentioned symptoms, which includes avoiding to confront the phobic situation, (Salas, 2001), by choosing intense avoidance (Shapiro & Forrest, 1997), I also experience clients talking nonstop and jumping from one problem to another. They will get increasingly confused and their feelings of anxiety, hopelessness and

overwhelm start to escalate. It is hard for them to stay focused, follow advice, or even remember what was said. In her paper *Diagnosis shock: the unrecognized burden of illness*, Dr Swack found that when someone is diagnosed with a serious physical or emotional illness, it creates a phobic reaction which can result in irrational reactions and behaviours which can compromise treatment choices, doctor-patient relationships and negatively affect relationships with other healthcare providers, caregivers and family and friends and lessen their overall quality of life (Swack, 2008). Perhaps the EP term, Psychological Reversal, which Karjala (2012, slide 6) defines as "a block or objection to implementing a desired change", and what David Gruder (in Karjala, 2012, slide 8) calls "Objections to success", is a phobic reaction to change. Phobic people understand that their fears are irrational, but they still can't change it; they cannot talk themselves out of sweating or hyperventilation which contributes to further shame and more fear (Callahan, 2001) and neither can a person with a psychological reversal according to Karjala (2012). Although a person might not identify their anxiety, fear and behaviours as phobic, these are symptoms that can prolong the undesired state and situation, and can prolong or even halt treatment and cause further unnecessary frustration for the client. According to Loebenstein (2006) the thinking and planning parts of the brain (the frontal lobe) are necessary for decision making and for rational thought processes and when a person is anxious, he/she cannot be rational, cannot make good decisions and is unable to hear and follow advice. Conversely, when anxiety is alleviated, the frontal lobe is included again in the decision making process and rational thought can proceed (Loebenstein, 2006).

To help clients progress towards a more functional state, relieving them from their paralyzing phobic symptoms seems logical. Relieving the client from the phobia with an Energy Psychology method can bring quick relief from phobic symptoms, (Feinstein, 2005a; 2005b; 2008a; 2008b; Lambrou, Pratt & Chevalier, 2005; Salas 2001; Schulz, 2007). To

neutralize the body's phobic reaction, a mind-*body* EP intervention, such as **Natural Bio-Destressing (NBD)**, is needed to activate the body's natural relaxation reflex, because techniques that only work with the mind (such as talk therapy) can be ineffective or incomplete (Swack, 2006 a; 2008; *n.d.* a). As clients experience less anxiety, they might also experience better participation and response during therapy. Schulz (2007) mentioned that therapy can proceed faster because of the lack of upsetting emotions, fundamental issues can be discussed without client distress, and clients can experience improved interpersonal and intrapersonal relationships.

I continue to think that perhaps phobias as subtle phobias are overlooked in their integrated importance to the therapy process, especially because they are not taken at face value – that phobias develop “in a response to a frightening event or situation” (Bener et al., 2011, p. 140). Life is full of frightening situations, so is it not logical that phobias are more a norm than a rarity? Just because a phobia cannot be categorized, does not mean that it does not exist. If awareness can be shifted to what a phobia is, rather than focusing on the types of phobias like specific or social phobias, then it is more likely that phobias such as phobias of change, transition and/or progression, will be noticed and addressed at the start of treatment.

Swack (2012) proposes that clients can avoid treatment because they might have an unconscious phobic reaction to just think about their past. Because a phobia of change, transition and/or progression can create so much anxiety and steer people towards avoiding that what they fear, I find it important to address the so called “white elephant in the room” as soon as possible so that the client can be put to ease and we can proceed with therapy. Motivation to lessen the client's distress and see progression in therapy and in his/her life as soon as possible can be good reasons to relieve clients from a subtle phobia(s).



### **1.2.1. Reasons for relieving individuals of subtle phobias with HBLU™, an Energy Psychology method**

Although mainstream psychology believes that phobias can't be cured (Callahan, 2001), the Energy Psychology field disagrees, based upon the preponderance of evidence in successful case studies (Association of Comprehensive Energy Psychology - ACEP). Confirming my own rapid results with Energy Psychology (EP) as a client and practitioner, Feinstein (2008a, p. 1) mentioned that EP practitioners experience EP treatment outcomes as “rapid, powerful and precise” and Schulz (2007, p. 102) mentions that the “rapid rate of healing may affect the treatment goals.” This rapid results treatment approach supports my motivation to help lessen the client's distress and help them progress towards their therapeutic goal as soon as possible. My interest in EP continues to increase as I noticed as Schulz's (2007) participants did, that after an EP intervention distressing emotions are no longer an obstacle and the important, primary issues can be discussed without client distress and the therapy process can proceed quicker. This is especially important when faced with a possible phobic situation where the client feels “stuck” and shows other symptoms of distress because of his/her lack of progression. I am interested not only in the “reports of unusual speed, range and durability of clinical outcomes” of EP (Feinstein, 2009, p. 1), but also to help people facilitate progressive transformation in this fast paced world with structure and depth.

Craig (2005) discovered that imbalances in the body's energy system (created by negative emotions and thought processes) greatly affects a person's personal psychology and that the true cause of negative emotions is therefore involved with a disruption in the body's energy system. I therefore prefer the inclusion of EP in the treatment session because adding a non-invasive tool, like an EP method to your own approach, helps facilitate neurological change, and brings relief for client and practitioner (Feinstein, 2005b; Feinstein, Eden, &

Craig, 2005). EP should not be seen as a replacement to a comprehensive clinical approach, but rather as an addition, as EP builds upon and works within the context of conventional psychology (Feinstein, 2005b; Feinstein et al., 2005; Schulz, 2007).

In order to resolve subtle phobias as painlessly and thoroughly as possible, I have chosen the pragmatic, structured and goal driven HBLU™ simple phobia treatment method. The structured nature of HBLU™ with its defined questions for the phobia protocol helps the client(s) to stay focused and help conquer their feelings of overwhelm. HBLU™ is further regarded as a holistic and inclusive EP method, since it simultaneously addresses the mind, body and soul and includes additional EP techniques during the phobia resolution process. HBLU™ incorporates the person's mind (conscious and unconscious) during the process of mapping out the phobia(s). It further includes the body when the person is relieved of the phobia by choosing a physical EP intervention like **E**motional **F**reedom **T**echnique (EFT) or **N**atural **B**io-**D**estressing (NBD), because phobias are viewed as a conditional response of the fight/flight/freeze reflex (sympathetic division of the autonomic nervous system) and therefore applying physical EP techniques to activate the calming reflex (parasympathetic division of the autonomic nervous system) will clear the phobia(s) by neutralizing the fight/flight/freeze reaction and deactivate the triggering response(s) (Swack, 2001a). The body's phobic reaction is neutralized because the phobic reactions are stored in the body and therefore these shock imprints should be released from the body with a physical intervention (Swack, *n.d.c*).

The HBLU™ phobia protocol not only makes provision for naming your own phobia, but has a further unique way of viewing phobias. It differentiates between, fear, shame, hybrid and anticipatory phobias, categories under which the person's unique subtle phobia will fall and which will determine the "story" of their phobia. Fear phobias, imply that the phobia(s) have a life threatening consequence for the person, and ends in some form of death,

internal torment or rejection (i.e. I am afraid to change, because I will kill someone and die in hell) ; shame phobias, involve character assassination (i.e. I am ashamed to change because it means I am an evil loser); hybrid phobias, are a combination of the fear and shame phobias (i.e. I am afraid to change, because I will kill someone and die in hell and that means that I am an evil loser); and anticipatory phobias, refer to the dread that something bad will happen again in the future (i.e. I am afraid to change and be confident in the future because it means that I will lose my job) (Swack, 2007b). A person can have more than one phobia on a subject, for example “I am afraid to change because 1) I will kill someone and die in hell and because 2) I will collapse and die alone, starving in the street”.

Clear, accurate, precise, certain and extreme wording is important and necessary to clear a phobia with the HBLU<sup>TM</sup> approach and Gallo (2005, p. 30) confirms when he said “specificity and precision seem to be factors involved in the most rapid and efficient results”. To assist in the formulation and mapping out of the phobia (parsing out the details of the phobia) and finding the most extreme consequence of the phobia, the practitioner can help the client by utilizing **Neuro Linguistic Programming** (NLP) language. To help with the formulation of the specific phobia and to create a phrase to describe the phobia in extreme specifics, the narrative process of “chunking down” are used and repetitive questions such as “What is the consequence of that?” and “What will that do to you?” and “And then what will happen?” are asked until the most extreme phrase of the phobia is found. For example, this might be, “I am afraid to retire because I will have no value” (which is not extreme enough) and the questioning will continue until the most extreme version is found – e.g. “and die a lonely death”. Gallo (2005, p. 30) states that “we can chunk up or chunk down in order to achieve therapeutic results”.

When this step is complete, the client is ready to move on to the EP intervention of choice (Swack, 2007b), an intervention that would target the neurological change, necessary for the release of a phobia (Feinstein, 2005b).

Because of its distinctive approach, the HBLU<sup>TM</sup> phobia protocol process makes it possible to discover subtle phobias which are less direct, common and obvious than specific phobias, name and map out the phobias and resolve them in a relatively short period of time. The HBLU<sup>TM</sup> method reveals the subtle phobias through the structured questions and muscle testing confirms all the client's answers.

The HBLU<sup>TM</sup> phobia protocol is further designed with the goal of processing traumatic memories with minimal abreaactions or painful re-experiencing. It does not re-traumatize clients, and treatment can be completed in one 90 minute session if clients are suffering from a simple phobia. With a simple phobia the understanding is that a trauma does not need to be cleared before addressing and resolving the phobia. If trauma treatment is necessary before the phobia can be resolved, HBLU<sup>TM</sup> makes provisions for that possibility with the HBLU<sup>TM</sup> trauma protocol.

Further research (specifically on efficacy, mechanism and indicated disorders) is required in EP according to Feinstein (2008a) and researching a holistic EP method which includes additional EP interventions, such as HBLU<sup>TM</sup>, would be appropriate to address in a world of fast changes where people have limited time and fewer financial resources. New and continual research and knowledge is needed to establish EP as a recognized addition to the field of psychology (Baker & Siegel, 2005; Darby, 2001; Feinstein, 2005a; Feinstein, 2005b; Fourie, 2006; Lambrou et al., 2005; Salas, 2001; Wade, 1990; Wells, Polglase, Andrews, Carrington & Baker, 2003).

With my research I expect to show that the simple, methodical, procedural structure of the HBLU™ simple phobia process is an effective treatment for simple, subtle phobias. It is time for a new viewpoint on how we perceive phobias and EP. Not only have numerous clinical trials treating phobias with EP techniques been conducted (Andrade & Feinstein, 2004), but incorporating EP with traditional therapies is starting to become a serious consideration when many experienced therapists include EP to compliment the approaches that work for them (Andrade & Feinstein, 2004; Feinstein, 2005b; Schulz, 2007). HBLU™ takes it one step further by including other EP techniques in its protocols and therefore seemed to be the one comprehensive treatment that seemed most appropriate to me in detecting and treating simple phobias.

#### **1.2.1.1. Reasons for relieving subtle phobias of change, transition and progression with HBLU™**

I am interested in people's change, how they change and how I can help them to facilitate progressive transformation in this fast paced world, so that they can live a full and purposeful life. I am further interested in ways to facilitate faster and more effective client progression, in ways where the client can experience the benefits of the treatment in more immediate and noticeable ways. My personal experience with EP helps me to go through continual transformational changes, internal shifts, and provides me with new perspectives on my world. This continual change in me and my world, where I constantly transition from a new paradigm to another and can see the progression in my life inspires me to facilitate similar changes and transitions in my clients.

My reason for wanting to resolve subtle phobias in the context of change, transition and progression is that change and transition can be a frightening experience and according to Bener et al. (2011) such an experience can be terrifying to such an extent that it can create

phobias, which in turn create stress and anxiety in most peoples' lives and can have a negative impact on their interpersonal and intrapersonal lives (Fourie, 2006; Schulz, 2007). When clients come to see me it is usually because they had a change or an unpleasant incident in their lives and want to change from their current undesired state which was created by the incident. My experience and knowledge with EP, especially HBLU™, helped me to look differently at the critical incident that changed the person's life, including their internal and external triggers with the consequences it had on their interpersonal and intrapersonal lives. I realized that the change/incident stopped the client to change towards advancement in their lives. If the client experienced the change as severe enough, it could create a phobia of the change, and halt his/her progression toward the required transition from being for example a working professional to a retiree. When a person cannot accept a divorce or retirement because it was too traumatising for them, they can develop a phobia (Swack, 2007b), and the person who is stuck at the time when the change happened will find it hard or impossible to move on and be present to live life as a single person or a retiree. Change, transition and progression are therefore intertwined with each other and only the client can determine whether he/she has a phobia of change, transition or progression.

Change does not have to be a crisis. If you can change the experience of the crises (Walsch, 2009), by addressing and treating subtle phobias of change, transition and/or progression (which could be fear, shame, fear and shame hybrid, or anticipatory based) can help the client to move forward in his or her life. If the negative emotions and thought patterns underlying these subtle phobias (whether they are phobias of change, transition or progression) are not addressed, and continue to be avoided, individuals might find it difficult or impossible to progress from the old situation where they were married or employed, into the new situation where they are single or retired/unemployed. The phobic reaction may keep them stuck in the old situation, but resolving the phobias can move/progress them toward

change and transition. If their inner experience could be changed with an EP method, like HBLU™, then perhaps they would not fear their change and transition (the movement inherent in the change) and they could move forward and progress towards the goal(s) in their lives.

Although there are studies where specific phobias such as phobias of needles, heights, spiders, darkness, etcetera, and social phobias have been successfully treated with a variety of interventions from systematic desensitization to EP interventions such as Emotional Freedom Technique (EFT), no studies have been conducted on subtle phobias, such as phobias of change, transition and/or progression (Feinstein, 2005a; Feinstein, 2005b; Andrade & Feinstein, 2004; Baker & Siegel, 2005; Darby, 2001; Fourie, 2006; Lambrou et al., 2005; Salas, 2001; Wells et al., 2003). In Feinstein's (2008a) paper where evidence regarding the efficacy of EP treatments were reviewed, the treatment of phobias with EP interventions were addressed, but not in the context of change, transition and progression. Apart from Dr Swack's (2007a; 2007b) personal research and anecdotal evidence, no study has been conducted on the effectiveness of the HBLU™ phobia protocol, nor have phobias of change and transition ever been mentioned. No literature has shown what a phobia of change or transition looks like, how it might influence a client's progression, and how it can be resolved. With my knowledge and experience of EP, especially HBLU™, I was encouraged to think differently about phobias and consider the correlation between change, transition and progression and phobias.

This study aims to reveal and discuss the different symptoms that are associated with subtle phobias of change and transition, show how they affect a person's life and progression towards their goals, and address the potential resolution of the subtle phobias by using the EP method, HBLU™.

A brief history and development of EP follows.

### **1.3. History and development of Energy Psychology (EP)**

EP is thought of as a new concept, even as an unknown concept, but according to Edwards and Edwards (2010) Freud was a pioneer in EP as we know it today. When he developed his original argument for psychoanalysis, he used an “energetic conceptualization” (Edwards & Edwards, 2010, p. 219). EP as a concept has evolved, so when we look at Freud with a contemporary lens of what EP is, he does not fit, however if we look at the original meaning, then Freud does fit because he believed in energy and his ideas like cathexis (charge with energy) and libido (sexual energy) were energetic concepts and showed that his belief in energy influenced his development of psychotherapeutic concepts like dream interpretations and free association (Edwards & Edwards, 2010).

According to Gallo (2005), EP has its roots in Chiropractic Medicine, and specifically in Applied Kinesiology, with the chiropractor Dr George J. Goodheart, who started to develop this “unique method of evaluating bodily functions by means of manual muscle testing” (p. 51) in the mid – 1960’s. He based his approach on the book *Muscle Testing*, written by Kendall and Kendall in 1949 (Gallo, 2005). According to Gallo (2005), Goodheart discovered that there was a relationship between the neuromuscular function, organ health and the acupuncture meridian system. States of health and sickness were therefore in correlation with muscle strength or weakness, which could be discerned by different testing methods (Mollon, 2007). A serendipitous experience brought Goodheart to experience the interplay of the cranial bones, respiration, and different types of muscles and brought him to the cranial-sacral primary respiratory mechanism, which is a diagnostic and treatment tool in one (Gallo, 2005).



These options for diagnosing and strengthening weak muscles, organs and glands can be seen as the essential foundation for a holistic approach to health and the role Goodheart played in EP. Most of his early discoveries and developments were serendipitous by nature and with his keen sense of curiosity and great observation skills, he continued to develop what we know today as EP (Gallo, 2005).

Gallo (2005) found the Meridian Connection in 1966 when he introduced acupuncture to applied kinesiology. He substituted the needles by applying pressure or tapping on the meridian end points. With the use of muscle testing, he discovered the connection between various muscles and meridian pathways, contributing to the existing knowledge of acupuncture that there are interconnections between glands, organs and meridians (Gallo, 2005).

From there, John Thie developed Touch for Health from Applied Kinesiology to make it more available to a wider audience, including lay people. This contributed to several offshoots, for example, Clinical Kinesiology, Educational Kinesiology and the Three-In-One concepts.

Then in the 1970's John Diamond, M.D. was the first to attempt to integrate Applied Kinesiology and psychotherapy, which became known as behavioural kinesiology, thus he was one of the first to extend this work to emotional and psychological states (Gallo, 2005; Mollon, 2007).

In 1979 Clinical Psychologist Roger J. Callahan, Ph.D. studied briefly under Diamond and developed a unique therapeutic approach: **Thought Field Therapy (TFT)**, which not only drew from applied kinesiology, but from other disciplines like acupuncture, NLP, biology, quantum physics (the work of David Bohm) and clinical psychology (Callahan, 2001).

Since Diamond and Callahan, more mental health practitioners have started to develop protocols that are based on applying the principles of acupuncture to psychological issues. The well-known **E**motional **F**reedom **T**echnique (EFT) developed (by Gary Craig) from here and Gallo himself has developed an energy diagnostic and treatment method called ED × TM. Both TFT and EFT require light tapping on the body and face, at the end points of the acupuncture meridians while focusing on the issue or object or the different aspects of it. In this way the clients' anxieties are neutralized (Gallo, 2005; Wells et al., 2003). Tapping on these designated meridian points restores balance to the energy system and neutralizes negative emotions at the source (Khan, Zafar, Giri, & Priyamveda, 2010). According to Swack (2001a) manipulating acupuncture meridian points releases cortisol and opioid peptides and so activates the relaxation response and inhibits the sympathetic alarm response (fight/flight/freeze). HBLU<sup>TM</sup> can be viewed from this Energy Psychology background while integrating the best of biomedical science, psychology, spirituality, applied kinesiology, hypnosis, Neuro-Linguistic Programming (NLP), and other Energy Psychology (EP) techniques, including TFT and EFT. One of the techniques that can be used in co-operation with the HBLU<sup>TM</sup> method, is Natural Bio- Destressing (NBD), a technique Dr. Swack modified form EFT (Appendix P). According to Mollon (2007), none of these new EP methods and techniques is based on theory, but is based on the reality of observation.

These new groups of behavioural interventions, that are based on the above principles, are collectively known as EP and have been proposed as treatment for a variety of anxiety disorders, including phobias (Feinstein et al., 2005; Wells et al., 2003).

As Freud's psychoanalysis was being criticized and labelled as being too time consuming (Edwards and Edwards, 2010), EP today is being criticized for being too rapid to be therapeutic. It seems that Freud set the pace for therapy - to be time consuming. Although it takes time to build rapport with the client, so that the problems and symptoms can be

explored in detail for the appropriate modality to be chosen and applied (Feinstein, 2005a), incorporating muscle testing and the linear approach and structure of an EP method such as HBLU™ speeds up the process and produces measured results. EP may seem non-psychological as it involves not only talking, but tapping on the body, muscle testing, incorporating mind, body, and spirit, and brings swift results. As Feinstein (2005b) mentioned, EP does not replace approaches that already work for therapists, but rather increases the effectiveness of their work by adding a tool to target neurological change, the apparent active ingredient in phobia cures. In the fast paced world we live in today, this criterion for professionalism seems relevant.

Everyone who contributed to the forming of EP did so for many years and built on others before them to refine and simplify the concepts of EP. Currently, new EP methods are continuously being developed, as the field is in a state of constant evolution and expansion (ACEP; Feinstein 2012a; Gruder, 2012). With this background, the next section explains the research objectives.

#### **1.4. Research objectives and question**

Change cannot be denied and it is constantly prevalent in our external and internal worlds. Such changes can be caused by societal changes, such as war or political change, social relocation, such as moving house, changes to the frame of activity, such as a job change, or an alteration in significant relationships, such as a divorce (Zittoun, 2008). Right now there are so many changes happening, from world economics and politics to new thoughts about relationships and marriage. On a personal level, it means that people are losing their jobs, savings and homes, and marriages and partnerships are ending. The fields of medicine and science and technology continue to discover new and innovative ways to advance our world, support our frantic pace of life, and to shift our understanding of how we

thought things were (Walsch, 2009). How we adapt to change or not has an important impact on our lives as it can define the quality of our lives. If the impact of the change is so profound that it leaves us paralyzed with negative emotions and thoughts, we can stay stuck in the past when the change happened and find it hard or even impossible to move on. So when a professional, such as a therapist, has clients who are confronted with life altering changes, they might start asking the “why” questions. Why can the client not forget the person/situation?; Why does the client’s emotions around the incident control and overpower him/her?; Why does the client have all these negative thoughts?; Why can’t the client talk her or himself out of it?; Why can’t the client do what he/ she knows he/she should do? They might also ask why the client does not move through the following five stages that define psychological and behavioural changes: 1) the pre-contemplation stage – no motivation to change, 2) the contemplation stage – start to consider a change, 3) the preparation stage – plan short term change, 4) the action stage – taking action although in danger of a relapse and 5) the maintenance stage – internalization of new behaviour (Dijkstra, Tromp & Conijn, 2003).

When we are familiar with the nature of phobias, we become aware of their subtle occurrence in our lives. The symptoms such as high anxiety, other negative emotions and avoidance behaviours might be obvious, but associating the symptoms with a phobia might be less obvious. This brings us to the research question: *Does HBLU<sup>TM</sup> (with its integrative approach as an Energy Psychology method) successfully detect and resolve subtle phobias regarding change, transitioning and progression?*

My first research aim therefore is to introduce an alternative way to view phobias from the HBLU<sup>TM</sup> perspective.

Once a client's symptoms are noticed, the presence of a subtle phobia can be detected and identified.

My second research aim, therefore, is to look at the person's symptoms and correlate them to a subtle phobia of choice which, in this study, involves phobias of change, transition and or progression.

Just diagnosing the client with a subtle phobia might bring some relief from the anxiety of not knowing what is wrong, but it might not help them to move on from the unfortunate incident/change which created such paralyzing distress. The event happened, but their reality about the event does not have to be the same. They can change their perspective of the event, which will change the reality of the event (Walsch, 2009). When clients have read self-help books, gone to seminars, followed advice, and are still not able to progress, they can become frustrated with their own unsuccessful efforts to progress and can feel hopeless, anxious and discouraged at this stage. They will need something to help relieve their symptoms and their negative perceptions of the event, so that they can move/change successfully into a new identity, for example from being a married person to a divorcee.

My third research aim is to determine if the phobia protocol of an EP method like HBLU<sup>TM</sup> can resolve subtle phobias, such as phobias of change, transition and/or progression, successfully and relieve the client of the associated symptoms.

Exploring the nature of phobias of change, transition and/or progress, and testing whether the HBLU<sup>TM</sup> simple phobia protocol can successfully detect and treat subtle phobias, such as phobias of change, transition and/or progress will hopefully contribute to new insights into phobias, how they can alternatively be viewed, and the role EP plays in the treatment of subtle phobias. It can further bring insight to what an integrated part of our lives phobias are, and when incorporated in therapy, how they can help to fuel progression in the

therapeutic situation and support progressive growth in a person's life.

## **1.5. Presentation**

Chapter 1 introduced the topic by referring to the connection between phobias and change, transition and/or progression, and explained the reasons for wanting to relieve individuals of their subtle phobias of change, transition and/or progression with HBLU™. This chapter also covered the history and development of EP and lastly covered the research question and objectives.

Chapter 2 aims to delineate the background to the research question: *Does HBLU™ (with its integrative approach as an Energy Psychology method) successfully detect and resolve subtle phobias regarding change, transitioning and progression?* by presenting the current literature on EP, phobias, change and the various treatments for phobias, including EP treatments.

Change and transition will be looked at before the etiology, prevalence and characteristics of phobias, conventional phobia treatments and the development of phobia treatments are reviewed and Energy Psychology is explained. This chapter portrays EP's effectiveness from an energetic point of view and includes acknowledgements of its efficacy, after which phobia resolution with HBLU™ and the EP approaches and techniques incorporated with the HBLU™ phobia protocol are described.

Chapter 3 consists of the method. It provides a description of the rationale for the chosen research design, the selection of data collection, research participants, data analysis, and a section on ethics.

Chapter 4 presents the research findings for the ten research participants.

Chapter 5 discusses the findings of the study. It also includes the interventions and the outcomes after administrating the HBLU<sup>TM</sup> simple phobia protocol directly after treatment, one week and two months after treatment. It also discusses the clinical implications of the findings, and provides a presentation of the HBLU<sup>TM</sup> simple phobia method as a working model integrated with a phobia therapy session, also which is graphically displayed in figure 5.1.

Chapter 6 covers the results, which comprise an integration of the major research findings, the answer to the research question, the limitations of the study, and suggestions for future research in EP.

## **2 REVIEWING THE LITERATURE: DEEPENING OUR UNDERSTANDING OF THE ENERGY PSYCHOLOGY APPROACH TO THE TREATMENT OF PHOBIAS**

The purpose of this study is to explore the effectiveness of an Energy Psychology method, HBLU™, in the resolution of phobias in the context of change, transition and progression. In chapter 1, I questioned whether HBLU™ an energy Psychology approach, can detect and resolve subtle phobias of change, transition and progression. Phobias, their correlation with change, transition and progression and the HBLU™ treatment approach of phobias are now further examined, so that phobias and their treatment can be viewed from a perspective which allows individuals to progress. The participants' changes and transitions, which resulted in specific phobias of change or transition, their progression or lack of it, their resulting phobias and the treatment of the phobias are of interest.

In this chapter the existing literature is reviewed with regard to the constructs change, transition, phobias, Energy Psychology, and phobia treatment in the context of Energy Psychology.

We will first look at change, transition and phobias and then at the six academic viewpoints on the etiology of phobias and the prevalence and characteristics of phobias. We will also look at conventional phobia treatments, Energy psychology and finally we address phobia treatments, including HBLU™, in the context of Energy Psychology.

### **2.1. Looking at change and transition**

#### **2.1.1. Phobias, change and cognitive dissonance**

Before we look at the correlation between phobias, change and cognitive dissonance, let's view the different definitions and viewpoints of cognitive dissonance. The online Oxford dictionary defines cognitive dissonance as "the state of having inconsistent thoughts, beliefs,



or attitudes, especially as relating to behavioural decisions and attitude change.” The online Merriam Webster dictionary explains cognitive dissonance in the medical dictionary as a “psychological conflict resulting from simultaneously held incongruous beliefs and attitudes (as a fondness for smoking and a belief that it is harmful)” and in the online Concise Encyclopedia as “a mental conflict that occurs when beliefs or assumptions are contradicted by new information.” We can conclude that when a person holds two incongruent attitudes or perceptions (for example expectations versus reality) or have two thoughts or a belief and behaviour that are in conflict with each other, these noticeable inconsistencies create a state of cognitive dissonance. For example, a religious Jew who does not follow a kosher diet would likely experience dissonance.

This theory was first introduced by the psychologist Leon Festinger in 1957. Festinger found that when most people are confronted with challenging new information which tests their old beliefs and creates dissonance, they will experience feelings of discomfort. In an attempt to correct the state and negative emotions, they will create consonance by maintaining congruency between the conflicting cognitions, perceptions or cognitions and behaviours. They can try to preserve their current, familiar understanding/perception of their world and reduce the dissonance by using the following strategies: 1) reject, avoid or reduce the importance of the new information/conflicting belief or behaviour, 2) rationalize it away or 3) convince themselves that there is no conflict (Colman, 2006; Huber, 2007; online Merriam - Webster dictionary; Oxford dictionary). Heflick (2011) and Tomasulo (2012) add that part of the rationalization is: 1) to adjust the thinking process and beliefs to create agreement between cognitions (for example focus on more supportive beliefs that outweigh the dissonant behaviour or belief), or 2) change one of the dissonant aspects, for example, adjust a behaviour (eat less to lose weight), adjust a belief after a behaviour (eating healthier can improve diabetes) or adjust the perception of what actually happened.

Because people seek consistency in their beliefs, perceptions and behaviours, they continually strive for harmony to eliminate the feeling of discomfort that is created by cognitive dissonance. Something must change to eliminate or reduce the dissonance (Fritscher, 2011). When the conflict is resolved by adjusting/changing a belief, behaviour, perception or attitude to reduce the dissonance, and the cognitions become consistent with each other or a belief is consistent with a behaviour, conflict disappears and the person's attitude changes. Therefore, resolution of cognitive dissonance can be considered as an explanation for attitude change (Huber, 2007). We might even logically reason that resolution of cognitive dissonance is also an explanation for behavioural change. According to Zittoun (2008) the quality of change should consider a person's wellbeing (for example the emotional state) and adaption to the social environment. She assumes further that changes that contribute to further changes are developmental, but changes which create alienation from the self and the environment are non-developmental. Therefore one can argue that where there is change and consequential development there is progression, and where there is a lack of change and development, there is a lack of progression.

When a person has a phobic reaction, their ability to change a thought, attitude, perception or behaviour is impaired because of the psychological and physiological nature of the phobia (Swack, 2002; 2007b). One can thus reason that neutralizing a phobia can help to resolve cognitive dissonance, by increasing the person's ability to make better judgments, choices and evaluations to support progression. Cognitive dissonance can be created through classical conditioning (the Pavlovian theory). We can see this happening when a divorcee needs to change into single status, but he/she finds it hard or impossible to do because the individual is conditioned to be part of a dyad. He/she thus finds it hard to perceive him/herself as single. A phobia of change can make this transition even harder as most people want to believe that they have good judgment and make good choices, but their new reality

brings conflict to their old beliefs which create the dissonance. In order to reduce the dissonance between belief and perception or attitude they will use some or all of the above named strategies to reduce the dissonance. If they are unable to do that, their feelings of discomfort and anxiety can increase, as well as other phobic symptoms (Fritscher, 2011).

### **2.1.2. Phobias and Psychological transitioning**

When there is a change in a person's life which requires transitioning from one stage of life to another or from one role to another, we can call it psychological transitioning as psychology is the "mental characteristics or attitude of a person or group" (online Oxford Dictionary) and transition means "the process or a period of changing from one state or condition to another" (online Oxford Dictionary). Zittoun (2008) says transitions can be seen as "processes that follow ruptures perceived by people. They include learning, identity change, and meaning making processes" (p. 164). Ellis (2010) adds that major life event changes should be referred to as transitions and mentions that these transition processes take longer than most people are aware of. These ruptures or changes, in which regular functioning and situations are disrupted of their usual flow, and adjustments are sped up to create newness, such as new emerging forms of conduct, have been studied by many such as Dewey, Peirce and Schutz (Zittoun, 2008).

I, myself, have experienced many changes and transitions in my life. One significant example was when I moved from one country to another (social relocation), loss of my job (change the frame of my activity) and transitioned from being a single person to being a married person (an alteration in a significant relationship) at the same time (Zittoun, 2008). I left one situation and place for a new one and there is often, if not always, a mixture of emotions which happen simultaneously. I felt sadness to leave a familiar place and people and excitement and anticipation for the new possibilities in the new place and in my new

status. The change from the known to the unknown can feel unsafe and make one feel less confident (Lickerman, 2010), and the transition requires behavioural and cognitive adaptations which serve to create alternative world views that enable us to respond resourcefully to our new reality (Ellis, 2010). I had to develop new forms of conduct for solving conflicts, for coping, for being resilient, and for constructing new schemes, as Zittoun (2008) suggests and use these “processes of transition” (p.165) to find a new form of stability so I could continue to function. Zittoun (2008) suggested that transition processes are: 1) identity processes, 2) knowledge acquirement and 3) sense making. I went through all three stages when I went through the identity processes in order to adjust to my new identity as an immigrant and as a married woman. Because transition involves changes in a person’s physical and figurative world, new possibilities, goals and actions are required. You are confronted with others and their reaction towards you and the position you fill now which might be the replacement of another, and this repositioning of roles suggests that your identity is changing (Zittoun, 2008). To overcome the unknown of my new status and new location, I tried to gather more information and knowledge about my new country in the hope that it would eliminate some of the unknown, and I tried to learn what I could expect. By knowing what I would face, I hoped to eliminate some of the fear and the “dangers” of the unknown and how to behave to become a member of my new society and in such a way receive validation from others (Zittoun, 2008). I tried to make sense of my new situation by talking and writing about it, but no amount of information, rationalization or other’s experience can really prepare you for your own personal change and transition and the unknown still created paralyzing fear, especially when there was no validation of who I am or was (Zittoun, 2008).

People respond differently to changes in their lives, and Ellis (2010) states that models of transition such as the concept of transition which was developed by Fisher from

the Personal Construct Theory by Kelly can describe how people respond to changes in their internal world and their environment and offer some insight how “the mind reconstructs itself to adapt to a new reality” (p. 1161). Because change is a subjective experience, an individual will have a personalized interpretation of how they define and make psychological sense of their changed reality which consists of five phases according to the Personal Construct Theory: 1) long or short term anticipation of the future, 2) commitment to the new reality, 3) involvement in the new reality, 4) making sense of the new reality through validation or confirmation/ invalidation or disconfirmation of the new reality and 5) the change in the person leads to constructive revision of anticipations (Ellis, 2010). Going through these phases, a person can also experience nine emotions during their transition which Fisher views as the stages of transition: 1) anxiety, 2) happiness, 3) fear, 4) threat, 5) guilt, 6) depression, 7) disillusionment, 8) hostility and 9) denial (Ellis, 2010).

Both Lickerman (2010) and Barth (2010) suggest practical ways to improve the period of transition and to view it as a time to practice self-improvement. Lickerman (2010) suggested to: 1) do one thing at a time, 2) to view the transitions (even negative ones such as a divorce) as adventures by seeing the value in hardships and 3) to remake and improve your reputation or self-view, by changing yourself. If you can therefore direct yourself, you will find it easier to direct your transitions. Barth (2010) suggests the following strategies to cope with transitions: 1) to recognize that mixed feelings regarding the transition are normal, 2) to realize that the mixed feelings do not make your decision wrong, 3) to put the confusing, mixed feelings into words by talking to someone about it, 4) to allow yourself time to reflect on both the positive and negative aspects of your change and transition and 5) to give yourself enough time to adjust to the new situation and or role and remember that the new situation will change with time. Through my personal experience I agree with Barth and Ellis that one does remember that which one has left behind as more positive than it might have

been. By comparing the old positive memory with the new situation, conflict is generated between the existing values and beliefs of the positive memory and the new anticipated changed values and beliefs. By remembering only the positive aspects, I increased the positive attributes of the places and people I left behind, and my memories about what was, are less complex than the actual situation was, thereby reinforcing my past values and beliefs.

These strategic arguments seem logical, but if an irrational fear is involved, such as a phobia, then these practical behavioural and tangible steps might seem impossible and illogical to a phobic person as rationalizing appears to have an insignificant effect on eliminating or reducing the phobic response (Gallo, 2005). Ellis (2010) mentions that because the transition process takes so long to move through, it often takes place subconsciously.

Let us now have a closer look at the etiology, prevalence and characteristics of phobias.

## **2.2. Phobias**

### **2.2.1. Etiology of phobias**

A phobia according to Plotnik & Kouyoumdjian (2008) is “an anxiety disorder characterized by an intense and irrational fear that is out of all proportion to the possible danger of the object or situation. Because of this intense fear, which is accompanied by increased physiological arousal, a person goes to great lengths to avoid the feared event. If the feared event cannot be avoided, the person feels intense anxiety” (p. 518), and Fourie (2006) adds that avoiding the feared event, situation or object keeps the phobia alive. Phobias are further viewed as subcategories of anxiety disorders (Bener et al., 2011; Plotnik & Kouyoumdjian, 2008).

Research shows that the cause and origin of phobias can be genetic, biochemical, cultural, psychoanalytical, cognitive and behavioural (Furnham, 1995; Plotnik & Kouyoumdjian, 2008; Salas, 2007).

Genetic factors may increase the chances for similar phobias to develop in families (Fritscher, 2008; Furnham, 1995; Villafuerte & Burmeister, 2003), although the identified number of risk genes which could contribute to the etiology of anxiety disorders are too low to be of any diagnostic value (Domschke & Deckert, (2010).

Furnham (1995) mentions that according to the biochemical viewpoint certain people are more susceptible to phobias than others because of the differences in their brain chemistry.

There are culturally specific phobias such as Taijin Kyofusho, a fear of offending or harming *others* in social situations, for example through staring or making eye contact, which literally translated from Japanese means “fear of interpersonal relations” (Plotnik & Kouyoumdjian, 2008, p. 522). This subcategory of a social phobia is prevalent in Japan which can make a person avoid social interactions all together. According to Plotnik & Kouyoumdjian (2008) culturally specific phobias are created by the unique cultural values and expectations of a culture which is learnt (Furnham, 1995). The cultural origin of phobias makes it different from other social phobias where the phobic person is afraid of being *personally* embarrassed or humiliated in social situations (Plotnik & Kouyoumdjian, 2008).

Phobias originate from early childhood experiences according to the psychoanalytical (Freudian) viewpoint and can have symbolic meaning deriving from the subconscious, for example a fear of snakes (ophidiophobia) being a smokescreen for a real inappropriate subconscious fear to have sexual feelings for inappropriate others (Furnham, 1995).

However, Furnham (1995) found in his investigation about the nature of phobias that observational learning and behavioural pairing can contribute to the cause of phobias. From this behavioural viewpoint Furnham (1995) and Plotnik & Kouyoumdjian (2008) mention

that a phobia can be learned when someone observes the fearful reaction of a situation or object in others and that one can be conditioned to associate fear with a frightening experience, situation or object in the past such as John Watson's study of Little Albert who was trained to fear white rats (Furnham, 1995; Plotnik & Kouyoumdjian, 2008; Salas, 2007). From the cognitive viewpoint a phobia can develop after a specific traumatic situation because of the person's perception and cognitive interpretation of the situation. If the person perceives the situation or object as harmful, it may increase fear and anxiety and create a phobia according to Bener et al. (2011) and Furnham (1995). If an individual then associates an object or situation with a traumatic event, it can create phobic reactions to objects and situations that appear not traumatic (Furnham, 1995). Fourie (2006) linked the two viewpoints as cognitive behavioural input, in which the person who was frightened earlier and then learned/was conditioned to perceive the situation/object as harmful and as a result developed a phobia. Feinstein et al. (2005) hold the viewpoint that phobias are caused by memories of a distressing event and therefore might be a conditioned response.

There are new viewpoints emerging on the etiology of phobias which have their foundation in energy psychology. Energy psychology is a "branch of psychology that studies the effects of energy systems, such as the acupuncture meridians, chakras, morphic resonance on emotions and behavior" (Gallo, 2005, p. 227). Callahan (one of the pioneers in EP) believes that most specific phobias are hereditary, although not in the genetic sense. Through clinical experience, Callahan started to realize the role energy plays as the primary component of psychological problems and his focus shifted away from more traditional viewpoints such as cognition, behavioural and psychodynamics, which he came to view as secondary components (Gallo, 2005). This subtle energy is often referred to as qi or prana, which many believe to be largely electromagnetic (Gallo, 2005) and which includes not only



the electromagnetic fields surrounding the whole body, but each organ, the electrical pathways in the nervous system and the electrical charge in every cell of the body (Khan et al., 2010). Callahan discovered that psychological problems, including phobias, could be further distinguished according to specific energy meridians/pathways through which this energy flows. He came to the conclusion that all negative emotions are caused when a distressing awareness/association about an experience and or object (for example the awareness of elevators) enters the person's thought field (thoughts which contain "subtle energy features" (p. 90) as well as sensory, linguistic, neurological and chemical features) and causes disruptions within the energy system (Gallo, 2005). Khan et al. (2010) added that experiences associated with psychological problems have a chain reaction where the brain sends out electrical signals which in turn lead to an emotion, a perception or a behaviour. The person might experience external (confronting situations) and internal (image, thought or recurring memory) triggers which could activate this chain reaction (Khan et al., 2010). When these disruptions in the energy field are removed by working directly with the energies maintaining the pattern, the psychological distresses are lessened (Gallo, 2005; Khan et al., 2010).

According to Dr Swack phobias are imprinted mentally and physically the moment when someone first feels the shock, fear or surprise of a traumatic experience. This "phobic – trauma imprint" (p. 65) is the consequence of the fight-flight-freeze reflex. The moment the phobia is imprinted, all the associated stimuli are imprinted as well and can later be triggered to offset the fight-flight-freeze responses which can be seen in physiological (for example rapid heartbeat, sweating, inability to move) and psychological (for example numbness, feeling stuck or blocked in one's life, feelings of dissociation or exaggerated or irrational emotional reactions) phobic reactions/characteristics (Swack, 2002).

All these viewpoints have an effect on the future treatment approaches, which will be discussed in this chapter, but first we will look at the prevalence and characteristics of phobias.

### **2.2.2. Prevalence and characteristics of phobias**

In essence, anything has the possibility to become a phobic stimulus and therefore the number of potential phobias is limitless. Phobic names are often related to the phobia at hand (combining an English (computer phobia), a Latin (claustrophobia) or a Greek prefix with a Greek suffix – *phobia* - from the Greek *phobos* (+ *ia* indicating a condition or quality)(Colman, 2006). According to Colman (2006) phobias can be diagnosed as a mental disorder where they are either a social or a specific phobia when the phobia leads an individual to experience "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 571). Phobias are the most common form of anxiety disorders for which people seek treatment (Fourie, 2006). According to Plotnik & Kouyoumdjian (2008) social phobias are the most prevalent, followed by specific phobias, but Bener et al., (2011) and Jensen & Ramasamy (2009) reported that specific phobias are more prevalent under adult Americans. In the study where Bener et al., (2011) examined the prevalence of common phobias in children and adolescents in the State of Qatar, he found that social phobias were the most prevalent, followed by agoraphobia as the second most common phobia and specific phobias as the third most common phobia. Social, specific and agoraphobia are viewed as common phobias (Plotnik & Kouyoumdjian, 2008) and Bener et al., (2011) mentioned that the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) categorizes them under anxiety disorders, although he mentioned that agoraphobia is more commonly associated with panic disorders.

A social phobia is defined as a “marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others” (American Psychiatric Association, 2000, p. 456). Such a person has an intense fear of personal embarrassment, humiliation and or scrutiny created by other people or social situations which can include parties, meeting strangers, public speaking or interacting with authority figures (Bener et al., 2011; Rowa & Antony, 2005). They have unrealistic expectations about their performance and behaviour in social situations where they believe they cannot meet these expectations because of personal shortcomings (Stopa, 2009), a lack of self-respect, self-devaluation, and by projecting this disdain on others (Leichsenring, Beutel, & Leibing, 2007). Although social phobias are “a very frequent mental disorder” (p. 56) which has an early onset with consequences of severe psychosocial impairments and high socioeconomic costs, there exists no manual for the psychodynamic treatment of social phobias (Leichsenring et al., 2007). Approximately 6.8% of the American adult population suffers from social phobias (Bener et al., 2011). Although individual responses might vary, the symptomatic consequences as the anxiety builds up about the impending social situation are similar and consists of the following: 1) amplified physiological distress (nausea, increased heart rate, difficulty breathing, inability to move, blushing and sweating) which encourages, 2) negative, inaccurate and distorted mental images/impressions and evaluations of the self and how they appear to others based on underlying beliefs (e.g. “Everyone thinks I am dumb”, “They will be negative and critical of me”), 3) the distorted self-view results in the inability to process feedback accurately and leads to increased self-focused attention and ignoring useful social cues from others, 4) which leads to avoidance behaviours (Morris & Ale, 2011; Rowa & Antony, 2005; Stopa, 2009; Swack, 2002). The focus on misperceived threat in social situations can have a devastating effect on the person’s quality of life (Rowa

& Antony, 2005). Although the person realizes that the fear is irrational, he or she is unable to contain it and as a result could avoid the social situation (Plotnik & Kouyoumdjian, 2008).

Specific phobias are what the name suggest, an excessive and irrational fear of a specific panic trigger which can range from arachnophobia (fear of spiders) to zoophobia (fear of animals) (Bener et al., 2011; Colman, 2006; Fourie, 2006). These unreasonable and persistent fears can be triggered by the anticipation or the exposure to a specific object or situation (American Psychiatric Association, 2000). For example if a person was bitten by a dog, or had a traumatic flying experience, he or she might develop an irrational fear of dogs (canaphobia or cynophobia) or flying (aerophobia or aviophobia) and as a result avoid dogs or flying at all costs or endure the phobic stimulus with dread (Colman, 2006; Fourie, 2006). Bener et al. (2011) states that 8.7% of the adult American population suffers from specific phobias, but it was only the third most prevalent common phobia in children and adolescence in the State of Qatar. Plotnik & Kouyoumdjian, (2008) explained that there is a variation of content and occurrence of specific phobias in different cultures. As with social phobias, specific phobias can have a negative impact on a person's quality of life because it disrupts their lives and can limit work efficiency, reduce self-esteem and strain relationships (Jensen & Ramasamy, 2009).

Agoraphobia is categorized by intense anxiety of experiencing a panic attack or having sudden, unexpected panic like symptoms such as diarrhea, in places where escape might be difficult or embarrassing (Bener et al., 2011; Plotnik & Kouyoumdjian, 2008). This phobia as with social and specific phobias can have a debilitating effect on a person's quality of life.

Although phobias of change or transition can be viewed as a specific phobia because a person is triggered by a specific event – the change or transition in their lives - I decided to

refer to phobias of change and/or transition as subtle and not specific because each event was specific to the person and not tangible and therefore hard to detect. And as Fourie (2006) discusses in his paper “Treating phobias or treating people?”, phobias are not socially isolated incidents, but happen in multifaceted social situations, involving interpersonal relations. Fourie (2006) also maintains that interpersonal factors influence the materialization and treatment of phobias. Because of the hidden nature of the fear trigger (change or transition), the appearance of the phobia is subtle, and can only be revealed as a phobia through 1) muscle testing and 2) through certain phobic characteristics such as a) language (for example when an individual mentions that he/she feels frozen, and/or mentions that he/she experiences high levels of anxiety, fear and other distressing emotions), b) behaviour, such as being unhelpful /not cooperating, c) having negative thoughts, d) panic attacks, e) disrupted lives, f) decreased work efficiency, g) strained relationships, and h) an overall negative impact on the person's life.

Should such phobias persist into adulthood, they will become chronic if they are not treated (Bener et al., 2011; Plotnik & Kouyoumdjian, 2008). The following section will therefore explore the different treatments that are available and have been used in the treatment of phobias.

## **2.3. Phobia treatments**

### **2.3.1. Conventional phobia treatments**

“Most mainstream psychologists actually believe that phobias can’t be cured”(Callahan, 2001, p. 135.), but Silverman, Pina, & Viswesvaran (2008) found in their review that substantial progress has been made in evaluating the effectiveness of psychosocial treatments for phobic children and adolescents.

Some conventional phobia treatment approaches are Behaviour Therapy, Cognitive Therapy, and Cognitive Behavioural Therapy (CBT). A collection of psychotherapeutic techniques such as Reciprocal Inhibition (RI), Systematic Desensitization (SD), flooding, and modelling are incorporated in behavioural therapy to alter unwanted or maladaptive behaviour patterns (Colman, 2006; Plotnik & Kouyoumdjian, 2008; Salas, 2001). Another form of conventional treatment is the use of drugs to control symptoms (Plotnik & Kouyoumdjian, 2008).

Behaviourists explore the relationship between behaviour and context, and behaviour therapy therefore identifies, changes, modifies, and replaces specific maladaptive, disruptive, undesirable, existing behaviours with certain adaptive alternatives to improve human functioning (Colman, 2006; Gallo, 2005; Plotnik & Kouyoumdjian, 2008). According to the behavioural perspective environmental factors such as stimulus-response and conditioning principles regulate behaviour (Gallo, 2002). Principles of operant conditioning are used in Behaviour Therapy since traumatic symptoms are viewed as classical (Pavlov's work) and operant (Skinner's work), and therefore conditioned responses can be unlearned (Plotnik & Kouyoumdjian, 2008; Schulz, 2007). Although behaviourists can acknowledge the fact that conditioning is an occurrence which manifests from within the person, the cause or trigger for the phobic reaction can be external/environmental (Gallo, 2005). With this approach to conditioning and learning, the phobic individual will learn to perform new behaviours and meet specific behavioural goals through practicing the new behaviours and by receiving rewards for their successful performances (Colman, 2006; Plotnik & Kouyoumdjian, 2008).

Systematic Desensitization (SD), specifically developed for treating phobias, is a specialized application of the behaviour therapy technique called Reciprocal Inhibition (RI). When RI is applied, an individual is simultaneously exposed to an anxiety provoking imaginary phobic stimulus while exercising a physiologically incompatible response to fear

and anxiety, such as deep muscle relaxation.

When an individual is taken through such a hierarchy of *increasingly* anxiety-provoking images and/or narrations (*in vitro exposure* – a mental image ranging from the least frightening item or situation to the most frightening) or being exposed to the actual phobic stimulus, for example a needle (*in vivo exposure*) or by using computer–simulated scenes (*virtual reality*), without the option to escape, while simultaneously exercising a physiologically incompatible response to fear and anxiety, such as breathing, it is called **Systematic Desensitization (SD)** (Colman, 2006; Fourie, 2006). If a real life phobic stimulus is not possible, **Virtual Reality (VR)** (a computer–generated reality, created through computer graphics and sensory input devices) can be used (Fourie, 2006). A person’s anxiety can be reduced in the presence (and not avoidance) of the phobic stimulus by repeating this experience, because it is assumed that avoidance keeps the stimulus - response intact (Fourie, 2006; Gallo, 2005). If the experience is repeated the bond will be severed after a period of time when it was proven that there was no value to their fear for the object and the symptoms will vanish (Gallo, 2005). **Progressive Relaxation**, where skeletal muscles throughout the body are first tensed and then deeply relaxed, can be used in conjunction with RI or SD to soften the exposure procedure (Colman, 2006; Gallo, 2005).

The therapist has to prepare the client for the three-step process of SD which consist of: 1) teaching clients prior to the exposure session how to induce a relaxed state with techniques such as progressive relaxation, diaphragmatic breathing or bilateral stimulation, 2) constructing a hierarchy from the least frightening item or situation to the most frightening and finally 3) beginning to expose the client progressively to the feared situation (Colman, 2006). SD, *in vitro*, *in vivo*, or a hybrid of the two is able to relieve phobic symptoms (Fourie, 2006). Salas (2001) mentioned that SD is the most widely used and successful treatment procedure for phobias and Leichsenring et al., (2007) add that it is particularly

important in the treatment of social phobias. According to Fourie (2006) the in vivo procedure is considered more effective than the in vitro procedure because the “realness” of perception plays an important role in the success of this specific treatment. This technique is mostly used by behaviour therapists, can take from 5-30 sessions (Plotnik & Kouyoumdjian, 2008) and should be practiced regularly, possibly every day (National Phobics Society – NPS - in the United Kingdom). Furnham (1995) found that lay people have understandable theories about the cure of phobias, and he reported that the phobic subjects' belief in SD was the most effective phobia treatment.

Flooding/ exposure therapy/ implosion therapy is another technique of behaviour therapy used to treat phobias. During this treatment an anxious individual is exposed “intensively to the anxiety-producing situation until the anxiety subsides” (Colman, 2006, p. 289). This treatment can be done in vivo, in vitro or through **V**irtual **R**eality (VR). If the client is exposed to and kept in a highly stressful imagined situation until the anxiety and fear diminishes, it is called *implosion* and if kept in an in vivo situation it is called *flooding*. Clinical studies suggested that this type of treatment is an effective phobia treatment, although therapists are hesitant to use it because the unrelenting exposure seems to be harmful to clients (Salas, 2001). According to Sturgis & Scott (1984) a longer (the exact treatment exposure time is vague) in vivo exposure and therapeutic encouragement towards exposure might be one of the best therapeutic choices for phobia treatment and is therefore in line with Freud’s recommendation for phobia treatment (Leichsenring et al., 2007). In a study by Furnham (1995) the results show that flooding may be the most successful way to treat phobias in people whose disposition makes them susceptible to phobias, but the subjects were strongly opposed to flooding as a treatment choice.

Another form of behaviour therapy, which is based on social learning and which can be used for treating phobias, is modelling. The client learns appropriate patterns of behaviour



by reproducing the behaviour of another person who demonstrates the desired behaviour. In this case contact and behaviour with the phobic situation or object is necessary and the therapist will encourage the client to repeat the modelled behaviour (Colman, 2006; Salas, 2001).

Cognitive Therapy (CT) was developed to make a person aware of, to identify and change/correct negative self-statements which come from involuntary maladaptive thoughts (such as “I am a failure” or viewing a negative outcome) which are thoughtlessly repeated to themselves, and to replace these specific negative, distorted, maladaptive thought patterns and the dysfunctional, anxiety provoking self-talk with adaptive alternatives (Colman, 2006). From the cognitive point of view, anxiety is caused by the person’s internal processing of information attained through the senses, with the focus on the interrelationship of language and emotions rather than by environmental stimuli (Gallo, 2002; 2005). The irrational thoughts and internal dialogue can be accompanied with vivid and frighteningly convincing internal images/scenarios of the negative consequences (Gallo, 2005). Aaron Beck (the originator of Cognitive Therapy) thought these automatic negative thoughts, which seem real and believable at the time, create a distorted worldview and self-view and therefore influence behaviour and feelings and contribute to various emotional problems and symptoms such as depression (Colman, 2006; Plotnik & Kouyoumdjian, 2008).

Since language is the main focus of this therapy the therapist can respond in a forceful directive manner, by using Albert Ellis’s approach of the *Rational Emotive Behaviour Therapy* (REBT) or the more nondirective manner of Aaron Beck’s *Cognitive Therapy* (CT). The clients are encouraged to challenge the legitimacy of their irrational thoughts and their distorted images and negative self-talk, by disputing their catastrophic thinking or by reframing their internal narrative and imagery in order to alter their responses (Gallo, 2005). To change the thought patterns, the clients are 1) told about the consequences of their

irrational thoughts and beliefs, 2) they are shown how to recognize and self-monitor (observation without making changes) their thoughts, 3) exercising the thought-stopping procedure (saying stop and counting to ten). Leichsenring et al. (2007) add that personal devaluation (negative self-talk) should be corrected and be prohibited during therapy, and 4) their negative thoughts patterns and beliefs should be substituted with a positive opposite according to Plotnik & Kouyoumdjian (2008). The National Phobics Society (NPS) in the United Kingdom, have 3 main stages for cognitive restructuring, namely: 1) identify the exact content of the debilitating thoughts, 2) verify the accuracy of the thought which can include collecting evidence to compare with the thought and 3) reconsider the thought after comparison with the evidence collected (test the thought by for example exposure to see whether it is true or not).

Both Behavioural and Cognitive therapy developed because of their creators' dissatisfaction with psychoanalysis and they believed that a more effective way to modify human behaviour occurs through learning principles and not through psychoanalytical concepts (Colman, 2006). As a result these two therapies were combined into what we know today as **Cognitive-Behavioural Therapy (CBT)** which assists people to overcome their anxiety by identifying and changing specific thoughts and behaviours (Plotnik & Kouyoumdjian, 2008). The steps included in the therapy are designed to modify these anxious thoughts and behaviours by looking at them and challenging them (Colman, 2006). These steps are: 1) identifying thoughts and behaviours that need change, 2) self-monitoring thoughts and behaviours to identify exact content, 3) setting specific goals which increase in difficulty, 4) learning to strengthen oneself to reach a goal, 5) applying a behavioural technique such as RI, SD, flooding or modelling new behaviours, 6) substitute negative thoughts with positive ones, 7) practice new behaviours in a safe environment before exercising them in a real life situation (Colman, 2006; Plotnik & Kouyoumdjian, 2008;

Schulz, 2007). Silverman et al.(2008) evaluated 32 studies on the status of evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents and found that cognitive behavioural treatments lead to positive treatment responses. However according to Fourie (2006) exposure-based treatments cannot be sufficient for the treatment of phobias if we take into account the socially complex situations in which most phobias occur and realize that they do not only occur within the person's mind, but interpersonally and socially as well and we should therefore also consider the social context of the phobic situation.

In the mid-1950's the discovery of an antipsychotic drug, Chlorpromazine which falls under the Phenothiazine group and reduces the effects of the neurotransmitter dopamine, changed the treatment of psychological disorders. If psychoactive drugs are used to change the biological dynamics in the treatment of mental disorders, it is called Medical therapy. This type of therapy can have unwanted side effects and a person can develop an intolerance towards the drug, and although the drug can be effective to reduce some of the phobic symptoms, when the person discontinues using the drug, the phobic symptoms can return (Plotnik & Kouyoumdjian, 2008). Using psychotropic substances (for example: marijuana, beta blockers or alcohol) is a kind of avoidance behaviour for individuals with a social phobia and can hinder emotional experiences/processes necessary for progress during psychotherapy (Leichsenring et al., 2007). In his study Furnham (1995) found that his research subjects did not think drugs were an effective way to treat phobias. Gallo (2005) reminds us that we have to recognize that we are not only spiritual, conscious, subconscious, cognitive and behavioural beings, but chemical beings as well with neurotransmitters, hormones and blood levels of oxygen also playing a role in our human functioning, including the manifestation of psychological function and dysfunction. Therefore psychotropic medication can be prescribed

to regulate neurotransmitters and bring symptomatic relief and in some cases patients can discontinue the drug without the return of symptoms (Gallo, 2005).

All of the exposure therapies address the characteristics of phobias where subjects have to confront and not avoid the feared situation in order to reduce their irrational fear. It is therefore important to remember that not only are the techniques important, but the social context and the client-therapist relationship as well. In this relationship the therapist can explain how the problem is viewed by the therapist and why a certain treatment modality or combination of modalities is chosen (Fourie, 2006). Because of the role of interpersonal factors, more than one treatment modality can be applied as Fourie (2006) suggested in the presentation of his two case illustrations to show how phobic behaviour is often entrenched in a social context. This process contributes to the therapeutic outcome as the therapeutic relationship and therefore the humanity is highlighted, and therapists are made more aware of their non-judgmental role of acceptance and respect. The therapist should continue to guide the client successfully through the process of facing his/her irrational fear till the end until the fear has subsided, in a respectful manner (Fourie, 2006).

We can see that these treatment methods work closely together with the character of the phobias, and rely strongly on the client's behaviour and on reconditioning. These treatments take time (can take 6-16 exposure sessions of 60-90 minutes), use repeated exposure and can strain a client further and might not always be successful (Feinstein, 2010; Gallo, 2005). These techniques are reliant on Pavlovian fear conditioning (a neutral stimulus is paired with an aversive stimulus several times which results in the neutral stimulus to cause a fear response without the aversive stimulus) where reconditioning occurs when the conditioned stimulus is repetitively presented without the aversive stimulus which then results in a new association without unlearning the old association. During these exposure

therapies the new association (no aversive consequence follows the neutral stimulus) is merely overriding the old association (an aversive consequence follows the neutral stimulus), meaning the old association stays intact and can be reactivated when triggered or can return spontaneously (Feinstein, 2010).

### **2.3.2. Development in phobia treatments**

New approaches towards the treatment of phobias have emerged as the field of psychology has evolved from Moral therapy in the 1800's to Freudian psychoanalysis (insight therapy) in the early 1900's to medical therapy, Client Centred therapy, Cognitive therapy, Behaviour therapy and Cognitive Behavioural therapy in the mid 1900's (Plotnik & Kouyoumdjian, 2008). With more than one option, the Eclectic approach emerged. In this approach the therapist can combine techniques and ideas from different therapeutic approaches (Plotnik & Kouyoumdjian, 2008). Today there is a new treatment methodology from the field of Energy Psychology, HBLU<sup>TM</sup>, which can be classified under the Eclectic approach because it incorporates and combines different techniques and therapeutic approaches.

Although bioenergetics/ Energy psychology is relatively new in the field of psychology, we can trace its roots back to the father of modern psychology himself, Sigmund Freud. Edwards & Edwards (2010) argue that Freud can be seen as a pioneer in modern day energy healing because “biographical evidence indicates that Freud used physical, suggestive, and radiant forms of energy healing, and that his personal life, metapsychology and psychoanalysis were founded on dynamic, energetic experiences and conceptualizations” (p. 219), such as the viewpoint to suggest that neurosis is sexual energy, libido, not being satisfactorily discharged and manifesting in symptoms such as anxiety and agitation (Zeiders, 2003). Thus we see that Energy psychology is the newest incarnation of phobia treatments,

which Gallo (2009) considers the fourth force in psychology, after Freudian psychoanalysis (first force), behaviourism, lead by Pavlov, Watson and Skinner (second force), and the humanistic and transpersonal approaches, which involved some leaders in the field such as Rogers, Maslow, Perls and Rollo (third force).

HBLU<sup>TM</sup>, like CBT, borrows from and combines different approaches and techniques during treatment, with the difference that with EP techniques, using exposure and acupoint stimulation simultaneously, only brief exposure is required and swift relief of distress is characteristic during a treatment session, thus minimizing traumatising as Schulz (2007) and others found in their research (Gallo, 2005; Feinstein, 2010).

Energy Psychology and its effectiveness will be described next, which will be followed by the different EP techniques that have been incorporated for effectively treating phobias.

## **2.4. Energy Psychology**

### **2.4.1. What is Energy Psychology (EP)?**

Lambrou et al. (2005) describe EP as an “innovative approach to psychological problems [which] often utilizes the acupuncture system to effect reduction or elimination of emotional distress” (p. 2). Kahn et al. (2010) add that “Energy Psychology quickly and thoroughly relieves mental health problems by eliminating emotional traumas or blockages from the mind/body continuum by touching or tapping key points on the body” (p. 86).

According to The Association for Comprehensive Energy Psychology’s (ACEP) website, [www.energypsych.org](http://www.energypsych.org), Energy Psychology is “Based on an integration of quantum physics, psychology, Eastern medicine, and spirituality, Energy Psychology posits that mental and emotional problems are a reflection of disturbed bio-energetic patterns. Energy Psychology utilizes tools that seem to directly balance the human energy systems” and can be conceptualized as “a family of evidence supported [by] modalities that balance, restore and

improve human functioning by combining physical interventions (using the acupuncture system, the chakras and other ancient systems of healing) with modern cognitive interventions such as imagery based exposure therapy” (on the homepage of the ACEP website, [www.energypsych.org](http://www.energypsych.org)), in order to generate therapeutic changes in targeted emotions, cognitions and behaviours (Feinstein, 2008a). ACEP recognizes three subtle energy systems that can be addressed by EP practitioners: 1) the energy pathways – the meridians, 2) the energy centres – the chakras and 3) the body’s surrounding energy field – the biofield or aura (Feinstein, 2012b).

During the brief introduction in his course handout, Feinstein (2013) gave a good synopsis of Energy psychology as “a self-empowerment approach that draws from ancient spiritual practices and healing traditions. It provides simple methods for shifting brain patterns that lead to unwanted thoughts, actions and emotions such as fear, anger, anxiety, jealousy, shame and depression. By tapping energy points on the surface of the skin while focusing the mind on specific psychological problems or goals, the brain’s electrochemistry can be shifted to quickly help: 1) overcome fear, guilt, shame, jealousy, anger, or anxiety, 2) change unwanted habits and behaviours, 3) enhance the ability to love, succeed and enjoy life.” (Feinstein, 2013, p. 3). Gallo (2012) states that "Energy psychology studies the effect of the mind, body, energy systems, emotions and behavior. Energy therapy is the application of that kind of a concept to the treatment of different psychological conditions" (Track 9).

EP includes conventional psychotherapy and when particular psychological procedures are combined with acupoint stimulation, it can shift brain patterns by sending “signals to the brain which may impact stress chemicals such as cortisol and DHEA, deactivate limbic system arousal, and rapidly alter neural pathways. In brief, undesired responses can rapidly be uncoupled from their triggers, providing you with greater ease and freedom to live your life more effectively and joyfully” (Feinstein, 2013, p. 3). So when a

person thinks about a problem, activation can take place at the amygdala, hippocampus, orbital frontal cortex and other central nervous structures (Andrade & Feinstein, 2004; Feinstein, 2012b). And when the client talks about the experience, the verbal areas are active, balancing the left and right hemispheres of the brain which is important for memory consolidation, as fragments of the memory are gathered by the hippocampus and the frontal lobes. When they feel or remember something and speak about it, they have the ability to express emotion, feel it in the body, make sense of the feeling and link it to a remembered event (Johanson, 2009). When the acupoints are simultaneously stimulated, receptors sensitive to skin pressure will “send an afferent signal, regulated by the calcium ion, through the medial lemniscus, that reaches the parietal cortex and from there is directed to other cortical and limbic regions” (Andrade & Feinstein, 2004, p. 19). This process generates deactivating electromagnetic signals which are sent directly to the amygdala, which produces brainwave patterns that reduce learned fear and cause a change in the biochemical foundation of the problem. This inhibits the release of cortisol and other stress chemicals, enhance serotonin secretion, and keep the hippocampus and higher cortical regions on track. Previously disturbed emotional responses to thoughts, memories and events are reconditioned and new constructive experiences can be united to create new internal representations and link them with adjusted neural networks (Andrade & Feinstein, 2004; Feinstein, 2012b). EP leans strong on the belief in recent research in neuroplasticity – showing the brain’s ability to modify neural pathways - because when for example the acupuncture points are stimulated simultaneously while the person evokes a memory or thought that creates anxiety, the stimulation will send “signals to the brain that turn off the anxious response in the moment and rapidly alters the brain chemistry that maintained the response” (Feinstein, 2013, p. 4). During EP interventions practitioners use Subjective Units of Distress (SUD) ratings to know and better understand the client’s subjective experience, verify the changes that occur and use



it as a gauge to determine which elements of the treatment needs adjustments, more attention, and/or repetition (Feinstein, 2012b; Gallo, 2005). Before, during or after a treatment they can be asked to think about the problem and give a measure of distress (SUD), for example: “When you think about the phobia, how much does it bother you now on a scale of 0-10 where 10 is the worst level of distress and 0 represents no distress at all” (Gallo, 2005).

EP focuses on emotional concerns by addressing the underlying energetic imbalances and is both a clinical technique used by mental health professionals and a self-help technique used by clients between sessions or a self-help tool for people not in treatment to help them manage everyday emotions, such as anxiety and grief (Feinstein, 2013).

We will now dissect the information further to see what is meant by these quotations and also to see the viewpoints of different authors on the concept of energy, meridians, chakras, qi, EP and the mind-body-spirit connection.

#### **2.4.2. Matter and energy in Energy Psychology**

If energy “resides at the most fundamental level of being” (Gallo, 2005, p. 10), and “each of the body’s cells stores and emits electricity” (Feinstein, 2012b, p. 73), then the blueprint for your body’s health can be energy as Feinstein et al. (2005) stated. For your cells to process information and communicate with each other, electrical activity is required. Electromagnetic (EM) pulses are produced in the muscles of limbs when they contract which can be measured on the surface of the skin with an electromyogram (EMG) and the movement of the limbs creates electrostatic fields (Benor, 2004; Feinstein, 2012b). The simplest movement like the bat of an eyelid includes electrical energy and “memories, feelings and thoughts are encoded in patterns of tiny electrical impulses” (Feinstein, 2012b, p. 73), which can explain why **pulsed EM fields** (PEMF’s) can support the healing of certain conditions such as fractures, osteoporosis, pain and even depression (Benor, 2004).

Everything in the universe consists of matter and energy, where energy is defined in physics as “the ability to do work” (Diepoldt, 2002, p. 23) and where matter is condensed energy (Gallo, 2002). Gerber (2001) noted that “the higher the frequency of matter, the less dense, or more subtle the matter” (p. 69). From physicists’ point of view and the law of thermodynamics, energy cannot be created or destroyed, although the nature of energy is changeable and adaptable (Upledger, 1997; 2003). An example of a density continuum of matter to energy can be observed where the solid form of ice (dense energy – matter), when heated, changes into the liquid form of water, and then changes into the gaseous form of steam (far less dense – energy). At the quantum level of subatomic particles, matter can be seen as energy frozen in time as Einstein’s equation,  $E=mc^2$ , states that matter and energy are interconvertible features of the same reality, meaning energy and matter is the same thing. Research in subatomic quantum physics has revealed that the particles or waves of electrons (the most rudimentary particles) are energy which is held together by four energy forces which is recognized by conventional science (gravity, electromagnetism, and the weak and strong nuclear forces) and fields (Benor, 2004; Benor, 2007; Gallo, 2002; Gallo, 2005, Gerber, 2001). On a day to day basis we harness the electromagnetic fields that are in and around our bodies to fill our energy needs (Benor, 2004).

Benor (2007) states that the human body can be perceived and be addressed as energy and matter and Feinstein et al. (2005) add that energy is the foundational blueprint for the body’s health as the body is composed of “energy pathways and energy centers that are in a dynamic interplay with your cells, organs, moods and thoughts” (pp. 2 & 3). If everything is essentially energy, and the shared basis of all things, physical and psychological, then our nervous system, neurochemistry, thoughts, emotions and behaviours is energy (Feinstein, Moore, & Teplitz, 2012; Gallo, 2005), which occurs in a variety of states and forms; electromechanical, electro-optical, electro-acoustical and electromagnetic (Feinstein et al.,

2005; Gallo, 2005) and this electricity is produced in the body through biochemical reactions and is in continuous interaction with external electromagnetic fields (Dunning & Woodrow, 2005). According to the Einsteinian viewpoint, which is also the energetic viewpoint, humans can be seen as “dynamic energetic systems” with “networks of complex energy fields that interface with physical/cellular systems” (Gerber, 2001, p. 39). And Dunning & Woodrow (2005) mention that our biological bodies not only generate electrical currents and electromagnetic fields, but that we are also surrounded by magnetic and electromagnetic fields, such as natural geomagnetic fields and modern day communication technologies, which act upon our internal fields. The earth is surrounded by EM fields, produced by the high percentage of iron at the molten core of the earth, and the sun emits fluctuating EM fields. These natural occurring EM frequencies are relevant to biological systems which seem to have adapted to the constant EM rhythms, although continuous exposure to environmental pollutions (e.g. cell phones, computers) can effect a human’s health negatively (Benor, 2004).

Electromagnetic (EM) signals, brain waves and energy fields and their ability to quickly change longstanding brain patterns, play vital roles in EP protocols (Feinstein, 2012b), since neural activity is believed to be organized by energy fields, just like electromagnetic fields organize cellular activity in wound healing. The process in EP protocols starts during the acupoint stimulation phase which generates piezoelectricity (electricity produced by mechanical pressure) and these electromagnetic signals reduce the threat arousal in the amygdala. The acupoint stimulation increases the production of delta waves which are believed to alter the neural pathways that maintained the maladaptive fear memories. This procedure also has an impact on the energy fields and this neurological sequence can permanently alter the conditioned response to the feared memories and its triggers (Feinstein, 2012b). Lambrou et al. (2005) did a study to show the normalization of ERG theta waves and changes in the electrical conductance between the acupuncture points

after a 30 minute claustrophobia treatment using self-applied acupressure, focused thought and structured breathing exercises.

As early as 1907 the heart's energy field was detected by Willem Einthoven and in 1924 Hans Berger measured the brain's energy field (Feinstein, 2009), showing that these energies are no longer just a speculation or 'voodoo' as some refer to them, but can actually be measured with instruments which all assume an electro-resonant body. Instruments such as the EEG (electroencephalography – which is a device that produces a record of brain activity by monitoring the electrical activity of different parts of the brain, “showing variations in the frequency, amplitude and voltage of the impulses, known as “alpha”, “beta”, “theta” and “delta” rhythms” (Feinstein, 2005b, p. 7), the EKG or ECG (electrocardiography – a device that records the electrical activity and the contractions of the heart muscle) and the MEG (magneto encephalography – “a method of brain imaging through the recording of magnetic fields induced by the electrical activity of brain cells” (Colman, 2006, p. 436; Benor, 2004; Dunning & Woodrow, 2005; Feinstein, 2009; Feinstein et al., 2005; Gallo, 2005). Further measurements occurred when scientists could detect the EM fields around the body, (the electromagnetic output of the body) and measured the strength of The **H**uman **E**nergy **F**ield (HEF) around the body with the **S**uper-conducting **Q**uantum **I**nterference **D**evice (SQUID) (Benor, 2004; Zeiders, 2003). The SQUID is sensitive to the EM currents which are created by ions in the blood and any changes in these currents can be mapped when the blood flows through the brain during certain brain activities. This resulted in alternative ways to study activity in the brain (Benor, 2004). Soviet researchers developed an electroauragram capable of measuring the electromagnetic frequencies which are formed around living tissue (Benor, 2004; Zeiders, 2003). The heart generates the most powerful EM activity around the body (Benor, 2004). We now have the **M**agnetic **R**esonance **I**maging (MRI) scanner that shows images of blood flow changes in the brain which is in correlation

with a person's mental experiences (Siegel, 2012) and it produces pictures, using CT computer programs, to show us how the body reacts to high intensity magnetic fields (Gerber, 2001).

Being able to measure these energies, made the medical and mental health care fields aware of the involvement of electrical impulses, electromagnetic fields and other energies in the body (Feinstein, 2009).

### **2.4.3. Meridians and acupuncture points**

Energy psychology works with the “subtle” energy systems which can be partitioned into vital life force energy or qi, energy pathways, energy centres and the aura which are all thought of as involving electromagnetic energy (Feinstein, 2012b; Feinstein et al., 2005).

The Chinese call the energy pathways ‘jing luo’ (p. 158) which can be translated as channels, conduits or meridians (Dunning & Woodrow, 2005). Einstein also named these invisible and difficult to detect and measured energy lines, meridians (Gallo, 2005) and according to acupuncture, qi circulates throughout the body via these channels (Dunning & Woodrow, 2005). The meridians are called nadis in the yogic tradition of ancient India (Feinstein, 2012b), although according to Gerber (2001) nadis, which are “formed by fine threads of subtle energetic matter” (p. 131), are different from meridians as they connect the chakras (which will be discussed later in this chapter) with each other as well as connect the chakras to parts of the physical – cellular structure of the body and distribute qi and the energy of each chakra into the physical body. According to Greene (2012) the meridians feed into the more than 71 000 nadis. A meridian is “a hypothesized channel that carries subtle energy through the body, interconnected with acupoints. There are 12 primary meridians, 2 collector vessels and 6 additional extraordinary channels” (Gallo, 2005, p. 227) which channel qi to 12 different organs, 12 sets of muscle groups and correspond with 12 pairs of

emotions (Pulos, 2002). Feinstein (2009, p. 7) explains the meridians further as “basic energy pathways on which the acupoints are situated and the meridians are the first system to be affected by acupoint stimulation”. Gerber (2001) explains the meridians as “electrical circuits which connect the superficial acupuncture points to deeper organ structures” (p. 178) which is “an interface of energetic exchange between our physical body and the energy fields which surround us” (p. 189) and which hold essential information about the status of the internal organs.

These meridians run from the head to the fingers and toes and are related to one or more organ systems and each meridian is further related to a certain emotion or emotions (Benor, 2007; Khan et al., 2010; Schulz, 2007). Stimulating the acupoints (which have a higher concentration of qi) can regulate the increase or decrease of the energy flow and can therefore strengthen or sedate the energy flow to a specific organ (Benor, 2013; Feinstein, 2005b). Dr Goodheart’s discovery of the direct relationship between the muscles and meridians plays a foundational role in **Behavioural Kinesiology (BK)** which will be discussed later in this chapter (Diamond, 1979).

There are in the region of 1 100 acupuncture points along these meridians (Pulos, 2002) that are “points on the surface of the skin” (Gallo, 2005, p.225) which interconnect along the meridians. These acupoints have an electromagnetic nature, making the electrical resistance on the skin overlaying the acupoints significantly lower than the surrounding skin which, according to **Traditional Chinese Medicine (TCM)**, allows the qi to enter or exit at these points (Benor, 2004; Dunning & Woodrow, 2005; Feinstein, 2005a; Gallo, 2005; Gerber, 2001; Pulos, 2002). They also have a higher concentration of receptors which make them sensitive to mechanical stimulation and when stimulated, they produce strong electrochemical signals, according to research conducted in China (Feinstein, 2005a). Gallo (2005) adds that the subtle environmental energy also enters through these portals. These

acupoints can be located by hand, through muscle testing and can be measured by a special direct-current (DC) electrical amplifier (Dunning & Woodrow, 2005; Gerber, 2001).

Acupuncture needles are inserted where the acupoints are located to balance energy flow (the qi) through the meridians. Stimulated acupoints can increase serotonin levels (Feinstein, 2005b) and in many energy psychology approaches, “the acupoints are employed in treatment to reduce subjective distress related to specific psychological issues” (Gallo, 2005, p. 225).

The electromagnetic energies of the meridians or acupuncture points are not only validated across cultures for thousands of years, but can also be measured with the Apparatus for Meridian Identification (AMI), an “instrument for quantitative measurements of the electrical currents along acupuncture meridians” (Benor, 2004, p. 183; Feinstein et al., 2005; Gerber, 2001; Pulos, 2002). This computerized system which was designed to measure the functions of the meridians and their corresponding internal organs and the imbalances within the meridian system was developed by Hiroshi Motoyama after studying over 5000 subjects (Benor, 2004; Gerber, 2001; Pulos, 2002). The results of the research confirm the TCM theory that particular meridians are associated with specific organ systems (Gerber, 2001). The AMI is used as a diagnostic tool to diagnose illness and can sometimes recognize an illness before it has manifested otherwise (Benor, 2004).

The Voll instrument, which observes the electrical features of a single acupoint at a time, can not only diagnose energetic imbalances in a meridian, but can also find the cause of the energetic dysfunction and provide potential cures for the resulting disorder. Both the AMI and Voll machine are electro acupuncture diagnostic tools which measure electrical changes in the meridian system to identify physiological and energetic imbalances in the body.

Another meridian diagnostic tool, Kirlian photography (an electro photographic technique) is used with Dr Dumitrescu’s Electrographic scan to reveal an enhanced Kirlian aura (the

related acupuncture point glows brightly) when a meridian is out of balance (Benor, 2004; Gerber, 2001).

#### **2.4.4. The role of Qi**

Subtle energy therapies or thought field therapies have their roots in Chinese medicine, because they are based on the understanding of the Eastern meridian system and as such use the same concepts as acupuncture (Schulz, 2007) which is “based on the principle of restoring equilibrium of the body’s energy state by regulating the flow of Qi in the corresponding meridians and acupoints” (Lee, Lee, Shin, Jeong, Kim, Eo, & Ko, 2005, p. 507).

Qi is considered to be an interacting flow of energy and this subtle energy or life force flowing through the meridians, interacting with surrounding energy fields is known as *qi* or *chi* (China), *ki* (Japan), *prana* (India), *mana* (Polynesians), *yesod* (cabalist Jews), *Holy Spirit* (Christians), *megbe* (Ituraea pygmies), *vis medicatrix naturae* (Hippocrates), *pneuma* (Pythagoras), *subtle spirit* (Newton), *l-fields/life fields* (Burr); *orgone* (Reich), *libido* (Freud), *adaptive energy* (Selye); *life energy* (Diamond); *L energy or heart’s code* (Pearsall), in Russia and Eastern and Central Europe it is known as *bioenergy* since the 1960’s, while Russian psychologists call it *biplasma* (Benor, 2007; Dychtwald, 1986; Gallo, 2005; Pearsall, 1998; Pulos, 2002; Zeiders, 2003). Qi translates from Chinese as a concept that simultaneously includes influence, power and mind (Gallo, 2005).

According to Dunning & Woodrow (2005) this subtle energy is comparable to the bioelectrical field associated with the body and Nathan Sivin points out that this energy is simultaneously a wave and a particle (Pearsall, 1998). Although this energy is not electrical in nature, it possesses magnetic properties which induce electrical fields and currents (Gerber, 2001). According to Pert (2003) this energy is the flow of information between systems,



carried by neuropeptides and their receptors. Pearsall (1998) believes the heart to be the main producer of this energy which is recorded and remembered in every cell of the body, serving as an informational template for the soul, and according to Diamond (1979) the thymus gland controls, monitors and regulates the flow of the qi, which he calls Life Energy.

To acknowledge the complexity of a person's mental life Chinese medicine identified a special kind of qi which they named *shen* which includes thinking, emotions and the spiritual characteristics of a person (Ferigno & Wang, 2000). Traditional energy medicines see the mind, body and qi as a complete unified energetic whole and therefore consider people's thoughts and emotions as having an influence on the qi and being able to affect the qi by increasing it, decreasing it, blocking or freeing the flow of this life force energy (White, 2000). Feinstein (2012b) adds that this energy, as we can conclude from the different names and opinions, is more than just electromagnetic energy.

Like gravity, subtle energies cannot be seen or photographed, but we know if we drop something it will fall so we believe gravity exist, in the same way qi's effects can be verified in being alive. If you don't have qi, you are no longer alive (Feinstein, 2012b). Indigenous people, ancient religious systems and medicine systems (excluding modern biomedicine/ allopathic/ western medicine), not only name this energy, but base their healing systems on it (Pearsall, 1998; Zeiders, 2003). The multicultural background of this energy and the resulting multicultural terminology that it has invoked brings to the foreground the requirement of sensitivity towards multicultural perspectives and move us away from the dogmatic biomedical perspective that recognizes only one way to view or do things (White, 2000). If this energy has been known through the centuries, by being named and used, it remains obscure as to why the biomedicine field does not recognize its existence despite many reports of its positive influence in peoples' lives. People who referred to this energy in previous centuries were not acquainted with the properties of electricity as we are today (for

example energy carried in devices such as wireless routers or radio waves that can extend over thousands of miles), but the concept of this subtle energy withstood the test of time and today contemporary scientific discoveries such as the relatively new fields of electromagnetism and bioelectricity can give us an understanding of how the body is permeated with and influenced by electromagnetic fields which give us the opportunity to reassess the idea of a life giving energy such as qi (Dunning & Woodrow, 2005).

According to TCM this life-giving/sustaining energy - qi - enters the body through the acupoints and through the breath, beginning at the lung meridian and travelling through the rest of the body via the meridians to vitalize, sustain and organize the nerves, blood vessels and organs (Gallo, 2005; Gerber, 2001). If the energy flow is blocked, it causes an excess or deficit of energy in a meridian and can cause disease, but when the qi is flowing smoothly it results in a more healthy constitution (Lee et al., 2005; Leskowitz, 2002). Dr Upledger and Dr Green from the Menninger Foundation noticed that the restriction of qi flow is caused by what they call “energy-cysts” which are pouches of blocked emotions in the body and which have a negative influence on a person’s general health (Upledger, 1997, p. 71). They maintain that these energy cysts are generally caused by physical or psychological trauma, such as surgery, accidents, falls, infections, emotional and spiritual trauma, toxins, etcetera which have harmful effects on nearby and distant tissue (Erickson, 2003; Upledger, 2003) as well as negatively affecting the body’s energy systems (Erickson, 2003). If the force of the energy enters the body during a physical trauma and the energy does not dissipate, it will form an energy cyst according to Erickson (2003).

To remove the blockages (the energetic constrictions) in the meridians with the aim of allowing balanced energy (qi) to flow, the acupoints can be stimulated and the body’s flexibility can be increased through yoga, by taking activating herbs, by facilitating the power of the mind, by moving and breathing such as in qi gong or by practicing meditation

(Leskowitz, 2002). When blocked emotions are released through touch or other physical methods, we experience the clearing of our internal pathways as energy and when an “energy cyst” (“localized, concentrated area of foreign, disorganized energy”) is released, electrical and thermo graphic changes can be and have been recorded according to Erickson (2003, p. 410).

With this realization we depart from the Newtonian mechanical body view where the body is merely seen as energy acting on matter to create behaviour and we move to the Chinese Medicine model which views the body as an energy-driven bionetwork whose health depends on balanced and flowing energy forces (Pearshall, 1998; Pert, 2003).

#### **2.4.5. Meridians, Acupuncture points, Qi and Energy Psychology**

In EP we mainly focus on the acupuncture points, employing them during treatment in order to reduce subjective distress which is related to specific psychological issues. They are stimulated (by tapping, pressure, or mental projection) on the surface of the body to regulate the energy flow by guiding the energy/qi in a helpful direction to support good health and affect the body at a deeper internal level (Benor, 2007; Gallo, 2005; Lee et al., 2005; Leskowitz, 2002; Schulz, 2007). Stimulating the acupoints does not only influence the flow of qi, but the blood as well which positively impacts on the tissues and organs (Lee et al., 2005). Feinstein et al. (2005) and Feinstein (2010) add that stimulating the electromagnetically sensitive acupoints send deactivating, electrochemical signals directly to the amygdala and other brain structures, which alter the brain’s electrochemistry and swiftly reduce hyper arousal in the amygdala. This has been confirmed by Harvard neuroimaging studies (Feinstein, 2010). The result is that the person’s threat responses to relevant triggers, which could have brought up old unconscious and associated memories, are being extinguished, which means that the brain’s response to the unwanted situation at hand has

shifted, which in turn helps to overcome and change unwanted emotions, habits and behaviour and instead enhances desirable emotions and behaviours (Feinstein, 2010; 2012b; Feinstein et al., 2005).

The sequence of an EP intervention is as follow: 1) anxiety producing memories or clues are induced which trigger hyper arousal in the limbic system, and at the same time 2) neutralizing signals are sent to the amygdala via for example acupoint stimulation which 3) prevents the memory or clue to trigger an anxious response in the person (Feinstein, 2009; 2010). Not only does the acupoint stimulation have an impact on the person's mind and body, but an added factor can be that bioenergy (qi) transfer takes place along the meridians between practitioner and receiver during, for example acupuncture treatment, and this bio-energetic transfer may act as an electromotive force to remove energy blockages and restore an equilibrium state as Lee et al.'s (2005) study results suggest. Suggesting that the practitioner should be mindful of his/her intentions and it can also suggest that cross-clearing can take place where not only the client, but the practitioner can also experience energy blockage removal.

#### **2.4.6. Chakras, biofields and morphogenetic fields**

##### **2.4.6.1. Chakras**

Although most Energy Psychology practitioners' main focus is on the meridians and their acupoints, ACEP includes the chakras ("body energy centers that serve as transformers of subtle energies") as well as the biofield as additional focus points in EP (Gallo, 2005, p. 226). "The chakras are assumed to convert subtle energy into chemical and cellular forms" (Gallo, 2005, p. 226), and these spinning energy wheels, the chakras, receive and disperse the qi throughout an individual's system, releasing excessive or blocked energy (Hover-Kramer, 2002). Gerber (2001, p. 128) adds that the qi flow from the energy transforming chakras into

the cellular structure of the physical body is via “specific subtle energetic channels”, and can bring forth hormonal, nerve and cellular activity and changes. It is believed that chakras carry psychological information and store emotionally significant memories, just as “memories are chemically coded in your neurons” (Feinstein et al., 2005, p. 199). The chakras integrate somatic and psychological aspects in a person and each chakra is associated with 1) a distinct body part within its energy field, (Eden, 1999; Hover-Kramer, 2002); 2) a neuro-emotional system (Pearsall, 1998); 3) a network of nerves, blood vessels or other vessels in the body; 4) the endocrine system which has an influence on moods, personality and overall health (Dychtwald, 1986; Eden, 1999); 5) they relate to certain human behaviours and development (Dychtwald, 1986), and 6) each chakra also corresponds to a specific sort of psychic perception (for example the brow chakra which is involved with clairvoyance) (Gerber, 2001). It is hypothesized that there is a chakra to chakra link between healer and patient which can serve as a “direct resonant transfer of multiple subtle frequencies” (p. 319) which may assist the patient back to an energetic balance of mind, body and spirit (Gerber, 2001).

The chakras are assumed to be connected to each other through energetic threads, the nadis, to form the chakra-nadi network. The chakra-nadi network is just as important as the meridian and acupuncture points system to keep the physiology and endocrine system of the physical body in balance (Gerber, 2001).

There are many chakras around the body, which “project as vortices of energy to the front and back of the body, as well as upwards and downwards” but we mainly focus on the seven main chakras that run in a vertical line from the base of the spine to the crown of the head, suggesting our ascendance to the Divine/ God/ Higher Power (Benor, 2004, p. 183; Myss, 1996). The seven chakras are 1) the root chakra, the Muladhara at the base of the spine, 2) the spleen chakra, the Svadisthana at the level of the genitals, 3) the navel chakra, the Manipura at the navel, 4) the heart chakra, the Anahata over the heart, 5) the throat

chakra, the Vishuddha at the front of the throat, 6) the brow chakra, the third eye, the Ajna in the space between the eyebrows, and 7) the crown chakra, the Sahasrara on the top of the head (Dychtwald, 1986; Myss, 1996). According to Chinese medicine, the heart or 4<sup>th</sup> chakra is the primary centre of all the chakras and serves as the most important centre to store and transfer the qi, as well as connecting the “lower” physical and “higher” spiritual chakras with each other (Pearsall, 1998). According to Myss’s (1996) interpretation of the chakras, each of the seven chakras carry spiritual messages, life lessons and teachings which are similar to the seven Christian sacraments and the ten Kabbalah Sefirot and they instruct us how to direct our qi and support our transformation into spiritual maturity as each chakra’s challenge is being mastered when we choose to learn the lessons in each one. The throat or 5<sup>th</sup> chakra is the place which represents change. A person will notice activity in the throat, for example a cough, when he or she is resisting change, is trying to change or is in the process of changing (Hay, 1999).

Research has been done to confirm the existence of chakras and Dr. Valerie Hunt’s Human Energy Fields laboratory at the University of California, Los Angeles (UCLA) found that the areas of the skin which are associated with the chakras, discharge electrical oscillations of a much higher frequency than had been detected on the human body before (Feinstein, 2010). Motoyama who associates the chakras with the nerve plexuses in the autonomic nervous system, also developed an electronic device to verify the presence of chakras called the AMI (Benor, 2004).

#### **2.4.6.2. Biofields**

Modern physics, unlike sciences such as biology and medicine which are not used to dealing with nonmaterial matter, have concepts for nonmaterial entities such as fields. The idea of invisible fields is not new and is accepted by physics (Dossey, 1989). In 1995 the

National Institute of Health, recognized the existence of the biofield and defined it as "a non-physical energy that permeates and surrounds the human body through the chakra, meridian and nadi system" (Greene, 2012, track 16 & 17). According to Dossey (1989), electric and magnetic fields surrounds our bodies and this flow field, although nonmaterial, are associated with matter. There are also fields that are meaningful without the presence of matter, for example radiation fields, velocity, energy and the moon's gravitational pull on the oceans, which creates tides (Dossey, 1989). The astrophysicist, turned healer, Barbara Brennan (cited in Hover-Kramer, 2002) suggests that there is an interactive dynamic between chakras and layers of the biofield. Brennan (*n.d*) refer to the Human Energy field or aura. She describes it is a incandescent body which surrounds and interpenetrates our physical body, is a manifestation of the universal energy and the level where our psychological processes take place and is therefore the medium for all psychosomatic reactions. The biofield is described by Gallo (2005, p. 226) as "the electromagnetic and subtle energetic field that surrounds and permeates the body, also referred to as aura", is "a holographic energy template that guides the growth and development of the physical body" according to Gerber (2001, p. 115), and "which looks quite similar to the physical body over which it is superimposed" (Gerber, 2001, p. 121). Biofields refer to biologically related fields including morphogenetic fields (the various fields that exist to "account for the inherited physical forms and instinctual behaviors of organisms" (Gallo, 2005, p. 38) and thought fields (the energetic field of thoughts) (Gerber, 2001; Gallo, 2005). Massey & Fraser (2003) talk about the human body-field which contains many subfields that are in constant interaction and which also constantly interact with the environment and therefore are influenced by geopathic stress, magnetic fields, toxins and stress. They define it as "a dynamic web of interrelations among all the physiological processes that the body must perform, as well as between these processes and the emotions and consciousness" (Massey & Fraser, 2003, p. 44). Greene (2012) adds that

this organized body-field (which she calls the vital body) is the blue print of not only our body, but of what is going on in our whole system. It is a replica of our physical body and is both external and internal to the physical body where they are interdependent on each other. This biofield/ vital body is an energy information system that programs the whole person as an interface with the mental, emotional and causal bodies (Greene, 2012).

These biofields have an effect on each of the chakras and also affect cellular patterns of growth and physical expression (Gerber, 2001; Hover-Kramer, 2002). The biofield consist of the etheric, emotional/astral, mental, and spiritual/intuitive/causal outer layers of subtle energy (Gerber, 2001; Greene, 2012; Hover-Kramer, 2002). These biofield layers are also referred to as subtle matter, as they are composed of matter of a higher frequency than the physical body. First there is the etheric subtle energy body, “a self-organizing holographic energy template” (p. 148) and “an energetic form which underlies and energizes all aspects of the physical body” (p. 135) which is superimposed over the physical body and supports and energizes it (Gerber, 2001). The next layer is the emotional/astral body which has a higher energetic frequency than the etheric body, and which is also usually superimposed over the physical body and is involved with a person’s emotional expression. The next higher frequency layer is the mental body which is concerned with the creation, manifestation, expression and transmission of concrete thoughts, ideas and intellect to the brain so it can be expressed in the physical realm. The etheric, astral and mental layers all have seven major energy transforming chakras which are linked to the physical body and are focused on the major endocrine and nervous centres. The next higher vibrational frequency layer is called the spiritual/intuitive/causal body which is involved with abstract ideas and concepts, the essence of a subject or substance and the truth about the “illusion of appearances” (Gerber, 2001, p. 155). Because the causal body deals with the underlying nature of the subject, it is a “world of realities” and no longer deals with emotions, thoughts, or ideas (Gerber, 2001, p.



155).

According to Benor (2004), Brennan observes the seven concentric levels of the aura as: 1) etheric (physical body), 2) emotional (emotions), 3) mental (thinking), 4) astral (I-thou emotions and desires), 5) etheric template (higher will), 6) celestial (higher feelings), and 7) ketheric (higher concepts) and even recognizes additional energy levels within the aura such as the *hara* (related to our intentions) and the *core star* (representing the divinity within us).

Each biofield layer overlays the other and envelopes those below it thus having a cascading effect (Benor, 2004; Gerber, 2001). The mental energies will influence the emotional/astral body, which will influence the etheric body which will influence the physical body. Therefore it is important for the mental biofield layer to be functioning properly so that a person can think clearly and be able to focus. The mental state will influence the person's emotional state, and the etheric field, and then have an effect on the body. From this perspective, healing that takes place at a mental level will be more effective and last longer than healing from an emotional/astral or etheric level. And healing at the causal body will be the most effective as the causal body overlays all the other biofield layers, so when healing takes place here, it will cascade down to the underlying levels until it reaches the physical body. It is therefore possible to observe disease in the etheric field before it is observed in the physical body (Gerber, 2001). Because the etheric body interacts with the physical body, it makes the flow of energetic information possible. One of these communication channels/systems between the etheric body and the physical body is the acupuncture meridian system with its associated acupoints. Illness which precedes in the etheric body, just like illness in the physical body is caused by energetic imbalances in the meridian system which stops healthy and balanced qi flow. It is therefore important to maintain the integrity and balance of the communication channels, the meridians system, in order to maintain and secure health (Gerber, 2001). Brennan (*n.d.*) adds that disease in the

physical body is caused because of an imbalance in the human energy field and when the imbalance in this field is healed, it will cause physical healing. Greene (2012) adds that the biofield plays a substantially big role in a person's well being as it is very responsive to our internal senses (which orientate us to our internal world), so it is important to pay attention to our inner world, our thoughts and emotions.

The *phantom leaf effect* implies the presence of an organized energy field with systematic memory as the detached part of a leaf was remembered when the precise image of the whole leaf was shown on an electro photographic picture in Kirlian photography (Upledger, 2003). Kirlian photography has the ability to demonstrate the existence of energy waves and currents around living things which reveals a holographic energy field around all living organisms and represents an abstraction of several somatic and nonphysical factors (Gerber, 2001). The *phantom limb phenomenon*, where sensations such as pain or an itch, can be felt after amputation, parallel the *phantom leaf effect* and can also be viewed as supporting the theory of the existence of energy fields within and around living organisms (Benor, 2004). No studies have confirmed that the aura seen in Kirlian photography is the same as the aura seen by people who can see auras, but it can be viewed as a useful instrument to assess healing effects (Benor, 2004). Disciplines such as physics, physiology, neurology and medicine suggest that invisible fields have an influence on organizing physical occurrences, from repair responses during a physical injury to influencing neurons involved in learning and they therefore acknowledge the alignment between the energy fields and the cells (McTaggart, 2002). Valerie Hunt has recorded the human aura ('the electromagnetic radiation around the body') with a high-frequency electronic measurement tool called the Aurameter (Hunt, 2003, p. xxxiv). During Hunt's study, investigating changes in muscle tension during Rolfing, the clairvoyant, Rosalind Bruyere, simultaneously described the aura changes in therapists and clients which was congruent with Hunt's findings which was

measured by her bio-electronic sensors (Benor, 2004). Studies done by The Institute of Heartmath in California, show EM interaction between healers and healees, suggesting that there is an EM aspect in bioenergy fields (Benor, 2004).

#### **2.4.6.3. Morphogenetic fields**

According to Sheldrake's controversial hypothesis, the current distinguishing shapes and behaviours of all chemical, physical and biological systems are as they are now, because they inherited systems with similar shapes. The shapes are organized the same way as before by organizing fields which he calls morphogenetic fields which through morphic resonance, influence subsequent systems. The recreation of the same organized shape and or event creates a new morphogenetic field, which is responsible for the sub sequential inherited physical forms and instinctual behaviours. It can be viewed as a replicate system similar to a blueprint guiding construction. This makes the occurrence of a similar event more likely and the subsequent events in turn strengthen the relative field and its influence. This creation of new habits can influence future systems, suggesting that physical laws can develop and change over time, since morphogenetic fields are susceptible to change. If, as Sheldrake suggested, the morphogenetic fields' influence is felt by our atoms and molecules, then our emotions and thoughts are affected by our internal chemistry, and past thoughts and emotions influence present thoughts which add to and change the fields (Dossey, 1989). According to Mollon (*n.d.* a), to heal a dysfunctional energy pattern (e.g. a trauma pattern) completely, it should be removed from the morphogenetic field in order to prevent this informational field to hold and reproduce repeating patterns.

Morphogenesis is not a new concept and has a relative long history in biological science which started with Alexander Gurwitsch and Paul Weis who developed the basic concept of morphogenetic fields in 1920 (Dossey, 1989). The phenomena of morphogenetic

fields and morphic resonance should not be confused with the Lamarckian inheritance concept that *acquired characteristics can be inherited*, but it rather suggests that behaviour and physical form involves an *energetic* hereditary which is also possibly distinct from DNA-based inheritance (Gallo, 2005). Findings, such as the work of John Cairns from Harvard, suggest that genetic changes can be directed by external circumstances and can benefit from life experience (Dossey, 1989).

According to Feinstein (2012b) these energy fields are believed to act upon matter, and we can speculate about the role they might play in energy psychology treatments where they are “*organizing fields* that (a) *coordinate* neural activity [which] are (b) *impacted* via energy psychology interventions to (c) *orchestrate* information-processing in ways that (d) *enhance* integration and coherence” (p. 71). The energy field surrounding our bodies carries information and therefore impacts a person’s biological and psychological functioning. So a disturbance in the energy field can reflect an emotional disturbance. Changes in the energy field have the power to move the organization of electrochemical processes, which can explain the rapid changes in long standing emotional patterns when we apply EP techniques as both the biochemistry and the invisible physical fields respond together during treatment (Andrade & Feinstein, 2004).

#### **2.4.7. The mind-emotion-body-spirit connection in Energy Psychology**

In this section the mind-emotion-body connection will be discussed first, which will be followed by a discussion of the spirit connection.

##### **2.4.7.1. The mind-emotion-body connection**

EP supports the holographic Chinese medicine model which assumes that a part of the body reflects the whole, where the ear, tongue, hand, foot, pulse, eyes, etcetera can be used to

diagnose or treat any disorder in the body (Benor, 2004). In a discussion between Doctors Durlacher, Walker and Gallo at the Second International Energy Psychology conference in Las Vegas on May 12, 2000, Dr Gallo said, in EP we acknowledge the interaction between the mind and body, and Dr Durlacher added that EP can be seen as instigating a physiological treatment for an emotional problem (Gallo, Durlacher, & Walker, 2002). EP moves away from the classical Newtonian physics model with its linear time, inflexible compartments of matter and energy, which sees the mind and body as separate and leans more towards the energy attuned Einsteinian model (Dossey, 1989; Feinstein et al., 2012). Although there is obviously a lot of talk about the mind in psychology (just as we cannot speak about the law without a law system), Siegel (2012) has not found in all his years of research, one field of psychology that has a definition of the mind. The question he then so rightfully asks is "How can we work with the mind if we cannot define it?" (CD1, Track 11). Siegel (2012) views the brain and mind as separate entities; he views the brain as an "embodied mechanism" and the mind as an "emergent, self-organizing process that emerges from and also regulates the flow of energy and information within and between us (p. 6 of handouts from CD 2). His definition of emergence stems from the probability theory of mathematics where the whole is greater than the sum of its parts and is viewed as "something arises from the interaction of elements" (track 13).

We are chemical beings with neurotransmitters, hormones, and oxygen levels in the blood and we are neurological beings with distinct brain structures which play a role in the manifestation of our human functioning, including cognitive, emotional, behavioural and psychological functioning and disturbances (Gallo, 2005). According to Siegel (2012), the brain is about electro-chemical flow and is constantly changing because it is always making new synaptic connections. Some of these brain structures that play a role in cognitive and emotional functioning are: 1) the hypothalamus which is influential in the regulation of basic

drives such as hunger, thirst, aggression, etcetera, 2) the hippocampus which is important in conscious memory functioning, and 3) the amygdala which is relevant in several aspects of emotional responsiveness and unconscious memory (Gallo, 2005). Pert (2003) mentions that researcher Paul MacLean, theorized that there are three layers of the human brain, the 1) brainstem or reptilian brain which is involved with autonomic functions such as breathing, blood flow, etcetera, 2) the limbic system which is involved with emotions, and 3) the cerebral cortex in the forebrain, which is the seat of reason, which represents different stages of human evolution. According to Siegel (2012), the prefrontal cortex is the most responsive to therapy, because it is the ultimate mediator of autonomic integration where the mind and body meet. And according to Diamond (1979), the thymus gland is the link between the mind and the body as emotions, attitudes and stress will affect this organ first. Dossey (1989), mentions that the brain can be seen as more than one brain where one brain is the *anatomic brain*, locked within the cranial cavity and the other one is the *functional brain* which is the “brainlike tissues and chemicals that serve brainlike functions and may or may not be located within the skull” (p. 81). Dossey (1989) came to this conclusion because certain cells in the blood make chemicals such as endorphins, a natural pain reliever and mood shifter, which are identical to those made by brain cells, and receptor sites for various hormones, and chemicals in blood cells are identical to those in the brain. The brain can then flow wherever the blood is flowing through the body and the mind is no longer confined to a specific place – the brain - , but is rather suffused through the body and we can start to see the mind as nonlocal.

Energy psychology brings about rapid results because it “target(s) the more primitive parts of the brain – the limbic system, medulla oblongata and Enkephalin system, which is in every cell of the body” and is therefore known as “power therapies” (Khan et al., 2010, p. 85). When we understand the energy system, the biofield layers and how they are part of the mind body connection we can understand why Gerber (2001) says the human has a

multidimensional anatomy by calling the human being “ a multidimensional organism made up of physical/cellular systems in dynamic interplay with complex regulatory energetic fields” (Gerber, 2001, p. 68). EP focuses on the body’s disturbed electromagnetic energies (the electrical charge in every cell and organ and the electrical pathways in the nervous system), the electromagnetic fields surrounding every organ and the electromagnetic field surrounding the body, and the qi energy, in order to relieve psychological problems so that the person can pursue personal goals (Khan et al., 2010).

From this perspective we will now have a look at the mind body connection in EP.

As the body reflects our mental life (Dychtwald, 1986), and “experiences change neural firing that change neural connections” (Johanson, 2009, p. 172), we can think of the mind body connection when we think about a very unpleasant situation or person and notice the emotional and physical reactions. We can feel our body tighten, we can feel ourselves clenching our teeth, we feel our heart beat faster and we breathe faster, and we can suddenly feel hot and start to perspire. On the other hand when we think of a loved one or a pleasant and happy time, we start to smile. So when an individual’s thoughts bring up positive or negative emotions, we notice that our body has a physiological response. When for example dopamine (a chemical in the brain that is called a neurotransmitter) is released, we experience happiness and pleasure. This chemical release or neurotransmitting starts when electrical impulses come down the nerve, hit the connection, and the connection results in the release of chemicals (neurotransmitters). The next nerve cell, is then infused with the chemicals, and binds to the receptors of the next nerve cell, which is called electrical change (Berns & Montage, 2011). Rolf, the biochemist and physiologist who created “Rolfing”, found that physical and emotional traumas tighten the body’s muscular and fascial muscles (Dychtwald, 1986). This becomes very evident when someone has for example aviophobia (an irrational fear of flying) and is forced to fly. We witness physical responses in the phobic person, such

as body rigidity, sweating, increased breathing and heartbeat, and the body chemistry (such as our neurotransmitters, hormones and oxygen levels in the blood) is being influenced when the phobic person experiences a surge of adrenaline when he/she has to board a plane to fly, which can result in the person being unable to fly (Dychtwald, 1986; Gallo, 2005).

Sometimes just thinking about the phobic object or situation triggers a negative emotional response and can create neurological changes, known as neural plasticity – the “ability of the brain to alter its structure based on its activity” (Feinstein, 2005a, p. 7). This ability of the brain makes it possible to rewire threat responses and EP interventions make use of the plasticity of the brain by calming the threat responses through acupoint stimulation or another type of intervention and therefore alter the brain structure and the reaction to the previously perceived threat (Feinstein, 2005a).

The physical reality of the mind – body connection through the work of the neuroscientist, Dr Candice Pert will be discussed next. Neimark (1997) discussed Pert’s (2003) discovery and mapping out of opiate receptors, “a chemical lock on a cell, into which a particular substance fits”, (Neimark, 1997, p. 1). The chemical key that goes into the chemical lock on the receptor is called a ligand and is a smaller molecule than the receptor it binds too. This process is known as “binding” (Pert, 2003, p. 23). Ligands are divided into three chemical types: 1) neurotransmitters, 2) steroids and 3) peptides. This binding process between the ligand and the receptor creates a disturbance which causes the molecule to rearrange itself until information can be transmitted from the cell’s surface into the cell’s interior and change the state of the cell. There are millions of receptors on the surface of a nerve cell waiting to bind with another matter, so the receptor can change shape and send a message into the cell (Neimark, 1997). The binding process is very specific where the opiate receptor will select only ligands which are members of the opiate group, like endorphins or morphine (Pert, 2003). Pert's study showed that the brain responds to the body’s internal



morphine and led to the discovery of the body's natural opiates – endorphins (Neimark, 1997). Pert discovered that many of the same receptors that are found in the brain, are also present on monocytes, a type of white blood cell which plays an essential role in our immune response. She came to the conclusion that the brain sends impulses which freely circulate intelligence throughout the body, instead of just sending the impulses straight down the neuron axes, so these cells are not only carried to the brain, but to the rest of the body as well (Dossey, 1989; Neimark, 1997; Schulz, 2007). Because peptide receptors are found all over our body, in all the organs, glands, spinal cord and tissue of the body, and certain chemicals that have emotional impact also control the routing and migration of monocytes, Pert came to the conclusion that consciousness operates at a cellular/body level as the peptides serve as a communication network for the body (Dossey, 1989; Neimark, 1997). She preferred to call these messenger molecules “informational substances” (Pert, 2003, p. 71), a term first introduced by Francis Schmidt, or just peptides instead of neuropeptides because they are not only present in all parts of the brain, but in the whole body as a whole body communication system (Pert, 2003). High concentrations of almost every neuropeptide receptor were discovered on other bodily locations, especially on the spinal cord site, the hippocampus (which is crucial in memory and which she called the brain's emotional gateway), the limbic cortex and the amygdala. This indicates that the emotional brain is no longer confined to the amygdala, hippocampus and hypothalamus (Pert, 2003). Pert (2003) took a huge theoretical step by stating that “emotional memory is stored throughout the body” (p. 3) and we can therefore “access emotional memory anywhere in the network” (p. 3), which makes us bodymind individuals where the body and brain is not separated, because the peptide network extends to all the organs, glands, the spinal cord, the entire lining of the intestinal tract (from the oesophagus through the large intestine), and tissues of the body (Dossey, 1989; Neimark, 1997; Pert, 2003). Schulz (2007) also indicated that Pert suggested that an individual's

emotional state is involved with the production of neuro-peptides and neurotransmitters and that the immune cells can carry emotions. Peptides were discovered to regulate our behaviour, mood and health, and Pert herself said “peptides are the biochemical correlate of emotion” (Neimark, 1997, p. 1), and they can alter each other as they are intricately interwoven with each other and as a result create a network where information is constantly being exchanged, processed and stored, linking brain, body and behaviour (Pert, 2003). Schulz (2007) further mentions that according to Foss, Pert’s research could be the missing link which connects messages from the mind to physiological responses, which is in congruency with Pert’s assertion that emotions produce an arrangement of bodily changes such as facial expressions (Neimark, 1997) and that peptides move with thought and serve as messenger molecules and connect thought and body reactions (Schulz, 2007) and retrieve and repress emotions and behaviours (Pert, 2003). Neuropeptide ligands produce emotional states which produce a behaviour, which fit the formulation of the body-emotion-mind connection (Pert, 2003).

Pert concluded that it is possible that emotion and memory are intertwined because the brain’s memory centres are filled with receptors for various neuropeptide chemicals, which not only regulate emotions, but have the ability to manufacture mind-altering chemicals (Dossey, 1989; Neimark, 1997). According to Pert (2003), the mind is the brain and the body and therefore material, but the involuntarily and unconscious flow of information among the cells, organs and systems of the body makes the mind immaterial as well. The mind holds the network together by linking the non-material nature of the psyche (mind, emotion and soul) to the material soma (molecules, cells and organs). The network represents a non-hierarchical system where all positions are equal to direct the flow of information. Because of this flow of information from one system to another system via the peptides and messenger specific peptide receptors to create communication, we realize

intelligence is involved in running our psychosomatic network, and creating behaviour and mental processes can no longer be believed to be limited to the brain alone as memory and intelligence are dispersed throughout the body in an infinite network of mind-body cellular communication (Pert, 2003). Siegel (2012) supports Pert's findings with his "mindsight principles" (p. 9) where he views the mind as: 1) "a self-organizing emergent property, a process that regulates energy and information flow" and 2) "being both embodied (within us) and relational (between us)" (p. 9). Pert calls these peptides and their receptors "the biochemicals of emotion" (Pert, 2003, p. 189) and they should no longer be considered to have less validity than physical matter. They play an important role as cellular signals in the process of translating information into physical reality - mind into matter, influencing both as they go back and forth between mind and matter (Pert, 2003). Johanson (2009) adds that when we experience influence and change, our neural firing consequently changes neural connections. Expressed emotions create a free flow of biochemicals, but when they are repressed or denied, the biochemical flow gets blocked (Pert, 2003). The physician and pioneer of disease treatment with biofeedback, Dr Green, asserts that all physiological change is correlated to fitting mental (conscious and unconscious) and emotional changes and vice versa (Pert, 2003).

It is important to understand the entangled mind-body relation and realize how psychodynamic aspects and physiological limitations are entwined to understand the relevant role it plays in psychosomatic conditions, such as eating disorders. Cognitive issues, like stress can contribute to the genesis of physical disorders such as fibromyalgia and in turn physical disorders can contribute to forms of psychopathology such as neuroses (Meissner, 2006). In the psychosomatic process a holistic view is embraced where the mind and body do not merely interact with each other, but they are synonymously integrated with each other through a joint frame where they cannot be disentangled; therefore the mind cannot

participate without the body and the body cannot participate without the mind (Meissner, 2006).

According to Pert's research, the body has to be healed through the mind and the mind through the body (Pert, 2003). Upledger (2003) has found through personal experience in his decades of intentionally dialoguing with his patients' body parts, systems, tissues, tumours, pains, viruses, etcetera at the cellular level and observing his patients' responses, that there is a relationship between cell activity and consciousness and that this may play a role in facilitating healing in the mind and body. Upledger came to the conclusion that individual cells, tissue and organs possess memory, emotional capacity and intellect (Fryer, 2003) which confirms what the hologram concept has shown – that every particle of matter encompasses information of the whole (Hunt, 2003). Through his personal and practical experience as a psychoneuroimmunologist, Dr Pearsall concluded that some type of cellular memory exists (Pearsall, 1998). Dr Schwartz and Dr Russek were the research team that initially proposed the theory that an energy that contains information is being communicated by the heart (Pearsall, 1998). This information containing energy is constantly being circulated through the body system by the heart which allows the cells of the body to create memories. They offer four hypotheses explaining how cells could create memories: 1) energy = information and all things in existence have energy which is full of information and this information energy is stored and creates cellular memory. These memories are constantly being exchanged amongst the different systems ("a set of interactions between inseparable units", Pearsall, 1998, p. 13), 2) our mind, consciousness or intentions are manifestations of this information energy which supports the physics point of view that information = mind, where information provides structure to a system and energy moves, communicates and connects all aspects of a system, 3) the heart is the main producer of the information energy, regulating the body's cells and organs which are immersed in this information energy, and 4)

we physically represent recovered cellular memories. According to cellular biology certain molecules, such as DNA (“a nucleic acid found in all cell nuclei that contains genetic information” Pearsall, 1998, p. 14), have good memories because of their ability to store multifaceted coded data. According to Siegel (2012) energy and information flow happens in us and between us. Because all cells have energy, they all hold and share information and we are therefore all essentially connected energetically (Pearsall, 1998). Feinstein (2012b) reminds us of the information energy carries when we think about the characteristics of energy, light waves, sound waves, radio waves, and the electromagnetic frequencies of x-rays, and came to the conclusion after investigating many studies that “Neurons resonate with brainwaves” (p. 71).

It is important to remember that in EP, when a memory is retrieved, it can be changed before it is stored again. The changes will include the limbic responses of the memory (Feinstein, 2008b). Therapeutic changes cannot be accomplished by in vivo or in vitro exposure to the aggravating stimulus alone, the limbic response must be altered and in EP it is done by manually stimulating particular acupoints which are believed to result in beneficial modifications in neurochemistry (Feinstein, 2008b). The beneficial modifications in neurochemistry are achieved when deactivating signals are being sent directly to the amygdala when the acupoints are stimulated Feinstein (2008b; 2012b). According to Feinstein (2012b) this results in the production of electromagnetic signals and brainwave patterns which reduce activation in the brain’s emotional centres and consequently stop the release of stress chemicals such as cortisol. A momentary balance in the meridians is thus achieved which resonates with the brain’s organizing fields, causing improved resolutions of problematic memories and emotions and support the emergence of intelligible clear memories, allowing neural pathways to revise or eliminate dated and problematic emotional memories (Feinstein, 2012b). Research shows that people report that after the healing

interventions they feel calm in response to previously distressing memories (Feinstein, 2005a; Gallo, 2002; Schulz, 2007; Swack, 2009).

If we look at the numerous placebo studies that have been done and noticed that sometimes the placebo is more effective than the active drugs they replace (if the subject believed the active drug would be effective), we realize the lack of separation between mind and body (Upledger, 2003). The impact of this nonlocal information energy and how it connects the body and mind could be observed during an experiment done by INSCOM (United States Army Intelligence and Security Command) where the white blood cells were scraped from a volunteer's mouth, centrifuged and placed in a test tube with a probe from a polygraph. While the cheek cell donor was in a separate room watching violent television programs, the donated cells stayed energetically and nonlocally connected to the donor as the polygraph detected extreme excitation in the cells when the volunteer was watching fighting or killing scenes (Pearsall, 1998).

Scientific disciplines such as epi-genetics, interpersonal neurobiology, psychoneuroimmunology and neuroplasticity supports the mind-body connection approach (ACEP website; Church, 2013; Feinstein & Church, 2010) and according to ACEP's website, there is an interconnection between the body, the brain and the mind's different systems which are recognized with a mind-body approach to treatment. Khan et al. (2010) explain that psychological problems cause the brain to send out electrical signals which results in an emotion such as fear, a perception or a behaviour that is incongruous with the present situation. And there are neuroscientists such as Joseph LeDoux who proposed that trauma can form certain neurological pathways, specifically in the amygdala which can result in a possible response process between emotionally involved somatic and neural responses (Lambrou et al., 2003), which supports Wiedermann & Wiedermann's (1988) statement that the nervous system is a stimulus-responsive system. During an EP treatment, the synergetic

effect of focusing on a specific undesired memory that brings up negative emotions while stimulating an acupoint, not only activates the body's energy systems and removes energy blocks, but also brings forth disruptions in the brain and brain stem by sending deactivating signals to the amygdala and other brain structures which typically results in extinguishing threat responses to harmless triggers and quickly reduces hyper arousal which results in spontaneous resolution of negative thoughts, feelings and memories without a conscious effort to change the experience (ACEP website; Feinstein, 2010).

The mind-body connection is not a new phenomenon in psychology as Breuer and Freud already concluded in their study of hysteria, that hysteria stemmed from repressed traumas, which manifested as symbolic physical symptoms, and Reich, who proposed the existence of *Orgone* energy, observed the energetic storage of psychological problems in various regions of the body (Gallo, 2005; Zeiders, 2003). Jung explored and expanded the theory of the unconscious and concluded that one of most noteworthy achievements of mankind is harmony between the conscious and subconscious mind (Gallo, 2005; Zeiders, 2003). Edwards & Edwards (2010) view the unconscious as a defence mechanism against reality, involving energetic exchanges, to which traumas, painful memories, ideas and wishes are transferred. And when any self-limiting emotional memories have not been processed, they will manifest in dreams, waking imagery and problematic behavioural patterns, until they have been adequately processed (Edwards & Edwards, 2010). This can restrict an individual's progress towards integration and coherence (Feinstein, 2012b). The accumulation of these repressions were initially regarded as energetic intensifications in the nervous system that have not been spread out by motor reactions and thus resulted in an accumulation of excitations which resulted in hysteria and conversions into physical disorders where the person's main gain is to avoid conflict, and a secondary advantage would be to receive attention for the disorder (Edwards & Edwards, 2010).

Pert (2003) states that suppressed traumas can be stored in the body. She also mentions that research suggests that countless conduits exist for the conscious mind to access and alter the unconscious mind and body (Pert, 2003). The concept of tissue memory confirms this theory by stating the body's cell and tissue ability to preserve traumatic memories, inclusive of the emotional environment. Tissue memory theory is clearly demonstrated through the experiences of donor transplant patients where they experience new traits and "memories" after the transplant surgery (Erickson, 2003). Louise Hay (1999) became an authority through her health challenges and life experiences on how and which mental patterns, limiting beliefs and ideas can create disease in the body. The body always talks to us and serves as a mirror of our inner thoughts and beliefs. An example of a metaphysical interconnection between mind and body will be for example the correlation between dis-ease such as insomnia which might have been caused by emotions of fear and guilt and lack of trust in the process of life. Or we can think of a permanently scowling face and ask ourselves what kind of mind produces a face like that – one with joyous thoughts or resentful thoughts. After years of practical experience Hay further came to the conclusion that only fear and anger patterns contribute to causation of illness in the body (Hay, 1999).

The body has a notion to be linked to consciousness where it becomes aware of external and internal functions that can be felt, sensed and expressed (Dunning & Woodrow, 2005). And Wilkinson (2000) asserts that the mind inevitably manifests in and through the body, and to suggest a disembodied mind seems compromised. Although the possibility that mental processes can positively influence the physical well-being of a person is still controversial and opposed, the field of psychoneuroimmunology (together with various other fields) indicate the influences that thoughts, images and feelings (mind) can have on the body (Braud, 1992). In Braud's (1992) personal research it was determined that there were considerable effects upon a range of bodily systems (such as reduced bodily tension), as well



as improvement in behaviour and academic performance when the individuals practiced relaxing and quieting mental techniques. A biofeedback machine can demonstrate that mind can move matter, where through your willpower you can make the meters move (Dossey, 1993). Chopra (2000) supports these theories by recognizing the interrelationships between biological, behavioural and psychological factors and their significance in the treatment of mental and physical issues. Feinstein et al., (2012) illustrated with the case study of Rose that although the client came in with physical complaints, correlated emotional issues organically surfaced. By working with the client's energy systems, the physical and emotional blocks to healing were simultaneously resolved energetically which in turn accelerated the client's progress because the presenting problem was addressed at the physical, emotional and energetic levels.

The coming together of these developments, from mind-body medicine to psychoneuroimmunology, highlights the strong influence emotional/ mental issues have on a person's overall health and healing, and research in Energy Psychology contributes to the investigation of the healing potentials of the mind-body model.

#### **2.4.7.2. The spirit connection**

Dualism, the split of the physical and spiritual realms, has been the dominating thought pattern for centuries in the west, starting with Plato (Foreman, 2008). Dossey (1989; 1993; 1999) speaks of different eras of Medicine as Era 1, 11, and 111, where Era 1 and 11 is similar to what was discussed before under mind–emotion–body connection. Era 1 is guided by Newtonian laws of energy and matter where the emphasis is on the material body, viewing it mainly as a complex machine. It is mechanical, material and physical and has a physical, body-based approach to health and healing. The mind is merely seen as a result of brain mechanisms and the effects of the mind and consciousness are absent. The mind is not a factor in healing and therapy is physical in nature, and includes for example drugs, irradiation

and surgery Dossey (1989; 1993; 1999). If the approach is mainly physical, which can include manipulation, nutrition and herbs, it can limit healing to the physical or it can also bring shifts to the emotions, mind and spirit as the body is closely linked to the other aspects of the human being. Holistically viewed, this era, has a less powerful effect than mental and spiritual approaches as it focuses on one aspect of the human being and excludes a healing relationship with the practitioner, but it can prepare the person for a deeper level of healing (Shannon, 2010).

The following era, is the era of mind-body medicine, Era 11, which expands on Era 1. The importance of the mind and consciousness and their attribution to physical change and healing within an *individual* is recognized (Dossey, 1989; 1993; 1999). The individual's mind affects the individual's body. Mind-body approaches have been in existence for a very long time, and additionally scientific evidence started to show that thoughts, emotions, attitudes, and perceptions can affect the body (Dossey, 1989; 1993; 1999). Although psychology is named after the soul, it redefined itself to be associated with the self (Foreman, 2008), making the mind the main factor during therapy and therapies in era 11. Therapies that depend on the mind and emphasize the effects of consciousness exclusively within an individual body such as meditation, counselling, hypnosis, most imagery-based therapies, psychoneuroimmunology and biofeedback can be associated with Era 11 medicine (Dossey, 1989; 1993; 1999).

Era 11 includes and goes beyond Era1. They exist side by side, complimenting each other, and sometimes they fuse, and a new discipline such as psychoneuroimmunology develops. They are both local in nature where Era 1 emphasizes a mind assured in the physical brain and an individual physical body in a specific place and time. Era 11 stresses the effect the *individual* mind and consciousness have on the individual body in a specific place and time (Dossey, 1989; 1993; 1999). When the individual surrenders him or herself to

a power bigger and beyond him or her, for example God, the above mentioned modalities of therapy can bring forth deeper healing on the body, mind and spiritual level (Shannon, 2010).

Era 1 and 11 have their limitations as so many phenomena are still unexplainable from their perspectives, and they bring us to Era 111 medicine. According to Dossey (1999) this is the first form of medicine that has a nonlocal approach to the relationship between mind, body and time. Era 111 views the mind as unbound in time and space, omnipresent and infinite, not confined to an individual brain and body, but extending beyond the limitations of an individual brain and body. Neither is it confined to the present moment or even a single lifetime. The mind is viewed as more than the brain, as it can behave nonlocally in the universe, acting remotely from the body, something the brain cannot do. Health and healing is collective and not limited to one individual and is possible at a distance. The nonlocal mind can share thoughts and feelings at a distance, gain information and knowledge through dreams and visions, have a knowing of the future, etcetera. The mind is a factor in not only therapy, but healing, both within and between people and any treatment where the effects of consciousness conduit between different persons, such as intercessory prayer, transpersonal imagery and other forms of distant healing, can all be associated with Era 111. Therapies in Era 111 incorporate therapies of Era 1 and 11 (Dossey, 1989; 1993; 1999). Benor (2001) mentions that systematic changes can go beyond an individual where the family can be influenced as well, and if the focus of healing was on resolving a relationship, the healing will have an effect on the relationship *and* the individuals involved. Ancient cultures followed a wholeness model to achieve wholeness by combining the mind (philosophical), the body (medicinal) and religion (soul) in their treatment approaches. Individuals were not separated from society, but were treated as part of it, making the wholeness of an individual vital for societal wholeness. Each element – mind, body, soul and culture – was important and were integrated with each other (Foreman, 2008).

Inclusive of the holistic, bioenergetic approach of Energy psychology is the spiritual dimension which Dossey speaks about in his Era 111 medicine. Dossey (1989, p. 1) asks why do we “speak of the soul in an age of science”? and perhaps it can be answered with a quote from a meditation of Julian of Norwich “Our soul is one to God, unchangeable goodness, and therefore between God and our soul there is neither wrath nor forgiveness, because there is no between” (Myss, 2004, p. 219).

Big scientific minds such as Einstein and Newton knew this, as Einstein’s theology and science (in which EP has its foundation) were inseparable, and physics for him was an attempt to “understand God’s work” (Dossey, 1989, p. 143). Isaac Newton, like Einstein, believed in God and most of his focus was on investigating alchemy which he initially thought would get him recognition. Both these great scientists stand in great paradoxical contrast to the ideal of modern science to purge all things God, resulting in the science that eventually followed Newton to regard nature as a neutral and godless machine. Science like any other subject, including psychology, becomes political when it picks the great minds’ insights and chooses those insights that are fashionable and permissible to decide which are scientifically valid or not. We cannot ignore a human’s soul when it is suggested that there is part of the human psyche that is not limited to space and time, which bridges consciousness between people, and which might even precede birth and survive death (Foreman, 2008; Dossey, 1989). Dossey (1989) speaks of the nonlocal mind, which is “*boundless* and *limitless*” (p. 213) like God, just as “L” energy or qi is called nonlocal, as it is everywhere all the time and not confined to a specific place and time (Pearsall, 1998). If we share these characteristics with God, we cross the division between God and us and we can say there is an element of God within us and an element of us in God, a meeting of God and creation (Dossey, 1989).

According to Gerber (2001) spirituality is the energetic foundation of all life. We realize that everything in life is a spiritual experience, if we are aware of every task and our every intention (Benor, 2001). You become aware how all human stress corresponds to a spiritual crisis, and there is an opportunity to gain insight in how you have used, misused or misdirected your spiritual power during an illness (Myss, 1996). I can think of an example when someone tells me about their continual anxiety and feelings of tiredness. If we are continuously anxious and fearful, we are in fight/flight mode which has an effect on our immune system, making us sick and tired, but ultimately it comes down to a lack of faith in God. If we trust in God, a Higher Power, and we have faith, it creates a mindset of surrender which results in a feeling of peace and joy. Spiritual healing allows the release of energy blocks in the body, reducing emotional tension which reduce physical tension, resulting in a more relaxed body and mind, which makes it easier for an individual to access higher levels of awareness and can help them come to deeper insights. Spiritual healing has the ability to unlock people to intuitive, spiritual awareness (Benor, 2001). Christel Nani (2006), a medical intuitive, says that she can see in an individual's energetic blueprint when they don't believe in God or a Higher power and that it has a damaging effect on their energy system.

People will start to recognize that their mental, emotional and physical states and degree of spiritual attunement with a Higher Power play an important part in their health and sense of well-being when they can view emotional or physical distress as a possible spiritual block and a message from a Higher Power that is trying to connect with them (Gerber, 2001). Caroline Myss (1996), like myself, find that the healing process is accelerated when the problem is viewed within a spiritual framework. We can look at the Biblical Scriptures and the healings of Jesus Christ which was more than just physical healings, it was spiritual as well, demonstrating Divine power at work, transforming lives, reclaiming lives and reawakening lives to their highest nature, making bodies and souls whole and holy (Myss,

2004), healing the whole person, showing the holistic viewpoint of Scriptures that all of life is spiritual, including the physical (Foreman, 2008).

We distinguish and make ourselves known to others through the heart's choices, preferences and opinions, which the Greeks referred to as the will, and which is known by many as the core of our being, the spiritual part (Foreman, 2008). The heart and the brain influence the entire body, but the heart reminds us continuously that we are sending and receiving information of our soul which is associated with qi and sees and knows everything, making all the choices (Pearsall, 1998; Walsch, 2009). Spiritual healing is transmitted through the heart of the healer to the heart of the recipient of the healing (healee), creating rapport through a deeply felt intuitive connection. When the heart is open and receptive during treatment, the healer experiences a deep, unconditional, accepting love, and knowing or sensing the healee on deeper levels. The healee becomes aware of the healers love which can open the healee to knowing the Creator's unconditional love which allows healing on all levels (physical, emotional and spiritual), pursuing wholeness in healing (Benor, 2001). Instead of functioning in the lower aspects of awareness where we project our fears and misunderstandings on the outside world, we can realize that the problem lies within when we release blockages in our heart chakra and open our heart. When our heart opens, we experience compassion and empathy for ourselves and others and move closer to experience and express the divine unconditional love of "Christ Consciousness" (Gerber, 2001, p. 480), the ultimate phase of spiritual awakening for many. This echoes Walsch's (2009) statement that "One does not understand God, one simply experiences God" (p. 243). Therefore it is important that our heart chakra is released of blockages and open as our personal and spiritual transformation relies greatly on it (Gerber, 2001).

Since Caroline Myss's first medical intuition she realizes that people's medical issues are about the human spirit, although they many times manifest physically, mentally or

emotionally (Myss, 1996). Foreman (2008) mentions that all humans are spiritual beings who make decisions about God and their relationship with God, even an atheist who decides that there is no God. There is a spiritual yearning in everyone and an emptiness in our hearts that cannot be satisfied by anything inside or outside ourselves, nothing can fill or satisfy that void, but the spiritual (Foreman, 2008).

Myss (1996) first used energy terms to explain the issue at hand as the word *energy* is neutral without any religious association. She started to include spiritual language after she realized the congruencies between the seven Hindu chakras, the seven Christian sacraments and the ten secret Cabbalistic truths which made her come to the conclusion that spirituality is a biological need just as it is a psychological and emotional need, as our biological design is a spiritual design (Myss, 1996). They share the same qualities and all three suggest 1) interactions with Power and taking increasingly more control of our own power, and to 2) not release one's spirit into the physical world through the faithless act of fear or negativity and therefore choosing personal will over Divine will. They are at the core of our spiritual power, instructing us how to direct our qi (Myss, 1996). Violating these truths weakens our spirit and what drains our spirit, drains our body, while honouring them strengthens our spirit and that which energizes our spirit, energizes our body. Part of our spiritual work in this lifetime is to learn to balance the energies of our body and soul, thoughts and actions, and that of our physical and mental power (Myss, 1996). It supports our transformation into conscious, mature spiritual beings. The sacred spiritual texts such as the Bible, Torah, Sanskrit, to name a few, emphasize that our life's purpose is to understand and develop the power of our spirit which is imperative for our mental and physical health. When we abuse or misdirect this power, we deplete our spirit and qi (Myss, 1996). Whatever people call this power, God or Divine or whatever their personal choice is, it cannot be ignored nor can we pretend that it does not exist, because life itself is expressed through it (Walsch, 2009).

## **2.5. Energy Psychology's effectiveness from an energetic point of view**

The field of Bioelectromagnetics (the study of “how bio organisms interact with electromagnetic fields”) according to Dunning & Woodrow (2005, p. 157) and Zeiders (2003) backs the assertion that energy affects both the physical and psychological health of organisms because magnetic fields producing electrical currents (extending outside the body) are present in all living organisms. Feinstein et al. (2005) believe that if you can modify these energies, you can have an impact on a person's health, emotions and state of mind. This in turn supports Gallo's (2005) hypothesis that energy directed therapy can prove to be comprehensive and immediately effective. Especially when you take into account McTaggart's (2002) view, whose data reported that invisible energies carry information, and organize mental health processes and matter. Gallo (2005) further hypothesized that if serotonin depletion in an anxious or depressed person could be explained, neurologically, biochemically and cognitively, it could also be explained through electrical, electromagnetic or photoelectric processes since serotonin is essentially energy. And if serotonin is energy, serotonin production could be regulated with a treatment intervention grounded in energy theory such as Energy Psychology, and therefore alleviate the symptoms of a disorder, such as anxiety and or depression (Gallo, 2005). According to Gallo (2005), Roger Callahan views the interaction between the energy system and mental disturbance in the associated thought field as the fundamental and primary cause for distress, rather than developmental and cognitive aspects. Wilhelm Reich observed the energetic storage of psychological problems in the musculature and numerous other areas of the body and believed that stored libido energy (the somatic core of neurosis) should be expressed, be fully discharged, because the psychosexual conflict hinders the flow of energy in the body and energetic release would help the patient to relieve further neurotic symptoms (Gallo, 2005; Zeiders, 2003). Craig (2005) discovered that imbalances in the body's energy system (created by negative emotions and



thought processes) greatly affects a person's personal psychology and that the true cause of negative emotions is therefore involved with a disruption in the body's energy system and adding a tool, like an EP method to your own approach, helps facilitate neurological change (Feinstein, 2005b; Feinstein et al., 2005). This follows the assumption that psychological disturbances can be treated by addressing subtle energy systems in the body as energy is the fundamental fractal of all psychological problems (Gallo, 2005).

## **2.6. Acknowledgement of Energy Psychology' efficacy**

EP is a clinical modality as it utilizes clinical methods (for example exposure and cognitive restructuring), combines verbal and physical procedures, and incorporates concepts and techniques from non-western healing systems to create therapeutic change (Feinstein, 2012a). EP recognizes the role human energy has in healing emotional distress, based on the concept that thought energy such as electrochemical, electromagnetic and bio magnetic energies, has the ability to interact with the body's energy systems down to the atomic levels (Lambrou, Pratt, Chevalier, & Nicosia, 1999). When incorporating EP in your work, you desire to facilitate holistic change, including principles and techniques that incorporate working with the person's physical energies to bring forth emotional, mental and spiritual changes. As EP techniques incorporate Traditional Chinese Medicine (TCM) principles, working with the body's subtle energies, research within EP is built upon a substantial body of research on acupuncture (Feinstein, 2005a).

To establish this new form of psychology, evidence to support existing theories had to be found in order to add veracity to the field (Feinstein, 2005a). This was accomplished by: 1) the accumulation of case studies and anecdotal reports, 2) systematic observation and 3) formal research which meets established scientific standards and is published in peer-reviewed professional journals. Numerous case studies, uncontrolled outcome studies, non-

peer-reviewed investigations and anecdotal reports exist and support the veracity of EP and can be found on different websites such as the ACEP website – [www.energypsych.org](http://www.energypsych.org), the HBLU™ website - [www.hblu.org](http://www.hblu.org), and various other websites such as <http://www.eftuniverse.com> - which focuses specifically on research studies, [www.eft-articles.com](http://www.eft-articles.com) - a link to about 300 articles on EFT, [www.innersource.net](http://www.innersource.net), [www.wholistichealingresearch.com](http://www.wholistichealingresearch.com), to name a few, and in books such as Gallo's *Energy psychology and psychotherapy*. Apart from ACEP, there are also several other EP organizations such as The Canadian Association of Integrative and Energy Therapies (CAIET), The Association for the Advancement of Meridian Therapy Techniques (AAMET) in the UK and numerous other European organizations. Feinstein's paper, *Acupoint stimulation in treating psychological disorders: Evidence of efficacy* (2012a) consists of a comprehensive literature search, up to April 2012, where he identified 51 peer-reviewed papers which reported or investigated the clinical outcomes of EFT and TFT on psychological issues. The paper excluded other EP approaches. Two of the peer-reviewed random controlled trials (RCT) meet APA Division 12 criteria which establishes "a form of EP as a 'probably efficacious treatment' for specific phobias" (Feinstein, 2012a, p. 19). One example of a peer reviewed case study to demonstrate the veracity of EP can be seen in Swack's (2009) treatment of a Vietnam Veteran with **Post Traumatic Stress Disorder** (PTSD), by using HBLU™, including EFT/ NBD. The patient completely recovered from PTSD after 6 sessions done over 3 months, which was confirmed with the PTSD testing measures one month post treatment.

I, as any other therapist who wants to gather data about the effectiveness of a new treatment, will observe it systematically as would a clinician who introduces a new therapy, or a researcher who introduces a new therapy to a specific population group under special circumstances, such as the study done by Johnson, Shala, Seidijaj, Odell, & Dabishevci

(2001) on severely traumatized war victims. In their study, 105 victims of ethnic genocide in Kosovo received TFT treatments over several months in five separate visits. The 105 victims had a total of 249 traumas, and according to self-reports 103 of the 105 patients treated, experienced complete recovery from the emotional effects of their traumas, and 247 of the traumas were completely resolved. Follow up data five months later reported that the improvements were sustained. Most of the treatments were done in one session, which lasted less than an hour. Johnson also travelled to Rwanda, the Congo and South Africa to offer his services to traumatized individuals and reported a high success rate (Feinstein, 2012a; 2008b).

In his dissertation, Schoninger (2003) systematically described his observations of 48 randomly assigned individuals with **public speaking anxiety (PSA)** by using objective measures such as standard anxiety inventories. Subjects received an one hour treatment with TFT and demonstrated a decrease in public speaking anxiety and a significant improvement in their anticipation of future public speaking experiences afterwards. The improvement was still present at the four-month follow up (Schoninger & Hartung, 2010).

Jones, Thornton, & Andrews (2011) did a subsequent study with 36 volunteers who had PSA and were randomly assigned to a treatment group and a wait-list control group. Subjective self-report measures were taken before, during and after treatment. The treatment group received a 45 minute EFT session and changes in scores taken before and after treatment revealed a significant decrease in PSA on all subjective and behavioural measures. The study concluded that EFT is a quick and effective treatment for PSA.

According to Darby's (2001) dissertation, discussed in the review article by Darby & Hartung (2012), he systematically observed 20 patients with needle phobias, serving as their own controls. The 20 patients reported significant improvements on the fear and distress levels for

blood, injections and injury after a one hour TFT treatment which was sustained during the one month follow up measures.

In comparison to acupuncture, there are only a few published empirical studies that directly investigate EP (Feinstein, 2005a), and they all mainly include TFT, EFT and/or breathing. We will now have a further look at some of these uncontrolled studies and randomized controlled trials to establish a measure of efficacy for EP. The first published random controlled trial (RCT), demonstrating the efficacy of acupoint tapping with an established *DSM - IV – TR* (American Psychiatric Association, 2000) diagnosis, was done by Wells et al. (2003). They investigated whether EFT procedures were similar to placebos, and how much improvement could be gained in a single session. The subjects had phobias of insects or small animals such as rats and were randomly assigned to two groups. The thirty five subjects were treated individually during a single thirty minute session with EFT ( $n=18$ ) or with DB ( $n=17$ ) (**D**iaphragmatic **B**reathing – a physical intervention widely used for anxiety disorders). The two treatments were kept as similar as possible between the groups, except for the physical intervention (tapping or breathing) which served as the primary variable. There was only imaginative exposure to the animals. The phobic reaction of the 35 participants improved considerably after just one short simple treatment session in the case of DB and EFT treatments. EFT, however, resulted in better behavioural improvement, especially in avoidance behaviour, which was maintained at the six to nine month follow ups. Baker & Siegel (2005) did a partial replication and extension of the Wells et al. (2003) study where they added a no-treatment control group and changed the comparative conditions by adding a supportive interview. Participants were randomly assigned to three groups: an EFT group, a supportive interview group, and a no treatment group. After a 45 minute intervention, EFT showed a significant decrease of fear for small animals directly after treatment, which was sustained more than a year later. The other two groups, the supportive

interview and no treatment control groups, showed no improvement in phobic reactions. A follow up study a year and a half later showed no relapse in phobic reactions in the EFT treatment group. The results supported the outcome of Wells et al.'s (2003) study (Baker, 2010; Baker & Siegel, 2005).

Salas (2001) conducted a partial replication study of the Wells et al.'s (2003) study for her master's thesis in 2001 to investigate the effectiveness of EFT in the reduction of anxiety associated with specific phobias such as heights, snakes, syringes, and darkness. She compared EFT and DB treatments by observing 22 college students. The group served as their own control, where half received EFT first and then DB, and the other half received DB first and then EFT. There was a visible improvement in both treatment groups (mean improvement = DB: 11.5 % and EFT: 30.14%) after a single brief session, although EFT proved to be statistically superior in all three measures that were used (SUD, BAI, Approach) in anxiety reduction and behavioural symptoms of specific phobias, regardless whether it was administered before or after DB (Salas, 2001; Salas, Brooks, & Rowe, 2011). This study also supports the Wells et al. (2003) findings (Salas, 2001; Salas, Brooks, & Rowe, 2011).

Wade, (1990) in his doctoral dissertation, investigated the effects TFT phobia treatments can have on self-esteem and self-concept without focusing on either self-esteem or self-concept during the treatment. Twenty eight experimental subjects and twenty five wait-list control group subjects were included in the study and treated with a TFT algorithm, including the reversal procedure. Wade (1990) concluded that there were significant improvements in self-acceptance, self-esteem and a decrease in self-incongruences, and these improvements were still present two months after the treatment, while the 25 subject wait-list control group showed no improvement. These results show that the TFT phobia treatment has positive effects on the self-concept.

Lambrou, et al. (1999) discussed two pilot studies on the effectiveness of TFT. The first study

observed the clinical effects of TFT on claustrophobic subjects. Psychological, physiological and behavioural tests were given to test subjects before and after exposure. After the 30 minute treatment, the experimental group, in contrast with the control group, experienced improvement with significant reduction in anxiety, a lower resting heart rate, using electromyography (EMG) showed a reduction in EMG, which indicated relaxation of the trapezius muscle, and they also experienced behavioural improvements (Lambrou, et al., 1999). There was also a difference in EEG measures of alpha and theta activity between the treatment and control group after treatment, where the treatment group experienced an increase in theta EEG frequencies which is associated with relaxation, and which further suggests that anxiety can produce disruptions in brainwave activity. Changes in the electrical conductance between acupuncture points along the meridians were also observed with an AMI apparatus. This study suggests the occurrence of specific physiological and psychological changes for claustrophobic individuals after a TFT treatment (Lambrou, et al., 1999; 2005).

Lambrou, et al.'s second preliminary study used a MEG to investigate the magnetic qualities of three emotionally charged thoughts, examined the magnetic output of the brain for distinguishing frequencies, power spectrums and pinpointing the source of the magnetic signals. TFT was self-administered to treat anger. Pre and post treatment differences could be seen in the power spectrum waveforms (Lambrou, et al., 1999; 2005).

The largest study of EP treatments to date was done over a period of 14 years, at 11 clinics in Argentina and Uruguay, and involved around 31 400 patients and 36 therapists. The overall study, under the guidance of Dr Joaquin Andrade, did not use a control group, but the sub-studies did. The overarching study and its sub-studies investigated the effectiveness of EP treatments in medical settings. The largest sub-study stretched over five and a half years and involved the treatment of 5000 people diagnosed with anxiety disorders. One half received

EP treatments, without any medication, and the other half received the standard procedure at the clinics - CBT, supplemented by medication when needed. Follow up interviews directly after treatment and follow up interviews 1, 3, 6 and 12 months post treatment showed EP treatments to be more effective than the existing treatment in both categories - the *some improvement* and *complete remission of symptoms* categories, which was supported by the pre and post test scores on the standardized psychological tests used. Noticeable changes in brain wave patterns showed on pre and post treatment brain scan images also matched the interviewers' findings. One sub-study found that the length of treatment was shorter with EP than when the standard procedure was followed and another sub-study found tapping the acupoints to be more effective than inserting needles into the points (Andrade & Feinstein, 2004; Feinstein, 2005a; 2012a).

Benor, Ledger, Toussaint, Hett, & Zaccaro (2009) conducted a pilot study to explore the treatment benefits of **W**holistic **H**ybrid **D**erived from **E**ye **M**ovement **D**esensitization and **R**eprocessing (WHEE), Emotional Freedom technique (EFT) and Cognitive Behavioural Therapy (CBT) on 15 Canadian university students with test anxiety. The participants were equally divided into 3 groups, where 5 received WHEE treatment, 5 received EFT treatment and 5 received CBT. All three treatments showed a significant reduction in test anxiety in two sessions, although the CBT group needed 5 sessions to achieve the same results as the WHEE and EFT groups achieved in 2 sessions. They came to the conclusion that both WHEE and EFT show promise as viable treatments for test anxiety (Benor, et al., 2009).

Schulz (2007) researched and evaluated the experience of 12 therapists who integrated EP (specifically meridian based Thought Field Therapy techniques) into their practice while treating adult survivors of childhood sexual abuse (CSA). The participants used a combination of EP techniques, and some combined the EP techniques with CBT and solution focused therapy as a treatment for CSA, but overall they found that EP techniques were most

effective with anxiety-related disorders. The therapists in Schulz's (2007) study also noted that clients showed improvement in both interpersonal and intrapersonal relationships, improved mood changes, experienced less negative emotions and flashbacks, less self-harming behaviours, could view the trauma with neutrality or positivity, improved self-confidence, self-esteem and assertiveness, and displayed improved self-care, when EP techniques were incorporated in the treatment. They all agreed that the integration of EP techniques enriched their lives and their client's lives.

The controversial approach of including EP in therapy and using EP techniques such as EFT in the treatment of psychological disorders, results in unusual speedy and precise therapeutic changes in affective, cognitive and behavioural patterns, and several international humanitarian relief organizations (such as the Green Cross, the TFT Trauma Relief Committee, the ACEP Humanitarian Committee) incorporate EP in their post-disaster missions. EP has been applied to victims of natural and human disasters in the Congo, Guatemala, Indonesia, Kenya, Kosovo, Kuwait, Mexico, Moldavia, Nairobi, Rwanda, South Africa, Tanzania, Thailand and the U.S. (Feinstein, 2008b).

Another great breakthrough and a huge contribution to EP's efficacy, is that since November 11 2012, ACEP has been approved by the American Psychological Association (APA) to be a provider of Continual Education (CE) credit for psychologists and is able to provide CE credit for their EP programs. This step is the starting point of acceptance of EP within the framework of more mainstream approaches. The APA approved provider status for EP, however, does not mean that the APA has approved any EP method per se (Retrieved from <http://energypsych.org/displaycommon.cfm?an=1&subarticlenbr=329>).



The above mentioned findings lend support to EP interventions such as WHEE, EFT and TFT's efficacy in the treatment of phobias and PTSD and invite further possibilities for EP research and to correct any shortcomings in already completed research.

This brings us to the discussion of some of the relevant EP approaches and techniques that can be used in the transformation of phobias.

## **2.7. Phobia resolution with HBLU™**

HBLU™ can be viewed from an Energy Psychology background while integrating the best of biomedical science, psychology, spirituality, applied kinesiology, hypnosis, Neuro-Linguistic Programming (NLP), and other Energy Psychology techniques, including TFT and EFT. This holistic therapeutic model on the structure of complex physical, mental, emotional and spiritual damage patterns has been developed from Dr Swack's original research and follow up tests (Swack, 2001b & 2003b). Its comprehensive structure alone makes for a valuable instrument in facilitating problem resolution, from phobias to supernatural interference. HBLU™ detects different layers and aspects of phobias, traumas, limiting beliefs, boundaries and other interference patterns and then uses an Energy Psychology technique of choice to transform it. HBLU™ does not see itself as separate or isolated from other Energy Psychology techniques, and neither does it see itself as separate from psychology and traditional therapy.

HBLU™ has its origins in biochemistry as Dr Swack's (a Ph.D. biochemist and immunologist) education and extensive training includes enzymology, neurochemistry, molecular biology and immunology. From this unique perspective, she moved to NLP where she discovered the unconscious mind and its workings. Her scientific oriented mind appreciated the NLP concept that all damage has structure, and from there she developed a structured approach where specific damage patterns can be treated with specific and

reproducible protocols. Through further investigation she found the body level through the work of Callahan (TFT) and Mary Louise Muller (applied kinesiology, cranio-sacral and polarity therapy). Not satisfied with incomplete results, her research took her further to discover the integration of the soul through the Enneagram personality structure. She discovered further supernatural interference patterns through her work and educated herself further in this direction. On each of these levels effective treatment protocols were created for different issues on the specific level (Swack, 2001b). An HBLU™ protocol usually includes an Energy Psychology intervention(s)/technique(s) (Swack, 2001b; 2003a; 2003b) which will ultimately work together with the methodological approach of the protocol to resolve an issue, such as phobias in this research study.

HBLU™ categorizes interference/damage patterns in three major categories. The first category comprises life experience interference patterns where the damage occurs in the conscious mind, unconscious mind and the body level. The second category of interference occurs in the personality/ego structure, and the last category refers to the external interferences caused by the supernatural, natural disasters, and “nasty people with free will” (Swack, 2003b). According to Swack (2003b) these damage patterns cause negative emotions which are energetic sensations felt in the body, hence the name feelings. Because emotions carry more energy than thoughts, they influence our perceptions and behaviour. Therefore it is important to identify the type of interference and on which level it occurs, feeling it in the body and then use a technique to balance the interference pattern. All the levels – body, conscious mind, unconscious mind and soul - are accessed and involved during treatment which results in resolution on all the levels simultaneously (Swack, 2003b).

As discussed above and in chapter 1, HBLU™ is a method that incorporates techniques. By applying HBLU™ the interference on the goal, such as a phobia can be detected, the type of phobia (fear, shame, hybrid and/or anticipatory) can be identified, the

phobia can be delineated, and finally an intervention of choice can be applied to release/neutralize it. The clearing takes place on the conscious, unconscious, body, and soul levels, which is verified with muscle testing. Phobias are an HBLU™ level 1 interference pattern for which there is a specific, pragmatic, structured, albeit flexible protocol. The flow chart of the HBLU™ Standard treatment protocol can be viewed in Appendix K and is described and explained in detail in chapter 1 under *1.2.1. Reasons for relieving individuals of subtle phobias with HBLU™, an Energy Psychology method.*

One of the techniques that can be used in co-operation with a specific protocol is Natural Bio- Destressing (NBD), a technique Swack modified from EFT (Appendix P). EFT will be further discussed in this chapter under *2.9.3. Emotional Freedom Technique (EFT) in the treatment of phobias.* She noticed that the meridian tapping sequence stimulates the same areas of the body we normally unconsciously touch when stressed to calm ourselves, for example holding the forehead, drumming the fingers, hugging yourself, etcetera. When we focus consciously on the issue while tapping on these points, the body's natural calming reflex is activated; this integrates the right and left brain information and neutralizes the negative emotion. The new association is then made within a relaxed state and not within a negative state (Swack, 2001a; 2001c). Swack (2001a; 2001c) alleges the more relaxed state alters the behaviour favourably. If a phobia is “an exaggerated, irrational emotional (and physical) reaction that is out of proportion with what is happening in reality and that *cannot be controlled mentally*” (Swack, 2001a, p. 6; 2007b), and negative emotions and thoughts create energetic imbalances which affect a person's psychology (Craig, 2005), then it is easy to understand the rationale behind using energy psychology techniques like TFT, EFT, NBD, etcetera in an attempt to relieve phobias and traumas.

As a phobic reaction is a conditioned physical reaction/reflex, we cannot control it consciously. Phobic people understand that their fears are irrational, but they still can't change them; they cannot talk themselves out of sweating or hyperventilation, which contributes to further shame and more fear (Callahan, 2001). To neutralize the body's phobic reaction, a mind-*body* intervention is needed to activate the body's natural relaxation reflex (Swack, 2006a). Conscious and unconscious mind techniques alone will not be effective because the phobic reactions are stored in the body and therefore these shock imprints should be released from the body (Swack, *n.d.c*). Not every technique is effective for a person or situation, and the beauty and strength of HBLU™ lies in its incorporation of different Energy Psychology techniques amongst a range of choice it offers so that treatment can be individualized.

We will now have a look at some of these EP approaches and techniques.

## **2.8. Energy Psychology approaches integrated with HBLU™ during phobia treatment**

### **2.8.1. Mindfulness**

Shannon (2010) reminds us that when we enter a relationship with another individual, the connection alters both individuals. In therapy, a connection in which no one can remain unaffected, the foundation for non-specific relational aspects such as sensitivity, understanding, compassion and acceptance, is formed. In this regard, people skills are as important or more important than technical skills. A therapist's presence, actions and words should create rapport, engagement and connection in order to provide a positive personal approach and support to their clients (Shannon, 2010).

An EP approach is more than just applying EP techniques and Gallo (2012) reminds us to not totally rely on a technique alone, because although it is useful, it can keep you away from the real truth and it can be disempowering to the client. Apart from being schooled in

and having knowledge of psychological principles and ethics, EP also requires of the practitioner to be mindful, which can be described as “being in the present” and “as accepting and observing without evaluation” and being “calm and not driven” (p. 367), “combining attention and the suspension of judgment” (p. 368), a practice which is present in several effective treatment methods (Childs, 2007). An attitude of mindfulness in the therapist can effectively assist with relaxing the client and help to prevent him/her to become overwhelmed by supporting the client to tolerate feelings and thoughts which they prefer to avoid (Childs, 2007). Siegel (2012) believes that mindfulness is such a profoundly integrative approach that it can actually grow integrative fibres in the brain. A mindful practitioner can guide a client to be mindful, curious, open, accepting and caring about their inner awarenesses in an intrapersonal way in order to keep the direction of attention focused on the present, allowing for a fuller experience of the present. A mindful practitioner can also steer clients away from judgment and thoughts about how things should be instead of how they are in the present. Therefore, mindfulness allows us to take a step back and become aware of how we respond to internal and external stimuli (Johanson, 2009; Siegel, 2012). Gallo (2012) adds that mindfulness helps us to observe the person in the present, and by our own presence as a therapist, we are drawn to the beauty of the person in front of us, reminding us to keep our eye on the God within us and the other, which is therefore not only beneficial for the client, but for us, the practitioners, as well.

Although most biomedical clinicians do not acknowledge the connection between a client's life story and the development of a physical illness, they would agree that a client's illness does have meaning for them (Broom, 2000). According to Broom it is important to refrain from devaluing subjectivity, but to include a client's story, by listening to their use of words and the personal meanings that they attach to their illness, as to become aware of the correlations between the symbolic, verbal meaning (their use of metaphors), the body

language they use and the manifestation of the physical illness. In his research, Broom found that the clients' language produced unexpectedly accurate applications to the presented illnesses. For example, a woman who had to keep a brave face had developed a facial rash. In this way, the woman could express her difficulties in a physical way and explained it verbally when she spoke about her brave face (Broom, 2000).

The practitioner can ask detailed questions about a smell, a colour, or even a phobia, and make the client aware of the physical sensations that are presently felt which can help to stabilize the organically unfolding, emerging memory (Johanson, 2009). Memories that are embedded in the body can have an impact on a person's thoughts, perceptions and behaviour and can therefore cause psychological symptoms (Feinstein, 2012b). When the client tells his/her life story, the verbal area in the brain is being kept active, which in turn helps to balance the left and right brain hemispheres (Johanson, 2009). Diamond (1979) adds that the two hemispheres of the brain are working together when we are not stressed. Diamond (1979) assumes that the content is not important, but rather the therapeutic tone of the therapist's voice, which will become therapeutic if the therapist's brain hemispheres are balanced, and if the therapist's Life Energy is high when he/she is speaking, and if his/her intention is based on love and concern to strengthen the client. The voice is therapeutic when the thymus is active, which means that the therapist's stress levels are low. According to Diamond (1979) a therapeutic voice has the ability to raise a client's Life Energy, rebalance energy imbalances, and correct an underactive thymus gland which releases stress hormones. The thymus gland can be stimulated by thumping it or by placing the tip of the tongue against the roof of the mouth in the front of the palate. This place is called the "centering button" (Diamond, 1979, p. 67). When the therapist has an attitude of comfort and trustworthiness, the client is encouraged to function on a different level other than on the conscious level (Upledger, 1997). A mindful approach includes meaning and imagination (Broom, 2000), and Johanson

(2009) reminds one to stay mindful, to be present, and to assist the client to stay mindful of what he/she is experiencing during the storytelling session, which brings the focus back to the client. People respond to the world in a multidimensional way, reacting and expressing themselves as a whole body, mind, and action entity (Broom, 2000). Focused attention on the body can help our systems to digest information, and the information can then be filtered and processed so as to effect healing (Pert, 2003).

This intelligent form of communication creates one body–mind (including both conscious and unconscious mind and emotions) as the body becomes the physical manifestation of the mind which reflects the TCM philosophy that the body is inseparable from the mind and therefore cannot be treated separately from each other, nor can only the body or only the mind be treated (Pearsall, 1998). This integrated mind/body approach should not view one part as more important than the other, and should resist a “body-first” or “mind-first” approach, but should rather think in terms of an integrated mind-brain continuum (Broom, 2000, p. 162).

Mindfulness reminds us about the importance to not only be fixated on a protocol, but to also joyfully and lovingly connect with our client. Practicing mindfulness provides the person with perspective of their inner world, but does not have to eliminate the practice of intention, by viewing the cause and consequences of a disorder.

### **2.8.2. Intention, intent and intentionality**

According to the *American Heritage Dictionary of the English Language*, intention is an aim that guides action. According to *Webster’s Encyclopedia Unabridged Dictionary* (p. 991) intention is 1) an act or instance of determining mentally upon some action or result and 2) purpose or attitude toward the effect of one’s actions or conduct. Ash (2003, p. 393) mentions that “Intention is the purposeful activation of the mind, but as intended.” According

to Zahourek (2009, p. 10) “intention, intent and intentionality have often been used as interchangeable terms (*sic*)”.

If we look at the word intent we see that according to *Webster’s Encyclopedia Unabridged Dictionary* (p. 991) it is 1) the state of a person’s mind that directs his/her actions toward a specific object, and 2) having the mind or will fixed on some goal. Zahourek (2009, p. 10) mentioned that “Psychologists are more likely to refer to intentionality as a complex, focused, purposeful, mental process that results in actions and behaviors”. Zahourek (2009) theorized that “intentionality is related to, but different from intent and intention” where intent and intention are defined as “having a purpose, plan or goal. It is the motivation(s) behind the goal” and intentionality is “both a *capacity* and an *energetic potential*. Intentionality is the capacity to create and modify intention. Without intentionality, intention is static and has no energy and no action.” (p. 18). Intention has a positive or negative potential as we can see when we use prayer or healing, then intentionality according to Zahourek is used in a good way, but when we are wishing for someone to get hurt (for example by cursing someone) it is used for evil (Ash, 2003; Zahourek, 2009). Intention can come from a place of love or fear, and as a therapist, it is important to remember this before and/or during therapy (Ash, 2003).

Factors such as mindfulness and intention need to be included in healing, and Gallo (2009) mentions that apart from stimulating acupoints, chakras, using imagery, and **M**uscle **T**esting (MT), there is also an emphasis on intention in EP, especially if energy and information flow can be directed by intention, according to Siegel (2012). Therefore both mindfulness and intention are active ingredients in the HBLU™ phobia protocol where both the therapist and client are intentionally focused on the storyline, outcome and resolution of the phobia. As proposed before, an EP procedure by itself will be insufficient. To produce therapeutic results and benefits, the therapist and client should include intention as an



instrument to guide the therapeutic process to an appropriate target or goal because “Intention directs the consciousness of the therapist” (Ash, 2003, p. 392). When the technique or modality is directed towards a goal in the mind, by using intention (Gallo, 2005; Zahourek, 2009), it will be beneficial for healing if healing is defined as “a fluid process representing a shift, a change, or a transition to a new or restored sense of balanced wholeness and wellness” (Zahourek, 2009, p. 18). And when we keep in mind that through intention we don't only change our mind, but our physical brain as well (the growth structure of the brain is changed, the size of particular cortical areas in the brain change their thickness) as Dr Richard Davidson (2011) and his team showed through their studies which were designed to measure how intention can create compassion through meditation. In his paper Braud (1992) mentions that many experiments indicate the human ability to influence other people's physiological reactions over a distance, using mental methods such as intention. According to Braud (1992), focused intention can produce increased calmness, activation or arousal, even if the intention is focused on another person and even if that person is not present. It is important for the “intentioner” though, to be in the intended state before he/she focuses his/her intention on another to bring forth change (Braud, 1992). Ash (2003) adds that clarity of thought is vital in terms of effective intention when it is used during therapy. He goes even further to suggest that if a person does not have a healing intention, healing will not take place, reminding us that intention, or the lack of it, can have a positive or negative effect on the healing process. We can see this theory taking effect during a treatment that involves a placebo product that is supposed to have certain properties but does not have those properties. When the person who is taking the placebo product, assumes that the product will have the intended effect, the person does tend to experience the intended effect of the drug. The placebo effect is well documented, especially in western allopathic medicine, which lends us to conclude that the body/mind relationship exists. Perhaps it is intention that makes the

placebo work as if it were the real product, thus according to Ash (2003) placebo and intention is the same thing.

Dossey (1999) summarizes several studies that show the positive correlations between 1) intentions and prayers to promote healing, 2) intentions to aid in wound healing, 3) intentions to limit injury in human tissues, 4) intentions to sterilize wounds and using intentions to encourage regaining consciousness after anaesthesia. Intentionality does not only have an effect on humans, but on machines as well, as demonstrated by the **Intentionally Imprinted Electrical Device (IIED)** of professor William Tiller when the machine was imprinted with the intention to alter the acidity (ph) of water. Imprinted devices were sent to distant laboratories where they either increased or decreased the acidity of the water according to their programming. The same effects were obtained in a laboratory in England before the device arrived, suggesting that intentionality alone could produce the same effects (Tiller, 2003). The **Princeton Engineering Anomalies Research (PEAR)** program, which for 20 years researched the interaction of human consciousness with sensitive physical devices, systems and processes, identified subtle energy connections between people and a person and a machine. In the PEAR program individuals who had the intention to connect to and influence their machines energetically in a loving, joyful and playful manner, could alter the behaviour of the machine and did better than those who tried to control and manipulate the machines through hard individual effort alone.

Hard effort and following a protocol without flexibility, human kindness, mindfulness and intention, can lead to frustration for both the practitioner and client. On the other hand EP protocols and techniques can help to keep a practitioner mindful and intentional.

## **2.9. Energy Psychology techniques incorporated in the HBLU<sup>TM</sup> phobia protocol during phobia treatment**

EP as “the branch of psychology that studies the effects of energy systems, such as the acupuncture meridians, chakras and morphic resonance on emotions and behavior” (Gallo, 2005, p. 227), has its foundation in Traditional Chinese Medicine. Because of the body’s composition of energy pathways and centres and their interchange with the individual’s cells, organs, moods and thoughts, EP’s most frequently employed protocols include a wide spectrum of psychotherapeutic interventions which incorporate applied principles and techniques for working with the body’s physical energies by the stimulation of specific acupuncture points and chakras while holding healing intentions to facilitate therapeutic change emotionally, mentally and behaviourally (Benor, 2007; Feinstein, 2012a; Feinstein et al., 2005). According to Kahn et al., (2010) touching these key acupuncture points, eliminates emotional traumas or blockages from the mind/body field and brings rapid, thorough relief from psychological problems. EP is also consistent with and builds upon contemporary western science (such as the work of Dr Candice Pert – discussed under 2.4.7.1. *The mind-emotion-body connection* ) and utilizes conventional psychology and psychotherapy methods such as exposure and cognitive restructuring such as visualization, as discussed earlier under 2.3.1. *Conventional phobia treatments* (Andrade & Feinstein, 2004; Feinstein et al., 2005; Feinstein, 2012a; Kahn et al., 2010). EP is also used to complement other psychotherapies, drugs and medical procedures. The verbal and physical procedures of Energy psychology with the intention to produce positive psychological therapeutic change is seen as a clinical and self-help modality (Feinstein, 2008b; Feinstein, 2012a).

Major EP texts by authors such as Gallo and Feinstein show four tiers or levels of EP treatments, which consists of: 1) immediate relief and stabilization, 2) elimination of conditioned responses, 3) overcoming complex psychological problems and 4) promoting

optimal functioning. EP treatments can incorporate all the above tiers/levels such as in complex stress reactions and in chronic disorders, or they can be made to fit the client's immediate need where the person might just need tier/level 1 (immediate relief and stabilization) during a crises intervention or when it is necessary to provide psychological first aid. EP treatments bring immediate relief when it utilizes an intervention which is incompatible with limbic arousal, such as tapping on acupoints (Feinstein, 2008b).

When a person develops a maladaptive conditioned response such as a phobia, EP techniques are also applied. At tier/level 2 (elimination of conditioned responses), limbic arousal is eliminated when the appropriate technique is used to target the relevant internal and external signals which trigger dysfunctional fear or avoidance in, for example, a phobia. The intervention interrupts the problematic existing cognitive and behavioural patterns and in doing so extinguishes the conditioned response.

At tier/level 3 (overcoming complex psychological problems), EP approaches have the ability to hone in on the core issue of complex psychological problems by identifying and targeting the relevant aspects of a complex issue, one by one, until the core issue is exposed and treated. A complex issue such as a phobia might include aspects of self-defeating beliefs, unresolved traumatic memories and associated beliefs, which will all be addressed during treatment.

Because the treatment releases the person from the limbic responses (the symptoms) connected to the triggers and memories of the core issue, the person(s) have the ability to be more functional and move on with life. At tier/level 4 (promotion of optimal functioning), EP approaches and techniques may also be applied to change self-concept, improve motivation, pursue personal goals, increase confidence, courage, and social skills and support spiritual growth.

EP approaches often incorporate additional clinical or personal development approaches

(such as CBT or Positive psychology) during tiers/levels 3 and 4 (Feinstein, 2008b; Khan et al., 2010). According to Gallo (2012) a method is powerful when it is flexible and includes a relationship between a practitioner and a client. In addition, research shows that believing in and enthusiasm about the method in both the practitioner and client is important, and can result in a very powerful method for achieving change (Gallo, 2012, track 8). One of the approaches added to the HBLU™ methodology is Kinesiology which is used to help direct the healing process. This will be discussed further in the following sections.

### **2.9.1. Kinesiology, Applied Kinesiology or Muscle testing**

“Kinesiology (pronounced kin-easy-ology) is a form of biomechanics which investigates and analyzes human motion.” (Bonnell, *n.d.*). Kinesiology is “the study of muscles and muscle movement (*kinesis*, motion)” (Gallo, 2005, p. 211). **Applied Kinesiology** (AK) developed by George Goodheart, is dissimilar from kinesiology and is described as “a unique method of evaluating bodily functions by means of manual muscle testing”(Gallo, 2005, p. 51). AK combines manual muscle testing with therapy localization which involves “touching specific points on the body, which is purported to assist in disclosing information relevant to the treatment of a structural, chemical or mental problem” (Gallo, 2005, p. 211). Chiropractors, nutritionists and homeopaths use Applied Kinesiology to dialogue with the body (Bonnell, *n.d.*; Gallo, 2005). “Muscle or Energy Testing, is the response of our individual energy systems to the vibrations of certain substances, people and even statements we make” (Bonnell, *n.d.*). Florence and Henry Kendall developed manual muscle testing, which is based on the fact that “structural and nutritional deficits results in impaired muscle functioning,” to evaluate muscle strength (Gallo, 2005, p. 211). We apply muscle testing as a feedback mechanism by receiving strong or weak muscle responses in the form of yes or no answers in, order to validate someone's unconscious awarenesses (Benor, 2004; Nicosia,

2012; Swack, 2007b). Friedman (2002) refers to muscle testing as energy checking and uses it when he wants to “assess energy flow and verify what is going on with clients” (p. 207).

According to Gallo (2005), Dr Goodheart used AK to tune into the body’s inner wisdom and Nicosia (2012) echoes this when he states that we are guided towards information that neither the practitioner or client is aware of, because muscle testing (MT) helps to provide (previously unknown) information to the practitioner and client and can therefore provide new inner reality perspectives through the client's own inner wisdom. Goodheart studied the acupuncture system in relation to the emotional body and how to achieve emotional balance. Through the use of MT he identified many acupuncture sites associated with certain emotions (Gallo, 2005). Goodheart also discovered that each large muscle is related to a body organ and that there is a direct relationship between muscles and meridians (Diamond, 1979). When the muscle was successfully treated, he found that the organ function improved as well (Diamond, 1979). Goodheart further found that there is a relationship between muscles, organs, neurology, the lymphatic, vascular, respiratory, energetic (meridian), and mental systems and their functions. Thus although muscle testing can assess muscle strength, it is not used to simply evaluate muscle strength, but it also assesses the function of the nervous system, meridian system, neuro-lymphatic system, neurovascular reflexes and various organ systems via muscle responses and can therefore help to determine and give insight into the underlying causes of a person’s emotional state and/or health problems (Gallo, 2005). A weak muscle is also an indication that the associated parts need a rebalancing of energy (Benor, 2004; Diamond, 1979). Therefore AK is based on the principle that specific muscles reflect conditions of internal organs because they share the same meridian. The fact that the language of the body never lies, provides us with the chance to use the body as an analytical instrument (Gallo, 2005).

Diamond (1979) also realized the association between meridians and emotions through kinesiology testing. He was the first to extend AK to emotional and psychological issues when he integrated applied kinesiology (AK) and psychotherapy and created behavioural kinesiology (BK), recently referred to as life energy analysis (Diamond, 1979; Gallo, 2005; Mollon, 2007). According to Diamond (1979) stressful thoughts and circumstances and negative thoughts can deplete life energy, therefore BK focuses on the factors in a person's environment and lifestyle that could raise or lower energy levels (Diamond, 1979; Gallo, 2005). This phenomenon becomes evident when a person is asked to think about something negative and they not only feel weak, but their MT is weak as well by showing muscular dysfunction. The weakened muscle indicates that the life energy has been compromised. On the other hand, if the person thinks about something positive the muscle will remain strong, displaying neuromuscular function, suggesting a strong life energy. So, positive emotions result in "strong" muscles and negative emotions result in "weak" muscles (Gallo, 2005). Diamond (1979) points out to keep in mind that when BK is applied that the mechanical strength of the muscle strength is not tested, but rather the energy of the associated meridian. The resulting assumption is that the energy supply to the muscle is evaluated, rather than the muscle itself (Gallo, 2005).

Callahan (2001) detected disruptions in the body's energy system by assessing muscle strength during his (TFT) treatments. After the thought field (energy field of thoughts) is effectively treated and the person is released from associated distress, the muscle that tested weak before will test strong again. Like Diamond's method, TFT utilizes MT because it has the ability to reveal specific information to treat psychological issues (Gallo, 2005) and Benor (2004) mentions that he personally found AK techniques helpful to help clients explore unconscious beliefs and conflicts. Because MT is a collaboration between the tester and the

testee in order to gain information outside their conscious awareness, it is also rapport-building by nature (Nicosia, 2012).

#### **2.9.1.1 Muscle testing in HBLU™**

In HBLU™ practitioners use the term muscle testing, although it is better associated with what Gallo (2005) refers to as neo-kinesiology. There is a distinction between AK and neo-kinesiology in which the latter includes TFT and several other approaches (Gallo, 2005). HBLU™ practitioners work with the person's conscious, unconscious, body, soul and energy fields simultaneously, and in order to facilitate healing, the client must be able to communicate and access information from all the levels of being. This is done when clients are taught to use the NLP technique of communicating with the relevant part of their body. To access information from the unconscious mind, body and soul, we use muscle testing which includes questions that are directed to the client's soul and deepest wisdom, before the answers are received by means of the body (Swack, 2002; 2007b). The body is addressed because it is the home of our physical survival, reproduction and values, and it provides "a good home for the soul so that the soul can live in the material world" (Swack, 2003b, p. 1). During MT the client's soul and deepest wisdom reveals hidden underlying issues of the client's problem, selects the priority goals, indicates interference patterns with regard to the goal, directions, and healing steps, and chooses the priority technique for clearing the interference patterns from a menu of techniques (Swack, 2007b). HBLU™ practitioners connect with the soul to direct the healing because "The soul is the land of soul mission and connection with God, and all [of] life on this planet and in the universe. The soul values making a contribution and living a full and meaningful life as long as the mortal body lives." (Swack, 2003b, p. 1). John Diamond sees the soul as "perfect, innocent and good" and he believes that "The more one is in touch with one's soul, the more profoundly balanced one's life energy becomes" (Gallo, 2005, p. 81). MT can be inaccurate or ambiguous when an



individual's system is not ready for energy work and either the tester or testee experiences energetic and/or polarity imbalances, is dehydrated, too stressed or fatigued, or under the influence of alcohol and drugs (Nicosia, 2012). To assure accurate MT, HBLU™ includes a simple clearing procedure (Appendix G) before the person is prepared for MT and before treatment starts. At the end of every treatment clients write down what they have learned from the healing (Swack, 2007b).

Any muscle in the body can be used to access information from the body (Nicosia, 2012). There are several different ways to muscle test as can be seen in Appendix I. I use the standing tilt test (description in Appendix I, # 6), because it is safe for the client and for the practitioner, when a practitioner is not licensed to touch a client or if he/she works with a severely abused or tortured client, who might not tolerate physical touch. It is also a strong convincer as the client does not feel manipulated by the practitioner and cannot accuse the practitioner of influencing the muscle testing by for example pressing too hard on the arm. From personal experience I also observed clients becoming emotional (e.g. bursting into tears, starting to laugh) when they realize that they can and do have control over their mind and bodies which can contribute to a feeling of self-empowerment. When the standing tilt method is used and the practitioner stands next to the client, it is less intrusive and the practitioner is better able to observe subtle changes, such as breathing patterns, changes in skin colour and heart beat changes in the client. The practitioner is also able to pick up finer nuances for example when the client moves to the side or in a circle or not at all during questioning, which give the practitioner and client the possibility to investigate the reason for this reaction providing both with more necessary information. All these non-verbal cues and insights help to guide further questioning. Observing these subtleties is what Nicosia (2012, slide 6) calls the "subtle Ideomotor cues", and these often overlooked motor cues (because of

their subtlety) can provide valuable unconscious information. I found that these nuances are very hard if not impossible to pick up with the other muscle testing methods.

Benor (2004) mentions that it is important to develop proficiency in muscle testing by attending training, workshops and to diligently practice this skilful art, as a lack of confidence and incorrect MT mechanics can lead to inaccurate MT, according to Nicosia (2012). It is important to be aware of your own limitations, hopes and wishes and also realize the possibility of personal unconscious expectations and unresolved issues when practicing muscle testing (Benor, 2004). One of the requirements to support accurate muscle testing is to make sure both the client and the practitioner are free from neurological disorganization (energies are switched, scattered or confused) and psychological reversals which contradict stated intentions (Nicosia, 2012; Wheeler, 2002). One of the most important requirements in this diagnostic and therapeutic process is to gain and maintain rapport with your client as you continue to assist the client to observe the issues and the relevant therapeutic needs in this process and to remember that MT is a rapport-building instrument (Nicosia, 2012). Gallo (2005) reminds us further that it is important to remember that the muscle testing response is not the ultimate truth, but should rather be considered an indicator or suggestion of the client's state and intention and an instrument to double check what we already know (Nicosia, 2012). Other measures such as interview questions and responses, observation, history, personal experience and education are just as important in order to assess a situation. The structured HBLU<sup>TM</sup> phobia protocol can be viewed in Appendix L.

The two leading approaches that have received the most attention and investigation in the field of Energy Psychology and the treatment of phobias is Thought Field Therapy (TFT) and Emotional Freedom Technique (EFT). Both of these therapies are based on the same concepts as acupuncture and their focus is on the meridian system (Schulz, 2007).

### **2.9.2. Thought Field Therapy (TFT) in the treatment of phobias**

A typical EP protocol which incorporates acupoint tapping, is composed of the client activating the symptom or presenting problem through imagination, evocative phrases, such as "I am very afraid of spiders", or sensing the problem during the initial rounds of tapping until the emotional edge is subsiding and the emotional landscape is changing. The brain experiences a mismatch with the original traumatic memory due to the deactivation of the limbic system during tapping. After treatment a person will remember the traumatic experience since they had the negative emotion such as irrational fear in the past, the new emotional reaction however, feels different, appropriate, and proportionate to the experience (Feinstein, 2012b). Two of the most widely used EP tapping techniques are TFT and EFT. We will now first have a look at TFT.

Thought Field Therapy (TFT) is a unique therapeutic response, that not only drew from applied kinesiology, but from other disciplines like acupuncture, NLP, biology, quantum physics and clinical psychology (Callahan, 2001). TFT is based on “diagnosing and treating energetic aspects of psychological problems as associated with the acupuncture meridians by percussion on acupoints” (Gallo, 2005, p. 230). TFT’s approach is new to the world of psychology, from the way it diagnoses to the approach of treatment and the interventions of choice (Callahan, 2001). TFT, like EFT can be called psychological acupressure as it involves gentle tapping on or near the beginning or ending of acupoints while thinking about the currently presenting psychological issue (Gallo, 2005). Tapping on these points relieves psychological distress and even physical pain (Khan et al., 2010).

There are two diagnostic approaches in TFT: muscle testing and voice technology. In voice technology, a trained practitioner decodes the nature of the client's problem by

assessing the voice as the voice carries the structure of the problem. The latter can be conducted over the phone as well as in person (Gallo, 2005).

The treatments are short and effective and do not require a long series of uncomfortable treatments that might drag on for months or years (Callahan, 2001). This rapid method to eliminate phobias and other psychological distresses, began with the case of Mary Ford and her phobia of water (Callahan, 2001; Mollon, 2007).

During the 1980's Callahan worked for 18 months with a client who had a severe water phobia and could hardly take a bath or go out when it rained. He tried several different therapies on her during an 18 month period, including client-centred therapy, rational-emotive behavioural therapy, systematic desensitization and hypnosis. After all these treatments, she could only sit at the shallow side of the pool without looking at the water and would complain of terrible headaches afterwards (Gallo, 2005). Callahan was frustrated with her minimal progress and decided to evaluate her through a variation of the applied kinesiology diagnostic testing methods he was studying. While thinking about the water while he tested her, he discovered her stomach meridian was out of balance and tapped at the end of the meridian. Within a minute the client said her problem was gone. They tested her phobia by exposing her to water. She splashed her face with water and said her anxiety was gone. And it never returned (Gallo, 2005).

Callahan himself was astonished and continued to explore the issue (Mollon, 2007). He shifted the way he was thinking about psychological disturbances, their cause and cure and started to focus on the role of energy as the central component. With only a 20% success rate tapping all phobic patients just under the eye (stomach meridian), he realized that not all phobias can be treated by using only this one meridian point. Through muscle testing he discovered that each psychological and sometimes physiological disturbance has a unique

pattern and specific sequence in the meridians similar to a DNA code which would therefore need a specific treatment procedure and so he started to create his algorithms - the exact sequence of the meridian points for specific conditions (Gallo, 2005; 2012). TFT uses specific algorithms for specific issues. Sometimes there will be more than one algorithm for a specific condition. Phobias for example have 2 algorithms; one for most fears and phobias and another for spiders, claustrophobia and air turbulence. These two algorithms for phobias change only in sequence (Callahan, 2001; Gallo, 2005).

Apart from the fact that Callahan clinically researched TFT for over two decades, a fair amount of research studies have been done on TFT. Noteworthy studies of TFT include several Figley/Carbonell studies conducted at the Florida State University. In one of the studies, the researchers carried out a systematic clinical demonstration study to compare and evaluate the effectiveness of four therapies in the treatment of PTSD. They compared the effectiveness of TFT, **E**ye **M**ovement **D**esensitization **R**eprocessing (EMDR), **V**isual–**K**inesthetic **D**isassociation (V/KD) and **t**raumatic **i**ncident **r**eduction (TIR) in 156 patients who suffered from a traumatic experience, including having phobic reactions. Although all 4 treatments were effective, TFT was reported to be the most effective, rapid and lasting (Callahan, 2001; Carbonell & Figley, 1999; Feinstein, 2008a; Gallo, 2005).

Carbonell and one of her students carried out an experiment as a follow up of this study, which involved treating 156 acrophobia college students with TFT using the Cohn Acrophobia Questionnaire and a behavioural test. After treatment, subjects showed a significant difference between the placebo group and the group that received TFT treatment, where the latter had far less anxiety and showed significant improvement (Callahan, 2001; Feinstein, 2008a; Gallo, 2005).

After the first unpublished radio study by Callahan (1985-1986), Leonoff repeated the study 10 years later (1995-1996), but included Voice technology as a diagnostic tool. The

results of these 2 studies were almost identical, where TFT resulted in quick changes, and both studies had a success rate of 97%, although the research was done almost a decade apart (Callahan, 2001; Flint, Lammers & Mitnick, 2006; Gallo, 2005).

Commentary was given by Efran, J.S (Ph.D.) in Feinstein's (2005b) article, *Energy Psychology and the Instant Phobia Cure*, that he tried the method on a few of his clients with no success. He did diverge from the protocol by not making the clients focus on the issue (singing happy birthday instead) and with that did not follow the *mind* body principle where the person should think and focus on the problem while tapping. Callahan's method is called *Thought Field Therapy* which is based on the perspective that a person's thoughts express information in the energy field of the body and the thought field sustains the problematic thoughts and emotional responses and behaviours (Feinstein, 2012b; Mollon, 2007).

According to Gallo (2005) "thought field" does not only entail sensory, linguistic, neurologic and chemical features like thoughts, but it also includes an energetic field. He therefore advises the client to tune into the thought field associated with that psychological issue (Feinstein, 2012b; Mollon, 2007). Efran also did not understand that Energy psychology has an integrative approach to psychology and does not see itself as isolated from psychology and traditional therapy, nor as a replacement. Feinstein (2005b) responded appropriately to not view Energy Psychology as a replacement to a comprehensive clinical approach, but rather as an addition, especially when it comes to more complex and multi layered issues. Energy Psychology builds upon and works within the context of conventional psychology by adding a non-invasive tool that helps to facilitate neurological change according to each practitioner's approach, which can be a welcome relief for client and practitioner (Feinstein, 2005b; Feinstein et al., 2005). Gallo (2005) confirms that some phobias are more complex and require more aspects to be treated before healing can take place.

TFT seems to be effective in the treatment of not only phobias, but a wide range of other psychological conditions. Part of the success might be attributed to its diagnostic approach which is very different from the traditional methods because it identifies the root of the problem, unlike the official diagnostic manual of the American Psychiatric Association, DSM-5 (2013), which only offers a descriptive diagnosis. Callahan views the interaction between the energy system and the mental disturbance in the associated thought field as the fundamental and primary cause for distress, rather than the developmental, cognitive and chemical aspects (Gallo, 2005).

### **2.9.3. Emotional Freedom Technique (EFT) in the treatment of phobias**

Gary Craig, inspired by Callahan's work, developed his own variation of TFT and called it EFT (Emotional Freedom Technique). Craig did not add anything to Callahan's method, but rather simplified TFT by removing certain complexities like the exact sequence of the meridian points for specific conditions (algorithms) and the two diagnostic tools such as **m**uscle **t**esting (MT) and **v**oice **t**echnology (VT) (Gallo, 2005). Craig replaced all the algorithms with one comprehensive algorithm that he refers to as the basic recipe. He claims to find an 80% success rate when he uses only this algorithm on a wide variety of problems. The basic recipe consists of tapping on all fourteen main meridians, on certain acupoints on the body and face while thinking about the emotion or issue and verbalizing it (Craig, 2005; Gallo 2005; Khan et al., 2010; Wells, et al., 2003). An essential part of the basic recipe is the setup statement which has two parts; 1) a statement of the client's presenting problem while tapping on an acupressure point and 2) a cognitive reframe - acceptance of the condition/state of the client as it is/they are, while tapping on an acupressure point (Church, 2013). An example of a setup statement can be: "Even though I have (this problem), I deeply and completely accept myself". Rather than using Callahan's diagnostic tools, Craig relies heavily on his NLP training to lead him to the related issues (Mollon, 2007). EFT is a client-centred

approach which focuses on the client's distress, rather than on the therapist's diagnosis and is therefore often successful in addressing and treating multiple diagnoses and symptoms concurrently (Church, 2013). Gallo (2005) notes, that Craig further simplified his Basic recipe by removing the 9 gamut, as he found them to be unnecessary. From Craig's (2005) perspective EFT is an improvement on TFT, as it covers a wider variety of problems with one simple routine.

Craig (2005) discovered that imbalances in the body's energy system greatly affect a person's personal psychology and that the true cause of negative emotions is therefore involved with a disruption in the body's energy system. EFT - which is the most widely used and well known of the meridian based therapies as an intervention for phobias and other psychological distresses - seems to work extremely well and fast, based on this understanding (Benor, 2013; Craig, 2005; Feinstein et al., 2005; Flint et al., 2006; Wells et al., 2003). Successful case studies of this method, based on self-help, peer-help and professional applications on a variety of issues from phobias to physical pain have been demonstrated repeatedly and can be viewed on a variety of websites like [www.energypsych.org](http://www.energypsych.org); <http://www.EFTUniverse.com>; [www.eft-articles.com](http://www.eft-articles.com); [www.ClinicalEFT.com](http://www.ClinicalEFT.com); [www.elevatedtherapy.org.uk](http://www.elevatedtherapy.org.uk); [www.eft-articles.com](http://www.eft-articles.com); and [www.innersource.net](http://www.innersource.net). These case histories show the effectiveness of EFT on many physical, mental, and emotional issues. Gruder (2012) could not find any research and/or articles to disconfirm the efficacy of acupoint tapping on psychological issues in his extensive literature search. Since the 11th of November 2012, EFT has been approved by the APA and moved from an extreme and questionable therapy to more extensive professional acceptance. Dawson (2013) defines clinical EFT and reviews numerous studies (current through May 2013) to show how it meets the APA criteria in his paper *Clinical EFT as an evidence-based practice for the treatment of psychological and physiological conditions*. Numerous studies were done on EFT as a



treatment modality for phobias and trauma and some are discussed under 2.6.

*Acknowledgement of Energy Psychology' efficacy* and we will look at one more here.

EFT was tested on one hundred and nineteen university students in 2003, to measure their fear and phobias and the effectiveness of a brief EFT treatment (two – three minutes, and only two rounds) by Waite & Holder (2003). The subjects were treated in group settings. The treatment included three conditions: 1) using The Basic EFT Recipe, 2) tapping on sham points on the arms (placebo), 3) tapping the points on a doll (modelling), and then there was a fourth no-treatment control group. There was a decrease in distress and discomfort at post – treatment in all 3 treatment groups, but not in the control group. The study showed that the basic EFT protocol quickly reduced fear levels, regardless which points were tapped on. This suggests that the success of EFT does not necessarily depend on tapping the specific meridian points. It is however still unknown whether the physical intervention, the verbalization or the combination of the two was responsible for the change in fear levels. With no follow up evaluations, the researchers came to the conclusion that the clinical significance of EFT still needs to be confirmed and needs further research (Waite & Holder, 2003).

It seems that meridian based techniques can be effective in the treatment of specific phobias to reduce or eliminate symptoms like anxiety and fear in a short period of time. Craig (2005) himself claims that EFT can effectively treat all phobias by eliminating the phobic part, while normal and healthy caution remains. Followers (both lay and professional people such as Benor, 2013) of TFT and EFT on websites such as the ones mentioned above on p. 120, claim great success in the treatment of phobias with an absence of abreaactions during treatment.

There are a limited amount of quality studies on this topic, and although there are an increasing number of anecdotal reports from clinicians trained in Energy Psychology

therapies, more research is needed, not only to show the effectiveness of TFT and EFT, but the incorporation of these techniques in other Energy Psychology methods, like HBLU™. The results of these studies also warrant further application and observation of Energy Psychology as a whole.

#### **2.9.4. Additional Energy Psychology treatment approaches**

The most popular EP treatments for phobias are the ones discussed above. TFT and EFT however are not the only EP techniques that can be incorporated within the HBLU™ phobia protocol. When Gallo (2005) reminds us that “all fundamental change entails transformation at the energy level” and the international renowned healer, Alla Svirinskaya, noted that “true healing starts on an energy level” (Svirinskaya , 2005, p. 119), we remember and realize that there are other effective techniques that can also have a positive impact on the energy system. Apart from applying mindfulness, intention, muscle testing, TFT and EFT, there are other techniques that can be used during the treatment process. Those that were used during this research process will be presented next.

#### **2.9.5. Energy psychology treatment approaches that were used during this research study**

All participants chose the priority interventions of choice (from Appendix O) through muscle testing. Five of the ten participants needed to apply EP techniques before they could successfully continue with muscle testing and the phobia process and all participants needed more than one intervention to clear the phobias.

##### **2.9.5.1. Tapping with the Watchmen in the tower**

This technique is a personal adaptation from an EFT variation which I found on one of the EFT websites. This technique includes the three necessary ingredients for clinical EFT

according to Church (2013), which is 1) exposure, 2) cognitive shift and 3) acupressure. I had used it before with great success in my private practice and when one of the participants requested this intervention as the priority intervention of choice; we applied it with great success. This technique helps to assess the client's nervous system and if it is in a healthy state, the amygdala (the symbolic watchman/watchmen) will be in a state of relaxed expectation. The client is required to visualize the watchmen and tell the practitioner what they see before the treatment begins and then after each round of EFT until the watchmen are in a relaxed state of expectation instead of being hyper vigilant all the time. This form of EFT requires presence, insight, guidance and skill from the practitioner.

#### **2.9.5.2. Boundary tap**

There are different variations of tapping and one of the variations is the boundary tap, a technique acquired during HBLU<sup>TM</sup> 1 training and which was applied during the course of this research. During the application of this technique the client brings to mind the person or thing with whom or with which he/she needs boundaries installed. The client identifies the negative emotion(s) or effect, due to the lack of boundaries. The client taps on the sternum to seal the boundary and uses a feathering motion from the sternum up to the base of the throat, up the neck, and out towards the chin to eject any negative energy such as a specific emotion, he/she does not want to keep (Swack, 2007b).

#### **2.9.5.3. Reversal/ Conflict tapping**

Another variation of tapping, is the Reversal/ Conflict tapping technique. This technique was also required during this research study for three participants' phobia treatments. During this intervention, the client taps in a semi-circle above and around the ear while he/she simultaneously follows the practitioner's crossed fingers forming an infinity sign (horizontal figure eight) while repeating: "In spite of this conflict in attitude, I deeply

and profoundly love, accept and respect myself” for a few short minutes (Swack, 2007b). The last part of the sentence is an EFT inclusion (Gallo, 2005).

#### **2.9.5.4. I Feel/ I am**

*I feel/ I am* is a technique that works together with the Behavioural Barometer from *There is One Concept*. The client finds the emotion on the Behavioural barometer which is divided into 4 categories: conscious, subconscious, body and choice/no choice, which are further divided into subcategories such as Acceptance/ Antagonism; Willing/ Anger, etcetera. Each of these subcategories is further subdivided into 8 emotional sub-subcategories, each with an opposite emotion. The emotions on the right side of the barometer start with *I feel* \_\_\_\_ and the left side emotions start with *I am* \_\_\_\_\_. The client chooses via muscle testing the appropriate category, subcategory and sub-subcategories. Once the sub-subcategory is determined, the opposite positive emotion on the chart is picked, such as "*I feel* stagnant vs. *I am* perceptive". The goal of the intervention is to move the client out of the negative emotion towards the positive *I am* identity. This is accomplished by the client focusing on the practitioner's crossed fingers drawing an infinity sign in the air while repeating *I feel* \_\_\_\_/ *I am*\_\_\_\_\_ for about a minute or two (Swack, 2007b).

In the techniques *Reversal /Conflict tapping* and *I feel/ I am*, eye movements play a role, which are similar to the eye movements in Eye Movement Desensitization and Reprocessing (EMDR). These approaches seem to relate to right and left brain hemisphere integration (Benor, 2004) and are based on the effects of eye-movements on emotional-cognitive processing (Shapiro, 2001). The originator of EMDR, Francine Shapiro discovered through personal experience and later through her own empirical observations that disturbing thoughts and emotions dissipate and learning takes place when the eyes are moved rapidly and repeatedly from left to right while focusing on the traumatic memory (Shapiro, 2001).

Although there is no evidence based research to explain these releases, Shapiro's work still confirms suggested correlations between healing (and change) and integrated left and right brain hemisphere functions (Benor, 2004; 2013). She later realized that this process entails “an information-processing mechanism rather than a simple desensitization treatment effect” and changed the name from EMD to EMDR (Shapiro, 2001, p. 27). She included a variety of eye movements (such as faster, slower or in different directions), and found that bilateral stimulation (alternate stimulation of the right and left sides of the body through tapping or sound) produced the same effects (Benor, 2004; Shapiro, 2001). When the eyes move by following the infinity sign during the above two techniques, the unbalanced system can (as Shapiro (2001) suggested during EMDR) be appropriately activated to transform old dysfunctional information, beliefs and emotions to functional therapeutic information which can contribute to the resolution of a problem. It thus seems possible that the eye movements help to integrate the feelings and thoughts of an experience (Benor, 2004; 2013).

#### **2.9.5.5. Emotional Stress Release**

This technique has a more global approach to treatment where specific meridians or an acupoint sequence play no role and the focus is on activating the energy system as a whole. Goodheart (in Gallo, 2005) found that the emotional neurovascular reflexes located on the small protrusions on the forehead, on the frontal eminences, halfway between the middle of each eyebrow and the normal hairline, are related to specific muscles. When these Bennet reflexes are stimulated, muscle functions improved, and therefore also affect meridian functioning (Gallo, 2005). Goodheart (in Gallo, 2005) also found that emotional conditions could be effectively treated when the Bennet reflexes are stimulated. Gallo (2005) uses the protocol by letting the client place his/her fingertips on the emotional stress release points (excluding the thumbs) to locate a pulse. The client's focus alternates between the pulses (until they are synchronized) and the emotionally charged issue until the SUD is down to a

one (Gallo, 2005). In HBLU™ the technique is slightly modified where the client places his/her hand on the forehead and allows the head to move at will (Swack, 2007b). One can further elaborate on the technique to deepen its effect by adding visualized colour or prayer to the process.

#### **2.9.5.6. Unwinding Frontal/ Occipital Holding (UF/O holding)**

This stress-defusing technique is similar to the emotional stress release technique. In both techniques the neurovascular reflexes are activated while the client thinks about and or visualizes the stressful experience while placing a palm on his/her forehead. In addition to one palm on the forehead, the other palm rests on the occipital bone at the back of the head during *F/O holding*. It is supposed that visual memories are activated in visual centres of the brain by the hand on the occipital area, which are then sent to the frontal lobes of consciousness (Gallo, 2005). The frontal cortex (forebrain) which sits just behind the forehead is rich in peptides and receptors and is home to all higher cognitive functions such as future planning, decision making and formulating intentions to change. It is interesting to note that this part of the brain is only fully developed in the early twenties (Pert, 2003). The practitioner can assist and give direction to the client throughout the process as well as assist the client to reframe the problem. This process helps the client to re-experience a trauma in a detached manner (Gallo, 2005).

In HBLU™ there are slight modifications and additions to Gallo's F/O holding and it is called Unwinding frontal/ occipital holding (UF/O holding). The head is allowed to move at will and if needed, light and or toning/chanting, which aims to stimulate the chakra system, can be added to the chakras (Benor, 2004; Swack, 2007b). Virtue (1998) uses toning/chanting to open the third eye (the chakra point between the two physical eyes) to improve clairvoyance. See Appendix Q for more details on the UF/ O holding protocol. Colour visualization and prayer can also be added to assist the client during UF/O holding.

#### **2.9.5.7. Drawing**

Non-verbal communication such as drawing can be viewed as a type of body language (sub symbolic, motoric communication) which symbolizes the communication between the psychic bodies of the client and the therapist and can be an important way of communication especially if the client is in a dissociated state. Freud advised that the therapist should direct his/her unconscious mind toward that of the patient when the patient practices free association and in doing so introduces the concept of unconscious communication between therapist and client (Arizmendi, 2008).

Drawing is a technique which is done simultaneously with both hands and is more of a flow of consciousness while thinking about the problem at hand than drawing an actual picture. The drawing happens automatically and is done when the client feels complete. After the first drawing, the client balances the charge of the drawing with UF/O holding and then draws a new picture (with both hands) that represents the situation as it is perceived after the UF/O holding (Swack, 2007b).

#### **2.9.5.8. Raking or aura-combing ritual**

Aura combing (I refer to it as raking) originates from a Russian tradition where it stems from a hair-combing/brushing ritual people used whenever they experienced deep negative emotions, were deeply hurt and were unable to free themselves from negative emotions. The hair would be brushed intensely with a wooden comb while the person looked in their eyes in a mirror while simultaneously focusing their attention on the disturbing emotion. After the emotion was “brushed out”, the comb was buried in the earth in front of an aspen tree which was believed to ward off negative energies and spirits. After the ritual, people experienced a feeling of deep release (Svirinskaya, 2005). We can see how this action

manifests when we want to stroke someone's head when they are upset, almost like we try to brush their worries away.

The adaptation of this age old ritual is raking or combing through the aura. The hand and fingers serve as the comb. The person visualizes their fingers to be a few inches longer than they are and starts to comb through the aura from the outside towards the physical body. The person will start above the head and continue to sweep down to the feet without touching the physical body. The practice is continued until the person starts to feel lighter. It usually takes a few minutes. The last step is to rinse the forearms under running water (Svirinskaya, 2005).

An alternative to this technique is to shake your body before you start to comb through the aura. This time, comb or rake as if you were clearing a spider's web from your body, again starting at the top of the head and ending at the feet. Rinse the forearms under cold running water and continue with the healing by starting to peel off a very tight body stocking from the head to the feet. This technique is good to apply when the person had a bad day or a negative experience (Svirinskaya, 2005).

#### **2.9.5.9. The Essence Process**

In HBLU™ The Essence Process is used when Enneagram layers are transformed, and it is very similar to aura-coming/ raking. The Enneagram is “a geometric figure that maps out the nine fundamental personality types of human nature and their complex interrelationships. It is a development of modern psychology that has roots in spiritual wisdom from many different ancient traditions” (Riso & Hudson, 1999, p. 9). It “reveals the patterns by which we organize and give meaning to all our experiences” (Riso & Hudson, 2000, p. 11). The 'Essence Process' is also used as an intervention for any other interference



when the person shows preference for it during muscle testing as was the case during this research process.

After an Enneagram layer has been mapped out completely (the whole story of the enneagram layer has been heard), the client will physically peel/comb/rake off all their life experiences' damaged energies from this lifetime, past lives and ancestry that mapped through the specific enneagram layer out of and off his/ her body. The energy is “piled” onto the floor and after the peeling is complete, the client describes what the energy looks like. After it is confirmed through muscle testing that all the energies are peeled out and off the person and the client feels neutral, calm and good, he/she is made aware of the realization that the energy is no longer part of him/her, but is separate and on the floor. The client is instructed to “expand his/her soul energy vibrationally and radiate right through this construct at the subatomic level (like x-raying or microwaving it) bringing it to a higher vibration, and continuing to radiate [it] through the whole matter/energy continuum in the universe in all directions out to infinity” (Swack, 2005, pp. 5 & 6, under Essence Process). This process releases the wound energy and transforms it from a dense energy to more fluid gaseous energy. The client is muscle tested to confirm a 100% transformation of all the energy and full reincorporation and reintegration of the transformed energy in the service of the soul. The new transformed energy is questioned for its greatest hope, now that it is free and transformed, messages about the meaning of life in general, and specific messages for the client's life (Swack, 2005; 2006b). For a more detailed explanation of the HBLU™ description of the Enneagram Operating system and the Essence Process see Swack, 2006b.

#### **2.9.5.10. Time scrambling**

This is a Neuro Linguistic Programming (NLP) technique which uses time-based language to disrupt a person's thought processes. Examples can be: “You want to make

changes haven't you?" or "What would it be like when you have made those changes now?" (James, 2005).

#### **2.9.5.11. Body talk**

Body talk is the first technique applied during the HBLU™ process. This NLP technique to go inside and talk to the part that needs healing is used to teach the client how to consciously access information (through visual, auditory or kinaesthetic channels) from the unconscious mind (Swack, 2002). Dychtwald (1987) says that the body reflects mental life which Johanson (2009) demonstrates in the case of Marguerite, when he asked her to turn her attention inwards so she can become aware of present experiences, such as sensations, tensions thoughts and feelings and to stay mindful of the experiences while they explored it further. Dr Upledger addresses the relationship between cell activity and consciousness, and through years of research and clinical observation realized that it is possible, if not necessary, to communicate with the body on a cellular level to facilitate healing (Upledger, 2003).

#### **2.9.5.12. Visualization**

Visualization/ Imagery can be defined as "thought using all the senses when images are internally rather than externally generated" (Achterberg, 1994, p. 1). It is a process to aid healing through imagining and visualizing certain images and is part of many healing approaches and is used extensively in therapy and the performance fields (Benor, 2004; Gallo, 2005; Pearsall, 1998). And if the biofield is sensitive and responsive to our internal senses according to Greene (2012), then Visualization, self-observation and self-talk can be used as effective healing techniques (Greene, 2012). Healers can use it to focus, summon and direct subtle energies (Benor, Von Stumpfeldt, & Benor, 2002). Visualization is an important component in self-healing and spiritual healing and one of its simplest uses is tension reduction (Benor, 2004). Visualization has a close and primordial connotation to the physical

body where direct neural connections are linked between areas of the brain that process the image to areas that are involved with emotion and the immune system, such as the thymus (Achterberg, 1994). Pert (2003) mentioned that visualization can be used to increase blood flow into a body part which increases oxygen and nutrient availability, which assists in the removal of toxins and increases cell nourishment (Pert, 2003).

Visualization was used during this research as part of other techniques where the participant mainly had to visualize colour and occasionally see how God was helping them. They could also visualize their phobic stories and the positive outcome after phobia resolution. Visualization can assist us to change our psychological reality and if visualization is “the deliberate holding of images in the mind’s eye with the intent of imprinting these images upon ones’ own mental and physical states or upon those of others.” (Benor, 2004, p. 334), it is an important part of healing as it is assumed that when you are able to visualize yourself in a new state of being, in a new activity or a positive outcome, it can enhance your actual ability to achieve these altered realities as it has now become a part of your reality (Benor, 2004; Gallo, 2005). According to Gallo (2005) visualization cannot be used on its own when treating a phobic client as the client will be unable to effectively visualize the desired outcome because the internal images are unclear or unavailable to him/her. Benor (2004) mentions that recent studies show that visualization can help to modify our relationships with past experiences as it seems to be an instrument for the mind to manipulate subtle energies (Benor et al., 2002).

Benor et al. (2002) describe a therapy session where a client who suffered panic attacks (which improved after the session) was encouraged through visualization to communicate with the devil that came out of a dark cloud inside of him. During my research I (as well) also encouraged the participant to go into the dark cloud that she "saw" above her,

meet God there and converse. The client was stuck and could not continue with the session until after this technique was successfully applied. Callahan (2001) found that a balanced energy system can enhance visualization and Gallo (2005) outlined a protocol (including specific algorithms of Callahan's work) to help a client improve their visualization abilities in order to overcome a psychological problem and visualize the desired outcome.

Research suggests that visualization is not only a reflection of relaxation, but is “a phenomenon capable of eliciting unilateral and even site-specific physiological changes” (Rider, 1992, p. 4). In one of his experiments Braud (1992) found that when individuals practiced relaxation, visualization and positive emotion mental exercises twice weekly, the immune system's search-and-destroy components against upper respiratory infection agents and precancerous and cancerous cells moved into action. Diamond (1979) found that when a person just thinks (visualize) about a pleasant (nice holiday) or unpleasant situation (being ill) it can strengthen or weaken the thymus. Achterberg (1994) adds that images that arouse an emotional response (from fear to joy) result in related physical changes and substantial biological changes, especially hormonal changes, which can result in emotional changes. Visualization has shown to enhance neurohormonal, antibody, and white cell functioning, and it can help with pain, allergies, and musculoskeletal and gastrointestinal disorders (Benor, 2004). After years of research Dr Upledger created craniosacral therapy that employs visualized manipulation instead of physical manipulation successfully (Upledger, 2003; Benor, 2004). Benor (2004) describes several different healers that used visualization successfully which are starting to confirm the theories that visualizing physical changes can actually cause change in body conditions. These findings also confirm the body-mind interconnectedness.

Visualization can include 1) a focus on body parts that need healing by sending healing light to those areas, 2) visualizing healing energies surrounding the whole body, 3) picturing the problem, such as pain, as a colour, 4) inviting white light to enter the body, 5) inhaling healing energies and 6) picturing coloured light connecting the healer and healee's heart. Therapeutic Touch practitioners for example visualize various colours projected onto the recipient (Benor, 2004).

This brings us to the next technique that overlaps with visualization where the participant inhales coloured healing energy. Benor (2004), through his professional experiences, observed that when visualization is combined with some type of physical intervention (such as breathing) it is more effective.

#### **2.9.5.13. Colour breathing**

It is important to notice that the colour breathing technique used during this research was not Diaphragmatic Breathing (DB) or any other form of structured breathing exercises, but is rather an extension of visualization as discussed above where the individual visualizes the inhaling of healing energy, and if they wish they could add colour to assist them (Benor, 2004). The participants intuitively picked the needed colours and their interpretations from the HBLU<sup>TM</sup> 3 colour chart. Andrews (2005) points out that colour associations are just guidelines.

What is light and what is colour? Colour is light waves that bounce off objects and reach our eyes. Colour is a result of the frequency of energy that is being reflected. What we see is reflected light. Light creates colour and form as it is electromagnetic energy created by the sun in different wavelengths, where the amount or frequency reflected determines the hue. Low frequency light waves register as red and high frequency light waves register as violet. Each colour has its own unique properties and can have a stimulating or depressing

effect. Therefore colour can be used to stimulate deeper levels of consciousness, can affect the energy field or personality and is effective in healing (Andrews, 2005; Tappe, 2009).

Colour visualization can be used to stimulate and balance the chakras (Virtue, 1998; Andrews, 2005).

Breathing is the process that assists air to become energy within the body. Our thoughts have an influence on the strength and frequency of that energy and therefore thinking about certain colours while inhaling them can assist an individual with his/her healing process (Andrews, 2005). In this form of conscious breathing, the mind is free from judgmental negative thoughts and opinions and peptide messenger molecules are released from the hind brain to regulate the breathing and at the same time merge all the systems (Pert, 2003). Changes in breath rate and depth create changes in the quantity and type of peptides that are released from the brain stem and therefore conscious, deep breathing is powerful as it can alter the flow of peptides, influencing the individual's mental-emotional state (Neimark, 1997; Pert, 2003). Braud (1992) found that just focusing on the breathing can have a substantial influence upon heart rate and blood pressure. After a year of working with the SAGE project, Dychtwald discovered that the Deep Breathing technique was superior in its effectiveness to relaxation training, electromyography biofeedback, hatha yoga, bodymind awareness exercises, massage, Feldenkreis exercises, individual counselling, meditation, T'ai, Chi, music therapy or Gestalt therapy for each of the participants in the restoration of their emotional energy, physical wellbeing and feelings of interpersonal connectedness to relaxation training (Dychtwald, 1986).

The breathing exercise that was used in this study is based on an exercise from Spring Forest Qigong 1 called *Energy Breathing* where you breathe through your lungs as well as your skin. The exercise goes as follow: Inhale while concentrating "your mind in your skin

and visualize the universal, unconditional love energy coming into your body through every cell and collect it in the lower dantian, which is deep behind the navel. As you exhale visualize any sickness or extra energy that is no longer needed shooting out from every cell of the body and returning to the end of the universe” (Lin, 2010, p. 31). This exercise assists you to bring the focus back into the body and wake up the internal energy (Lin, 2005). Andrews’ (2005) colour breathing exercise is similar to Lin’s exercise (described above) where he adds that the breathed in air is seen and felt as a particular colour, filling the whole body, healing and balancing what needs to be corrected. Svirinskya (2005) and Virtue (1998) describe several techniques that combine breathing and visualization (some with colour breathing) in their respective books.

#### **2.9.5.14. HRT (Heart technique)**

A direct neurochemical and electrochemical communication link was found between the heart and brain when neurotransmitters in the brain were also identified in the heart (Pearsall, 1998; Pert, 2003). The heart’s electromagnetic field (EMF) is five thousand times more powerful than the brain’s EMF (Pearsall, 1998). This brings us to the following technique that can be compared to Pearsall’s merging, collective and connective process called cardio-contemplation.

HRT is a technique that I adapted from Trudy and David Robertson’s technique called ERT. ERT is a simple technique where a hand is placed on the heart, while feelings/trauma are/is allowed to be experienced in the body and are then released into the hand or into a colour imagined /visualized between the hand and the heart. When the hand starts to feel heavy or full from the energy it is shaken, to get rid of the energy. When we receive good or bad news we normally place one or both hands over our chest and when we then focus quietly and attentively on the heart, it helps to relax the heart and send a more balanced

energy through the body (Pearsall, 1998). I added another hand, so the hands are lying crossed over the heart or over the centre of the chest while the person breathes in and out of the heart. Colour or a prayer to assist a person during the intervention, can be added.

Leigh (2012) calls this Creating Compassion and describes the following method to achieve compassion. To create compassion in the compassion centre between the heart and throat chakra you will do the following: a) Put one hand on the compassion centre. Do not cross the palms of two hands as this might block the energy (according to Leigh), b) Breathe into this space and feel how the whole area is filling up with your breath, c) Breathe the colour and energy of rose quartz into the compassion centre. Bring the colour in from the horizon, d) feel the warmth and fullness of this space as it fills up with the rose quartz energy, e) be still and listen as you focus on this space, f) a string of energy (formed like an 8) will appear from the compassion centre. Move it down to the heart chakra. The energy string between the compassion centre and heart chakra (which runs like the number 8 between the two), exchanges energy, and (The 8 energy) connects the two.

A person can do this once a day in the morning which will allow the streaming of compassion the whole day.

Mollon (*n.d.c*) also created two techniques (from a combination of other techniques) which include hands crossing over the heart: 1) the Comprehensive stress relief technique and 2) Lung meridian breathing.

After Pearsall (1998) summarized cardio-energetic research in his book, he came to view the heart (in short) as follows: 1) the heart is the most powerful, dynamic organ in the body, physically, plus it generates the most electromagnetic energy in our body, 2) it's an energy conductor of the body cells and does not have to be strong to be influential in cellular functioning, 3) it responds directly to the environment, reacting to electromagnetic energy, 4)



it uses its information energy to connect the brain and body and works with the brain, although not directed by it and therefore is the body's main organizing force, 5) it resonates with information – containing energy as it is the body's core, and exchanges information – energy with other brains and hearts, 6) it speaks and sends information and when we silence the brain and quietly focus on the heart, we can sense what it says, we can hear the memories it retrieves from its very cells where they were stored.

Different heart rate patterns are caused by different emotional states, where the heart rate pattern of frustration is shown to be chaotic and appreciation is the emotion that shows the most coherent heart rate pattern on the HeartMath heart coherence apparatus (Leskowitz, 2012). A blissful, balanced, steady heart energy state is called cardiac coherence (Pearsall, 1998) or a high heart rate variability (HRV) according to the HeartMath institute, and which enhances your psycho-physiologic coordination (Leskowitz, 2012). This state is achieved through cardio-contemplation, where instead of thinking of ways to reduce stress, stress is transformed by resonating with the natural world and other surrounding hearts, and in doing so, cardiac coherence is a state of making contact with the world through your heart. The result is that stress has less control over the brain/mind, heart/body. It is not a mental reflection but rather an emotional focus on the heart, which is the energy centre of the body. It is a form of receptive prayer where one listens to the power within the heart and its deep awareness of your personal connection with the Creator. Doing so the heart is given time to feel and be free from the mental processes of the brain (Pearsall, 1998). And according to Siegel (2012) HRV coherence is created when the you balance and coordinate the autonomic nervous system's sympathetic and parasympathetic parts.

The Institute of HeartMath does pioneering work in cardiac coherence and uses a process they call Freeze Frame Technique to achieve this stress-free state. In this technique

the individual 1) recognizes a specific stressful feeling, 2) makes a mental effort to move his/her focus to sensations coming from the heart instead of the head, 3) recalls a positive past event, and 4) mentally asks the heart for insights for better ways to deal with the stressful situation which could create a state similar to the positive past event. This institute has found that cardiac coherence enhances immunity and healing as it creates neurohormonal balance (Pearsall, 1998). Pearsall (1998) has his own version of this technique where the person does not mentally recall a positive past event, but rather experiences feelings from the heart. Pearsall (1998) asks his clients to differentiate between brain time and heart time.

The PEAR program and Pearsall's experience with his heart transplant patients led him to the conclusion that the following five steps which are similar to practices suggested by healers of ancient and indigenous people, can help one become aware of the heart's knowledge and it can also help to protect and heal the physical heart itself as suggested by the fields of psychoneuroimmunology, health psychology and cardiac psychology (Pearsall, 1998). The summarized steps are: 1) be patient, still, tolerant, quiet, become aware of the sensitive life "L" energies (a phrase he uses to propose subtle life energy) and realize that the heart's way is to "let it be" as opposed to the mind's way of "just do it", 2) be connected, united and control less, and allow the force of natural connection to happen, be accepting and open minded, 3) feel and connect with all your senses, 4) learn, 5) be pleasant, go along, lighten up, have fun, 4) be humble, be less territorial, self-assertive, demanding and rejoice and be grateful for God's gifts and 5) be gentle – take it easy, take it as it comes, take time (Pearsall, 1998).

When we face, rather than avoid or deny that part of us that we dislike, the heart is nurtured (Pearsall, 1998). The **heart** process (HRT) makes facing the unlikable easier and

gentler as it works with the beautiful characteristics of the heart in a contemplative, prayer like manner.

#### **2.9.5.15. Healing/ Holy Light**

HBLU<sup>TM</sup> uses a technique called the White Light with the angel, which I call Healing Light or Holy Light. During the White Light with the angel technique you connect with the White Light by putting your hands together over your head and pull a bubble of white light down and around yourself (Swack, *n.d.b*). I used this method during this research study when, and as it was needed. Sometimes the participants chose a colour to aid them. I chose to be specific about the chosen light and its Source as it is written in 2 Corinthians 11: 14: “for Satan himself masquerades as an angel of light” (The Amplified Bible, 1987). Gallo (2005) mentions that he uses a similar method, called the Healing Energy Light Process (HELP) where someone imagines healing light entering the body, according to an ancient yoga exercise. He incorporates other disciplines such as educational kinesiology, the negative affect erasing method, diaphragmatic breathing, Qigong and an aspect of a HeartMath, by accessing heart energy in the HELP technique.

#### **2.9.5.16. Curses and prayer**

Curses are normally only addressed from HBLU<sup>TM</sup> 2, but I found that people many times come in with a curse that needs to be addressed immediately before treatment can proceed, as was in some of the cases during this research study. In HBLU<sup>TM</sup> curses can have two meanings: they can either be 1) an evil spell or 2) an emotional *feeling* of frustration due to the inexplicable lack of results. When the person just *feels* cursed, this is called an elemental which is not supernatural, and can be cleared with one of the HBLU<sup>TM</sup> protocols and EP techniques (Swack, *n.d.b*).

If the curse is supernatural, these energies have to be met with God power and not through

your own energy. The intervention of choice in HBLU™ is the JC Intervention which is a single prayer evoking the power of Christ: “I call upon the power of Jesus Christ of Nazareth. You are bound and defeated. Leave me now and go where God leads you.” If a Jewish person objects to referring to Jesus, they can use the word God (Swack, *n.d.b*). This prayer is powerful and clears curses which are confirmed through muscle testing. Through all my years of using this prayer, I have never found it not to clear a curse. In her book *The beautiful side of evil* Johanna Michaelsen used a similar prayer with success to revoke demons (Michaelsen, 1982). An attitude of prayerfulness where there is a sense of holiness, feelings of empathy, caring and compassion for the person in need is an important foundation for healing (Dossey, 1993) and Benor (2002) adds that prayer and the accompanying intentions are healing for the person who is doing the praying and the person who is being prayed for.

Spiritual healing interventions, such as prayer and laying on of hands is inherited from Christianity as an important part of the teachings of Christ. Such teachings include the healing of people, as we can see through most of the New Testament in the Bible when Jesus intervenes to heal people physically, mentally and spiritually. Healing prayer accompanied with energy experiences is not a new phenomenon and we see an example of this phenomenon when Jesus Christ felt that energy flowed from him when the haemorrhaging woman touched his garment and was healed in Matthew 9: 20-22 and Mark 5:25-31 (The Amplified Bible, 1987; Zeiders, 2003). Although many of the people in the crowd touched Jesus, when the healing touch took place, Jesus felt it (Mark 5:30), which even surprised His disciples (Mark 5: 31). Prayer speaks of the power of God and includes the resonating energies of intention and words (Gallo, 2005) such as the woman in Matthew 9: 21 and Mark 5: 28, who kept repeating her intention "If I only touch His garments, I shall be restored to health". Prayer is an attitude of the heart and the desire to connect with the Creator (Dossey, 1993; Pearsall, 1998). According to Zeiders (2003), God's grace and power are introduced to

the wounded person to facilitate healing according to God's will. Dossey (1999) sees the combination of intentions and prayers as a good formula for healing and techniques such as the 1) direct method where one seeks a specific outcome and the 2) non-direct method where no specific outcome is expected, are both effective.

The word prayer comes from the Latin word *precarius* – “obtained by begging” – and *precari* – “to ask earnestly, to beseech, to request” (Dossey, 1993, p. 5). Prayer is used for more than requests and can be used to worship, celebrate, meditate and intercede (Gallo, 2005). There are also prayers of petition, confession, lamentation, adoration, invocation and thanksgiving and it is safe to say that prayer classification can be endless (Dossey, 1993). Dossey (1993) suggests that the two most common forms of prayer are petition (asking something for one self) and intercession (asking something for someone else). These prayers are used in my practice and were used during the research process, where I asked for God's guidance and healing for the participants before each session.

There are many anecdotal reports on the benefits of prayer (Gallo, 2005) and Dossey (1993; 1999) and Benor (2001) reviewed several researches done on distant and local intercessory prayer which received widespread empirical support. Some of the studies they cited could be considered as psycho kinesis (Gallo, 2005) – “the ability to influence the nature of physical matter without any physical contact, purely with the powers of the mind (Dychtwald, 1986, p. 241). According to Gallo (2005) intercessory prayer also referred to as distant healing, is associated with morphic resonance and psycho kinesis. Christian minded therapists usually believe that they introduce the grace and/or power of God to the wounded psychological area which helps to transform the wound into God's image of health (Zeiders, 2003). Gerber (2001) adds that spiritual healers go into a meditative state to connect with “forces of the divine” (p. 316) to mentally project/direct /deliver this divine energy to the

subtle energetic, physiological, and mental systems of the sick individual to assist in the resolution of the problem, and to allow shifts at several levels simultaneously, including the spiritual level. They perceive themselves as “channels” or “vehicles” of this higher source of energy (Gerber, 2001, p. 316).

There are sceptics that say prayer does not work, as results are a placebo response and that researchers have hidden agendas (advancing their own religious beliefs) and therefore should not even be studied (Dossey, 1993; 1999). The **M**onitoring and **A**ctualization of the **N**oetic **T**raining (MANTRA) project helped to reject the latter objection when they recruited prayers from a variety group of religions and successfully showed that the outcomes of the prayed for groups were 50-100% better than the groups not being prayed for. While members of the clergy don't see the need to confirm the effects of prayer and rather view their lives and the lives of those they serve as their laboratory, Father Sean O'Laoire, a Catholic priest and psychologist, is an exception. His research showed that not only did the prayed for subjects improve their anxiety, depression and self-esteem, the people doing the praying improved even more than the subjects they prayed for (Dossey, 1999). Daniel Wirth & Jeffrey Cram did a study where they found that the healers experienced deeper states of healing during prayer than during the LeShan or Reiki healings (Benor, 2001). Zeiders (2003) described the effects of a desperate, silent prayer of a psychotherapist during a frustrating session with a difficult client. The therapist's prayer was merely launched with the intention to help the client in an effective way. He immediately, without expectation, felt an electrical current coming from his chest going towards his client which the client also felt with great surprise. Gerber (2001) mentions that what he calls “spiritual healing” (p. 324) seems to rebalance the client at the physical, etheric, astral, mental and other higher energetic levels and it transcends time and space limitations and can therefore be done in the presence of the person or at a great distance as shown by experiments done on the Worall healers by Dr

Miller. According to Gerber (2001) the Woralls could increase the growth rate of rye seedlings, although 600 miles away, during their prayer time. They visualized the plants and how they filled with light and energy. After the healing session, the growth rate gradually decreased, but never regressed to the original level of growth. The distance at which this phenomenon took place, suggests a wide spectrum of multidimensional energy influences and shows evidence for a non- electromagnetic energy influence as EM energy decreases in intensity over a long distance from the source of energy (Gerber, 2001). Pearsall (1998) mentioned that one of the characteristics of "L" energy (a phrase he uses to propose subtle life energy) is that it travels faster than the speed of light and can account for the nonlocal effects of intercessory prayer.

## **Conclusion**

The EP approaches discussed in this chapter have an impact on the body's energies and suggest transformations at the energy level when the traumatic memory patterns (which determine the effect) become disrupted and changed because the information is stored differently in the nervous and energy systems after the disruption (Gallo, 2005). When the acupoints are stimulated while the individual focuses on the problematic issue, the synapses, which maintained the related learnings, are unlocked and reconsolidation can take place. The reduced arousal of the limbic system, while the problematic memory is active, creates a new association and becomes the new reality (Feinstein, 2012b). Because activation of the amygdala is not associated with the new memory, the new memory therefore excludes any associated negative emotions and cognitions (Gallo, 2005). Feinstein (2012b) delineates the process as follow:

*“a) electrochemical impulses reduce arousal in the limbic system during the reconsolidation window, which allows neural pathways maintaining outdated emotional learnings to be*

*revised or eliminated; b) delta waves are generated, which are also involved in depotentiating maladaptive emotional learnings; and c) balancing the body's meridian energies by stimulating acupoints brings greater order and coherence to the organizing fields that regulate neural activity” (p. 76).*

Among traditional psychotherapeutic modalities, Systematic Desensitization (SD) is the closest to energy therapy as both approaches bring a problematic situation, object or emotion to mind and introduce a physical procedure to neutralize the alarming situation, object or emotion. The difference is that an energy intervention corrects the affected, disturbed pattern in specific meridians, rebalances the meridians and brings them back into harmony with the body's overall energy system, while a modality such as SD relaxes the muscle tension associated with the problem. Both deep muscle relaxation and calming a disturbed meridian can neutralize an undesirable fear (Andrade & Feinstein, 2004). Anxiety disorders such as agoraphobia and specific phobias are reported to respond better to energy interventions than to other modalities, although social phobias and phobias of loud noises are reported to be less responsive to energy interventions (Andrade & Feinstein, 2004). The effectiveness and speed of EP interventions depend on resonances between acupoint stimulation and the meridians, which impact the meridian system, which impact the organizing fields, which impact neural activity – all through resonance (Feinstein, 2012b).

We can come to the conclusion now that it is important for all healing processes to involve the physical, emotional and mental aspects of a being as Svirinskaya (2005) suggested. Healing can take place on any level and on more than one level, varying from a physical level to a spiritual level. When healing takes place on a spiritual level it can be said that an individual's Higher self is making an attempt to integrate with the physical body and personality (Gerber, 2001). If we consider what the literature has said about the mind- body- spirit approach we realize that there are no purely biological or psychological disorders and



that we will do a client/patient a disservice when we approach them from that perspective and apply a purely biological or psychological treatment (Meissner, 2006). The therapeutic goals of EP are similar to what Payne & Stott (2010) found in their **Bodymind approach** (BMA) study and that is, to 1) promote a change in perception, 2) make correlations between feelings and the body, lifestyle, and symptoms in order to understand the self better and give meaning to it all, 3) reduce negative emotions and states such as anxiety and depression, 4) increase well-being, and 5) increase the ability to self-heal, self-manage and create empowerment through independence rather than over reliance on medical cures, medication and/or therapy.

A prerequisite for all good science, *which includes psychology*, is to be open minded and explore all avenues (Peck, 1998). The next section describes the method for exploring the application of Energy Psychology in the treatment of phobias of change and/or transition.

### **3 METHOD**

#### **3.1. Rationale for the chosen research design**

1. In this study, phobias are addressed from the perspective that does not consider them as an isolated experience with regard to specific subjects or objects of some people, but rather as a possible experience that all people can have on some level, especially if there is stagnation in their lives.

2. Apart from Dr Swack's research, which is very obvious in the literature review, very little is known about HBLU™. To date, no research is known to exist on non-obvious/subtle phobias in the context of change, transition and progression. Because of this lack of research and evidence, I have chosen to use HBLU™ as an integrative Energy Psychology approach toward the detection, confirmation and treatment of subtle phobias in the context of change, transition and progression. Subtle phobias, such as phobias of change, transition or progression, have never been researched and therefore it has never been shown that any Energy Psychology method or technique has been able to heal such phobias.

3. By using the Energy Psychology, HBLU™ phobia protocol I am aiming to achieve a greater understanding of Energy Psychology, and specifically the HBLU™ protocol, and the role it plays in psychotherapy. This research project also advocates for the expansion of the field of psychology to include Energy Psychology protocols as a means to improve people's lives via improved (mental, emotional, spiritual and physical) health and wellness, thus empowering them to have higher functioning in all areas of their lives.

4. Addressing the topic of phobias is addressing an important social issue. We don't like to address feelings that create overwhelming fear, and when we have overwhelming fears, we can develop a phobia, and that reaction creates procrastination or stagnation. Most

people don't realize that they have a phobia, and therefore this issue is overlooked and halts progression in various aspects of their lives. Phobias of change, transition or progression can be detected in several ways, such as not doing what you set out to do and not knowing why, or, not progressing on mental and physical health issues. Because the participants were actively involved in the method (the HBLU<sup>TM</sup> phobia protocol), their awareness was raised about phobias and the impact it has on our lives.

This research aims to show that changes are needed in how phobias are viewed, and that existential phobias, such as a phobia of change, can indeed be effectively resolved.

## **3.2. Research Design**

### **3.2.1. Qualitative research**

This research design falls into the realm of the qualitative research design. The three major components of Qualitative research are :1) data which comes from interviews and observations, 2) procedures, such as coding and categorizing and 3) written and verbal reports like scientific journals and talks (Dexter, 2010). All three components are incorporated in this study. The data were collected from the participants by the use of questionnaires, psychological tests and procedures during interviews and I, the researcher made observations, wrote memos and described the collected data. Then the data were analyzed. The applications of these three major components are discussed in detail in the *Research Procedures (3.4.) and Data analysis (3.5.) sections.*

### **3.2.2. Grounded theory approach**

The grounded theory approach is the qualitative research approach that was used in this study to collect, and analyze the data in the hope that a theory might emerge from the analyzed data (observations). Since little is known about the subject of phobias of change,

transition, and/or transition, and equally little about the HBLU<sup>TM</sup> phobia protocol, the grounded theory approach was the most appropriate method for the process of data collection and analysis, because this method has the ability to explain phenomena, thus going beyond simply describing them (Dexter, 2010). Since the majority of the pieces of the data overlap with each other they are in close relation with each other, therefore the researcher gains deeper insights and a better understanding of the phenomena at hand.

The three processes in grounded theory are : 1) to generate a detailed description about the subject(s) problems (which is the data) without interpretations or explanations, then 2) to organise the data into categories and subcategories, and 3) to see if a possible theory will emerge from the categorised data set (Dexter, 2010). This three part process is an effective means to explore processes and focus on the meaning that certain events have for a person (Creswell, 2009; Maykut & Morehouse, 1994).

The grounded theory approach is the best choice for this research study, because it can be used to gather detailed information about the participants' emotions and thought processes (Strauss & Corbin, 1998). The researcher examines “people’s words and actions in narrative or descriptive ways more closely by representing the situation as it is experienced by the participants” (Maykut & Morehouse, 1994, p. 2). The researcher’s focus is on “learning the meaning that the participants hold about the problem or issue,” (Creswell, 2009, p. 175). The foundational idea of qualitative research is to learn about the issue from the participants and to obtain the information through the research participants' stories as it explores and brings understanding about human phenomena and problems (Creswell, 2009). Because of the lack of research information on the topic, the grounded theory approach is appropriate, because it facilitates investigation of a phenomenon where little was previously known or researched (Creswell, 2009).

Incorporating and utilizing the combination of the components of qualitative research (data, procedures and reports) and grounded theory processes (describing data, creating categories and building theory), guides the research process. The data gathering process consists of obtaining in-depth information from the subjects through in depth interviews, unstructured questions, personalized questionnaires and the HBLU™ phobia protocol, to understand the participants' phobias in the context of their lives (e.g. emotional, mental, physical, spiritual, social, interpersonal, and the effects on their work and productivity). I collected descriptive data in multiple forms by conducting telephone and face to face interviews, observing participants' behaviours, voices (vocal tone, volume, vibration and speed), thought processes and emotions through my own questionnaires, four psychological tests and the HBLU™ phobia protocol, which included muscle testing. I verified what I heard, saw and observed by verbally asking for confirmations and through muscle testing. I categorised and coded the data and wrote memos and reports in the hope of seeing a theory emerge from the gathered and analysed data.

### **3.3. Participants**

#### **3.3.1. Number of participants**

Ten participants (seven women and three men) between the ages of 18 – 68 were recruited.

The researcher began to note that with the sixth participant the participants' language (i.e. common phrases and laments) and symptoms (i.e. tiredness, anxiety) became repetitive. This was the beginning of saturation. The researcher elected to involve four more participants to ensure that saturation was reached. A total of ten participants were necessary for ensuring that saturation was reached.

### **3.3.2. Participant screening and selection**

Potential participants were contacted through emails, phone calls and personal meetings by using my HBLU™ data base, Neuro Linguistic programming (NLP) data base, the Osher Lifelong Learning Institute, the Free Spirit Yoga School and through word of mouth. The advertising was focused towards people who were experiencing problems with changes, transitions and lack of progression in life, and felt they could not progress in a certain area in their life (see Appendix A for advertising). The sampling was drawn from the people who responded to the advertising or heard about the research, called me, showed an interest, fit the inclusion criteria and kept all of their appointments for all the screening interviews, treatment sessions and follow ups.

The participants for this research were carefully screened to insure that they met the inclusion criteria, first by 1) an in depth screening telephone conversation (Appendix B), 2) one week later by filling out 2 psychological tests measuring the psychological and the physiological impact of anxiety with the Hamilton anxiety scale (HAM-A) and measuring the impact of the event/change with the Impact of event scale (IOE), in Appendix J, and then by 3) a preliminary muscle testing session to teach them the art of muscle testing and to test their ability to muscle test. The final selection tools were 4) to muscle test them and see if they had a phobia in the context of change, transition and/or progression and 5) if they did, if it could be cleared with the HBLU™ simple phobia protocol, as opposed to another phobia protocol (Appendix L).

My sample technique was non-representative because it was not in proportion to a given population with regard to ethnicity, religion, socio-economic class, age, gender, sexual orientation or education. Even though the sample size was very limited, the results are

expected to be valid because saturation was achieved. Further discussions on validity will be discussed later in this chapter under 3.6. *Reliability and validity*.

### **3.3.3. Inclusion Criteria**

The fact that the 10 participants were between the ages of 18 – 68, ensured that people at different stages of life were included in the sample. At the age of 18 they are at the legal age of adulthood and consent. All participants, up to the age of 68, had the physical ability to maintain the standing tilt muscle testing throughout the entire muscle testing and treatment session without any physical strain. All the participants were able to speak and understand English, were mentally healthy and physically functional. The participants cognitively understood the concept of an Energy Psychology method and interventions, were open to it, and able to follow directions.

Participants were not of any specific ethnic or economic group or nationality, but all resided in the United States of America, specifically Southern California, which has a rich cultural diversity. One participant was first generation Lebanese and one was first generation El Salvadorian. The remainders of the subjects were second generation Americans.

They were willing and able to participate in a telephone or in person screening process, complete 4 psychological tests before and after treatment, participate in a preliminary in person meeting where they were prepared for muscle testing, and tested via muscle testing to confirm their ability to accurately muscle test. They all committed to a 90 minute or longer (where necessary) therapeutic session and two in depth telephonic follow up interviews. The first follow up interview was one week after treatment and the second two months after treatment.

During the screening interview, potential participants indicated that their distress, fear and anxiety levels in the context of change, transition and lack of progression was at least 5 or higher on a scale from 1 to 10 on the Subjective Units of Distress Scale (SUDS) inventory on most of the subjects (see Appendix B – telephone screening form). In the cases where their SUD levels were not very high during the screening interview, but they used “phobic language” such as “I feel stuck, I feel paralyzed, I know I should do it, but I just cannot, I should not be afraid, but I am, I cannot talk myself out of it”, they were included when their muscle testing confirmed the presence of a phobia in the context of change, transition and progression. If they were able to muscle test via the standing tilt method and had a study appropriate phobia, which was confirmed through muscle testing, and the phobia could be cleared with the HBLU™ simple phobia protocol, as opposed to another the HBLU™ phobia protocol for more complex phobias which includes the trauma protocol, they were included in the study.

All participants were comfortable with the concept of God and possible discussion of the concept of God and supernatural interference.

Inclusion was approved when the potential subjects successfully showed that they had met all inclusion criteria during the telephone interview and the preliminary in person muscle testing meeting.

#### **3.3.4. Exclusion criteria**

Potential subjects were excluded from the study when they could not speak or understand English, or if they had physical or cognitive impairments. Other reasons for exclusion included: being an alcoholic, being anorexic (anorexics might not have enough energy to muscle test), not being able to actively participate in the treatment, not being able to



stand and sit for 90 minutes or more, being physically unable to muscle test while standing, and people who were unwilling to discuss the concept of God.

Once the study had begun and the subject was unable to continue with muscle testing, he or she was excluded. Ten out of twelve people who were interested in the study and met the inclusion criteria were included. One person did not show up for the treatment and was therefore excluded. Another person muscle tested that he/she did not have a phobia in the context of change, transition and progression and was therefore excluded.

### **3.4. Research Procedures**

#### **3.4.1. Data collection**

As a qualitative researcher, I collected and analyzed all the relevant data, which consist of the participants' language patterns, feelings, thought patterns, behaviours, attitudes and physical reactions. Formal instruments in the data collection process were 1) the 4 psychological scales (DASS – Depression, Anxiety and Stress scale, GAD 7 – General anxiety 7 question scale, HAM-A – Hamilton Anxiety Rating Scale - and, the IOE - Impact of Event Scale in Appendix J), 2) the researcher's self-composed in depth screening questionnaire (Appendix B), 3) the HBLU<sup>TM</sup> phobia protocol (Appendix L) which was used during the muscle testing (Appendix H) and treatment (Appendix N) sessions, and 5) the personalized follow up questionnaires (Appendices R & S). The questionnaires and HBLU<sup>TM</sup> simple phobia protocol were used to generate data and uncover in-depth information about each participant's phobia and its resolution.

The first step for all participants was the telephonic or in person screening interview, where the screening questionnaire was used (Appendix B). The second step was the completion of two psychological questionnaires (HAM-A and IOE tests in Appendix J), one

week after the screening interview. Three participants did the muscle testing session before completing the two questionnaires, because they felt more comfortable meeting the researcher in person before the treatment. All participants completed all four psychological questionnaires before and after the treatment. The third step was the muscle testing session (Appendix H) and the fourth step was the treatment session (Appendices L & N). Every participant received treatment at least two weeks after the screening interview. They all had long-standing issues related to the phobias that were treated. The fifth step was the first follow up session one week (Appendix R) after treatment and the completion of all 4 psychological questionnaires (Appendix J). Eight participants could be contacted for the follow up session the first week after treatment. All participants were willing to be contacted, but two participants could not be contacted due to work/travel schedules and being out of the country. Those two participants were available two and three weeks after treatment. The final step was the second follow up session (Appendix S), two months after treatment. All participants participated in both the follow up interviews and completed all four questionnaires after the treatment.

Data was collected through the interviews and during the muscle testing and treatment sessions. The interviewing process began after the potential participants replied to the advertising and a telephone interview was scheduled. During the telephone screening interview, which took approximately one to one and a half hours, I, the researcher employed a conversational interaction style with the potential participant and enquired about the pressing issue in his/her life and why he/she thought this study could help him/her. The researcher further inquired about what he/she would like to achieve. To focus on what each participant wanted to achieve, the researcher helped them to focus on a potential goal. Then the researcher started to follow a more structured approach, with open ended questions from

the telephone screening questionnaire and ended with the demographic questions on the questionnaire in Appendix B.

Once the researcher was satisfied with the information of the presence of phobic answers and phobic language patterns and words, she decided that the person would possibly be fit for the study. The potential participant was immediately informed that he/she fit the criteria, and that they would receive two psychological questionnaires via email during the next week, and a week after that, a preliminary half an hour face-to-face interview would be scheduled to teach them the art of muscle testing, as well as a muscle test to see whether or not they had a phobia in the context of change, transition and progression. During this interview, they would also be muscle tested to determine whether their phobias could be healed with the HBLU™ simple phobia protocol, which was the final criterion they had to meet before being included in the study. When they met all the criteria, they could receive the treatment directly after the muscle testing session or schedule it for another time.

The muscle testing session (15 – 30 minutes long) followed two weeks after the screening interview, and one week after they had completed and returned the HAM-A and IOE psychological tests. The two week lapse between the screening interview and the muscle testing session was necessary to eliminate the possibility of time resolution, which eliminates issues that can be resolved organically by the duration of time. During the muscle testing session, each participant was informed how HBLU™ views phobias and how we would utilize HBLU™ as an Energy Psychology method. They were trained in the tilting muscle test method and when they could successfully muscle test, they were tested to confirm that they had a phobia in the context of change, transition and/or progression, which could be cleared with the HBLU™ simple phobia protocol. When they met all the criteria, the in-person treatment session followed or was scheduled at an appropriate time.

At the beginning of the treatment session, all participants filled in an informed consent form, an Audio record consent and Participant Bill of Rights (See Appendices C, D and E). The participants also completed the DASS and GAD-7 tests just before the treatment session. The participants were reminded of their voluntary participation and their right to withdraw anytime without consequences. To put the participants at ease and bring their focus back to the issue at hand, the researcher recaptured/summoned all the information she gathered by reading it to each participant. Each participant was given the opportunity to correct the researcher, add information and ask questions and raise concerns. The treatment session consisted of semi-structured (Appendix F) and structured questions (Appendices L & N). The first part of the interview started with the semi-structured questions and open ended answers, focusing on creating rapport with the client and refocusing them on the issue they sought treatment for. Then we proceeded with the simple clearing process (Appendix G) and when the participants were able to accurately muscle test, we proceeded with the treatment session and structured questions (Appendices L & N).

The second part of the treatment session which consisted of the treatment by means of the structured HBLU<sup>TM</sup> phobia treatment protocol questions, was designed to elicit the participant's type of phobia, amount of phobias, the nature of the phobia(s), intervention(s) of choice and the resolution of the phobia and goal (See Appendices L & N for the HBLU<sup>TM</sup> structured questions). Once the phobias were identified during the protocol, NLP language was used – “what is the consequence of that” and “then what happens” to probe and help the participant to get to the core of the phobia and to the extreme language of the phobia, which is absolutely essential for an in depth and accurate resolution of the phobia. Results were tested immediately after the treatment by muscle testing the participants to see if the phobia had been resolved on all levels - the body, the unconscious, conscious and soul. All

participants were also muscle tested to confirm that their goal had been achieved a 100% on all levels - the body, unconscious, conscious and soul levels.

Further questions were answered after the treatment, and the dates for the first and second follow up interviews were addressed with each subject. The duration of the treatment session was between 1 – 4 hours, depending on: 1) how much the participant needed to talk, 2) how much difficulty he/she experienced with muscle testing (deception and/or resistance), 3) the number of phobias, 4) and the participant's ability to access deeper thought patterns while they mapped out the phobias with ease or difficulty.

During the treatment protocol and muscle testing process, the researcher stood next to the client to be less intrusive and was able to observe subtle changes, such as breathing pattern change, skin colour change and heart beat change by observing the visual pulse in the neck area, as well as subtle nuances in the muscle testing that the researcher used as clues to appropriately direct the treatment process. The researcher could immediately notice if the answer was not given in a clear yes or no fashion. For example, if the participant was leaning to one side or made a swirling motion during the muscle testing, the researcher knew that the participant needed to say something before the muscle testing could proceed without interference and deceit. In this way, the researcher could address difficulties and resistance immediately. Each treatment session was recorded via digital audio recording and written notes, therefore information was noticed and recorded as it occurred, including the physical changes or any other unusual aspects. The use of the standing tilt method as a muscle testing instrument is especially useful in the treatment of subtle phobias where most people are not even consciously aware that they are phobic, although the body is telling a different story. This helps to guide questioning as it provides non - verbal insights that are further confirmed with muscle testing.

The first telephonic follow up interview followed one week after treatment. The researcher compiled a personalized questionnaire (Appendix R) for each subject so that she could ask in-depth personal questions that focused on information gathered during the screening interview and treatment session to note positive changes and progressive changes in attitude, behaviours, and in mental, emotional and spiritual states. Their progress was discussed with regard to resolving the phobia(s) and achieving their goal, the effect it had on their lives, and how it affects them now. The participants also had to complete and return all 4 psychological questionnaires (the DASS, GAD-7, HAM and IOE scales) after the first interview took place.

The second telephonic follow up interview followed 2 months after treatment. Personalized questionnaires (Appendix S) compiled by the researcher were used to enquire about the change in approach and attitude towards the treated issue in the participants' lives. The researcher also inquired about positive tangible changes in their lives as well as new issues that surfaced.

The treatment sessions and follow up interviews were digitally recorded and the researcher took handwritten notes on the subjects' observations, behaviours, attitudes and reactions. The audio files were not transcribed by an external source. While the researcher took notes during all recordings she felt that she would gain better understanding and deeper insights if she listened to and transcribed the recordings herself. While she transcribed the recordings, she compared the recordings with her personal writings. (All study documents are kept in a secure location and will be securely disposed of when they are of no further use for research purposes.)

Although the different kinds of data collection through observations and interviews could have made the researcher biased towards the subject matter, (participants might bring

up similar experiences and issues as the researcher might have experienced during the treatment phase), muscle testing was employed to assist the process of positively resolving the problem in a clear and un-biased way, since muscle testing remains unaffected by the researcher's experience. In addition to being a researcher, I was also an observer and participant (as I played the role of practitioner) and the participants were aware of my roles as I directed the questioning during the screening interview, treatment session and follow up interviews.

All the participants fit the study's inclusion criteria after their screening interview. One potential participant who used phobic language but responded with 'no' when he was muscle tested for having a phobia of change, preferred to have a 2 hour talk therapy session instead of the energy psychology treatment session. He was therefore excluded from the study.

### **3.4.2. Debriefing**

At the end of each interview and treatment session, participants had the opportunity to ask questions and were encouraged to continue with healthy life choices. They could contact the researcher if they had any further questions or concerns. The final interview was concluded by thanking each participant for their time, willingness and contribution.

### **3.5. Data analysis**

The grounded theory approach was chosen to explore the experiences of the phobic participants in order to facilitate a deeper understanding of the phenomenon of phobias, which is in line with the goals of this method (Maykut & Morehouse, 1994). The researcher aimed for organizing and ordering the data into themes without interpreting the data. The themes were thus only recorded and described. In order to understand the findings that

emerged from the interviews and the treatments by following the grounded theory approach, the collected data was treated in depth with ongoing analysis from the first screening interview to the last follow up interview by reflecting on the participants' answers to the researcher's questions, and to the answers from the four psychological questionnaires. During the data collection phase, the data was analysed after each treatment by comparing the participants' pre-treatment phobic reactions with their post treatment phobic experiences. SUDS ratings (and muscle testing during pre-treatment and treatment) were used throughout the pre-treatment, treatment and post-treatments in order to confirm the phobias and measure phobic resolution.

During the two follow up interviews, (the first one, one week after the treatment session, and the second one, two months after the treatment session), the researcher compared information, results and outcomes with the previous screening interview, the four psychological tests and treatment session data. During the first interview, the effectiveness of the treatment, regarding phobia and goal resolution, was tested through clinical observations and comparisons, by analysing the personalized questionnaires compiled by the researcher, by analysing the four psychological tests and by means of analysing the clients' feedback. Further investigation, during the two month telephonic follow up interview followed, during which the same test instruments were used, with the exclusion of the four psychological tests, to evaluate the participants' progress regarding the resolution of their phobias, the achievement of their goals, and the effects the treatments had on their lives. I will now describe the process of data analysis that I used to better understand the phenomenon of having a subtle phobia in the context of change, transition and progression.



### **3.5.1. The process of data analysis**

#### **3.5.1.1. Interviews**

I listened to the recordings and read the information I wrote down during the interviews to gain a general sense of the information while sorting information by participant names. I went through the information gathered during the screening interview, then the muscle testing and treatment session, and finally the first and second interviews. Lastly, the questionnaires were evaluated. During this stage, the recordings and written information were compared with each other and any noted incongruences were noticed and corrected. During the second reading, the interview findings were described by just reporting the findings, without any interpretation. During the third reading notes of similarities were made.

At the fourth reading, conceptual ordering started to take place where major ideas, phenomena and patterns were noted, categorized and coded (open coding). During the next reading, there was more clarity for creating subcategories by describing the categories and coding them. The next step consisted of a comparative analysis which was used to correlate the described and coded categories with corresponding themes, by noticing their interrelationships. I then proceeded to code these correlated categories by means of axial coding.

Finally, during the third phase of the grounded theory approach to analyzing data, preliminary theories (which laid the foundation for the final theoretical model) emerged from the interconnected categories. The preliminary theories which will be discussed at the conclusion of this paper provides a new understanding of the participants' phobic experiences in the face of change, transition and progression, and provides further insight into HBLU<sup>TM</sup> as an effective treatment for phobias.

Dr Swack (founder of HBLU™) and John Freeman from ACEP advised me to include psychological tests in order to improve the quality of the research.

#### **3.5.1.2. Questionnaires**

Because of the unique nature of the phobias, I included four psychological questionnaires as additional test instruments. The Depression, Anxiety, Stress Scale (DASS), the Impact of Event Scale (IOE), General Anxiety Disorder assessment 7 question scale (GAD 7) and the Hamilton Anxiety Scale (HAM-A) were included.

##### **3.5.1.2.1. The Depression, Anxiety, Stress Scale - DASS**

#### **Justification for inclusion**

The DASS scale was included as it measures depression, anxiety and stress, all of which could be a symptom of a subtle phobia.

##### **3.5.1.2.2. The Impact of Event Scale - IOE**

#### **Justification for inclusion**

The Impact of event scale is relevant because an event, the change, occurred in the participant's life, which created the phobia of change.

##### **3.5.1.2.3. The General Anxiety Disorder assessment 7 question scale - GAD 7**

#### **Justification for inclusion**

The GAD 7 scale was included to measure the participants' general anxiety as phobias are normally related to anxiety, and to see the effect a subtle phobia can have on their general anxiety.

#### **3.5.1.2.4. The Hamilton Anxiety scale - HAM-A**

##### **Justification for inclusion**

Lastly, the HAM-A scale was included as it measures not only the psychological but the physiological impact of anxiety. These measures are relevant if we work with the mind and body and to note the impact the mind and emotions can have on the body, i.e. the psychosomatic effect.

The IOE and the HAM-A scale were given to the participants one week after the screening interview, but before the treatment session and the DASS scale and the GAD 7 scale were given just before the treatment session. All four questionnaires were given to the participants right after their first follow up interview.

The researcher organized, sorted and hand coded all data from the answers of the screening interview questionnaires, muscle testing and treatment session recordings and the answers from the two follow up interviews via grounded theory coding procedure, which includes open coding (where major categories are constructed) followed by axial coding (where minor or sub-categories are constructed).

#### **3.6. Reliability and Validity**

To maintain qualitative reliability, the researcher consistently documented all of the steps in the study in rich detail to provide a clear and accurate picture of the research process. To further insure reliability, the recordings were thoroughly compared with the written information and information was added when missed during writing. The data and codes were constantly compared with each other to ensure that the codings have consistent definitions and meanings. Another person (who was briefed with regard to confidentiality) assisted me with cross-checking the codes to assure the appropriate coding of the text.

Although reliability is not seen as a strength in qualitative research because of examining instability and inconsistency of responses, validity is, because the accuracy of the findings could be based on the perspective of the researcher, the participant or the reader (Creswell, 2009). Five of the eight primary validity strategies that Creswell (2009) mentions were employed to enhance the researcher's capability to assess the accuracy of the findings and to ascertain credibility in this study:

1) Neutrality: being as unbiased as possible. Although the researcher has a bias in favour of Energy Psychology due to her professional background and training in HBLU™, and her previous success in using HBLU™ to resolve phobias, the process of muscle testing is not affected by the researcher's personal beliefs, feelings or experiences. Muscle testing was incorporated as a strategy for increasing the validity of the participants' responses during the treatment session. The tilting stand muscle test procedure further eliminated physical manipulation, as no physical contact between the researcher and participant took place. Addressing the participants' soul and deepest wisdom (an HBLU™ protocol) in combination with the muscle testing procedure and checking for deception, contributed to even greater credibility and authenticity. Possible projections by the researcher were eliminated by the participants' muscle testing responses.

The researcher also utilized her NLP observation skills by focusing on changes in breathing patterns, skin tone, voice patterns and vocabulary choice to enhance objectivity.

2) Member checking and repeated observation: to ensure and confirm the researcher's understanding of the participants' statements through regular and repeated observations during the screening interview, muscle testing and treatment sessions and 2 follow up interviews.

Trustworthiness of findings was strengthened by gaining different perspectives about how the participants view and name their phobias and how the phobias influenced their lives. Detailed answers from participants' responses to questions (and then reading back the summary to them to confirm accuracy of interpretation) throughout the different stages of the research, for example during the pre-interview, the muscle testing training session, the treatment session, and the follow up interviews contributed to the researcher's observations, which strengthened the credibility of unbiased data collection.

3) Triangulation of *different data sources* was achieved by using: multiple sources (energy psychology literature, personal and psychological questionnaires, muscle testing and interview and treatment transcripts) of data collection to ensure validity. Data were collected by observing, recording and noting participants' answers, perspectives, reactions and behaviours during the multiple interviews.

4) External auditor: a neutral person not familiar with the research project. To strengthen validity of the data further, at the conclusion of the study, I, the researcher, used an external auditor to review an extensive conclusion of the project. This external auditor was unfamiliar with me and the project and provided an objective assessment by reviewing the data and the quality of data analysis. I carefully adjusted the study's findings (when needed) to incorporate the external auditor's suggestions in order to increase the validity and credibility of this study.

5) Peer debriefing: a person who reviews the study and asks questions. I, the researcher located a peer debriefer who was familiar with the research subject, and who continually throughout the course of the study reviewed the study and asked questions. This validity strategy helps that the study information resonates with not only the researcher, but

with other people as well. Verification of my own understandings, adds validity to the research information.

According to Gall, Borg & Gall (1996) as cited in Hale (*n.d.*), verifying the perceptions of the research participants in a systematic manner can also contribute to the validation of a study. This was done from the start of this study during the screening interview, during the treatment interviews and sessions, until the end of the study during the final follow up interviews.

Another study validation is what Gall et al. (1996, as cited in Hale (*n.d.*)) call pattern matching, which is one of the five strategies to establish the chain of evidence in a research study. The chain of evidence is when a reader can arrive at the same or similar conclusion(s) as the researcher, because of the logical relationship between the research question(s), research procedures, raw data and the results. In this study the perceived benefits of an intervention (the HBLU <sup>TM</sup> simple phobia protocol can resolve phobias) was researched, matched and confirmed (pattern matching), which contributed to the validation of the study, according to Gall et al. (1996) cited in Hale (*n.d.*).

### **3.7. Protection of participants**

For ethical considerations, and to respect the rights, needs, values and desires of the participants, I, the researcher, consulted the research guidelines of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* as well as the Ethical Code for Psychologists of the Psychological Society of South Africa (<http://www.psyssa.com>) and followed the guidelines of the Board for Psychology of the South African Health Professions Council (<http://www.hpcs.co.za>), as well as the Ethics approval screening checklist provided by UNISA.

The participants were informed that their participation is voluntary and that they can withdraw at any time without any further consequences. During all the interviews they were encouraged to ask questions whenever they needed more information. Each signed an Informed Consent Agreement, an Audio Record Consent, as well as a Participant Bill of Rights. Conscious signing of the agreement, as well as muscle testing confirmed their 100% permission for treatment.

They were informed that all data will be kept confidential, although the material from the study will be used as a part of the researcher's dissertation for her Master's Degree in Psychology. To further secure privacy, pseudonyms were used to conceal the participants' identities.

During the muscle training session, participants started to experience the nature of an Energy Psychology session. Time was allowed for familiarizing them with the procedure and to address all of their questions about it.

The research study can in no form or way harm the participants physically, mentally, emotionally or spiritually. One of the strengths of HBLU™ is that it protects clients from harm as the protocol requires that their soul and deepest wisdom direct the treatment process which in turn is confirmed by muscle testing. When a participant was not ready to address an issue, it was shown in his/her muscle testing and the researcher always respected the participant's direction and worked with that.

## **Conclusion**

Very little is known about the subject of treating subtle and/or existential phobias such as phobias of change, transition and progression and therefore the grounded theory methodology was employed as a strategy of inquiry in the context of a qualitative research

design to discover the impact of phobias of change, transition and progression on people's lives and to further describe and explain the phenomena at hand.

By treating nine participants for their phobias of change and one participant for his phobia of transition and by analysing that data, the researcher was able to gain insight into the creation, manifestations and impact of the phobias on individuals, and observe how a preliminary theory emerged from the analysed data that can explain how phobias of change and transition create difficulties with change, transition and progression.

A detailed description of the research findings will be presented in chapter 4, which will include the participants' profiles and the conceptual ordering of the categories drawn from the data.



## **4 PRESENTATION OF THE FINDINGS**

The purpose of this study was to explore the impact of an Energy Psychology approach, the HBLU™ simple phobia protocol, on phobias of change, transition and progression through qualitative research with the grounded theory approach to collect, and analyse the data in the hope that a theory would emerge from the observations. This chapter provides a summary of each participant based on data collected during the screening interview. Pseudonyms were used for the seven women and three men who participated in the study. The changes and transitions in their lives which created their phobias are described as well as the consequences of the change and subsequent phobias in the participants' lives. The process of discovering the phobias, the treatment of the phobias and the findings of the study investigation (Did the treatment work?) are also presented. Most of the discussions will be presented individually.

To grant inclusion in the study, the participants had 1) an in depth telephonic or personal screening interview (Appendix B), 2) a preliminary muscle testing session to teach them the art of muscle testing and to test their ability to muscle test and 3) then muscle test them to see if they had a phobia in the context of change, transition and/or progression, and if they did, 4) if it could be cleared with the HBLU™ simple phobia protocol, as opposed to another phobia protocol (Appendix H).

Once the participants met all the inclusion criteria, an appointment was set for the treatment session (Appendices F, L & N). The participants all completed four psychological tests; The Depression, Anxiety, Stress Scale (DASS scale), the Impact of event scale (IOE scale), General Anxiety Disorder assessment (GAD 7 scale) and the Hamilton Anxiety Scale (HAM-A scale) in Appendix J. The IOE and HAM tests were completed one week before the

treatment session and the GAD-7 and DASS tests were completed right before the treatment session started. All four tests were completed again after the first follow up session.

All of the participants had two follow up interviews after the treatment session, with the exception of Grace who had three follow up interviews.

This chapter provides 1) the participants' profiles, and 2) the conceptual ordering of the major categories, sub-categories and sub-subcategories that emerged from the data. A brief description of each participant's personal history follows:

#### **4.1. Participants' profiles**

The participants met the criteria necessary for the study and were included thereafter. Their ages ranged between 21 and 68. Eight of the participants were Caucasian Americans and two were first generation Americans - one from Lebanese ethnicity and one from El Salvadoran ethnicity. Nine lived in southern California, not more north than Los Angeles and one participant lived in San Francisco. Only two participants were employed during the time of the interviews and treatment; two were students, two were retired, two were unemployed, one had her own practice and one was at the end of his working contract. Five of the participants believed they were phobic of change prior to treatment, two thought there might be a possibility of a phobia of change and the remaining three did not believe they were phobic of change. Believing they had a phobia of change was not a criterion to participate in the study.

A brief description of each participant follows where they further mention their sexuality, religious orientation, familiarity with Energy Psychology, the change which impacted their lives and their beliefs about being phobic or not.

Table 4.1 presents the demographic profiles of the ten participants in this research study.

**Table 4.1: Demographic Profiles of the ten participants**

Name	Age	Ethnicity and Nationality	Sexual preference	Relationship status	Occupation	Religion and spirituality	Familiarity with EP	Believe to be phobic	Sex
Angie	41	Caucasian American	Heterosexual	Single	Unemployed	Raised catholic, now not following a particular religion	No	Yes	Female
Elizabeth	22	Caucasian American	Heterosexual	Single	Student and part time employed - retail	Catholic	Yes	Yes	Female
Bunny	45	Caucasian American	Heterosexual	In a relationship	Somatic trauma healer	“Love everybody”	Yes	No	Female
Jane	21	1 <sup>st</sup> generation American – Lebanese	Heterosexual	Single	Student	Christian	Yes	Yes	Female
Grace	68	Caucasian American	Heterosexual	Divorced	Retired	Raised Catholic, now New Belief	Yes	No	Female
Michael	62	Caucasian American	Heterosexual	Married	Magician, composer and musician	No religious orientation – attracted to Buddhism	Yes	Yes, a possibility	Male
Bam	64	Caucasian American	Homosexual	In a relationship	Art Director	Raised Christian – now not following a particular religion	Yes	Yes	Male
Mr Blue	41	Caucasian American	Heterosexual	Married	Product design manager	Christian	Yes	No	Male
Peggy Sue	61	Caucasian American	Heterosexual	Married	Retired	Christian	No	Yes - probably	Female
Tallulah	31	1 <sup>st</sup> generation American – El Salvadoran	Heterosexual	Single	Unemployed	Raised Catholic	No	Yes	Female

### *Angie*

Angie is a 41 year old single, heterosexual, Caucasian American woman who is currently an unemployed office worker and is volunteering her services at a yoga centre as a receptionist. She said she does not follow any religion, but was brought up Catholic. She believes in the concept of God and describes herself as having a strong connection with God.

She is familiar with Energy healing modalities such as reiki, pranic healing, cranio sacral therapy, but not with Energy Psychology per se. She had not received any Energy Psychology treatments prior to the phobia treatment.

The change in her life that affected her and she focused on was when she started to have extreme back, leg and hip pain and became unemployed as a result. She had back surgery a year before she participated in this research. She has not been able to move forward and participate in life.

She believed prior to treatment that she had a phobia of change because “I choose to stay in a situation when I know I should change it.” Muscle testing confirmed her phobias of change and she was treated for 6 fear phobias.

### *Elizabeth*

Elizabeth is a 22 year old single, heterosexual, Caucasian American woman who is a student. She was raised as a Catholic and believes in God.

She is familiar with Energy Psychology and has experienced the Energy Psychology techniques of breathing and Hypnosis during therapy with her psychotherapist. She stopped therapy five months before she became a research participant because she perceived that her therapist did not understand her.

The life changing situation she presented for treatment was her sudden break up with her boyfriend six months ago. She felt that she could not move on from the situation and move forward with her life since then.

She believed prior to treatment that she was phobic of change because “I am scared of change, I am scared of the future.” Muscle testing confirmed her phobias of change and she was treated for 5 fear phobias.

### *Bunny*

Bunny is a 45 year old single, heterosexual, Caucasian American woman who describes herself as a Trauma healer and has a private practice as a trauma healer. She describes her religion as “Love everybody” and calls upon a higher power, but is not comfortable with the word God.

She is familiar with a wide variety of Energy Psychology techniques and methods and she herself is using and teaching Somatic trauma resolution in her practice. She continues to learn more about the subject of Energy Psychology.

Her life changing event is a new romantic relationship with a much younger man since January 2012. She feels that she cannot focus on her life and her main focus is on him and the outcome of the relationship.

She did not see herself as phobic of change prior to her participation because “I do not see myself as phobic, but wounded. If I was phobic, I would not go near a relationship.” Muscle testing confirmed that she had a total of 8 phobias of change; 3 fear phobias, 4 shame phobias and 1 hybrid phobia.

### *Jane*

Jane is a 21 year old, single, first generation American female from Lebanese ethnicity. She is a student and identifies as heterosexual. She is a practicing Christian and believes strongly in God.

She is familiar with Energy Psychology and has received one EFT treatment and three HBLU™ sessions in the previous three years. Her main focus was on relationship issues during these treatments.

Her life changing event happened eight months ago when she moved from her hometown to a big city, far away from home, family and friends to attend a new university. She could not adapt and her grades suffered significantly.

She saw herself as phobic of change because “Everything changed in my life and I have very strong feelings and if you are phobic you have very strong feelings.” Muscle testing confirmed that she had 8 phobias of change; 4 fear phobias, 2 shame phobias and 2 hybrid phobias.

### *Grace*

Grace is a 68 year old divorcee. She is a Caucasian American woman and identifies as heterosexual. She is a retired educator. She was brought up Catholic, but identifies more with the New Thought movement now. She is comfortable with the concept of God.

She is familiar with Energy Psychology techniques and has received EFT and Hypnosis treatments regarding her marriage and divorce. EFT brought only short term relief – “release in the moment,” and she had a negative experience with Hypnosis where she felt worse than before the treatment. She has been muscle tested for various nutritional supplements and has also received Energy healing treatments such as Reiki and Quantum Energetics.

Although Grace has many issues in her life that may need attention, such as the death of her son and father and her move from one city to another, she choose to focus on the life changing event of her divorce in 2004 after 37 years of marriage. Since then, she reported that there is a lack of progression in all areas of her life and that “she just got stuck where she cannot do things that are good for her.”

She did not see herself as phobic of change because “I walked through so many changes already.” Muscle testing confirmed that she had a total of 9 phobias of change; 4 fear phobias, 4 shame phobias and 1 hybrid phobia.

### *Michael*

Michael is a 62 year old heterosexual, married, Caucasian American male. He works independently as a magician, composer and musician. He has no religious orientation, but is attracted to Buddhist beliefs, but does not see himself as a Buddhist. He has no problem with the concept of God.

He is familiar with various Energy Psychology techniques and has received EFT treatments and one HBLU<sup>TM</sup> treatment 4 years ago. He participates in sound meditation and teaches laughter yoga.

The life changing event he chooses to focus on is the release of his Broadway musical, which he has been working on for almost three years. He feels that he cannot get to the next step of finishing it, letting it go, and releasing it to the public.

He believed that there might be a possibility of a phobia of change because “the screening questions gave him a bigger awareness of himself and his situation.” He muscle tested positive for 8 phobias of change; 3 fear phobias, 2 shame phobias and 3 hybrid phobias.

### *Bam*

Bam is a 64 year old homosexual, Caucasian American male. He is in a long-term relationship. He works in the film industry and does contract work as an Art director. He was raised Christian (Presbyterian) and is comfortable with the concept of God.

He knows about Energy Psychology, but is not familiar with it and has experienced EFT once in a group setting.

His life changing event is an ongoing process for the last thirty years. Because of his work situation, he is never sure after a project if he will find a job again. The time in between contracts affects him, his personal relationship, and friendships negatively, where he ends up not doing anything and just focuses on money issues. He cannot continue with his life and make plans during these times.

He believes that he is phobic of change as it is part of the fear of not knowing - “It is part of my fear of success.” His muscle testing confirmed that he had 2 phobias of change; 2 fear phobias. He also had 1 anticipatory phobia related to his goal.

#### *Mr Blue*

Mr Blue is a 41 year old heterosexual, married Caucasian American man who was raised Christian and is comfortable with the concept of God. He is a product design manager.

He is familiar with Energy Psychology and has received EFT and HBLU™ treatments for various different issues. He reads about the subject and researches it on the internet.

The life changing event he chooses to work on is the new independent business he started two and a half years ago. He does not have clarity about the next step and the ability to find solutions for the communication problems with his partners so they can move forward. The business has been stuck in one place for the last 8 months.

He did not believe he was phobic of change before the treatment as “None of my anxiety is about the possibility of change; it is the lack of change.” He muscle tested positive for 3 phobias of transition (and not change); 2 fear phobias and 1 hybrid phobia.



### *Peggy Sue*

Peggy Sue is a 61 year old heterosexual, married Caucasian American woman. She is retired from her event planning career. She was raised Christian and views her religion as “totally God and angel based.”

She is familiar with the Energy healing concept of Reiki, but not familiar with Energy Psychology.

Her life changing event is her retirement one and a half years ago. She feels she cannot move forward in any area of her life, she just became “stuck.” She cannot go for a walk, read a book, or even work in her beloved garden.

She believed herself to be probably phobic of change, because “I fear that if I change, my family won’t like me, my husband will divorce me, I won’t have money, I will be alone and if I don’t do what they want and please them, they will dispose of me.” Her muscle testing confirmed 5 phobias of change; 2 fear and 3 shame phobias.

### *Tallulah*

Tallulah is a 31 year old single, heterosexual first generation American, from El Salvadorian ethnicity who is currently unemployed from her telephone distribution job. She was brought up Catholic, but has no affiliation with the church. She is comfortable with the concept of God.

She is familiar with Energy healing and received chakra healing, but said she is unfamiliar with Energy Psychology.

The life changing event she chooses to focus on is the loss of her job in January 2012. She reported that fear and confusion held her back from moving forward with her life. It had a great physical impact on her, where she lost 20 pounds and her menstrual cycle ceased.

She believed that she was phobic of change because “I want to move forward, but I can’t, I am holding myself back with one hand.” She muscle tested positively for 7 phobias of change; 3 fear and 4 shame phobias.

#### **4.2. Conceptual ordering of the categories drawn from the data**

Coding took place after listening to the audio recordings of the treatment sessions and rereading the transcripts several times. The change and transition of each participant was coded as well as the consequences of the change, the realization of the presence of a phobia, the treatment of the phobias, and the effectiveness of treatment directly after treatment, one week after treatment and two months after treatment. These codes were used to create seven categories (open codes). Further coding took place where the changes, transitions, emotions, thoughts, awareness, behaviours, physical, spiritual, interpersonal, social and occupational impacts, lack of progression, progression, desired outcomes, phobic language and the results of the four psychological tests of each participant were coded. Self-realization, realization through muscle testing, the different steps of the HBLU<sup>TM</sup> protocol, energy psychology techniques applied, resolution of phobias, participants’ statements, written learnings, unresolved issues and emerging healing needs were further coded. A total of forty two sub-categories (axial codes) emerged from the seven categories. Some of the sub-categories were further divided into sub-subcategories.

Table 4.2 shows the categories, sub-categories and sub-sub categories which emerged during conceptual ordering.

**Table 4.2: Categories, subcategories and sub-sub categories**

Categories / Open codes	Subcategories / Axial codes	Sub-subcategories
1. The life changing event in each participant's life	1. The change 2. A transition	1.1. Work 1.2. Relationships 1.3. Relocation
2. The consequences of the change and transition in each participant	3. Emotional impact 4. Mental and behavioural impact 5. Physical impact 6. Spiritual impact 7. Interpersonal impact 8. Social impact 9. Occupational impact 10. Lack of progression 11. Desired outcomes 12. Consequences shown in 4 psychological tests	4.1. Negative mental impacts: thoughts and beliefs 4.2. Maladaptive behaviour
3. Realization of the presence of a phobia	13. Phobic language 14. Self-realization 15. Realization through muscle testing	14.1. Fear of change 14.2. Fear of going through a period of transition 14.3. Fear of progression
4. Treatment of simple phobias with the HBLU <sup>TM</sup> simple phobia protocol.	16. Simple clearing and solutions 17. Establishing muscle testing 18. Establishing a goal 19. Mapping out phobias 20. Energy Psychology techniques applied <i>before</i> phobia resolution 21. Energy Psychology techniques applied <i>during</i> phobia resolution with the HBLU <sup>TM</sup> phobia protocol 22. Resolution of phobias	
5. Treatment efficacy directly after treatment	23. Participants' statements 24. Participants' written learnings	24.1. Greater self-awareness 24.2. Optimism about the future and new possibilities

<p>6. Treatment efficacy one week after the treatment</p>	<p>25. Emotional changes  26. Mental and behavioural changes  27. Physical changes  28. Changes in spiritual awareness  29. Interpersonal and social changes  30. Occupational changes  31. Progression towards participant's individual goals.  32. Participants' unresolved issues  33. Measured changes in 4 Psychological tests</p>	<p>26.1. Awareness of mental changes: new thoughts and beliefs  26.2. Behavioural changes    32.1. Unresolved emotional issues  32.2. Unresolved mental and behavioural issues  32.3. Unresolved physical issues</p>
<p>7. Treatment efficacy two months after treatment</p>	<p>34. Further emotional changes  35. Further mental and behavioural changes  36. Further physical changes  37. Further developments of spiritual awareness  38. Further interpersonal and social changes  39. Further occupational changes  40. Progression towards participants' individual goals  41. Desired outcomes met  42. Participants' unresolved issues  43. Emerging healing needs</p>	<p>42.1. Unresolved emotional issues  42.2. Unresolved mental and behavioural issues  42.3. Unresolved physical issues  42.4. Lack of progression towards goals    43.1. Unresolved grief  43.2. Interpersonal relationship management  43.3. Physical concerns</p>

The seven categories and forty three sub-categories together with their sub-subcategories which emerged during the data analysis will now be discussed in detail. They are all labelled by numbers.

#### **4.2.1. Category 1: The life changing event in each participant's life**

Each participant was asked during the screening interview to describe the event in his or her life that brought change and had a negative impact on his/her life. Six of the participants had negative work related experiences, three had relationship experiences, and one experienced difficulties after she moved.

Category 1 is divided into 2 subcategories: 1) The change and 2) A transition.

##### **4.2.1.1. Subcategory 1: The change**

The participants' changes fell under the sub-subcategories of 1) work, 2) relationships and 3) relocation.

###### **4.2.1.1.1. Sub-subcategory: Work**

Angie's change came when she started to have back problems in the beginning of 2011 and as a result went on pain medication. She stopped working because she had too much pain in her back, legs and hips and had back surgery in June 2011.

Michael had been working on a Broadway musical for the last 3 years, which he could not finish, as he was compelled to keep reworking it. He was unable see himself as a musician and composer and could not transition from a magician – his current career – into a musician and composer – his new career.

Bam had a change affecting his life for the last 30 years. He has never been able to adapt comfortably to his life as a temporary employee in the film industry. This situation has

been affecting and interrupting his life for the last three decades. He was fine with the change – when his project is completed - it was the transitioning into his unemployment status that was hard for him.

Mr Blue started up a company with two partners more than two years ago; the company grew and then came to a halt when they needed to go into production. He found it difficult to accept and handle the lack of progression in the company's growth.

Peggy Sue retired as an event planner and could not adapt to her and her husband's lives as retirees and she felt her life came to a halt. She was unable to participate in life in any way. She retired to get away from her boss, whom she felt attacked her relentlessly. During the time of her retirement a few other major life events occurred. Her daughter and two grandchildren who used to live with her and her husband, moved out because her husband did not want them living there anymore. Her daughter in law was diagnosed with lymphoma, her brother in law died, and her mother in law was hospitalized with dementia. Her thirteen year old dog died of cancer. Finally, her husband who retired the same time she did is in a weak emotional and physical state. He has heart health issues and diabetes and constantly makes anxious comments about his health.

Tallulah lost her job six months ago and felt she was at a crossroads where she did not know what to do with her life and time. She questioned whether she should look for a new job or spend the time on self-development. She had a lack of clarity on which direction to go.

#### **4.2.1.1.2. Sub-subcategory: Relationships**

Elizabeth described her change when her live-in boyfriend of two years blindsided her with a text messaged break up. She could not accept the fact that he had broken up with her;

she could not forget about him and move on. The only way she was able to participate in life, was to numb herself and self-destruct with parties, alcohol and indiscriminating sex.

Bunny started a new relationship with a man 20 years her junior, which brought up negative feelings in her with regard to her non marital state and her needs and wants to be married. It reinforced her feelings of sadness about not having experienced marriage or a fulltime partner. She was unable to relax into the current relationship and enjoy it for what it is – a new relationship with a much younger man. The relationship was all consuming.

Grace's life changed when her husband abruptly separated from her in 2001 and then divorced her in 2004. She had a problem accepting this reality and moving on with her life as a divorcee. It consumed her in such a way that she was unable to mourn her father's and son's deaths.

#### **4.2.1.1.3. Sub-subcategory: Relocation**

Jane had a life changing experience when she moved from her hometown and community college to a bigger city and a university. It was all new to her - the area, the new university, not having friends and being without her family. She moved away from her family and friends for the first time in her life and now had to do everything on her own. She could not adapt being alone with no support system, nor to the university which had more difficult subjects and higher standards than her previous college. She felt that the change broke her – “change can make or break you. It broke me.”

#### **4.2.1.2. Subcategory 2: A transition**

Apart from the change, nine of the ten participants felt that the change in their life also required a transition which created distress, anxiety and fear. One participant, Bunny, did not know if she was experiencing a transition. They each described their transitions below.

Angie said that she had to transition from “who I was before the back problems and surgery – I was healthy - to not knowing who I am now – unhealthy and in pain.”

Elizabeth was transitioning from being in a very close relationship with someone to being single. She found this transition hard and said “it is hard to be alone.”

Jane saw herself as transitioning into being more independent where all the outcomes of her decisions were her responsibility and not a shared responsibility with her family and friends. She moved from having many friends to having no friends. She felt that this transition has taken a toll on her.

Grace transitioned from being married to being single. She found it hard to transition because “being a mature single woman is different from being a young single woman.”

Michael said that his transition required a great leap of faith to accept the outcome of his composition and start to see himself as a musician and composer and not only as a magician.

Bam saw his ongoing and repetitive change as a transition every time when he has to transition from being employed to being unemployed.

Mr Blue described his transition as “moving into having less free time and personal time.”

Peggy Sue described her transition into retirement as “wanting to move into what I love to do and striking out on my own and being secure in that.”

Tallulah transitioned from being employed to unemployed and “stepping out of my comfort zones.”

Each one of the changes and transitions had consequences for the participants, which will be discussed next.

#### **4.2.2. Category 2: The consequences of the change and transition in each participant**

As the study looked at the consequences of change and if it can create a phobia or phobias of change, transition and/or progression, and if it can effectively be treated with the



HBLU™ simple phobia protocol, the participants were asked to discuss the impact the life changing event had on their lives before and after the treatment. Here the participants discussed the consequences that the life changing event and transition had on their emotional, mental, physical, and spiritual lives. They were also asked about the impact on their social and interpersonal lives, the occupational impact, the consequential lack of progression and their desired outcomes. Most of the participants were able to measure the impact of the change and transition on a SUD (Subjective Units of Distress) scale, where 1 had the lowest impact and 10 had the highest impact.

Their anxiety, stress, and depression levels and the impact of the event were also measured by using four different psychological tests before and after treatment; The DASS scale (Depression, Anxiety and Stress scales), the IOE scale (Impact of Event scale), the GAD 7 scale (General Anxiety Disorder 7 –item) and the HAM-A scale (Hamilton Anxiety Rating scale). The IOE and HAM-A tests were completed one week before the treatment session and the GAD 7 and DASS tests were completed right before the treatment session started. All four tests were completed again after the first follow up interview.

Category 2 is divided in 10 subcategories: 3) Emotional impact, 4) Mental and behavioural impact, 5) Physical impact, 6) Spiritual impact, 7) Interpersonal impact, 8) Social impact, 9) Occupational impact, 10) Lack of progression, 11) Desired outcomes and 12) Consequences shown in 4 psychological tests. The subcategory for mental and behavioural impact, is further divided into two sub-subcategories: 1) Negative mental impacts: thoughts and beliefs and 2) Maladaptive behaviour.

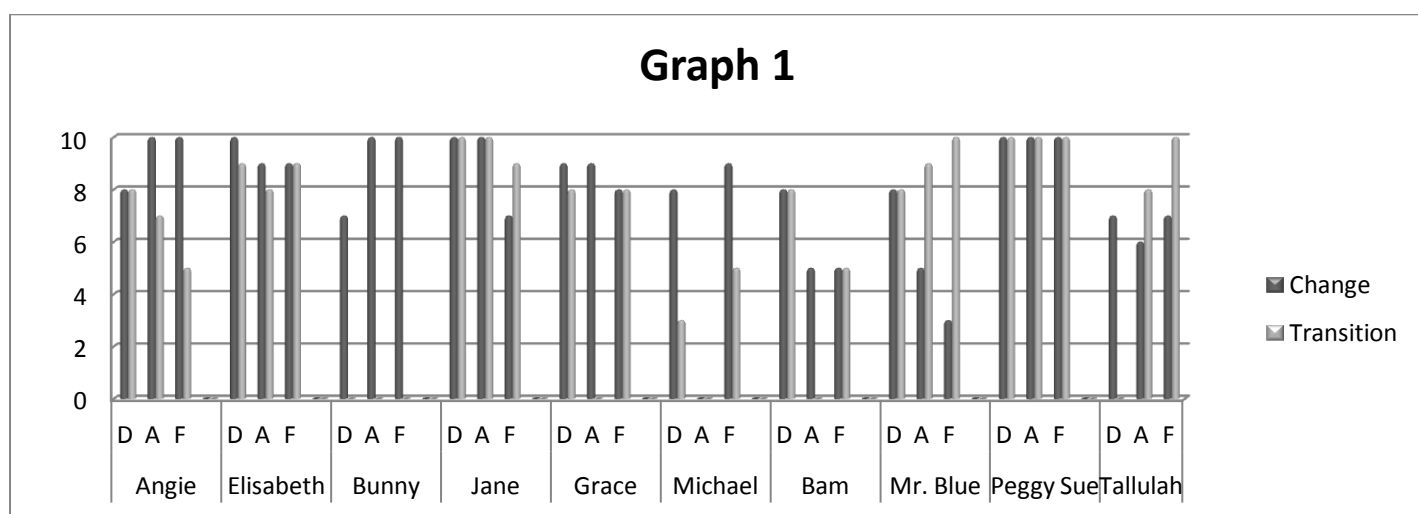
#### **4.2.2.1. Subcategory 3: Emotional impact**

All the participants felt that the event in their lives impacted them on an emotional level where it created a lot of negative emotions, and that this emotional state stopped them

from moving on with their lives. They all experienced high levels of distress, anxiety and fear with the change and transition, and each participant could rate the emotions with the SUD scale. Other relevant emotions were also named and explained. Anger and sadness were overwhelming emotions that stood out where seven participants felt anger and six felt sadness. Five participants said they were depressed (another participant, Peggy Sue, was diagnosed with depression, but denied it), six were frustrated, three were stressed, two felt guilt and shame and a further two participants felt worried.

Graph 4.1 shows the SUD of each participant's feelings of distress, anxiety and fear during the change and transition.

**Graph 4.1: Participant's SUD on distress, anxiety and fear during their change and transition.**



Note: D = distress; A = anxiety; F = fear.

Angie experienced distress at an 8, anxiety between 7-10 and fear at a 10 when she thought about the *change* in her life - her back problems, surgery and subsequent unemployment. Her fear was about being out of work and not being a 100% healthy and pain free. She also feared that she could not heal herself. She felt that she lost a sense of herself. When she thought of her *transitioning* into being a healthy, working person, she experienced

distress at an 8 as well, anxiety between a 6 and 7 and fear at a 5. Her fear was at a 9 just after the surgery, but it was down to a 5 at the time of the screening interview.

When she thought about *both* the change and the accompanying transition it affected her emotionally on the scale at 9, where she felt lost and did not know how to move forward. She had a full range of emotions from feeling love to frustration, feeling grateful (10), anger (5), and annoyance with people (9), impatience (7) and happy (6). She felt frustrated and depressed at 8, and felt lost at a 9 where she did not know how to move forward.

When Elizabeth thought of her *change*, the breakup with her boyfriend of two years, she felt distressed (9-10), anxious (9) and fearful (9). Her fear (10) was about never finding someone to love again.

While thinking about her *transition* into living as a single person, she felt distress at a 9, anxiety at an 8 and fear at a 9.

She also felt lonely and when she thought about *both* the change and transition and said it affected her emotionally on a scale of 9. She described herself as being a very emotional and sensitive person and very open with her feelings – “when someone else cries – I cry.”

According to her, everyone knows how she felt all the time. She was confused and upset all the time and cried a lot because she missed her boyfriend so much. It created further feelings of guilt (10), frustration (10), anger (7) and a lot of sadness (10). She felt suicidal before and was severely depressed, but those feelings have improved although she still “just wants to die.” She also feared and distrusted people at an 8 and mentioned that she had “bad anxiety” all her life and had always been paranoid and scared of change and the future. She felt a lot of shame around herself and her self-destructive social choices.

The *change* of a new romantic relationship with a much younger man in Bunny’s life created distress at a 7, anxiety at a 10 and fear at a 10. She felt distress (7) and anxiety (10) when thinking that a new romantic relationship might lead to marriage. She saw it as a fear of

rejection (10) because her relationships never lasted. This fear made her feel hopeless – “nothing will ever change.” She felt her new relationship will not work out and her partner will get tired of her and think she is too difficult. She was worried that she would not find a real life partner. She said her feelings created thoughts that he will find a reason to find her unacceptable and leave her and the old pattern of rejection will start all over again. She worried a lot about the age difference – “the fact that we are not at the same life stage influence our values and priorities.” She mentioned that if she would date a man her own age, she would not have to worry about the differences and his needs so much as they would be more in sync. She also worried about the physical signs of aging and how this issue could affect and influences him. She had a lot of sadness because she is not married yet. She was aware of her age when she spent time with him and it reinforced her sadness about not having experienced marriage and a full-time partner.

She did not know if she was experiencing *a transition* and therefore had no feelings around it. She also experienced feelings of frustration (8) and worthlessness (9).

Jane’s *change*, her move to another city, created distress and anxiety at a 10 and fear at a 7. She feared to be on her own and said she “could not go with the change.” She realized that everyone needed change but that change could be a “yes or a no for someone,” meaning that change could be good for some, but not for others. She had more anger toward people close to her as she feared they will forget her. She was also angry about the situation she was in and the steps that brought her where she was. She had to go to a community college, not because of her grades, but because of financial reasons. Because she was not a first year student at the new university, she felt she missed out on first year experiences which made it more difficult to make friends. Her anger was focused on her dad because she felt that he based his decision to send her to community college on money and not what was best for her and therefore it was his fault that she was in her current situation.

Her *transition* into independence created distress and anxiety at a 10 and fear at a 9.

The emotional impact of *both* the change and transition affected her at a 10 where she felt extremely anxious and more emotional. She experienced some anxiety attacks and allowed negative circumstances to bother her more than before. She felt down (9) where she used to be high spirited before. Furthermore, she felt depressed (9), discouraged (7) and unmotivated (9). She was constantly worried that she would not meet the expectations that she set out for herself and will let herself and others down. She was very discouraged and felt betrayed which affected her motivation to study and carve out a new life.

She also described herself as being very sad and she wanted to go back home all the time.

Grace experienced distress at a 9 when she thought about her *change*, the divorce. She did not think about it every day, but it affected her life and what she did or did not do on a more subtle level. Depending on what she was doing, her levels of anxiety could go between an 8 and a 9. She experienced fear between a 7 and 8. Her fear of rejection was a 9 when she thought about her divorce. She said her fear created limitations for her and when her fear and anxiety comes up, she went into paralyses. She also feared that she will always be alone and felt sadness and grief when she saw other couples.

Her *transitioning* into being a mature single woman brought up a lot of emotion for her, especially feelings of sadness; it created great pain and feelings of loss. She felt distressed at an 8. She felt no anxiety, just distress of what the reality is – she is divorced from her husband and he is happily remarried. She experienced fear between 7 and 8.

She also experienced depression, anger with herself and others, guilt and shame. These were not states that she was in every day and they might vary from a 6 to an 8. Other emotions she experienced when thinking of the change and transition were feelings of regret (7) and resentment (8).

Michael mentioned that he had a strong rationaliser component in his psyche that made him unable to process emotion well. The distress (8) he felt when he thought of his *change* – writing and finishing his musical - was with himself because he wanted the current musical he was working on to be perfect before he released it – “I am waiting for it to be perfect.” He felt frustrated (8) when he worked on the piece and about the fact that he cannot read music. He had no anxiety about it, but experienced fear at a 9. He had a fear of failure (9) and heard the words –“you are not good enough” and he believed that his fear is the central issue that holds him back from finishing and releasing the play. His fear of imperfection (9) made him feel that he was not ready to share it with the world although he realized that “the work should go out; otherwise I can just as well throw it in the trash.” He also felt embarrassment around this process. He was angry about the fact that he could not finish his play and he believed the anger was related to his fear.

When he thought of *transitioning* into becoming a composer and musician, he was reluctant to say that he felt any distress and thought it might be at a 3. He experienced no anxiety, but just a “steady level of resistance.” His fear level was at a 5. He found it “crazy to think you have to share it with the world, because the world can decide by itself if it is precious or not.” He also had feelings of disappointment with himself as sometimes he would be motivated and work very hard on the piece, but other times he would procrastinate and just walk away from it. He was quick to add that he did not get depressed about it. He carried a general feeling of dissatisfaction.

Bam’s continual and repetitive *change* as a temporary employee in the film industry distressed him between a 2 and an 8. It created anxiety and fear at a 5. His fear grew larger the longer his unemployment continued, and eventually it became so overwhelming that “I become paralyzed.” When he thought of these ongoing *transitioning* periods going from being employed to unemployed, he experienced distress at an 8. He had no anxiety, just stress

and fear at a 5. During his unemployment periods he would get depressed and his emotions became more intense and raw – “they are coming to the surface and anything can set me off” and he felt threatened and used by his partner.

Mr Blue was distressed when he thought about the *change* of starting his new business and the lack of progression he currently experienced in the business, on a level of 8 and experienced anxiety at a 5 and fear at a 3.

His *transition* into becoming a full time business man created more intense emotions where his levels of distress were an 8, his anxiety was at a 9 and his fear at a 10. His anxiety was created by feeling that he put in so much effort and was not being rewarded for it. He was fearful that his efforts were in vain and that the business will not take off.

When he was thinking of *both* the change and transition, he felt it affected his life at a 5. It made him angry and upset at a 4 and created feelings of frustration and irritability at a 6. He felt stressed and anxious because of “the unknowingness” of the situation and that he was not able to move forward.

When Peggy Sue thought about her retirement (*the change*) and the effects it had on her life, her distress, anxiety and fear levels were all at a 10. She added that everything for her was fear based. She had fear to strike out on her own and do things by herself like walking the dog, do exercise, shop, walk on the beach and go out with friends. She mentioned that she never used to be like this before her retirement. She found this change in herself overwhelming and it made her feel stuck. She tried to ignore the fear, but it was impossible to do, as it was always there. She felt sure that the fear kept her from eating and sleeping. She even became fearful and anxious when she was invited to attend a workshop on gratitude with a friend, which to her mind, should have been a gentle, non-anxiety provoking activity. Thinking of *transition* into a retiree created distress, fear and anxiety at a 10. She wanted to “be free like a bird, but I cannot do it, I am stuck.” This state created further frustration in her

as she just wanted her life back and move forward.

*Both* the change and transition affected her emotionally at a 10 and made her feel devastated as she felt she was not in control. She felt a lot of sadness (10), anger (10) and loneliness (10). She felt disappointed with herself (10+) because she could not pull herself together and move forward to find joy and gratitude – “I am stuck.” She explained her emotional state as “falling down a big black hole, full of oil in the centre of the earth” and it did not matter how hard she tried, she could not come out. Her doctor diagnosed her with depression, which she denied as she feared the medication he would put her on.

She felt needy, helpless and angry to be in this position and state at this stage of her life and having to do it all alone without the help, support, nurturing and understanding of her husband and children.

She had several panic attacks; one attack was so severe that she had to be taken to the emergency room.

The *change* of losing her job and the lack of direction since her unemployment, created distress at a 7, anxiety at a 6 (it was a 10 directly after she lost her job) and fear at a 7 for Tallulah. She questioned her fear and wondered where it came from.

She experienced no distress when she thought about the *transitioning* into her unemployment status, but the “not knowing what it will lead to” and her inability to make decisions made her feel anxious at an 8. She added that the fear of not knowing how things will work out could “get crazy at a 10.” The need to be perfect and the fact that she had no control over perfection in her life and environment also created a lot of fear – “I want to be perfect, my environment where I grew up was not perfect.”

She mentioned that she knew that she was meant to do something special, but had a fear of success that was holding her back. She also felt a lot of sadness (7) where she used to be a naturally happy person before. She wanted to enjoy her time off, but she was fearful about



her age, because she was anxious about being “left behind” in her career field. This awareness brought additional stress, which made her want to make changes as soon as possible regarding her career.

Table 4.3 represents the SUDS of the remaining levels of negative impact the change and transition had on the participants; mental, physical, spiritual, interpersonal, social, and occupational. The behavioural impact was not measured in SUDS. They are described in further detail in subcategory 4.

**Table 4.3: The negative impact SUDS of the change and transition on the mental, physical, spiritual, interpersonal, social, and occupational levels of the participants.**

Levels of impact	Angie	Elizabeth	Bunny	Jane	Grace	Michael	Bam	Mr Blue	Peggy Sue	Tallulah
Mental	8	9	8	10	5	6-7	6-8	5	10	5
Physical	5	7-8	10	9	6-7	10	<i>n.s.</i>	5	10	10
Spiritual	++; <i>n.s.</i>	p & n; <i>n.s.</i>	5	6	+9	++; <i>n.s.</i>	n.i.	n.i.	++; <i>n.s.</i>	++; <i>n.s.</i>
Interpersonal	10	8	9	9	++	4	<i>n.s.</i>	2	10	<i>n.s.</i>
Social	7	8	8-9	10	8-9	<i>n.s.</i>	7	4	10	<i>n.s.</i>
Occupational	<i>n.s.</i>	8	<i>n.s.</i>	10	9	<i>n.s.</i>	-	2	10	<i>n.s.</i>

*Note:* *n.s.* = no SUDS; ++ = enhanced spiritual life ; p & n = both positive and negative impact; ++ = improved interpersonal life; n.i. = no impact; - = data not reported

#### **4.2.2.2. Subcategory 4: Mental and behavioural impact**

The change not only had emotional impacts on the participants, but mental impacts as well. They had negative thought patterns and beliefs they did not have before, which often surprised them. These negative thoughts and beliefs walked close together with their emotions and influenced their behaviour. Like with their emotions, they had very little to no control over these thoughts and new behaviours. Their focus and self-esteem seemed to be affected the most and four of the participants were in a state of confusion.

In this subcategory the participants discussed these changes under two different sub-subcategories: 1) Negative mental impacts: thoughts and beliefs and 2) Maladaptive behaviour.

#### **4.2.2.2.1. Sub-subcategory: Negative mental impacts: thoughts and beliefs**

Angie experienced memory loss from the nerve and muscle relaxant medication and she was worried about the fact that her doctor told her the medication will cause “a lower IQ.” She lost her self-confidence during this time and therefore did not feel sure of anything. She questioned herself more and questioned all her decisions. She felt she was affected mentally at an 8.

Elizabeth thought about the breakup and her ex-boyfriend all the time, trying to figure out why he left her. She felt it affected her at a 9 on a mental level. The situation lowered her self-esteem as she did not feel “good enough” after he blindsided her with the break up. The whole situation confused her as she could not understand why he left her. As a result her main focus was on trying to figure out why he broke up with her instead of moving on from the situation. She was procrastinating “badly” as she found it hard to focus on anything of importance. It was extremely hard to focus in school because her “thoughts hurt her so bad.” She over analyzed everything, from her breakup to why people want to be with her, as she trusted no one and believed everyone was lying to her. She felt that she had lost herself and that she was not who she used to be.

Bunny felt her situation impacted her at an 8 on a mental level. She was totally distracted and occupied with the new man and relationship in her life. It took her focus away from everything in her life.

Jane was affected at a 10 where her self-esteem suffered greatly since her move. She could not think rationally and she felt that her “mental state has weakened a lot,” because she could not focus or control her negative thoughts. She had constant thoughts of “I am not going to be as successful as I and others hoped. I will let everyone down. I really doubt myself.” She could not focus on her studies as her thoughts were preoccupied with her family and friends back home – “my brain is trying to figure out how to handle my new life now and at the same time I think of the past.”

Grace described herself as being very confused over her husband’s behaviour before and during the divorce. She was still very confused about the divorce and had problems making decisions. She did not know what direction to take in her life and how to start again. She felt affected on a mental level at a 5.

Michael said that he tended to shrink when he thought about himself as a musician and composer, although he consciously knew that he was good at it. He had some hesitation to make his work and the new identity his own. He felt he was affected on a mental level between a 6 and a 7 where he was criticizing himself for not “getting with it.” He said to himself “Just do it, Buddy,” but he could not, and this created great frustration for him. Because his musical talent is “without structure,” (he hears music in his mind, but he cannot read music) he believed his gift is limited. He thought being able to read music would be very useful to him. He further thought that his work was only good enough for him, but perhaps not for others. They would think of him as an illegitimate composer because he had not earned it through a degree or diploma in music – “People will say I am a fraud!”

Bam thought he was too old and not qualified enough to compete with the younger people in his field. These thoughts overwhelmed him every time his projects ended and he had problems on focusing on anything else but the end of the contract and how to find

another project to be able to generate money. He thought the young people were awesome and knew so much more than he did about technology and were therefore more advanced than he was. During his unemployed periods these thoughts made him depressed, made him sleep a lot, and made him withdrawn. It affected him between a 6 and 8 on a mental level.

Mr Blue said he was slightly unfocused and grouchy because of all the stress the situation in his new business creates. He could not move forward as he was relying on his business partner to start playing his designated role and get financing in order for the business to progress. This was not happening, and he was stuck with a repeated scenario in his head where he thought they would get financing and then it did not materialize. He thought that his reputation and honour were being tarnished among his industry peers and it would jeopardize his business relationships. He felt affected at a mental level at a 5.

Peggy Sue acknowledged that her “huge mental stress at a 10” stops her from moving forward. She mentioned that the change and transition affected her nervous system and brain because she could not move forward and do the simplest things. She could not think, and her attention span was so short that she could not even watch a movie or read a book. She described herself as having no focus or concentration. This state of mind “feels like fingers on a chalk board.” She said that her family thought she went crazy and this attitude from her family contributed to her state of confusion and created more anxiety in her. Her husband mentioned that he was so concerned about her mental state that he wanted to get her committed. She felt very lonely as she had to endure this situation by herself and she kept searching for something and someone to help her move forward. She felt that nothing and nobody was helping her to move forward to the person she used to be – a very organized and successful event planner, able to do things and determined to reach her goals. She spent a lot of her time wondering why she could not move forward and why she was so stuck. She did not feel and think that she was on top of the world as she hoped she would feel after

retirement. She felt unsure of herself and had no self-confidence – “I cannot move forward to do what I love to do.” She believed that she should give into every whim and desire of her family, otherwise they would reject and leave her and she would be left all alone.

Tallulah felt confused since she lost her job and could not move confidently forward with any decision she was trying to make. She did not know what to do next and felt confused to an extent where she could not do anything. All she could focus on was how to be more frugal with her money. She thought constantly about the situation she was in (being jobless) and the stress about the situation made it impossible for her to think of any solutions or surrender to the situation - “I think more about the problem than the solution.” She continued to go into negative questioning which created more confusion. She felt the mental affect at a 5.

#### **4.2.2.2.2. Sub-subcategory: Maladaptive behaviour**

The change created maladaptive behaviour in nine of the participants.

I observed that it was difficult for Angie to speak fluently and express herself. She could not exercise or work because of her physical pain and the medication she had to take.

Bunny had to force herself to focus on her work and her painting as she would rather be with her new boyfriend and had no interest in doing anything else. She was waiting for him or his phone calls. When he didn't call she was devastated, and when he did call her, she felt relieved. She described herself as having the behaviour of an addict.

Elizabeth found it hard to study and work and displayed self-destructive behaviour where she was using drugs, alcohol and had indiscriminating sexual encounters.

Jane believed her studies could help her get back on her feet, but the problem was that she could not concentrate on her studies.

Because Grace could not decide where to live, she found it hard to decide if she should buy or rent a house. As a result she moved around a lot, even from city to city. She moved at least once a year (sometimes to a different city) since her divorce as she could not settle down. She looked to others for help because “I don’t think I can help myself, everything is too hard to do, except watching TV.” She procrastinated and avoided making any business decisions regarding her father’s estate and did not return phone calls. She created messes at home and didn’t clean up. She made “impulse buys” and spent money without thinking of the consequences.

Michael could not finish his musical play and kept reworking it. He was unable to call himself a musician and composer.

Bam drank, smoke and slept more during his unemployed periods.

Mr Blue could not know how to move forward with his new business and approach his business partners.

Peggy Sue found it hard to do even the simplest things because she could not focus and could not organize anything, she just left everything as it was and did not even know how to start working in her beloved garden again. She used to love working in her garden. One thing she could do was to give everything away, including all her garden tools and all her books. She did not understand her strange compulsion to want to give things away that she loved before. She stopped taking the dogs for a walk and stopped exercising because she was too fearful to go out on her own and always needed to have someone with her. When she had to do something on her own, she would freeze.

She also stopped being a vegetarian after 7 years. She stopped because her family pressured her as they found it offensive. She started to eat chicken and fish again to fit in with her

family dynamics as she feared that if she didn't, they would reject her and she would be totally alone.

#### **4.2.2.3. Subcategory 5: Physical impact**

Each participant acknowledged that the change took a physical toll on them. They identified several different and unique physical issues in connection with the change.

Angie's change was caused by physical reasons – her pain. The back surgery did not improve her pain and she continued to take pain medication, nerve medication, anti-inflammatory medication and sleep medication after the surgery. Her medication made her feel sleepy during the day and at night she had to take sleep medication. She also got very tired and could not exercise, neither could she work. She used to work out 5 days a week and now she was just watching people exercise. She still experienced pain and numbness in her legs. She had no feeling from her left hip down to the outside of her left foot. She scaled the physical impact at a 5.

Elizabeth found it hard to wake up and physically get up in the morning and continue with her daily activities. Right after the breakup she stayed in bed for a week. She could not speak; she just cried. When she heard her ex-boyfriend's name or saw a picture of him, she instantly felt "sick in the stomach" and it felt like her heart was "dropping." She was physically affected on a level of 7-8.

Bunny mentioned that she had a lot of physical symptoms since she started the relationship and she scaled it at a 10. She only named two: 1) she could not sleep with her new boyfriend in the same bed, 2) nor could she reach orgasm with him. She saw it as a part of her psyche holding back because she did not feel safe in the relationship and did not trust

that he would stay in the relationship with her. She did not have this problem with her last boyfriend, because she felt secure with him.

Jane explained that she gained a lot of weight, felt unhealthy and had developed acne. She said it was a combination of stress and a result of her bad eating habits (eating mainly junk food) and the lack of exercise. She could not get herself to exercise and found it hard to eat well. She felt the impact of the physical changes at a 9.

Grace experienced a decrease in her overall health; her asthma increased, she gained weight and could only sleep 4-6 hours a night. Her knee bothered her a lot and she felt it limited her as she had to constantly consider it when she decided to do something. Her physical limitations got in her way and the business of “moving on with my life.” She also felt the situation made her “insides twisted” when she thought about it. She said the physical changes impacted her on a level of 6-7.

Michael’s physical impact was experienced as a “tragedy” and he rated it at a 10. He could not run for the last 2 years because of his knee problems and this was a difficult change for him. Running was a huge part of his life as he had been running for 40 years. He described it as his “martini” and he mentally created most of his work when running.

Bam felt more tired during his unemployed periods.

Mr Blue felt tired and had a lack of energy because he was working two jobs. Because of time limitations he had a lack of physical activity and he felt less healthy and less fit. It affected him at a 5.

Peggy Sue said that her troubles regarding her retirement first manifested as health issues where she woke up one morning with her whole body itching. It was bad enough for her to go on medication, which made it impossible for her to get up in the mornings and she



had to stop taking the prescribed medication. To cope with her discomfort she started to clean her house and pets vigorously. Her belief was that the itching was caused by her emotions.

The itch was better at the time of our interview, except for her left shoulder, which still itched.

Over the last year she had one physical symptom after another. One symptom was her disturbed sleep; she could only sleep an hour or two at a time because of her need to get up and urinate, although she did not drink anything before bed. She underwent many tests to find the cause, but no physical explanation had been found for this pattern. She said that she realized that emotions can create sleeplessness.

She also lost 40 pounds. She said that her feelings of overwhelm kept her from eating and sleeping.

She no longer exercised regularly.

Abandoning her vegetarianism did not affect her health.

She had problems with her shoulders; they were so tense that she could not lift her arms above her head. She blamed it on her stress and anxiety – “it makes my body shut down.” She felt the physical changes affect her life at a 10.

Tallulah mentioned that she went through a lot of body changes since her job loss and scaled it at a 10. She lost 20 pounds and she found it hard to digest food. She felt pressure on her gallbladder and had pain in her hips. She only got her menstrual period every second month.

#### **4.2.2.4. Subcategory 6: Spiritual impact**

During the screening interview eight of the participants could connect spiritually to the change in their life where they seemed to be aware of not only the emotional and mental changes in their lives, but the spiritual ones as well. Every participant had a unique way of

perceiving their spirituality. Six of the participants connected their spirituality with the word God and Elizabeth and Tallulah connected God with symbols and signs. For Bunny spirituality was about self-evolution and love.

Two participants felt that their spirituality was not influenced by the changes and transitions in their lives. Five participants said that the change in their lives impacted their spiritual life in a positive way and that they experienced spiritual growth. Elizabeth felt her break up had a positive and negative effect on her spiritual life, and Jane said her move affected her spiritually in a negative way. Bunny felt she was not evolving spiritually as desired during her new relationship. Not all participants were able to rate their spirituality on a SUD scale.

Angie described herself as having a strong connection with God. She would like it to be even closer and have an even better relationship with God. She wanted to be able to “let go and let God” and have more trust and faith in God. Her back problems and surgery which left her with physical challenges started to affect her spiritual life in a positive way where she felt a stronger connection to God as she was praying more and started to put more thought into her spiritual life and her relationship with God.

Elizabeth felt her break up with her boyfriend affected her spiritual life in both a positive and a negative way. On the positive side she prayed more to God, and on the negative side she was over consumed with noticing signs, ghosts and people around her. Symbols and signs connected to her previous relationships showed up daily and everywhere. This confused and consumed her because she was trying to find the meaning and the reason for the signs. The signs upset her and haunted her, especially because such banal occurrences were nothing she would have ever paid attention to before. She felt that it held her back from

moving on with her life. She described it as crazy and that she felt “out of it – I can’t focus, like I am on a high, it just feel so weird.” It affected her at an 8.

Bunny felt that she was not evolving as she would like on a spiritual level. She explained that she had certain expectations of herself and how she would like to be. The fact that she is not there yet, made her feel disappointed in herself because she could not be like “a cool cucumber” and casual about her new romantic relationship as she would like to be. She would also like to be more satisfied with being alone. It affected her at a 5.

Jane felt her move affected her spirituality negatively at a 6. She did not have a strong connection to God and found it hard to address God. She had no passion to pray and was very angry about what she was going through. She was angry at God as she felt that God should help her and did not understand why she was stuck in her position. She said she was losing her faith. Sometimes she would have what she described as “a breakthrough and saw the light” where she could pray, but mostly she only saw darkness.

Grace felt her single life as a divorcee enhanced her spiritual life with a 9. She contemplated her spirituality during her resting time. She was contemplating who God was for her and was moving from her Catholic upbringing beliefs about God to New Thought beliefs about God. Her understanding about spirituality and the role it played in her life was shifting. She felt growth in her spiritual life and connected spiritually to others and herself at a different level than she had before. She felt that something was occurring in her being because people were responding differently to her. They could hear that she was different and reacted positively to her. She stated that “I hear the truth and am reaching a higher level of awareness.”

Michael felt more aware, more conscious of his spirituality since he started to work on his musical play. He was meditating more, although he felt his work on the play distracted him from the quiet part of his spirituality.

Bam and Mr Blue did not feel that their situations effected them on a spiritual level. Bam thought that he should probably do more on a spiritual level. Mr Blue did not discuss his spirituality, and just said he believed in God and saw God everywhere, especially in nature.

Peggy Sue kept her connection with God and she said that she knew that she was not alone during this period in her life. She experienced growth in her spiritual life since her retirement where she started to pray, meditate, and go to church. Her hope was in God and she believed she would not be let down, that there was a reason why she was going through trials and tribulations and that God would send someone to help her. She told me that this “research program” was a Godsend to her. Her spiritual life did not mesh well with the rest of her family’s and it created big conflict. They were very opinionated because she didn’t fit into their more conservative belief system and they thought there was something wrong with her.

Tallulah spoke about her spirituality with other people and was starting to see correlations in occurrences that seemed to be confirmations for her thoughts, like meeting a woman on the beach with a tattoo that said “surrender” when she thought about surrendering her situation to God. She felt that she was growing in her spirituality since her unemployment and gave more thought to it.

#### **4.2.2.5. Subcategory 7: Interpersonal impact**

Eight participants experienced the change as not only having an impact on them personally, but also negatively impacting their relationships with others. Grace reported that the change, her divorce, improved her relationships with friends and family. Bunny felt that the change had no effect on her interpersonal relationships.

Angie, Elizabeth, Jane, Peggy Sue and Tallulah felt unsupported since the change happened in their lives. Angie felt stressed and Elizabeth felt sad because they were not supported. Elizabeth, Jane and Peggy Sue mentioned further that they felt the support they have given others was not returned and Jane experienced a sense of betrayal because of this. Angie, Elizabeth, Peggy Sue and Tallulah also felt not accepted. Jane and Peggy Sue felt a sense of disconnection and Elizabeth mentioned that people cannot relate to her. Elizabeth and Peggy Sue further felt misunderstood.

Elizabeth had distrust in herself and others and Jane and Bam experienced a sense of distrust and alienation where both felt it was because of their negative attitude and emotions. Jane mentioned that she pushed her friends away and Bam and Michael said they retreated from people where Michael felt he “pulled away from people”.

Peggy Sue and Tallulah also experienced feelings of alienation where Peggy Sue felt alone and saw her family withdrawing from her because of her neediness and Tallulah feared getting closer to people.

Angie felt that some of her friends were not accepting of her unemployment status and it strained their relationships. Her family frowned upon her being on disability and put a lot of pressure on her to go back to work while she was still in pain and not ready to return to the workforce. The relationship with her sister was especially strained, as she worked for her sister’s company before her back surgery, and due to her prolonged recovery, her sister was

forced to work in the company again, which made Angie feel guilty. She felt unsupported by her family and the strained relationships caused her extra stress. This situation impacted her at a 10.

Elizabeth terminated her previous therapy as she felt misunderstood and unsupported by her therapist. She also felt that her family and friends misunderstood her because none of them understood why she did “not move on and hang on to him and the past.” She felt that people cannot relate to her, not even her younger brother, who is her best friend. Because she perceived that everyone misunderstood her and nobody could relate to her, she felt that something was wrong with her. This brought a lot of sadness to her, as she always thought of others and “rescued them” and she did not understand why people did not understand her, or help her, or at the very least, listen to her talk about the relationship and how she was feeling about the breakup. She lost all trust in people and felt the break up destroyed her trust in people and herself. She feared and distrusted people at an 8.

Jane felt her interpersonal relationships had been hurt at a 9. She felt disconnected from her family and friends since her move. Her relationship was especially strained with her father. She was very angry with him and blamed him for her situation. She was angrier at people close to her at home because she thought they would forget about her. She had trouble trusting people, and she felt that everyone was just out to get her, and that no one cared about her. She felt betrayed because she felt that she helped everyone, yet not one of her friends back home was helping her. She realized that her thoughts and feelings created behaviour that pushed her friends away from her, but she could not help herself. She did not feel as strong as before and felt that she was getting weaker as a person, and the weaker she got, the more she pushed her friends away with her behaviour.

Grace felt that her interpersonal relationships had actually improved since her divorce. She had closer relationships with her female friends and felt a strong connection and great support. The relationships were more intimate and personal when she connected with people on a one on one basis. This is something she had not experienced before. She did not reach out to these people though; they always contacted her first, and that created shame and guilt in her because “I don’t give as much to them as they give to me. They help me and fill me up and I just take.” She learned to be open and honest with other people. She was also very close to her children.

Michael said that working on his musical affected everything in his life, including his close relationships. “I will be surprised if it didn’t; it leaks out into my whole life.” He mentioned that it affected him to a smaller degree (4) and that “It has to, because I don’t operate a 100% on all levels.” He had a feeling of dissatisfaction because he felt that he was pulling away from people and friends and he is not in total agreement with his spouse, “It is nothing major, but it is there.”

Bam’s continual changing and transitioning in his career path had a marked effect on his relationship with his partner. He became nagging, distrustful, and a “bitch and yelling father” to his partner. He started to think that his partner is using him and started to feel like his partner’s caretaker. It created conflict as he vocalized his thoughts and feelings. He became unpleasant and lost his sense of humour, retreated, and hid from his friends.

Mr Blue saw his friendship relationships as strained as he was more likely to snap at people because he was angry, upset and frustrated with his business situation. His attitude created some stress with his spouse. It affected him slightly at a 2.

Peggy Sue’s retirement impacted her interpersonal life at a 10. She became needy for her husband’s and children’s interaction and love and wanted them to give her everything that

they gave before, plus more. She longed for their love and communication. Her family was not accepting of her and did not support her during this difficult time. On the contrary, they thought that she was crazy. Her children were busy with their own lives and were withdrawing from her as she became needier and clingier.

Her husband was becoming increasingly controlling and verbally abusive. He was very critical of her and was not accepting of her on any level. He shamed her when she spoke about her feelings and thoughts. He did not understand her need to socialize and would criticize all her friends, including calling her and her single friends lesbians. She felt that she and her husband had a total disconnect with each other, that it was stressful to connect with him on any level, and she felt no joy in her relationship with him, although she loved him. Because she could not do anything on her own, and needed him to go everywhere with her, she had to give in to his restrictions; he decided when they went grocery shopping or took the dog for a walk. She felt like a wimp and totally beaten up. She felt “I am an alone person sitting there who gets no nurturing, don’t get my needs met and have to do it all by myself.” She feared her family and did everything to please them and did whatever they expected from her, even if it went against her own values, wants and needs.

Tallulah felt that she was not getting support from her family and friends as she felt they judged her for her unemployment status. She felt she accepted them for who they were and where they were in their lives, and she wanted the same from them. She had a fear of getting close to people and did not have a lot of communication with other people. She was holding back a lot of her emotions with her intimate family members and friends and found it hard to say that she cared for them. She felt stagnant with her personal relationships and said that she would like to meet new people who could help her grow.



#### **4.2.2.6. Subcategory 8: Social impact**

All the participants were affected personally and in their interpersonal relationships, which also had an effect on them socially. They had very unique social experiences where some, like Angie, Jane, Michael, Bam, Mr Blue, Peggy Sue and Tallulah were less social during this time and tended to retreat socially, while Elizabeth could not be alone at all and would go to extremes to surround herself with other people. Jane and Elizabeth felt they had a lack of trust in people. Bunny and Grace were triggered during social situations to be reminded of their discontent regarding their single status.

Before her back problems, Angie thought that she had to be with people, although it was difficult for her. She used to join groups to be more social, but since her back problems and surgery she no longer went to groups and experienced a lack of social bonding. Now she liked and chose to be by herself. She found it hard to go out in public as she tended to get easily tired. This social impact affected her at a 7.

Since the breakup Elizabeth could not stand being by herself and couldn't even tolerate being on her own when her parents were at work – “I hate being by myself.” She had to be with someone to distract her – “When I am alone I have those feelings again.” As a result she made social choices that had a negative impact on her and isolated her from the friends she needed. She spent time with a crowd who indulged in alcohol, drugs and endless parties. She would force herself to participate, just to have a sense of belonging and to “do things.” To ease her sense of discomfort with the new social crowd, she drank to feel more comfortable in the environment she was in. She started to engage in promiscuous sex when she got drunk. As a result, she had no self-respect and just pretended that it was not happening.

She fell in love with anyone who was sweet and kind to her. She fell for their lies because

she just wanted to be with someone, and said “anyone would do.” She knew that she was attracted to men who “would be trouble for me, not good for me and I know what I will get,” but she could not stop her behaviour. She was aware that she had lowered her standards when it came to men, but she said that “I don’t care, I have lost faith in all guys and I don’t trust and believe what anyone is saying to me. I just try to fit in as I don’t know who I am anymore.” She believed that she wouldn’t know how to handle good people anymore. Her social behaviour was new to her as she was never like this before, and she felt the impact at an 8.

Bunny felt that the social impact of the new relationship was all in her head. Although she was in a new romantic relationship, she still viewed herself as single and she got negatively emotionally triggered about her long-term singlehood around couples when she was at social gatherings or on a trip. It reminded her of her single status and that “single has become my new normal.” This made her think that something was wrong with her. She explained “In our culture, if you are not in a relationship, there is something wrong with you.” This social mindset impacts her between an 8 and 9.

Jane saw herself as being less open; she kept to herself, because she felt she could not help people and her friends in her current state, something that is very important to her. Because she felt helpless to help herself and others, she felt disconnected and now believed that instead of having many friends like before, she now had none. She only spoke to a select few people and reported that she would rather be alone and had no need to meet new people, as she just wanted to be with her friends back home. She did not trust people and was not able to connect with them and get closer. The new social situation since her move to a new city made her feel very lonely and impacted her at a 10.

Grace felt odd in social situations as a single person and when she saw couples, it brought up fears in her that she would always be alone. Her friends and activities are different since she had been divorced. When she was married, her husband was the initiator in social plans, and he took the lead in the decision making for the couple. Being on her own meant that she had to take initiative and make all social plans by herself, which she disliked. Now she felt that she had no one to make plans with and no one to help her to make decisions. These social changes impacted her between an 8 and a 9.

On a positive side she believed that she was doing things that she would have never done as a married woman. She travelled more, went to workshops, and was experiencing growth and freedom she did not know before. She felt she had more connections than ever before.

Michael was not eager to go to social events when he was working on a musical piece. He said that he could disappear for long periods of time. He felt that he “dissociated” from his family and friends, but did not see it as negative; this is how he worked best.

Bam withdrew socially when he finished a work contract. He felt affected at a 7.

Mr Blue said working full time and on his business hurt his social time as he had less time to be social. He worked hard to achieve his goal and was unpleasant to be with. He felt affected at a 4.

Peggy Sue had a lot of social contact and felt loved when she was working. Since her retirement she was more “cocooned” and not socially active, which hurt her. Her husband was never socially active, and he did not understand her need to socialize. Furthermore, he did not approve of her friends. Her situation was not helped by his retirement either. She felt affected at a 10.

Tallulah was staying at home more since her unemployment because she had less money to spend and she wanted to be frugal. She would like to go out more to meet new people who would help her grow. She did not feel as pro-active as she should be socially and did not have a lot of interaction with people which made her feel that she would never meet anybody.

#### **4.2.2.7. Subcategory 9: Occupational impact**

All the participants felt the impact on their lives, whether it was in their current jobs, as retirees, being unemployed, in their studies, or possible future work related situations. Elizabeth and Jane could not focus at school and their grades suffered. Angie, Bunny, Grace, Michael, Peggy Sue and Tallulah all felt they could not do what they were supposed to do regarding their work situation. Angie could not start working again, Bunny could not do her marketing, Grace could not start a second career, Michael could not finish his musical, Peggy Sue was unable to start her own business, and Tallulah did not know which direction to take in her life - work or study. Mr Blue's emotions regarding his new business created problems for him at his current job.

Angie did not feel comfortable to go back to work since her surgery, although she did some volunteer work as a receptionist at a yoga studio.

Elizabeth found it very hard to focus at school since her breakup with her boyfriend. She used to be a grade A student, but now she did not care about or even liked school - "I care, but I don't care. I have the 'whatever' feeling." Her personal life stressed her and she felt lazy and although she was very behind with her studies, the best she could manage was some last minute study. She could not focus in her job either and lost some shifts at work, which impacted her financially. It affected her at an 8.

Bunny said that her new romantic relationship did not affect her work with her clients, but made everything that she already did harder. She was unable to attend to aspects of her business that she did not like, for example, her marketing. She had to generate business, and this part of her work did not come easily and naturally to her, and given her situation it was even harder for her to do. Instead of working, she would rather be out working in the garden with her new young boyfriend.

Jane found it hard to focus and concentrate on her studies since her move. Her grades suffered as a result and she was no longer a grade A student, which she said reflected her negative mental and emotional state. She added that it was hard to learn and regain new information as her focus was on other things which occupied her mind. She explained that she was trying to figure out how to handle the move and her new environment. She felt that she could not go on like this. It was affecting her at a 10.

Although Grace was retired, she would like to start a second career. During her divorce she was injured at work and lost all her self-confidence. Since then she felt too old, incapable, scared, and had an intense fear “to put myself out there.” She attempted to do many things since her divorce, but could not seem to get started because she had “a fear of rejection” and did not feel competent. Although she knew it was not true and she knew she was competent, she was still too fearful to do what she knew she could do. She did not believe people when they told her that she was good at what she did, because she felt stuck, had a lack of energy and just did not feel good enough. Before her divorce, change was easy for her and there used to be constant movement in her life where new opportunities were easy to embrace and work came easily to her. She felt affected at a 9.

Michael would like to continue writing and producing musicals and make it his main occupation, his final career. He would like to be a full time musician and composer where he

would produce shows and put music into his magic shows. He currently had problems finishing his current musical. His current job as a magician was not that gratifying for him, although it was important to him.

Mr Blue felt that because he didn't get paid in his business, his frustration and anger created a problem in his job. It only affected him at a 2.

Peggy Sue thought when she retired that she would do her own events, go on trips and have her own business. She was well known in the event planning field and people had asked her for her services, but she said she was "frozen" and could not do it. She felt this at a 10.

Tallulah felt "okay" about losing her job, but felt lost since then. Nothing gave her more pride than her job. It gave her a sense of accomplishment. When she first lost her job, she started to look for a job and then stopped because she wanted to enjoy her time and find herself. She was at a crossroads and did not know what direction to take. She was not looking for a job at the time of the interview because she did not know if she should go back to school or go back to work.

#### **4.2.2.8. Subcategory 10: Lack of progression**

Apart from discussing the impact of the change and transition on different levels, the participants were also questioned about their overall lack of progression during the screening interview. The participants all agreed that there was a lack of progression in their lives, on different levels, because of the life changing event, and that it brought up feelings of distress, anxiety, fear and for some shame. Most of the times thoughts and emotions rendered them "paralyzed," "frozen" or "stuck" where they would like to progress but could not. Although there was a lack of progression on certain levels that became clear during the interview and as discussed above, it was interesting to note that when this specific question was asked, they

did not notice the lack of progression in all areas they discussed before. At this stage of the questioning the participants might have been saturated by the process because they started to repeat information and lost interest and some participants became agitated.

Table 4.4 represents the SUDS on the Lack of Progression (L.O.P.) the participants felt on an emotional (general), mental, physical, spiritual, interpersonal, social, and occupational level and the emotions of distress, fear, anxiety and shame they felt about their overall lack of progression on all these levels.

**Table 4.4: Lack of progression SUDS on the emotional (general), mental, physical, spiritual, interpersonal, social, and occupational levels, including the SUD levels of distress, fear, anxiety and shame participants felt about their overall lack of progression on all these levels.**

<b>L.O.P.</b>	<b>Angie</b>	<b>Elizabeth</b>	<b>Bunny</b>	<b>Jane</b>	<b>Grace</b>	<b>Michael</b>	<b>Bam</b>	<b>Mr Blue</b>	<b>Peggy Sue</b>	<b>Tallulah</b>
Emotional	9	7	8-9	8	7	<i>n.s.</i>	<i>n.s.</i>	6	10	<i>n.s.</i>
Mental	8	9	8	5	8	8	<i>n.s.</i>	5	10	<i>n.s.</i>
Physical	5	-	<i>n.s.</i>	10	7	<i>n.s.</i>	-	7	10	-
Spiritual	-	<i>n.s.</i>	8-9	5	<i>n.s.</i>	<i>n.s.</i>	-	-	10	-
Interpersonal	<i>n.s.</i>	<i>n.s.</i>	<i>n.s.</i>	7	<i>n.s.</i>	-	<i>n.s.</i>	-	10	<i>n.s.</i>
Social	-	8	-	10	-	-	<i>n.s.</i>	-	10	-
Occupational	-	8	-	10	<i>n.s.</i>	<i>n.s.</i>	<i>n.s.</i>	3	10	<i>n.s.</i>
<b>Emotions</b>										
Distress	10	9	10	10	8-9	-	5	-	10	8
Fear	8	8-9	8	9	9	5	7	3	10	8
Anxiety	8	9-10	9	10	9	3	4	5	10	8
Shame	8	10	-	-	-	<i>n.s.</i>	-	-	10	5

*Note: n.s. = no SUDS; - = data not reported*

Angie said that she felt a lack of progression on an emotional (9), mental (8), physical (5), and interpersonal level. She could not work out because she got extremely tired, she had less self-confidence, did not feel sure of anything and just did not know how to move forward.

This lack of progression in her life made her feel distressed (10), fearful (8), anxious (8), and shameful (8).

Elizabeth could not progress emotionally (7) and mentally (9) as she felt depressed and was constantly thinking about her ex-boyfriend and why he left her. She felt she did not progress socially (8) because she spent time with a group that encouraged destructive behaviour through the use of drugs, alcohol and excessive partying and who did not uplift her morally and did not support and encourage her towards personal growth and healing. On a spiritual level, she felt that the signs she saw everywhere stopped her from moving on with her life. She could not focus on her studies (occupational - 8) and on an interpersonal level her old friends didn't want to be with her because of her social behaviour and her constant talk of her previous relationship and the breakup.

The above mentioned lack of progression created distress (9), fear (8-9) anxiety (9-10), and shame (10). She feared that she wouldn't find another partner again and she described this fear as being very real for her.

Bunny felt she did not progress because she was stuck in the same relationship pattern. She felt that physically she was stuck in the same house and country. She wanted to move with a partner into a house and live together. She lacked money to buy a house and her rented apartments always felt temporary to her. She did not progress mentally (8) because she thought that she was a failure because "I haven't been able to catch me a man." Her grief and sadness about being at this age and still alone held her back emotionally (8-9). She also felt hopeless about ever finding a partner who would go through life with her. On a spiritual level, she would have liked to have been at a level where she felt satisfied to be alone and therefore felt that she had not evolved as she should (8-9).

Her overall lack of progression made her feel distressed (10), fearful (8), and anxious (9)



because she felt if she was more evolved she would not worry so much about a partner and would be satisfied with other things in her life.

Jane felt her lack of progression on a physical level at a 10. She could not lose weight, although she wanted to. Her skin was also worse than before her move and her eating habits regressed. Her mental state was “down” (5) most of the time and it took over from the positive where she could think “O, it was all worth it.” Her change was emotionally draining (8) to her as she came here to progress, but she felt she regressed. “I take one step forward and ten back, I am on an emotional rollercoaster and feel down and depressed as I waste my life away by not going forward.” Her spiritual life regressed (5) as well, as she was angry with God and didn’t have a close relationship with him. Socially she could not connect with people and make new friends (10) and she could not focus on her studies (10). She regressed on an interpersonal level (7) because she felt betrayed by her friends and was pushing them away.

She felt distressed and anxious at a 10 and fear at a 9 about her [overall](#) lack of progression.

Grace felt that physically she could not progress (7) because she could not manage her finances and gave into impulse spending with no regard to the future. She felt irresponsible and missed her husband being there to handle the finances. She did not trust her financial adviser and the lack of trust made her feel paralyzed.

She described her lack of progression on a mental level (8) as a lack of decision making. It especially affected her when she had to decide where she would like to live and whether she should buy or rent a home. Emotionally this created a high level of anxiety, as she was scared to make the wrong decision and was constantly looking for help from outside. Her fear and anxiety around decision making created paralysis (7). This situation made her move nine times in the last eight years.

When people close to her made harmless comments, she took it personally. She held on to her

hurts and felt that she had made no progress in her interpersonal life for the last 10 years. She did not progress spiritually as she wished, as she was not reading about spirituality and meditating daily and found it hard to do so. On an occupational level she felt stuck and lacked the confidence to start something new.

When thinking about the general lack of progression, Grace felt distressed (8-9) that she could not get past her divorce and she just felt “numbed out” by the anxiety. She experienced fear and anxiety at a 9 and saw the fear as irrational because she knew that she could do this - get over the divorce - but she got so overwhelmed and confused that she found it impossible to break down the situation into smaller pieces so she could make sense of it and progress.

Michael found that he was not progressing in his career choice and on a spiritual level he felt that there must be a “drag somewhere” as he was reluctant to share his art /music. The lack of progression on a mental level (8) was that he knew a lot was going on, but still could not progress – “I see a ton of things going on, but I cannot channel the information.” He did not know how to complete and share his work and it felt like a dead end, there was no flow to the next stage. He felt that he could improve on an emotional level to find an emotional state of peace and serenity “where it all flows.”

His overall lack of progression did not create distress, but rather frustration (3) because of his inability to make a full connection with the process and flow of his work. The lack of progression created anxiety (3) especially because it affected him on a physical level where he could not exercise anymore. He would like to “dig in there and be more open” so that he can progress. It also created fear (5) because he was getting older and he felt he “better do it now, I am running out of time and I don’t have time to waste.” He felt that his shame was creating a lack of progression for him.

Bam felt he lacked progression in his career because he believed that he “did not get smarter and more talented” through the years and therefore could not hold himself against the

other, younger people in his job. He mentioned that although he must be used to the nature of his work after thirty years and be able to handle the periodic and predictable unemployment times between contracts better, he still could not handle it with ease and without anxiety and it was still affecting him negatively through all these years. He withdrew socially and became difficult with his partner during these times. He overate when he was nervous and bored during his unemployed periods.

This lack of progression created distress (5), fear (7), and anxiety (4) where he could go into a panic. He saw his fear as a waste of energy that did not solve anything, but still the fear never changed.

Mr Blue felt there was a lack of progression on a physical level (7) because he did not get his money from the company and he felt that mentally he could not move forward (5) because he kept seeing a repeated scenario where he was on the verge of getting financing and then nothing happened. Emotionally he did not progress (6) as he had not achieved the happiness and success he set out to achieve. He did not see progression in his occupation – the business - (3) because he did not get rewarded for the efforts he put in – “I don’t get paid.”

He felt stressed (6) about the situation and had fear (3) and anxiety (5) about the overall lack of progression.

The distress, anxiety, fear and shame Peggy Sue felt when it came to her general lack of progression was very high at a 10. It affected her on all levels at a 10 where she felt that she could not move forward and she said that she felt stuck on each level. She was never afraid to move forward before and wondered “Where have I lost it?” She could not exercise even if she wanted to, she felt frozen. She wanted to go forward and do things on her own, but she was too afraid. She could not connect socially and meet with new people because of her fear to venture out on her own. Her fearful state upset her and made her feel frustrated

because she was so stuck. Even spiritually she would move forward and then got stuck again. She did not know how to start her own event planning business and was just stuck in a place of overwhelm. Her relationship with her children and husband had regressed and she felt alone, isolated, misunderstood and unsupported.

Tallulah said that she did not do much to go forward career and job wise. She did not look for a job or look into career alternatives. Mentally she was still in a place where she thought more about the problem than the solution and she was very caught up in her emotions which interfered with her ability to find solutions for her situation. She realized that she reacted out of emotion, instead of taking a breather and then acting. She felt stagnant in her interpersonal life.

Her overall lack of progression created distress, fear and anxiety at an 8. She also felt shame (5) because she was smart, but did not do what she needed to do to reach her potential.

#### **4.2.2.9. Subcategory 11: Desired outcomes**

The participants not only spoke about their lack of progression and the impact the change had on their lives on different levels, but they also voiced what they would have liked to have instead of what they were experiencing. Some aspects of their desired outcomes stood out, like physical health, focus, confidence, peace, happiness, not wanting judgment and getting back to who they were. Angie, Bam and Tallulah mentioned that they would like to improve their physical health. Elizabeth and Jane stated that they wanted to improve their focus, so they could improve in school. Angie, Bunny, Jane, Grace, Bam and Tallulah all desired an increase in their confidence levels. Grace, Michael, Peggy Sue and Tallulah wanted a peaceful state of mind and Jane, Grace, Bam and Tallulah longed for happiness. Peggy Sue and Tallulah wanted their families to stop judging them. Angie, Elizabeth, Jane, Grace and Peggy Sue wanted to get back to “who they were before” the incident.

Angie mentioned that she would like to have a stronger connection and better relationship with God. She would like to trust God more and have more faith. She would also like to exercise more and have more mental clarity and get her physical health back. She mentioned that “I would like to get back to who I am and be more confident and clear on my life path and which direction to take.”

Elizabeth wanted to go back to being herself again, who she used to be and move on from her previous relationship. She wanted to focus on school and get good grades so she could transfer from a community college to a good university. She wanted to slow down socially and wanted people to start calling her back again. She was tired of the disrespect and wanted to be respected again.

Bunny would like to enjoy her new relationship, be confident in it, and be more casual about it. She believed she would be more satisfied if she was not so worried about a partner and could rather be satisfied with all the other things in her life. On the other hand, she wanted to find a partner for life and move in with him.

Jane wanted to lose weight and be able to focus on her studies and do well in school. She mentioned that she wanted to get back to who she was - happy and confident.

Grace wanted to accept the reality of her divorce and move on. She wanted peace – “I want to stand in this world and be happy and confident.” She desired to move from her pain, shame, guilt and sadness to peace. She wanted to reclaim who she was before the divorce. She would like to have confidence in her decision making and handle her finances better and stop spending money thoughtlessly.

Michael wanted to be able to call himself a musician and composer, be successful in it and have it as his final career. He would also like to produce shows and put music in his

magic shows because his work as a magician was not gratifying without it. He desired to finish and release the musical he was currently working on. He also wanted to have a more peaceful state of mind and serenity to improve his meditation practice.

Bam would like to feel more self-confident when he hits unemployment and know that he will survive and be okay. During his time of unemployment he would like to smoke, drink and eat less. He would like to enjoy his time off and be happier.

Mr Blue's needs were very concrete – he would like his business to receive funding so that they could move forward.

During the interview Peggy Sue mentioned repeatedly that she would like to stand in her own power again; “(I want to) own my own power and be strong enough to believe in my own powers again.” She explained that this power meant that she wanted to “strike out on her own” where she would not be afraid to move forward, even by herself and follow her path, enjoy her life and live in joy and love and be grateful and thankful for what she has and be secure in that.

She did not want to feel afraid to be alone anymore. She wanted to have her own opinions, wanted her family to respect her opinions and be unafraid to voice them. She did not want to feel beaten up anymore because they didn't agree with her life choices. She wanted her family to accept her, approve of her for who she is and stop judging her. She wanted to have strong relations with them, wanted to be at peace with them and wanted to be loved by them so she could feel less needy for their love.

She wanted to be more socially and physically active.

She wanted to be whole again and “get back to Peggy Sue.”

Tallulah wanted to be more confident in her decision making as she was unclear about what to do next. She would like to have peace of mind about her job loss and loss of

income. She would also like to be healthy again and be happy. She desired more support from her friends and family during this time, acceptance for who she was and not to be judged by them. She also longed to do something creative and do volunteer work with children and the elderly. She would like to go out more and meet new people who can help her grow as a person. She would like to be less fearful.

#### **4.2.2.10. Subcategory 12: Consequences shown in 4 psychological tests**

In order to improve the quality of the research and because of the unique nature of the phobias, I included four psychological questionnaires to measure the participants' levels of depression, anxiety, and stress levels with the Depression Anxiety Stress Scale (DASS), their anxiety with the Generalized Anxiety Disorder assessment 7 question (GAD 7) and Hamilton Anxiety Rating (HAM-A) scales and their PTSD on the Impact of the Event (IOE) scale.

The DASS scores were divided into 3 categories; depression, anxiety and stress. The DASS score interpretations are illustrated in table 4.5 and are as follows:

**Table 4.5: Score interpretations for the DASS test, measuring depression, anxiety and stress**

	<b>Depression</b>	<b>Anxiety</b>	<b>Stress</b>
<b>Normal</b>	0 – 9	0 – 7	0 – 14
<b>Mild</b>	10 – 13	8 – 9	15 -18
<b>Moderate</b>	14 – 20	10 – 14	19 – 25
<b>Severe</b>	21 -27	15 – 19	26 – 33
<b>Extremely severe</b>	28+	20+	34+

A total score >8 suggests anxiety or panic disorder on the GAD-7 scale.

The HAM-A scale score interpretations were as follows: Mild Anxiety = 18+, Moderate Anxiety = 25+, Severe Anxiety = 30+. Most of the participants found the HAM-A test confusing and had trouble completing it.

The IOE scale has a cut-off point at 33, which indicates that the participant is suffering from

PTSD if the total score is >33. Six of the participants indicated that they had PTSD symptoms and one was one point short from being on the PTSD list.

Table 4.6 represents the mean scores for the following four psychological tests: the DASS, GAD 7, HAM-A and IOE. These tests were administrated before all participants were treated.

**Table 4.6: Participants' DASS, GAD 7, HAM-A and IOE mean scores before treatment.**

Names	DASS (refer to table 4.5)			GAD 7 >8: anxiety or panic disorder	HAM-A Anxiety: mild (18+), moderate (25+), severe (30+)	IOE >33total PTSD
	Depression	Anxiety	Stress			
Angie	29	35	37	2	35	53
Elizabeth	39	19	35	11	28	64
Bunny	37	17	19	6	21	44
Jane	42	29	37	20	31	76
Grace	10	6	12	10	22	36
Michael	1	1	2	5	4	10
Bam	13	6	8	7	13	29
Mr Blue	8	2	15	14	17	32
Peggy Sue	24	14	21	14	26	50
Tallulah	4	2	3	4	16	26

On the DASS scale Angie scored 29 for depression, 35 on anxiety and 37 on stress which all fell under the extremely severe category. On the GAD 7 she scored 2, which indicated that she did not have an anxiety or panic disorder. Her HAM-A score was 35 which indicated severe anxiety. She scored 53 on the IOE scale, indicating PTSD.

Elizabeth scored 39 (extremely severe) for depression, 19 (severe) for anxiety and 35 (extremely severe) for stress on the DASS scale. She scored 11 on the GAD 7 scale which indicated a panic or anxiety disorder. Her score on the HAM-A was 28 which indicated moderate anxiety. Her IOE score of 64 indicated PTSD.



Bunny experienced depression at 37 (extremely severe), anxiety 17 (severe) and stress 19 (moderate) on the DASS scale. She scored 6 on the GAD 7 which indicated no panic or anxiety disorder. She scored 21 on the HAM-A which indicated mild anxiety and 44 on the IOE scale, indicating PTSD.

The DASS scale showed that Jane experienced depression (42), anxiety (29) and stress (37) as extremely severe. She scored 20 on the GAD 7 scale, indicating an anxiety or panic disorder. Her HAM-A score at 31 showed severe anxiety and the IOE score of 76 indicated PTSD.

Grace experienced depression as mild at a 10, anxiety as normal at a 6 and stress as normal at a 12 on the DASS scale. Her GAD 7 score was 10 and suggested a panic or anxiety disorder. Her HAM-A score was 22 which indicated mild anxiety and her IOE scale was at 36 indicating PTSD.

Michael's DASS scores were all normal; depression (1), anxiety (1) and stress (2). His GAD 7 score was at a 5, indicating no panic or anxiety disorder. His HAM-A was a 4 (no anxiety) and his IOE a 10 (no PTSD).

Bam had a difficult time filling in the questionnaires and needed prompting. He especially struggled with the HAM-A test. He filled it in twice on the same day with different answers. He needed assistance to complete the HAM-A test before treatment. During his treatment it was revealed that the psychological tests were part of one of his phobias. His fear of psychological tests was created during childhood. For him the tests equalled very high expectations where he was not allowed to fail because he had to shine for the whole family. He had mild depression (13) and normal anxiety (6) and stress (8) on the DASS scale. His GAD 7 was a 7, indicating no panic or anxiety disorder. His HAM-A score was 13, showing no anxiety and the IOE was 29 (no PTSD).

Mr Blue was normal for depression (8) and anxiety (2) and mildly stressed (15) on the DASS scale. His GAD 7 scale had a score of 14, indicating a panic or anxiety disorder. On the HAM-A scale he had no anxiety at a 17 score. He was 32 on the IOE and one point short of having PTSD on this scale.

Peggy Sue showed severe depression (24) and moderate anxiety (14) and stress (21) on the DASS scale. Her GAD 7 scale read 14, indicating a panic or anxiety disorder. She scored 26, moderate anxiety, on the HAM-A test and 50 on the IOE, indicating PTSD.

According to the DASS scale Tallulah showed to be normal for depression (4), anxiety (2) and stress (3). She was a 4 on the GAD 7 scale, not having a panic or anxiety disorder. Her HAM-A test was at 16, showing no anxiety and her IOE was 26, indicating no PTSD.

#### **4.2.3. Category 3: Realization of the presence of a phobia**

I used a four stage process to verify the presence of a phobia in the context of change, transition or progress in each of the participants: 1) a verbal assessment of their distress, fear, and anxiety SUD levels and their use of phobic language, 2) self-realization and 3) realization and confirmation through muscle testing.

During the screening interview it started to become apparent which potential participants might have a phobia based on their distress, fear and anxiety SUD scores (discussed in category 2). I noticed that they all, but four participants, had high (7+) SUD levels on their distress, fear and anxiety scores. Tallulah had anxiety at a 6, Bam had anxiety and fear at a 5, and Mr Blue had anxiety at 5 and fear at a 3 with regard to their change, and Michael had no anxiety regarding his change.

The possible presence of a phobia also started to become apparent through their language.

The participants' use and repetition of certain words and statements, which are discussed in this section, made me believe that they were phobic.

Close to the end of the interview, I asked them directly if they thought they were phobic. Even though some were doubtful that they did have a phobia, I finally muscle tested each participant to determine whether or not he/she had a phobia of change, transition or progression. Nine participants muscle tested positively for a phobia of change and Mr Blue muscle tested positively for a phobia of transition. None had a phobia of progression.

Category 3 is divided into three subcategories: 13) phobic language, 14) self-realization and 15) realization through muscle testing. Self-realization subcategory 14 is further divided into 3 sub-subcategories: 1) fear of change, 2) fear of going through a period of transition and 3) fear of progression.

#### **4.2.3.1. Subcategory 13: Phobic language**

During the screening interview I paid attention to the language of the potential participants. I noticed that all the participants experienced a lack of progression in their lives, a halt, or toward their goals which they expressed by using certain words like “stuck,” “paralyzed,” “stagnant,” “resistance,” “frozen” and “stopped” to describe themselves and/or their situations. Grace spoke about her procrastination and repeatedly said “I am stuck.” She straightforwardly said that emotionally she had made no progress in 10 years. Mr Blue, Bunny and Peggy Sue also used the word “stuck” and Peggy Sue added “frozen” to describe herself and her situation. Grace as well as Bam mentioned that they get paralyzed to the point where they cannot do anything. Bam explained further that it was impossible for him to talk himself out of his paralyzing fear. Tallulah mentioned that she felt stagnant and Angie said the change stopped her life. Elizabeth “procrastinates badly” and Michael described himself as “having a steady level of resistance” and said that he can procrastinate to such a level that

he just walked away from his work. He noticed that he was not progressing in his career choice.

I also noticed that all the participants had a lack of action towards changing and progressing in their lives and could not move on from where they were, even if they desired to do so. Peggy Sue mentioned repeatedly throughout her interview that she would like to move on with her life but could not. Elizabeth and Grace could not move on from their old relationships and Michael felt that there was no flow in his work and that it felt like a dead end. Tallulah also mentioned her need to move forward, but she felt she just could not do it.

None of the participants could take action in the way they wanted to. Jane and Elizabeth could not study, Michael could not release his work and Tallulah, Angie, Grace and Peggy Sue could not take steps towards new careers. Tallulah described herself as not being very pro-active. Bam and Mr Blue could not take action towards accepting their situation and making peace with it and in doing so find better solutions for their problem and preventing unnecessary stress.

Three of the participants vocalized that they had problems with change. Elizabeth said she always feared it, while Jane said that this change broke her. Grace mentioned that change used to be easy for her and now it was very difficult.

#### **4.2.3.2. Subcategory 14: Self-realization**

During the screening interview the participants were asked if they thought of themselves as having a phobia in the context of needing to change and going through a period of transition as they described. Six participants thought of themselves as having a phobia, one thought it might be a possibility and the remaining three did not think of themselves as having a phobia.

They were further questioned about their fear of change, and going through periods of transition and progression, and whether they thought their fears were irrational or not. This subcategory will be further divided into sub-subcategories 1) Fear of change; 2) Fear of transition; and 3) Fear of progression in order to see if and how they view their fear - as rational or irrational - with regard to changing, and going through periods of transition and progression.

#### **4.2.3.2.1. Sub-subcategory: Fear of change**

I asked the participants whether they thought their fear of change was *irrational*; seven thought it was.

Elizabeth said her fear of change (9) was about not finding another partner and it was irrational because it went against the fact that she was young and she knew she would in all likelihood have another partner.

Bunny said her fear of change was about rejection (10), which was irrational, but justified because it was a well-established pattern in her life where her relationships always ended – “I will be rejected again. Even if I break up, I break up because I have not been claimed. It is a reoccurring cycle with no end.”

Jane said her fear of change (7) was somewhat irrational because “it was normal to feel fear if you are all alone and have to do everything on your own.”

Grace believed her fear of change (7-8) to be irrational because “I am very capable and competent and my fear comes in the way of my capability and competence.”

Michael thought his fear of change (9) was irrational because it did not make any sense to him.

Peggy Sue said her fear of change (10) was irrational because she could not even sit down for a few minutes as she was panicky all the time.

Tallulah’s fear of change (7) was irrational for her because she put more pressure on herself.

On the other hand she didn't think it was irrational because as she asked "Who will not be fearful?"

Mr Blue, Angie and Bam (5) said their fear was *rational*, although Bam said he became paralyzed with fear. Bam also added that there was danger out there, which justified his fear. He explained it as "My fear checks in with me to warn me and then I can solve the problem."

Although Angie's fear was high at a 10, she said it was rational, because her pain is real and she feared that she was losing who she was – "I was healthy before and now I am sick and in pain."

Mr Blue's SUDS were low at a 3 and fear was therefore rational for him.

#### **4.2.3.2.2. Sub-subcategory: Fear of going through a period of transition**

When they were asked about their fear of enduring a period of transition, four participants viewed their fear as *irrational*.

Michael thought his fear of being in transition (5) was irrational because the fear once again did not make sense to him.

Bam's reason why he thought his fear (5) of transition was irrational was because "experience tells me that I have been able to survive this for 30 years, but I just cannot embrace it. I can't go there in this fearful, panicky and stressful state. I cannot talk myself out of it."

Peggy Sue said her fear (10) was irrational because she "cannot pull the trigger," she could not do what she wanted to do – live life without fear and she felt "stuck."

Tallulah viewed this fear (10) as irrational because "I should have faith and I don't."

Five participants thought that their fear of going through a period of transition was *rational*. Bunny did not know if she was experiencing a period of transition.

Angie once again did not see her fear (9 after surgery and a 5 now) as being irrational because “everybody takes time to get used to things.”

Elizabeth had no reason why she thought her fear (9) was rational.

Jane felt her fear (9) was rational because “When people feel they lose themselves, it is normal to wonder what will happen in the future.”

Grace felt her fear (7-8) was rational because it (her fear) was true.

Mr Blue thought his fear (10) was rational because “I put something into my business, so I should get something out, but I don’t see any evidence yet.”

#### **4.2.3.2.3. Sub-subcategory: Fear of progression**

The *fear of progression* was *irrational* to four of the participants. Michael did not know if his fear was irrational.

Bunny said her fear (8) was irrational because she worried too much about her partner and could not be satisfied with other things in life.

Grace thought her fear (9) was irrational because she was confused, overwhelmed and knew that she had the abilities to do what she needed to do, but could not do it.

Bam’s fear (7) was irrational because he viewed fear as a waste of energy which did not solve anything.

Peggy Sue thought her fear (10) was irrational because she could not help being fearful about her lack of progression.

The other five participants thought their fear was *rational*.

Angie thought her fear (8) was rational because the fear was happening and it got her where she was supposed to go.

Elizabeth said her fear (8-9) was rational because it was real and the truth. She feared people, did not trust them, believed everyone would lie to her, overanalyzed everything and thought

she would never find a romantic partner again.

Jane said her fear (9) was rational because “Everyone is fearful of making the best of themselves.”

Mr Blue felt his fear was rational fear at a 3.

Tallulah said she needed to change and her fear (8) was therefore rational.

#### **4.2.3.3. Subcategory 15: Realization through muscle testing**

Although not all the participants' cognitive responses were to view themselves as being phobic and not everyone's SUDS levels were very high, their behavioural responses and use of language suggested that they might be phobic of change, transition or progression. I therefore scheduled an in person muscle testing session with each of the potential participants in order to verify the discrepancy between their cognitive responses and their behavioural responses. Each participant was asked to think about their situation and was then asked if they had a phobia in the context of change, transition and/or progression. Each of the participants confirmed through muscle testing that they had a phobia in the context of change or transition with regard to their specific situation.

#### **4.2.4. Category 4: Treatment of simple phobias with the HBLU<sup>TM</sup> simple phobia protocol**

All of the participants were muscle tested to confirm that they could use the HBLU<sup>TM</sup> simple phobia protocol to transform their phobias. With the exception of Elizabeth, none of the participants had ever received treatment for phobias or anxiety. Elizabeth's therapist had incorporated hypnotherapy and breathing techniques during past therapy sessions for her chronic anxiety and panic attacks. She reported that it had helped her with her anxiety as it had taught her to calm herself down when she had a panic attack, and that the breathing



helped her to focus on something else. However, these techniques did not help her with her break up and she instead chose to discontinue with therapy because of her therapist's inability to empathize with her emotional state and her therapist's frustration that she could not move on.

After the screening interview Grace and Peggy Sue reported that they started to feel better and both reported that the line of questioning started to give them more clarity and Grace said that she felt calmer because she received more information. Jane on the other hand felt worse, more anxious and stressed and very irritable and angry after the screening interview. She called me twice between the screening interview and treatment session where she spoke about her family relations. During these calls she was severely anxious and needed prayer and I helped her refocus by doing the skin breathing technique and told her to administrate the stress release technique while putting her shoulders down as she spoke to me. I advised her to keep a log of her emotions, until she received the treatment, which she did not do.

During the HBLU™ process (Appendices L & N) a combination of EP techniques (Appendix O) were used, as well as talk therapy to encourage and assert communication and coping skills. The process was done in five stages: 1) Simple clearing (Appendix G), 2) Establishing Muscle testing (Appendix H), 3) Establishing a goal, 4) Mapping out phobias, and 5) Phobia resolution (Appendices L & N).

This category will be divided into 7 subcategories: 16) Simple clearing and solutions, 17) Establishing Muscle testing, 18) Establishing a goal, 19) Mapping out phobias, 20) Energy Psychology techniques applied *before* phobia resolution, 21) Energy Psychology techniques applied *during* phobia resolution with the HBLU™ phobia protocol and 22) Resolution of phobias.

#### **4.2.4.1. Subcategory 16: Simple clearing and solutions**

The HBLU™ process started where each of the participants' energy fields were tested and cleared directly before muscle testing by using the simple clearing protocol (Appendix G). All sessions were in person.

Seven of the participants had only one simple clearing and muscle test session right before their treatment started. Angie and Tallulah had two simple clearing and muscle testing sessions before treatment and Bunny had three because she needed a second treatment session. Angie, Bunny and Tallulah had their screening interviews in person and wanted to experience the simple clearing and muscle testing before they started with the treatment. Because simple clearing and testing the accuracy of muscle testing are tested before each treatment they each experienced a session again before their treatment session.

Simple clearing is an important part of the treatment as it sets the participants up for treatment. Only two participants (Grace and Peggy Sue) had no problems during the simple clearing process. The belly, back and K27 rub helped for Michael, Bam and Tallulah (during both sessions) when their arms were "spongy" during simple clearing. Tallulah needed to add Cooks hook-up during her first session and ducks lips during her second session. Michael and Tallulah were dehydrated and had to drink water.

Angie, Elizabeth, Bunny and Jane had a block on "no" where their arms did not go down. Angie had to talk about it, Elizabeth needed a minute of Cooks hook up, Bunny had problems during her first simple clearing and needed two energy psychology interventions (Raking and NLP mind scrambling) and Jane needed to talk, pray and do a round of EFT. Mr Blue's arms went down on both "yes" and "no" and he needed to talk.

Angie said that she could not say no (when her arms did not go down on "no") because she could not say no to people because she would feel conflicted – “What if I could not follow through?” She felt this in her lower back where she felt unsupported. She was reassured of her safety in this particular situation and reminded of the fact that she can back out at any time with no consequences. She was retested and her arms went down on "no". During her second simple clearing session just before the treatment she had a partial blocked energy field. We acknowledge how difficult it was to operate with a blocked energy field and I asked her what created anxiety for her. She felt upset and “all twisted up inside.” With more probing she answered that she had a hard time relaxing because she thought there was damage in her spine and her spine was “holding in” and did not allow the energy to flow because it was good to hold in energy. We acknowledged these parts, thanked them for sharing and invited them to participate in the healing. We asked them to relax and work with us so the healing could proceed. We put a sphere of Holy Light around us for protection and asked God and His angels for guidance and healing. She felt better and was cleared and could proceed.

After a minute of Cook’s hook up, Elizabeth’s arms could go down on "no" and we could proceed.

Bunny explained her block during her first simple clearing as “making a boundary,” so she would not be rejected. After applying the two EP techniques the blocks were cleared. During her second and third session, she had no problems with her simple clearing.

Jane explained that she was anxious as she woke up with her parents screaming and fighting and not wanting to lend her the car. She was worried that she would be late and unable to show up for the session. We prayed and used EFT to tap out the story of her

morning. She yawned and stretched and felt relaxed. She said out loud that she chose to unblock now and she was cleared on her simple clearing.

Mr Blue had very weak energy where his arms just fell down during simple clearing. I asked him “What took your power away?” and he answered that he was tired, disappointed and mentioned that he had a number of emotions going on which distracted him. I probed further by asking him what the main thing was that made him powerless and he answered that it was a lack of sleep. He was advised to say “I choose to take my power back” after which he immediately sighed, and stood up straight and was cleared.

#### **4.2.4.2. Subcategory 17: Establishing Muscle testing**

The participants’ ability to muscle test was tested directly after the simple clearing process. Through my personal clinical experience, I found that the tilting muscle test method was the best to use, because certain nuances could be picked up which was not possible with other forms of muscle testing. An example which came up frequently was when a person did not move forward on a "yes" or backward on a "no", but instead swayed to the side or in a circle. That was an indication that there was something the participant needed to verbalize. Once they were heard, the muscle testing was corrected and we could continue.

During muscle testing set up and throughout treatment, some of the participants not familiar with HBLU<sup>TM</sup> and the muscle test questions, would reverse (their yes would be a no and vice versa), would not move at all or sway to the side when we got to the second and third muscle test questions of “Did you deceive on that answer?” and “Would you tell us if you did deceive?” Most of the participants just needed to be reassured and be given an explanation and reason for the questions. If further issues came up, they were immediately addressed so that muscle testing and treatment could proceed in the right direction.

Six participants performed muscle testing easily and accurately during the muscle test establishing session. Elizabeth, Bunny, Jane, Bam, Mr Blue and Peggy Sue had no problems with their muscle testing and Elizabeth and Bam laughed and giggled a lot as they realized they could muscle test. Peggy Sue said she loved the muscle testing process.

Bunny had a reversal on her muscle testing during her first treatment session; she did Cook's hook-up for 1 minute and was fine on "no", but could not go forward on "yes". She believed it was an entity and we put ourselves in a sphere of Holy Light and asked God and his angels for protection and guidance. She yawned and when tested, her muscle testing was accurate.

The remaining number of participants needed simple clearing techniques before they could continue with accurate muscle testing. Angie, as during her simple clearing, could not say "no" during muscle testing. She said she felt stubborn about life; she wanted to know more about her life and this process. She feared hurt and was scared to be alone. After she voiced this, and her questions about the process was answered, she was muscle tested again and she went to the side on "no". After further inquiry she said she realized that being stubborn does not help her. After this statement, she could muscle test accurately.

At the beginning of her treatment session she was reversed during muscle testing – she needed to be barefoot. After she took off her shoes, she could muscle test accurately.

Grace was blocked on "no" during muscle testing. Her block was caused by her feeling unworthy. We recognized the part, thanked it and reassure that we will not ignore it. When we muscle tested again, she was reversed which was caused by a limiting belief that she was not deserving of being healed and all the good that is coming her way. We heard it, recognized it, thanked and acknowledged it. Her muscle testing was strong and clear.

During Michael's muscle testing set up process he went slightly left on "no" and when asked why he has a problem with no, he said he did not want to commit to things he did not

want to do, because it will keep him away from the things he wanted to do, and he will become unpleasant and resentful. He is cautious about giving away his time and he said "no" to everyone who wants to take his time. We heard, recognized, thanked and acknowledged that part, reminded him that this was his choice and that he could stop at any time. He wanted to continue and realized that the quicker he chose to unblock, the less time he will waste. He said out loud, "I choose to unblock now" and he was cleared and could muscle test.

Tallulah was reversed on her muscle testing. Her anxiety was about the limiting belief that she wanted the healing and wanted it to work so she could see changes in her life, but fear that she would not fit the profile or that the treatment would not be able to help her. We invited all her parts to participate in the healing and I reassured her that I will help her, even if she does not fit the profile. She had a need to talk about everything that was overwhelming her and we acknowledged and recognized the overwhelmed and confused parts. I continued to tell her that the more she relaxed, the better her muscle testing would be and then we could proceed. She started to feel calmer and she experienced a tingling throughout her body as we spoke and could muscle test.

When she was muscle tested whether she could clear the phobias with a simple phobia protocol, she suddenly had problems with muscle testing again, where she could not muscle test on "no". She spoke about it and did stress release with the colour purple for 2 minutes. She started to cry and pray and asked God to help her and surrendered her problems to God. She needed to upgrade an enneagram 7 layer where she could not process negative emotions through her heart centre. We used the essence process to transform it in six minutes without mapping out the enneagram. She released a lot of sadness during the process which made her nose run excessively. She said she started to feel a release, felt lighter, and felt hot. Then she started to smile and mentioned that she felt really good. She needed prayer and God's protection and guidance to proceed. She also needed more body talk as she felt pressure on

the side of her body. We spoke about her fear to let go of the past, rejection and that she might not like "the new me." She could continue to muscle test accurately.

During her second muscle testing set up session right before treatment, she had a reversal with her muscle testing and did Cooks hook up for one minute to correct it.

#### **4.2.4.3. Subcategory 18: Establishing a goal**

Setting goals for healing took between 3 minutes to 50 minutes. Some of the participants' first identified goals were not their priority goals (as verified via muscle testing). In these cases, the client had to rethink his/her goal until we could establish his/her priority goal and confirm it through muscle testing. Four of the participants had their goal right the first time, five during the second try, and one during the third try. Establishing Bunny's goal brought up more issues with muscle testing and she needed EFT to help her through the process.

Angie established her first goal, "I'd like to have more confidence," in 5 minutes, but she had no phobia of change, transition or progression on it. We got more specific and focused on the two problem areas in her life: her health and her work situation. Her goal was established as "I'd like to work in a meaningful, purposeful career." The process took 16 minutes and she had 77% NEC (**n**egative **e**motional **c**harge) on the goal.

Before the treatment Elizabeth sent me 4 goals she wished to work on. We discussed the goals and found the highest priority goal to be: "Letting go of the past with my relationship with my ex- boyfriend, A." She had a 100% NEC on the goal, which was established in 15 minutes.

Although I suggested a goal for Bunny – to break her relationship pattern – she immediately said she wanted to be married and set that as her goal. After I probed her about

the kind of marriage she said “a soul connection marriage.” When we muscle tested her for confirmation of her goal – “I want a soul connection marriage,” she balked and said she did not trust muscle testing done by herself and would rather I do it for her. We acknowledged and spoke to her parts (i.e. parts of her body, psyche, and/or soul that spoke up) which felt distrust, not worthy, deserving and perfect. She yawned a lot and needed to add “until I die” to the goal statement. She started to question her muscle testing again and I reassured her of her safety and reminded her that she could stop at any time. She wanted to proceed and felt her goal statement was right, but she also felt that something was wrong with her and that she had too many traumas and entities around her. She got hung up on the word deception and felt stuck where she felt she would continue to deceive me. With more talking and probing, she finally shouted out that she hated muscle testing because she had too much power and control over it and therefore it was inaccurate because she was the one answering the questions. She did not feel confident that her answers were accurate and would prefer me answering for her. More explanation followed about the tilting method and 3 questions asked to help eliminate deception during muscle testing and the importance of her (and not me) answering the questions. We used EFT tapping to resolve this situation. We tapped on “I don’t like to come up with answers by myself”. She did not feel better and still needed to speak a lot, especially about her not feeling authentic. She continued to tap as she told her stories, from being between two life times to church camp, the reasons why she does not like to come up with her own answers, her frustrations, feelings that God does not talk to her, and her preference for relying on others rather than on herself. Afterwards she felt better, wanted to continue with the session and could muscle test. Lastly, we discovered and acknowledged a judge archetype in her, which made her cry, and we asked her to sit in the corner until the session was done. After 50 minutes we could confirm her goal - “I want a soul connection



marriage for the rest of my life” through muscle testing. She had negative emotional charge (NEC) of 40% on the goal.

Jane’s goal was established in 3 minutes where she first wanted to be happy and on suggesting that might be too broad a goal, she wanted to be “focused in school” because it will bring down her anxiety and stress. The goal was confirmed through muscle testing with a negative emotional charge (NEC) of 98%.

Apart from Grace, no one else received any kind of treatment on their goal prior to this treatment session. Grace had two EFT sessions around her marriage and divorce before this session with an EFT practitioner. She had no problem to immediately talk about what she wanted – she wanted to be “free, competent, capable, and joyful and living her life as fully as she could.” She was directed to be more specific, thinking of her situation. The next goal she chose was: “I want to have mental clarity to make healthy decisions that are in my highest and best interest.” She muscle tested negative for this goal as well. After more probing she became very emotional and started to cry and said she wanted “Inner peace about the situation (the divorce).” The confirmed goal with a NEC of 80% was established in 10 minutes. She said the 80% NEC was made up of guilt and shame.

Michael’s first goal was that he wanted to identify a specific timeline to complete his musical play – set a date. We discussed the lack of control we have over timelines, but that we could change how we move towards our goals, change our attitudes, and have a better vision of what we want and the steps to take to get us there. He confirmed his goal: “I want to own, accept and believe that the title of composer/musician belongs to me.” He had 70% NEC on the goal and the process took 8 minutes. He felt this goal was more specific and not so “out there,” it made sense to him and he saw how his timeline would fall into place at the appropriate time.

When we started to focus on Bam's goal, he started by saying that he did not want to be lazy and spoke about the lists he wanted to make so it would be realistic, so he could actually do what was on the lists and not become stuck and stopped. He spoke about how he needs to rest physically and mentally. He became very anxious and spoke about the pain in his feet and knees and the need for a cigarette. We did some EP body talk and spoke to his feet, which were saying that they stop him from moving forward, they were afraid that he might go too far and fall. Although he meant it literally (during muscle testing), it was also a metaphor for him. After I pointed out that it was impossible for him to fall as he was on the ground and could stop himself, he said "Oh!" and was surprised about that reality. He could muscle test accurately for his goal: "Set realistic goals for myself to accomplish in the next 6 weeks – fulfil them and move on." It took 20 minutes to establish the goal.

Mr Blue was very sure of his goal and it was confirmed in 3 minutes – "To be focused, patient and relaxed so I can be prepared for the work and success of my business" with a 70% NEC.

Peggy Sue focused on and established her first goal in 7 minutes as "I don't want to be fearful." I asked her to be more specific and we probed more. Her second goal of "I want to embrace life as I move through it" muscle tested as not being a priority. Her third and final goal was "I want to be fearless with moving forward with life." This goal had a NEC of 60% and took 15 minutes to establish.

She had some muscle testing issues around her final goal where she needed to voice how difficult it was for her to move forward as she always put her family first. She also realized that she allowed people to manipulate her, which made her doubt herself. This made her not stay true to herself and she ended up not doing what she wanted to do. During this process, she needed to surrender the process and healing to God before she could proceed.

When she was asked if she had a phobia of change on her goal, she moved to the side and had

to voice fearing her husband's rejection when she went against his wishes too much. We acknowledged, thanked and reassured the parts and invited them to participate in the healing. She could muscle test again. She moved to the side again at the last question when we muscle tested for a 100% permission to proceed with the goal. She was afraid that the final step will be commitment – commitment to a mental institution and not to her life. We needed to bind a curse and allowed her to visualize filling up with the unconditional love of God, which was a pink light. After about two minutes she felt great and wanted to talk a lot about God and could continue to muscle test and establish her goal.

Tallulah confirmed her goal with a NEC of 87% in 8 minutes; "I want mental clarity."

#### **4.2.4.4. Subcategory 19: Mapping out phobias**

Once their ability to muscle test and the goals were established, we could confirm the phobia names, the types of phobias (fear, shame, hybrid and anticipatory) and the number of phobias they had. After this, the "mapping out" of the phobias started. "Mapping out" phobias is the part of the protocol where the story of the phobia is discovered. The mapping out of the phobias brought us to the most extreme form of their phobias and sometimes the end results looked similar, as in Angie's case where five of her fear phobias were the same. The stories that brought each client to his/her most extreme or insulting consequence of the phobias were all different from each other, though. Most of the time, the end result of the fear phobias ended in death or turmoil and the shame phobias ended in severe character assassination.

Some of the participants became very tired during the mapping out of the phobias. Elizabeth and Bunny wanted to physically lie down and Jane started to whisper. Grace and Tallulah cried while they mapped out their phobias. Tallulah had a need to talk and pray

while she was mapping out some of her phobias. Elizabeth and Bam became fearful when we started to map out the phobias and had a need to talk and needed reassurance.

Table 4.7 presents what kind of phobia each participant had on his/her goal and how many of each they had.

**Table 4.7: Number and type of phobias each participant had on their goal.**

Names	Fear phobias of change/transition	Shame phobias of change/transition	Hybrid phobias of change/transition	Anticipatory phobias
Angie	6			
Elizabeth	5			
Bunny	3	4	1	
Jane	4	2	2	
Grace	4	4	1	
Michael	3	2	3	1
Bam	2			1
*Mr Blue	2		1	
Peggy Sue	2	3		
Tallulah	3	4		

*Note:* \*Mr. Blue had phobias of transition

Except for Mr. Blue, who had a phobia of transition, they all had a phobia of change on their goals and through muscle testing confirmed that they gave a 100% permission to clear the phobias as the priority interference on the goal with the HBLU™ simple phobia protocol.

Only Bam and Michael had anticipatory phobias which were discovered after the other phobias were cleared.

Angie had six fear phobias of change to have a meaningful and purposeful career. She mapped them out in 35 minutes and mentioned the words “nothing,” “depressed” and “sad” repeatedly during the mapping out of her phobias. Almost all her phobias lead to nothingness, but the stories where all different.

She said that “I am afraid to change and have a meaningful and purposeful career because 1)

there is nothing there, a void and no reason to be, 2) there is nothing, no words, no pictures, 3) nothing happens, 4) there is nothing left, 5) nothing can reach me in my dark, sad place of change where I am stuck, 6) it is a taboo. When she started to map out phobia 6 she started to notice a difference and said this one is external while the others were internal.

When Elizabeth started to talk about her phobias, she could not focus and she started to notice a lot of fear. She had five fear phobias which took her 70 minutes to map out. The words “fear,” “scared,” “anxious,” “dying” and especially “falling” came up a lot. Her fear phobias were: “I am afraid to change and let go of the past with my relationship with A. because 1) I will fall down and be in a big puddle of sadness and tears, 2) I will smash my head on the inside and die slowly ( she started to drift and said she felt very tired and could hardly speak), 3) I will fall out of an airplane to my death (during mapping out this phobia she slumped and lay down in her chair), 4) I will pee in my pants and won’t be able to move and will just stand there and look and 5) I will be alone in hell where everything is burning around me.”

We mapped out Bunny’s eight phobias: three fear, four shame and one hybrid. It took her 45 minutes to map out the phobias. She was very focused on the fear to deceive and the word “stuck” was repeated.

We started with her fear phobias where she said: “I am afraid to change and be in a conscious, soul connection marriage for the rest of my life because 1) I will be a zombie and vegetable, 2) I will be a slave, and 3) I will be stuck on this planet where I don’t want to be.” After mapping out these phobias she said that marriage will save her from all of this. I had to point out the irony of a phobic situation where she would not go near it though, because of these irrational fears she just mapped out. She suddenly felt very tired and defeated and needed to lie down. She, like Elizabeth, needed a lot of encouragement and recognition which helped them to continue.

Next were her shame phobias where she felt ashamed to change and be in a conscious, soul connection marriage for the rest of her life because it meant that I am a 1) fuck up, 2) a wicked witch, 3) a neurotic basket case and 4) a submissive peasant.

Her hybrid phobia said that she was afraid and ashamed to change and be in a conscious, soul connection marriage for the rest of her life because something was wrong with her and it meant that she was a worthless cow.

After it was established through muscle testing that Jane had four fear, two shame and two hybrid phobias, we mapped out each of them. It took her 45 minutes to map out her phobias. The words that repeatedly came up during her mapping out the phobias were "useless", "not motivated", "die" and "falls apart".

She was afraid to change and be focused in school because 1) everybody was just going to die – there is no more life, 2) everything is useless and I die, 3) there is no point in living and 4) everything falls apart.

She was ashamed to change and be focused in school because that meant that she was a 1) failing loser and a 2) useless cow.

She was afraid and ashamed to change and be focused in school because 1) there is no world and it means that I am a failing, stupid loser and 2) I will die in a dark, small house and that means that I am an idiot loser.

It took Grace 25 minutes to map out her four fear phobias, four shame phobias and one hybrid phobia. The phrase "I will die", was repeated.

She was afraid to change and have inner peace because "1) I'll be buried alive, 2) I will perish in the desert and die slowly and painfully like I was buried alive in a coffin, 3) I will slowly drift into nothingness/orbit into nothingness, and 4) melt away until there is no remnant left."

She next mapped out a hybrid phobia: "I am afraid and ashamed to change and have inner

peace because I will die a horrible death and be buried alive and it means that I am a horrible bitch." Her shame phobias were "I am ashamed to change and have inner peace because it means that I am 1) a mean and cruel cunt, 2) a tramp, whore and slut, 3) a lying, cheating destroyer and 4) a "ravenger" that shreds the joy of others".

Michael mapped out his three fear, two shame, three hybrid phobias and one anticipatory phobia in half an hour. He did not repeat certain words, but used words that fell under a similar genre; "busted", "found out", "be a lie", "dishonest", "out of integrity", "not truthful", "fraudulent" and "deceived".

He was afraid to change and own, accept and believe himself to be a composer/musician because 1) I will die unfulfilled because I had a purposeless life, 2) I will choke to death (he laughed and thought the process was fun), 3) this dark, bleak, purposeless world and life is a dead end. He needed to clear these three phobias before we could continue.

We focused next on his two shame phobias of I am ashamed to change and own, accept and believe myself to be a composer/musician because that means that I am 1) an untalented fool and 2) an unworthy loser. They were both cleared before he mapped out the three hybrid phobias.

The first one was "I'm afraid and ashamed to change – to own, accept and believe that I am a composer/musician because I get nothing done and that means that I am a fearful losing wimp." He became very tired and we had to rest so he could eat something. The second one was "I'm afraid and ashamed to change – to own, accept and believe that I am a composer/musician because I am fraudulent and undeserving of success and that means that I am an ineffective, uninspiring, soulless dead liar". The last one read as "I'm afraid and ashamed to change – to own, accept and believe that I am a composer/musician because I would have an inability to connect with God and that means that I am lost and am a creative wannabe/ a fraudulent charlatan, a cheat and thief."

After clearing the hybrid phobias he muscle tested yes for an anticipatory phobia – “I am afraid that I won’t own, accept and believe that I am a composer in the future.”

Bam had two fear phobias of change to set realistic goals and accomplish them. He started to become very fearful and said he could not stay focused. We had to stop and talk first. I reassured him that I was there to guide him and that the “chunking down” process would help to keep him focused. The words “failure” and “suicide” came up a lot during the mapping out of his phobias.

He had long story lines and it took half an hour to map out the two fear phobias.

He was afraid to change and set realistic goals and accomplish them in the next six weeks because “I will commit suicide by jumping of a bridge into traffic.” He had to clear his first phobia before he could continue with the second which read as “I am afraid to change and set realistic goals and accomplish them in the next six weeks because I will have a wasteful life and commit suicide.

After his phobias cleared he was suddenly worried and anxious about the future, which made me believe he had an anticipatory phobia. He muscle tested for one anticipatory phobia: “I am afraid and ashamed that I will fall back on bad habits (not accomplish my goals) in the future and not learn from this lesson and healing.” It took him just 2 minutes to map it out.

Mr Blue had two fear phobias and one hybrid phobia to transition into being more focused, patient, relaxed, prepared and ready for work and success in his business because 1) he will die of a heart attack and 2) will see only blank and have no solutions and possibilities. After we cleared the two fear phobias, he mapped out his hybrid phobia of “I’m afraid and ashamed to transition into being focused, patient, and relaxed and ready for work and success in my business because I feel I want to die and life is not worth living and that means that I am a total loser.”



He mapped out his phobias in 25 minutes and the words "not happy" and "fail" were repeatedly used.

Peggy Sue had two fear and three shame phobias and it took 10 minutes to map them out. The words "lonely", "wither away", "worthless" and "alone" stood out during the mapping out of the phobias.

She said she was afraid to change and move fearlessly forward with her life because 1) I will wither away in dust and 2) I will wither and die by myself.

She described her shame phobias as "I am ashamed to change and move fearlessly forward with my life because it means that I am 1) a worthless slut, 2) a worthless creep and 3) a money grabbing whore."

Tallulah mapped out her three fear and four shame phobias in 25 minutes. The words "alone" and "die" showed up a lot during the mapping out of the phobias. She was afraid to change and have mental clarity because "I will die alone on a twin bed and watch time go by through my window." She mentioned this described her and what she was doing with her life at the moment. Her next phobia was "I am afraid to change and have mental clarity because I will be in a dark, black hole where there is nothing, but chaos." This phobia was difficult for her to map out and she got lost in her story and then felt a need to pray for the world. Her last fear phobia she described as "I am afraid to change and have mental clarity because I will die with a lack of growth – as a failure". She cried a lot and had a great need to speak about God. Her shame phobias were: " I am ashamed to change and have mental clarity because it means that I am 1) an absolute failure, 2) a deceitful, hypocritical liar, 3) a crazy, out of control, evil lunatic and 4) a crazy, hurtful, mean, careless, selfish, destroying and destructive bitch."

#### **4.2.4.5. Subcategory 20: Energy Psychology techniques applied *before* phobia resolution**

Some participants did not only require an intervention (applying an EP technique) once the phobias were mapped out, but required interventions before they reached this stage of the process.

Angie for example put a sphere of Holy Light around us for protection and asked God and His angels to guide and protect us during her simple clearing session.

Elizabeth needed Cooks hook-up during simple clearing.

Bunny used the NLP mind scrambling technique and raking to help her unblock her energy fields during simple clearing. She did Cooks hook-up when she had reversed muscle testing during her first treatment session and also put a sphere of Holy Light around us and asked God and His angels for protection and guidance. When she had great resistance to self-muscle test and mentioned how much she hated and distrusted it during her first treatment session (when she had to establish her goal), we used EFT tapping to resolve this situation.

Jane had a blocked energy field and needed prayer and EFT to tap out her upsetting morning during her simple clearing process before treatment.

The belly, back and K27 rub helped for both Bam and Michael when their arms were “spongy” during simple clearing. We did body talk with Bam when we worked on his goal, so he could successfully proceed with muscle testing and establish his goal.

Peggy Sue had deception while muscle testing for her last goal and needed to surrender the process and healing to God before she could proceed. Before she could establish her goal we also needed to bind a curse and allowed her to visualize filling up with the unconditional love of God, which was a pink light.

Tallulah needed the belly, back and K27 rub, Cooks hook-up and ducks lips during her simple clearing sessions. Before she could give permission to clear her phobias with the

HBLU™ simple phobia protocol during her muscle testing session, she needed to do stress release with the colour purple. She also prayed, asked for God's protection and guidance and asked God to help her and surrendered her problems to God. She upgraded the enneagram 7 layer with the essence process and did body talk during this session. She did Cooks hook-up again during her second muscle testing session when she had a reversal with her muscle testing.

After the use of these interventions the participants still had all their phobias. The EP techniques were used to help them through the process and to continue with accurate muscle testing.

#### **4.2.4.6. Subcategory 21: Energy Psychology techniques applied *during* phobia resolution with the HBLU™ phobia protocol**

All the participants were able to successfully follow and finish the methodological process of the HBLU™ simple phobia protocol (Appendix L & N) including choosing and applying the interventions of choice (Appendix O) to clear their phobias. At this stage they were all well prepared and had a greater understanding of the process. Because they all established a goal to keep their focus on their specific phobia of change, they were all still very focused when they picked the intervention of choice to neutralize the mapped out phobias.

Once the phobias were mapped out, all the participants needed more than one intervention to transform/neutralize all their phobias a 100% on the conscious, unconscious, body and soul levels and to balance them 100% on their goals. All the female participants acknowledged a Higher Power – God – during their treatment process, and Peggy Sue and Tallulah had a greater need to talk to God during and after treatment.

They all had 1 treatment session averaging one to two hours 30 minutes, except for Bunny who had 2 treatment sessions and whose treatment time added up to three and a half hours. She needed to have two treatment sessions for various reasons; two of the reasons were that she wanted to be surrogate muscle tested and she went from one issue to another.

All choices and decisions were confirmed through muscle testing.

The number of interventions applied during phobia resolution and the collective time varied for each participant as shown in Table 4.8.

Angie needed 4 variations of one intervention which took 20 minutes.

Elizabeth needed 2 interventions, which took 10 minutes.

Bunny had a total of 14 interventions which took 86 minutes in total.

Jane's phobias were cleared after 2 interventions with a total intervention time of 4 minutes.

Grace's phobias were resolved in 5 minutes after 3 applications of 1 intervention.

Michael's total intervention time was 22 minutes for the 6 interventions he chose.

Bam's phobias cleared in 15 minutes after using 4 interventions.

Mr Blue cleared his phobias with 2 interventions in 4 minutes.

Peggy Sue needed 5 interventions and the combined time was 8 minutes.

Tallulah used 3 interventions for 8 minutes.

Talk therapy as an intervention was not included in these calculations. Recapping the screening interview answers, simple clearing, establishing muscle testing and a goal, the mapping out of the phobias, discussion of the phobias and writing the learnings took up the remainder of the session time.

Table 4.8 presents the types and number of Energy psychology interventions each participant applied during treatment, the total amount of EP intervention time and the total amount of treatment time.

**Table 4.8: Energy psychology interventions applied, number of Energy psychology interventions applied, Energy psychology intervention time and total treatment time.**

<b>Names</b>	<b>EP interventions applied during treatment</b>	<b>Total number EP interventions applied during treatment</b>	<b>Total amount of EP intervention time</b>	<b>Total treatment time</b>
<b>Angie</b>	UF/O holding with singing into the chakras, colour visualization and prayer. UF/O holding with no extras.	4 variations of 1 intervention	20 minutes	2 hours 10 minutes
<b>Elizabeth</b>	Skin Breathing with colour, Boundary tap	2	10 minutes	2 hours
<b>*Bunny</b>	Drawing (3 times, 1 time with prayer), Callahan phobia technique (twice), UF/O holding with colour visualization, UF/O holding with no extras (x3), stress release with colour, boundary tap, raking, skin breathing with colour and I feel/I am.	14	86 minutes	3 hours 30 minutes
<b>Jane</b>	HRT with colour, skin breathing with colour	2	4 minutes	1 hour 15 minutes
<b>Grace</b>	RT with 3 colours	3 applications of 1 intervention	5 minutes	2 hours
<b>Michael</b>	NBD, UF/O holding (x2), Reversal conflict tapping, Callahan phobia technique, stress release with colour	6	22 minutes	2 hours 30 minutes
<b>Bam</b>	Callahan phobia technique, NBD with “watchmen in the tower,” UF/O holding with colour visualization and prayer, NBD	4	15 minutes	1 hour 15 minutes
<b>Mr Blue</b>	HRT, Reversal/Conflict tapping	2	4 minutes	1hour
<b>Peggy Sue</b>	Boundary tap (x2), Reversal /Conflict tapping, I feel /I am, UF/O holding	5	8 minutes	2 hours 45 minutes
<b>Tallulah</b>	Callahan phobia technique, UF/O holding with colour visualization, I feel/I am	3	8 minutes	2 hours 30 minutes

*Note:* \*Bunny had 2 treatment interventions

Angie focused on phobia six as her priority phobia, “I am afraid to change and have a meaningful and purposeful career because it is a taboo,” to clear all her fear phobias simultaneously. She focused on the most recent example of the phobia of her not working. She needed UF/O holding with all three possibilities – singing into the chakras, colour visualization and prayer. She first sang from her root chakra up to her crown chakra and then she picked the colours blue, orange and white to be on her crown chakra, third eye and sacral

chakra. She visualized for one minute on each chakra. Thirdly she prayed, asking Jesus Christ and the Holy Spirit for healing while doing UF/O holding. After this she said she could see herself working purposefully and we installed this picture with UF/O holding. The whole process took 18 minutes. Through muscle testing we established that the phobias were not a 100% healed on the soul level and she needed another 2 minutes of UF/O holding before the phobia was cleared on the soul level as well.

Her phobias were cleared a 100% on all levels, but she swayed to the side during muscle testing when asked if her goal was a 100% cleared on the unconscious level. She needed to talk about her fear for the unknown and then after that she muscle tested that she was a 100% balanced on her goal on the unconscious level, as well as the other levels.

Elizabeth could heal all her phobias with her priority phobia where she was falling out of an airplane to her death. She started to feel the phobia in her head at a 9 where she did not feel good enough. She focused on the worst example of this phobia when her friend died during the same time when she had a terrible relationship with her dad. She picked skin breathing with the colour turquoise as the intervention of choice, and did the intervention for eight minutes. The phobia moved from her head to her chest and was at a 3 on the SUD scale. She spoke very softly now and seemed very tired. She picked the boundary tap next to bring the SUDS down to a zero and did it for two minutes. She put up boundaries with people that did not make her feel good enough about herself and tapped out the feelings of aloneness.

Bunny muscle tested that she could clear all her fear phobias with fear phobia three where she did not want to live and was stuck on this planet where she did not belong or wanted to be. She did not have to focus on a specific example and her intervention of choice was the drawing technique, which she did for 8 minutes. Her drawing after the UF/O holding was soft, round and interconnected. Afterwards she said she was relaxed, but exhausted

(“cooked”) and said she would like to sleep and that it was impossible for her to continue to clear the rest of the phobias. We scheduled a second appointment.

During the second appointment, two days later, she was very upbeat, but wanted to lie down as soon as we had to clear the phobias. She needed additional interventions to clear the fear phobias. She focused on the same phobia as before and did one round of the Callahan phobia technique and her SUDS went down from a 10 to a 5. She did a second round and it went down to a zero. The process took 5 minutes. Immediately after her SUDS of zero, she started to doubt herself and said she was not a 100% sure and started to doubt her muscle testing again. She wanted another intervention and we did UF/O holding with visualizing light on the crown, solar plexus, root chakra and her feet. She also visualized with green on her crown, green at her solar plexus and yellow at her root chakra, and magenta at her feet. She cried a lot during this process and finally she filled herself up with healthy pink light and expanded it to the ends of the universe. This whole process took 15 minutes. She said she felt better but not a 100%. She still had charge on the fear phobias and did the drawing intervention again for 10 minutes. Her final drawing was a simple infinity sign and she said change is infinite. When asked what she thought of her fear phobias now, she said her despair seems further away, at home. She did stress release with orange for two minutes. She yawned and sighed a lot during the interventions. She started to laugh and told me about a funny cat video on YouTube. She installed the new association with her house – happy cats – with UF/O holding for 4 minutes. After this the phobia moved to her mother’s house where she felt dread at an 8. She picked the drawing technique again and made a lot of “aggh” and “ugghhh” sounds during the drawing (2 minutes). During UF/O holding process which is incorporated in the drawing technique, she started to make a long “aahhh” singing sound and actively began to decontrol. We needed to talk a lot while she held the UF/O holding position (15 minutes). I suggested to her to go into her dark cloud (which she said was above her) and

meet God there and have a conversation while she did UF/O holding for 4 more minutes. She sighed a lot during the process. After the UF/O holding position, she spoke about the trauma of her mom cutting her hair as punishment when she was little. We then put the whole trauma and its triggers into an imagined pot and did UF/O holding for another 3 minutes and prayed. She was able to finish the drawing intervention and drew another picture for 2 minutes. After this intervention which took 26 minutes in total, she felt there was now more space between her and the phobia, which made her feel better and calmer. We integrated the healing with UF/O holding for 2 minutes. Next she needed to put up boundaries with her mother's "stuff" (she is a hoarder) and we did the boundary tap for 2 minutes and she let go of the emotions of anger and anxiety. After the intervention she thought she should accept her mom and her house and let her be and love her without wanting to change her.

After these nine interventions, all her fear phobias were cleared and she cross cleared shame phobias one and four, "I feel ashamed to change and be in a conscious, soul connection marriage for the rest of my life because it meant that I am a 1) fuck up and 4) a submissive peasant". Next she cleared shame phobia two, "I feel ashamed to change and be in a conscious, soul connection marriage for the rest of my life because it meant that I am a wicked witch" with the Callahan Phobia Technique for 3 minutes. She felt wicked all over at SUDS 8. After the first round she was down to 4 and mentally saw grass, which she hated, as she perceived it is as a waste of water. We did another round of UF/O holding for a minute and then raking for 4 minutes until she saw a clear quartz in her mind. She liked crystals and did not have to transform it further to clear the phobia. She cleared shame phobia three where she was "a neurotic basket case" with skin breathing and the colour lavender for 2 minutes. Finally she cleared her hybrid phobia with intervention four – I feel/I am (I have no choice VS I am at choice). After 2 minutes she burped and the phobia was cleared.



We established via muscle testing that Jane could clear all her phobias simultaneously while she focused on her priority fear phobia of “there was no point in living.” She needed to focus on the worst example of this phobia where she saw her mom crying and her dad accusing and she felt sadness at a nine. She picked the technique HRT – crossing her hands over her heart - and the colour of baby blue for 2 minutes as the priority intervention to clear all the phobias simultaneously. While she did this intervention, she was also guided to see God’s hand pulling the fear and sadness from her like a magnet. Muscle testing showed that she cleared all the phobias on all levels, except her conscious level. She needed skin breathing with the colour purple to clear the phobia on the conscious level. For two minutes she inhaled the colour purple of forgiveness and trust and exhaled all remains of the fear and shame she carried. She yawned and remarked that her back pain was gone. Her back was hurting so much that she wanted to cry when she came in (she did not mention it).

Grace could clear all her phobias simultaneously with her shame phobia where she saw herself as a mean, cruel “ravenger,” shredding other people’s joy. She needed to focus on the worst example, which was when her husband belittled her rape. Her priority intervention was HRT, crossing her hands over her heart with the colour purple for 2 minutes. She put God’s hand between her hand and heart to help her pull the shame and memory of the worst example from her. She needed the colour black for another 2 minutes. She cried a lot during this intervention. Lastly she called for the colour white and did the intervention for 1 minute. She was still crying a bit, but mentioned that she now was feeling peaceful, calmer and more relaxed.

Michael needed to clear his three fear phobias before he could continue to map out his other phobias. He could cross clear the three fear phobias by choosing to focus on priority phobia number one where he had a purposeless life and was dead. He further needed to focus on the root cause/origin of the phobia when he was six years old and created a puppet show

for his parents. His body started to tense up and his breathing almost stopped when he thought about it. He felt the phobia at an 8 on the SUD scale and said that he felt rejected. The highest priority intervention he chose was personalized NBD which took 12 minutes. Close to the end of the tapping, he started to laugh and said that he was amazed and had a totally different perspective of the original phobic story. The SUDS was down to a zero. He chose to install the positive opposite of the phobia with 1 minute of UF/O holding. Next he cleared both shame phobias with the focus on the shame phobia where he felt as if he was an unworthy loser. Once again he needed to focus on a root cause event where he was twelve years old and his pet rat died because he forgot to give it water. He chose Reversal/Conflict tapping for 2 minutes. After clearing the phobia he said she felt exhausted but felt better again after he did UF/O holding for another 2 minutes while installing the positive opposite of the phobia. He could clear his three hybrid phobias simultaneously while focusing on the third hybrid phobia, "I'm afraid and ashamed to change – to own, accept and believe that I am a composer/musician because I would have an inability to connect with God and that means that I am lost and am a creative wannabe/a fraudulent charlatan, a cheat and a thief ". To facilitate the healing he had to focus on the most recent example of the phobia, which was his day at work. He chose the Callahan Phobia Technique as the highest priority intervention and did it for 3 minutes. Lastly, he cleared his anticipatory phobia with the stress release technique and the colour orange for 2 minutes.

Bam had to clear one phobia at a time. With his first fear phobia ("I am afraid to change and set realistic goals and accomplish them in the next six weeks because I will commit suicide by jumping off a bridge into traffic") he had to focus on the worst example which was psychological tests in school. We talked about how it influenced him now when

he had such difficulty filling out the tests. He picked the Callahan phobia Technique and immediately said he felt the phobia in his hands, back of his neck and his right knee and foot. We tapped for about 3 minutes and afterwards he could not remember the phobia, not even when I repeated it. He did not feel it in his body and gave it a SUDS of three. To bring the SUDS down to zero he picked NBD and “the watchmen in the tower” which he did for 7 minutes. He started to laugh and said the SUDS were down to a zero.

After he mapped out his second phobia ("I am afraid to change and set realistic goals and accomplish them in the next six weeks because I will have a wasteful life and commit suicide"), he went directly to the intervention of choice, UF/O holding, as he did not have to focus on a specific example. He muscle tested that he needed prayer and the colour yellow with the UF/O holding and needed to do it for 2 minutes.

He cleared his anticipatory phobia (“I am afraid and ashamed that I will fall back on bad habits and not learn from this healing”) with NBD for 3 minutes where he tapped out the anticipatory phobia scenario. He started to laugh while we were still tapping and said he did not believe that and wondered why we were tapping on it.

Mr Blue cleared his two fear phobias simultaneously with phobia number two: “I am afraid to transition and be more focused, patient, relaxed, prepared and ready for work and success in my business because I will see only blank and have no solutions and possibilities.” He did not have to focus on a specific example to clear them and picked HRT, crossed hands over the heart with the colours blue and green, as the highest priority intervention. It took him 2 minutes and he reported that he felt good and energetic afterwards. He remembered that he felt so tired and powerless when we started that he could not even lift his arms. He chose Reversal/Conflict tapping (for 2 minutes) as the highest priority intervention to clear the hybrid phobia: “I am afraid to transition and be more focused, patient, relaxed, prepared and ready for work and success in my business because I feel I want to die and that

means that I am a total loser.” He did not have to focus on a specific example of the phobia to clear it.

Peggy Sue cleared both her fear phobias with the second one where she “will wither and die by herself” and had to focus on the most recent example where her husband humiliated her in public. She did the boundary tap for 2 minutes. She installed boundaries with her husband and let go of the emotions of fear, anger and sadness. She also installed boundaries with her daughter with the boundary tap for a minute and she let go of the emotions of sadness and fear.

She could not clear her shame phobias simultaneously and had to clear number three, “I am ashamed to change and move fearlessly forward with my life because it means that I am a money grabbing whore,” first. She did not have to focus on a specific example and proceeded to clear the phobia with the Reversal/Conflict tapping for 2 minutes.

Next she cleared the shame phobia where she felt like a “worthless slut” with I feel/I am (“I feel morbid, I am fulfilled”) for a minute. She cross cleared phobia two (“I am a worthless creep”). She felt a bit “woozy” and did UF/O holding with blue light for 2 minutes.

Tallulah cleared all her phobias simultaneously with the shame phobia of her being a “crazy, out of control, evil lunatic.” This was the most difficult phobia for her to map out and she had to talk about it again. She focused on the worst example when she had to “act crazy” in a love relationship so that her then boyfriend could accept her. Her intervention of choice was the Callahan Phobia technique which she did for 4 minutes. She was laughing and felt good, but also felt a bit dizzy and she did UF/O holding for 2 minutes with a blue light and purple light coming in through her crown chakra. She used the purple light to forgive others and herself. Afterwards she mentioned that she felt good and felt “things” moving through her stiff hip which made a “pop” sound, and which felt like a release. Although she was cleared on all her phobias, she was not a 100% cleared on the conscious level on her goal.

She needed to speak about it for about 5 minutes where she saw eye glasses and realized that she could see clearer now and spoke about her new images. She was also not cleared at the body level on the goal and picked the intervention I feel/I am (I feel conquered, I am co-operative) for 2 minutes.

The interventions themselves might have taken only a few minutes, but to get to the point of readiness for the interventions, the participants still needed to talk about their issues and had to be muscle tested. All of the participants showed a strong muscle testing response after the treatment.

#### **4.2.4.7. Subcategory 22: Resolution of phobias**

All the participants' phobias were resolved after the treatment on the body, conscious, unconscious and soul levels; this was confirmed through muscle testing. They were all a 100% balanced on their goals on all four levels as well. For some participants, it took longer to resolve their phobias, because they felt compelled to talk about the realizations around the phobias, the origins of the phobias and the examples they needed to focus on in order to resolve the phobias. Bunny, for example, mentioned that none of her symptoms improved with her chiropractor and other treatments she received.

The treatment effectiveness is discussed in the next category by looking at the participants' statements and their written learnings.

#### **4.2.5. Category 5: Treatment efficacy directly after treatment**

Immediately after the phobia resolution sessions, all participants had new and different perspectives about their phobias and their goals. They all experienced an improved attitude towards living and felt ready to move on. Changes were noticed on the emotional, mental, physical and spiritual levels.

Six participants mentioned that they felt good. Feeling calmer, more relaxed and at peace were also common statements. After treatment Grace, Michael, Peggy Sue and Tallulah were very appreciative and grateful.

Grace, Michael, Bam and Peggy Sue said that their phobias sounded silly, ridiculous, untrue and made no longer sense to them.

Laughter and smiles were symptoms that stood out when a phobia was resolved and Elizabeth and Bunny giggled a lot.

After the phobia resolution Jane, Bam, Peggy Sue and Tallulah, could feel the difference in their bodies. After the treatment Jane yawned and mentioned that her back pain was gone, Bam did not feel pain in his feet, knee and leg anymore, Peggy Sue's shoulder felt better and the pressure on Tallulah's side was gone.

Five participants (Elizabeth, Bam, Mr Blue, Peggy Sue and Tallulah) mentioned that they felt more energized and Jane and Grace's voices sounded stronger and clearer after treatment.

After treatment Grace, Peggy Sue and Tallulah had a need to speak about God, Bam realized how God and Jesus Christ plays a role when people realize and resolve problems and Michael mentioned God when he wrote his learnings. Bunny who described her religion as "Love everybody" felt a lot of love after her treatment.

In subcategories 23) participants' statements and 24) participants' written learnings, the participants state their opinions and new awareness after their treatments.

#### **4.2.5.1. Subcategory 23: Participants' statements**

Angie started to notice a difference after her first intervention. She said that she could see herself working purposefully now instead of not wanting to even look for work before.

After her second intervention she noticed that she felt even better than after the first intervention. She smiled and said she felt calm and relaxed. She saw herself turning her back

on her fear and moving forward purposefully. She realized that she had a choice where she could use her fear for her own good or do nothing with it. Moving towards a purposeful career felt clearer and less overcast.

After her last intervention Elizabeth started to giggle and smile and said she felt good. She also noticed that she had much more energy. She further mentioned that she felt alive, something she has never felt before. She said that she felt different and peaceful and “had a smile and will be smiling all the way home.”

After Bunny’s last intervention during her first treatment she giggled and said she felt positive, relaxed and more peaceful “like the birds outside.” She thought the last intervention might help to influence her artwork. She noticed that she felt great and thought this was perhaps how “regular” people must feel all the time. She did not feel so attached to her new boyfriend after her first treatment, but that feeling did not last until the next session two days later.

Throughout her second treatment she continued to experience a range of emotional and mental states and laughed and cried many times throughout the session. After an intervention, she would range from feeling nothing, to curiosity and anticipation, to her issues seeming further away. She had new perspectives and became more accepting of her mom and could love her without having to change her. Towards the end she felt better, calmer and at peace about herself and life and said that she felt a lot of love. She felt there was a bigger possibility for her to “change and be on this planet.”

After her first intervention, Jane immediately mentioned that she felt “good,” “calm” and “relaxed.” When she was asked to now think about the worst example of her phobia, she said that she felt good and calm about it. She yawned a lot afterwards and her voice was strong and no longer a whisper. When I asked her how she felt about her goal and if she

thought she could focus in school now, she said “I am kind of excited to go back to school now.”

Grace mentioned that she felt neutral, strong, clear, confident, peaceful, calmer and more relaxed after her treatment. Her voice was strong, she sat up straight, and did not cough as she did throughout the treatment. She laughed a lot when she spoke about her new insights, what she did in her life and her responsibilities. With her new insights she could draw clear correlations and saw connections between life events where she had no realization before. She said she now took more responsibility for the role she played in life and did not see herself only at the effect of people and situations. She said the phobias were all lies and she realized that she made this all up. She laughed a lot and was very thankful, grateful and appreciative and said this work will help her greatly as a certified grief specialist.

Michael was amazed about what he said before about himself and his work and now had a totally different perspective on his goal. He laughed and thought that his phobias were ridiculous. He mentioned further that he felt “pretty good” and lighter and voiced his appreciation and gratefulness for the process. He said that he chose to be at peace and one with the natural world around him.

After Bam’s first intervention, he could no longer remember the phobia. After his second intervention, he started to laugh and thought his phobia sounded silly when I read it back to him. He felt exhausted after his third intervention and thought the particular phobia he just cleared sounded silly and contradictory. After treatment none of his phobias rang true anymore and they made no sense to him. He said he did not want to believe the phobias anymore as they don’t serve him and they sounded terrible. He had new insights and had a great need to vocalize them. He was amazed that his problem “got solved” and mentioned that he now realized that the problem was not as huge as he thought it was and that all his



problems can be solved by himself and with the help of others – “so we can solve anything.” He said he felt great, smiled and laughed and mentioned that he felt that he now had very high energy. He further mentioned that he felt optimistic, was content and ready to go forward fearlessly with courage and joy and be present.

After the treatment, Mr Blue felt great, optimistic and energized about his goal and he felt it could be done.

Peggy Sue felt better and noticed that she had less tension in her shoulders after her first intervention. After treatment none of her old phobias made sense to her and she felt energized. She said she saw the gate coming up and the horses were running out – meaning the obstacle, the gate, had been removed. She was highly appreciative, wanted to talk about God and get more information about nutrition and energy psychology.

Tallulah started to laugh after her first intervention and said she felt warm, good and light. After the treatment she laughed and said she felt very hot and thirsty. She felt good and very “up” and needed to stretch. She was very appreciative and grateful and mentioned that she was ready to heal others and stop watching from the sidelines.

After treatment the participants were requested to write down their new awareness. This process brought further new insights to themselves and me.

#### **4.2.5.2. Subcategory 24: Participants’ written learnings**

All the participants wrote their new awareness and thoughts down as “learnings” after the treatment. A few quotes from the participants follow to illustrate the point.

All of their statements were positive and different from their viewpoints before the treatment and fell under two sub-subcategories: 1) Greater self-awareness; and 2) Optimism about the future and new possibilities.

#### **4.2.5.2.1. Sub-subcategory: Greater self-awareness**

Elizabeth, Jane, Grace, Michael, Bam, Peggy Sue and Tallulah had a greater and a new positive self-awareness.

*Elizabeth:*

I feel pure and alive, I feel happy.

I have learned that I can be okay.

*Jane:*

My back feels much better

*Grace:*

It is true that I am loving, capable, competent, worthy, deserving, safe and giving.

I am giving, have a true gift to offer, safe to be seen and am cared for.

I can step into my truth, into the light.

I am worthy and deserving of a deep, loving, passionate love.

I am safe! I am free!

*Michael:*

I am an open, creative spirit hearing and receiving the music of God and passing it through my soul and beyond for any or all to enjoy – or not – with no conditions or needs placed upon them other than the hope that they might “hear” a melody within their own hearts.

He said that he did not think this a couple of hours ago.

*Bam:*

I have an awareness that what will be, will be.

I am present and aware of what I need.

*Peggy Sue:*

I have personal growth, love, fulfilment and power.

This is about soul movement.

*Tallulah:*

I am worthy, a healer, blessed, real, loved, great, healed, beautiful, trustworthy, and abundant and I am here to do my business.

#### **4.2.5.2.2. Sub –subcategory: Optimism about the future and new possibilities.**

Angie, Elizabeth, Bunny, Jane, and Mr Blue were optimistic about the future and new possibilities.

*Angie:*

I move forward towards being a purposeful and productive person.

I acknowledged and identified my phobias and I am ready to move on.

*Elizabeth:*

There is someone out there for me whom I will connect with and fall in love with when the timing is right.

She mentioned that she really felt this.

*Bunny:*

I feel more hopeful about possibilities for transformation in life.

*Jane:*

I'm excited to go to school and see my focus levels.

I am hopeful to get my grades up and start doing better in school and take care of myself.

*Mr Blue:*

Things may be hard or seem impossible but they are not and I can do it (be successful in my business) because I am smart and successful and I am not a failing loser.

#### **4.2.6. Category 6: Treatment efficacy one week after the treatment**

Six of the participants were available one week after the treatment for their first individual telephonic follow up interview (Appendix R). The remaining four participants were interviewed no later than two weeks after the treatment. Reasons for the delay included illness and travelling schedules.

The follow up interviews took from fifteen minutes to an hour. Each individual follow up questionnaire was crafted from the information gathered up to this point (Appendix R). The participants were not muscle tested again to test the resolution of the phobias, but answered questions about the effects of the treatment.

All participants were willing and able to complete all four psychological tests (Appendix J) after the interview.

Treatment efficacy one week after the treatment will be discussed under 9 subcategories: 25) Emotional changes, 26) Mental and behavioural changes, 27) Physical changes, 28) Changes in spiritual awareness, 29) Interpersonal and social changes, 30) Occupational changes, 31) Progression towards participants' individual goals, 32) Participants' unresolved issues and 33) Measured changes in 4 psychological tests.

##### **4.2.6.1. Subcategory 25: Emotional changes**

The participants experienced a wide range of emotions and all, but Bam who found it difficult to access his emotions regarding his change and phobias, experienced positive changes.

Eight participants experienced a positive change on an emotional level. It was difficult for Bam to access his emotions regarding his previous issues. Grace mentioned that she did not notice a remarkable difference, although peace stood out as a dominant emotion for her.

The new feeling of peace also stood out as a dominant emotion for the other participants.

Nine of the participants' levels of distress and anxiety improved (Bam could not access his emotions) where Grace mentioned that although her level of anxiety was still high, she experienced it less often, which was an improvement for her and Michael did not even mention his levels of distress and anxiety.

Nine of the participants had an improvement on their fear levels (Bam could not access his emotions). Grace still had fear when she thought about her divorce, but the moments of fear were less and her fear of rejection regarding her divorce improved. Michael's specific states of fear, fear of imperfection, rejection and failure, all improved significantly. Tallulah had no longer a fear of success and Bunny's fear of rejection was not on the foreground of her conscious anymore.

Elizabeth, Jane and Mr Blue no longer experienced anger, Grace's level of anger improved and Angie said she handled her anger differently.

Elizabeth and Peggy Sue no longer experience any frustration, Angie and Michael's levels of frustration improved and Mr Blue only had fleeting moments of frustration. Bunny did not mention her feelings of frustration any longer.

Elizabeth and Tallulah no longer experience any sadness and Grace and Peggy Sue's levels of sadness were reduced.

Angie and Elizabeth no longer experienced any depression, Jane's depression improved and it was difficult for Bam to access his emotions, including feelings of depression.

Angie, Elizabeth, Grace and Tallulah had feelings of gratitude for the treatment.

Mr Blue and Tallulah experienced no stress relating to their specific situations.

Most of the participants could scale their emotions by using SUDS.

When Angie was asked to think about her change, the back problems, the surgery and the consequences, and scale her distress, anxiety and fear, the SUDS levels were down from 8 to 4 on distress and from between 7-10 to 3 on fear and anxiety. She was less annoyed with people (from 9 to 7) and less impatient (from 7 to 5). She handled her anger differently and instead of being reactive and giving into her frustration, she could now bring herself back to being calm, talking to herself and remembering a time when she was tolerant. Her levels of frustration went from an 8–10 to 3 and she added that it changed and that it was in the past and that she now had more an attitude of “what happens now happens now.” She said that she might feel down, but not depressed, and on a SUD scale it was now at a 3, while it was 8 before. She saw her lows as balancing out the highs and therefore wouldn't label it as depression. She had feelings of gratitude for the treatment.

Elizabeth felt calmer and happier and her friends even commented on how this new calm state was not normal for her. She was not upset at all when she heard about her ex-boyfriend's new girlfriend. She said that she had no shame, worry or guilt anymore – “it's in the past” and she felt more confident. Her distress, anxiety and fear were at a zero when she thought about him and the break up, where it was at a 9-10 before. Her thoughts were on college, which she no longer feared, and she mentioned that it was – “weird that I don't feel

fear.” She saw things differently and realized overanalysing created stress and worry. She further felt no depression, anger (was 7), sadness or frustration where they were at a 10 before. She said it was “weird and cool” to feel happy. She was scared (at a 10 before) that she would never fall in love again, but now that fear was gone. She did not fear change anymore (where she used to be paranoid about change all her life) and felt a big change was coming and she was ready to see where her life was going – “I am ready for the next chapter in my life and am excited to see what will happen in my new school.” She felt very grateful and said “one time with you has changed my life.” She showed continual gratitude since the treatment through emails and text messages where she mentioned that she felt calm and at peace and remarked that “you really saved my life.”

Bunny reported that she felt better since the treatment. She did not feel hopeless and consumed by her new romantic relationship anymore and her fear about the longevity of the relationship was at a 3. Her distress about her new romantic relationship with a much younger man went from a 7 to a 5, her anxiety went from 10 to 4 and her fear went from a 10 to a 3. She felt no more distress (7 before) or anxiety (was 10) when thinking that a new romantic relationship might lead to marriage. She did mention that her anxiety would be at a 7 if she did not get it. Before the treatment she was very worried that she would not find a real life partner, but now she did not know and said that it might be a concern, but that she was not feeling it acutely. Her fear of rejection which was high at a 10 was not on the forefront of her consciousness as we spoke and she said although it was there, it was “behind the scenes.” She did carry anxiety at a 5 about the possibility of her partner judging her and their age difference. She did not mention experiencing feelings of frustration (8 before) and worthlessness (9 before).

Jane’s distress and anxiety went down from a 10 to a 4 and her fear went down from a 7 to a 5 when she thought about her move. She did not get angry and snap at people anymore.

Her depression went from a 9 to a 5 and she felt much better because she did not only see dark anymore and instead was trying to look on the bright side. She no longer felt sorry for herself. She was now putting her focus and energy on things she could do and that were good for her, instead of feeling sorry for herself, even when she did not have money. She said she just stayed positive and knew something would happen. Her feelings of discouragement went from a 7 to a 5, but she still felt a bit discouraged because the competition of getting into law school was very high. Her feeling unmotivated reduced from a 9 to a 3. She was instead motivated to prove everyone wrong and show them that she was not this depressed person they could walk over. She felt less down (from 9 to 5) and was looking forward to future changes and was excited for another move. She did not fear change any more, but rather wanted another change and felt prepared for any change.

During Grace's first follow up, she could not discuss the questionnaire and just spoke about her newfound spiritual awareness.

During her second follow up interview, one week later, we could continue with the questionnaire and explore her emotional changes. She said that she did not see a big improvement emotionally. She still felt depressed, as she did not want to do much and experienced sadness, guilt, shame and pain on a SUD scale between 7 and 8 when she thought about the divorce. She did mention that her sadness was reduced and of a different quality. Her feelings of loss and regret stayed the same. Her anger and resentment, which were at an 8 before, improved to a 6 and 7 respectively. Her fear of rejection improved from a 9 to a 6 when she thought about her divorce and it was at an 8 when she thought of a new occupation. When she thought about her divorce her distress was at a 7 (an 8 before), but her fear and anxiety levels still averaged at an 8. The moments were fewer and she continued to say that in general she felt that her anxiety levels were lower and that she was not in a hyper state anymore. She could let go of some of the hurt and when she thought about the divorce



her insides felt less twisted. When questioned about inner peace with her divorce, she said she still thought about it, felt confused, questioned herself about her decision and she felt regretful. Although she did not want to admit it, she said that she did feel more peace, acceptance and understanding of what happened and then said: “I want to argue with you and myself and say I am not more peaceful, but I do feel more at peace!” She then expressed her gratitude for the work we had done.

Michael said that his fear of imperfection was at a 0, where it was a 9 before. His fear of rejection which was very strong, was now very slight, almost non-existent – 1 to 0. Instead of feeling frustrated at 8 about his musical goal, he experienced it now at a 2 only when there was something he could not do. He was pleased at his “amazing progress” and felt a lot of faith that it will all come together. He was surprised when he was reminded that his fear of failure was at a 9 and said it was “way, way low now” at a 1. He further did not feel dissatisfied about getting his work out there, but rather disappointed in himself and disbelief that it took so long.

It was difficult for Bam to access his emotions regarding his change and he was hopeful that he would be less nervous and worried about future situations when a work contract ends and he will face unemployment. He had house guests since his treatment and he said he could get through it without a meltdown. He said that he felt more confident and comfortable in general.

Mr Blue said his levels of stress and anxiety, relating to his business, were very low to non-existent. His feelings of frustration were 0 to 1 and he did not feel grouchy and irritable anymore and therefore did not snap at people. When he had fleeting moments of frustration, he could look at it differently and he felt that his new perspectives overrode his frustration. Because of his lack of anger and frustration, he did not create additional problems at work.

His anxiety (9 before) when he thought about his effort and lack of reward were at a 0 because he had peace and a knowingness about the situation. He realized the situation was moving forward as it should and he handled the situation as it was and not as he expected it should be. He felt no fear (10 before) when he thought about himself moving into the phase of transition towards becoming a businessman. He was anxious and excited for it to happen, instead of being fearful for it to happen. He felt conscious and aware.

Peggy Sue said her overall fear which was a 10 before was going away and was at a 4. She felt emotionally stronger and everything was not fear based for her anymore –“I am not feeling it”. She mentioned that she was finding joy again and was even joyful about their upcoming cruise, something she never felt joyful about before. She experienced no feelings of panic, even when she was in conflict with her husband. She did not feel stuck and fearful to strike out on her own and had no more fear to have her own opinions. Her distress, anxiety and fear levels which were at a 10 before regarding her transition into becoming a retiree were now at a 4. She added that she felt really blessed to have this time and so many options. There were no feelings of devastation left with regards to not having control of her life and she felt surer in her walk of life where she saw herself moving forward one baby step at a time. Her sadness shifted from a 10 to a 3 and she did not feel upset, fearful and frustrated (were all at a 10) anymore because of her lack of forward momentum. Instead she felt a lot of love and caring for herself. She was also more forgiving towards herself and she felt that her heart was opening “like a lotus flower”. She did not see herself “falling down a big black hole, full of oil in the centre of the earth”, but was now sitting on top of the dark hole. She was able to see all the goodness in herself and it made her feel less restless, and more accepting, loving, non-judgmental and peaceful. She was no longer anxious about her life and felt that what will happen, will happen because “all is in God’s timing”.

Tallulah had peace of mind and could think about the same situations without feeling any pain. The absence of fear and emotional pain was at first scary to her because she was not used to it – “like it was not normal” - but now it was nice. Her fear did not hold her back anymore and she no longer worried about everything – “I do something instead of worrying.” She experienced the lack of worry and the more relaxed state as a bit scary because she was used to just being worried before, unable to think of a solution. Her distress and fear, which were at a 7, and her anxiety, which was at a 6 before the treatment, went down to a 0 after the treatment, but went up to 2 after she spent some money. The stress about her situation was gone though. Her not knowing what the future might hold and feeling it at a 10 (“it gets crazy”), was down to a 0, because now she could breathe and relax and think about it, even though she might not have the answers. Her sadness levels also went down from a 7 to 0-1. Her fear of success was gone and she did not feel unaccomplished or uselessness anymore. Tallulah was very grateful, and in a thank you card she mentioned that it felt “like the weight of the world has been lifted off my chest...literally. The pain I felt is not there, I feel liberated and free to now inspire.”

Table 4.9 represents which participants improved on the mental, behavioural, physical, spiritual, interpersonal, social, and occupational levels after treatment during the first follow up.

**Table 4.9: Mental, behavioural, physical, spiritual, interpersonal, social, and occupational improved changes one week after treatment.**

<b>Levels of Improvement</b>	<b>Angie</b>	<b>Elizabeth</b>	<b>Bunny</b>	<b>Jane</b>	<b>Grace</b>	<b>Michael</b>	<b>Bam</b>	<b>Mr. Blue</b>	<b>Peggy Sue</b>	<b>Tallulah</b>
Mental	+	+	+	+	+	+	+	+	+	+
Behavioural	+	+		+	+	+			+	
Physical	+					+		+		+
Spiritual	+			+	+	+			+	
Interpersonal & Social	+	+	+	+		+	+		+	+
Occupational	+	+		+	+	+		+	+	+

#### **4.2.6.2. Subcategory 26: Mental and behavioural changes**

All participants were aware of intrapersonal changes unique to their situations since the treatment. This awareness falls under two sub-subcategories: 1) Awareness of mental changes: new thoughts and beliefs and 2) Behavioural changes.

##### **4.2.6.2.1. Sub-subcategory: Awareness of mental changes: new thoughts and beliefs**

The participants had new realizations, perceptions, thoughts and beliefs after the treatment which had an influence on their attitudes. An attitude of acceptance (of their situation) and allowing (their lives to unfold) was noticeable in most of the participants. It was especially noticeable in the language of seven of the participants. Angie said “things can work themselves out as she was going with the flow of life,” Elizabeth said “it will happen at the right time” and “everything will happen the way it is supposed to,” Bunny said she felt more allowing and stated that she could “allow a relationship to happen when it needed to,” Grace was more accepting which reflected in her statement that “things are as they are,”

Michael said “it will be perfect the way it is,” Mr Blue “believed that it would happen at the right time” and Tallulah stated that “answers will come at the right time.”

Six of the participants (Angie, Elizabeth, Jane, Mr Blue, Peggy Sue and Tallulah) mentioned that they felt they had more clarity, focus and experienced an improvement in their concentration. Tallulah added that she felt less confused and Grace mentioned that her decision making skills improved.

Six of the participants (Angie, Jane, Michael, Bam, Peggy Sue and Tallulah) had increased confidence where Michael no longer had any reluctance or hesitation to share his work with the world.

Angie, Bunny, Jane and Peggy Sue felt more positive after the treatment and Elizabeth and Michael felt “good enough” and deserving of their dreams.

Four participants (Angie, Bunny, Peggy Sue and Tallulah) were open to exploring new possibilities about themselves, relationships and new life directions. Grace mentioned that her mindset was changing.

Angie and Peggy Sue mentioned that they were no longer “stuck” and could move on from where they were and Elizabeth said she already moved on from the situation that created so much pain and procrastination for her.

Angie said she felt lighter and more stable. She felt no longer stuck, as if she could not move through her limitations. She felt very positive and she appreciated the treatment process and said it helped her to stay focused. She also mentioned that she now saw the “clicks” and correlations in her life. Instead of being reactive, she now had the ability to look inside herself and ask herself what triggered her before she would react to a situation or person. Her confidence levels were very good (instead of feeling that she lost her confidence

- before treatment) and she questioned herself less. She felt more balanced and thought things can work themselves out as she was going with the flow of life. She was exploring possibilities to get more clarity of who she really was – “perhaps I am not who I thought I was.” She wanted to eat better and realized that she wanted to start cooking again.

Since Elizabeth was not over analyzing everything anymore, she said she could handle stressful situations much better. She did not feel “spacey – like on a cloud” anymore. Instead, she felt grounded and present. Her current focus was on herself, her own relaxation and her passions and dreams, instead of on her ex-boyfriend. She did not think about her ex-boyfriend at all. She realized that it was not real love and that he was just thinking of himself and was holding her back. During their relationship she lost her passion for fashion and her desire to become a fashion designer. Now the past is the past for her and she said “I have moved on.” She realized she was good enough as a person and deserving of her dreams and real love – *her* definition of love. She just wondered what would happen with her love life and with whom, but she also realized it (a romantic relationship) will happen at the right time as this was not the right time for her because her priorities had shifted. She mentioned in her email messages to me that “I know everything will happen the way it is supposed to and I know I will be okay.”

It was easier to focus on what was important to her, like her grades, her job, and getting into a good school.

She further mentioned that she never felt truly alive before and wanted someone else to make her feel alive, but she realized now that she could make herself feel alive.

Bunny was feeling more positive; more allowing where she believed she could “love whomever she loved” and accepted people for who they were versus her thinking before that she should not lower her standards and settle, but had to wait for the perfect match. She said that a lot of the pressure she felt had been relieved and she could now allow a relationship to

happen when it needed to and that she could take a deep breath and relax into her current relationship. She was still distracted by the relationship, but experienced less obsessive thinking (5) and rather thought about her new and young boyfriend in a more relaxed way. She was grateful that she met him and she had hope for new possibilities in the relationship and had hope that her relationships not always had to end. She could see herself moving from being single into being married – “whoever it will be, will be good, it will meant to be.” She felt happy that she had someone to love and thought they had a “cool” connection.

Jane reported that she had more clarity and confidence since her treatment and was sure about her future plans. She now felt focused and more prepared for her life in general. She reported that her focus and concentration was better in school, and she was more motivated to study, which improved the efficacy of her studies. She felt comfortable with herself and did not doubt herself and her future success anymore. She did not feel that the move broke her anymore and felt more positive about life.

During her first follow up interview Grace stated that her mindset was changing and she had a deep desire to understand things better. She continued to tell that she thought differently about her deceased dad and son, as well as her husband. The many new thoughts and awareness made her felt scattered and she therefore had a need to talk about it for better perspective and clarity. She further mentioned that she felt powerful and strong the first day after the treatment, but the following day after an ill-fated massage she felt terrible and felt “everything” was triggered again.

She was unable to answer the questionnaire as she only had a need to talk about her new found spirituality. To be able to get answers from the questionnaire, another follow up interview was scheduled in a week.

During Grace's second follow up she focused on the difficulties she still had, but as the interview continued, she started to realize the positive changes in her and was aware of new ideas coming to her.

She was starting to get inner realizations where she realized that she had never mourned her mother's death. She also realized that nobody ever apologized to her and that her experiences and feelings were always discounted; she realized she might have done the same to her daughter and as a result apologized to her.

She found that her decision making skills improved and she felt clearer.

She started to see the role she played in the disintegration of her marriage and she did not blame her ex-husband for everything anymore. She mentioned that she now had new and heightened awareness about her marriage. Before the treatment they were individual memories, but now they are linked and tied together and she could see the correlations of events, which created greater clarity about her husband's behaviour, their marriage and divorce. She cried as she said the progression of weaving the story and making sense of it was a painful process. She also had more awareness of the repercussions of the divorce and the paralyzing effect it had on her life. She said she was able to realize and accept her new reality now; he was living his life with his new wife and was happy and now she got to live her life.

She realized "things are as they are and I just realized this acceptance is bringing me to peace," but at the same time she wondered if she will only feel *total* inner peace when all the fear and anxiety is released around the divorce or if she should just step into peace now.

Michael came back from a successful business trip and realized that he was not hesitant or reluctant to share his work with the world anymore and he was ready to take the right steps in the right direction and was clear about what the steps were. He was laughing about his previous statement that he had to wait for his piece to be perfect before he could



release it; instead he was thinking “Its perfection will be in itself, not how I want it to be. When it is released, it will be perfect the way it is.” He could not believe that he said “It is crazy to share my work with the world because they could decide if it was precious or not.” He believed that his work was good enough and he no longer had a “steady resistance” to get it out there – “this is the time, it is going.”

Instead of getting down on himself, he now liked himself, was patient with himself and at peace which resulted in better work. He did not feel like a fraud and illegitimate composer anymore as he was no longer frustrated with his inability to read music. It did not concern him any longer and he realized that many people in the music industry did not have this ability and he thought it was an unnecessary language for him.

He was willing to cooperate with people who were waiting to help him and could see himself collaborating with people to produce shows.

Bam now valued his work experience and felt more confident competing with younger people. He felt he can work together with them and could see how his work experience and skills complimented their technological skills. He had a “glimmer of hope” that he could now “hold himself better against them” and did not feel the same intensity about his belief that he is too old to find a job and the younger generation is better qualified and has more to offer. He felt more comfortable with the idea of surviving his unemployment periods, although he would like to experience the real life situation to confirm this.

Mr Blue still felt a bit worried about his honour and reputation being tarnished in his industry, although he said he was “1% more protective than worried” and was just conscious about it now. He said his focus was better and he had a high level of clarity. He no longer felt as if all his efforts were in vain. Instead of believing that his product production would never happen; he believed that it would happen at the right time.

Peggy Sue said her core felt more solid since the treatment and she felt strong enough to believe in her own power. She did not feel like a beaten up wimp any longer and saw herself as much, much stronger and as coming out of a cocoon. She said she definitely felt self-confident and more secure on her own and could stand her ground with her husband and children. She started to realize that everyone, including her family, had their own issues and she had hers too and it was okay. She was not relying on her family to meet all her needs and she was starting to meet her own needs – “I am becoming unstuck!” She noticed that she was starting to be herself again and was becoming more independent.

She reported that her focus and attention span was "50 % - 60%" better. She also felt because she was not moving forward at a frantic pace, that she was able to think about things, prioritize and organize better. The “fingernails on a chalkboard feeling” was going away and she said she was letting go of her stories. Instead of being in her dark hole, she saw herself sitting on the top where she started to have control over things. She had a more positive attitude and felt that her perspectives were getting healthier where she realized how good she had it in comparison with others.

She also felt better about herself and her aging process and could accept her more mature looks and felt motivated to take better care of herself.

She felt sure in her walk of life and no longer experienced disappointment in herself as she realized that she had done what she wanted to do with her life. She had wanted to have a family and to care for them, but she also realized that it was no longer her role. There were many new opportunities waiting for her during retirement and she saw retirement now as having a lot of choices. She did not feel like a caged bird anymore because “the door opened and she was sitting on the roof of the cage” and she wondered if she should fly or not. This was a new feeling of freedom she had not experienced before.

Tallulah spoke easily and freely and was not so involved in the answers, almost like she lost interest in the issue. She felt a “transition in her mind” and saw things differently and said she was maturing. She said before the treatment she had no direction and felt almost hopeless, but now she did not feel lost anymore. She did not know where she was going with her life, but she did not worry about it because she realized that this was “a time to recoup and the answers will come at the right time.” She said she felt more confident in her decision making as she felt more grown up and not like a small, scared child anymore. Because she had more mental clarity, she could focus on the outcome she wanted and was open to different solutions and possibilities which made thinking about a solution much easier.

#### **4.2.6.2.2. Sub-subcategory: Behavioural changes**

The new mental awareness brought new behaviours to seven of the participants.

Angie spoke easily and fluently during the interview and shared a lot – before treatment she had difficulty speaking and did not have a lot of energy. She continued to say that if she needed rest, she allowed it without questioning herself too much and she felt refreshed afterwards. She did not have the overwhelming feeling to sleep in the afternoon anymore, and if she did take a nap it was because she needed rest and not because she was depressed. If she had physical pain, she would “check in on her pain,” speak to the pain, and used visualization to help move the pain out.

Elizabeth could now sleep or take a nap and feel good, relaxed and refreshed afterward. She no longer spent time with unsavoury characters just to have company, she no longer had indiscriminate sexual intercourse, and she no longer drank, took drugs or partied endlessly. She now preferred to stay at home by herself or to spend time with her family and a few selected friends.

Although Jane had been sick (flu), she was trying to eat better, but had not been able to exercise. She also studied more.

During her second follow up interview Grace felt she progressed when she asked someone to help her with her taxes and was able to choose a new bank and open an account. The help and direction created clarity and she felt she could move forward. She was also starting to keep her commitments. She started reading *The Artist's Way*, which helped her to realize her negative thought patterns and made her aware of the shifts and changes in her. She started to see the beauty in things and she became more creative.

Michael surprised himself on his business trip when he told people (for the first time ever) that he was a musician and composer.

Mr Blue was more tolerant and no longer snapped at people at work.

Peggy Sue was moving at a less frantic pace and was taking everything slower, “cautiously moving forward” and allowing herself to enjoy everything, instead of overwhelming herself with too much on her plate.

She was able to monitor her opinions and was able to see when she had to voice them.

She got a better night's rest since she started to tell her body that she was going to sleep through and that it was unnecessary to get up every hour to urinate.

Although it took a bit of an effort to get started, she made herself run errands, walked for exercise, and took the dogs out on her own. She was starting to think about her garden again and bought a few plants for the gardener to put into the ground.

#### **4.2.6.3. Subcategory 27: Physical changes**

Six of the participants were aware of physical shifts one week after treatment.

Apart from feeling tired since the treatment Angie said she felt different; more positive and upbeat. It was easier to take her dogs for their daily walk. She started yoga and felt once she made up her mind and decided consciously to hold a strong pose for a longer period; she could achieve it. She was able to attend a two hour yoga workshop and it barely affected her.

Elizabeth no longer felt physically affected (feeling “sick in the stomach” and feeling like her heart was “dropping”) by her x-boyfriend and their breakup.

When Grace thought about her divorce her insides felt less twisted.

Michael said it was possible that the aches and pains in his legs were getting better.

Mr Blue felt less tired.

Tallulah’s digestive issues improved and she gained some weight (positive for her), her menstrual period returned and she did not feel the pressure on her side as much anymore.

#### **4.2.6.4. Subcategory 28: Changes in spiritual awareness**

Six of the participants were aware of spiritual changes and behaviours since the treatment.

Angie said she was getting out of her own way so the “Light Power” could come through her.

Where Elizabeth was consumed with seeing signs everywhere before, she said she might have noticed a sign once or twice since the treatment. She actually forgot about the signs until I mentioned it.

Jane was no longer angry at God and watched an online church sermon on the internet - something she had never done before.

During her first follow up interview, Grace was very talkative and could not stop talking about her spiritual awareness. I allowed her to speak and realized that it was not the right time to ask the planned questions during this interview (a second interview was scheduled to answer the questionnaire). She was especially focused on the word *grace* and started to research the meaning obsessively. She felt that she now had a new and deeper understanding of the principle of grace and Jesus Christ and it made her understand her tears better. She was starting to understand unconditional love and honour. During Grace's second follow up one week later (she had a total of 3 follow up interviews) she was aware of even more spiritual changes and awakenings as she continued to explore her relationship with God.

Michael was meditating more often.

Peggy Sue said God spoke to her about her family and she was able to just surrender them to God and love them. She said that one of the best things she got out of the treatment and her biggest shift was her ability to now surrender everything to God.

#### **4.2.6.5. Subcategory 29: Interpersonal and social changes**

Nine of the participants' saw their interpersonal relationships changed for the positive. There was no impact on Grace's interpersonal relationships or social life as it stayed good as before.

For some, like Elizabeth and Jane, it was easier to be on their own and Elizabeth actually preferred it.

Seven of the participants became more social; Angie and Michael said it was easier to converse with people and socialize, it was more comfortable for Jane to make new friends, existing relationships improved for Bam and Mr Blue, and Peggy Sue and Tallulah's social

lives improved where they met more people.

Angie, Jane and Peggy Sue felt more connected to people.

Elizabeth and Tallulah no longer feared people and Elizabeth and Jane's trust in people were restored.

Angie said she was more receptive now when people talked to her. She was in a more receiving mode and felt more connected to people. It was easier for her to converse and stay in the moment with someone, even when there were distractions. She was open to support from others and realized that she needed it. She could admit to it and allowed it without feeling threatened. She no longer mentioned the strain with her family.

Where Elizabeth was fearful to be on her own before, she now was "doing her own thing" and preferred to "hang out by myself" at home, instead of seeking the company of anyone available. She did not go out to drink and party at all and preferred quality social time with people who mattered to her, like her family and best friends. There was no more fear and distrust (was 8) toward people. She only distrusted people for her own protection because of her recent past and did not want to do the wrong things again. She mentioned further that people used to cause her stress, but they did not anymore.

Bunny did not feel that the change had an effect on her interpersonal relationships before treatment and was only triggered in social situations by couples who reminded her of her single status. She reported that it was easier for her to be around couples now.

Jane felt more like herself and this awareness made her feel less disconnected from people and made making new friendships more comfortable. She went out once (she was sick the rest of the week) and had fun. Because she felt better about herself, she did not feel left out or hurt when she heard that her friends back home had a social life. She still felt alone, but less than before. She did not feel that everyone was "out to get her" and that nobody

cared and therefore she felt that she could trust people more. She giggled when she said that she still felt a bit betrayed by people. She said she would still like to have a support system because she likes to hear other people's opinions and thought that was just her personality. She felt more independent from her parents, although she said she still needed them.

Michael said that it was probably easier for him to socialize because he made appointments with several people, something he did not normally do. He met with different people, including a musician with whom he could discuss a future collaboration. He also called someone back who wanted to help him and could listen to his suggestions.

Bam's social life was going well and he could enjoy his house guests without having a meltdown. He enjoyed taking care of them. His relationship with his partner was good.

Mr Blue's relationships with his business partners improved. There was open communication between them and they had made some commitments to move forward.

The negativity from Peggy Sue's husband was not affecting her as much anymore and she was not taking his negative comments seriously. She said that she was reacting to him in a more self-assured and confident way and realized a lot of his comments were projections. She could listen to him with compassion, but she did not allow his fear to overcome her, and she found she could discern whether his point was valid or not. She chose not to listen to his stories and ranting any longer and was able to cut him off at the appropriate time. She felt capable of sending him love, surrendering him to God and carrying on with her own affairs. She was starting to experience a stronger connection with her husband because of her changed attitude. She felt the joy and love in her marriage was starting to get better because she looked forward to going on the cruise with him.

She listened more to her family and felt more accepted by them. She did not feel that she had to comply with all of her family's demands and that they would reject and leave her if she did



not comply. She was cautious how she interacted with her children by being aware of the stresses in their lives. She was not needy for the interaction and love of her family anymore, but just wanted to interact with them because she loved them and enjoyed being with them – “I am not needy any longer, I just like it.”

She was meeting a lot of new people on her walks and felt more connected to people and felt carefree in her interactions.

Tallulah did not feel unsupported by her family and friends anymore and realized that she was not connecting with certain friends because they had children and she did not. She felt like a new person, who was open to know more people with new and different interests. She no longer feared getting closer to people and instead desired to build strong relationships with them. It also helped that she did not “pick up other’s emotions” anymore and that she now could listen and feel for people without “falling into their pain.” She was surprised that her social life had already improved and that she was meeting “better” people who supported her growth and new interests.

#### **4.2.6.6. Subcategory 30: Occupational changes**

Eight participants (Angie, Elizabeth, Jane, Grace, Michael, Mr Blue, Peggy Sue and Tallulah) felt the treatment brought occupational changes. Bunny was not focused on her career yet and she did not feel motivated to promote her work as she was still caught up in her relationship. Bam could not measure his occupational impact yet as he had not yet started his new work contract.

Angie felt open and ready for new possibilities. She had a lack of knowledge and experience and direction to pursue her exact career of choice in the healing field which created some frustration and anxiety. She started to read and practice *The Artist’s Way* and was exploring Neuro linguistic programming (NLP).

Elizabeth once again wanted to follow her dream and continue her studies in fashion design. Her focus and concentration was better in school and her attitude towards school improved. She was doing her homework and spoke to her teachers to find ways to further improve her grades.

She used to be scared at work, but she was happy now and was performing well there. She was making more money than she ever had before at the job and they gave her more shifts.

Jane's focus and concentration were better at school, and she was more motivated to study. Her grades improved and she felt more comfortable at school. She was looking forward to see what the future held and was looking at new possibilities in her study direction, including where she might transfer to a better university or study abroad for a semester.

Grace still had fear of rejection (6-8) regarding her level of competence in an occupation. She was starting to think about new possibilities and realized she would like to be a photo journalist. She was excited about this possibility.

Music as a final career was now a reality for Michael and he thought it would be a huge part of his next twenty years – “I feel and hear it in my bones.” He had a huge mental shift around his work as seen under Subcategory 26.

Mr Blue's improved mental, emotional and physical states improved his work situation where he did not create additional problems and stress between himself and his co-workers.

Peggy Sue realized that she did not want to be tied down during her retirement and wanted to embrace this new found feeling of freedom. As a result, she was no longer sure

whether she wanted to start her own event business or not. She was looking into different possibilities, a thought that scared her before.

Tallulah felt less confused about the crossroads (work or study) in her life and had more hope. In her thank you card she mentioned she was aware of “a new beginning and I know with all my heart a happy ending”.

#### **4.2.6.7. Subcategory 31: Progression towards participants’ individual goals**

Apart from progressive emotional, intrapersonal, behavioural, physical and interpersonal changes, all the participants also experienced overall progression toward their individual goals.

Angie was allowing growth to take place and felt she was moving forward. On her goal of “I would like to work in a meaningful and purposeful career,” she said that she was getting good inputs and insights and was ready for the change. Not having all the knowledge and experience was creating some frustration and anxiety for her because she would like to be effective in her career. She started to read and practice the exercises in *The Artist’s Way* to help create clarity and was looking into NLP training. She did not feel lost at all (it was at a 9 before treatment) and felt guided on her journey. She knew how to move forward and felt that she had “the wind at her back.”

Elizabeth was progressing toward her goal of “Letting go of the past with my relationship with my ex-boyfriend, A.” when she said that she was not only not thinking of him, but not thinking of men at all. She was glad and thankful that he was out of her life. She saw him unexpectedly at Easter and felt nothing to her surprise – “it was crazy, but good.” It was hard for her to even remember being with him. She wanted to be single and knew the right person would come when it is supposed to happen and she did not want to force a new

relationship or pursue a new man. She mentioned that this never happened before. She felt she was good enough and deserving of her dreams and real love. She felt that her life completely changed, so much that she could feel it in her body.

Bunny was moving toward her goal of “wanting a conscious, soul connection marriage for the rest of my life” when she said it now felt possible and that it will happen and that she just needed to be patient. She was not worried about getting a real life partner and was hopeful that her notion of “being single is my new normal” was changing. It was easier for her to be around couples and a part of her felt that a relationship might work and that her partner will not get tired of her.

Jane was in alignment with her goal of “I want to be focused in school” as she said her focus and concentration was better, and she was more motivated to study. She was doing better in school, her grades improved (she earned 100% on a test) and she felt more comfortable and prepared.

Grace was moving toward her goal of “wanting inner peace, (with her divorce)” as she was accepting her divorce and was coming to terms with her new found inner peace about the divorce, although she was still struggling to accept *total* inner peace about the situation. She found it hard now to even remember what happened and being married– “it is like a blank,” except when fear and anxiety would creep in occasionally.

Michael’s goal was “I want to own, accept and believe the title of composer/musician belongs to me” and he was not only actively working on his goal by composing music, meeting his deadlines and feeling free to share his work with the world, but he also called himself a musician/composer when he was asked about his occupation on a recent trip. He felt that he owned, accepted and believed this title and said “it was like a new coat and the

more I would wear it, the more it would fit and the more comfortable it would feel.” This title belongs to him now, he said.

Bam’s goal was to “Set realistic goals for myself to accomplish in the next six weeks, fulfil them, and move on.” He did something he was never able to do before - he sat down and wrote very specific goals about what he needed to get done.

Mr Blue felt that he moved forward in his business and felt that he progressed because he felt more comfortable about the financial situation, instead of feeling anxious, concerned and worried about it. He saw the situation now as part of the process which allowed him to handle the work and keep moving things forward. He felt no more stress and said “everything is where it should be now and how it should be.” He felt productive and active – “willing active and not forced active.” This brought him in alignment with his goal of “To be focused, patient and relaxed so I can be prepared for the work and success of my business”.

Peggy Sue said she could see herself moving forward towards her goal of “I want to be fearless with moving forward with my life”. She did not feel stuck any longer and felt no fear to strike out on her own and move forward with her life, and could do it with joy and gratefulness. She mentioned that “I don’t have the fear I had before” and felt great joy “like a kid at Christmas.”

Tallulah’s progression was congruent with her goal “I want mental clarity” where she felt that she had more clarity as she could “see” her thought processes and received clear messages about herself, the way she looked at things, understood things and what was happening with her and her life. She realized the messages must have been there before, but that she was unable to see them. Because she had more mental clarity, she could focus on the outcome she wanted and was open to different solutions and possibilities which made thinking about a solution much easier.

#### **4.2.6.8. Subcategory 32: Participants' unresolved issues**

The personalized questionnaires involved a section where the participants were questioned about possible issues that they felt were not resolved. Some of the participants mentioned a lack of progression in certain areas during this questioning. Their unresolved issues were on an emotional, mental, behavioural and physical level and are discussed under 3 sub-subcategories: 1) Unresolved emotional issues, 2) Unresolved mental and behavioural issues, and 3) Unresolved physical issues.

##### **4.2.6.8.1. Sub- subcategory: Unresolved emotional issues**

Bunny felt she could not let go 100% and did not feel safe in her new relationship.

Jane's anger towards her dad did not change and she still worried about disappointing others. She also still felt betrayed by people.

Grace said she did not see a big improvement emotionally, although she felt more at peace with her divorce. She felt hopeless about ever having another romantic relationship because she continued to be discontent and critical with herself and others. Although she made progress in her decision making, she still felt "anxiety ridden" about it. When thinking of starting a new occupation she still feared rejection at an 8.

##### **4.2.6.8.2. Sub- subcategory: Unresolved mental and behavioural issues**

Grace was still overeating and especially overate when new issues surfaced, like the death of her parents and child.

She still felt that she over extends herself and gives more than she receives.

She still overspends and "impulse buys" without thinking of the consequences.

She did not feel more capable when thinking of a new occupation and did not feel that she

could move forward in regard to this goal. She would get excited about an idea, but could not execute it.

Bunny did not feel motivated to promote her work as she was still caught up in her relationship.

#### **4.2.6.8.3. Sub-subcategory: Unresolved physical issues**

Angie mentioned that she still had the numbness in her left leg.

Bunny felt betrayed by her body as she could not sleep in the same bed with her new partner and could not achieve orgasm with him.

Grace said her asthma was worse and the pain in her leg and hip made it hard for her to walk. She generally had low energy.

#### **4.2.6.9. Subcategory 33: Measured changes in 4 Psychological tests**

The same four questionnaires (DASS scale, GAD 7 scale, HAM-A scale and IOE scale) were completed by all participants after their first follow up interview. Most participants completed the tests directly after the interview, but Grace completed the GAD 7 one week after she completed the first three. Bam took a week before he sent back the GAD 7 scale, HAM-A scale and the IOE scale and sent the DASS test one day after the other were received. Peggy Sue completed the GAD 7, IOE and HAM-A tests six days after her treatment and completed the DASS scale a few days after the other tests as she only answered it half way the first time through.

I had to prod Bam and Peggy Sue to finish and return their tests. Although Bam seemed reluctant to complete the tests, he could do it without mistakes this time.

Table 4.10 represents the mean scores for the following four psychological tests: the DASS, GAD-7, HAM-A and IOE before treatment and one week after treatment. The *before* treatment scores appear on the *left* side of the column and the *after* treatment scores appear on the *right* side of the column.

**Table 4.10: Participants' DASS, GAD-7, HAM-A and IOE mean scores before treatment and one week after treatment.**

Names	DASS (refer to table 4.5)						GAD - 7 >8: anxiety or panic disorder	HAM-A Anxiety: mild (18+), moderate (25+), severe (30+)	IOE >33total PTSD			
	Depression	Anxiety	Stress									
Angie	29	<u>10</u>	35	<u>4</u>	37	<u>9</u>	2	2	35	<u>13</u>	53	<u>5</u>
Elizabeth	39	<u>2</u>	19	<u>1</u>	35	<u>2</u>	11	<u>2</u>	28	<u>4</u>	64	<u>34</u>
Bunny	37	<u>26</u>	17	<u>5</u>	19	<u>17</u>	6	<b>9</b>	21	<u>21</u>	44	<u>34</u>
Jane	42	<u>3</u>	29	<u>5</u>	37	<u>16</u>	20	<u>5</u>	31	<u>13</u>	76	<u>20</u>
Grace	10	<b>14</b>	6	6	12	<b>13</b>	10	<b>15</b>	22	<u>16</u>	36	<u>25</u>
*Michael	1	<i>1</i>	1	<i>1</i>	2	<u>1</u>	5	<u>1</u>	4	<i>4</i>	10	-
Bam	13	<u>4</u>	6	<u>0</u>	8	<u>0</u>	7	<u>4</u>	13	<u>1</u>	29	<u>4</u>
Mr Blue	8	<u>2</u>	2	<b>3</b>	15	<u>2</u>	14	<u>1</u>	17	<u>3</u>	32	<u>2</u>
Peggy Sue	24	<u>8</u>	14	<u>3</u>	21	<u>8</u>	14	<u>9</u>	26	<u>17</u>	50	<u>19</u>
Tallulah	4	2	2	<b>6</b>	3	<b>9</b>	4	2	16	8	26	11

*Note:* Before treatment scores are on the left side of the column. One week after treatment scores are on the right side of the column.

The underlined scores indicate that the score went down since treatment; **Bold scores indicate that the score went up since treatment**; *Italic scores indicate no change*; \*- Michael no longer thought the test was applicable to him

Angie scored mild for depression (10) and normal for anxiety (4) and stress (9), on the DASS test. She had a score of 2 on the GAD 7 test, still indicating no anxiety or panic disorder and she had no anxiety on the HAM- A scale with a score of 13. She had further no indication of PTSD on the IOE scale with a score of 5.

Elizabeth's test scores were normal for depression (2), anxiety (1) and stress (2) on the DASS scale and her GAD 7 now showed no anxiety or a panic disorder with a score of 2. On the HAM-A test she scored a 4 which showed no anxiety. She indicated that she had PTSD



with one point with a score of 34 on the IOE test. For her the higher scores (on the IOE test), on for example “I feel as if it hadn’t happened or it isn’t real” was a positive score, which could make the outcome and interpretation of this test inaccurate for her.

Bunny had severe depression indicated by her score of 26 on the DASS test. On the same test she scored 5 (normal) for anxiety and 17 (mild) for stress. She scored 9 on her GAD-7 test, now indicating an anxiety or a panic disorder. According to the HAM-A test she still had mild anxiety with a score of 21. With a score of 34 on the IOE test, it indicated PTSD by one point.

The DASS scale showed that Jane’s depression of 3 was now normal, as was her anxiety at a 5. Her stress levels were mild at 16. On the GAD -7 scale she measured 5, which indicated no anxiety and no panic disorder now. Her scores of 13 on the HAM-A scale showed no anxiety. Her score of 20 on the IOE scale, showed no indication of PTSD.

Grace completed the DASS, IOE and HAM-A tests directly after her first follow up interview and the GAD-7 test one week later directly after her second follow up (she had a total of three follow up interviews). Her depression was moderate at 14 and her anxiety (6) and stress (13) were normal on the DASS scale. Her GAD 7 test (taken one week after the other tests) had a score of 15 still indicating an anxiety or a panic disorder. She had a score of 16 on the HAM-A test which indicated no anxiety. Her score of 25 on the IOE scale indicated no PTSD.

Michael scored 1 (normal) for depression, anxiety and stress on the DASS test as well as 1 on the GAD 7 test, indicating no anxiety or panic disorder. He had no anxiety with a score of 4 on the HAM-A test. He did not think that the IOE test was applicable to him as his changes had been positive and the answers did not seem to fit.

Bam scored 4 on depression and 0 on anxiety and stress on the DASS scale, indicating all scores to be normal. His GAD 7 score was 4 suggesting no anxiety or panic disorder and his score of 1 on the HAM-A scale showed no anxiety. His score of 4 on the IOE scale showed no PTSD.

Mr Blue scored normal for depression (2), anxiety (3) and stress (2) on the DASS scale. His GAD 7 score of 1 showed no anxiety or panic disorder. He scored 3 on the HAM-A scale, showing no anxiety and he had no PTSD on his IOE test of 2.

Peggy Sue's scores on the DASS test were normal for depression (8), anxiety (3) and stress (8). On the GAD 7 scale she scored 9, indicating an anxiety or a panic disorder with one point. She scored 17 on the HAM-A test indicating no anxiety and 19 on the IOE test, indicating no PTSD.

Tallulah's scores of 2 (depression), 6 (anxiety) and 9 (stress) were all normal on the DASS scale. Her count of 2 on the GAD-7 scale showed no anxiety or panic disorder, her score of 8 on the HAM-A scale showed no indication of anxiety and her score of 11 on the IOE scale showed no PTSD.

#### **4.2.7. Category 7: Treatment efficacy two months after treatment**

All participants were available for their second individual follow up interview two to three months after treatment (Appendix S). The second follow up interviews took from fifteen minutes to an hour. Each individual follow up questionnaire was crafted from the information gathered up to this point and focused on the participants' progress since the last follow up interview (Appendix R). Once again the participants were not muscle tested to test the resolution of the phobias, but answered questions about the effects of the treatment on

their lives. Everyone was willing and able to answer their individual second follow up questionnaires.

Their SUD levels were measured against the SUDS of their last follow up, at one week after the treatment. Most of the participants' progression and changes were congruent with those of the last follow up and only the new additional progressive changes are mentioned below in the following subcategories and sub-subcategories.

Angie's second follow up was two months after her treatment and seven weeks after her first follow up. She sounded strong, clear, grounded, sure and specific. As with the other participants, her progressions and changes were congruent with her last interview and just the additional ones are mentioned here. The word *balanced* surfaced a lot during the interview.

Elizabeth was reluctant to have this interview as she did not want to talk about the subject any longer and she said "I am done with it." This second follow up interview took place almost ten weeks after treatment and nine weeks after the first follow up. She continued to notice many changes in her, to the point that she felt "weird" about it, but at the same time she liked it.

Bunny's second follow up interview was ten weeks after her last treatment and nine weeks after her first follow up. During this interview she talked a lot about her romantic relationship.

Jane felt that she was in a much better place; she was more relaxed and could handle everything in life better at her second follow up almost ten weeks after treatment and two months after her first follow up. She felt that she had progressed since the last interview and felt better overall.

For Grace there was a significant and positive shift from her last interview six weeks ago to this final follow up. During this last follow up interview (two months after treatment) she was grounded, clear, conscious, specific and positive, instead of being confused and negative.

Michael was very upbeat and enthusiastic during his second follow up that took place ten weeks after his treatment and seven weeks after his first follow up. He freely and easily shared information about his musical play and volunteered to send me one of the songs that had been recorded since we last spoke.

Bam sounded strong and upbeat, although he was sick, during his second follow up nine weeks after his treatment and eight weeks after his first follow up. He used the word *hope* and *confident* a lot, instead of comfortable.

Mr Blue's second follow up was three and a half weeks after his first follow up and three months after his treatment due to his work travel schedule.

Peggy Sue had her second follow up thirteen weeks after her first treatment and seven weeks after her second follow up due to a series of family crises and deaths. The words *in control* and *unfold* surfaced a lot.

During Tallulah's second follow up two months after treatment and seven weeks after her first follow up, she was clear, confident, upbeat and strong.

Treatment efficacy two months after treatment will be discussed under 10 subcategories: 34) Further emotional changes, 35) Further mental and behavioural changes, 36) Further physical changes, 37) Further developments in spiritual awareness, 38) Further interpersonal and social changes, 39) Further occupational changes, 40) Progression towards

participants' individual goals, 41) Desired outcomes met, 42) Participants' unresolved issues and 43) Emerging healing needs.

#### **4.2.7.1. Subcategory 34: Further emotional changes**

Everyone continued to have an improvement on an emotional level. The lack of fear was prominent in every one. There was further a lack of frustration, anxiety and depression and Angie and Bam felt more confident. Increased joy and happiness were mentioned, as well as feelings of acceptance and feelings of strength and being in control.

Since our last interview Angie said she went through highs and lows and felt she was now “in the middle of the spectrum.” She was able to feel more balanced when experiencing emotions without reprimanding herself for having emotions. She realized emotions were natural, hers and other people's, including negative emotions. Her distress was the same at a 4 and her anxiety went slightly up from a 3 to a 4 when she thought about her back problems, surgery and unemployment, but mentioned that she did not have a lot of fear about it (maybe a 2, down from 3 since the last follow up interview). She did not experience a lot of anger (perhaps at a 3), her annoyance with people and impatience went down to a 3 (7 at the last interview) and there was no more frustration (maybe a 2). She said the word depression was no longer applicable to her. She was experiencing a powerful feeling of joy which she said was “expanding from within her into the universe.”

Elizabeth continued not to be scared or paranoid and had no panic attacks or any other negative emotions – it was all behind her.

Bunny felt both apathy and hope when she thought about having a conscious, soul connection marriage. A part of her felt it might happen and another part said it might never happen. She felt “more at choice” where she realized she can make choices regarding this

relationship and realized she chose to stay in this relationship with the idea and hope that it might turn into something that she wanted. Her fear about the longevity of the relationship went down from a 3 to 1.

Although she felt frustrated to take the lead in the relationship where she had to do all the initiating, she felt that she had progressed emotionally and felt joyful in the relationship when they were together, although she also still felt vulnerable and “could get destabilized” easily.

Jane’s feelings of depression and discouragement went down further from a 5 to a 1 since the last interview and feeling unmotivated went from a 3 to a 1. She no longer felt down (was 5) and neither did she worry constantly. She felt happy and content.

She now had no anxiety (both were 4) and fear (was 4) and only a 2 on distress (was 5) regarding her move, and she had no distress, anxiety or fear (distress and anxiety at a 10 and fear at a 9 before treatment) when she thought about becoming more independent.

She did not regret her move, but was excited about her decision to move again to go to a better university.

Grace experienced a deep gratitude for the treatment and was interested in the research results. There was a real shift with her depression, anger, guilt, shame, sadness, regret, resentment and feelings of loss in general where it felt different. Her sadness was much lower – from a 7-8 to 3-4 and she experienced only occasional bouts of sadness and grief about her divorce. She could accept that she was a mature single person and the transition from being married to being single no longer created pain, shame, guilt, fear and sadness for her and neither did it prevent her from moving on with her life. She felt no distress (8 before) about it and rather felt that it was a time of opportunity, and she was excited about having more possibilities and freedom and doing something different with her life. She found acceptance and neutrality in her process.

When she thought about her divorce, there was no distress, anxiety or fear where she felt

distress at a 7 and anxiety and fear at an 8 before. She no longer got paralyzed with fear. She could let go of the hurt and her “insides continued to be less twisted as things were moving out.” She said she found a way to let go of her stressors and anxiety and therefore felt stronger in her core and more peaceful.

She no longer had a fear of rejection when it came to a new occupation (was at an 8).

Michael felt no frustration with himself and his musical goal and he was really happy with how the music progressed and showed up for him. He no longer even considered fear of rejection, and he had no fear as he did his work – “it will fly or not, that is not in my hands, but regardless, it (writing a musical) was a great, great experience for me.” He was sure that his fear of failure was gone – “really everything has changed as I neared the finish line – I am finished” and he was ready to move on to other things. His frustration with himself in terms of this project (at an 8 before treatment) was gone and he now instead regarded it as a joyful process.

Bam did not have the stress to hunt for work but said that if he had to think about a future situation where he did not have a job lined up, that he felt very confident that he will feel no fear, instead he feels hopeful. Since the last follow up, he still carried the same anxiety about it at a 5. He felt more confident, also in his work situation where he was working with a younger generation, which is technologically more advanced than he is. He realized he just had to work harder, but was no longer worried or stressed about the differences and said he relied on his experience, which complimented their skills.

Mr Blue had occasional anger about the lack of progression and commitment from his business partner, but it came and went instantaneously as he surrendered his anger and the situation to God. He realized that anger will do no good and he was able to release it. He had no further stress, concern, worry, shame, anger or upset about the situation and felt anxious at

a 1. His distress was at a 1 (an 8 before treatment) when it surfaced and he said he had no fear - “honestly no fear, just a knowing that it will happen.” He had no frustration, but just excitement about what was coming. He said that he no longer got upset over things he could not control. The lack of progression in his business was not the basis of his happiness anymore and he no longer based his happiness on that and added that he did not allow the lack of progression in his business to “drag him down.”

Peggy Sue felt strong and in control and did not feel like a little girl anymore - always being afraid. She said her anxiety and stress was going away and her fear (a 4 before) had gone. She realized that she did not want to live like she did before – in a state of constant fear. She no longer had the “fingernails on the board” feeling. She had no distress, anxiety or fear (all at 4 during the last follow up) regarding her change and transition and neither did her lack of progression create distress, anxiety or fear - she said she could “pull the trigger now.” She did not sit on top of her dark hole any longer, but was now flying above it and felt in control and therefore had no feelings of devastation about not being in control of her life. She had no more sadness, just hope for more. She said she was more peaceful.

Tallulah’s distress and anxiety regarding not having an income continued to not be there anymore as she felt that she had things under control and could budget her finances. She had a little stress left about her unemployment status and lower income, but thought it was healthy and said that she needed this stress to stay in control. Instead of having a fear of success, she wanted more success. She did not worry much and said she was more at the stage of “letting go.”

One of her biggest changes was that she didn’t feel emotional pain anymore and most of all didn’t get lost in other’s pain. She was looking for solutions, instead of dwelling on the pain. This “painless state” was so strange to her that she started to “search for her sadness,” but realized that she was looking for something that was no longer there.



#### **4.2.7.2. Subcategory 35: Further mental and behavioural changes**

Developments continued mentally and behaviourally for all participants and the additional changes are mentioned below. Three of the participants (Angie, Elizabeth and Grace) no longer thought about the distressing occurrence in their lives.

Grace, Peggy Sue and Tallulah started to read more.

Angie felt she could ground herself, stay in the moment and feel more at ease. The feeling of not being sure of anything was not there anymore. She remembered that “desolate place” and was grateful that she did not feel that anymore.

She mentioned that she no longer thought about her surgery. She was grateful for her physical health, instead of taking it for granted. She felt even more confident and was less worried about what others thought of her. She could see and appreciate the beauty in herself and others. She was accepting of her body, no longer desired another body, and was able to receive compliments. She was revelling in the fact that her body was talking to her and that she could talk to it. She felt it was important to listen to her body and obey it and not try to overdo things, like when she followed a suggestion from her doctor to start physical therapy, which set her back and brought back all the old symptoms. She realized that her situation was not that bad, it was completely tolerable and she saw it as a learning experience where she got something out of it on a daily basis. Because she was accepting of who she was and what she had, she felt less covetous of others.

Elizabeth’s focus was still on her school work and job; she still did not think of her ex-boyfriend at all. She felt very confident and kept improving at school and in her job. She felt more aware of her surroundings and she felt present and was able to listen to people without “zoning out” or thinking of something else. She felt she could discern who was good for her or not. She realized when she did not like certain aspects in people, she no longer

tolerated it and no longer sacrificed her values. She preferred to be focused on positive people, rather than on negative people.

Although Bunny started to feel more independent in the relationship, she said she was still too “obsessed with him,” but that her obsessing was less, “down with one point” (5 to 4 – originally an 8). She was able to go camping on her own.

She still did not do any marketing for her healing practice, but she no longer blamed this lack of progression on the new relationship, but rather saw it was where she was with her life.

Jane was ready to be independent (she feared it before treatment), liked responsibility and did not want her dad to pay for anything (instead of blaming and accusing him for not paying enough before treatment) and instead used her savings. Her self-esteem was strong at a 9, instead of a 1 before treatment, and she had no doubt or questions about herself and her success.

She continued to study more and more effectively.

The divorce was not something that was on the foreground of Grace’s consciousness anymore and instead she experienced an internal shift where she knew she would find a partner again and was interested in having a new romantic relationship.

She felt better about doing things and did not feel that she had to force herself to do something. She allowed things to come into her life and made decisions at that time, instead of worrying about the future. She felt her decision making skills continue to improve and that she did not have to force her decisions any longer, especially her financial decisions.

She felt “clearer” and more focused and she was able to read two books, including *The Artist's Way* since the last follow up interview, made sense of it and could follow their directions and practice what they suggested.

She was putting thought into her money and purchases which improved her impulse buying.

She recently took back an unnecessary purchase. She moved into her daughter's guesthouse to save money, as she was considering buying a house.

Michael could not believe that he said that he felt dissatisfied and disbelief about not getting his work out to the world. He was happy to let his work go and did not think that he could fail in any sense that was meaningful to him, even when someone said it was "crap." He was eager to see the production getting a life of its own and said whatever life it was, would be fun to watch and he could see himself getting a standing ovation. He really liked his work and thought he had done a good job and was encouraged how it read back to him. All this was an unusual experience for him as he never used to be satisfied with his work and therefore could not finish it. He was clear about his part in the production and realized that he had to let go of the technical parts and saw the importance of collaboration. He was very clear when he mentioned the next steps of his project and knew who he had to contact.

He could exercise again and was cycling now (instead of running), spoke to his knees - expressing gratefulness - and breathed through any discomfort he experienced in his knees.

Bam sensed a "huge change of attitude" in himself where he was happy during this time between jobs and described the time as great, although it helped that he had a job lined up already. He smoked less and slept better and said he was "definitely more active" and was doing (and juggling) a lot of different things, although he did nothing strenuous. He enjoyed his garden, saw his friends and went to dinner parties and felt very relaxed and peaceful.

Although there was still a lack of progress in Mr Blue's business, "I'm in a helpless situation, waiting on my partner," he said that he was taking it in his stride and that he was at peace where things were and that they would happen when they were ready. He said that he continued to approach situations with logic and new perspectives and still believed like the

last time that everything was where it should be, but now he had an added insistence to push forward.

He no longer thought that his reputation/honour was tarnished in the industry.

Before the second follow up interview, Peggy Sue texted me that her boundaries were improving every day and that it felt good. During the interview she continued to say that she was not allowing her husband to control her anymore; she was standing her ground (with humour and not like a kid crossing her arms) and realized that she could get along without him or his money. She felt solid and said she was standing more in her own power and felt she was getting back to a better and stronger Peggy Sue.

She no longer had a problem with her attention span and her focus improved. She mentioned that instead of being unable to sit down and being unable to read even one page, she was reading a lot now.

Her lack of progression where she could not move forward with her life in general had gone and she felt it was time to do more and she thought she was able to do it now. She took the dogs for walks and went shopping by herself. She was helping her son with his sick wife and planned a vacation and was working in her garden again. She was not pushing forward as she felt during the last interview, but allowed everything to unfold in due time without forcing it.

Tallulah no longer doubted and questioned herself. She realized that she needed less support than she thought and felt it was up to her to change her life, but realized at the same time that the support was there if she needed it. She could see how she needed to do things differently and was taking chances to break out of her comfort zones.

She also took in a roommate to help her financially and to help her improve her communication skills.

She started to consider the possibility of having children – something she never considered before.

#### **4.2.7.3. Subcategory 36: Further physical changes**

During the final follow up interview, nine of the participants were aware that the treatment continued to influence them positively on a physical level as well, even though it (the need to heal physically) was not mentioned in their goals, and another participant (Elizabeth) continued to feel no physical effect of her breakup.

Angie said her body felt stronger. She was impressed with what she could do; she could get out of bed without a struggle, her upper body felt stronger and she felt more stable. She still had pain, but the numbness in her leg started to dissipate. She felt triumphant that she was able to wean herself from her medication and not be on the emotional and physical rollercoaster of being dependent on medication. She occasionally took a muscle relaxant and anti-inflammatory capsule for the pain, which was there every day, but she noticed it went away when she did not think about it. If she did dwell on the pain, she noticed a distraction would appear, like a friend would happen to come by to distract her. She started doing more yoga and was interested in pursuing water therapy.

Bunny felt progression – “a huge shift” - at a physical level where she was able to have sexual intercourse and orgasm with her new boyfriend.

Jane said that she managed to eat better because she was managing her feelings better which improved the condition of her skin.

Grace started to eat better after she consulted a nutritionist and was following a sugar, gluten and dairy free diet.

Michael said the aches and pains in his legs were becoming less of an issue and his thoughts that he might never walk again had gone.

Bam felt more energetic and was less tired at work. He was hopeful that his physical problems, which he saw as “the normal aging process,” would improve.

Although Mr Blue just came back from a month abroad, he was quick to notice that he had no jet lag, was not tired and had good focus after a two day flight.

Peggy Sue only got up every three to four hours during the night—a marked improvement – which improved her sleeping patterns. Her shoulders were not as tense anymore and she can now lift her arms up above her head.

Tallulah felt she improved physically because she gained ten pounds and her menstrual cycle remained normal.

#### **4.2.7.4. Subcategory 37: Further developments in spiritual awareness**

Seven of the participants had additional spiritual awareness; of those seven, five mentioned God.

On a spiritual level Angie realized that God was living within her, in her heart and soul, He was everywhere. She could internalize God more. This was a huge realization because before she was always looking to connect with God outside her body. She could not connect with her spiritual path and always saw it as a work of progress - where she wanted to be, but now she was okay with where she was. This realization helped her to stop worrying.

When asked about her spiritual changes and progression, Bunny spoke about the qualities she would like to have as a person, qualities of a romantic relationship and the qualities she desired in a future partner.

Jane continued to grow in her spirituality.

Grace was getting herself in alignment with God and the books she was reading lead her to be closer to God. She felt one with God and felt her spirituality was growing in action. Whenever she would say there was no God, God would show up in tangible ways, through a book, a friend or another kind of sign. She gave God credit and said her spiritual life was active. She realized that the work we did together was the shift for her – “that is when the shift happened - it was the starting of this whole thing, something happened, something occurred in what we did”.

Michael said his meditation became very important to him and he practiced more, even at work.

Mr Blue was able to surrender his negative emotions and the “helpless” situation around his business to God.

Peggy Sue said she put a lot in God’s hands so that she did not over do or worry too much, but rather allowed things to unfold – something she could never do before. She said she continued to become “unstuck,” felt more relaxed every day and just allowed things to happen, as “Everything is God’s will and I am fine with that. I’m more patient and I say my prayers, ask for guidance and take one day at a time and all happens as it should.”

Tallulah thought her spiritual life continued to grow as she was praying randomly throughout the day, she was aware of messages from God and could draw correlations between them and in that way was aware of God’s communication with her.

#### **4.2.7.5. Subcategory 38: Further interpersonal and social changes**

All participants’ interpersonal and social lives stayed positive and continued to change and improve and the additions are mentioned below. Angie, Jane, Grace, Michael, Bam, Mr Blue, Peggy Sue and Tallulah all continued to have improved social lives where

they experienced more social contact and improved social interactions. Elizabeth and Bunny's interpersonal and social lives continued to stay positive and satisfactory.

Socially Angie could feel at ease around other people, have a good time, be present and could take in what people said, instead of being self-conscious and anxious. She continued to say that she was very confident in social situations and when she worked with people as a volunteer.

Jane's social life was good, she had a few good friends and she was okay with that. She did not feel alone or disconnected from people and was no longer worried about disappointing them, nor did she feel betrayed by them. She said her connection with people was more satisfying and healthier as her attitude was better and she no longer felt dependent on her friends.

Grace realized that her critical and judgmental thoughts about herself and others were "bad acts of violence" and she realized the negative effect it had on her relationships. She was accepting the fact that she was more of a responder than someone who reached out to people. She was having a lot of social contact and returned all phone calls. She also realized that she needed alone time to replenish after social interactions.

Michael said that although his wife could see an improvement in his social interactions, he was aware that he longed to get closer to people and connect with them.

Bam mentioned that his social interactions were easy and pleasant during his time of unemployment. He felt that his partner's moods did not affect him as much and he experienced no angst over his partner's mood changes. He mentioned that he handled his own emotions differently and allowed his partner "to (just) be when he was going through a difficult time."



Mr Blue no longer felt that working on his business stunted his social time.

Peggy Sue said that working on the lack of joy and love in her marriage was a work in progress and there had been moments she felt really joyful. Because she felt more in control, she could see their connection now as that of equal partners. She no longer did all the fitting in with her family and did what she felt she could do and was only as supportive as she wanted to be. She no longer thought her family would dispose of her when she did not give in to all their demands. She was not taking everything so seriously and personally (she could see and consider her children's stressors), including confrontations with her son. She noticed that she had been a rock to her family during difficult times – she was not always aware of that. She thought she was doing quite well and had a closer connection with her family. She was contacting a lot of people and went for lunches with her friends.

Tallulah took in a roommate to help her improve her social and communication skills and continued to be more social.

#### **4.2.7.6. Subcategory 39: Further occupational changes**

Further occupational changes were experienced by seven participants (Angie, Elizabeth, Jane, Grace, Michael, Peggy Sue and Tallulah). Bam could still not measure his occupational impact as he had not yet started his new work contract. Mr Blue was congruent with his occupational change of the first follow up interview and had nothing further to add. They both reported positive mental shifts regarding their occupations.

Apart from enrolling in NLP training, reading a new book and continue to read and practice *The Artist's Way*, Angie also did healing sessions with clients at the yoga centre on a barter system.

Elizabeth enrolled in and was accepted at her university of choice and continued towards her dream as a fashion designer and was excited about this positive change.

Bunny still did not do any marketing for her healing practice, but accepted that was where she was with her life.

Jane felt determined to continue her studies in law at a better university.

Grace was excited about the future and the new possibilities and now *believed* that she could become a photo journalist.

Michael was excited to finish his musical play and could not wait to get his work out by the following week. He felt that he got really good at tying everything together and he added three unexpected and perfect songs which “flowed easily through him” to the production.

Apart from everything going on in Peggy Sue’s life (sickness and deaths in the family), she was able to plan and execute an event that went “perfect” where she was less afraid and worried to make mistakes. She was thinking of hosting smaller events, but did not want to commit herself to anything. She had a new attitude where she allowed herself more freedom to do what she wanted to do and was okay when something did not get done and added, “If you decide to retire, you need to retire.”

Tallulah realized she wanted to focus on a new career and was very pro-active in that direction. She became relicensed as a life insurer and had her first client. She signed up for an in investments exam, something she remembered she always wanted to do. She was goal orientated and felt it was time to “work and play hard” and added that “This is the time to make changes and I feel good.” She was looking for a job and received a call from an employment agency and was scheduled for an interview, but chose not to go as she realized

that it was not exactly what she wanted. She took action towards a volunteer job and contacted two agencies and was looking into a third one. She was looking at her forward momentum with positivity and said she was taking “baby steps at a time” to see where it will take her.

She was reading more about different topics which opened up new ideas for her career.

#### **4.2.7.7. Subcategory 40: Progression towards participants’ individual goals**

Every participant continued to show progression towards their chosen goals during the final follow up interview.

Angie progressed towards her goal – “To work in a meaningful and purposeful career” – when she enrolled for a NLP certification course. She did not feel anxious about her upcoming NLP certification training and felt more open to receive new information. Instead of over researching the topic and closing herself off from receiving new information, she now felt relaxed and open to receive. She was also reading a new book that helped her to progress towards a new career path.

During the last interview she felt guided on her life’s journey and felt she had the “wind at her back,” but now she felt more balanced and guided and less pushed. She felt things moving and happening and felt open where she could receive and listen and said “I just get it.”

Elizabeth said her ex-boyfriend was part of her past and she no longer had a desire to even talk about him. She knew that she would find the right person at the right time.

Bunny continued towards her goal of wanting “A conscious, soul connection marriage for the rest of my life” when she mentioned that she no longer felt that single was her new normal and that she could see herself being in a relationship. During the first

interview she said that she could move from being single to being married, and during this interview she added that she wanted it.

Jane was focused and motivated to study for her exams, and her concentration was still strong at a 9, which kept her consistent with her goal of “I want to be focused in school.”

Grace was in alignment with her goal “I want inner peace about my divorce” because she said she was accepting the reality of her divorce and was ready to let go and move on. She said she had inner peace with her divorce and life and that “It is a time of new beginnings. I have so much awareness and am more allowing to my awarenesses and people – that is inner peace.”

She felt that she was moving into an interesting time of her life and will have fun with it and find joy in the things that she will do.

Michael was progressively working towards and was in alignment with his goal (“I want to own, accept and believe that the title of composer/musician belongs to me”) as he spoke about the final stage of his production. Saying that he was a composer and musician who had written a Broadway play, was normal for him now.

Bam’s goal was to “Set realistic goals for myself to accomplish in the next 6 weeks – fulfil them and move on.” During his first follow up interview he mentioned that he wrote down concrete goals and during this interview he mentioned that he got half of his goals done, and did not blame himself for not completing his list yet.

Mr Blue was in congruency with his goal of “Being focused, patient and relaxed so I can be prepared for the work and success of my business” because he mentioned his awareness of his new focus, even after a two day flight. He was patient and relaxed as he could allow the situation to unfold when and how it should. He also added that he was

looking forward to become a businessman and said a whole world was opening up for him and he felt no distress about the transition at all (an 8 before treatment).

Peggy Sue was confident, willing, and fearless to move forward, overcoming roadblocks, and do what she loved to do and start living again, even by herself. This statement kept her in alignment with her goal of “I want to be fearless with moving forward with my life.” She saw everything as a work of progress and if there were roadblocks they were taken care of like she did the last couple of months.

Tallulah wanted mental clarity and she achieved that when she said: “I don’t see myself as the same, I have changed, and I am different. I know who I am; I don’t struggle anymore with who I am and who I am supposed to be. I accept the different parts of myself. I am aware of myself.”

She was also clear about her life direction – she wanted to work and not study – and in which direction she would like to pursue a career.

#### **4.2.7.8. Subcategory 41: Desired outcomes met**

Before treatment when the participants spoke about their lack of progression and the impact the change had on their lives, they were also questioned about their desired outcomes. Although they all showed progression towards their goals, most of the participants also showed that they achieved their desired outcomes. Angie, Bam and Tallulah mentioned that they would like to improve their physical health, which Angie and Tallulah achieved. Elizabeth and Jane succeeded to improve their focus, so they could improve in school. Angie, Bunny, Jane, Grace, Bam and Tallulah all desired an increase in their confidence levels, which they all achieved, except for Bunny. Grace, Michael, Peggy Sue and Tallulah, wanted and achieved their peaceful state of mind, and Jane, Grace, Bam and Tallulah achieved the happiness they longed for. Peggy Sue's new attitude made her not care about her family's

judgments which then seized, and Tallulah realized that her family's support (instead of judgment) was there if she needed it. Angie, Elizabeth, Jane, Grace and Peggy Sue wanted to get back to "who they were before" the incident and they did and as Peggy Sue said "stronger than before".

#### **4.2.7.9. Subcategory 42: Participants' unresolved issues**

Although all participants resolved most of their named issues and all showed congruency with their goals and their desired outcomes during this interview, some still viewed existing issues as unresolved issues, although they were not part of the goal statement. Not all the issues of all the participants were 100% resolved during the final follow up interview and are further discussed under sub-subcategories: 1) Unresolved emotional issues, 2) Unresolved mental and behavioural issues, 3) Unresolved physical issues, and 4) Lack of progression towards goals.

##### **4.2.7.9.1. Sub-subcategory: Unresolved emotional issues**

Angie's levels of distress and anxiety about her back problems, surgery and the consequences of being unemployed improved since treatment, but was still at a 4 – the same as during her first follow up interview.

During the second follow up, Bunny shifted from not knowing if she was worried (first follow up) back to being worried about not getting a real life partner. She said that her happiness levels depended on her partner and the amount of attention he would give her. She felt that she was too accommodating and did not feel that he supported her the way she desired. Her distress about romantic relationships could go between a 4 to a 7, depending on the day. Her anxiety about the relationship stayed the same at 4.

Although Jane was not angry with her father regarding her school situation any longer, she still carried anger towards him about different issues.

Bam said that he still had an ingrained fear of success which he needed to work on and said that he needed more treatment for that. He wanted more “reinforcement, more of those interventions we did” and said that he needed more treatments to help him handle his stress.

#### **4.2.7.9.2. Sub-subcategory: Unresolved mental and behavioural issues**

Angie can now allow people to help and support her, but she felt it was still a work in progress because she felt if someone helped her that it came with ties. She mentioned that it came from having a low self-esteem where she might feel not deserving to receive.

Bunny still had obsessive thoughts about her new relationship and new partner, although it improved. She had set ideas about how he should be in the relationship (for example, taking the lead and supporting her more) and was disappointed when he did not meet her unspoken expectations. She said that her thoughts were too focused on potential negative disappointments, rather than on something positive.

#### **4.2.7.9.3. Sub-subcategory: Unresolved physical issues**

Grace started to eat better, but mentioned her continual struggle with weight loss (she had been obese most of her life) and her lack of energy. She named her pain in her back, leg and hip and her problems with her asthma as unresolved issues. Her sleeping patterns of four to six hours did not improve.

Bam’s eating habits were still the same, he did not eat less or healthier foods.

Mr Blue did not receive funding for his business venture yet.

#### **4.2.7.9.4. Sub-subcategory: Lack of progression towards goals**

A part of Bunny still felt that she might just be going around in circles where she will never have a conscious, soul connection marriage for life.

#### **4.2.7.10. Subcategory 43: Emerging healing needs**

During the first and second follow up interviews new issues started to emerge for three of the participants. They fall under sub-subcategories: 1) Unresolved grief, 2) Interpersonal relationship management, and 3) Physical concerns.

##### **4.2.7.10.1. Sub-subcategory: Unresolved grief**

The death of Grace's parents and son was not a priority for her when she first came for treatment, but as her focus was not primarily on her divorce any longer, she started to focus on their deaths during the follow up interviews. During her last follow up interview, she realized that she had never mourned her mother's death.

##### **4.2.7.10.2. Sub-subcategory: Interpersonal relationship management**

Michael mentioned that a new issue for him to work on might be his interpersonal relationships where he would like to reach out more to people, connect and get closer to them.

##### **4.2.7.10.3. Sub-subcategory: Physical concerns**

Angie started to wake up at odd hours where she needed to stretch.

## **Conclusion**

After treatment, all the participants experienced progression towards their goals and the resolution of the phobias on an emotional, mental, behavioural, physical, spiritual,



interpersonal, social and occupational level.

Some experienced a lack of progression on certain levels and had some unresolved issues, which identified new healing needs.

The participants' experiences provided insights into the discovery, language, treatment, resolution and effects of treatment on phobias of change and transition.

By treating nine participants for their phobias of change and one participant for his phobia of transition and by analyzing that data, the researcher was able to gain insight into the creation, manifestations and impact of the phobias on individuals, and observe how a preliminary theory emerged from the analyzed data that can explain how phobias of change and transition create difficulties with change, transition and progression.

A detailed discussion of the findings will be presented in chapter 5.

## 5 DISCUSSION OF THE FINDINGS AND RECOMMENDATIONS

### 5.1. Discussion of the findings

If "Life is movement" and "Movement is change" and because change "is the nature of life itself" (p. 47) and therefore should be expected, and not be avoided, but instead be created (Walsch, 2009), it was important to focus on difficulties surrounding change and to investigate why change is difficult if not impossible for people and how to overcome this. According to Gallo (2012, track 9) "EP studies the effects of mind, body and energy systems on emotions and behaviour" and "EP *therapy* is the application of this kind of concept to the treatment of different psychological conditions". Therefore the aim of this qualitative study was to examine the effectiveness of an Energy Psychology method, HBLU<sup>TM</sup>, in the resolution of phobias in the context of change, transition and progression. To understand the findings that emerged from the interviews, psychological tests and treatment and to create selective codes I engaged in memo writing to analyze and conclude what the open and axial codes meant in order to create the selective codes, and to answer the research question. The selective codes are: 1) a life changing event can have positive and negative consequences, 2) a life changing event can create a phobia of change and/or transition and 3) a phobia of change and/or transition can be successfully treated with HBLU<sup>TM</sup>.

The major findings which emerged from the analyzed data will be discussed in the following section. The findings are discussed in relation to the meaning of the treatment of phobias of change and/or transition and in relation to the existing literature and research.

Although most people shrink back from change, because they do not like it as it requires them to step out of familiarity into unfamiliarity, leaving something or someone behind and venturing into the unknown, change and transition is a reality we cannot avoid

(Walsch, 2009). A discussion of the findings with regard to the participants who were assisted with HBLU™ to overcome the negative effects of change in their lives, follows next.

### **5.1.1. Life changing events**

All of the participants experienced an event in their lives, that required them to go through certain life changes in their work, relationships or during relocation, which changed their lives, had a negative impact on their lives, and brought unwanted change. For some people change is about facing uncertainties and they might even feel that it threatens their survival (Walsch, 2009) as some of the participants in this research felt when they experienced a major change in their lives. The change threatened Elizabeth's survival which made her feel suicidal, Jane felt it broke her apart, and Peggy Sue "fell into a big black hole". Michael's survival was threatened because he could not make a living as a composer, as he was unable to share his work with the world.

When something is not like it was before, such as being married, and then getting divorced, change such as a divorce can make people feel that it is "the end" and that there is "nothing [there] after" (Walsch, 2009, p.15). Rather than viewing such changes as just another change in their lives which indicates that something new is coming (Walsch, 2009) they tend to think the world has come to an end, like Peggy Sue when she retired and Grace who got divorced. They both experienced it as "the end" and not just a change in their lives and could not experience or even anticipate a new "[there] after".

People often believe that they cannot change, will not and do not change, and on some level yearn for their situation to stay in place as it feels unsafe to change (Walsch, 2009). This observation is consistent with this study where the significant change in the participants' lives rendered all of them with a feeling of immobility and inability to move forward with their lives or participate in life. They seemed to hang onto the past and found it hard to change and

move into the present.

According to Walsch (2009, p.13) the feeling that "everything is lost" is a feeling of being disrupted which translates into a feeling of being threatened, especially if the change refers to relationships (Elizabeth and Grace), health (Angie), and money (Michael, Mr Blue, Tallulah, Peggy Sue and Bam).

All but one participant (Bunny) also experienced their change as a transition, showing that not all participants experienced their life changing experience as a transition, although Ellis (2010) mentions that major life event changes should be referred to as transitions.

As a result a phobia can develop after a specific traumatic situation because of the person's perception and cognitive interpretation of the situation. If the person perceives the situation or object as harmful, it may increase fear and anxiety and create a phobia (Bener et al., 2011; Furnham, 1995).

A more in depth look at the consequences of change in people's lives will attempt to show if it is possible that a life changing event can create a phobia or phobias.

### **5.1.2. A life changing event can have positive or negative consequences**

We react to our perceptions, which are most of the times distorted as a result of traumas, experiences, limiting beliefs and thought patterns, and not to reality (to what actually is). These distortions and our reactions to them, create our reality and affect our lives (Greene, 2012). In 1994, Siegel (2012) discovered that every mental disorder in the DSM-IV was an example of chaos, rigidity or both. Phobic symptoms are inclusive of both chaos and rigidity. In this study all the participants demonstrated phobic symptoms that are consistent with the description of a phobia in the existing literature, such as the Oxford online dictionary's, (*n.d.*), Swack's (2007b), and the Webster Encyclopedic Unabridged Dictionary of the English Language's (2001, p. 1455) definition of a phobia, Plotnik & Kouyoumdjian's

(2011) description of a phobia and Bener et al.'s (2011), Callahan's (2001), Feinstein's (2008a), Salas's (2001), and Swack's (2007b; *n.d.c*), findings of phobias, after people have experienced an influential life change.

All the participants were viewed as integrated individuals from a holistic perspective and therefore the impact of change in their lives was observed on the emotional, mental, behavioural, physical, spiritual, interpersonal, social and occupational levels.

#### **5.1.2.1. Emotional consequences**

"Emotions are information" (Gallo, 2012, track 13) and therefore reveal more about an individual. From the qualitative findings which included the semi-structured interview questionnaire, all the participants reported that they experienced an emotional impact when they thought about the change and transition in their lives. The indication of their high SUD scores for distress, anxiety and fear suggest the presence of a phobia, because phobias are viewed as "an anxiety, disorder characterized by an intense and irrational fear that is out of all proportion to the possible danger of the object or situation" (Plotnik & Kouyoumdjian, 2008, p. 518). The high SUD scores for anxiety are not totally in agreement with the DASS and HAM-A tests (discussed later in this section) which indicated that not all participants suffered from severe anxiety, nonetheless, it was obvious to me during the meetings with each participant, that every one of them was experiencing significant anxiety.

According to Gallo (2005), Callahan came to the conclusion that all negative emotions are caused when a distressing awareness/association about an experience and/or object (for example the awareness of having to change) enters the person's thought field (thoughts which contain "subtle energy features") and causes disruptions within the energy system (Gallo, 2005, p. 90). When I required and requested more information about the emotional impact the change had on their lives, the other negative emotions that stood out

were the emotions of anger (7), frustration (6), sadness (6), feeling stressed (3), guilt and shame (2), feeling worried (2), and there was also the mentioning of depression for 5 participants. The feelings of loneliness, fear to be alone, and fear of rejection also stood out for 5 participants. According to Hay (1999) only fear and anger patterns contribute to causation of illness in the body and in this study these two emotions were two of the most prevalent emotions. All of the participants experienced physical consequences (which will be discussed later in this chapter under *5.1.2.3. Physical consequences* ), although these were not illnesses that arose from the phobias of change or transition.

The participants' change also made them feel lost, confused, indecisive and overwhelmed. Some of the participants also reported an annoyance with people (1), impatience (1), irritability, and feelings of threat (1), betrayal (1) and distrust (1) in others. Other emotions that some participants mentioned were feelings of upset, hopelessness, worthlessness, pain, regret, resentment, embarrassment, dissatisfaction, disappointment, devastation, helplessness, neediness, feeling misunderstood, and feeling unsupported. There was also the mention of fear of failure, fear of imperfection, fear of success and fear of lack of control.

The four psychological questionnaires (DASS, GAD 7, HAM-A, and IOE) that measured the participants' levels of anxiety, stress, depression, and PTSD provided the following evidence:

Before the treatment the mean scores on the DASS scale which measures depression, anxiety and stress, showed that seven participants (Angie, Elizabeth, Bunny, Jane, Grace, Bam and Peggy Sue), suffered from depression, of which four of the participants suffered from extremely severe depression (Angie, Elizabeth, Bunny and Jane), one from severe depression (Peggy Sue), two from mild depression (Grace and Bam), and three from no depression. Of these seven, only five of them (Angie, Elizabeth, Jane, Grace, Bam) self-reported depression and although Peggy Sue was diagnosed, by her medical doctor, with depression, she denied

it. These finding brought the SUD and test scores in greater congruence with each other. It also indicated that depression is present when there is a phobia of change or transition.

The DASS scale further showed that five participants suffered from anxiety, of which two (Angie and Jane) suffered from extremely severe anxiety, two (Elizabeth and Bunny) suffered from severe anxiety, and one suffered from moderate anxiety (Peggy Sue), while the anxiety levels of the other 5 participants were normal on this test.

The DASS scale showed that six participants suffered from stress, of which three participants (Angie, Elizabeth and Jane) reported extremely severe levels of stress, two had moderate stress (Bunny and Peggy Sue), one had mild stress (Mr Blue) and four participants' stress levels were normal.

Five of the participants (Elizabeth, Jane, Grace, Mr Blue and Peggy Sue) suffered from anxiety disorders according to the GAD 7 test, although only Jane and Peggy Sue self-reported that they suffered from panic/anxiety attacks and Elizabeth reported that she had received treatment for anxiety before. Although Angie suffered from extremely severe anxiety and Bunny suffered from severe anxiety according to the DASS test, they both tested "no" for an anxiety disorder on the GAD 7 test, indicating an incongruence between the GAD 7 test and the DASS test. This might indicate that one of the tests fails to measure what it is meant to measure, nl. anxiety, thus compromising its validity.

The HAM-A test scores suggest that six participants suffer from anxiety. Two participants suffered from severe anxiety (Angie and Jane), two from moderate anxiety (Elizabeth and Peggy Sue), two participants (Bunny and Grace) suffered from mild anxiety, and four participants (Michael, Bam, Mr Blue and Tallulah) suffered from no anxiety. Grace suffered only mild anxiety and Mr Blue no anxiety according to the HAM-A test, but they both indicated an anxiety disorder on the GAD 7 test and Angie, once again, scored severe

anxiety on this test (so both on the DASS and HAM-A tests), but no for an anxiety disorder on the GAD 7 test, showing incongruence between the tests.

Six of the participants (Angie, Elizabeth, Bunny, Jane, Grace and Peggy Sue) indicated that they had PTSD symptoms and one participant (Mr Blue) was one point short from being on the PTSD list according to the IOE test. This was interesting as no one muscle tested to have a trauma on the phobia, and everybody confirmed that they could heal the phobia with the simple phobia protocol which excludes trauma treatment.

By only looking at the numbers it can appear that there was a level of congruency amongst the psychological tests, as the DASS test reported 5 of the participants as having anxiety, ranging from extremely severe to moderate, which was congruent with the GAD-7 test which reported 5 participants with anxiety disorders. However, by looking at the names, it is evident that only Elizabeth, Jane, and Peggy Sue, who suffered from anxiety on the DASS test (Peggy Sue had only mild anxiety), indicated an anxiety disorder on the GAD 7 test. Grace and Mr Blue both indicated anxiety disorders on the GAD 7 test, although they did not indicate anxiety on the DASS test, and mild for (Grace) and no anxiety for (Mr Blue) on the HAM-A test. Once again the tests are not in alignment with each other, bringing the reliability of these psychological tests into question.

According to all the tests seven participants suffered from anxiety (with the exclusion of Michael, Bam and Tallulah), seven suffered from depression (excluding Michael, Mr Blue and Tallulah), six had stress (excluding Grace, Michael, Bam and Tallulah), and six had PTSD symptoms (excluding Michael, Bam, Mr Blue and Tallulah) which shows a correlation between negative emotions and phobias of change or transition. Refer to table 4.5. and table 4.6. in chapter 4.



It appears that when there is the possibility of a phobia of change, anxiety and depression are both present, confirming Bener et al.'s (2011) findings. The person does not only experience irrational fear, but also have feelings of depression, which is defined as a "state of sadness, gloom, and pessimistic ideation, with loss of interest or pleasure in normally enjoyable activities" and it includes "feelings of worthlessness or guilt, diminished ability to think or concentrate" and also includes "recurrent thoughts of death or suicide" (Colman, 2006, p. 202) as we can see when the participants had similar experiences during this study.

Phobias of change and/or transition can result in other feelings than just anxiety, stress or depression and it is therefore important to not only rely on psychological tests, but to include mindful personal open ended inquiry as well, when confirmation of the presence of such phobias are sought.

Khan et al. (2010) mentions that experiences associated with psychological problems have a chain reaction, where the brain sends out electrical signals, which in turn lead to an emotion, a perception or a behaviour. We observe this connection when the participants mentioned their general lack of forward momentum and progression when I inquired about their emotional consequences. The lack of progression is discussed in more detail under *5.1.2.6. Lack of progression and desired outcomes.*

#### **5.1.2.2. Mental and Behavioural consequences**

The life change in the participants' lives had negative mental consequences for all of the participants, which manifested as negative thought patterns and beliefs, which were in close relation to their emotions and influenced their behaviour in a way that was not beneficial for them. If the associated stimuli which were imprinted with the phobia during the first moment of shock and fear during the traumatic event, and later triggered and set off the

fight - flight - freeze responses, the psychological phobic reactions will appear as feeling stuck, dissociated or as exaggerated emotional reactions (Swack, 2002), which can explain the lack of control they reported to have over the negative direction their emotions, thoughts, beliefs and new dysfunctional behaviours took. This can be an indication of a phobia because according to Swack (2002; 2007b) when a person has a phobic reaction, they cannot change a thought, attitude, perception or behaviour because of the psychological and physiological nature of the phobia, since a phobia is “an exaggerated, irrational emotional (and physical) reaction that is out of proportion with what is happening in reality” (Swack, 2007b, Phobia section, p. 9 & 10), and this phobic reaction is a conditioned physical reaction/reflex, which cannot be controlled consciously (Swack, 2001a). Although the phobic person is aware of the irrationality of the fear, he/she cannot rationalize him/herself out of it (Salas, 2001; Swack, 2007b).

#### Lack of focus

The phobias of change and transition affected the participants' focus and self-esteem the most. All of them had problems with focusing, and eight mentioned a lack of focus during this part of the questioning. They were unable to focus on anything current for a significant amount of time, but would rather constantly focus on the problem/situation that was creating the pain and difficulties and not much else. They were focused on the past, and avoided the present, the change, the phobia, and therefore demonstrated typical phobic behaviour (Plotnik & Kouyoumdjian, 2008). They also showed that instead of being dissociated from past memories, they were instead dissociated from the present, which can be seen as a symptom of a phobia of change or transition.

### Confusion

Six of the participants (Angie, Elizabeth, Bunny, Grace, Peggy Sue and Tallulah) were in a state of confusion where some were distracted, some were unable to make decisions, some were constantly over thinking, overanalyzing and questioning their behaviours and some participants were also confused about their own behaviour. If a phobic person is faced with his/her phobia, and in typical phobic fashion is overcome with irrational fear, and their entire focus is on avoiding the situation or object (Plotnik & Kouyoumdjian, 2008; Swack, 2002), it can explain their confusion and lack of focus in the present. As the present situation demands change, i.e. to move away from the past, they cannot move, because moving is the very thing they fear. Because they are immersed in their fear, they are unable to avoid their phobia, the change, which maintains their confusion.

### Low self-esteem

Eight of the participants (Angie, Elizabeth, Jane, Michael, Bam, Mr Blue, Peggy Sue and Tallulah) reported low self-esteem, loss of self-confidence, negative self talk, limiting negative and fearful thoughts about themselves and how others perceive them, which are some of the symptomatic consequences of a social phobia: the lack of self-respect, self-devaluation (Leichsenring et al., 2007), negative, inaccurate and distorted mental images/ impressions and evaluations of the self and how they appear to others based on underlying beliefs (Morris & Ale, 2011; Rowa, & Antony, 2005; Stopa, 2009; Swack, 2002). These perceptions of the self can also reflect symptoms of a phobia of change or transition.

### Procrastination

The low self-esteem, lack of focus and their state of confusion contributed to procrastination for all of them on some level, which some of the participants explain as the

inability to move forward and do what they want to do. This feeling of being stuck is also an indication of a phobia (Swack, 2002), including a phobia of change or transition. If a person can be conditioned to associate fear with a frightening experience, situation or object in the past (Plotnik & Kouyoumdjian, 2008; Salas, 2001) and go through great lengths to avoid the feared event (Plotnik & Kouyoumdjian, 2008) or can only endure the phobic stimulus with dread (Colman, 2006; Fourie, 2006), a possible explanation for their procrastination can be that they were avoiding change (the feared event), because the problematic and frightening experience involved change - a huge change in themselves and their lives. If they perceive change as harmful, it may increase fear and anxiety and create a phobia and they can even have phobic reactions to associated objects or situations that might not appear traumatic or related (Furnham, 1995), like change into a new identity, way of life, a new way of being, healing, etc.

#### Maladaptive behaviour

The change created maladaptive behaviour in Angie, Elizabeth, Bunny, Jane, Grace, Michael, Bam, Mr Blue and Peggy Sue. They could not work, study, make business decisions, organize and do activities that they could do and liked before.

#### **5.1.2.3. Physical consequences**

According to Dossey (1989), Neimark (1997), Pert (2003) and Upledger (2003) cellular consciousness exist, and the body reflects our mental life (Dychtwald, 1986), always talking to us, serving as a mirror of our inner thoughts and beliefs. If consciousness then operates at a cellular/body level according to Dossey (1989), Neimark (1997), Pert (2003) and Upledger (2003) and memories which are embedded in the body can have an impact on a person's thoughts, perceptions and behaviour and can cause psychological symptoms (Feinstein, 2012 b), where the mind inevitably manifests in and through the body (Wilkinson,

2000), it makes sense that each participant reported physical consequences due to the traumatic life changing event. An example of a metaphysical interconnection between mind and body will be for example the correlation between dis-ease such as insomnia which might have been caused by emotions of fear and guilt and/or the lack of trust in the process of life (Hay, 1999). In this study six participants (Angie, Elizabeth, Bunny, Grace, Bam and Peggy Sue) reported a change in their sleeping patterns, and it was further observed that the participants' embedded memories influenced their behaviour (Feinstein, 2012b) when five participants (Angie, Jane, Michael, Mr Blue and Peggy Sue) reported that they no longer exercised, and Jane and Mr Blue felt unhealthy, and Elizabeth, Jane and Bam had increased their unhealthy habits such as eating more, and eating less healthy, and drinking and smoking.

When the phobic person thinks of or is actually confronted with the traumatic phobic situation, experience or object and experiences a surge of adrenaline, the body chemistry (such as the neurotransmitters, hormones and blood level oxygen), are influenced (Dychtwald, 1986; Gallo, 2005). We saw this with one of the participants (Tallulah) who found it hard to digest food and as a result lost weight. The participants identified several different and unique physical issues in connection with the traumatic change, confirming Dr Green's (biofeedback creator), statement that all physiological change is correlated to fitting mental (conscious and unconscious) and emotional changes and vice versa (Pert, 2003). Four participants' weight was influenced where Peggy Sue and Tallulah lost weight and Jane and Grace gained weight. Mental patterns, limiting beliefs and ideas can create disease in the body (Hay, 1999) which the participants observed when they reported more physical symptoms related to the change in their lives: acne, anorgasmia, increased asthma, knee problems, body itches, stiff shoulders, menstrual cycle interruptions and feeling a pressure on the gallbladder.

Not only can cognitive issues, like stress from a phobia, contribute to the start of physical disorders or issues, physical disorders or issues can also contribute to forms of psychopathology such as neuroses (Meissner, 2006). One of the participant's (Angie) life change was caused by disabling back pain, which resulted in job loss, and increased immobility, which surgery brought no relief. The result was to use medication which negatively influenced her body clock and made her sleepy during the day and awake during the night. All these factors could create stress and contribute towards creating a phobia.

It is important to listen to a client's words, the context and the personal meaning and symbolism of the words as to become aware of the correlations between the symbolic, verbal meaning (use of metaphors), the body language used and the manifestation of the physical illness (Broom, 2000). Broom (2000) found in his research that the patients' language produced unexpectedly accurate applications to the illnesses presented; for example the case of a woman who had to keep a brave face and developed a facial rash. Two participants' gave physical metaphors to describe how they felt when they thought of their traumatic situation and the persons associated with it: feeling sick in the stomach, feeling that my heart is dropping, my insides feel twisted. Tallulah who reported that her insides felt twisted, also mentioned that she could not digest food and lost weight which supports Broom's (2000) findings.

#### **5.1.2.4. Spiritual impact**

Eight of the ten participants could connect spiritually to the change in their lives and were aware of the spiritual changes in their lives since the change that created the phobias. Six of the participants connected their spirituality with the word God, and Elizabeth and Tallulah connected God with symbols and signs. Six participants experienced spiritual growth, reminding us how human stress can be consistent with a spiritual crisis and can

create an opportunity for spiritual learning, insight and growth (Myss, 1996). The findings of this study are in accordance with Myss (1996) by reflecting that a significant negative change can have a spiritual impact on a person's life.

#### **5.1.2.5. Interpersonal, Social and Occupational impact**

Interpersonal factors, such as relationships, influenced the materialization of phobias as Fourie (2006) suggested, and phobias can disrupt relationships (Bener et al., 2011) and have a negative impact on a person's quality of life because they disrupt their lives and can limit work efficiency, reduce self-esteem and strain relationships (Jensen & Ramasamy, 2009) as all the participants in this study reported. One participant (Elizabeth) demonstrated this as she could not be alone at all and would go to extremes to surround herself with other people and in the process not only disrupted her own life, but the life of others as well and as a consequence strained even close relationships.

If a social phobia is defined as a “marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others” (American Psychiatric Association, 2000, p. 456), then we can say that the participants reported more symptomatic consequences of a social phobia when we discussed the interpersonal, social and occupational impact of the change on their lives.

Only one participant (Grace) experienced a positive impact on her relationships with others such as family and friends. Bunny felt that the change had no effect on her interpersonal relationships.

All the other participants experienced a negative impact on their interpersonal relationships, such as feeling alienated, disconnected, unaccepted, misunderstood, judged and unsupported, and they distrusted others.

Phobias are not socially isolated incidents, but happen in multifaceted social situations, involving interpersonal relations (Fourie, 2006). This became obvious when the participants reported that they were affected personally and in their interpersonal relationships, which also had an effect on them socially where seven of them (Angie, Jane, Michael, Bam, Mr Blue, Peggy Sue and Tallulah) reported to be less social. The focus on misperceived threat in social situations can have a devastating effect on the person's quality of life (Rowa & Antony, 2005), where they believe they cannot meet (their own unrealistic) expectations in a social situation because of personal shortcomings (Stopa, 2009). We observe this when one of the participants, Jane, reported that she was unable to help people in her current state and therefore kept to herself.

Leichsenring et al. (2007) mentioned that social phobias have consequences such as severe psychosocial impairments and high socioeconomic costs which were observed in this study as all the participants felt the impact of the change in their lives, whether it was in their current jobs, as retirees, being unemployed, in their studies or possible future work related situations. Two participants could not focus in school and their grades suffered. Seven participants (Angie, Bunny, Grace, Michael, Mr Blue, Peggy Sue and Tallulah) reported that they felt they could not do what they were supposed to do regarding their work or work situation. They reported that they could not start working again, were unable to start a new business, could not do marketing, start a second career, could not finish a music project, created additional problems at a current job and did not know which direction to take in life.

#### **5.1.2.6. Lack of progression and desired outcomes**

All participants agreed that there was a lack of progression in their lives, on different levels (emotional, mental and behavioural, physical, spiritual, interpersonal, social, and occupational - Table 4.4. in chapter 4) because of the life changing event, which brought up



intense feelings of distress, anxiety, fear and for some, shame. This study also supported the theory that an indication of a phobia is the display of psychological phobic reactions such as feeling stuck, dissociated or having exaggerated emotional reactions (Swack, 2002). Most of the times thoughts and emotions rendered the participants in this study "paralyzed", "frozen" or "stuck" where they would like to progress but could not and could not do what they needed to do to receive the outcomes they desired, such as physical health, focus, confidence, peace, happiness, not wanting judgment and getting back to who they were before the change.

Their lack of forward momentum and progression was described as "do not know how to move forward", "scared of change and the future", "fear to not adapt to change", "feeling discouraged, unmotivated, paralyzed", "unable to move forward", having "a steady level of resistance", having "anxiety about the unknown" and "feeling stuck". These observations are consistent with Plotnik & Kouyoumdjian (2008), who state that when people are phobic, they avoid the feared object or situation at all cost, which in this case can be change.

Instead of change, the participants stayed stuck, resistant, paralyzed, etc. and did not move forward and away from the situation. Therefore it can be concluded that they were not phobic of the traumatic situation because they kept revisiting it as we saw in 5.1.2.2. *Mental and Behavioural consequences* section, but rather phobic of the change they had to make to progress away from the traumatic situation. If they avoid the feared situation, in this case an action to change, it will keep the phobia alive (Fourie, 2006) as we observed during this study when they could not change and progress.

Walsch (2009) suggests that people follow nine steps, and he provides specific instructions for how people can change their approach to change, to better deal with it, and in that way create change in their lives. But if a person is phobic, he/she cannot control and/or change their thoughts, attitudes, perceptions or behaviours because of the psychological and

physiological nature of the phobia (Swack, 2002; 2007b), which will make it impossible to follow his (Walsch, 2009) steps which include changing your choice of emotions, thoughts and truths. Eight of the participants' (Angie, Elizabeth, Jane, Michael, Bam, Mr Blue, Peggy Sue, Tallulah) low self-esteem, loss of self-confidence, negative self talk, limiting negative and fearful thoughts about themselves and how others perceive them, can also play a role in not taking steps towards their healing, as can the feelings of depression. We have seen in this study that some of the participants, already felt isolated and unsupported, so the "go it alone" first step would make them feel even more alone and isolated. Some participants such as Peggy Sue desired to "stand on her own", but could not, as she lacked self-confidence and desired more support as did Tallulah.

Walsch (2009) suggests further that a person should change his/her idea about why change occurs, and although some of the participants would replay the "why" of the change over and over in their heads, they could not receive an answer and it lead to increased confusion, instead of an answer to why the change occurred. Although all the participants could change their idea about future change and all could express desired outcomes (such as the ability to move on, increased focus, confidence, peace and happiness) they could not change their idea about life as is, in order to progress. They also could not change into a new identity as

Walsch (2009) suggests, although Angie, Elizabeth, Jane, Grace and Peggy Sue reported that they wanted to get back to "who they were before" the incident.

Because of the psychological and physiological nature of phobias discussed so far, it will be very difficult if not impossible for a phobic person to follow the steps which Walsch (2009) suggests in order to bring forth new changes during a big change. What can support a person to bring forth change, is an EP method and interventions as we observed in this study.

### **5.1.3. A life changing event can create phobias of change and/or transition**

The four stage process (1: a verbal assessment of their distress, fear, anxiety SUD levels, 2: looking at the use of phobic language and behaviour, 3: self-realization and 4: realization and confirmation through muscle testing) to verify the presence of a phobia in the context of change, transition and progression in each of the participants was adequate to confirm the presence of a phobia of change in nine participants, and a phobia of transition in one participant. All these steps are relevant for future research or assessments of phobias of change, transition and/or progression.

If phobias are viewed as “an anxiety disorder characterized by an intense and irrational fear that is out of all proportion in relation to the possible danger of the object or situation” (Plotnik & Kouyoumdjian, 2008, p. 518) where a person goes to great lengths to avoid the feared event (Plotnik & Kouyoumdjian, 2008), and where psychological phobic reactions will appear as feeling stuck, dissociated or as exaggerated emotional reactions according to Swack (2002), and Broom (2000), who found that a patient's language produced accurate applications to the illnesses presented, I realized that the participants displayed phobia characteristics. For example seven of the participants had high (7+) SUDS on distress, fear and anxiety, they all used phobic language such as feeling "stuck", "paralyzed", "frozen", "resistant" and all participants demonstrated behaviour where they procrastinated (there was a lack of action and they could not move forward with their lives).

After interviewing the participants and recognizing phobic characteristics in each of them, I wanted to stay mindful as a therapist as Gallo (2012) suggests, and investigate their self-awareness. To be mindful means that all possible issues are addressed, without avoiding, suppressing or over engaging certain aspects (Gallo, 2012). To evaluate the participants' perception of their current reality regarding the change, I asked them if they thought of

themselves as being phobic in the context of the change and transition they just discussed with me. Although six participants thought of themselves as phobic and one thought it might be a possibility, this question created cognitive dissonance for some as the new information tested their old beliefs (Colman, 2006). To create consonance by maintaining congruency between the conflicting cognitions, perceptions or cognitions and behaviours, they tried to preserve their current, familiar perception of their world and reduce the dissonance by using certain strategies, such as rationalization (Colman, 2006; Huber, 2007). Bam explained and justified his fear by saying that "there was danger out there, which justifies my fear. My fear checks in with me to warn me so I can solve the problem". He rationalized about his fear, although this fear could not solve his problem which is in alignment with The Oxford Online English dictionary's (*n.d.*) definition of cognitive dissonance as "the state of having inconsistent thoughts, beliefs, or attitudes, especially as relating to behavioural decisions and attitude change."

Although all the participants recognized some kind of irrationality in themselves, whether it was an irrational fear of change, transition or progression, and although they all gave explanations why they thought their fears were irrational or rational, not all pointed to cognitive dissonance. The correlation between phobias and cognitive dissonance is that there is incongruence between thoughts and action in both cases and one can reason that neutralizing a phobia can help with cognitive dissonance resolution, create consonance, and thus increase the person's ability to make better judgments, choices and evaluations and support progression.

Although all participants displayed phobic language and behaviour, not all the participants saw themselves as being phobic and not everyone's emotional SUD levels were very high. The language of the body never lies, and seizing the chance to use the body as an analytical instrument (Gallo, 2005), brought me to the final step of admitting possible

participants to the study: assessment through muscle testing (MT). Like TFT, HBLU™ utilizes MT because it has the ability to reveal specific information to treat psychological issues (Gallo, 2005) and it is useful to help clients explore unconscious beliefs and conflicts (Benor, 2004). Therefore if a practitioner's intent is to approach and treat a client holistically and receive authentic answers to queries with regard to the client and to give a reliable and effective treatment, the inclusion of MT should be a strong consideration. MT played an important role in this study, not only confirming suggested information, but it also sorted out conflicting information and helped to direct the healing process. Each of the participants confirmed through muscle testing that they had a phobia in the context of change or transition regarding their specific situation and confirmed through muscle testing that the HBLU™ simple phobia protocol would in all likelihood transform their phobias. If this fear of change in a therapeutic situation is not addressed successfully, the clinical outcome can be insignificant (Shapiro, 2001) and we therefore turn our focus on the resolution of phobias of change or transition with HBLU™.

#### **5.1.4. Clearing phobias of change or transition with the HBLU™ simple phobia protocol**

For nine participants, their life changes resulted in phobias of change and for one participant (Mr Blue) his life change resulted in phobias of transition which could be treated with the HBLU™ simple phobia protocol in one session, except for one client (Bunny) who needed two sessions. The two sessions were unexpected, but allowed me to treat without harming or traumatising the participant who desperately wanted treatment, and also to see if resolution could be achieved with this method, although the participant presented multiple issues.

According to Walsch (2009) there are three kinds of truth: 1) The Actual truth (based on the limitless viewpoint of the soul), 2) The Apparent truth (what we observe - based on the limited perspective of the mind) and the 3) The Imagined truth (what we have distorted). To experience transformation on a personal and global level, you "will want to journey upward from Imagined truth to Apparent truth to Actual truth, so you may shift your basis from Distorted Reality, to Observed reality to Ultimate reality" (p. 71). A person can experience intense emotions because they come from their Imagined truth (the negative things you believe that will happen to create a negative outcome) and not their Apparent truth (forming thoughts about a present day event) (Walsch, 2009). We saw this during this research when the participants described their thoughts, emotions and lack of progress and therefore stayed in their Distorted reality. We cannot observe what is real if it is filtered through an ascent of past emotions and experiences (Pert, 2003). Reality is fluid and not fixed, because our experience of it changes (Walsch, 2009). When we are "stuck" emotionally or fixated on a chosen reality (a Distorted reality of choice that does not serve us well), there is not only a mental, behavioural or spiritual potential for change, but a biochemical one as well, when we realize that our body is in constant motion where "receptors are not stagnant, and can change in both sensitivity and in the arrangement they have with other proteins in the cell membrane" (Pert, 2003, p. 146). If repressed emotions are stored in the body through the release of peptide ligands, and memories are stored in their receptors, then it is possible that transformation can sometimes occur through the use of body-mind therapies if the focus was on releasing emotions stuck in the psychosomatic network (Pert, 2003).

This brings us now to see if the research question: *Does HBLU<sup>TM</sup> (with its integrative approach as an Energy Psychology method) successfully detect and resolve subtle phobias regarding change, transitioning and progression?* can be answered affirmatively.

According to Shapiro (2001) the fear of change can be the most difficult to address because secondary gain issues, which can involve a variety of possible aspects of the expected therapeutic process or outcome, such as fear of success, failure, the unknown, loss of identity, loss of control, etc., need to be determined and reprocessed before the original goal can be reengaged. When the participants spoke about their change and the consequences of the change, some of these fears were mentioned. Shapiro (2001) suggests that these fears, which may originate from old dysfunctional experiences, should be addressed and processed with an intervention, in this case EMDR, but could cause further complications ("an insidious web", p. 195) which can create reluctance in the client to cooperate. It is therefore important to try and identify the dysfunctional beliefs behind the fear of change (Shapiro, 2001). Not only are the dysfunctional beliefs behind the fear of change discovered in the HBLU<sup>TM</sup> phobia protocol, but fears and other negative emotions and negative limiting beliefs are discovered and addressed as well during the phobia mapping out process and can be simultaneously released/ transformed when the intervention of choice is applied. A thorough healing process like this can address many underlying issues of the presenting problem and eliminate guessing, which can result in more effective results. The beauty of such a healing is that all of the pieces of the presenting issue can be effectively resolved once the healing goal is complete. This does not mean that there are not to be other related facets of the problem that may manifest at a later date. This can sometimes lead to a person falsely assuming that the healing of his/her goal is not complete, which is erroneous thinking. In such situations, after MT confirmation and further mindful questioning confirming that the healing goal is complete, the subject needs to be reassured that his or her healing is complete. However, what is happening, is that another related facet of the problem is emerging and is desirous of healing.

The simple and structured process of the HBLU<sup>TM</sup> phobia protocol keeps complications

(what Shapiro (2001, p. 195) calls "the insidious web") limited and helps to keep the client and therapist focused on their goal. A further benefit of this approach is that it can prevent both the client and the practitioner to feel overwhelmed and confused and keep the process focused while proceeding towards the goal with greater precision and success.

Only after the most extreme fear or/and shame is established, it is processed/healed with the intervention(s) of choice. The benefit of using the most extreme fear or/and shame is that it gets to the root cause, the core of the phobia, and by doing so addresses the biggest fear or/and shame. Once the biggest fear or/and shame is found, addressed and neutralized with an intervention, all lesser fears can be neutralized simultaneously, and cross clearing takes place, as was the case for some of the participants in this study.

Fear of change can occur when a client is a long term client, who is noncompliant, controlling of the therapeutic process, if the therapeutic effect is not maintained, or after a number of key traumatic events were successfully treated and he/she becomes fearful of the new personal identities, where he/she is adjusting to his/her new behaviours and becomes aware of the need to integrate in an old, still dysfunctional family, workplace or social system (Shapiro, 2001). This noncompliance was demonstrated when Jane did not do her homework (to keep a log of her emotions) in order to help her reduce her anxiety after the screening interview. Although she was desperate for help, she could not do what was requested of her that would actually help her. Therefore, it is prudent to suggest that a phobia of change should be addressed in the beginning of therapy to increase trust, ease and progress in the therapeutic process as the client may unconsciously sabotage the therapy by his/her phobias of change, transition or progression.

A therapist's presence, actions and words should create rapport, engagement and connection in order to provide a positive personal approach and support to their clients (Shannon, 2010) and if fear of change is addressed then it can also prevent therapists'



frustration as we observed with Elizabeth's therapist when she was unable to progress with Elizabeth, and as a result Elizabeth sensed her therapist's frustration and terminated therapy. When the therapist stays mindful of the client's language and notices a lack of progression or notices the use of fearful language or language that suggest stagnation or procrastination or notices the characteristics named above, the client can be muscle tested to confirm the presence of a phobia of change. And when confirmed, therapy can continue with phobia treatment.

Before the HBLU™ protocol was applied for phobia treatment, one of the participant's, Jane, received two interventions - prayer and skin breathing to assist her with her anxiety. Because I chose to stay mindful, it allowed me to take a step back and become aware of how the participant responded to internal and external stimuli (Johanson, 2009) so I could continue to support and assist her with her immediate needs in order to progress with the therapy in an ethical way where the participant is not traumatized or harmed. When a person tells his/her life story, the verbal area in the brain is being kept active, which in turn helps to balance the left and right brain hemispheres (Johanson, 2009) and when the two hemispheres of the brain are working together, we are not stressed (Diamond, 1979), which can explain why two of the participants, Grace and Peggy Sue, actually felt better after the screening interview when they received more clarity after the questions and Grace reported that receiving more information made her feel calmer. Therefore it is recommended that practitioners stay mindful during therapy and are sensitive to a client's needs, including their need to talk and tell their story and not to be overly focused on a method, rushing to get through the protocol. Verbalization not only helps the client, but can also supply the practitioner with helpful information and help to build trust, as we have observed in this study.

During the HBLU™ simple phobia process I used a combination of EP techniques as well as talk therapy to encourage and assert communication and coping skills. I completed the process in five stages: 1) simple clearing, 2) establishing muscle testing, 3) establishing the priority goal, 4) mapping out the phobias, 5) phobia resolution which includes testing the results.

#### **5.1.4.1. Simple clearing**

Karjala (2012) mentions during her 2012 ACEP presentation that one of the six major treatment success saboteurs is when a client is not energetically ready to benefit from the treatment. If all negative emotions are caused when a distressing awareness about an experience and or object enters a person's thought field (according to Callahan) and causes disruptions within the energy system (Gallo, 2005), we understand why simple clearing is an important part of the treatment as it set the participants energetically up for muscle testing and treatment. Life can interfere with a client as we saw when Mr Blue reported a lack of sleep and Jane reported that she was disturbed by her parent's fight and her fear of being late. She needed to talk, pray and do a round of EFT to reset her energetically so she could muscle test accurately.

The practitioner can ask detailed questions and make the client aware of the physical sensations that are presently felt which can help to stabilize the organically unfolding, emerging memory (Johanson, 2009). This was done when Mr Blue talked about how he felt and attention was drawn to the powerlessness in his arms (both just fell down on a yes and a no during the simple clearing process). This imbalance was corrected by intentionally asking him what took his power away and then instructing him to tell himself to take his power back, which immediately cleared his energies and rebalanced him. I, as the "intentioner" was in an intended state before I focused my intention on the participant and had clarity of thought as

Braud (1992) suggested for effective use of intention. We saw here what Braud (1992) means when he mentions that focused intention can produce increased calmness or activation, which was demonstrated in the case with Mr Blue.

We also notice that when the verbal area in the brain was kept active, and the left and right brain hemispheres were balanced and were working together, it helped the participants to become aware of how they responded to internal (feeling tired, disappointed and powerless) and external stimuli (the family fight) (Johanson, 2009), which helped them to address the issue and balance their energies in order to give accurate muscle testing answers.

Only two participants (Grace and Peggy Sue) had no problems during the simple clearing process. Apart from Mr Blue who received intentional talking and Jane who received prayer and EFT, six of the other participants needed interventions to correct their energetic fields in order to proceed and muscle test, demonstrating the importance of this section of the treatment process. Apart from talking, they drank water (for dehydration - Michael and Tallulah), did the belly, back and K27 rub (Michael, Bam and Tallulah), the Cooks hook-up (Tallulah, Elizabeth), and Tallulah did duck lips, which are the interventions normally used during simple clearing (Appendix G). Raking, NLP mind scrambling (Bunny), surround with a sphere of Holy Light and asking God and his angels for guidance and protection (Angie) were additional techniques used from Appendix O during simple clearing.

We observe here that EP techniques are used before starting the phobia protocol in order to set up the participants energetically for (accurate) muscle testing and treatment, which is crucial for accurate EP work.

#### **5.1.4.2. Muscle testing**

One of the approaches added to the HBLU™ methodology is Kinesiology or Muscle testing which is used to help direct the healing process. The participants' ability to muscle

test was tested directly after the simple clearing process. In HBLU™, practitioners work with the person's conscious, unconscious, body, soul and energy fields simultaneously, and in order to heal, the client must be able to communicate and access information from all the levels of being. This is done by verbalization, through the use of the NLP technique which directs the participant to go inside and talk to the relevant part of his/her body, and by addressing the soul and deepest wisdom during muscle testing (Swack, 2002; 2007b).

When difficulty in muscle testing was detected, it was important for me to stay mindful, ask questions and listen to the participants' story as they had a need to talk about it. I had to follow Johanson's (2009) and Gallo's (2012) advice to stay mindful and present, and to assist the participant to stay mindful of what they were experiencing during their storytelling. It is important to not devalue subjectivity, but to include a participant's story, listen to their words and the personal meaning they attached to the illness/disturbance for becoming aware of the correlations between the symbolic, verbal meaning (use of metaphors), their use of body language and the manifestation of their physical illness/disturbance (Broom, 2000). In this case the nuances of the muscle testing was also included when the participants did not give clear "yes" or "no" answers, but displayed a reversal where the "yes" tested as "no" and vice versa, and where they moved to the side (instead of moving back or forth) or did not move at all. An example was when Angie could not muscle test for "no" (and stayed put) and voiced that she felt stubborn about life. After she realized that her stubbornness was not helpful, she could muscle test accurately. Michael also had a problem with "no" which he related to not wanting to commit to unwanted things (perhaps not realizing then that it could be change) that would keep him away from things he wanted to do (his music). Once he realized he had a choice though, he could verbalize that he chose to unblock by letting go of his stubbornness, which he did. Karjala (2012) mentioned that issues can resolve by simply addressing the objections that can help the client to succeed and move forward. Focused

attention on the body can help our systems to digest information, and the information can then be filtered and processed so as to effect healing according to Pert (2003), even something as simple as removing your shoes, as Angie realized, had a positive effect on her muscle testing.

Nicosia (2012) mentions that the unconscious is accessed through the body and when an individual is aware of different physical sensations, it can offer a way to double-check conscious thoughts and theories, accessing the body's wisdom as the final authority. When the focus was brought back to what the body was indicating, the participants could relate to the specific block, through a limiting belief such as Grace's belief that she was not deserving of healing or through negative emotions such as Tallulah's feelings of being overwhelmed and confused. Once they voiced what they were feeling or thinking, had recognized, acknowledged and thanked the part, the muscle testing was corrected.

Apart from talking to, recognizing, acknowledging and thanking the body parts that spoke to them about their resistance, Cook's hook-up was used to correct Bunny and Tallulah's reversals, and they both also called for a sphere of Holy Light and asked God and His angels for protection before they could continue to muscle test successfully. Tallulah also needed the stress release technique with the colour purple, body talk and an upgrade of an enneagram 7 layer with the essence process during her muscle testing session.

Once again mindfulness of the client's individual need is shown to be an important tool for the practitioner and client which at this stage accompanied and assisted with MT. Additional EP techniques were also applied when needed to calm a client's fight-flight reflexes (i.e. anxiety response), showing the importance to be mindful to the client's needs and supply him/her with whatever is needed in the process.

#### **5.1.4.3. Establishing a goal**

Setting goals for healing took between 3 minutes to 50 minutes and can take up a significant amount of therapy time. Some of the participants' first identified goals were not their priority goals (as verified via muscle testing). In these cases, the client had to rethink his/her goal until we could establish his/her priority goal and confirm it through muscle testing. Ash (2003) reminds us that in order to produce therapeutic results which benefit the practitioner and client, intention should be included as an instrument to guide the therapeutic process to establish an appropriate target or goal. Karjala (2012) mentions that if the focus of a treatment is not specific enough, it can sabotage the success of a treatment. This was important to remember for me when only four of the participants had established their true goal right the first time around. It is important to not get discouraged during this stage of the process and to continue to persist towards finding the priority goal. For clients who are uninitiated in EP work, it can sometimes take up to an hour, to establish his/her highest priority goal. The client might think it is a goal, but muscle testing can disconfirm their initial ideas about what their goal should be.

Setting up an accurate goal is part of the healing process and can establish greater clarity for the client. A goal is important because clarity of thought is vital in terms of effective intention when it is used during therapy and if a person does not have a healing intention, healing might not take place, reminding us that intention, or the lack of it, can have a positive or negative effect on the healing process (Ash, 2003). This intentional, goal orientated approach helped the participants to achieve their goals as Elizabeth showed when she received clarity and could establish her goal in 15 minutes after initially presenting 4 goals.

Establishing a goal can also bring up more issues and being intentional and mindful was also helpful when more issues arose for Bunny during establishing her goal. Although she needed to talk more and needed an intervention (EFT), she was able to stay focused and establish a goal. Through personal experience I learned that when issues during goal setting are ignored, it can create stress and anxiety, and can confuse and overwhelm a client more and make problem resolution more complicated and difficult. It is therefore important to maintain an attitude of mindfulness to assist in the relaxation of the participant, help prevent feelings of being overwhelmed and support the participant to tolerate feelings and thoughts which they prefer to avoid (Childs, 2007).

Factors such as mindfulness, intention and muscle testing need to be included in healing, and are active ingredients in the HBLU<sup>TM</sup> phobia protocol where both the therapist and client are intentionally focused on the storyline, outcome and resolution of the phobia. All these factors played an active part in establishing a goal where muscle testing was used to access information from the participants' unconscious mind, body and soul and helped them to streamline their goals, it also brought greater clarity and directed them towards the correct goal.

Mindfulness helped me to continue to stay attentive and listen to the participants' words (Broom, 2000) which helped me to probe more, especially when the goal was not very specific or too grandiose. Grace had such a grandiose goal: to be “free, competent, capable, joyful and living her life as fully as she could” which is a goal that even the most balanced person would like to achieve, but which seemed too all encompassing and therefore unrealistic. With further mindful probing Grace could become more specific and finally with muscle testing we were directed to go deeper to establish her final goal.

Michael had a need to control the timeline for his goal and was directed and advised to not let that be his focus. When Michael was not so focused on his timeline, he felt his goal to be

more specific and less "out there".

I continued to stay mindful and listen to the participants' words and the personal meaning that they attached to their words to continually be aware of the correlations between the symbolic, verbal (metaphors) meaning of their words and the manifestation of a physical discomfort as Broom (2000) suggested. This helped when Bam became anxious during goal setting and mentioned the pain in his feet and knees and I remembered that the body reflects our mental life (Dychtwald, 1986). To access information from his unconscious mind and body, we used the NLP technique to go inside and talk to the relevant part so he could discover what his body and unconscious were trying to communicate to him and continue to muscle test accurately and establish his goal.

#### **5.1.4.4. Mapping out the phobias**

The "mapping out" process is important because memories that are embedded in the body can have an impact on a person's thoughts, perceptions and behaviour and can therefore cause psychological symptoms, such as phobias (Feinstein, 2012b).

Because mapping out the phobias brought us to the most extreme form of their phobias, it is important to remember to stay in a state of mindfulness to assist with relaxation, prevent the client to feel overwhelmed, and support the client to tolerate feelings and thoughts which they prefer to avoid (Childs, 2007). Most of the time, the end result of the fear phobias ended in death or turmoil and the shame phobias ended in severe character assassination, confirming Swack's (2007b) findings. According to Dr Swack (2002), phobias are imprinted mentally and physically the moment when someone first feels the shock, fear or surprise of a traumatic experience. This "phobic – trauma imprint" is the consequence of the fight-flight-freeze reflex (Swack, 2002, p. 65). The moment the phobia is imprinted, all the associated stimuli are imprinted as well and can later be triggered to offset the fight-flight-



freeze responses, which can be seen in physiological phobic reactions, such as rapid heartbeat, sweating, inability to move, according to Swack (2002), which was observed in Elizabeth and Bunny who wanted to physically lie down during the mapping out of the phobias, and Jane who started to whisper.

The phobic imprints also have psychological manifestations such as feeling stuck or blocked in one's life, feelings of dissociation or exaggerated or irrational emotional reactions (Swack, 2002). Psychological problems cause the brain to send out electrical signals which result in an emotion such as fear, a perception or a behaviour that is incongruous with the present situation (Khan et al., 2010), so just thinking about the phobic object or situation can trigger a negative emotional response (Feinstein, 2005a). During the mapping out process I observed the psychological reactions in the words which the participants used to describe their emotional and mental state, words like die, suicide, wither away, fear, scared, anxious, failure, lonely, alone, no focus, stuck, not motivated, fear to deceive, busted, dishonest, lie, not truthful, fraudulent, useless and worthless. Their behaviour also demonstrated psychological distress as we see when Grace and Tallulah cried while they mapped out their phobias, Tallulah had a further need to talk and pray and Elizabeth and Bam became fearful, needed to talk and needed reassurance when we started to map out their phobias. When any self-limiting emotional memories have not been processed, they will manifest waking imagery and problematic behavioural patterns, until they have been adequately processed (Feinstein, 2012b). At this stage of the treatment the memories had only been made conscious, but had not yet been processed. Unprocessed memories can restrict an individual's progress towards integration and coherence according to Feinstein (2012b), and it is therefore important to process and transform emotional memories once they emerge so as not to let the participant feel exposed, vulnerable and overwhelmed with the information which is brought to the surface. After EP healing interventions participants have reported that they feel calm in

response to previously distressing memories (Gallo, 2002; Feinstein, 2005a; Schulz, 2007; Swack, 2009). Specific techniques are thus chosen in EP therapy sessions to accomplish that.

The following section describes how these phobias were resolved.

#### **5.1.4.5. Energy Psychology techniques applied *before* clearing phobias**

Some participants did not only require an intervention (applying an EP technique) during treatment, but, apart from talking also required EP interventions before they reached this stage of the process during the 1) simple clearing process, 2) setting them up for muscle testing, 3) establishing the priority goal, and 4) providing me with the permission to proceed and clear the phobias.

Because EP focuses on the body's disturbed electromagnetic energies and the electromagnetic fields surrounding the body and organs to relieve psychological problems according to Khan et al. (2010), the HBLU<sup>TM</sup> simple clearing process is therefore an important foundational part of HBLU<sup>TM</sup> treatments as it energetically sets up the client for accurate muscle testing and treatment.

Upledger (2003) has found through personal experience in his decades of intentionally dialoguing with his patients' body parts, systems, tissues, tumours, pains, and viruses, at the cellular level and by observing his patients' responses, that there is a relationship between cell activity and consciousness and that this may play a role in facilitating healing in the mind and body. According to Upledger (2003) such a relationship could explain why some of the participants only needed to address the particular body part that voiced the reason for not muscle testing accurately. Once that part was recognized, heard, thanked and reassured, the particular participant could continue to muscle test accurately. Nicosia (2012) adds the *intention to MT correctly* as a requirement to his MT

procedure, and the participants who spoke to their body parts in order to correct their MT all had the intention to correct their MT, which could also contribute to the resolution of their MT difficulties.

In this research study, focusing on the goal and establishing it brought up more additional issues for some of the participants. These issues needed to be addressed and resolved through the application of EP interventions. There is an increased awareness and recognition of the embodied nature of emotional states (emotions are bodily as well as mental) and this awareness made clinicians aware of the importance to not ignore the body, but rather focus on it as well. If the practitioner asks the client to notice the sensations in the body or the client becomes aware of the sensations in the body, it engages body, brain and mind (Mollon, *n.d.d*). Wilkinson (2000) and Nicosia (2012) assert that the mind inevitably manifests in and through the body which was observed when the participants' issues were mainly reflected in the muscle testing problems that appeared. Bunny needed to address her muscle testing issues with EFT/NBD to help her through this process. Bam became very anxious and spoke about the pain in his feet and knees. Since focused attention on the body can help our systems to digest information, and the information can then be filtered and processed so as to effect healing (Pert, 2003), and the body has wisdom that is accessible (Nicosia, 2012), we did EP body talk and spoke to his feet to hear why they were so painful at the moment.

Before Peggy Sue could get a 100% permission to proceed with clearing the goal, she had to bind a curse and use visualization with colour. Before Tallulah could give permission to clear her phobias with the HBLU™ simple phobia protocol, she needed to do 1) stress release with colour, 2) pray (twice), 3) upgrade her enneagram 7 layer with the essence process and do 4) body talk. We observed the nervous system as a stimulus-response system (Wiedermann & Wiedermann's, 1988) when Tallulah released sadness during the essence

process which made her nose run excessively, she also felt lighter and very hot. This made her smile and said that she felt really good.

The EP techniques mentioned above were used to assist the participants through the process before treatment and to assure accurate muscle testing to preserve the integrity of a thorough and honest treatment. After the use of these preliminary interventions, the participants still had all their phobias, just as Swack (2012) found in the case of Artist Mary who still showed high PTSD scores before HBLU™ treatment, although she was previously treated for PTSD with both EMDR and EFT. These cases support Swack's (2012) case as well as her statement that in order to support effective treatment, it is important to understand the pairing of pattern structure (of an issue) and EP techniques/methods.

#### **5.1.4.6. Phobia resolution**

Except for Mr Blue, who had phobias of transition, all participants had phobias of change as an interference pattern on their goals and through muscle testing confirmed that they gave me 100% permission to clear the phobias as the priority interference on the goal with the HBLU™ simple phobia protocol. The previous procedural steps (simple clearing, establishing muscle testing and a goal, and mapping out the phobias) of the HBLU™ process prepared the participants and gave them a greater understanding for the next stage of the process - applying techniques to resolve the phobias. All the participants were able to successfully follow and finish the methodological process of the HBLU™ phobia protocol (Appendices L & N) including choosing and applying the interventions of choice to clear their phobias.

They all had 1 treatment session (which included recapping the screening interview answers, simple clearing, establishing muscle testing, establishing a goal, mapping out the phobias, discussion of the phobias, phobia resolution, testing the results and writing the learnings),

averaging one to two hours 30 minutes, except for Bunny who had 2 treatment sessions and whose treatment time added up to three and a half hours.

I was reminded once again that phobias are not socially isolated incidents, but happen in multifaceted social situations, involving interpersonal relations (Fourie, 2006), when Elizabeth focused on the worst example of her priority phobia and mentioned that her friend died during the same time she had a terrible relationship with her dad, and Jane's worst example of her phobia was where she saw her dad accusing her crying mom. Taking all this into consideration together with the presenting PTSD of seven participants, the average treatment time of 90 minutes was good and practical for use in therapy. I suggest that if the traditional treatment time of one hour is followed (instead of the 90 minutes treatment time for HBLU™), the practitioner should allow for two to three sessions for treating a client thoroughly.

#### **5.1.4.6.1. Energy Psychology techniques applied *during* phobia resolution**

Energy psychology brings about rapid results, because it “target[s] the more primitive parts of the brain – the limbic system, medulla oblongata and Enkephalin system, which is in every cell of the body”, and is therefore known as “power therapies” (Khan et al., 2010, p. 85). Gallo (2005; 2009) adds that EP views psychological problems inclusive of the mind-body and bioenergy fields and further adds that energy is the fundamental fractal of all psychological problems. Therefore psychological disturbances can be treated by addressing subtle energy systems in the body by adding a tool, like an EP technique, which can help to facilitate neurological change (Feinstein, 2005b; Feinstein et al., 2005). If you modify these energies, you can have an impact on a person’s health, emotions and state of mind (Feinstein, et al., 2005) as it was shown in chapter 4 and will be discussed in this chapter.

Not every technique is effective for a person or situation, and the beauty and strength of HBLU™ lies in its incorporation of a wide range of Energy Psychology techniques that goes beyond the scope of tapping techniques.

All the participants needed more than one intervention during treatment to transform/neutralize all their phobias a 100% on the conscious, unconscious, body and soul levels and to balance them 100% on their goals. The average EP intervention time was between 4 minutes to 22 minutes, except for Bunny whose total EP intervention time took 86 minutes. The longer times include talking during the application of the technique.

All the female participants acknowledged a Higher Power – God – during their treatment process, and Peggy Sue and Tallulah had a greater need to talk to God.

Apart from incorporating prayer as a technique, the following 12 techniques were used during the phobia resolution process, some with multiple applications: 1) 11 UF/O holdings (with and without extras), 2) 3 skin breathing with colour, 3) 4 Boundary taps, 4) 3 Drawings, 5) 5 Callahan phobia techniques, 6) 2 Stress release with colour, 7) 1 Raking, 8) 3 I feel/ I am, 9) 5 HRT (with and without colour), 10) 1 NBD , 11) 1 NBD with "watchman in the tower", and 12) 3 Reversal conflict tappings.

All techniques were effective, fast, and gentle in their application. All techniques were about equal in their popularity, with the exception of UF/O holding, which was the most popular with 11 applications, followed by the Callahan phobia technique and HRT (5 applications each). The variety of EP techniques chosen by the participants shows the importance of diversity and to not be wedded to only one technique as it might not be effective for everyone. It also shows that more than one technique or more than one application might be necessary to resolve an issue. Not all the EP techniques included tapping and seemed to be just as effective to neutralize the body's phobic reactions. It seemed that

these procedures also had an impact on the energy fields and permanently altered the neurological sequence of the conditioned response to the feared memories and its triggers as Feinstein (2012b) suggests tapping does. Lambrou et al.(2005) did a study to show the normalization of ERG theta waves and changes in the electrical conductance between acupuncture points after a 30 minute claustrophobia treatment using not only self-applied acupressure, but focused thought and structured breathing exercises as well, illustrating the effectiveness of techniques other than tapping techniques in the treatment of phobias.

Talk therapy was also included as a technique and we noticed that Angie needed to use talk therapy at the last intervention before she could finally balance her goal on all the levels. Tallulah had to talk about her mapped out priority phobia before she could use an intervention to transform it and then also needed to speak about her conscious insights after all her phobias were cleared to be able to clear the goal on the conscious level. We notice once again the importance of verbalization which balances the left and right brain hemispheres, making them work together, which helped the participants to become aware of how they responded to internal (the phobia story) and external (the intervention(s)) stimuli (Johanson, 2009). This also shows that talk therapy is the perfect marriage partner for EP.

#### **5.1.4.6.2. Physiological reactions during phobia resolution**

Because the nervous system is a stimulus–response system, I saw during the phobia treatment that some of the participants demonstrated physiological reactions. Elizabeth for example spoke very softly and seemed very tired, Bunny said that she felt exhausted after her first intervention and wanted to sleep. In the beginning of her second session Bunny wanted to lie down as soon as we had to start working on the phobia resolution, she also cried, yawned, sighed, burped and laughed during the process. Jane also yawned and Grace cried. The men demonstrated their physical reactions in a different way. Michael did not talk about

his responses, but I could see how his body started to tense up and his breathing almost stopped when he thought about the priority phobia's origin, confirming Rolf's (the biochemist and physiologist who created "Rolfing") findings that physical and emotional traumas tighten the body's muscular and fascial muscles (Dychtwald, 1986). Through his personal and practical experience, Dr Pearsall (in Pert, 2003) concluded that some type of cellular memory exists, and Pert herself (2003) came to the conclusion that consciousness operates at a cellular/body level, which can explain Bam's reaction when he immediately and without prompting said he could feel the phobia in his hands, back of his neck and his right knee and foot and Mr Blue said he felt so tired and powerless when we started, that he could hardly lift his arms. These findings support evidence from fields such as epigenetics, neural plasticity, psychoneuroimmunology and different fields of biology that there is a fundamental link between emotion and physiology (Church, 2013).

#### **5.1.4.6.3. Emotional, Cognitive and Physiological reactions directly after treatment**

According to Mollon, (*n.d.b*), when the energy levels are addressed during treatment, not only do the issues subside, but the client becomes increasingly aware and insightful regarding the emotional and mental conflicts associated with the addressed issue. A significant component of exposure therapies, which includes EP and is part of this process because the participants were exposed to their phobias when they mapped out the phobias, is that a retrieved memory and its limbic responses can be changed before it is stored again (Feinstein, 2008a). The limbic responses are altered through acupoint stimulation which are believed to result in beneficial modifications in neurochemistry (Feinstein, 2008a). We see this here when Michael immediately noticed a different perspective after NBD and Bam forgot what the issue was which he tapped on a few seconds before. Both used an acupoint



stimulation technique. Grace, Michael, Bam and Peggy Sue further reported that their phobias sounded silly, ridiculous, untrue and made no longer sense to them after treatment. According to Dunning & Woodrow (2005) Bio electromagnetic energy affects both the physical and psychological health of organisms and further research shows that people report feeling calm in response to previously distressing memories after EP healing interventions (Gallo, 2002; Feinstein, 2005a; Schulz, 2007; Swack, 2009). This was confirmed in this study when laughter and smiles were symptoms that stood out immediately after a phobia was resolved and the participants reported feeling relaxed (Bunny and Grace), peaceful, calmer (Grace), good (Mr Blue and Tallulah), energetic (Mr Blue), happy (Elizabeth), and laughed (Elizabeth, Bunny, Michael, Bam, Tallulah).

The physical affects were experienced when Jane, Bam, Peggy Sue and Tallulah, could feel the difference in their bodies and Elizabeth, Bam, Mr Blue, Peggy Sue and Tallulah mentioned that they felt more energized, and Jane and Grace's voices sounded stronger and clearer after treatment.

Cognitive issues, like Jane's stressful morning, can contribute to the start of physical issues according to Meissner (2006) as an individual's mind affects the individual's body (Dossey, 1989; 1993; 1999). Jane experienced a very painful back issue (which she did not mention before), which disappeared after her phobia treatment with the HRT technique (with God's assistance) and skin breathing with colour. Neither of these techniques are acupoint stimulation techniques, yet not only did they resolve her phobias, they also resolved her backache.

After her treatment with three mind-body techniques (2 include tapping techniques), Tallulah felt a physiological release when she felt "things moving through her stiff hip" and she was also aware of feeling dizzy, which points towards a mind-body connection and that phobic reactions are stored in the body according to Swack (*n.d.c*) which could explain Tallulah's

physical sensations once the phobic energy was released. As a result, EP treatment influences the whole person as it focuses on the whole person (Benor, 2013).

#### **5.1.4.7. Effectiveness of HBLU™ phobia treatment**

All the participants' phobias were resolved after the treatment on the body, conscious, unconscious and soul levels; this was confirmed through muscle testing. All participants were 100% balanced on their goals on all four levels as well. For some participants, their phobias took longer to resolve than for others because they felt compelled to talk about the realizations around the phobias, the origins of the phobias and the examples they needed to focus on in order to resolve the phobias.

The treatment will be discussed by looking at the efficacy 1) directly after treatment, 2) one week post treatment and 3) two months post treatment.

##### **5.1.4.7.1. Treatment was effective directly after treatment**

According to Benor (2013) and Craig (2005), energy directed therapy can be comprehensive and immediately effective. A discussion of the efficacy of the treatment for this study follows, by taking the participants' statements and their written learnings with regard to positive emotional, cognitive, physical, and spiritual changes into account.

##### **5.1.4.7.1.(a) Positive emotional changes**

Treating phobias of change or transition with the HBLU™ phobia protocol resulted in immediate positive emotional changes in all the participants directly after completion of the treatment. Six participants mentioned that they felt good. Feeling calmer, more relaxed and at peace were also common statements. Four participants (Grace, Michael, Peggy Sue and Tallulah) were very appreciative and grateful, which shows a coherent heart rate pattern (Leskowitz, 2012). These results indicate that after the treatment the phobias of change or

transition were resolved and that resolution can have a positive effect on a person's emotions. The lack of negative emotions about the original phobia can also be considered to be a sign of a successful resolution.

#### **5.1.4.7.1.(b) Positive cognitive changes**

According to Gallo (2005) energy is the fundamental fractal of all psychological problems. All the participants' psychological disturbances were thus treated by addressing and modifying the subtle energy systems in the body to help facilitate neurological change, and to bring forth an impact on their health, emotions and state of mind (Feinstein et al., 2005). Such changes were the result of the treatment in this study when the use of the EP techniques resulted in a positive cognitive effect on all the participants. All the participants' statements reflected new and different cognitive perspectives about their phobias. Four participants (Grace, Michael, Bam and Peggy Sue) went so far as to say that their phobias sounded silly, ridiculous, untrue and made no longer sense to them.

I observed further mental changes when all the participants stated new and different perspectives on their goals. It is helpful to make inquiries about how clients perceive their goal after treatment to further confirm healing transformations on the goal, which can serve as further confirmation that the goal has been achieved.

The attitude of all the participants improved and they felt ready to move on and therefore addressing phobias of change and transition with the HBLU™ phobia protocol can assist clients who struggle with procrastination.

All the participants' written learnings also reflected greater positive self- awareness and optimism about the future and new possibilities.

Positive cognitive changes as the ones mentioned above can be a reflection of successful treatment and the resolution of a phobia of change or transition.

#### **5.1.4.7.1.(c) Positive physical changes**

Dossey (1989; 1993; 1999) states that scientific evidence shows that thoughts, emotions, attitudes, and perceptions can affect the body, which we realized in this study when laughter and smiles were common reactions when a phobia was resolved. After the treatment Tallulah, Jane, Bam and Peggy Sue could feel the difference in their bodies. Five participants (Elizabeth, Bam, Mr. Blue, Peggy Sue and Tallulah) mentioned that they felt more energized, and Jane and Grace's voices who were weak before, sounded stronger and clearer after treatment.

#### **5.1.4.7.1.(d) Positive spiritual changes**

According to Myss (1996) all human stress corresponds with a spiritual crisis, and awareness does create an opportunity to gain insight into how one has used, misused or misdirected one's spiritual power. This aspect became evident when after treatment five participants (Grace, Bam, Michael, Peggy Sue and Tallulah) mentioned God, had a need to speak about God, realized how God and Jesus Christ play a role in resolving problems, and when they mentioned God in the context of what they had learnt.

#### **5.1.4.7.2. Treatment maintained its effectiveness one week after the initial treatment**

Six of the participants were available one week after treatment for their first personalised, individual telephonic follow up interview (Appendix R) and the remaining four participants were interviewed no later than two weeks after the treatment date. The follow up interviews took from fifteen minutes to an hour where the participants were not muscle tested again (most could scale their emotions using SUDS), but just answered questions about the

effects of the treatment (through individualised questionnaires) and completed the four psychological tests (Appendix J).

According to Gallo (2005) energy directed therapy can be comprehensive, and major EP texts by Gallo and Feinstein show the four levels of EP treatments as : 1) immediate relief and stabilization, 2) elimination of conditioned responses, 3) overcoming complex psychological problems and 4) promotion of optimal functioning. This study confirms the wide-ranging effect of EP on these levels when the first three levels were immediately verified after the treatment and, once again one week after the initial treatment. Level 4 changes occurred one week post treatment as some participants such as Elizabeth already showed optimal functioning in her studies and work. Levels 2-3 changes occurred when treatment efficacy was maintained one week post treatment and measured on an (i) Emotional level, including the 4 psychological tests (ii) the Mental and behavioural levels, and on the (iii) Physical level. There were also (iv) Changes in spiritual awareness, (v) Interpersonal and social changes, (vi) Occupational changes, and (vii) Progression towards participants' individual goals.

One week after the initial treatment, a few participants had unresolved issues which appeared as new issues.

Treatment efficacy on all these levels will be discussed next and the appearance of new issues will also be addressed.

#### **5.1.4.7.2.(a) Emotional improvements**

Eight participants mentioned that they experienced an overall positive change on an emotional level. Grace mentioned that she did not notice a significant difference, although she reported that peace stood out as a dominant emotion for her. She also experienced anxiety and fear (including fear of rejection regarding her divorce) less often, and she had less anger

and sadness, which contradicted her initial answer of failing to notice a difference.

Sometimes it is difficult for clients to perceive improvement and it is therefore important to continue the questioning with more specific questions to give the client and practitioner more clarity about the deeper states of transformation. Gentle probing with more specific questions and the resulting answers can also help to guide the direction of possible future treatments. Such dialogue can inform the practitioner as to what issues need to be addressed next in the healing process. The questioning after the interview and being mindful to the resulting answers gave me a deeper and more accurate insight into the authenticity of the participants' initial answers as they can appear to be contradictory, as in the case of Grace. For more comprehensive and authentic answers and to assure validity as best as possible, comprehensive in-depth and mindful questions should be included in follow up interviews during treatment and during the research process.

It was difficult for Bam to access his emotions when he thought of his phobias. It was a big step for him, since he was so overcome by fear and anxiety before treatment, that when he was faced with his phobias, he could not focus, which made it difficult for him to address and resolve his phobias. It is important to notice the difference between the inability and the lack of willingness to focus on a phobic situation, and the indifference towards the phobic situation, since indifference indicates that the phobia has been successfully resolved. The lack of emotions about a previously phobic situation can also be an indication that the phobia is resolved.

If Grace and Bam's statements are taken into account, then all ten participants experienced a positive change on an overall emotional level one week after treatment. The HBLU™ simple phobia treatment resulted in seven (eight if we include Grace who experienced it less frequently, nine if we include Michael who did not even mention it and ten when we include Bam who could not access his emotions regarding the change)

participants' who experienced an improvement in their levels of distress and anxiety. Eight (nine if we include Grace who experienced it less frequently and ten when we include Bam who could not access his emotions) participants also reported an improvement in their levels of fear. The treatment resulted in significant improvements in the majority of the participants' distress, anxiety and fear levels which are the most obvious and main emotions associated with phobias (Colman, 2006).

They also showed further improvement in the emotions they associated with their phobias where two (Angie and Elizabeth) of the five previously self-reported depressed participants no longer experienced any depression, Jane's depression improved and it was difficult for Bam to access his emotions, including feelings of depression. Only Grace mentioned that she still had depression as it was difficult for her to do anything. Apart from Bam who found it difficult to access his emotions regarding his change, there was furthermore an absence or an improvement in emotions such as anger (5 participants), frustration (6), sadness (4), and stress (2) in all the participants, which signified the continual overall emotional improvement in all ten participants one week after treatment.

In the absence of overwhelming negative emotions, I noticed that the participants were able to experience positive emotions. Not only were negative emotions neutralized and/or had improved, but the participants also became aware of positive emotions, such as happiness, excitement, feeling comfortable, love, acceptance, and understanding. Instead of experiencing phobic anxiety, Angie could calm herself and Elizabeth's new calm state was such a dramatic change that it was evident to her friends. Three of the participants reported that they continued to experience increased confidence, four expressed gratitude for the treatment, and four reported that they felt at peace. The HBLU<sup>TM</sup> phobia treatment with its application of EP techniques, can thus neutralize negative, old associations with their related negative emotions about a specific situation and can as a result have a positive emotional

effect on clients, because psychological disturbances can be treated by addressing subtle energy systems in the body by adding a tool, like an EP technique, which can help to facilitate neurological change (Feinstein, 2005b; Feinstein et al., 2005). Because a retrieved memory and its limbic responses can be changed before it is stored again by using an EP technique (Feinstein, 2008a), associated negative emotions which are neutralized, are actually replaced by new positive emotions. They are not just overriding the conditioned phobic responses with positive emotions as is the case with Pavlovian conditioning (Feinstein, 2010). What is noteworthy about this, is that other techniques such as EMDR, bring up the aversive memories which are accompanied by negative emotions, but they fail to neutralize such emotions (Shapiro, 2001). The value of this particular HBLU<sup>TM</sup> method is that it brings up the traumatic associated phobic memories, but then neutralizes them with an EP intervention, therefore not leaving the client traumatized and vulnerable to re-experience the triggering phobic emotions at a later date.

The emotional changes will now be looked at once more by discussing the same four questionnaires (DASS, GAD-7, HAM-A and IOE scales) which were presented in Table 4.10. All the questionnaires were completed by all the participants after their first follow up interview.

On the DASS scale which measures depression, anxiety and stress, seven of the participants (Elizabeth, Jane, Michael, Bam, Mr Blue, Peggy Sue and Tallulah) showed normal *levels* of depression, Angie indicated mild depression, Grace indicated moderate depression and one week after treatment Bunny still had severe depression, although her scores improved. Bunny never self-reported during the interview as being depressed, which shows a contradiction between the DASS test and her self-report. Although the previously depressed Angie and Bunny did not show normal depression levels, their depression scores and levels on the DASS test improved. Grace's depression scores worsened and went up with



4 points, showing moderate depression. Angie, Jane and Grace (who all showed depression on the DASS scale before treatment) reported during their first follow up individual interviews that they felt depressed before treatment and Angie self-reported one week post treatment that she no longer experienced depression, Jane felt her state of depression improved, leaving only Grace's self-report statement and DASS test in alignment one week post treatment.

Of the seven participants who were depressed before treatment (Angie, Elizabeth, Bunny, Jane, Grace, Bam and Peggy Sue) according to the DASS scale, four (Elizabeth, Jane, Bam, and Peggy Sue) now had normal mood *levels* on the DASS scale. Michael, Mr Blue and Tallulah had no depression before according to the DASS scale and their mood levels continued to stay normal.

Eight of the participants' depression *scores* improved, Michael's scores indicated no change and Grace's depression scores worsened.

The DASS results reflect the positive emotional impact of the treatment with the overall improvement of the mood levels and scores of the participants. A further indication of the positive emotional impact is that all ten participants had normal anxiety *levels* according to the DASS scale which is an improvement from before treatment where five suffered from anxiety on this scale. A further indication of a positive emotional impact according to this scale is that eight participants now showed normal stress *levels* one week post treatment, including the six who suffered from stress before treatment. Not only did they show normal stress levels, but apart from Grace and Tallulah, all the participant's stress *scores* improved according to the DASS scale as well.

Four participants (Angie, Michael, Bam and Tallulah) did not have an anxiety/panic disorder before treatment and one week after treatment according to the GAD 7 test. Of the five participants (Elizabeth, Jane, Grace, Mr Blue and Peggy Sue) who indicated that they

had an anxiety/panic disorder before treatment according to the GAD 7 test, only three (Elizabeth, Jane, and Mr Blue) no longer had one. Peggy Sue still had a panic disorder on the GAD 7 test, although her *scores* went down, showing improvement according to this test, and Grace also still had a panic disorder, but her *scores* worsened, showing regression according to this test. Grace is the only one whose scores worsened, and Bunny, who had no panic disorder before treatment, now indicated that she had a panic/anxiety disorder by one point. The other eight participants' scores all improved according to the GAD 7 test.

Although all participants had normal anxiety *levels* according to the DASS test, three participants (Bunny, Grace and Peggy Sue) indicated an anxiety/panic disorder on the GAD 7 test, contradicting the DASS findings.

Grace (who indicated an anxiety/panic disorder) completed the GAD 7 a week after the DASS test, while Peggy Sue (who also indicated an anxiety/panic disorder) completed the GAD 7 test before the DASS test which could have influenced their test scores, indicating that a person's life experiences can influence test scores. It is therefore important to view tests in context with information gathered through other means, such as personal in-depth questionnaires and interviews.

Nine participants (Angie, Elizabeth, Jane, Grace, Michael, Bam, Mr Blue, Peggy Sue and Tallulah ) had no anxiety according to the HAM-A scale one week post treatment. Bunny still had mild anxiety at the same score on this test. Once again we observe incongruence with the DASS test as Bunny showed mild anxiety on this test, although she indicated normal anxiety levels according to the DASS test. And although she has only mild anxiety according to this test, she showed incongruence with the GAD 7 test that indicated she has an anxiety or panic disorder (although only with one point).

Bunny and Michael's HAM-A *scores* indicated no change in anxiety, while the other eight participants' HAM-A anxiety scores all improved.

All ten participants had normal anxiety levels on the DASS scale, seven participants had no anxiety or panic disorder on the GAD 7 test and nine participants had no anxiety on the HAM-A scale, and although incongruent, the participants' anxiety did not worsen since treatment.

All three tests are congruent with the self-reports in which all participants experienced improved anxiety levels. If according to Gallo (2005) serotonin is viewed as energy, serotonin production should be able to be regulated with a treatment intervention that employs energy as its main component of change, as in the case in Energy Psychology. Symptoms of a disorder, such as anxiety and/or depression could therefore be alleviated. Not only did the participants' anxiety levels normalize, but their depression levels showed improvement as well.

Michael thought the IOE test was no longer applicable to him. Eight participants, including Michael, (compared to the six participants who had PTSD before) showed no indication of PTSD. Elizabeth, who had a very high PTSD score before, indicated that she had PTSD by one point now. For her, the higher scores on for example “I feel as if it hadn’t happened or it isn’t real” was a positive, which could make the outcome and interpretation of this test inaccurate for her. Once again it shows the importance to see the tests in context and the importance to include personal in-depth interviews with open-ended questions. Bunny also indicated that she still had PTSD (with one point now).

All the participants' scores (with the exclusion of Michael, because he felt the test was no longer applicable to him) improved according to this test.

In this study the psychological tests created confusion rather than validation for the in-depth qualitative findings. The tests did not create confidence that they reflect accurate answers in this qualitative research study with its small number of participants. Therefore tests such as these cannot be seen as reliable research tools to assure validity in qualitative

research, but if they are included, they should rather be combined with in-depth open ended questionnaires.

#### **5.1.4.7.2.(b) Mental and behavioural improvements**

In this research study all participants experienced that EP methods and techniques can shift brain patterns that lead to unwanted emotions, thoughts and actions to positive emotions, thoughts and actions which corroborates with Feinstein's (2013) research. Feinstein (2013) specifically referred to acupoint tapping, but as witnessed in this study other EP techniques that did not include acupoint tapping can also alter the brain's electrochemistry to overcome negative emotions and change unwanted habits and behaviours. All participants were aware of intrapersonal changes such as 1) new and heightened realizations, thoughts and beliefs (which positively influenced their attitudes) and created 2) behavioural changes. As Grace said: " my mindset is changing" and Tallulah mentioned that she felt a "transition in her mind".

An attitude of acceptance (of their situation) and allowing (their lives to unfold) was noticeable in most of the participants. It was especially noticeable in the language of seven of the participants, for example Angie stated "things can work themselves out as I am going with the flow of life" and Elizabeth said "it will happen at the right time".

Seven of the participants (Angie, Elizabeth, Jane, Grace, Mr Blue, Peggy Sue and Tallulah) mentioned that they felt they had more clarity, focus, felt less confused and experienced an improvement in their concentration and decision making skills, which echoes Greene's (2012) statement that a feature of a healthy mental body is to have the ability to concentrate.

Six participants reported increased confidence, such as Michael, who showed confidence by no longer having any reluctance or hesitation to share his work with the world.

Six participants felt that they were more positive after the treatment which manifested in an absence of negative self judgment in Angie, Bunny, Jane and Peggy Sue, while Elizabeth and

Michael felt “good enough” and deserving of their dreams, and it had helped Angie to question herself less. This all resulted in more self acceptance and a better relationship with themselves.

Feelings of victimization had diminished in Elizabeth, Jane, Grace and Peggy Sue who no longer blamed others for their situation, but recognized the role they played in their individual situations.

Six participants (Angie, Elizabeth, Bunny, Grace, Peggy Sue and Tallulah) felt a mindset change, were open to explore new possibilities about themselves, relationships and new life directions and were ready to move on from where they were.

According to Greene (2012) consciousness is at work when someone is competent enough to be insightful and aware and is therefore able "to connect the dots" (track 15).

The new and positive mental shifts brought new and positive behaviours to seven of the participants - Angie, Elizabeth, Jane, Grace, Michael, Mr Blue and Peggy Sue. New and positive behavioural changes were further reflected in Angie's life, who was able to speak easier and more fluently and shared a lot of information during this interview. She now allowed her body rest when needed and she could handle her physical pain better, using visualization. Elizabeth chose the company she kept and how to spend her time better and had no longer any self-destructive behaviour. Jane ate better and studied more, Grace became more proactive and creative, Michael could tell people about his work and identify himself with his new identity as a composer and musician, Mr Blue was more tolerant and no longer snapped at people at work, and Peggy Sue could pace herself, be more discerning, slept better and became more proactive.

When phobias of change and transition are successfully treated, it can result in intrapersonal and behavioural improvements as observed in this study. This can support a

person in being more functional and can therefore enable him/her to progress towards a more meaningful, constructive and productive life, leading to greater personal satisfaction.

#### **5.1.4.7.2.(c) Physical improvements**

The individual's mind affects the individual's body (Dossey, 1989; 1993; 1999) as was noticed when six of the participants (Angie, Elizabeth, Grace, Michael, Mr Blue and Tallulah) were also aware of positive physical shifts (e.g. being physically more able, not feeling the physical impact, less aches and pains, improved digestion, weight gain, return of menstrual cycle) one week after the treatment. Although not part of their goal statements we see that when an holistic approach is followed, holistic results follows, where a person can experience change on any level, including the physical level.

#### **5.1.4.7.2.(d) Positive spiritual changes**

Six of the participants (Angie, Elizabeth, Jane, Grace, Michael and Peggy Sue) were aware of positive spiritual changes and behaviours, which manifested as an attitude of surrender for Angie and Peggy Sue, and Jane, Grace, and Michael reported that they spent more time on spiritual pursuits. According to Myss (1996) our biological design is also a spiritual design as spirituality is an innate biological need and not only a psychological and emotional need. When we view our spirit and energy as one force which work together for our own well being and progression, it creates possibilities of communication between faiths and can support people to return to spiritual beliefs they previously rejected or create a new spiritual awareness. And when an individual views his/her problem in a spiritual framework it can accelerate the healing process because it can add meaning, depth and purpose to their problem (Myss, 1996). The impact of the treatment on a holistic level by recognizing, including and working with the multi-dimensional reality of the whole human being, demonstrated that it can also have an impact on a person's spiritual life, allowing the person

to become more self-actualized. This is in congruence with Benor (2001) who points out that being aware of every task and every intention makes us realize that everything in life is a spiritual experience.

#### **5.1.4.7.2.(e) Interpersonal and social improvements**

When there are such personal changes in oneself that influence one's emotional and mental state to such a degree that they create behavioural changes, it will flow over and influence one's relationships with others. This was noticeable when nine of the participants' experienced positive changes in their interpersonal relationships and Grace's interpersonal relationships and social life stayed as good as it was before.

A few participants reported that existing relationships had improved, while others felt more connected to people.

The positive social changes were reflected in seven of the participants who said that they became more social. Resolving phobias of change and transition can reduce or eliminate typical social phobic symptoms (i.e. feelings of inadequacy and alienation) as was evident in the case of Angie, Jane, Michael, Bam, Mr Blue, Peggy Sue and Tallulah. Becoming more social and feeling more connected to people (Angie, Jane and Peggy Sue) are not the only signs of positive social change. Although Jane felt less alienated and it was easier to make new friends, it was easier for her and Elizabeth to be on their own now. Elizabeth actually preferred to be on her own now while she could not tolerate it before.

Jane and Elizabeth also reported a lack of fear of people and restored their trust in people.

The restored relationships with the self and others and the improved, healthier social life style can create a more balanced life by reducing or eliminating the feelings of inadequacy and alienation that the participants felt before the treatment.

#### **5.1.4.7.2.(f) Positive occupational changes**

The positive intrapersonal and behavioural changes had a positive rippling effect on the participants' attitudes towards their occupations. With the exception of Bunny (who was not focused on her career and did not feel motivated to promote her work) and Bam (he was on a hiatus), all the other participants felt that the treatment brought about positive occupational changes. Jane, Grace, Michael, Peggy Sue, Mr Blue and Tallulah reported positive mental shifts regarding their occupations and three participants (Angie, Elizabeth and Jane) already became more proactive towards their new goals.

The absence of phobias of change or transition created improved concentration and focus in the context of two participants' studies and made one work faster and more effectively.

#### **5.1.4.7.2.(g) Participants progressed towards their individual goals**

EP techniques and methods (including non tapping techniques) also have the ability to enhance a person's ability to succeed and enjoy life as we see here when all the participants experienced overall progression toward their individual goals (Feinstein, 2013). If the goal did not materialize yet, they had an allowing attitude towards the timeline, did not worry about it, had no anxiety around the goal, believed it would happen, felt deserving of it (Elizabeth and Michael) and became proactive (when needed) to make it happen.

The holistic change on all the above mentioned levels, created activity and movement within the person, which worked together to create progression and move the individuals towards their goals and personal development.

If energy is the fundamental fractal of all psychological problems according to Gallo (2005), then when you modify the subtle energy systems of the body with a tool such as an EP technique, you can help to facilitate neurological change and you can have an impact on a



person's health, emotions and state of mind (Feinstein et al., 2005). Therefore we can safely say that the resolution of phobias of change moved these individuals away from procrastination towards progression, bringing satisfaction to both the client and practitioner.

#### **5.1.4.7.2.(h) Participants' new issues**

Although all the participants experienced overall progression toward their individual goals, a few of the participants had unresolved issues which appeared as new issues. After healing is completed on a specific goal, new facets of a problem or new issues can appear. As observed in this study, the participants showed a need to move on from their previous issues and had no interest in further discussing their original presenting issues. Sometimes, however, although clients confirmed through muscle testing that the original problem is completely solved, they are confused when they still experience negative emotions after having been treated. Clinical experience has revealed that clients sometimes may falsely conclude that their healing was not completed, while the appearance of new issues is likely to be an indication that the original problem has been healed (M.L. Dexter, personal communication, August 9, 2013), because when the disruptions in an individual's energy fields are addressed by applying EP, it is assumed that the changes in the participants' energy fields have the power to change their long standing emotional patterns, as both the biochemistry and invisible physical fields work together during treatment (Andrade & Feinstein, 2004). The energy that was needed to deal with the original in the past, is now freed so that the client can deal with the new related issues that lay dormant while the original problem was still unresolved. When you modify these energies, you can have an impact on a person's health, emotions and state of mind (Feinstein et al., 2005).

With specific, mindful and intentional questions a practitioner can establish if indeed the issue was resolved, not resolved, or if there are unresolved aspects about the same

problem, or if new issues have surfaced. Grace, for example, mentioned that she experienced emotional issues after treatment. Her new and negative emotions, are unresolved emotions, but not necessarily about her previous issue, but can be about the next phase in her life - a new romantic relationship. This is then viewed as progression as the newly surfaced emotions and thoughts are seen as a progressive new issue after she resolved the issue of not being able to have peace about her divorce. Her thoughts and emotions are already busy with the next phase and should be seen as a new goal and addressed as a new issue. This is not a strange phenomenon and instead of feeling despondent, the practitioner and client should be encouraged to progress to the next goal.

More examples of possible new issues that were observed during this study were when Bunny and Jane, together with Grace experienced unresolved emotional issues where Bunny still did not feel safe in her new relationship and Jane was still angry with her dad, she still worried about disappointing others and she also still felt betrayed by people. Bunny's emotional issue can be a related facet to her goal of “wanting a conscious, soul connection marriage for the rest of my life” that can be viewed as a new goal. Jane's emotional issues can be a related facet to her goal “I want to be focused in school” or not and should be muscle tested as such, or they can be viewed as new goals.

Both Grace (overeating, overspending, negative self-talk regarding herself and other people, lack of confidence and action regarding a new occupation) and Bunny's (not promoting her work) mental and behavioural issues are unrelated to their original goals and can be seen as new issues and goals.

Angie's (numbness in her left leg), and Grace's (asthma, pain in her leg and hip, low energy) did not seem to be related to their original goals and could be viewed as new issues and goals. Bunny's physical issues where she could not sleep in the same bed with her new

partner or achieve orgasm with him, can be new, but related facets of her original goal and should be muscle tested to see if they interfere on the original goal or not and be treated accordingly.

#### **5.1.4.7.3. Treatment maintained its effectiveness two months after the initial treatment**

All participants were available for their second follow up interview two to three months after the initial treatment. Their second follow up personalised and individual questionnaires were completed over the telephone, and the interviews lasted from fifteen minutes to an hour. These final follow up questionnaires were crafted from the information gathered up to this point (Appendix S).

All the participants' SUDS levels when possible, were measured against the SUDS of their last follow up (one week post treatment) to track their progression.

Most participants' progression and changes were congruent with those of the last follow up, and they continued to show progression on an a) emotional level b) mental and behavioural levels, and c) on a physical level. There were further more d) changes in spiritual awareness, e) more interpersonal and social changes, f) more occupational changes, and g) there was progression towards the participants' individual goals. Elizabeth was so focused on "building the new" that she was reluctant to have the interview as she "was done" with the issue and did not want to talk about it anymore.

During this second follow up, levels 3 and 4 of the EP treatments, the participants continued to show that they had overcome complex psychological problems (level 3) and continued to function optimally (level 4).

Only the participants' new additional progressive changes are discussed below.

During this follow up interview I noticed that Angie, Grace, Michael, Bam and Tallulah sounded clear, confident, upbeat, strong, grounded, sure and specific. Jane was more relaxed than before, felt better overall, and said she could handle everything (as opposed to not being able to handle anything before treatment). Peggy Sue used the words *in control* a lot, which is positive for her as she felt she had no control on anything in her life before treatment.

Critics such as Beyerstein (2001) state that alternative/integrative therapies lack support that the treatment is safe, effective, ethical and rely on reports of subjective relief by clients after an intervention. As the treatment is individualized and personal, one can argue that relief is subjective, but apart from subjective relief, I also received results from the four psychological tests, and their in-depth personal questionnaires, one week and two months after treatment. All results remained congruent with one another and the use of different measurement tools, maintained a certain measure of objectivity, validity and reliability. The lasting results of the healing process imply that treatment of a phobia of change or transition was not only successfully and safely treated with an EP method and techniques, because of the structured efficacy of the method, but thoroughly as well, as is evident in the lasting life improvements and changes of the participants on different levels.

A discussion of the participants' continued additional positive changes, follows below from a - j in conjunction with what they perceived to be unresolved issues, and further healing needs, that emerged during the final interview.

#### **5.1.4.7.3.(a) Further emotional improvements**

When an individual's energy fields are addressed by applying EP, it is assumed that the changes in the participants' energy fields have the power to change their long standing emotional patterns, as both the biochemistry and invisible physical fields work together

during treatment (Andrade & Feinstein, 2004). It appears that all the participants' positive emotional changes continued to improve with time as everyone reported further improvement on an emotional level. The lack of fear was prominent in every one. The participants further reported a lack of distress, anxiety, frustration, anger, worry, sadness, stress, shame, guilt and depression. Jane reported to no longer experience any level of depression the way she did at the last interview. Some participants reported increased confidence, patience, joy, happiness, hope, acceptance, peace, contentment, excitement, and feelings of strength and being in control.

These results show that the holistic approach to treatment continues to have a positive emotional effect on the participants, even two months after treatment.

#### **5.1.4.7.3.(b) Further mental and behavioural improvements**

As with the emotional changes, all the participants also continued to experience new and improved developments mentally and behaviourally two months after the initial treatment. These continual improvements became apparent when three of the participants (Angie, Elizabeth and Grace) reported that they no longer even thought about the distressing occurrences in their lives, four participants were more accepting and allowing of *who* they were (Angie, Grace, Michael and Tallulah) and five participants (Angie, Bunny, Grace, Mr Blue and Peggy Sue) with *where* they were in their lives.

There was further a positive shift in attitude for some participants such as for Peggy Sue who said her positive attitude change includes her standing her ground now with humour.

Further mental changes included a greater clarity, feeling more present and gratefulness.

A new behavioural change that stood out in Grace, Peggy Sue and Tallulah's lives, was that they started to read more. This change towards reading more was especially positive for Grace and Peggy Sue, because they found it impossible to sit down and concentrate on

one thing before treatment.

Bam reported that he smoked less.

In this study the continually new and positive mental and behavioural changes the EP treatment had on the participants, confirms Feinstein's (2012b) observation that problematic behavioural patterns will no longer manifest when self-limiting emotional memories are adequately processed.

#### **5.1.4.7.3.(c) Further physical improvements**

Addressing and treating the participants' phobias with EP also continued to positively influence nine of the participants on a physical level which added veracity to Dr Green's findings that all physiological change is correlated to mental (conscious and unconscious) and emotional changes and vice versa (Pert, 2003). By acknowledging the interaction between the mind and body in EP according to Gallo, Durlacher & Walker (2002), all participants were motivated by the positive cognitive changes to be active in improving their lives. This change influenced the participants' physical lives where six participants could make better decisions about their physical health and follow through with it: Angie weaned herself off her pain medication, felt physically stronger and more stable, the numbness in her leg started to dissipate and she exercised more. Jane, Grace and Tallulah started to eat better, and Bam and Michael became physically more active. The healing also resulted in more positive thoughts for Michael and Bam, who previously had negative thoughts about their physical problems, such as no longer walking again in Michael's case. As Grace could let go of her emotional hurt, she became more aware of the mind-body connection when she said that her “insides were less twisted as things were moving out”, showing how the body always talks to us and serves as a mirror of our inner thoughts and beliefs (Hay, 1999).

If mental patterns, limiting beliefs and ideas can create disease in the body (Hay, 1999), then it can also create healing in the body, which became evident when some participants reported further positive physical changes. Angie said that her body felt stronger, Elizabeth continued to feel no physical effect of her breakup, Bunny mentioned that she experienced a huge overall physical shift, Michael reported less aches and pains in his legs, Mr Blue was aware of not having jet lag after a very long flight and Bam and Peggy Sue slept better.

The participants had thus become more integrated in their body and mind by remaining focused in the present as they became more conscious of their bodies after treatment.

#### **5.1.4.7.3.(d) More changes in spiritual awareness**

During this interview seven participants (Angie, Jane, Grace, Michael, Mr Blue, Peggy Sue and Tallulah) mentioned that they experienced increased spiritual awareness. Of those seven, five mentioned God. Angie, Grace, Mr Blue, Peggy Sue and Tallulah experienced new, closer and more frequent connections with God, which helped Angie and Peggy Sue to worry less. Mr Blue and Peggy Sue surrendered more to God and Grace, Michael, Peggy Sue and Tallulah's spiritual lives became more active. According to Gerber (2001) spirituality is the energetic foundation of all life, and according to Foreman (2008) all of life is spiritual. Spirituality should therefore not be ignored during the healing process, but should rather be incorporated since the human soul is part of the human psyche (Foreman, 2008).

When an individual surrenders him or herself to a power bigger and beyond him/herself, such as God, modalities that are used in therapy can bring forth deeper healing on the body, mind and spiritual levels (Shannon, 2010). This study confirmed that by healing

phobias of change or transition with EP, influenced the whole person, including the spiritual aspects, which created a more conscious individual with greater awareness of himself or herself as a whole being.

#### **5.1.4.7.3.(e) Further positive interpersonal and social improvements**

Two months after the initial treatment the participants continued to experience further positive interpersonal and social changes which were reported by all the participants. Grace's greater conscious awareness resulted in a positive realization about the negative affect her critical and judgmental thoughts had on her past relationships. She was now aware of positive changes in her social life which was absent during the last follow up.

Positive social changes had different meanings for the participants. Eight participants (Angie, Jane, Grace, Michael, Bam, Mr Blue, Peggy Sue, Tallulah) experienced an improved social life where they experienced more social contact and improved social interactions. Elizabeth and Bunny's interpersonal and social lives continued to stay positive and satisfactory.

Jane, Bam and Peggy Sue were less affected and depended on other's opinions and moods. Jane and Peggy Sue had closer and more satisfying connections with friends and family and Michael became aware that he wants a closer connection to people. Jane, who still felt a bit betrayed by people during the previous follow up, no longer felt people betrayed her now.

The positive intrapersonal changes in the participants since the treatment were reflected in the participants' interpersonal and social lives, which showed the rippling effect of the treatment and how mind-body-spirit changes can bring forth environmental changes as well.



#### **5.1.4.7.3.(f) Further occupational changes**

The above mentioned changes continued to serve a useful purpose in the participants' lives as seven participants (Angie, Elizabeth, Jane, Grace, Michael, Peggy Sue and Tallulah) continued to experience further occupational changes since their last interview and were all proactive towards their new and old goals and dreams. Bam and Mr Blue reported positive mental shifts regarding their occupations. Bunny was still not focused on her career. These findings demonstrate that most participants continued to be functional human beings, participating and progressing in life. This shows that the treatment was more than a moment of fleeting euphoria after the treatment and not a need to please me, the practitioner, as Beyerstein (2001) suggested.

#### **5.1.4.7.3.(g) Progression towards participants' individual goals**

The participants' self-limiting emotional memories were adequately processed, since their progress towards integration and coherence were no longer restricted (Feinstein, 2012b). Every participant continued to show active progression towards their chosen goals during this final follow up interview. Seven participants (Elizabeth, Jane, Grace, Michael, Mr Blue, Peggy Sue and Tallulah) had already achieved their goals, Bam had partially achieved his goal, and Angie (who was actively working towards achieving her goal) and Bunny's goals needed time to unfold, showing that level 4 of the EP techniques were achieved.

In order to assist individuals with change, a goal specific treatment, such as the HBLU™ phobia treatment, can help him/her to progress and achieve goals that seemed impossible before, since the personal creation of a goal statement keeps the process intentional and focused, and serves as a reflective convincer for successful treatment for both practitioner and client.

#### **5.1.4.7.3.(h) Participants' desired outcomes are met**

Although all the participants showed progression towards their goals, nine of them (Angie, Elizabeth, Bunny, Jane, Grace, Michael, Bam, Peggy Sue and Tallulah) also showed that they achieved their desired outcomes, such as improved physical health, improved focus, an increase in confidence levels, achieving a peaceful state of mind and happiness, no family judgments and getting back to “who they were before” the incident.

#### **5.1.4.7.3.(i) Participants' perceived unresolved issues**

The participants continued to show that they lack the need to please the practitioner, challenging Beyerstein (2001), when they mentioned unresolved or new issues during the final follow up interview. Although all participants muscle tested that they cleared their phobias a 100% on all levels and were a 100% balanced on their goals and showed progression in and towards their goals, issues came up which five participants perceived as unresolved. These issues were emotional issues (Angie, Bunny, Jane and Bam) mental and behavioural issues (Angie and Bunny), physical issues (Grace and Bam), and confusion about progression toward a goal (Bunny) and are discussed individually. It is important to continue to be aware of new issues and listen to the participants, because as Feinstein (2012 b) reminds us, when memories are not processed, they can restrict an individual's progress towards further integration and coherence.

When a client still experiences emotional, mental, behavioural, or physical issues and/or a lack of progression in a certain area(s) of their lives, it is important to stay mindful of the goal and be specific during further questioning as to separate the achieved goal from new facets of the previous issue and new and separate issues. This will give the practitioner and client clarity to discern if the issue is indeed a 100% resolved on all levels or if the emerging issues are new related or unrelated issues. These new issues can then become the

next priority for treatment. Clients should also be reminded that goals often demand more than one treatment, which will now be discussed in conjunction with the issues that five participants mentioned during this final part of the questionnaire.

Although improved and not disabling, emotionally Angie said she experienced a degree of distress and anxiety about her back problems, surgery and the consequences of being unemployed. The latter issue seemed related to her initial goal "I'd like to work in a meaningful, purposeful career" because her back problems and surgery resulted in her unemployment and can be viewed as a new, related facet of her initial goal and be viewed as a new goal. Anxiety about her back problems and surgery are now new issues and goals. On a mental level Angie felt she had a low self-esteem because she could not allow people to help and support her because she did not feel deserving to receive. She did mention earlier on that she felt very confident in social and work situations which makes her low self-esteem very specific to a particular context. This comes across as a new, but related issue, because it will help her on her career path when she allows herself to receive help.

Bunny's goal was "I want a soul connection marriage for the rest of my life". On an emotional level, her anxiety about her current relationship stayed the same and she became worried again (as opposed to not worried at the previous interview) about not getting a real life partner, although she mentioned previously in this interview that she felt both apathy and hope when she thought about having a conscious, soul connection marriage. She was still distressed about her current romantic relationship and felt her happiness depended on her partner, although she remarked earlier on in the interview that she felt more independent in the relationship.

On a mental level she still had obsessive thoughts about her current relationship and partner (although improved), and mentioned that her thoughts were too focused on potential negative disappointments, rather than on something positive. This is a new, but related issue

(supporting her goal about a soul connected marriage), and should be addressed as such.

These issues were less about her goal and more about current issues regarding her current relationship, which she was advised to work on, but chose not to do so. Working on issues regarding her current relationship can be addressed as new goals.

Bunny muscle tested for a 100% healing on her phobias and her goal, and said that she felt she progressed towards her goal, but added that a part of her still felt that she might just be going around in circles with regard to never attaining a conscious, soul connection marriage for life. This can indicate that she has another interference pattern, such as for example a trauma, with her goal.

She also seemed to be in conflict as she contradicted herself a few times during this interview, depending on the questions asked. This section appeared at the end of the questionnaire which could also indicate saturation and frustration with the line of questioning. Too much probing could have also made her think too much about her situation and could have confused her, which could have lead to answers that seemed to contradict each other. As she mentioned, the relationship makes her feel vulnerable and she "could get destabilized" easily.

Jane's goal was to be "focused in school". Her anger at her dad was no longer about his lack of support in her school situation. This issue was separated from her goal (once again showing the importance of a goal) and can be seen as a new issue and potential new goal.

Bam's goal was to "Set realistic goals for myself to accomplish in the next 6 weeks – fulfil them and move on". He noticed that he still had an ingrained fear of success and mentioned that he needed more treatment for that. This is a new issue and goal and when addressed could help him to not only set out new goals and accomplish half of them, but all of them.

He still had weight problems, which is unrelated and a new issue and goal.

Grace who had weight problems all her life, still reported to have weight issues, although she started to eat better. A lifelong weight problem probably cannot be resolved in two months, especially if that was not the goal. She still had back, leg and hip pain, asthma, a lack of energy and her sleeping patterns did not improve. None of these physical issues were part of her goal, which was “Inner peace about the situation (the divorce)”, but came up as I inquired about her physical well being to assess the physical impact of released phobias. They should all be viewed as new goals.

#### **5.1.4.7.3.(j) Emerging healing needs**

Mollon (*n.d.c*) experienced during his client treatments that once an issue is resolved and a space is created (in what he calls the mind-body-energy matrix) after a healing treatment, different layers of conflict and distress may emerge in their place. His experiences are similar to mine in my private practice and during this research. Apart from new issues that emerged from the participants' perceived unresolved issues during the first and second follow up interviews, additional new issues started to emerge for Grace (unresolved grief), Michael (interpersonal relationship management) and Angie (a physical concern). When new needs emerge, it should be seen as a sign of progression, where the client moved on from the previous issue(s) and should be addressed as such. The new issues should be discussed and there should be a focus on new goals. Once new goals are established, the practitioner and client can proceed with the treatment process.

## **5.2. Clinical implications of the findings**

The findings have several implications, based on the responses of the participants.

### 5.2.1. The role of talk therapy

One of the advantages of HBLU™ is that psychological issues can be *addressed* and neutralized without re-traumatizing the client. Some EP practitioners and researchers, who mainly research TFT and EFT, believe that trauma can be reduced without the client having to re-experience the full negative impact again by not having to talk about an event and therefore not consciously addressing it (Schulz, 2007). However, in order to keep therapy effective, long lasting and clean without the "insidious web" of negative affect Shapiro (2001) talked about, and to receive a deeper, more meaningful treatment, it is important not to eliminate an important part of the client - the conscious mind - when the client is treated holistically. Energy psychology has the word psychology in it for a reason - we work with the person's psychology as well as with their body and energy fields. This makes energy psychology treatments different from other energy treatments, such as Reiki, where an energy treatment is done *to* the client without actively involving the client's conscious mind. Mollon (*n.d.d*; *n.d.e*) states that EP methods on their own cannot resolve every problem, especially when someone has deep-rooted emotional and psychiatric conditions. EP has its place and is embedded as *part* of the treatment. The severity and the extent of a client's problems should not be ignored or minimized, but the multiple factors that can contribute to the weakening and sustaining of a person's mental health should be recognized and respected.

Dialogue enhances the EP process and therapy also becomes more explorative, allowing the work to be psychoanalytical and energetic (Mollon, *n.d.b*). Data from this study shows that talking to the participants about issues that emerged from the *Simple clearing process* to the *Mapping out* of their phobias, actually helped the participants (and me) in this study to achieve greater understanding and insight of themselves, and of the impact and correlations the phobias had in their lives. Therefore a comprehensive EP method should involve communication in the form of discussing the presenting issues as well.

### 5.2.2. The need for mindfulness and intention

When the participants talk about an event or situation, it is important that the therapist (who is according to Gallo (2012), the most powerful tool in therapy and according to Siegel (2012) an integrationist) remains mindful and intentional, always working towards a goal to release the underlying memories and attached emotions to eliminate the phobic symptoms of the client. Mollon (*n.d.d*) echoes this when he states that a therapist's most important skill is to listen well - deeply, carefully, patiently - with his/her whole being, in order to receive information the client was not even aware of having. This study showed that mindfulness and respect towards the clients' needs to speak, was respected when they were allowed to converse, when they had the need to do so, thus showing that this is an important part of EP therapy. And Benor (2002) reminds us that words which are spoken from the heart, are healing. As a therapist, I am after all the most powerful guiding instrument in the situation, more than the technique or the method I choose for helping the client. When a practitioner is too wedded to the formula of the technique or method and demonstrates total reliance on the technique/method, without being mindful of the client's needs, it can be unhelpful and disempowering for the client (Gallo, 2012; Mollon, *n.d.d*). The most empowering sessions are the ones where clients and practitioner work together and it is therefore important to pay attention to your intentions and be mindful to make your intentions coherent with your client's (e.g. your intention is to help the client who wants to be helped and less on your need for money, recognition, success, etcetera), as incoherent intentions can result in a lack of energetic congruency and rapport between you and the client (Greene, 2012; Siegel, 2012) . Therefore when a practitioner includes an EP technique or/and a method in therapy, he/she can still tailor the sessions to the client's needs, without compromising the technique and/or the method.

### **5.2.3. The need for EP techniques and structured methods**

When dealing with a phobia treatment it is required of the client to be exposed in vivo or in vitro to the phobic object or situation, which in the case of HBLU™ phobia treatment happens during the in vivo mapping out process. There is no need during this process to expose the client to the actual feared object/situation while the phobias are mapped out. The mapping out process gently, but insistently probes the client to go deeper into his/her psyche to discover the most extreme scenario associated with the phobia. It is a step by step process which does not overwhelm the client by suddenly making them face their biggest fear. When it was necessary to reduce the emotional impact of a memory and if the participants showed any distress during any stage of the HBLU™ process, an EP intervention was chosen to neutralize the fight-flight response. Schulz (2007) states that if the distressing emotions are not a hindrance, core issues can be discussed without discomfort, resulting in speedier treatment, which was confirmed in this study when the approach to apply an EP technique when necessary helped the participants who experienced distressing emotions to move towards their goals. Although some of the participants needed an EP intervention(s) to help them through the HBLU™ process, the phobias were still not eliminated, implying not only the need for EP techniques when required during the process, but the need for an in-depth and thorough phobia methodology as well.

### **5.2.4. The need for more than one technique when required**

According to Benor (2013), EP has a diversity of clinical paths which all point to psychological and physical improvements and he further mentions that "evidence suggests that it may be combinations of diverse mechanisms that contribute to the rapid changes achieved through each of the various EP approaches" (p. 17). Mollon (*n.d.d*) echoes this by stating that through personal experience he has found that the best approach for optimum



results is to combine the appropriate components of a range of different approaches, as not one approach contains everything needed to help everyone. All the participants in this study showed that they needed more than one technique (a variety of techniques) or the same technique applied more than once during their healing process. Some participants needed EP techniques to set them up energetically in order to muscle test accurately and for the treatment to proceed as smoothly and painlessly as possible.

Therefore a therapist should maintain an open mind for what the client needs and when the client needs something. S(he) should also familiarize him/herself with and train him/herself in more than one technique because not all people need only one technique all of the time, as this study showed.

#### **5.2.5. The need for muscle testing accuracy**

During the HBLU™ method the client's soul and deepest wisdom guides the healing through muscle testing and if the client does not give a 100% permission to proceed, this will be reflected in the muscle testing procedure. To maintain and assure the authenticity and integrity of the healing process, and prevent projection from the practitioner to the client, it is important to assure accurate muscle testing by 1) setting up the client energetically to assure accurate muscle testing, 2) address the person's soul and deepest wisdom, 3) familiarize oneself and the client with the standing tilt method (or any other preferred MT method) and 4) to ask the extra two questions that were used in this study in order to make sure that the client deceives neither him/herself nor me (the practitioner) by providing incorrect answers. The three questions that were asked during this muscle testing procedure are an important component for accurately directing the therapy process as described in this study. Several participants for example revealed important and relevant information when muscle testing was inaccurate.

Muscle testing should also be incorporated as a strategy for ascertaining the veracity of the findings. The tilting stand muscle test procedure will further eliminate the possibility of physically manipulating the outcome by the researcher and/or the participant, as no physical contact between the researcher and participant will take place.

It is further important that the practitioner is aware of his/her intentions as to not compromise his/her integrity and in the process abuse the practice of muscle testing (Gallo, 2005) and to be aware of his/her own limitations, hopes and wishes when applying muscle testing (Benor, 2004).

### **5.2.6. Therapeutic implications**

#### **5.2.6.1. Healing emotionally, mentally, physically, and spiritually**

The findings from this study show that the HBLU™ simple phobia protocol treatment had a positive emotional, mental, behavioural, physical and spiritual impact on the participants. All phobic participants were not only relieved from the anxiety and other negative emotions associated with the phobias, but from related depression as well. The participants were aware of new positive emotions and achieved a new and different awareness and perspective about their phobias. They had greater spiritual awareness, self-awareness and optimism about the future and new possibilities. With their improved clarity, confidence and attitude, they had a need to progress and were proactive toward their goals. They further also experienced a positive physical influence. For example, one participant reported the return of her normal menstrual cycle, and another participant could reach orgasm, something that failed to happen in the past.

Healing can also occur on all these levels simultaneously and create positive behavioural changes, such as improved eating habits for Jane and Grace and a lack of self-destructive

behaviour (drinking, using drugs, indiscriminating sexual behaviour) in Elizabeth.

Finally, muscle testing is applied in order to confirm that changes have occurred.

#### **5.2.6.2. Positive interpersonal, social and occupational impact**

The treatment not only had a positive intrapersonal and physical impact on the participants. It also improved their relationships with themselves, with less negative self-judgment and more self-acceptance. This outcome also engendered a positive interpersonal, social and occupational impact which manifested in an improvement in their social relationships and in their existing close relationships.

By directly addressing the issue, a positive interpersonal, social and occupational impact can be achieved with this protocol, or it can be one of the effects of the treatment as shown in this study.

#### **5.2.6.3. Holistic healing effect**

When integration ("the linkage of differentiated parts") takes place, it results in harmony instead of chaos and rigidity which is a result of impaired integration (Siegel, 2012, p. 8). The findings show that all the participants were relieved of all their phobias and achieved their goals on the conscious, unconscious, body and soul levels and reflected a state of harmony in the participants.

It thus seems that by applying the HBLU™ simple phobia protocol phobias can be healed and goals can be reached on all these levels, resulting in a more harmonious state.

#### **5.2.6.4. Treatment goals**

Every participant continued to show active progression towards their chosen goals up to the final interview where seven participants achieved their goals, one participant achieved partial success of his goal (Bam) and two participants' (Bunny and Mr Blue) goals needed

time to unfold. The latter two participants had an allowing attitude towards their timelines (i.e. they allowed their goals to unfold at the right time).

When a client is muscle tested on a new goal to see if a phobia of change, transition and/or progression is interfering, and if that is so, and it is addressed and treated, it can speed up the overall treatment process, which can affect the client's treatment goals, by for example eliminating some of their previous goals. Phobias of change, transition and/or progression are a common underlying issue that undermine therapeutic progress. Even when people are able and willing to make therapeutic progress, their underlying phobias of change, transition and/or progression can stop their progress. In this study, Elizabeth and Grace experienced such rapid transformations. Both women were so devastated after their relationships had ended, that they developed a phobia of change which debilitated them to such an extent that they could not forget the past and move on with their lives. After the treatment Elizabeth did not even want to talk about the man she had obsessed over for a year, and Grace was finally, after about 10 years, ready to move on with her life and was even thinking about a possible new relationship.

The treatment can have a positive effect not only on the client's goal, but also in different areas of the person's life, as we saw when Elizabeth showed improvements in her studies, job, personal and social life, when she achieved her goal after the phobia treatment. However, in some situations, clients may have multiple goals that are interrelated which may be treated all at once (cross-cleared) without any extra energy treatments. In such cases therapists/energy practitioners should apply muscle testing as a post treatment procedure in order to ascertain whether such cross clearing has occurred.

In such cases, the clients may need fewer sessions than previously anticipated, which requires the long term therapy goals to be modified accordingly, as was seen in this study in which all participants had long standing phobias (1+ years) that were rapidly transformed and

needed an adjustment of their initial goals. Bam for example had his phobia for 30 years, while Grace had hers for 10 years. Both Bam and Grace were able to transform their phobias in one session which resulted in new and positive emotions, thoughts and beliefs, and created positive behavioural changes which helped them to progress with their lives.

#### **5.2.6.5. Improved client - therapist relationships**

When the client receives a holistic treatment, such as the HBLU<sup>TM</sup> phobia treatment, and achieves rapid relief and results, it may improve the existing client - therapist relationship. It can also establish trust in a new (therapeutic) relationship.

#### **5.2.6.6. Self - empowerment**

Because the client is not only passively receiving treatment, but is an active participant and at the same time learns simple healing techniques to apply to themselves, the client is encouraged to be independent and empowered to take responsibility and participate in his/her own healing.

#### **5.2.6.7. Multiple applications**

If this treatment is successfully used with people with longstanding, disabling phobias as we saw in this study, then it can also be used with newly acquired phobias of change and/or transition, for example, in a divorce. Addressing and overcoming this phobia as soon as possible can help a client to progress faster in their new or existing relationships, career, studies, locations, etc., towards their new reality, and for their new life. The applications of the simple HBLU<sup>TM</sup> phobia treatment are countless as they can be used for a straightforward phobia such as a phobia of doctors (Iatrophobia) to social phobias to more subtle existential phobias such as phobias of change, transition or progression.

Phobias of change, transition or progression can be used whenever someone experiences a change or transition and/or experiences a lack of progression. It can, for example, be applied in an educational setting in order to assist students with improving their grades. When therapists look at clients' underlying issues, they can detect if a student who is not doing well in school can perhaps have a phobia of change, especially if he/she is a freshman, a new student, or has changed his/her study direction or study location. More examples of changes and transitions can be: immigration, emigration, divorce, death, leaving or going to a (new) school/university, adoption (for both parents and child(ren)), foster care, release after being incarcerated, going into or leaving halfway houses or hospitals.

#### **5.2.7. Therapeutic and research uses**

Such a wide all encompassing impact on the participants' lives suggests that using the HBLU™ simple phobia protocol can be of great help for many therapists, including physical and spiritual therapists and counsellors, who have the holistic interest of a client in mind. Examples of therapists who could include the HBLU™ protocol in their treatment repertoire include: clinical psychologists, clinical social workers, marriage and family therapists, counsellors, counselling psychologists, school psychologist and /or social workers, spiritual counsellors, hospice workers, coaches, and disaster relief workers. Healthcare practitioners such as Medical Doctors, Acupuncturists, chiropractors, and other Holistic Health Practitioners should also be aware of their own limitations and when needed refer their clients to EP practitioners.

The qualification criteria for this study were obtained through the use of semi-structured and structured questionnaires and confirmed through muscle testing. This approach might also be useful for other therapists and could also be valuable for guiding future research with regard to phobias of change, transition and/or progression.

During treatment the structured HBLU™ phobia protocol was followed with the inclusion of muscle testing. This is also a useful guideline for other therapists and future researchers who pursue research in phobia resolution with the HBLU™ method.

As HBLU™ claims to assist clients in eliminating phobias, it seemed fitting to examine this methodology's effectiveness in the treatment of phobias of change, transition or progression.

The method is simple enough to learn so that it can also be used as a self-help tool.

### **5.3. Integrating the HBLU™ simple phobia method into a phobia therapy session**

The findings of the study show how the HBLU™ simple phobia method can be successfully integrated as a working model into therapy when phobias are addressed. HBLU™ further fit each treatment session to the individual, without compromising its structure, and it therefore "allows for specificity and reproducibility" (Gallo, 2002, p. 59).

If change is "the shifting of any circumstance, situation, or condition, physical or nonphysical, in such a way that the original is rendered not merely different from what it was, but altered so radically as to make it utterly unrecognizable and impossible to return to anything resembling its former state" (Walsch, 2009, p. 16) and it is understood that both client and therapist seek change in order to progress during therapy, then phobias of change should be a consideration in therapy. Since phobias can render us unable to change a thought, attitude, perception or behaviour (Swack, 2002; 2007b), and this inability to change can increase feelings of discomfort and anxiety and other phobic symptoms (Fritscher, 2011), and "HBLU™ is a holistic psychotherapeutic system that simultaneously addresses the somatic, psychological, and spiritual aspects of an issue"(Gallo, 2002, p. 59), it is wise to consider

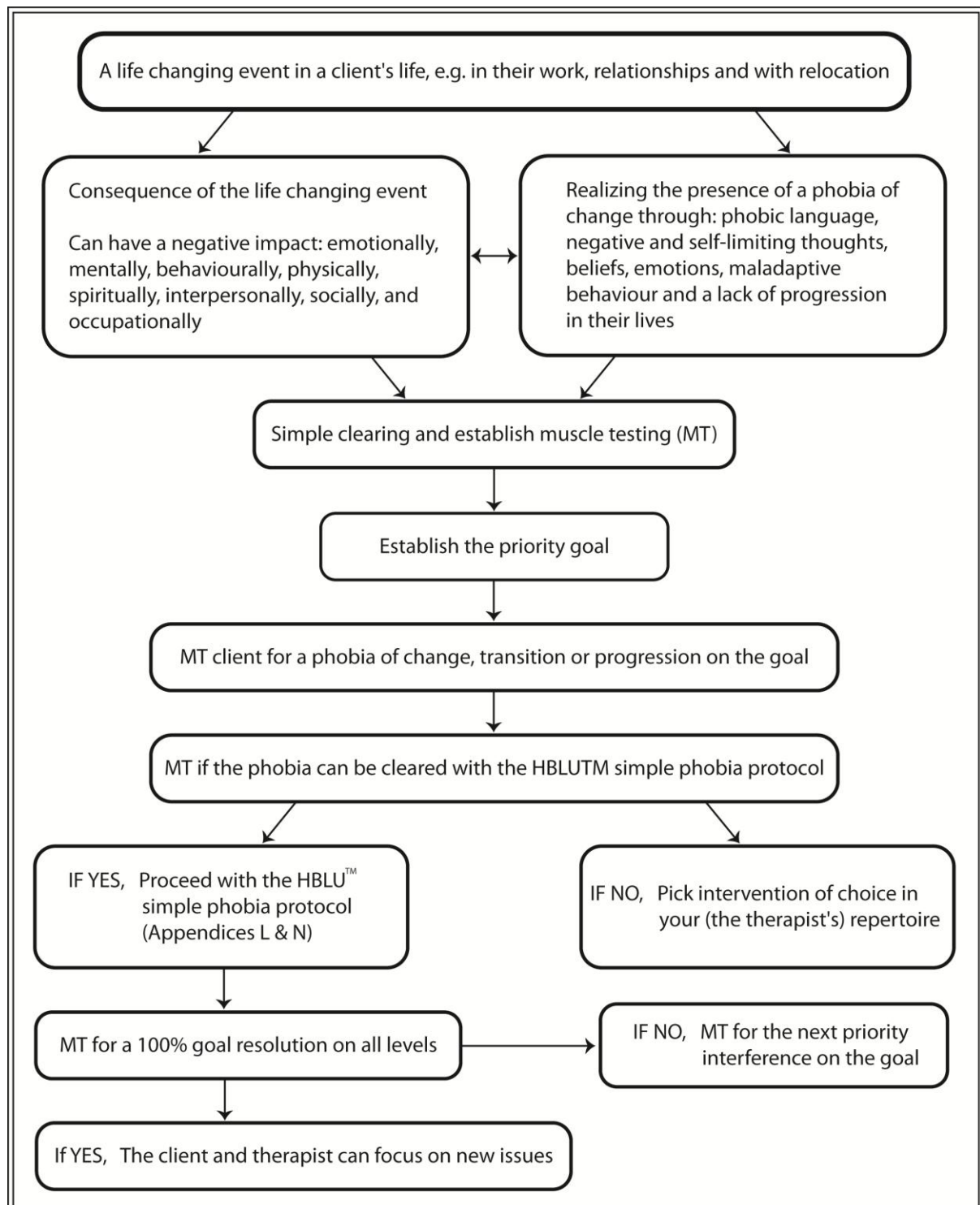
incorporating a holistic EP method, such as HBLU™ in the treatment of phobias of change, transition or progression.

Encouraging therapists and clients to consider the possibility of a phobia of change, transition or progression in the beginning or during therapy when a client shows a lack of progress through disabling emotions, thoughts and behaviours, may be the first step to help them through their changes and transitions towards progression and optimal functioning.

A delineation of the integration of the HBLU™ simple phobia protocol in phobia treatment during therapy is provided in Figure 5.1. on the next page. The figure displays the flow of a possible session.



**Figure 5. 1. The delineation of the integration of the HBLU™ simple phobia protocol in a phobia treatment session**



## Conclusion

This study aimed to answer the question *Does HBLU™ (with its integrative approach as an Energy Psychology method) successfully detect and resolve subtle phobias regarding change, transitioning and progression?*

The qualitative nature of this research allowed for in-depth semi-structured questionnaires and interviews, a structured in-depth, but flexible treatment process which resulted in in-depth data analysis. The categories and subcategories that emerged from the data can provide ideas for future quantitative and qualitative research on phobias of change, transition or progression and/or the HBLU™ phobia protocol.

The complete HBLU™ simple phobia protocol was discussed in this study, including the variety of approaches and techniques used. The study further discussed all the symptoms effectively treated, the goals reached and the effects of the treatment on the emotional, cognitive, physical, spiritual, social and occupational levels. All the participants experienced positive changes on all the levels discussed and there was a 100% success rate on achieving their goals, confirmed immediately after treatment, and during the two in-depth follow up interviews one week after treatment and two months after treatment. These results support Schulz's (2007) study where her participants found that EP techniques are the most effective treatment for anxiety related disorders.

As clients seek change when they seek therapy, but often find it hard if not impossible to achieve such change, the cumulative information gathered from this study is relevant for all types of therapy and/or counselling. It can encourage and support a wide range of mental health care practitioners who are interested to integrate Energy Psychology into their practices in order to achieve more rapid and efficacious results.

Since meridian based and other therapies were used in this study, EP practitioners who only

use TFT or EFT should be encouraged to broaden their spectrum of therapeutic techniques by using more than one technique and by learning the different techniques mentioned in this study. They should also be encouraged to not only use techniques, but to also incorporate more structure in their sessions by including an EP method such as the HBLU™ phobia protocol to streamline their sessions.

EP in itself brings a change in how we approach therapy and should therefore be consciously introduced into therapy by informing and educating the clients and obtaining informed consent without making false promises and guaranteeing success after one session. When success does occur in one session the therapist should remain grateful for the breakthrough and mindful of new, possible related issues that are surfacing as the ten participants have experienced in this study.

This study added value to the treatment of phobias when phobias are viewed in a broader spectrum and individuals receive healing as holistic beings with mindful questioning, listening, intention, and an EP method, and various EP techniques. The results of this study add value to this new and innovative way in treating phobias.

To help generate change in the world (if we so wish to do) it can help when we contribute to assist with change in one person at a time. This can be achieved when there is an awareness of the clients' changes, their desire to change and their inability to do so. Integrating EP and specifically the HBLU™ simple phobia protocol into therapy, can enable practitioners and their clients to change and enrich their lives one step at a time.

## **6 CONCLUSION**

### **6.1. Detecting and resolving phobias of change and transition with the HBLU™ simple phobia protocol**

The aim of this qualitative study has been to examine the effectiveness of an Energy Psychology method, HBLU™, in the detection and resolution of phobias in the context of change, transition and/or progression.

The research findings show that the ten participants who all experienced life changing events regarding their work, relationships and relocation, felt those events had positive and negative impacts on their lives. The impact of the participants' life changing events created positive consequences for one participant (Grace) on a social and interpersonal level, and six participants experienced spiritual growth as a result of the life changing event. Every participant experienced negative consequences which were observed on the emotional, mental, behavioural, physical, spiritual, interpersonal, social and occupational levels. The significant change in the participants' lives further resulted in all of them feeling stuck, unable to move forward with their lives or participate in life, and thus created a general lack of progression in their lives. These negative consequences resulted in all participants demonstrating phobic symptoms, such as feeling high levels of anxiety, fear, distress and depression. The life changing event in the participants' lives resulted in phobias of change for nine participants and phobias of transition for one participant (Mr Blue).

According to ACEP's website, [www.energypsych.org](http://www.energypsych.org), "Energy Psychology posits that mental and emotional problems are a reflection of disturbed bio-energetic patterns" and therefore "Energy Psychology utilizes tools that seem to directly balance the human energy systems." Feinstein et al. (2005) add that if you modify these energies, you can have an impact on a person's health, emotions and state of mind. The research findings reflect these

statements as all the participants' phobias were successfully treated with an Energy Psychology method, the HBLU<sup>TM</sup> simple phobia protocol.

## **6.2. Answer to the Research Question**

The resolution of the phobias were measured on the emotional, mental, behavioural, physical, spiritual, interpersonal, social and occupational levels and was confirmed through muscle testing and by observing the participants' reactions, listening to their statements and reading their written learnings directly after treatment. The resolution of the phobias were further confirmed with in-depth personalized questionnaires and four psychological questionnaires (DASS, GAD 7, HAM-A, and IOE) one week after treatment and with in-depth personalized questionnaires two months after treatment. During the one week and two month follow up interviews the participants' progression towards their individual goals further confirmed the resolution of their phobias. During these two interviews some of the participants also discussed new issues that came into view from their perceived unresolved issues during the first and second follow up interviews, as well as additional new issues. These new issues were perceived as a sign of progression, where the participants moved on from their previous issues onto new ones.

As a result of the treatment all participants experienced positive emotional changes, cognitive changes (they were more optimistic about the future and new possibilities, had new positive and constructive thoughts and beliefs) and behaviours.

All the participants were aware of physical shifts and had an awareness of the continual positive physical influence the treatment had on them.

Nine of the participants (with the exception of Bunny) were aware of spiritual changes and behaviours since the treatment.

Nine of the participants' saw their interpersonal relationships change for the positive and one

participant's (Grace) interpersonal relationships stayed good as before. All the participants' social lives changed for the positive and continued to change and improve.

Except for Bunny and Bam (who could not measure his occupational impact yet as his new contract has not started), eight participants also felt that the treatment brought positive occupational changes.

Every participant continued to show active progression towards their chosen goals up to their final interview.

According to Gallo (2005) energy directed therapy can be comprehensive, and major EP texts by Gallo and Feinstein show the four levels of EP treatments as : 1) immediate relief and stabilization, 2) eliminate conditioned responses, 3) overcome complex psychological problems and 4) promote optimal functioning. This study's findings confirm the wide-ranging effect the HBLU™ simple phobia method had on all these levels and suggest that the HBLU™ simple phobia protocol was successfully implemented to treat all the participants, thereby relieving them of their phobias of change or transition. Echoing Gallo's (2005) observation that psychological disturbances can be treated by addressing subtle energy systems in the body as energy is the fundamental fractal of all psychological problems.

### **6.3. Limitations of the study**

According to the literature review of this study it is clear that alternative practices such as EP have their foundation in Traditional Chinese Medicine (TCM), physics, neuroscience, and biology, and that EP incorporates mainstream psychological approaches and methods. The field of EP does not oppose biomedicine and mainstream psychological practices, but rather respects its place and use. This study also points towards the importance of adhering to adequate education and training practices, and the importance of honesty, integrity and ethics in preparing and conducting healing work with EP.

This study aimed to explore the efficacy of EP by documenting the experiences of ten phobic participants, and to examine the results of the HBLU™ simple phobia protocol treatment on participants who had a phobia of change or transition. The participants in this study were volunteers, which can make their results different from results obtained from people who did not volunteer to participate in psychological research and/or who might be less motivated to work on their issues. Results, therefore, may not be generalized to all clients with phobias of change and transition.

Some practitioners might find the HBLU™ simple phobia protocol too complex, especially during the mapping out process when the practitioner might be unable to stay mindful and intentional to guide the client successfully to the most extreme phobic story.

Even when a practitioner does find the HBLU™ simple phobia protocol easy to follow, not all practitioners might be skilful or confident in muscle testing which can skew the treatment process and results. If a practitioner is not confident in his/her competence in muscle testing, or the process or skills as a therapist, it can influence the process and results.

Not all people can practice the standing tilt muscle test (e.g. they are infirm, paralyzed, etc.). Alternative muscle testing methods should then be used, or a skilful therapist can use his/her intuition to guide the process. However, intuition can sometimes fail and should be used judiciously (Dexter, 2010).

The HBLU™ process cannot be used in all therapeutic situations such as when a licensed clinician is not allowed to use EP techniques or methods.

The sample size of 10 participants in this qualitative study is relatively small and the results can therefore not be generalized. Although the intent and value of a qualitative study is not to generalize, but rather to be specific and thereby gain an in-depth understanding of

the issue (Creswell, 2009), this study can be generalized with regard to a broader theory of EP techniques, as and when I study additional cases and generalize the findings to the new cases as Creswell (2009) suggested.

So far no known cases of the EP process and outcome of this study are known and may thus differ in different cultures and/or in other countries.

There were many similarities between the participants: 1) although some had different ethnic backgrounds, they were all English speaking Caucasians, born in America and were all from southern California, 2) 7 of the 10 participants were female, 3) all but one participant was heterosexual, 4) they had no physical or cognitive impairments, 5) none were substance dependant, 6) they were all older than 18, 7) all participants had finished high school (indicating a certain level of intelligence and education), 8) they were all self-motivated to improve their current life situation, 9) they were all able to cognitively understand the concept of an Energy Psychology intervention, were open to it, and were able to follow directions, 10) they were all able to use the Subjective Units of Distress Scale (SUDS) and 11) all participants were comfortable with the concept of God.

Although I made every attempt to remain bias free throughout the study, the qualitative researcher acts as an instrument by drawing upon past experiences, past knowledge, education, training and selective biases when collecting relevant literature sources and analysing the data. Therefore, in the event of attempts to replicate this study, the future researcher's background with its different experiences, choices and biases might provide different results to the results of this study.

To minimize experimenter bias and stay as objective as possible, I used a conversational interview method during the semi-structured interviews to gain in-depth information. I also used four psychological tests, adhered to the structured HBLU™ simple phobia protocol,



stayed mindful during the interviews and refrained from interjecting personal opinions, used muscle testing during the treatment process (including two extra questions to try and eliminate muscle testing deceptions as much as possible) and used member checking by conducting two follow up interviews. I also abstained from including my personal ideas in the results and focused on presenting results which reflected only the participants' personal experiences.

Although the study has limitations, the research is still valid as it incorporated five of the eight primary validity criteria mentioned by Creswell (2009) to ensure the accuracy of the findings.

#### **6.4. Suggestions for future research**

Although the field of Energy Psychology had a great breakthrough in 2013 when EFT was accepted by the APA, and plenty of research has been done on EP as Feinstein (2008a; 2012a) recorded, more research still needs to be conducted, especially in fields other than EFT. The field of EP is vast and EFT is only one technique of the many techniques and methods that are practiced. Because qualitative research can serve as a foundation for research in which little is known about a topic to stimulate new research questions for future research, this study can be viewed as foundational, providing suggestions for future research in phobias of change, transition and/or progression and/or in the use of the HBLU™ phobia protocol.

Some suggestions for future studies include the following: 1) the application of the HBLU™ phobia protocol by professional healthcare practitioners compared to self-application, 2) applying the HBLU™ phobia protocol without administering the simple clearing process and muscle testing the client, 3) applying only one technique (for example EFT) throughout the HBLU™ simple phobia protocol.

In the future this study might be duplicated with participants with more diverse demographic information.

Phobias of change, transition or progression can be tested in different settings or in one specific setting such as a university/schools, (addiction or physical) rehabilitation centres, half way houses, the prison system, refugee camps, hospitals, or dating services.

More quantitative empirical studies could be conducted to verify the efficacy of this EP method for treating phobias.

More research in the field of EP with its diverse variety of techniques, methods and applications in general can help to contribute to its validity and simultaneously expand the field of psychology, especially if there is a focus on the implications of the treatments. This will add knowledge and bring a deeper understanding of how the mind-body-spirit is connected and how this connection influences the healing process. A greater understanding of the mind-body-spirit connection in the treatment of disorders can not only benefit different psychological schools of thought, but the medical field as well.

Biology-psychology and neuropsychology would also benefit from more research on the effects and/or implications of EP on the human body.

## **Conclusion**

This research includes only one methodology (albeit incorporating several additional techniques) and is only a drop in a vast ocean of energy psychology possibilities, but hopes to inspire mental health care practitioners to consider change by the inclusion of EP methods and techniques in their work and possible future research.

Finally, an explanation of the Chinese character for the word *change*, summarizes and depicts this journey of change for me and the participants of this study.



Although this is the traditional character for *change*, and not the simplified character, it has already been simplified from the ancient characters. The Chinese character or "ideogram" for the word *change* consists of three parts, which are also referred to as *radicals*. These three parts - the *radicals* - literally paint the picture of the ideas combined in the character for change. The sharp linear brush strokes of each part encrypt the ancient character (which was originally smoother and had more rounded images). This development makes it quicker and simpler to write, as opposed to drawing a whole picture for every character (Sears, *n.d.*).

According to the online Chinese - English dictionary, the centre part of the Chinese character of change, is the *radical* which denotes the concept of speech, to speak or to talk. This radical also forms part of words, such as to quarrel, to bicker, to argue by means of verbal communication and conversation. The small square (which replaced the round circle from the ancient script) in the centre *radical*, symbolizes a mouth, and the horizontal lines above it, is a small abstraction of a linear illustration for sound waves, similar to the circles formed by rain drops falling on water in a pond.

The original form of the of two *radicals* for "silk" or a "silk thread" on either side of the centre *radical* for "speech", were oval-shaped cocoons, one hanging from the other by a single thread of silk, but they had been reduced to linear strokes for simplification and speed (Terblanche, 1998).

Underneath the double silk cocoon images, three threads of silk (the three strokes) are being unravelled simultaneously to form (spin) one strong thread of silk. The final strong thread of silk can now be used for the weaving process to make the finest products.

The bottom part, on which the silk cocoons and speech *radicals* rest, depicts a hand, holding an object, such as a tool, an instrument or a hand-made article.

Together, these three different sub sections form the character for CHANGE (Terblanche, 1998; Personal communication with Stephan Terblanche on September 9th, 14th & 16th, 2013).

The intricate process to start unravelling a silk cocoon starts by finding the beginning of the thread. To be able to do so, one has to be silent, still, in order to find the thread. The centre radical can represent the internal talking, arguing and quarrelling that is happening within a phobic person. In order to bring forth change, so that there can be stillness to unravel the silk thread, the phobia should be resolved. This was done in this study with the HBLU<sup>TM</sup> simple phobia protocol which makes provision for a person to verbalize his/her internal dialogue during the mapping out process. Once that was done, the participant could find the thread of the silk cocoon(s) (the priority phobia) and start to unravel the cocoons simultaneously, so to speak, as the phobias were being transformed through an EP intervention. Once the phobias were neutralized, there was clarity and direction and focus - representing the single strong thread that then was used to produce a fine end product/ result for each of the participants. The change the participants experienced after neutralizing their phobias of change is comparable to the metamorphosis that takes place when a silk worm changes into a moth and yields something as precious and useful as a beautiful silk cloth in the process.

The hands-on approach, from beginning till end, with a therapist using an EP method and/or technique(s), is characterized by the hand (therapist) holding a tool or an instrument (an EP technique/method) in the bottom *radical*. The more hands-on you go about using and applying your capacity and gift to heal and assist people with their transformation, the more definite, certain and durable the end result will be. Just like a good thread of silk will lead to an excellent woven textile.

To change and to be able to adapt to changing conditions is of just as much importance for our personal survival as it is for all human beings in a constantly changing world and environment. Having to change does not necessarily come at a time when it is convenient, but the ability to change at the right time is significant, just as it is imperative for the silk worm to change into a moth at the right time. Without this metamorphosis, there would be no silk.

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## APPENDICES

### Appendix A

#### ADVERTISING FOR PARTICIPANTS

##### **MOVE TO CHANGE study looking for participants**

##### **Do you feel stuck in an area in your life?**

- You have trouble moving ahead in an area in your life and you just cannot figure out why **or**
- You know what you should do, but you just cannot get yourself to do it.
- You experienced a change in your life (death, divorce, a relationship ended or started, retirement, job loss, the loss of your home, father/motherhood, a move, a new school, surgery, loss of health, or any other change in your life) that is troublesome for you, and since then you have a lack of progression in your life.
- You feel that you have trouble adapting to your new circumstances, relationship status, it is hard to make decisions and you feel anxious, “low” and tired.
- You just cannot move ahead.

You might have a fear of change!

The **good news** is - we are doing a study using an innovative, simple and drug free Energy Psychology method to clear intense, irrational fears (phobias you might be unaware of) in one session which might help you move ahead with your life.

If you think that you might benefit from this study, call or email today to set up an appointment to see if you qualify for this study.

I may have a solution if you qualify!

Please contact me, MARI SCHURIAN, at 1310 961 8867 or email me at [www.healyourcore.com](http://www.healyourcore.com) to set up an appointment for your 1<sup>st</sup> telephone screening interview.

*NOTHING ENDURES BUT CHANGE – HERACLITUS –*

## Appendix B

### TELEPHONE SCREENING FORM

*Tel:*

*Email:*

*This questionnaire can be used over the phone or during a personal face to face interview.*

*An option is to start with #26-28.*

1. Date: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Pseudonym \_\_\_\_\_
3. Date of Birth /age: \_\_\_\_\_
4. Relationship status (i.e. married, single, divorced): \_\_\_\_\_
5. Ethnicity: \_\_\_\_\_
6. Nationality: \_\_\_\_\_
7. Sexual orientation – hetro- or homosexual: \_\_\_\_\_
8. Highest Level of Education completed? Where: \_\_\_\_\_
9. Occupation: \_\_\_\_\_
10. Where do you reside? \_\_\_\_\_
11. Religious orientation: \_\_\_\_\_
12. If necessary, during treatment, will you be able to discuss the concept of God? \_\_\_\_\_
13. Do you have any physical impairments? \_\_\_\_\_  
If yes, what?: \_\_\_\_\_
14. Are you dependent on alcohol or any other drugs? \_\_\_\_\_
15. Are you anorexic? \_\_\_\_\_
16. Are you familiar with Energy Psychology? \_\_\_\_\_  
If yes, which modality? \_\_\_\_\_  
If no, would you be open to learn more about the concept of Energy Psychology interventions? \_\_\_\_\_
17. Have you ever received an Energy Psychology treatment? \_\_\_\_\_  
If yes, when and which modality/technique? \_\_\_\_\_  
Why? \_\_\_\_\_  
How many treatments? \_\_\_\_\_
18. Would you be open to an Energy Psychology treatment method in the context of change, transition and progression? \_\_\_\_\_  
If not – reason: \_\_\_\_\_
19. Are you willing to participate in an in person preliminary interview where you will be taught the art of muscle testing? \_\_\_\_\_

20. Are you willing to be tested during the same 30 minute interview via muscle testing for a phobia in the context of change, transition and progression and if it is treatable with the HBLU™ simple phobia protocol?\_\_\_\_\_
21. Are you willing to fill in 4 psychological questionnaires before and after treatment?\_\_\_\_\_
22. Are you willing to participate in a 90 minute treatment session with an Energy Psychology method?\_\_\_\_\_
23. Will you be able to actively participate for 90 minutes where you will be required to stand for a great length of the time so that muscle testing can take place?\_\_\_\_\_
24. Will you be able to come to my office in Long Beach or my office in San Diego for the treatment session?\_\_\_\_\_
25. Will you be available for telephonic follow up interviews 1 week and 2 months after the treatment session?\_\_\_\_\_
26. *What is the tangible or not so tangible issue that you have?* \_\_\_\_\_
27. *What happens because of this problem?* \_\_\_\_\_
28. *What would you like instead?* \_\_\_\_\_
29. Did the above issue require a change in your life? \_\_\_\_\_
30. *What* is the change you experienced and *when* did it happen?\_\_\_\_\_
31. When you think about that change, can you rate your *distress* on a scale of 0-10 where 10 is the most distressed?  
SUDS:\_\_\_\_\_
32. When you think of the change, does it create *anxiety*?\_\_\_\_\_
- If yes, can you place your anxiety on a scale from 0-10 where 10 is severe anxiety?  
SUDS:\_\_\_\_\_
33. When you think of the change, does it create any *fear*?  
If yes, can you place your fear on a scale from 0-10 where 10 is severe *fear*?  
SUDS:\_\_\_\_\_
34. Would you rate this *fear* as being irrational?  
If YES, why?\_\_\_\_\_
35. Does the change affect your personal life? \_\_\_\_\_
- If YES, how \_\_\_\_\_
- and how much on a scale from 0 to 10? SUDS: \_\_\_\_\_
36. Does the change in your life require a transition? \_\_\_\_\_
- If YES, what is it?\_\_\_\_\_ OR
- Does the transition stand on its own?  
Describe the transition:\_\_\_\_\_
37. On a scale from 0 to 10, what would your level of *distress* be when you think of the transition?  
SUDS:\_\_\_\_\_
38. On the same scale, what would your level of *anxiety* be when you think of the transition?  
SUDS:\_\_\_\_\_



39. When you think of the transition, does it create any *fear*?  
If yes, can you place your fear on a scale from 0-10 where 10 is severe *fear*?  
SUDS: \_\_\_\_\_
40. Would you rate this *fear* as being irrational?  
If YES, why? \_\_\_\_\_
41. Does the above mentioned information, regarding change and transition affect you physically? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
42. Does it affect you mentally? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
43. Does it affect you spiritually? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
44. Does it affect you emotionally? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
45. Does it affect you socially? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
46. Does it affect you occupationally? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
47. Does it affect you interpersonally? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
48. Does it affect you in any other way? \_\_\_\_\_  
If yes, how much on a scale of 0 to 10?  
SUDS: \_\_\_\_\_  
and how? \_\_\_\_\_
49. Do you feel there is a lack of progression in your life regarding the change and/or transition? \_\_\_\_\_
50. In which area in your life don't you progress? \_\_\_\_\_  
Explain \_\_\_\_\_  
How would you rate your lack of progression, where 10 is the biggest lack?  
Physically? \_\_\_\_\_

SUDS:\_\_\_\_\_

Mentally?\_\_\_\_\_

SUDS:\_\_\_\_\_

Emotionally?\_\_\_\_\_

SUDS:\_\_\_\_\_

Spiritually?\_\_\_\_\_

SUDS:\_\_\_\_\_

Socially?\_\_\_\_\_

SUDS:\_\_\_\_\_

Occupationally?\_\_\_\_\_

SUDS:\_\_\_\_\_

Interpersonally?\_\_\_\_\_

SUDS:\_\_\_\_\_

Other?\_\_\_\_\_

SUDS:\_\_\_\_\_

51. On a scale of 0-10 what would your level of *distress* be when you think of the lack of progression in your life?\_\_\_\_\_

52. On a scale of 0-10 what would your level of *anxiety* be when you think of the lack of progression in your life?\_\_\_\_\_

53. When you think of the lack of progression, does it create any *fear*?

If yes, can you rate it from 0-10 where 10 is severe *fear*?

SUDS:\_\_\_\_\_

54. Would you rate this *fear* as being irrational?

If YES, why?\_\_\_\_\_

55. Does the lack of progression create any shame?\_\_\_\_\_

How?\_\_\_\_\_

SUDS:\_\_\_\_\_

56. What other emotions, apart from *distress, anxiety and fear*, do you experience when you think about the change, transition and lack of progress? Provide SUDS levels:\_\_\_\_\_

57. Do you believe you might be phobic of change?\_\_\_\_\_

If yes,why?:\_\_\_\_\_

If no, why?:\_\_\_\_\_

58. If NO on #57, will you still be willing to come in for the muscle testing interview to be muscle tested for a phobia in the above context?

59. Have you or are you currently receiving treatment for anxiety or /and phobias?\_\_\_\_

60. What kind of treatment and for how long?\_\_\_\_\_

61. Do/did you find the treatment effective?\_\_\_\_\_

If yes, how?\_\_\_\_\_

62. Are you on any medication?\_\_\_\_\_

63. If yes, what and for what?\_\_\_\_\_

For how long?\_\_\_\_\_

## Appendix C

UNISA – University of South Africa

UNISA Main Campus  
Muckleneuk, Pretoria  
South Africa

+27(0)12 429 2970

### **Informed Consent Agreement**

Addressing difficulties with change, transition and progression in life: HBLU™ as an effective treatment for phobias.

You are being asked to participate in a research study. However, before you give your consent to be a volunteer, we want you to read the following and ask as many questions as necessary to be sure that you understand what your participation will involve.

#### Researcher:

Mari Schurian  
(310) 961 8867  
[healyourcore@gmail.com](mailto:healyourcore@gmail.com)

Chair of dissertation research: Dr. Beate von Krosigk

#### Purpose of the research:

1. The purpose of the research is to explore the effectiveness of an Energy Psychology method, HBLU™, in the detection and resolution of phobias in the context of change, transition and/or progression.
2. No research is known to exist on non-obvious/subtle phobias in the context of change, transition and progression, nor has any investigation been done on the role and treatment of more subtle and indirect phobias with an energy psychology method and choice of intervention techniques. This study seeks to showcase HBLU™ as an integrative Energy Psychology approach towards the detection and treatment of subtle phobias in the context of change, transition and progression.
3. The research objectives are to: (1) understand the correlations between change, transition and lack of progression in the participants lives (2) detect and test for phobias in the context of change, transition and/or progression that influence the participants' lives (3) treat the phobia(s) effectively in one 90 minute session and (4) note progression after the treatment in the participants' lives.

My main objective is to demonstrate the effectiveness, and therefore relevance, of a structured mind body Energy psychology method, such as HBLU™, in the treatment

of phobias related to difficulties with life changes and transitions, which in turn block progression in life.

4. You will have one or two in person meetings with the researcher to participate in an interview where you will be taught muscle testing and be tested for a phobia in the context of change, transition and/or progression. You will meet immediately after this interview or at another time for the 90 minute treatment session that will be digitally recorded (audio only). The duration of the treatment session is estimated to be approximately 90 minutes.

#### Duration of Participation in the Research and Number of Subjects to Participate:

Ten participants will be included in this study.

Parts of the research are the 3 screening interviews that are conducted over the phone or in person. During the first interview the researcher will inform you about the nature of the research, the treatment plan and how phobias are viewed from the HBLU<sup>TM</sup> perspective. The first screening interview will be a personal assessment and will consist of about 60 questions to establish a subject profile. During this interview demographic and background questions will be asked. The researcher will also be asking you questions about the change and transitions in your life, the lack of progress and how you might benefit from this treatment. The duration of this interview will be approximately 45 minutes to 1 hour.

When assessment was successful and you qualify, a second interview will take place a week later where you will be required to answer two psychological questionnaires: the Hamilton anxiety assessment questionnaire and the Impact of event scale questionnaire by phone or via email. All remaining history information will be completed if needed.

A week after the second screening, the last screening and assessment will take place in person where you will answer a further two psychological questionnaires: the DASS and GAD -7 questionnaires, learn the skill of muscle testing and be tested for a phobia in the context of change, transition and/or progression.

If you are able to muscle test and tested yes for a phobia in the context of change, transition and progression which can be treated with a simple phobia protocol, you qualify for the research. You will be invited to continue to participate in this research study and will sign all relevant consent forms and bill of rights. The 90 minute treatment session will follow immediately after this interview or at another suitable time.

After the treatment session, each participant will be interviewed two more times in person or by telephone to review their progression. The first interview will be one week after treatment and the second interview will be 2 months after the treatment. The duration of the follow up interviews are estimated to be approximately 30 minutes.

If you do not meet the criteria for the study and/or have other symptoms that require treatment, I will discuss treatment options with you outside the scope of this study. You will have the choice to agree or not to any of the treatment recommendations, which may include continuing to stay in treatment with me.

### Procedures to be Followed During the Research:

If you qualify and agree to participate in this research, you will follow a detailed step by step process during the treatment session. The treatment will consist of open ended and structured questions, which are part of the HBLU™ phobia treatment protocol. The SUD (Subjective Units of Distress) levels will be measured throughout the protocol and confirmed through muscle testing. Your soul and deepest wisdom will be addressed during muscle testing. Results will be tested immediately after treatment where participants will be muscle tested to see if the phobias have been resolved on the body, unconscious, conscious and soul levels. The results and new awareness (learnings) will be documented by the participant. The date for the follow up interview will be addressed.

### Experimental Procedures:

The treatment and procedures are standard with the HBLU™ practice. The experimental part is that we are collecting the information and comparing it with information with other individuals. We also compare your experiences before and after the treatment.

### Risks:

The risks of participation in this research study are minimal.

This study poses no known physical, psychological, or social risks to your health.

There is however a chance that negative emotions or memories may arise, which will be addressed during the treatment session. I, the researcher, will be available to help you process the negative feelings. You will be encouraged to contact the researcher if questions arise following the interview. If you continue to experience distress and uncomfortable feelings after the treatment session, you are encouraged to discuss them with a therapist. Referrals to qualified helping professionals will be offered to you if for some unforeseen reason it is needed.

### Benefits of the Research:

You might benefit from this study and observe changes and progression in your life. You also might not benefit from your participation in this research study. We are investigating the use of these techniques and method, so therefore benefits may or may not be evident.

### Alternatives to This Research:

There are alternative treatments available and I will inform you if you need the information. Alternative treatments can include, but are not limited to, specialized chiropractic and/or acupuncture treatment, talk therapy, cognitive behavioural therapy, cranio sacral therapy, NET, etc.

### Confidentiality:

You have a right to privacy, and all information identifying you will remain confidential, unless otherwise required by law. The results of this study along with digital audio recordings, if appropriate, may be published in books and scientific journals, and presented at academic conferences as long as you are not identified and cannot be reasonably identified from it. However, it is possible that under certain circumstances data could be subpoenaed by court order. It is also not guaranteed that efforts to disguise identifying information with regard to case studies will keep your identity anonymous.

### Questions about the Research:

Should you have questions about the research or any additional concerns, please contact Mari Schurian at (310) 961 8867) or [healyourcore@gmail.com](mailto:healyourcore@gmail.com).

### Mandatory Reporting of Child or Elder Abuse:

California law mandates the filing and reporting of reasonable suspicions of child or elder abuse. Participation in this research could result in the researcher being required to report child or elder abuse.

### Subject Cost/ Compensation for Participation:

As a research participant, you don't have to pay for your treatment, nor will you be compensated for your time.

### Previous Research Participation:

I have participated in the following research studies within the last three months: \_\_\_\_\_

### Subject Rights and Research Withdrawal:

Your participation in this study is voluntary. You may refuse to participate or withdraw once the study has started.

I have tried to explain all the important details about the study to you. If you have any questions that are not answered here, I, the researcher will be happy to give you more information.

### Signature and Acknowledgement:

My signature below indicates that I have read the above information and I have had a chance to ask questions to help me understand what my participation will involve. I agree to participate in the study until I decide otherwise. I acknowledge having received a copy of this agreement and a copy of the Subject's Bill of Rights. I understand that by signing this consent form that I am not giving up any of my legal rights.

Signature of Research Participant: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix D

UNISA – University of South Africa

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### Consent to be Audio Recorded

Addressing difficulties with change, transition and progression in life: HBLU™ as an effective treatment for phobias.

#### Researcher:

Mari Schurian  
(310) 961 8867  
[healyourcore@gmail.com](mailto:healyourcore@gmail.com)

As part of this research project on phobias in the context of change, transition and/or progression, interviews with participants are digitally recorded so that the most accurate representations of the participants' responses can be used for the final project. Audio recordings will be transcribed after the interview for analysis.

I hereby give my consent to participate in this study and to be recorded for such purposes. I understand that these materials will be held in strict confidence at all times during the course of the study, being used only for the purpose of answering the research questions. I also understand that when these recordings and written transcriptions of the recordings are no longer of value for the study, they will be destroyed.

However, other written documents may not be destroyed. These documents will not include my name. My signature indicates that I have read this document and agreed to voluntarily participate in digital recording.

Signature of Research Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix E

### PARTICIPANT BILL OF RIGHTS

As a participant in a research study, or as someone who is requested to give consent on behalf of another for such participation, you have certain rights and responsibilities. It is important that you fully understand the nature and purpose of the research and that your consent be offered willingly and with complete understanding. To aid in your understanding, you have the following specific rights:

1. To be informed of the nature and purpose of the research in which you are participating.
2. To be given an explanation of all procedures to be followed.
3. To be given a description of any risks or discomforts, which can reasonably be expected to occur.
4. To be given an explanation of any benefits, which may be expected to come to the subject as a result of this research.
5. To be informed of any appropriate alternative procedures, drugs, or devices that may be advantageous and of their risks and discomforts.
6. To be informed of any available resources for the subject if complications should arise from this research.
7. To be given an opportunity and encouraged to ask any questions concerning the study procedures involved in this research.
8. To be given a copy of the signed and dated consent form if requested.
9. To not be subjected to any element of force, fraud, deceit, duress, coercion, or any influence reaching your decision to not consent to participate in the research.

If you have any questions or concerns about your rights as a research participant, please contact the researcher at phone number: **1310 961 8867** or email address: [healyourcore@gmail.com](mailto:healyourcore@gmail.com).

Signature of Research Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_ Date: \_\_\_\_\_



## Appendix F

### SEMI-STRUCTURED INTERVIEW GUIDE

Through this study I hope to explore how subtle phobias that we might not even be aware of can halt our progress in life, especially if we are undergoing huge changes and/or transitions in life. I chose the Energy Psychology method, Healing From the Body Level Up/HBLU™, because of its integration of mind, body and soul. This method has the unusual, but effective, approach of addressing a person's deepest wisdom when questions are asked and receiving the answers through muscle testing. This combination supports a lack of projection in the practitioner and in you, the participant, and increases objectivity in the research procedure.

We will start by asking you about your background in the context of the possible phobia and further explore the answers to the questions asked during the screening process. That will get you focused on the issue again. Once I have received adequate information, we will proceed with the second part of the interview - the treatment part - where the questions will be more structured by following the HBLU™ protocol. We will start this part by testing you for dehydration, correct any neurological disorganisation, and confirm your muscle testing skills. From there, the HBLU™ protocol will direct the questioning.

Although you will be introduced to a new therapeutic approach and are learning new skills at the same time, you should be relaxed, as I will direct us. If you feel uncomfortable at any stage, please feel free to let me know and ask any question you need to ask. You are free to take a break at any point.

As seen in the Informed consent agreement (Appendix C) you have just signed, together with the consent to be audio recorded (Appendix D) and your bill of rights (Appendix E), your personal information will stay confidential, and will be presented using pseudonyms and will be written in such a way as to conceal any other information that appears necessary to protect your identity.

Do you have any questions before we start?

1. Let's review the phone screening interview questions. Tell me more about this issue.
2. When do you believe this phobia started? Maybe an age is coming up for you?
3. Do you remember anything significant that happened during that time?
4. Do you believe there is a correlation between that event and the issues you now have regarding change, transition and progress?
5. It seems that you are ready to start with the treatment. Are you ready?  
Let's start with the simple clearing.

## Appendix G

### SIMPLE CLEARING

Possible Imbalance	Assessment	Balancing
1 Blocking	<b>Muscle test</b> by pressing on extended forearms. Say, "Give me a yes." Test. Muscle should feel strong. Press again and say, "Give me a no." Test. Muscle should feel weak.	If the forearms test strong for BOTH the "yes" and the "no", have them take a deep relaxing breath and say "I choose to unblock."
2 Dehydration	Muscle test one forearm. While pressing, ask person to tug on hair. The muscle should remain strong.	If the arm goes weak during the hair tug, have the person <b>drink water</b> .
3 Overload or Switching	Ask the person to hold their arms firm. Muscle test with your arms uncrossed and then crossed. Muscle test with one of your hands at a time. Each arm should maintain equal strength no matter which hand you test with.	If one arm feels weaker when pressed with one hand compared to the other hand, ask person to balance as follows:  Hold one hand over the navel and rub the sacrum, K27 (area beneath the centre of the collar bone), and the upper and lower lips (duck lips).
4 Over/Under Energy	Ask the person to hold their arms firm. Muscle test. <b>Zip Up</b> the energy field by moving your hand "3-6" in front of the body from the crotch to the lower lip. Muscle test. <b>Zip Down</b> by moving hand from lower lip to crotch. Muscle test. <b>Zip Up</b> and test. The person should test	If the response is different than expected balance with a Cook's Balance or a Meridian Flush.  <b>Cook's Balance:</b> Cross one leg over the other. Clasp palms together and fold hands up so that the pinkie's touches the chest. Then

strong on the Zip Ups and weak on the Zip Downs.

stand with feet apart. Touch fingertips together and point towards ceiling at heart level.

**Meridian Flush:** Perform a series of Zip Ups from the crotch to the lower lip in front, and from the base of the spine over the top of the head to the upper lip and back. Have the recipient stand sideways to you and flush front and back simultaneously.

## Appendix H

### MUSCLE TESTING SESSION

Name:

Date:

Issues:

Blocked on body testing:

Zip up and down issues:

Dehydration:

Deepest wisdom muscle test problem:

Have a phobia in the context of change, transition and progression?

The phobia can be cleared with the simple phobia protocol?

Giving a 100% permission?

## Appendix I

### SELF MUSCLE TESTING

#### 1. CIRCLE AND PRESS:

- a. Make a circle with the thumb and ring finger of your non-dominant hand.
- b. Insert the thumb and index fingers of the other hand into this circle from the bottom.
- c. Hold light tension in the circle.
- d. As you ask questions, press the fingers inserted into the circle outward.
- e. Yes = the circle stays closed and holds the press fingers inside.
- f. No = the circle opens.

#### 2. CIRCLE AND POINT:

- a. Make a circle with the thumb and ring finger of your non-dominant hand.
- b. Insert the index finger of the other hand into the circle from either the top or bottom.
- c. Hold light tension in the circle.
- d. As you ask questions, pull the index finger and circle apart.
- e. Yes = the circle stays closed and holds the index pointer inside.
- f. No = the circle allows the index pointer to pull out.

#### 3. FINGER RUBBING:

- a. Lightly touch the pads of the index finger and thumb of one hand together.
- b. As you ask questions, lightly slide the pads across each other.
- c. Yes = the pads slide very smoothly, there is no resistance.
- d. No = the pads are sticky against each other, there is resistance.
- e. This can also be done using both hands rubbed against each other.

4. ONE HANDED:

- a. Place the pad of the middle finger of one hand on the top of the nail of the index finger on the same hand.
- b. The index finger is straight with the middle finger bending to touch it.
- c. As you ask questions, press down on the index finger with the middle finger.
- d. Yes = the index finger stays straight.
- e. No = the index finger bends downward.

5. LEG TESTING:

- a. Place one ankle on the top of the opposite thigh at the knee.
- b. Place both hands against the back of the calf of the top leg.
- c. As you ask questions, press the top leg away from you.
- d. Yes = the top leg stays on the thigh of the bottom leg.
- e. No = the top leg falls off the thigh of the bottom leg.

6. STANDING TILT TEST:

- a. Stand up and face North.
- b. Relax your whole body particularly around the ankles
- c. Yes = tilt forward (North)
- d. No = tilt back (South)

## Appendix J

### FOUR PSYCHOLOGICAL TESTS: GAD 7, HAM-A, IOE and DASS

#### **Generalized Anxiety Disorder 7-item (GAD 7) scale**

Over the last 2 weeks, how often have you been bothered by the following problems?

Not at all sure = 0

Several days = 1

Over half the days = 2

Nearly every day = 3

1. Feeling nervous, anxious, or on edge 0 1 2 3

2. Not being able to stop or control worrying 0 1 2 3

3. Worrying too much about different things 0 1 2 3

4. Trouble relaxing 0 1 2 3

5. Being so restless that it's hard to sit still 0 1 2 3

6. Becoming easily annoyed or irritable 0 1 2 3

7. Feeling afraid as if something awful might happen 0 1 2 3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_

Somewhat difficult \_\_\_\_\_

Very difficult \_\_\_\_\_

Extremely difficult \_\_\_\_\_

## **Hamilton Anxiety Rating (HAM - A) Scale**

### **Instructions:**

Below is a list of phrases that describe certain feelings and symptoms that people have.

\*Focus on the relevant change, transition and lack of progression discussed during our interview(s). Rate yourself by finding the answer which best describes the extent to which you have these conditions over the last week. DO: 1) Select and underline one of the 4 responses for each of the 13 questions AND 2) Underline the symptoms that you have under each question.

If you prefer to complete the test with me, please let me know immediately.

#### **1) Anxious mood**

**Worries, anticipation of the worst, fearful anticipation, irritability**

0 = Not present

1 = Mild

2 = Moderate

3 = Severe

4 = Very severe

#### **2) Tension**

**Feelings of tension, fatigability (\*\**susceptible to fatigue*), startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax**

0 = Not present

1 = Mild

2 = Moderate

3 = Severe

4 = Very severe

#### **3) Fears**

**Of dark, of strangers, of being left alone, of animals, of traffic, of crowds**

0 = Not present

1 = Mild

2 = Moderate

3 = Severe

4 = Very severe

#### **4) Insomnia**

**Difficulty falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors**



- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**5) Intellectual**

**Difficulty in concentration, poor memory**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**6) Depressed Mood**

**Loss of interest, lack of pleasure in hobbies, depression, early waking, mood swings**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**7) Somatic (muscular)**

**Pains and aches, twitching, stiffness, myoclonic jerks** (*brief, involuntary twitching of a muscle or group of muscles. This can happen when you are on the verge of falling asleep and suddenly have a sensation or feeling that you are falling through the air*)  
**grinding of teeth, unsteady voice, increased muscular tone**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**8) Somatic (sensory)**

**Tinnitus** (*usually described as a ringing noise, a high-pitched whining, electric buzzing, hissing, humming, tingling or whistling sound, or as ticking, clicking, roaring, "crickets" or "tree frogs" or "locusts (cicadas)"*), **blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**9) Cardiovascular symptoms**

**Tachycardia** (*a heart rate that exceeds the normal range*), **palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**10) Respiratory symptoms**

**Pressure or constriction in chest, choking feelings, sighing, dyspnea** (*shortness of breath*)

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**11) Gastrointestinal symptoms**

**Difficulty swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi** (*stomach "growling"*), **looseness of bowels, loss of weight, constipation**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**12) Genitourinary (*reproductive organs and the urinary system*) symptoms**

**Frequency of micturition** (*urination*), **urgency of micturition, amenorrhea** (*absence of menstrual periods*), **menorrhagia** (*abnormally heavy and*

*prolonged menstrual period*), **development of frigidity, premature ejaculation, loss of libido, impotence**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

**13) Autonomic symptoms**

**Dry mouth, flushing, pallor** (*an unhealthy pale appearance*), **tendency to sweat, giddiness, tension, headache, raising of hair**

- 0 = Not present
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Very severe

\*Underlined inserts were done by me, the researcher, to help direct the participants in completing this questionnaire.

*\*\*The italics were inserted by me, the researcher, to make the questionnaire more understandable to the participants*

## Impact of Event scale

Your name:

Today's date:

**Please focus on the relevant change, transition and lack of progression discussed in interview(s) over the last week. (\*Inserted by me, the researcher)**

on _____ you experienced _____ <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>(date)</span> <span>(life event/change)</span> </div> <p>Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how <b>distressing</b> each difficulty has been for you <i>during the past 7 days or other agreed time:</i></p>		<i>How distressing?</i>				
		<i>not at all</i>	<i>a little bit</i>	<i>moder -ately</i>	<i>quite a bit</i>	<i>extre -mely</i>
		0	1	2	3	4
<i>a.</i>	any reminder bring back feelings about it					
<i>b.</i>	I have trouble staying asleep					
<i>c.</i>	other things keep making me think about it					
<i>d.</i>	I feel irritable and angry					
<i>e.</i>	I avoided letting myself get upset when I think about it or am reminded of it					
<i>f.</i>	I think about it when I didn't mean to					
<i>g.</i>	I feel as if it hadn't happened or it isn't real					
<i>h.</i>	I stay away from reminders about it					
<i>i.</i>	pictures about it pop into my mind					
<i>j.</i>	I am jumpy and easily startled					
<i>k.</i>	I try not to think about it					
<i>l.</i>	I am aware that I still have a lot of feelings about it, but I don't deal with them					
<i>m.</i>	My feelings about it are kind of numb					

<i>n.</i>	I find myself acting or feeling like I was back at that time	
<i>o.</i>	I have trouble falling asleep	
<i>p.</i>	I have waves of strong feelings about it	
<i>q.</i>	I try to remove it from my memory	
<i>r.</i>	I have trouble concentrating	
<i>s.</i>	Reminders of it causes me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	
<i>t.</i>	I have dreams about it	
<i>u.</i>	I feel watchful and on-guard	
<i>v.</i>	I try not to talk about it	

# DASS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Please turn the page ➡

Lovibond, S.H. & Lovibond, P.F. (1995). *Manual for the Depression Anxiety Stress Scales (2nd. Ed.)*. Sydney: Psychology Foundation.

*Reminder of rating scale:*

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

## Appendix K

### Flow Chart of HBLU™ Standard Balance Protocol

1. Establish Priority Goal

2. Get Permission

3. Determine % Negative Emotional Charge

4. Find Priority Interference Pattern

5. Explain and Understand Priority Interference Pattern

6. Choose Technique to Clear Interference Pattern

7. Locate Feeling Associated with Interference Pattern in the Body

8. Do Technique

9. Test the Results

10. Write Learnings

11. Check for and clear any withdrawal

12. Test that client is 100% balanced on the goal



## Appendix L

### STRUCTURED HBLU™ PHOBIA PROTOCOL INTERVIEW GUIDE

#### NAME THAT PHOBIA (HBLU™ PHOBIA PROTOCOL)

MT = Muscle Test the client. Preface all muscle testing questions with, “From your soul and deepest wisdom...” and use double checking (is it not) system after each question. *\*I added 2 extra questions during the research: 1) Did you or any part of you deceive in that answer and 2) Will you tell us if you did deceive?*

1. “What is the phobia about?”  
(*“What is the subject of your phobia?” - in the context of change, transition and progression as discussed*) e.g.: saying no, feeling a certain emotion, change, the truth, etc.
2. MT: “How many phobias do you have (on that subject)?”
3. MT: “Are any of them fear, shame or hybrid phobias?”

If yes, how many of each?

*If there are more total phobias than the number of fear and shame hybrid phobias, continue to muscle test with the following questions until you have accounted for all the types of phobias.*

- MT: “Are any of them (the others) fear phobias?” If yes, how many?
- MT: “Are any of them (the others) shame phobias?” If yes, how many?

4. List the phobias and word them exactly. MT the accuracy of the wording.

I’m **afraid** to \_\_\_\_\_ because \_\_\_\_\_.

**For fear phobias** MT: “Does the wording of this phobia get any more extreme than this?”

*If the phobia doesn’t seem extreme enough* MT: “Are there any consequences that follow from that phobia?”

Example: I’m afraid to feel anger because I’ll lose control. Adding consequences we get: I’m afraid to feel anger because I’ll lose control and kill someone.

I'm **ashamed** to \_\_\_\_\_ because it means that I'm a \_\_\_\_\_.

**For shame phobias** MT: "Does the wording of this phobia get any more insulting than this?"

Hybrid phobia: I'm **afraid** and **ashamed** to \_\_\_\_\_ because \_\_\_\_\_, and it means that I'm a \_\_\_\_\_.

5. MT: "Can we clear all the phobias simultaneously?", after all the phobias are mapped out.

If no: "Which is the priority phobia to clear first, going for indicator...?"

6. Simple Phobia Protocol

MT: "Can we clear the phobia with the simple phobia protocol?"

If yes, continue with step 7 below.

### PROTOCOL FOR CLEARING SIMPLE PHOBIAS

7. Treating the Initial Shock

"Do we need to focus on a specific example of this phobia to facilitate the healing?"

- If no, continue with step 8.
- If yes, identify which example of this phobia would be the best one to use for the focus.

MT: "Shall we use the root cause event that started this phobia?"

MT: "Shall we use the worst example of this phobia?"

MT: "Shall we use the most recent example of this phobia?"

If the client can't consciously remember which event would be best, go for indicator and find the age at which this event occurred and keep guessing and muscle testing till you find it.

8. MT: "Do you understand this phobia well enough to proceed directly to the intervention of choice?"

If not, discuss until client gives permission to proceed.

OPTIONAL "On a scale of 1-10+ (Appendix M) how bad is this phobia, going for indicator..."

*Note: If the client went numb and registers a 10+ on the discomfort scale (Appendix M), remind him that he might feel worse before he feels better because as he thaws out he'll feel the fear. Just continue to treat until it clears.*

9. MT: "Which technique would be best to use to clear this phobia, going for indicator...?"  
(see Appendix O for list of interventions)

10. Ask verbally, "Where in your body do you feel the phobic emotion?" MT the answer.

11. Apply the technique of choice.

12. Test the results. "How do you feel now when you think about that situation?"

MT: "Are you 100% healed/cleared of that phobia at all four levels body to soul?"

"Are you 100 % healed of this \_\_\_\_ at the body level?"

"Are you 100 % healed of this \_\_\_\_ at the unconscious level?"

"Are you 100 % healed of this \_\_\_\_ at the conscious level?"

"Are you 100 % healed of this \_\_\_\_ at the soul level?"

a. If the client is cleared at all 4 levels, write the learnings.

b. *If not, MT: "Will you finish clearing when you write the learnings?"*

*If yes, write the learnings and recheck.*

*If no, treat again from step 8 or ask: Do you need any other treatment to clear interferences on the goal a 100% ?*

c. If the client had more than one phobia on the subject MT that each phobia is cleared.

If any of the phobias are left, determine the next phobia to clear and return to step 7.

When all the initial phobias are clear, continue with Anticipatory Phobias.

## **ANTICIPATORY PHOBIAS**

1. MT: "Do you have any anticipatory phobias on this subject?"

If yes, "How many anticipatory phobias, going for indicator...?"

2. Name them: "I'm afraid \_\_\_\_\_ will happen again in the future."

3. If there is more than one anticipatory phobia, MT: “Can we clear all of the anticipatory phobias at once?”

If no, MT: “The priority anticipatory phobia to clear first, going for indicator...?”

4. Clearing the Anticipatory Phobia:

- Find the best example to use for Focus.

MT: “Would it be best to use an example of a time when you actually experienced feeling the anticipatory phobia?”

MT: “Would it be best to use the imagined worst case scenario?”

- Describe the best example to use as a focus for this anticipatory phobia.

5. MT: “Do you understand this phobia well enough to proceed directly to the intervention?”

6. MT: “The priority technique to clear this phobia, going for indicator...?”

7. Ask verbally, “Where in the body do you feel the phobic emotion?” MT the answers.

8. Do the technique of choice.

9. Test the results. Ask verbally, “How do you feel now when you think about that situation?”

MT: “Are you 100% healed/cleared of that anticipatory phobia at all four levels body to soul?”

“Are you 100 % healed of the anticipatory phobias \_\_\_\_ at the body level?”

“Are you 100 % healed of the anticipatory phobias \_\_\_\_ at the unconscious level?”

“Are you 100 % healed of the anticipatory phobias \_\_\_\_ at the conscious level?”

“Are you 100 % healed of the anticipatory phobias \_\_\_\_ at the soul level?”

“Have you learned everything you needed to learn in a way that serves your highest purpose?”

- a. If the client is cleared at all 4 levels, write the learnings.
- b. *If not, MT: will you finish clearing when you write the learnings?*  
*If yes, write the learnings and recheck.*  
*If no, treat again.*

- c. If the client had more than one anticipatory phobia on the subject MT that each phobia is cleared. If any of the phobias are left, determine the next phobia to clear and return to step 4.

10. *Reality test* if possible. Ask verbally, “Now how do you feel about doing \_\_\_\_?” If the client still feels a little nervous, but it isn’t a phobic reaction, remind the client that he/she doesn’t have to feel frightened to be cautious. He/she should test the situation carefully until he/she knows that he/she is ok. If any additional reactions surface while in the actual situation, he/she can treat himself *at that moment* with Natural Bio-Destressing (Appendix P).

## Appendix M

### PHOBIA DISCOMFORT SCALE

- 10+ : I am numb, frozen; I feel nothing.
- 10 : Panic. The discomfort is the worst it can possibly be. I can't tolerate it.
- 9 : Discomfort is very close to intolerable.
- 8 : Fear is very severe.
- 7 : Fear is severe.
- 6 : Fear is very uncomfortable.
- 5 : Fear is uncomfortable, but I can tolerate it.
- 4 : Fear is noticeable and bothersome, but I can deal with it.
- 3 : I feel a slight degree of fear, but I am totally in control.
- 2 : I'm rather calm, quite relaxed, with no fear.
- 1 : I am perfectly calm - totally relaxed.

## Appendix N

### TREATMENT SESSION

Name:

Date:

Goal: \_\_\_\_\_ % NEC  
(be specific – in the context of the change in your life and what you want to achieve)

1. Do you have a phobia of change interfering on the goal?

If NO – Do we need to change the goal, the name of the goal?

- Would you call the phobia something different? (e.g. A *phobia of transition or progression*?) \_\_\_\_\_

2. Do we have a 100% permission to proceed clearing the phobia(s) as the priority interference on the goal with the HBLU™ simple phobia protocol?

3. What is the phobia about? (e.g. *phobia of change to* \_\_\_\_\_)

4. How many phobias do you have on (e.g. *phobia of change to* \_\_\_\_\_)?

5. How many are fear phobias ?

6. How many are shame phobias?

7. How many are hybrid phobias?

8. Write /map out the phobias exactly and MT for accuracy:

8.1. I am **afraid** to \_\_\_\_\_ because \_\_\_\_\_

***For fear phobias*** MT: “Does the wording of this phobia get any more extreme than this?”

*If the phobia doesn't seem extreme enough* MT: “Are there any consequences that follow from that phobia?”

8.2. I am **ashamed** to \_\_\_\_\_ because it means that I am a \_\_\_\_\_

***For shame phobias*** MT: “Does the wording of this phobia get any more insulting than this?”

8.3. I'm **afraid and ashamed** to \_\_\_\_\_ because \_\_\_\_\_,  
and it means that I am a \_\_\_\_\_

9. MT: "Can we clear all the phobias simultaneously?"

If no: "Which is the priority phobia to clear first, going for indicator...?"

10. CONTINUE WITH **#7** TO THE END OF THE STRUCTURED HBLU™ PHOBIA  
PROTOCOL INTERVIEW GUIDE in APPENDIX L.

11. Are you now a 100% balanced on your goal at the body, conscious, subconscious and  
soul level? (*Ask each level individually*)

If NO, ask: Do you need any other treatment to clear interferences on the goal a 100% ?



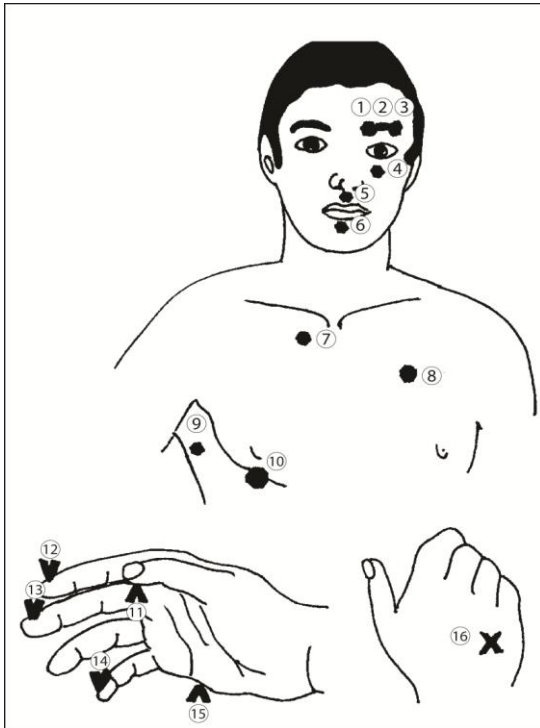
## Appendix O

### LIST OF INTERVENTIONS

1. a) Unwinding Frontal/Occipital Holding – as is;  
b) with light on chakras;  
c) singing in the chakras;  
d) with prayer
2. Emotional Stress Release
3. Reversal/Conflict Tapping
4. I Feel/I Am
5. Drawing
6. Boundary Tap
7. Callahan Technique for Phobias. A shortened version of Natural Bio-Destressing which uses 5 points plus the 9 gamut: under eye, armpit, eyebrow by bridge of nose, collarbone, pinkie, 9G
8. a) Natural Bio-Destressing (NBD) (start with karate point, tap all 14 meridians, 9G)  
b) watchmen in the tower  
c) personalized NBD
9. Raking
10. Essence process
11. Time scrambling
12. Visualization
12. Colour breathing
13. Body talk
14. HRT
15. Healing/Holy Light
16. Curses and prayer

## Appendix P

### Natural Bio-Destressing



### Natural Bio-Destressing (modified EFT process)

- A. Concentrate on a specific feeling and notice its location in your body.  
On a scale of 1-10, rate how severe is the feeling.
- B. Tap the Karate Chop Point : #15,  
while saying three times: *“I totally and completely accept myself, even though I have this (problem, feeling of fear, guilt, anger, etc.)”*
- C. Stimulate nerve endings 1-15 by tapping with fingertips for a few seconds.  
If you feel a lot of energy moving, or the scene is changing, stay on that point till the activity plateaus. If nothing happens on a specific point, move to the next one.  
Use your intuition about how long to stay on a point.

1-4. Tap around the entire eye socket starting at the bridge of nose by eyebrow

5. Under nose

6. Under mouth

7. Under collar bone

10. Bottom rib below nipple

11. Side of thumb

12. Side of index finger

13. Side of middle finger

8. Sore spot on chest (rub gently)
14. Side of little finger
9. Under arm on rib (ouchy spot)
15. Karate chop spot

D. Do the 9-Gamut

Tap the Gamut Point, #16, on the back of the hand through the following steps:

1. Close eyes
2. Open eyes
3. Look down to one side
4. Look down to the other side
5. Roll eyes around in a circle in one direction
6. Roll eyes around in the other directions
7. Hum a tune
8. Count to 40 by 2's
9. Hum a tune

E. Repeat Step C

F. After every round, recheck how severe the feeling is.

It should be gone altogether or very low on the scale.

Think about what you learned and what feels or seems different about the situation to you now.

If the level of that emotion still seems high, notice what *else* about the situation makes you feel frightened, angry, sad, etc.

Focus on that subject and repeat the process.

## Appendix Q

### Emotional de-fusion by **Unwinding Frontal/Occipital Holding**

A. Determine whether or not the person needs Frontal/Occipital Holding. If so, determine whether or not the person also needs light on the crown or pineal and for how long. Determine whether the being needs light on any other chakras or toning/singing or prayer into any chakras. Elicit the necessary chakras in indicator mode.

Chakras used with Frontal /Occipital Holding Intervention:

1. Crown
2. Pineal
3. Throat
4. Heart
5. Solar Plexus
6. Navel
7. Sexual Centre
8. Perineum

B. The person places their palms on their forehead and on the back of their head. Tell the client: "Wallow in the feeling, while your hands are placed lightly on your forehead and on the back of your head. Your head will move however it wants to for several minutes and stop automatically. At this point you may be able to feel even bands of heat on both the front and back of your head or you may notice synchronized pulses on the right and left side of both the forehead and the back of the head."

C. If the person needs light on the crown (top of the head), pineal (space between eyebrows), or other chakras, shine a flashlight on the region for the number of minutes indicated.

D. A blocked chakra will vibrate and open with the correct pitch. If the person needs to sing into any of the chakras, start with the highest chakra and work your way down. Sing one tone using a vowel sound (ah, oh, oo, ee) which makes the chakra resonate. If you place your hand about 6" in front of the designated chakra, you may feel a vibration when the client has chosen the correct pitch. You can generally assess when there has been enough singing because the vibration feeling converts from a feeling of rough idle to smooth idle (as in a car engine). If you cannot feel the vibration, you can hear the tone change from a weak tone to a strong vibrant tone. Use a higher pitch for higher chakras and a lower pitch for the lower chakras. If you can match the client's tone, sing with them to add energy and facilitate clearing. Muscle test to determine if there has been enough singing.

## Appendix R

### PARTICIPANTS' 1<sup>ST</sup> FOLLOW UP: INDIVIDUAL QUESTIONS

#### ANGIE

Date: March 28<sup>th</sup>

Duration: 1 hour

1. What has changed for you since the treatment?
2. If you now think of your back problems and surgery and the consequences – being unemployed – what are your levels of distress (8), anxiety (7-10), and fear (10) now?
3. And where are your emotions of anger (5), annoyance with people (9), and impatience (7) now?
4. Where are your levels of frustration (8-10) now?  
And your levels of depression (8)?
5. Any other emotions you are experiencing?
6. Do you think there is a level of change on the physical level?  
How are your energy levels? Do you perhaps feel less tired?  
Did you start to exercise?  
Do you experience any pain?  
How is the numbness in your left leg?
7. How are your confidence levels now? Before, the lack of confidence was at an 8, where is it now?  
Do you feel that you question yourself less now?  
Do you still feel that you are not sure of anything (8)?
8. Do you feel that you are getting back to who you are?  
Getting more clarity on who you are?
9. Do you still feel lost (9) where you don't know how to move forward?
10. On what levels do you feel you have progressed?
11. Do you feel you have more clarity on what will be a meaningful and purposeful career for you and how to achieve it?
12. Have you moved into looking into career possibilities?

#### ELIZABETH

Date: March 30<sup>th</sup>

Duration: 20 min.

1. Tell me about any changes since your treatment
2. How do you feel now about your x-boyfriend when you think about the break up?  
Do you still feel sick to your stomach?

- Does your heart still drop?
- Do you think less about him now (before he was always on your mind (9-10)?
- Does thinking about him still create distress (9-10), anxiety (9), fear (9)?
3. Where are your anger (7), frustration (10), and sadness (10) levels now?
  4. Do you still fear people (8) and distrust people (8)?
  5. Are you still scared that you will never fall in love again (9)?
  6. How is school?  
Do you feel it is better to focus and concentrate in school?  
Do you start to care about school again?  
Do you feel more grounded and less spacey?
  7. Do you feel it is better to go forward in life?  
To get up and move on?
  8. Is it easier to focus on what is important now?
  9. Is it easier for you to be single now?
  10. Is it easier for you to be alone?
  11. Would you say that you feel more confident now?
  12. Tell me about your social life and choices.
  13. Do you still see a lot of signs everywhere?
  14. Do you still fear change?
  15. If you think back now on what was, what do you see and feel?
  16. Do you feel that you are getting back to who you were or are you discovering a new positive you?

## BUNNY

Date: March 27<sup>th</sup>

Duration: 35 min.

1. Is there any difference in how you experience your new relationship now?
2. Any distress (7), anxiety (10), fear (10)?
3. How does it affect your personal life now?
4. How do you feel now about new romantic relationships that might lead to marriage?  
Do you feel any distress (7) or anxiety (10) now? SUDS  
Moving from being single to being married?
5. How is your fear of rejection (10)?
6. How do you feel about the old pattern –the relationships always end. The reoccurring cycle that never ends?
7. How do you feel about transitioning into being married for the rest of your life?
8. Does the change and transition now still affect you  
physically (10)? SUDS:  
How?  
mentally (8)? SUDS:  
How?

- |                             |       |
|-----------------------------|-------|
| <u>spiritually</u> (5)?     | SUDS: |
| How?                        |       |
| <u>emotionally</u> (8)      | SUDS: |
| How?                        |       |
| <u>occupationally</u> (3-5) | SUDS  |
| How?                        |       |
| <u>any other way</u> ?      |       |
9. Do you feel there is still a lack of progression on a  

<u>physical</u> level(10)?	SUDS:
How?	
<u>mental</u> level(8)?	
How?	SUDS:
<u>spiritual</u> level(8)	SUDS:
How?	
<u>social</u> level (8-9)	SUDS:
How?	
<u>emotional</u> level (8-9)	SUDS:
How?	
  10. Do you feel that you have progressed in any way?
  11. Are you still worried about not getting a real partner in your life?  
How much?
  12. Do you still feel being single is your new normal?
  13. How do you feel around couples now?
  14. Is there a part of you that feels now that a relationship might work? That your partner will not get tired of you?
  15. Is there a difference for you now when you think about having a conscious, soul connection marriage for the rest of your life?

JANE

Date: April 4<sup>th</sup>

Duration: 30 min.

1. What are the differences for you now since your treatment?
2. How do you feel about your move to S.F. now?
3. Do you still feel that the move broke you?
4. Do you feel you have a change in attitude?  
A bit more positive?
5. Are you still angry with your Dad and blame him for your situation?
6. Has it been easier to make friends?  
Do you still feel disconnected from a lot of people?  
Do you still get easily angry with people and snap at them?
7. Do you still feel very alone?

8. How are your health and weight/eating habits now?
9. How are your studies now?  
Do you spend more time studying?  
Are you more motivated?  
How is your concentration/focus in school?  
Your grades?  
Motivation?
10. Where are your distress (10), anxiety (10) and fear (7) levels now if you think of this change?
11. If you think of the change (your move) and the transition into a university and becoming more independent, how is your  
Mental state now? (10)  
Do you still constantly worry?  
Your self-esteem?  
Do you still worry about disappointing others?  
Do you still doubt your success and yourself?  
Spiritual state? (6)  
Do you still just see mostly dark?  
How is your social life? (7)
12. Do you feel you can trust people a bit more now?  
Or do you still feel everyone is just out to get you and no one cares?
13. Do you still feel betrayed by people?
14. Do you feel you have progressed?  
Physical level? (10)  
Mentally( 5)  
Emotionally (8)  
Do you feel you progress more than you regress now?  
Spiritually (5) Are you still so angry at God?
15. How are your feelings of depression now (9)?  
Feelings of discouragement(7)  
Feeling unmotivated (9)  
Feeling down(9)
16. How do you feel about being independent now?  
Being responsible?

## GRACE

Date: March 29<sup>th</sup>

Duration: 70 min.

1. How do you feel now about being a mature single person?
2. What has changed for you since a week ago?  
2.1. On a physical (6-7) level – how is your asthma?



- How is your sleeping pattern (4-6 hours before)?
- Eating patterns?

2.2. On a mental (5) level ?

2.3. Do you feel there is a shift on an emotional level?

How and what emotions do you experience now?

How are your levels of depression, anger (8), guilt (7), shame (7), sadness (8), loss (8), regret (8) and resentment (8) now?

Where would you say is your fear of rejection (9) now in terms of your competence level when you think of an occupation?

3. Do you feel that you have *progressed* on a physical level (7)?

How you manage your finances and impulse spending?

Do you still feel paralyzed when you need to make financial decisions?

4. Mental level (8)? How are your decision making skills now?

Do you still avoid doing things that you know are good for you?

5. Emotional level (7)? How are your fear and anxiety levels? Do you still go into paralysis?

Do you feel that you have let go of some of the hurt already?

Do you feel your insides are less twisted now?

6. Socially?

Do you take more initiative already or do you still wait for others to call you?

7. Occupationally?

Do you feel more capable?

Do you feel less stuck and can you now move forward?

8. What are your distress (9), anxiety (8-9), fear (7-8) levels now when you think about your divorce?

9. Would you say that you feel more peaceful about the situation?

Why would you say that? Tell me about your feelings now.

10. Is the divorce more acceptable to you now?

11. Do you feel that you are experiencing the *transition period* from being married to single differently now?

How are your sadness (8) levels now?

And your fear (7-8) levels?

12. How is your energy level?

13. Do you feel more at peace?

## MICHEAL

Date: May 2<sup>nd</sup>

Duration: 25 min.

1. How do you feel now about sharing your composition(s) with the world?
2. Do you still feel hesitant/reluctant to share it (them) with the world?
3. Do you feel more ready to share now?

4. Do you still think you should wait until it (they) is (are) perfect before you release it (them)?
5. Is your fear of imperfection (9) still holding you back?
6. Would you say you still have a fear of rejection?
7. Do you still feel frustrated with yourself (8) about your musical goal and when you work on it?
8. Where is your fear of failure (9) now?
9. Do you still believe you are not good enough?
10. Do you still feel dissatisfied about not getting it out there?
11. Do you still have a steady resistance to getting it out there?
12. Do you still think it is crazy to have to share it because the world decides if it is precious or not?
13. How are your levels of frustration (7) with yourself now?
14. Do you still get down on yourself?
15. How are your legs and aches and pains and sinus conditions now?
16. Do you feel you can meditate easier and more now?
17. Do you feel it is easier to socialize now?
18. Do you believe now that this can be a reality for you – that music can become your final career?
19. Can you see yourself producing shows now?
20. Do you still feel frustrated because you cannot read music?
21. Do you still believe that people will think you are a fraud – an illegitimate composer - because you have no formal musical education and have not “earned” it?
22. Does it come easier to you now to say you are a musician and composer?
23. Have you composed anything new since we spoke last?

## BAM

Date: April 26<sup>th</sup>

Duration: 20 min.

1. Since the treatment, would you say that you have had a change in attitude during this time around (with your unemployment status)?
2. Are you less nervous about future situations like this where you would worry about your ability to find a job?
3. Do you still believe that you are too old to find a job and that the younger generations are better qualified than you?
4. How do you feel now about the value of work experience vs. the skills that the younger generation brings?
5. Do you believe they can work together and need each other?
6. Do you feel that you can hold yourself against them better now?
7. How is your social life?

8. How is your relation with your partner?
9. How do you sleep now?
10. Do you feel more comfortable now with the idea that you can survive these periods of unemployment?
11. Do you eat better?
12. Do you still fear success?
13. Have you started to set goals for yourself ?
14. Do you feel that you have learned something from the healing experience?
15. Are you more aware of what you need?

### MR BLUE

Date: April 29<sup>th</sup>

Duration: 20 min.

1. Do you feel that you have moved forward in your business?
2. Is there any progression?
3. If there is a lack of progression /moving forward, does it still create a lot of stress for you?(6)
4. How?
5. How are your relationships now with friends/ business partners?
6. How do you feel about your honour/reputation being tarnished in the industry?
7. How is your level of stress and anxiety now with regard to your business, and when you think about it?
8. Do you still easily snap at people?  
Are you still grouchy and irritable?
9. Do you still feel very tired?
10. How is your focus?
11. Where are your frustration (6) levels now?
12. Does your anger and frustration still create problems in your job?
13. Where are your anxiety levels now (9) when you think about how much effort you put into the business not getting rewarded financially?
14. Where are your fear (10) levels now when you think about this transitioning into R as a businessman?
15. Do you still feel that all your efforts were in vain and it won't happen?

### PEGGY SUE

Date: April 27<sup>th</sup>

Duration: 1 ½ hours

1. Since the treatment, do you feel you are starting to stand more in your own power?

2. Do you believe more in your own power already?
3. Do you feel more self-confident?
4. How is the itch on your shoulder?
5. How are your sleeping patterns (10) now? Do you still get up every hour or 2 to urinate?
6. Are you still very restless where you cannot sit still at all?
7. Can you read a book? Watch a movie?
8. Would you say that your attention span is better now? It was weak at a 10 before.
9. And your focus? Lack of focus at a 10 before.
10. Can you start to organize things more now?
11. Do you still have the fingernails on a chalkboard feeling?
12. Did you start to work in your garden again?
13. Do you feel that you are starting projects and finishing them now?
14. Have you had any panic attacks?  
Do you still feel panicky?
15. Do you still feel stuck and fearful to strike out on your own?
16. Are you starting to do things on your own, like exercising, walking the dogs?
17. Do you feel more accepted by your family?  
And if NOT – does it bother you as much as before?
18. Do you still feel you have to do all the fitting in and if you don't that they will reject you and leave you?
19. Do you still feel that you have to be quiet of who you are?
20. Do you still fear that if you change that your family won't like you anymore, your husband will divorce you, you won't have any money and that you will be all alone?
21. Do you still feel if you do what you like, your family will dispose of you?
22. Do you still feel very needy for interaction and love from your family? SUDS?
23. How do you feel now about them being unable to meet your needs?
24. Are you still feeling a lack of joy and love in your marriage?
25. Do you feel there is more of a connection between you and your husband?
26. Do you see your husband in a different light now? For example that he might come from a place of fear?
27. Are you still afraid to have your own opinion?
28. Are you still afraid to move forward (10)? Even by yourself?
29. Have you started to do/change simple, little things already?
30. You said before that it feels that you are starting to climb out of the dark hole you were in, do you still feel that, and is it even better than you thought?
31. Your distress, anxiety and fear levels were all at a 10 before regarding your *change and transitioning*, where is it now?
32. Do you still feel stuck? And afraid to strike out on your own?
33. Do you feel you can start to “pull the trigger” now as you say?
34. Are you still afraid to move forward and do what you love and start living again?
35. Do you feel more secure to be on your own?
36. Do you have a better understanding now of why you were stuck?
37. Is everything still fear based for you?

38. Do you feel emotionally stronger? Weak at a 10 before.
39. Do you still feel devastated because you are not in control of your life? (10)
40. Do you still feel a lot of sadness (10)
41. Do you still feel upset, fearful and frustrated (10) because you cannot or could not move forward?
42. Are you still disappointed in yourself?
43. Do you still feel socially disconnected?
44. Do you feel you can move forward and start your own event business now or start organizing events again? (not - at 10 before)  
Do you still feel frozen here?  
Do you feel you can do it? SUD?  
Do you feel more sure of yourself in this aspect?  
Do you feel more self-confident doing it?
45. Are you less hard on yourself?
46. Do you still feel like a beaten up wimp?
47. Your *lack of progression* created distress, fear, anxiety and shame at a 10, where is it now?
48. Are you feeling strong enough to believe in your own power?
49. Do you feel fearless with moving forward with your life?
50. Are you getting back to Loretta? An even better and stronger version as you stated?
51. Are you starting to feel more fulfilled?
52. Are you starting to feel more free, where you can soar like a bird?
53. Do you believe now that you can follow your path and enjoy it and be grateful and thankful?
54. Do you feel God has kept his promise and is helping you to move forward?

## TALLULAH

Date: May 4<sup>th</sup>

Duration: 35 min.

1. You mentioned in your letter that you have more peace of mind, that it feels that a weight has been literally lifted off your shoulders. Do you still feel like that?
2. Do you worry less now?
3. Do you still feel that fear holds you back?
4. Before your distress and fear was a 7 and your anxiety a 6 regarding you not having an income, where is it now?
5. The *lack of progression* created anxiety at 8 and fear at a 10 (“gets crazy, the not knowing”) for you, where is it now?
6. How do you feel now about not knowing how things will work out?
7. Tell me about your physical changes? Your digestive issues, the pressure on your gallbladder, did you get your period?
8. Do you think you still have a fear of success?

9. Do you still feel lost?
10. Do you feel more confident in your decision making?
11. Do you feel less confused as you are at this crossroad in your life?
12. Do you still feel useless and unaccomplished?
13. Do you still feel unsupported by your friends and family?
14. Do you still fear getting closer to people?
15. Do you still pick up on all their emotions?
16. Has your social life improved?
17. Do you meet with 'better' people now?
18. Where are your sadness levels now?(7)
19. Do you start to think more about the solution than the problem now?
20. Do you feel that you have mental clarity?
21. Do you have more clarity in what to do next?
22. Do you still feel you hold yourself back with one hand?
23. Do you feel you have progressed? On which level? Why?
24. Do you still feel that you can do better?
25. Have you taken action to do volunteer work?
26. Have you taken action towards looking for a job?

## Appendix S

### PARTICIPANTS' 2<sup>ND</sup>/3<sup>RD</sup> FOLLOW UP: INDIVIDUAL QUESTIONS

*Grace had 2<sup>nd</sup> and 3<sup>rd</sup> follow up questionnaires*

#### ANGIE'S 2<sup>nd</sup> Follow up questions

Date: May 14<sup>th</sup>

Duration: 90 min.

1. Tell me about your life since our last interview.
2. If you now think of your back problems and surgery and the consequences – being unemployed – what are your levels of distress (4), anxiety (3-4), and fear (3-4) now?
3. Do you still have any emotions of anger (5), annoyance with people (7), and impatience (5) now concerning the back surgery and the consequences?
4. Are you still frustrated (3) now?
5. And your levels of depression (3) or do you just still feel down sometimes like you said before (3)?
6. Any other emotions you are experiencing?
7. Are you still able to be present /in the moment?
8. Tell me about your social life and if there are any changes since we last spoke. Are you still comfortable with being more on your own?
9. How are your interpersonal relationships now, for ex. with your family/sister?
10. Are there more changes on the physical level?  
How are your energy levels? Do you perhaps feel less tired?  
How are your exercises?  
Do you experience any pain?  
How is the numbness in you left leg? Is there a shift?
11. How are your confidence levels now? Before the lack of confidence was at a 4, where is it now?
12. Do you feel that you question yourself even less now?  
Do you go more with the flow?
13. Do you still feel that you are not sure of anything (4-6)?
14. Do you feel that you are getting back to who you are?  
Getting more clarity on who you are?
15. Are you still of your medication? And how do you feel now being of the medication?
16. Are you more able to admit that you need help and allow people to help and support you now?
17. Do you still feel guided on your life's journey? Like you have the wind at your back?
18. Do you still feel that you have progressed on the physical, mental, emotional and spiritual level? Tell me more about each level of progression.

19. Have you taken any steps to help you get more clarity on what will be a meaningful and purposeful career for you?
20. Have you started *The Artist's way* NLP?
21. Do you have more clarity in the steps you have to take to get to your career of choice?

### ELIZABETH'S 2<sup>nd</sup> follow up questions

Date: May 31<sup>st</sup>

Duration: 15 min.

1. Tell me about any changes since we spoke last.
2. Do you still not think about your x- boyfriend?
3. Do you still see the whole situation with your x differently now?
4. So are there still no distress, anxiety and fear when you think about him and the situation?
5. Do you still feel confident?
6. Would you say there is still a lack of stress and anxiety in your life regarding the x ?
7. Would you say that your general anxiety went down significantly (9-10)?
8. Would you still describe yourself as scared and paranoid?
9. Any problems with panic attacks?
10. Would you still say that your anger, frustration and sadness levels are at a 0 in context with the breakup?
11. Do you still fear people (8) and distrust people (8)?
12. How is school?  
Do you still feel it is better to focus and concentrate in school?  
Do you still care about school and like it?  
Do you still want to go to fashion school?
13. Do you still feel present?
14. Do you still feel it is better to go forward in life? To get up and move on?
15. Is it still easy to focus on what is important now?
16. Would you say that you lack procrastination now?
17. Do you still feel you will feel in love again with the right person at the right time?
18. Have you fallen in love again?
19. Or are you still ok not being in a romantic r/ship?
20. Is it easier for you to be single now?
21. Is it still easy for you to be alone?
22. Tell me about your social life and choices. Do you still spend quality time with important people in your life?
23. Have you see any signs anywhere?
24. Do you still feel that you are completely free of your x and the past with him?
25. Is the past still the past and you have moved on?
26. If you think back now on what was, what do you see and feel?



27. Do you still look forward to the changes in your life and feel ready for it?
28. Are you still discovering a new positive you?
29. Do you still feel alive, with no depression, where you know you don't need a guy and can do it alone.
30. Do you still feel that your life has completely changed and that you are getting back to who you really are?

### BUNNY'S 2<sup>nd</sup> follow up questions

Date: May 23<sup>rd</sup>

Duration: 55min.

1. Is there any difference in how you experience your new relationship now?
2. Does it still occupy your mind a lot?  
Do you still think about it obsessively?  
Do you feel more independent in the relationship now?
3. Any distress (5), anxiety (4), fear(3) about romantic r/ships?  
Is there a difference for you between this r/ship and romantic r/ships in general?
4. How does it affect your personal life now?
5. How do you feel now about new romantic relationships that might lead to marriage?  
Do you feel any distress (7) or anxiety (10)? SUDS now?  
Moving from being single to being married?
6. How is your fear of rejection (10)?
7. How do you feel about the old pattern –the relationships always end. The reoccurring cycle that never ends?
8. Does the *change and transition* still affect you  

<u>physically</u> (10)?	SUDS:
How?	
<u>Mentally</u> (5)?	SUDS:
How?	
<u>Spiritually</u> (3)?	SUDS:
How?	
<u>Emotionally</u> (7)	SUDS:
How?	
<u>Occupationally</u> (3-5)	SUDS
How?	
<u>Any other way?</u>	
9. Do you feel there is still a *lack of progression* on a  

<u>physical</u> level (10)?	SUDS:
How?	
<u>Mental</u> level (8)?	
How?	SUDS:
<u>Spiritual</u> level(5)	SUDS:

How?

Social level (0)

SUDS:

How?

Emotional level (0)

SUDS:

How?

10. Do you feel that you have progressed in any other way?
11. Are you still worried about not getting a real partner in your life?  
How much?
12. Do you still feel being single is your new normal?
13. How do you feel around couples now?
14. Do you still feel alone on this planet?
15. Do you feel you are at choice?
16. Do you still feel there is a part of you that feels now that a relationship might work?  
That your partner will not get tired of you?
17. Is there a difference for you now when you think about having a conscious, soul  
connection marriage for the rest of your life?
18. What emotions come up for you when you think of this change and possibilities in  
your life?
19. And the thoughts?
20. Are you still hopeful about transformation in life?

### JANE'S 2<sup>nd</sup> follow up questions

Date: May 30<sup>th</sup>

Duration: 20 min.

1. What are the differences for you now since we spoke last and since the treatment?
2. How did your exams go?
3. Did you get good grades?
4. Did you study a lot?
5. Are you motivated to study?
6. How was your concentration and focus (where your lack of was at a 10 – 7 before)?
7. How do you feel about your move to S.F. now?
8. How do you feel about your move to LB?
9. Do you still feel that the move broke you?
10. Will this move break you?
11. Do you feel you have a change in attitude?
12. Are you still angry with your Dad and blame him for your situation?
13. Do you still feel disconnected from a lot of people?
14. Do you still get easily angry with people and snap at them?
15. Do you still feel very alone?
16. How is your health and weight/eating habits now?

17. Where are your distress (10 - 4), anxiety (10 -4) and fear (7-5) levels now if you think of this change (the move to SF)?
18. If you think of change (your move) and the transition into a new university and becoming more independent, how is your levels of distress (10), anxiety (10), fear (10) now?
19. If you think of change (your move) and the transition into a university and becoming more independent, how does it affect you?  
Mentally? (10)  
 Do you still constantly worry?  
 Your self- esteem?  
 Do you still worry about disappointing others?  
 Do you still doubt your success and yourself?
20. Spiritually?(6)  
 Do you still just see mostly dark?
21. Emotionally (10)?  
 Did you had any panic attacks since the treatment?
22. How are your feelings of depression now (9 -5)?  
 Feelings of discouragement (7 -5)  
 Feeling unmotivated (9 -3)  
 Feeling down (9 -5)
23. How is your social life? (7)
24. Interpersonally? (9)  
 Do you feel you can trust people a bit more now?  
 or Do you still feel everyone is just out to get you and no one cares?
25. Do you feel you have progressed?  
 Physical level (lack of – 10 -6)  
 Mentally ( lack of - 5)  
 Emotionally (lack of - 8) Do you feel you progress more than you regress now?  
 Spiritually (5) Are you still so angry at God?  
 Socially (10) How is your connection with people now?  
 Interpersonally (7) Do you still feel betrayed by people?
26. How is your relationship with D now?
27. How do you feel about being independent now?  
 Being responsible?
28. How do you feel about being focused in school now when you start again?

### GRACE'S 2<sup>nd</sup> follow up questions

Date: April 11<sup>th</sup>

Duration: 1 hour

1. How are you doing now as you were not doing so well the last time we spoke? You had some difficulties.

2. How do you feel now about being a mature single person?
3. How do you feel about inner peace with you divorce now?
4. And since the treatment?
5. What has changed for you since 2 months ago?
6. On a physical(6-7) level – how is your asthma?
  - how is your sleeping pattern (4-6 hours before)?
  - eating patterns?
7. How do you feel about the divorce now on a mental(5) level ?
  - Do you still think about the divorce over and over and over?
  - How do you feel about not knowing? Mental level(8)?
8. How is your decision making skills now?
  - Do you feel clearer now when you make decisions?
9. Do you still avoid doing things that you know is good for you?
10. Do you feel there are any other emotional shifts for you regarding the divorce?
  - What emotions do you now experience about your divorce?
11. How are your depression, anger (8), guilt (7), shame (7), sadness(8 ), loss(8 ), regret(8) and resentment (8) levels now?
12. Do you still have a fear of rejection (9) when you think about the divorce?
  - Now in terms of your competence level when you think of an occupation, do you still fear rejection?
13. What are your distress (9), anxiety (8-9) , fear (7-8) levels now when you think about your divorce?
  - What will trigger you?
  - Do you still go into paralyzes?
  - Do you feel that you have let go of some of the hurt already?
  - Do you feel your insides are less twisted now?
14. Do you feel that you have progressed on a physical level(7)?
  - How you manage your finances and impulse spending?
  - Do you still feel paralyzed when you need to make financial decisions?
15. Socially?
  - Do you take more initiative already or do you still wait for others to call you?
16. Occupationally?
  - Do you feel more capable?
  - Do you feel less stuck and that you can move forward?
17. Would you say that you feel more peaceful about your divorce?
  - Why would you say that?
18. Is the divorce more acceptable to you now?
19. Do you feel that you are experiencing the transition period from being married to single differently now?
  - How is this different from just after your divorce?
20. How is your energy level?
21. Do you feel more at peace on some level?

GRACE'S 3<sup>rd</sup> follow up questions

Date: May 25<sup>th</sup>

Duration: 1 hour

1. In the context off your goal and what we worked on, what has changed for you since our last interview regarding your divorce and the affect it has on your personal life?
2. Do you feel there is a shift on an emotional level?  
How and what emotions do you experience now?  
How are your depression, anger (8), guilt(7), shame(7), sadness(8), loss(8), regret(8-) and resentment (8), pain (7-8) levels now when you think about the change and transition?
3. How are your fear and anxiety levels in general?
4. How are your sadness(8)levels now?
5. Do you still go into paralyzes?
6. Do you still get triggered by thoughts, memories, music?
7. Do you feel that you have let go of some of the hurt already?
8. Do you feel your insides are less twisted now?
9. Does the *transition* from being married to single still create pain, shame, guilt and sadness for you and prevent you from moving on?
10. If you think of this transition, does it still create distress (8)?  
Does it still bring up a lot of emotion, especially sadness?  
Does it still create great pain and loss?
11. Does it still create fear (7-8) in you?
12. The divorce and then becoming a single woman, affected you on a physical (6-7) level before, where is it now?  
How is your asthma?  
How is your sleeping pattern (4-6 hours before)?  
How is your eating patterns?  
Does your physical limitations still get in your way?
13. On a mental(5) level ?  
How is your decision making now?
14. Before your social life was affected at a 9 where you did not take any initiative to plan and make decisions, would you say that have changed?  
Do you take more initiative already or do you still wait for others to call you?  
Do you connect with people now and make phone calls?
15. Do you still experience shame and guilt when you think about how people give to you and help you and you don't give back?
16. Tell me about your spiritual life.
17. How do you manage your finances and impulse spending?
18. Do you still feel paralyzed when you need to make financial decisions?
19. Do you still avoid doing things that you know is good for you?
20. Are you still reading and practicing *The Artist's* way?

21. Occupationally?

Where would you say is your fear of rejection (9) now in terms of your competence level when you think of an occupation?

Do you still feel that your fear comes in the way and make you less competent and capable?

Do you feel more capable and competent now?

Do you still believe you don't have the ability to do things?

Do you still believe you are not good enough?

22. Do you feel less stuck and that you can move forward?

23. So where would you say is your *lack of progression* now (8-9)?

24. How do you feel about being divorced now?

Can you move pass your divorce and accept the reality of being divorce now?

25. Do you still numb out because of anxiety when you think about your divorce?

26. What are your distress (9), anxiety (8-9) , fear (7-8) levels now when you think about your divorce?

27. Would you say that you feel more peaceful about the situation?

Why would you say that?

28. Is the divorce more acceptable to you now?

29. How do you feel now about being a mature single person?

30. Do you feel that you are experiencing the transition period from being married to single differently now?

31. Do you feel more at peace now when you think of your divorce?

32. Would you say you have inner peace now regarding your divorce?

33. Are you able to move on in a more peaceful state?

34. Do you feel more at peace in general?

MICHAEL'S 2<sup>nd</sup> follow up questions

Date: June 24<sup>th</sup>

Duration: 35 min.

1. How do you feel now about sharing your compositions with the world?

Do you still feel as positive as the last time we spoke?

2. You set a goal for the 1<sup>st</sup> of May to release the final block – did you achieve your goal?

3. Do you still feel there is **no** reluctance to share it with the world?

4. Have you started to take the next steps by networking with the proper people?

5. Have you been reluctant to show up with the right people “on the backburner to help”?

Did you show up?

6. What do you think now about the thought you had that you should wait until it is perfect before you release it?

7. Is your fear of imperfection (9 -0) holding you back? Or is it still at a 0?

8. Would you say you still have a fear of rejection? Last time we spoke it was very slight – almost nonexistent.
9. Do you still feel more ready to share now?
10. Do you still just feel a minor frustration with yourself (8 -2) about your musical goal and when you work on it?  
Can you still see your major progress?  
Do you still have a lot of faith that it will all come together?
11. Where is your fear of failure (9 - 1) now? Is it still at a 1?
12. Do you still believe that you are good enough?
13. Do you feel dissatisfied about not getting it out there? Or is it still just disbelief?
14. Do you still believe this is the time, it is ready to get out there? OR Do you have a steady resistance to getting it out there?
15. What are your thoughts now on “ it is crazy to have to share it because the world decides if it is precious or not”?
16. Do you still get down on yourself or are you like the last time more patient with yourself and more at peace?
17. How are your levels of frustration (7) now with yourself?
18. How are your legs and aches and pains and sinus conditions now?
19. Do you still meditate more often now?  
Is there a noticeable change in your meditation practice?
20. Do you feel it is easier to socialize now?  
Are there any differences? For ex. the last time you called someone back who wanted to help you and actually listened to his suggestions
21. Do you still think that this can be a reality for you – that music can become your final career?
22. Can you still see yourself producing shows now?
23. Are you still good with the fact that you cannot read music?
24. Do you still believe that people now think you are a legitimate composer ?
25. Is it even easier for you now to say you are a musician and composer?  
Do you refer to yourself as a composer on a regular base now?
26. What have you composed since we spoke last?

### BAM'S 2<sup>nd</sup> follow up questions

Date: June 23<sup>rd</sup>

Duration: 35 min.

1. Since we spoke last, would you say that you could sense a change in attitude during this time around during your off period?
2. Are you less nervous about future situations like this where you would worry about your ability to find a job?

3. If you think of the future and when unemployment will hit you again, what are your levels of distress (2-8), anxiety (5), fear (5)?
4. Do you still believe it will affect your personal life negatively at a 7?
5. Were you affected physically?  
How?  
How did you sleep?  
Did you eat better?  
Did you drink and smoke more like you have done previously?
6. This time around did your unemployment period affect you negatively on a mental level (6-8) where you would get depressed, withdraw and sleep?  
How was it different for you this time around?
7. Did it affect you on a spiritual level?
8. How was your emotional state during your time off?
9. How was your social life during your off time?
10. How was your relation with M?
11. Do you still believe that you are too old to find a job and that the younger generations are better qualified than you?
12. How do you feel now about the value of work experience VS the skills that the younger generation brings?
13. Do you still believe you can work together and need each other?
14. Do you feel that you can hold yourself to them better?
15. Would you say you feel more confident now?
16. Do you still feel very comfortable with the idea that you can survive these periods of unemployment since we spoke last?
17. How do you feel about your fear of success now?
18. Do you feel since the treatment that there is a level of progression on a  
physical  
mental  
emotional  
spiritual  
social  
occupational  
interpersonal  
other level?
19. Did you set goals for yourself during your time of?  
Did you get it done?
20. What did you learn from the healing experience?
21. Are you more aware of what you need?

MR BLUE'S 2<sup>nd</sup> follow up questions

Date: June 30<sup>th</sup>

Duration: 15 min.



1. Do you still feel that you have move forward in your business?  
Is there still progression where you feel comfortable with the financial situation that you face?  
Or do you still feel anxious (5), concerned , worried and fearful(3) when you think of a *lack of progression*?
2. If there is a lack of progression /moving forward, does it still create a lot of stress for you (6)? OR do you still believe, like the last time we spoke, that everything is where it is should be?
3. Does a lack of progression still affects you emotionally (6) where you believe ‘that you don’t achieve the happiness that you set out to achieve’?
4. Do you still believe the lack of progression affects you interpersonally by making you unhappy, negative and anti-social?
5. Do you believe you are more pleasant to be with?
6. Do you carry any shame (3) because of the lack of progression?
7. How are your relationships now with friends/ business partners?  
Is there still open communication and positive commitment to move forward?
8. How do you feel about your honour/reputation being tarnished in the industry?
9. How are your levels of distress (8), anxiety (5) and fear (3) now relating to your business and when you think about it?
10. Do you easily snap at people?  
Are you grouchy and irritable?
11. Do you still feel very tired?
12. How is your focus?  
Do you still have a high level of clarity?
13. Where are your frustration (6- 0-1%) levels now regarding your new business?  
Do you still feel conscious and aware of things?  
Does logic and new perspectives still override the frustration?
14. Are you still upset (4) and angry (4) about R and where it is at and your position in it?
15. Are there any related anger and frustration that create problems in your job?
16. If there are any anger, feelings of upset and frustration left – does it still come out in your personal r/ships?
17. Do you still feel it stunts your social time?
18. Are your anxiety levels still from a 9 to a 0 when you think about how much effort you put into the business and not getting rewarded financially?  
Do you still have peace and acceptance about the situation?  
If not- why?
19. Are your fear levels still at a 0 (10 before) now when you think about this transitioning into R as a businessman?  
How do you feel about it now?
20. Where are your distress (8) levels now when you think about transitioning into R as a businessman?
21. Do you still feel that all your efforts were in vain and it won’t happen? The last time we spoke, you said no.

PEGGY SUE'S 2<sup>nd</sup> follow up questions

Date: July 18<sup>th</sup>

Duration: 50 min.

1. Since our last conversation, do you feel you are starting to stand more in your own power?  
Do you still feel more solid?  
Are your fear levels still at a 4 regarding your situation?  
Are you still finding joy?
2. Lack of progression was at a 10 -6 before, where is it now?
3. Do you still feel more self-confident where you can stand your own ground?
4. How is the itch on your shoulder?
5. How are your sleeping (10-6) patterns now? Do you still get up every hour or 2 to urinate?
6. Are you still very restless where you cannot sit still at all OR do you still have the peaceful feeling inside of you?
7. Can you read a book? Watch a movie?
8. Would you say that your attention span is better now? It was weak at a 10 -6 before.  
And your focus? Lack of at a 10 -5 before.
9. Can you organize things better now?
10. Do you still surrender everything to God?
11. Do you still have the fingernails on a chalkboard feeling (2-3)?
12. Did you start to work in your garden again?
13. Do you feel that you are starting projects now and finish them?
14. Are you still letting go of your stories?
15. Have you had any panic attacks? Do you still feel panicky?
16. Do you still feel less stuck and less fearful (just slightly) to strike out on your own?
17. Are you still doing things on your own now, like exercising, walking the dogs?
18. Do you still feel more accepted by your family?  
And if NOT – does it bother you as much as before?
19. Do you still feel you have to do all the fitting in and if you don't that they will reject you and leave you? During the last conversation you said no – 0- and said you don't have the fear you had before to go on your own. Do you still feel the same?
20. Do you still feel that you are becoming you again?
21. Do you still fear that if you change that your family won't like you anymore, your husband will divorce you, you won't have any money and that you will be all alone?
22. Do you still feel if you do what you like, your family will dispose of you?
23. Do you still feel very needy for interaction and love from your family or do you still realize now that your need for them is healthy and natural?
24. How do you feel now about them being unable to meet your needs?  
Are you still meeting your own needs now?
25. Do you still feel that you are becoming unstuck?
26. Are you still feeling a lack of joy and love in your marriage?

27. Do you feel there is more of a connection between you and your husband?
28. Do you still see your husband in a different light? For ex. that he might come from a place of fear?
29. Are you still confident to have your own opinion?
30. Are you still confident and sure to move forward (10) ? Even by yourself?
31. Are you even more secure to be on your own?
32. Are you still NOT afraid to move forward and do what you love and start living again?
33. Do you feel you can start to “pull the trigger” now as you say?
34. Do you still see yourself moving forward step by step
35. Do you still see yourself at the at the top of the dark hole? Flying above it.
36. Do you still feel you have control over things?
37. Is there any part of you that still feels devastated because you were not in control of your life? (10 -2-3)
38. Your distress, anxiety and fear levels were all at a 10-4 before regarding your *change and transitioning*, where is it now?
39. Do you still feel any inappropriate sadness (10 -3)
40. Do you feel emotionally even stronger? A 10 and then 3 before.
41. Is your perspective of yourself still better where you don’t feel so old?
42. Do you still feel a lot of love, caring and forgiveness for yourself now, being less hard on yourself?
43. Are you still satisfied with your life choices which equalized your disappointment with yourself?
44. Do you still feel socially disconnected? OR are you still meeting a lot of new people?
45. Do you feel you can move forward and start your own event business now or start organizing events again if you choose to, because this might not be what you want to do? ( not at 10 -5 before)  
Do you still feel frozen – unsure regarding this choice?  
Do you still feel this is your retirement and that you have a lot of choices?  
Do you feel you can get back on the horse and do what you choose to do?  
Do you still feel self-confident doing it – more sure in your walk?
46. Your *lack of progression* created distress, fear, anxiety and shame at a 10-3, where is it now?
47. Are you still feeling strong enough to believe in your own power -8?
48. Do you still feel fearless with moving forward with your life -9 where you push forward with caution and not fear?
49. Are you getting back to Loretta? An even better and stronger version?
50. Are you starting to feel more fulfilled- 5?
51. Are you starting to feel more free, that you can soar like a bird?
52. Do you still believe that you can follow your path and enjoy it and be grateful and thankful?
53. Do you still feel God has kept his promise and is helping you to move forward?

## TALLULAH'S 2<sup>nd</sup> follow up questions

Date: June 26<sup>th</sup>

Duration: 1 hour 15 min.

1. Do you still have peace of mind, feeling that a weight has been literally lifted of your shoulders?
2. Can you still think about the same things and don't feel pain?
3. Do you still feel that the fear and pain is not there anymore?
4. Do you still worry less now?
5. The last time we spoke you said fear is not holding you back anymore, do you still feel like that?
6. Before your distress and fear was a 7 -2 and your anxiety a 6-2 regarding you not having an income, where is it now?  
Regarding this, do you still feel the stress is gone?
7. The last time we spoke you said that "The lack of progression which created anxiety at 8 and fear at a 10 ("gets crazy, the not knowing") before the treatment is gone and that you don't have fear anymore, do you still feel that way?  
Do you now still do something instead of worrying?
8. Do you still feel ok now about not knowing how things will work out?
9. Tell me about your physical changes?  
Your digestive issues, the pressure on your gallbladder is it even less than before?  
Is your menstrual cycle still normal?
10. Do you think you still lack a fear of success?
11. Do you still feel that you have more of a sense of direction now where it is time for you to recoup and with this you will get answers?
12. Are there any feelings left of feeling lost? OR Do you still feel confident in your decision making?
13. Are you still clear as you are at this crossroads in your life?
14. Do you still feel useful and accomplished?
15. How do you feel now about being supported by your friends and family?
16. Are you still open to get to know people and get close to them and build relationships?
17. Do you still want to build strong relationships?
18. Do you still have healthy boundaries with other people's emotions or Do you pick up on all their emotions again?
19. Do you still feel like a new person with different interests?
20. Is your social life still improving?  
Do you meet with 'better' people now?
21. Where are your sadness levels now?(7)
22. Do you still think more about the solution than the problem now?
23. Do you feel that you have mental clarity?
24. Do you have more clarity in what to do next?
25. Are you still pushing forward?

26. Do you feel you have progressed? On which level? Why?

mental

emotional

spiritual

physical

interpersonal

occupational

other

27. Do you still feel that you can do better?

28. Have you taken action to do volunteer work?

29. Have you taken action towards looking for a job?

