

TAPPING THE HEALER WITHIN

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*Using Thought Field Therapy
to Instantly Conquer Your Fears, Anxieties,
and Emotional Distress*

ROGER J. CALLAHAN, PH.D.,
WITH RICHARD TREMB

Foreword by Dr. Paul Mendenhall

A Tele-Class Series Guide to Thought Field Therapy®

Callahan Techniques, LTD

Program Outline

Week 1: Introducing a new paradigm

- History
- Discoveries
- TFT terms and glossary
- Types of applications
- Levels of effectiveness
- Q & A's – submitted in advance

Week 2: Measures of Effectiveness

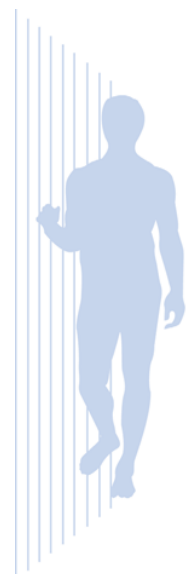
- SUDS
- HRV
- Voltmeter
- Radio studies
- Current Research
- Demonstrations – submitted in advance

Week 3: Application – Key Components of TFT

- Case studies
- Psychological reversals
- Major treatment points
- Nine Gamut procedures
- Collar bone breathing
- Floor to ceiling eyeroll
- Advanced procedures (just mention- 7 second and chakra)
- Demonstrations – submitted in advance

Week 4: Application – Trauma

- Case studies
- Trauma
- Complex trauma
- Anger
- Guilt
- Q & A's – submitted in advance



Week 5: Application – Fears, Phobias and Anxiety Related Problems

- Case studies
- Common phobias
- Other phobias
- Panic and anxiety disorders
- Q & A's – submitted in advance

Week 6: Application – Addictions and Obsessive Behaviors

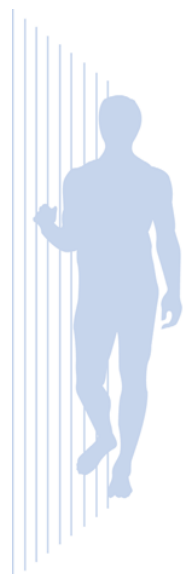
- Case studies
- Addictive cravings or urges
- Underlying anxiety
- Obsessive behaviors
- Q & A's – submitted in advance

Week 7: Application - Miscellaneous

- Case Studies
- Physical pain
- Depression
- Shame
- Embarrassment
- Jet lag
- Visualization and peak performance
- Q & A's – submitted in advance

Week 8: Troubleshooting

- Toxins
- Products that support toxin identification and elimination
- Chronic problems
- Recurring reversals
- Products that support psychological reversal corrections
- Apex problem
- Further support

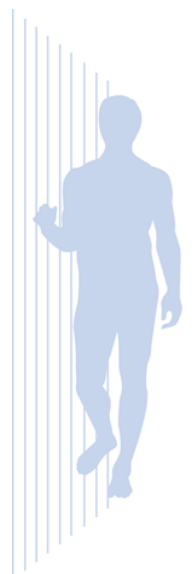


TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears,
Anxieties, and Emotional Distress

Week 1: Introducing a new paradigm

1. History – Timeline handout
2. Discoveries
 - i. Psychological Reversal
 - ii. Severe water phobia – Mary
3. TFT terms and glossary – Glossary handout
4. Types of applications – examples of emotional, physical, spiritual
5. Levels of effectiveness – handout
6. Q & A's – live interaction at the end of the class



Thought Field Therapy® (TFT) and Optimal Health

The Evolution of Callahan Techniques® and Thought Field Therapy®

Levels of TFT – From algorithms to the most effective



During the late seventies and early eighties, Dr. Roger Callahan worked diligently on finding a simpler, more effective way to help his patients. He found traditional psychological methods slow, sometimes painful and often ineffective.

As a clinical psychologist, his focus was on emotional problems. Through his research and clinical testing, he discovered some simple procedures that quickly eliminated phobias and identified and eliminated self-sabotage, which he termed psychological reversal.

His book, *The Five Minute Phobia Cure* (Enterprise, 1985) detailed and presented these new discoveries and brief treatments, "The Callahan Techniques". He demonstrated them live, on radio and television across the country. While treating thousands around the world, he developed procedures for many other psychological problems including grief, trauma, addictions and cravings, depression, anxiety disorder and many other emotional problems.

This work led to his development of a causal diagnostic process, where he could quickly determine a specific tapping sequence (healing code) for any problem. This diagnostic process, repeated over many years, led to the development of commonly used algorithms. The Callahan Techniques® now had two levels of treatment, simple algorithms and a causal diagnostic procedure for more complex problems.

As Dr. Callahan was asked to treat more and more people and do more radio shows, he realized he needed to find a way to treat these people successfully, over the phone as well as face-to-face. This work led him to discover the Voice Technology, which has proved to be the most effective and rapid level of the Callahan Techniques® treatment procedures.

Then in 1994, Florida State University began a search for a cure for PTSD. They invited Dr. Callahan and I to participate in the study along with three other therapies, EMDR, TIR and VK/D a form of NLP. They told Dr. Callahan to come up with a descriptive name. And so, we had the birth of Thought Field Therapy® from the Callahan Techniques®.

Our first newsletter published details of the study as did an article in the *Family Therapy Networker* where the author, stated "if it had been a horse race, the TFT contingent would have won hands down". Thought Field Therapy® (TFT) was off to a great start.

Over the next fourteen years, TFT was used by more and more practitioners and lay people alike, treating and helping not only emotional problems but many physical problems with amazing success. We began to realize TFT must be "nature's healing system" as we saw miraculous improvements with problems like menieres disease, cancer, chronic pain, immune disorders, anaphylaxis, and so many others. TFT was appearing to be equally effective in the physical realm.

Dr. Callahan found that many physical problems responded to TFT very quickly and the healing lasted. He also found that much of poor health, both emotional and physical, was affected or aggravated by toxins, and, that TFT could be used to identify and treat these toxin problems with great success. He was even able to find a way to eliminate the side-effects of necessary medications, greatly improving the quality of life for those individuals needing them.

Today we receive reports daily, from all over the world, about how TFT has helped healing from many physical problems and chronic diseases. Dr. Callahan and our VT practitioners, can work with anyone, anywhere, and have had amazing healing successes for their friends, family and clients. Dr. Callahan's latest book, *Tapping the Healer Within*, teaches methods for many of life's daily stresses and is available in 10 languages throughout the world.

As Dr. Callahan has been developing TFT in the physical realm, we have others who have used TFT to improve in the spiritual realm. We first presented this in an article for our newsletter. Fr. Luis Jorge Gonzalez, ocd., PhD, said "TFT opens a door to God's grace and makes possible the spiritual healing for people who have been suffering for years and years."

Our recent work with the genocide victims of Rwanda also suggests TFT can help remove blocks to spiritual growth. Many who were locked in trauma, nightmares, anger, grief, move into higher levels of consciousness. After treatment they could express love and caring for others and demonstrated improved self-esteem. Others have reported they can use TFT to successfully quiet their mind and aid in the meditation process.

TFT can help heal the whole person, in the emotional, physical and spiritual domains. It is truly a divine healing system and a gift to the world. Join us in achieving Optimal Health.

For information on individual telephone treatment with Dr. Callahan, personal appearances and shows, up-coming training schedules, or the latest TFT self-help products available, contact:

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La Quinta, CA. 92247
Emails: Joanne@tftrx.com or

Order Line: 1-800-359-CURE

Office Line: (760)564-1008
Chris@tftrx.com

Out of country: 760 564-1008

Fax: (760) 347-0934
Website: www.tftrx.com

TFT Time Line

Late 1970's/Early 1980's
Callahan Techniques
Five Minute Phobia Cure
Psychological Reversal

1978
1980
1985

Late 1980's/Early 1990's
Diagnostic procedures
Common Algorithms
Voice Technology
Thought Field Therapy

1988
1994

Late 1990's/Early 2000's
Physical conditions
Spiritual applications
HRV
Toxin treatments
Vultmeter

1998
2000
2001
2002

Mid 2000's to date
Objective Self-testing
Self-treatment
VT for the masses
Personal spiritual
applications
Optimal Health

2008



Callahan Techniques® Thought Field Therapy®

(TFT) Glossary © 1996, 1997, 2003, 2006, 2009

Roger J. Callahan, Ph.D.

ADDICTION

An addict does the same thing that most modern psychiatrists recommend—“when anxious, take a tranquilizer.” The typical addict chooses from a far wider variety of tranquilizers than the psychiatrist. Addictions are very powerful (compulsive) urges or overwhelming desires to consume some substance (heroin, nicotine, sweets, cocaine, tranquilizers, etc.) or engage in some activity (nail biting, hair pulling, counting, hand washing, etc.). The substance or the activity is in some degree (mild to severe) harmful for the individual and his well-being.

ADDICTIVE URGE

The immediate desire, urge, or compulsion to engage in consuming an addictive substance or engage in an addictive behaviour. It is powered by a growing intensity in anxiety and the consequent need for a tranquilizer. It is Dr. Callahan’s TFT theoretical position that all tranquilizers merely mask anxiety; they do not eliminate the cause. An effective masking tranquilizer becomes addictive.

ADDICTIVE URGE TREATMENT

The Thought Field Therapy® procedure for reducing intense anxiety and thereby reducing or eliminating cravings and the withdrawal symptoms associated with addiction.

ALGORITHM

The general definition of an algorithm is “A sequence of instructions to be followed with the intention of finding a solution to a problem. Each step must specify precisely what action is to be taken, and although there may be many alternate routes through the algorithm, there is only one start point and one end point” (Youngson, R. M., 1994; The Guinness Encyclopaedia of Science, Guinness, Middlesex. England, p. 232). The starting point in TFT usually is a high SUD (Subjective Unit of Distress) 8-10, and the end point, hopefully, is a 0. In TFT, an algorithm is a recipe or formula for treatment of a particular problem, discovered by TFT diagnosis, that has been tested on many people and found to have a high success rate. An algorithm permits an untrained person to enter the domain of TFT treatment success without needing to learn the more complex diagnostic procedures that permit a higher success rate.

ANECDOTE

A disparaging term used against reports of therapy success, even therapy success that is witnessed by many professionals. This term is used in contrast to anecdotes of “controlled research,” which consists of stories told of “research” carried out in secret that the readers fervently hope is honest and reliable. [Alas, it has been established that scientific research may be fraudulent.] If the research does not support the favored idea, perhaps the researchers have not been sufficiently trained or did not carry out the proper protocol. [See The Wall Street Journal, 4-25-96, page 1. Bitter Pill is the headline.] The makers of a popular drug found that a study they financed did not report the findings they wanted to have. [The study showed that cheaper versions of the drug had as much effectiveness as the more expensive drug.] Although the research passed peer review, it was withdrawn. This reminds me of the very controlled drug study, the first double-blind

study ever done on psychotropic meds, in which I (Dr. Callahan) was one of the authors and researchers, where much to our surprise, we found no support for the drug. Although the study was reported in an American Medical Association journal, the company gave us no more money. Some researchers quickly learn what response receives the reward.

ANXIETY

A type of vague, intense fear that is pervasive, non-focused, and extremely unpleasant.

ANTICIPATORY ANXIETY

There is no special character to “anticipatory anxiety.” It is identical to tuning into a perturbed thought field (see below). It may be called “anticipatory” when the tuning takes place immediately prior to engaging in a feared situation.

APEX PROBLEM

The apex problem is when a treated client accurately reports that the problem is gone but is unable to see that the therapy did the job. It is a robust tendency—it could be called a compulsion—for treated clients or even scientific observers of therapy to give “explanations” of the treatments that careful thought reveals to be totally inappropriate and irrelevant. The common “explanations” are “distraction,” “hypnosis,” “exposure,” or “placebo.” Many therapists who observe TFT will say that the treatment works by suggestion, placebo, or hypnosis, even though there is no basis in reality for such a claim. Typically, professional observers of the phenomenal demonstrated results of TFT will not ask but rather will compulsively tell the therapist their (usually totally irrelevant) version of what took place. A good example was a host of a radio show that had a riverboat theme. He called himself “Captain Andy.” He asked me to demonstrate my treatment with his teenage daughter who had been quite bothered about something for some years, which we did not go into. I guided her through some treatments and took her from a SUD level of 10 to a 1. She was, quite naturally, pleased by this result. Captain Andy then accused her of lying. Many TFT-trained therapists record therapy sessions because some clients “forget” that they had a problem after the rapid successful therapy. We call this phenomenon the “apex problem” since the mind is not operating at the apex or top level. When confronted with something as strange and revolutionary as TFT, the mind has trouble shifting out of the inertia gear. Mental work at the apex of the mind is required to grasp and understand these new treatments. Most of us attempt to avoid such work and mistakenly attempt to fit our observation into something we believe we understand. As mentioned, many therapists who witness dramatic, rapid changes appear to be compelled to give an “explanation.” It is the rare and, we must add, wise therapist who asks, “Why?” The identification of the apex problem has scientific utility in that it refines prediction, i.e., we predict that the client will report improvement, and we further predict that the client is not likely to credit the therapy for the improvement. The apex problem is a form of cognitive dissonance, or “left-brain interpreter,” which is common in split-brain research.

AMYGDALA

An almond-shaped portion of the brain that is receiving much attention from some of the most accomplished researchers in psychology. They believe that this portion of the brain will ultimately be shown to be the basis for controlling anxiety and other problems (LeDoux). There is no current support for this promise of ultimate control, and there is not likely to be any since, like the chemical theory, the researchers, we believe, are looking in the wrong place. The meridian system can be readily shown to be the fundamental control system for the negative emotions.

ATAVISM

A term in biology that refers to a throwback to an earlier ancestral form, e.g., a human baby born with a tail or extra nipples. In TFT, the term refers to the return of a psychological problem, within the individual's lifetime, that has been eliminated by therapy or has been subsumed naturally because the person has matured (see NEOTENY). Biological atavisms have been shown to occur under toxic influence, radiation, anaesthesia, etc. In a similar fashion, we find that toxins can generate the return of a problem that has either been successfully treated or eliminated through maturation. An example of the latter is a person who, through normal development, outgrew the fear of heights, which is universal in crawling infants (indeed, is universal in all land-based chordates), but the fear suddenly returns at some later point in life. This is analogous to a successful treatment that is undone.

CAUSALITY

“The most practical and the only foolproof method of scientifically testing a causal connection between A and B is ‘wiggling’ one of them and watching the response of the other. We are not interested here in what might be called ‘historical causality’ (establishing a causal connection in a single chain of events) but in ‘scientific causality’ (establishing such a connection in repeatable events). . . . It is the external control of A together with the correlation with B that establishes, in a good Humean sense, the causal connection between them, as well as the fact that A is the cause and B, the effect.”

Newton, R. (1970). Particles that travel faster than light? *Science*, 167(3925), 1569-74.

This principle illustrates the fundamental TFT finding of the isomorphic and causal relationship between the perturbations in the thought field and their bodily counterparts as revealed by TFT diagnosis and the powerful, and almost always immediate treatment results that are achieved when proper TFT tapping is done.

CHEMICAL THEORY

The theory that holds that chemical changes in the brain and body are the basic or fundamental causes of disturbed emotions. Although there are certainly chemical hormonal facts concurrent with negative emotions, I propose that the chemistry is secondary or tertiary to the more fundamental perturbations or healing data (see below). The positive treatment effects in TFT are too rapid to be fundamentally chemical.

COMPULSION

A powerful urge or desire that is extremely difficult or impossible to resist.

CONCATENATION

To link together in a link or chain. Codes or healing data for subsumption or elimination of perturbations are concatenated (determined) by diagnosis. This is a big word that accurately describes what is done in TFT causal diagnosis.

CONTROL SYSTEM

A small system that governs or controls a larger system. The control systems on an automobile consist, for example, of the accelerator, the steering wheel, the gears, and the brake. The control system for the negative emotions and much healing resides in the body's little known but demonstrably palpable and real energy or meridian system.

CURE

The eradication or significant reduction of a problem. A complete cure means that no symptoms or aspects of the problem remain after treatment. After a cure, it is relevant to track for endurance. If there is no toxic exposure or other extreme stress, the cure will likely endure. A very important discovery of mine is that a cure can be undone by a toxin or Individual Energy Toxin, IET, to be more specific.

DIAGNOSIS

The art of discovering the fundamental causal conditions responsible for a problem. Conventional psychological diagnosis is typically nosological, directed toward classifying a person according to symptoms with little or no direct implication for treatment. Diagnosis in TFT is directed toward identifying the specific causes of the problem for the purpose of treatment (p's—see perturbations below). TFT diagnosis does not consist of bestowing descriptive terms but rather is a dynamic revelation of causal constituents. Diagnosis may be considered to be a translation of the encoded language of the negative emotions and healing (information) into a form that can be addressed in treatment. (See Language of negative emotions below.)

ENERGY SYSTEM

A palpable, tangible series of electric or electromagnetic circuitry or meridians throughout the whole body that acts as a transport system for information, the governing force in healing and growth. These electric systems have been scientifically established at various research centers. The energy or meridian system acts as a control system for healing by hypothesis. The reality and powerful relevance of these systems becomes apparent with TFT.

FEAR

A highly focused unpleasant emotion that provokes avoidance. It is a natural capacity of higher chordates that helps protect the individual by influencing the avoidance of danger (see Anxiety and Phobia).

FIELD

The (regular) dictionary defines field as “a complex of forces that serve as causative agents in human behaviour.” More generally, a field is an invisible non-material structure in space that has an effect upon matter. “Field” was introduced to science by Michael Faraday, the brilliant self-educated genius of science. Einstein gave credit to Faraday in his Nobel acceptance speech. He stated that if Faraday had gone to college, he probably never would have been able to invent the revolutionary concept of field, which is fundamental to Einstein's and (also) Maxwell's work in physics. For example, the gravity field is seen to cause the ocean to curve around the gravity-curved earth. In the psychological realm, the thought field is considered to be more like an electromagnetic pattern on video or recording tape, i.e., it is neither chemical nor cognitive in its basic constituency. Today, many scientists consider that everything is composed of fields. “The visible world is neither matter nor spirit but the invisible organization of energy” (Heinz Pagels, physicist). The term, “morphoic field,” was introduced into biology to explain the shape and form of living things by Alexander Gurwitsch (Russia) in 1922 and independently in 1925 by Paul Weiss (Vienna). In the 1950's, Waddington in England added the concept of the “chreode” (necessary path) to the biological field, which incorporated time in embryological development. Rupert Sheldrake introduced the concept of morphic resonance between similar fields, which can account for how instinctual information is transmitted. Such information cannot be contained in the DNA but can only be learned in interaction with the environment. In 1991, I introduced the concept of perturbation (see below) to account for the fundamental causal aspect of negative emotions.

GAMUT SPOT

A commonly used treatment spot in TFT that is located on the back of either hand in the indentation between the bones of the ring finger and the tiny finger.

GAMUT TREATMENTS

A series of nine treatments that are done while tapping the gamut spot on the back of the hand. This series of treatments, which is useful to see as a unit, is used for treating most problems. The nine treatments were originally conceived separately and later added into a new unit now known as the “nine gamut treatments.”

HABIT

An automatic behavioural routine carried out without conscious awareness. Habits allow us to focus our attention on other issues. Sometimes, they are confused with addictions. They can be distinguished from addictions because they are relatively easy to change if a person focuses conscious attention on the issue. Addictions are difficult to change, and habits are easier to change; however, habits require continuing conscious attention over a period of time in order to be modified.

HEART RATE VARIABILITY (HRV)

HRV is a very important medical test that measures the variation of intervals between heart beats and yields information that gives an index of the person's general health or risk of mortality. It is the best predictor of death there is. For example, a big problem is the death of seemingly healthy people who suddenly drop dead with no warning. In a special study carried out in the famous Framingham collection of studies, the researchers found that HRV was the only test that could predict those who succumb to sudden death with no other warning. It measures the variation of the intervals between heartbeats in milliseconds and gives a score called SDNN. SDNN means standard deviation in the intervals from normal to normal, meaning that the program omits very atypical beats from the computation. HRV was discovered about 40 years ago at Yale University Hospital by a Dr. Hon in the maternity ward. Dr. Hon discovered, much to the surprise of cardiologists, that if the variation of intervals between heartbeats became less and less, it was a sign that the baby may be born dead. When doctors checked on HRV in geriatric wards, they found the same result. When the variation of intervals between heartbeats in older people became more and more even, this was also a sign of danger. I believe that HRV is the very best measure of health that we have, and it is known as a means of assessing the degree of success of different therapeutic interventions. The results with TFT in improving HRV are unprecedented. Nothing else, so far, shows a more immediate and significant impact on HRV than TFT.

HOLON

Holon refers to an architectural feature of TFT that refers to the structure of the therapy sequence: majors - 9 gamut - majors. Most problems require but one holon; however, some complex problems may require 40 or more holons before relief is experienced. Each holon is like a 9 Gamut sandwich and defines a holon.

HOW LONG WILL THE TREATMENT LAST?

This is a relevant question that can only be answered with the passage of time for an individual. Interestingly enough, prior to doing TFT, no one ever asked me how long a treatment would last, since not much was taking place in the treatments—in other words, there was nothing to last. The question, whether intended or not, is always an implied compliment, since it acknowledges by implication that something significant happened. Orville Wright's first controlled flight in an aircraft lasted but 12 seconds and travelled but 40

yards, but it was the start of a radical revolution in transportation. Interestingly, a week before the brothers developed a control device, Orville had a terrible crash, and in despair, echoing his many critics, cried out in deep frustration, “Man will never fly in a thousand years!” This shows the natural tendency for discouragement, which the brothers overcame. In order to make important discoveries, people must break through the obstacle of discouragement, as did the Wright brothers. For a therapist who is trained in TFT, the undoing of a cure is not a tragedy but is an opportunity to discover the cause of why the cure has been undone. Through diagnosis, the toxin can be discovered, treated, and avoided until the cure is stabilized for over two months.

IET (Individual Energy Toxin)

IET's are distinguished from the more general toxins such as lead, mercury, cadmium, and arsenic by the fact that they represent an individual's sensitivity to certain common substances, such as wheat, milk, eggs, perfume, laundry detergent, etc. It can be demonstrated that such substances affect the energy system first. IET's can be treated (usually not cured) by treating the individual. This appears to temporarily boost the bodies ability to handle the toxin. See Seven Second Treatment and the Seven Second Plus treatments.

INERTIAL DELAY

This term refers to an unusual situation in TFT treatment where the client shows no further perturbations in diagnosis, and yet the problem or some degree of the problem remains. After the passage of time, varying from minutes to hours, the client then reports that the problem is gone. Toxins can cause inertial delay. It can also occur when we are treating the person for pain, or physical problems as more time can be required for the treatment to go through the body's mass. Since we expect a problem to be gone almost instantly in TFT, we take special notice of delays. It is audacious that we expect problems to be completely gone so quickly, but that is our common experience.

INSTINCT

Sometimes called “knowledge at a distance.” The distance is usually expressed in time. Instinct is the only way to account for the complex navigational skills used by butterflies, salmon, and birds. Instinct is a set of complex behaviours that have not been learned by the individual but which obviously required learning in interaction with the environment by living creatures over a period of millions of years. I have evidence to believe that the DNA does not carry this kind of complex information (see Stop the Nightmares of Trauma). The theory of morphic resonance of Rupert Sheldrake offers the most likely explanation of the transmission of information over great distances of time and space.

ISOMORPHISM

Isomorphism is defined in dictionaries (math) as a one-to-one relation onto the map between two sets, which preserves the relations existing between elements in its domain; something identical with or similar to something else in form or structure. This term in TFT clearly summarizes and expresses the basic finding that there is a strong one-to-one relationship between the perturbations (which are diagnosed or assumed to exist) in the thought field and specific meridian points on the body. A “wiggling” or tapping of the appropriate meridian point or points (in proper order) will result in an immediate reduction or elimination of the disturbing emotion. It is from this strong relationship that we derive our causal notions.

LANGUAGE OF NEGATIVE EMOTIONS

The causal aspect of the negative emotions exists in encoded form. This refers to the particular perturbations

(p's), in their specific discrete order, which generate negative emotions. The requirement for specific order is similar to a combination lock; if the wrong order is offered, it doesn't work. P's are often contained in certain common orders for specific problems, which makes it possible to determine algorithms or common recipes for many psychological problems. Each negative emotion exists in encoded form, which accurate TFT causal diagnosis reveals. Another language appearing in nature is that of DNA, which determines the structure of proteins.

LEVELS OF TFT PROFICIENCY

The lowest level is the algorithm level, which is quite simple and can be learned by reading and studying *Tapping the Healer Within* (Callahan & Trubo, 2001). It is also beneficial to take an approved algorithm training seminar by a certified TFT instructor. We also recommend that anyone who works with people study the Introduction to TFT DVD, which is available at www.tfttx.com. The next higher level is what we call the diagnostic level where the individual is trained in the more complex TFT diagnostic procedures and becomes certified after completion of diagnostic training. At this level, the practitioner learns to diagnose and treat problems with greater success, and to address a much greater number of problems in the office than can be done with the algorithm level. Training at the diagnostic level is done through a combination of DVD and CD instruction, writings, and hands-on live instruction and supervision. The certified diagnostic level practitioner also gains a much higher degree of understanding of theory and is empowered to causally diagnose and treat most psychological problems with a high degree of success. Practitioners desiring to become algorithm trainers need to devote six months to learning TFT. They also receive six months of VT support in working with difficult cases. The highest level is Voice Technology, which requires training beyond the diagnostic level. This level is a significant advance above the previous two levels. The Voice Technology training is now accomplished in a three day live course and is open only to those who are certified at the diagnostic level. Voice Technology has the highest precision and success rate and allows one to treat effectively by telephone, which opens up world-wide potential markets for practice and consultations. As in all professions, those who practice the treatments gain the highest degree of competence.

MAGNETITE

Joseph L. Kirschvink, Professor of Geobiology at Caltech, surprisingly discovered the presence of magnetite throughout the human brain. Magnetite is an oxide of iron, and, like iron, it responds to a magnet. On November 5, 1992, Joanne and I saw him demonstrate this startling fact in a lecture. A magnet brought near brain samples under the microscope clearly showed the particles of magnetite. Keeping in mind that nature is rarely frivolous, one wonders: what is magnetite doing in the human brain? Could it be there to be responsive to electromagnetic fields? We don't know, but it is an interesting, little known, and surprising indisputable fact.

MAJORS

A term that refers to the tapping sequences that use standard meridian points such as under the eye, under the arm, beginning of eyebrow, etc. The term, "majors," distinguishes this aspect of the protocol from the 9 gamut, floor to ceiling eye roll, and the psychological reversal treatments. The major tapping points occur before and are typically repeated after the 9 gamut procedure.

NEOTENY

A problem or condition due to immaturity or the lack of full development. For example, all infants (and all land-based chordates) are born with an instinctive fear of heights, which ripens when the neonate begins to

crawl or move under its own power. The fear (acrophobia) is usually outgrown with normal development. A person who has been afraid of heights since childhood is considered “neotenuous.” A fear of heights that suddenly develops (returns) in adulthood would be considered atavistic (see definition above). I believe that such an atavistic phobia is very similar in principle to a person who has a phobia cured, but sometime later, it returns. The cause in all instances, I believe, is the presence of what I call an IET, or “toxin.”

PERTURBATION

(P) A perturbation (p) is an entity in the thought field. The p is viewed as the fundamental and basic cause of all negative emotions. A perturbation is the unit of fundamental causation of a negative emotion and correlates in a spectacular isomorphic relationship with specific alarm and treatment points on the body. Successful therapy subsumes or reduces the impact of p's in the thought field (see below). A p is a subtle, but clearly isolable aspect of a thought field that is responsible for triggering all negative emotions. Without a P, no negative emotion is present. The p is the generating structure that determines the chemical, hormonal, nervous system, cognitive, and brain activity commonly associated with, and an intrinsic and necessary part (but not the fundamental cause), of the negative emotions. The perturbation contains the active information (see Bohm and Hiley, 1993), which triggers negative emotions. Bohm and Hiley described their pivotal concept in quantum physics: “We have . . . introduced a concept that is new in the context of physics—a concept that we shall call active information. The basic idea of active information is that a form having very little energy enters into and directs a much greater energy. The activity of the latter is in this way given a form similar to that of the smaller energy” (Bohm & Hiley, p. 35). The process described here for quantum theory appears to fit the notions of numerous investigators in the bio-energy realm as the process by which biological control systems operate. One may understand the relevance of the TFT usage of “active information,” in that the microstate of the perturbations generate the macro state results of the person feeling depressed, angry, anxious, etc. Successful psychotherapy is the transformation (or subsumption) of this active informational microstate (perturbation), which results in the commonly observed and successfully predicted elimination of the negative emotions in TFT. A perturbation (p) is the fundamental and easily modifiable trigger containing specific active information that sets off and guides and controls the physiological, neurological, hormonal, chemical, and cognitive events, which result in the experience of specific negative emotions.

The need for, and the evidence supporting the concept of perturbation is demonstrated, e.g., in my television treatment of a woman in Baltimore who was terrified of driving on freeways and over bridges. Every person who is treated will demonstrate this, but the TV demo dramatically reveals the process and can be seen by everyone. First, she is calm and speaking to me in a highly relaxed manner that is appropriate for a mild social encounter in the comfort of her own home. She shows no signs of anxiety; however, in preparation for my treatment, I ask her to think about the driving situation. Immediately, she is intensely anxious and breaks down with tears and is obviously upset. Next, you see her driving a car on a freeway with no trace of fear. She then goes over a bridge with no problem. What happened? In order to answer this question seriously and with depth, one needs to understand the concept of a perturbation. It obviously exists in the thought field. Why is this obvious? Before tuning the problematic thought field, she had no anxiety. As soon as she thought of driving, the perturbation generated the extreme fear. Obviously, the perturbation is not present when she is actually driving. I saw the evidence of the collapse of the perturbation as I treated her. In a few minutes, she could not get upset when she thought about the problem. This meant that since she got very upset prior to this that the perturbation was completely subsumed. The acid test occurred as she was actually driving with no trace of fear. This is a fairly representative case.

I knew for years that there was an entity in the thought field that caused emotional upset, and that this entity could be completely collapsed with our typical powerful treatment. For years, I did not name this entity. One day, it hit me all of a sudden that the name “perturbation” might be appropriate as a designation of

this causal entity. I immediately got out my (regular) dictionary, and the last definition thrilled me. It said, “Perturbation is a cause of mental disquietude.” I jumped for joy because that is exactly what I was looking for. I changed the “a” to THE cause of mental disquietude. Some assume that emotional and other problems are caused by blockages in meridians. Psychological reversal can cause a blockage; however, a perturbation is not some random disturbance in a meridian. Instead, it is a highly specific bundle of critical information, healing data, that has the marvellous capacity to control all of the chemical, hormonal, and neurological phenomena that we see and know take place in anxiety, depression, and other disturbing emotions and the healing process. The term, “isolable,” refers to the amazing fact of nature that the problem is gone without disturbing or removing necessary information from the thought field..

PHOBIA

A persistent fear of a harmless object or situation. Most people with phobias are very much aware of the irrationality of the fear, which only adds to their difficulty. The knowledge that the fear makes no sense does not reduce the fear but merely adds embarrassment to the bad feeling. The commonly held idea that the problem is due to a lack of courage is without foundation and shows a fundamental lack of understanding.

PSYCHOLOGICAL REVERSAL (PR)

A state or condition that blocks natural healing and prevents otherwise effective treatments from working. Evidence for the state of PR is revealed when an otherwise effective treatment does nothing. Then, after the PR has been corrected, the same treatment, which did nothing the moment before, suddenly works. A person may be fine in most domains of life and be psychologically reversed in just one or a selected few. The PR state is usually accompanied by negative attitudes and self-sabotaging behaviour. A most interesting symptom of PR is that concepts are reversed 180 degrees. In other words, people who are reversed will say “South” when they mean “North,” but they will not say “East” or “West” when they mean “North.” The implication of this reversal of concepts is quite profound and is in need of investigation. It seems to relate to a fundamental aspect of direction (chirality, polarized light, etc.) in elemental reality. A similar and related symptom of PR is getting numbers or letters out of order. A special proof reader’s mark exists for this type of error, which illustrates how common it is. The upside down and backward writing of dyslexic people is due to the PR. PR in most of us is a temporary condition. When we are PR and reverse concepts, letters, and numbers, PR may be viewed as a kind of temporary “dyslexia.” A research study (Blaich, 1988) showed that of a number of rather complicated and specialized treatments designed to improve human performance, including my treatment for PR (tapping the side of the hand), the rapid (10 seconds) and simple treatment for PR was by far the most effective, producing a 45% increase in reading comprehension. Today, the PR treatments are routinely used in many elementary schools. We find the presence of PR on treatment effect to be quite lawful and predictable. We have found a high correlation between presence of cancer and PR. In a highly significant study done at Yale University back in the 1940’s, the researchers found that cancer patients had an overwhelming disposition to show a literal polarity reversal (as compared to normals) as measured by a sensitive instrument that measured body polarity (see Harold Saxton Burr, *Blueprint for Immortality: The electric patterns of life*, Neville Spearman, London, 1972). The concept of PR is relevant to all applied fields. The absence of PR is a vital prerequisite to successful treatment. My treatments would be significantly less successful (by 20% to 40%) if we could not correct this condition. MASSIVE PR is a reversal in most areas of life. MINI-PR is a block that kicks in during treatment and prevents the treatment from being complete. RECURRING PR is a reversal that returns as soon as it is corrected. Each of these variations of PR requires its own special treatment or action. We are now using voltmeters to show the presence of PR, and we have robust evidence that when we treat the PR, the reversal on the voltmeter literally changes from negative to positive before your very eyes! The introduction of the voltmeter to our work is resulting in better and more thorough treatments. One of the treatments I found to help PR in 1979 was the use of the Bach Rescue Remedy. Our recent use of voltmeters has resurrected my interest in and use of Rescue Remedy.

PSYCHOLOGICAL TRAUMA

A psychological trauma is an experience or event that engenders significant emotional upset. The upset seems reasonably based. Examples of trauma are rape, robbery, murder of a friend, mugging, loss of a loved one through death or perhaps even worse, loss of a loved one through rejection, loss of a job, kidnapping of a child, etc. One of the worst traumas is when the person you love rejects or leaves you. These are the types of experiences that we label traumas. It seems perfectly reasonable and appropriate for one to be upset in response to such events. The appropriateness of the disturbing emotion accompanying the event appears to be a hallmark of the notion of trauma. One might not expect trauma to be as responsive to therapy as it is to TFT. This surprising fact carries important theoretical significance. If someone loses a pen and is obsessed and very upset over this event, has nightmares, etc., it is not considered a trauma, though it is an obvious psychological problem. In other words, it is not the upset per se that is relevant, but the appropriateness of the emotion to the event that is relevant.

PUBLIC DEMONSTRATIONS

In the early days of psychotherapy, treatments were secretive. Even today, one can hear strong claims for success, yet it is rare that public demonstrations are given. A gentleman in his late 80's went for a physical examination since he was losing interest in sex. His doctor pronounced him in good health and told him that his decline was a normal function of aging. The man said, "But doctor, my friend Sam is 90 years old, and he says that he has sex every night!" The doctor replied, "You can say that too!" In secrecy, it is safe to make strong claims. I have done public demonstrations since I first discovered TFT. Recently, for the first time, I read an acknowledgment recognizing the relevance of a public demonstration. The author of an article in The Wall Street Journal on Monday, January 29, 1996, page A9A mentioned public demonstrations in an article on the controversial subject of cold fusion. A new claim that purports to create more energy than goes into a reaction (which, if true, will be revolutionary and doubtless nuclear in reaction) received the attention of Jerry E. Bishop, a writer for The Wall Street Journal in the article, "A Bottle Rekindles Scientific Debate About the Possibility of Cold Fusion." The gadget was called the Patterson cell, after its inventor. Bishop pointed out, "The Patterson cell might have been dismissed as easily as other reputed 'cold fusion apparatus.' But Mr. Reding and his colleagues have been bold enough to demonstrate it at three technical conferences in the last nine months. Most cold-fusionists are reluctant to show off their devices, because they are never sure whether or when they will work."

There it is—a statement, the first I have ever seen in print, that acknowledges the significance contained in a willingness to publicly demonstrate one's revolutionary claims. I have been doing such demonstrations on behalf of TFT for over a decade and a half (see the Callahan/Leonoff data), and to all appearances, either the professionals are unable to see what they are shown, or they do not realize the significance of being willing to put one's discoveries to a public test. The public, of course, is almost always skeptical.

QUANTUM LEAPS IN THERAPY

It was apparent from the outset with TFT that not only is the therapy rapid and effective, but the manner of progress is unique, i.e., the progress takes place in large, definite leaps, with the client evidently not necessarily passing through intermediate stages of the problem. My first case, Mary, for example, moved from a 10 to a 0 instantly and did not pass through intermediate stages of the problem. One would expect that a life-long and intense problem would not only be slow but might necessarily entail passing through a number of intermediate stages on the way to getting well. The typical case that begins with a SUD of 10 progresses with each stage of TFT therapy to a 7, then to a 4, and then to a 0 within minutes. The intermediate stages are typically bypassed.

REPRESSION

A habit of avoidance of awareness of a painful emotion to the extent that the choice to be aware is lost. The repressed person usually remains unaware of the extent of emotional pain present unless the pain is overwhelming. People who are repressed are as easily diagnosed and treated as anyone else, except they do not know how they are doing, e.g., as in a phobia, until they are in the phobic situation. The majority of people are not repressed and are aware of emotional pain when they attune the relevant thought field. We have demonstrated that a repressed person will show evidence of the repression through the use of HEART RATE VARIABILITY. The pre-treatment score may be SDNN=80 as the person thinks of the terrible event over which he/she feels nothing. Then, the traumatic event is treated, and the person's SDNN jumps up to 120.

RESONANCE

The process that brings about attunement (see Tuning). Resonance is a kind of physical bond that is brought about by a non-physical connection. It may be operative in memory and when a person tunes into a thought field. The concept was proposed by Ninian Marshall in 1960 in the article, "ESP and Memory: A Physical Approach." It was published in The British Journal for the Philosophy of Science, Vol. X, No. 40, pp. 265-286, in February, 1960. The concept provided the foundation for Rupert Sheldrake's notion of morphic resonance. Resonance is commonplace in the use of tuning forks and oscillating circuits used in radio and television; the oscillating circuitry in the receiver is adjusted to that of the transmission. When they resonate, the program enters the receiver. When people attune a perturbed thought field, they become disturbed. For an excellent example, see the case of driving phobia demonstrated on the national television show called "Evening Magazine." When the poor woman thinks about driving on freeways or over bridges, she can be seen to become immediately and severely upset (see Perturbation above).

REVOLUTIONARY EXPERIMENT

An experiment in science that reveals new facts that cannot be explained by conventional or accepted notions that are current at the time of the experiment. For example, the clinical psychologist, Martin Seligman, director of clinical training at the University of Pennsylvania, in his book, What You Can Change and What You Can't Change, stated on p. 253, "There are no quick fixes," and "Optimism is necessary for change to take place." Our reproducible experiment (therapy) overturns both of these cherished commonsense notions, as well as many others. It is absolutely impossible to explain the results of TFT with conventional ideas in psychology. TFT may be seen as a repeatable revolutionary experiment in clinical psychology that many people can carry out on their own by tapping the appropriate points on the body.

SCIENCE

The proper function of science is to respect facts and to revise theories in the light of new facts. Science is by nature conservative and therefore slow in carrying out its proper function. It is typically difficult for conservative scientists to be able to observe easily demonstrable new facts (see Apex Problem).

SEVEN SECOND PLUS TREATMENTS

These are treatments for toxins that have been added to what I initially called the "7 sec. treatment" but now take a little longer and are far more powerful than 7 second treatment. The modifications include suggestions by Joanne Callahan, including the addition of our reversal corrections, as well as the collarbone breathing treatment for specific toxins.

SUD

SUD is an abbreviation for the useful term “subjective units of distress” (introduced by Wolpe), which is a way to quantify the degree of stress, pain, or disturbing emotion experienced by the client. In TFT, the SUD is considered the “bottom line” by which therapy is evaluated for success. SUD may be evaluated on a 0 to 10 scale or on a 1 to 10 scale. Behavioural indices may be quite misleading, since many people can do things when pushed. If their suffering remains intense, however, we do not consider this to be therapy. Many people in conventional therapies learn that they can withstand a great deal more suffering than they thought they could. Successful therapy removes all traces of suffering.

THERAPY

Therapy, or rather effective therapy, results in the bottom line, which is dramatic improvement in the client. The improvement referred to here is not merely behavioural change, which is relatively easy to obtain, but the removal of all traces of a psychological problem. We believe that effective therapy is a result of the subsumption (this appears to be the most appropriate term in this context), removal, collapse, elimination, or reduction of p’s in a thought field, resulting in the elimination or reduction of negative emotions or problems, whether relevant to reality (emotions that may be considered appropriate and normal) or not (“neurotic”). The difference, after treatment, must be clinically, and not merely statistically, significant in order to qualify as therapy. (See November, 1993, APA MONITOR, report of the Science Directorate, and Psychology Today, March/April, 1994 issue with an article called, “Oops! A very embarrassing story.”) TFT is typically saltatory in its progression (saltus is a leap) or discontinuous in movement; it develops in leaps. This fact has led us to investigate quantum theory, since the jumps are quantum-like. We currently believe that the actual treatment occurs at a quantum level. Presently, it seems likely that a molecular bond is either broken or connected by the treatment or by natural maturation or healing. It is interesting that I discovered how to cure phobias during a time when it was believed impossible.

THOUGHT FIELD (TF)

Albert Einstein, in his Nobel Prize acceptance speech, thanked Michael Faraday, the brilliant British scientist who never went to college. Einstein conjectured that if Faraday had gone to college, he never would have been able to come up with the concept of a field. Of course, Einstein used the concept in his theory of relativity. The concept of thought field is the distinguishing characteristic of TFT. Professionals in other professions such as acupuncture, acupressure, chiropractic, medicine, dentistry, etc., perform on the rather static body or being of the person. The dynamic and limitless potential of the thought field is what makes TFT a psychological treatment. When one is trained to diagnose TF’s, it becomes immediately apparent that the structure of the TF creates dynamism in the individual. For example, it makes no difference to a dentist what one is thinking about when working on the teeth. For the TFT clinical psychologist, it makes all the difference in the world what is attuned. When the relevant TF is attuned, it brings to the fore the specific p’s and related information that are active in a problem and vital to understanding what is called for in the treatment situation. In order to diagnose and effectively treat a person, the person must tune into the appropriate TF. Not attuning to the proper TF is equivalent to asking a tailor to alter your trousers without bringing the trousers. The notion of a thought field is an imaginary scaffold upon which one may project or imagine causal entities such as a perturbation. Empirical tests and clinical experience reveal the relevance and power of such imaginings, i.e., we then discover whether our imaginings are “on-line” or “off-line” with reality. There is overwhelming evidence for the “on-line” nature of our theoretical speculations. All human invention and discovery are initially in the human imagination and must be tested in reality to determine ultimate status. Young children and animals do not have the ability to volitionally attune a thought field, and for such cases, the term, “perceptual field,” is appropriate. In order to treat young children or animals, they must be exposed to the situation so that they can attune the appropriate perceptual field. As a result, the child or animal can be treated.

TRACKING

Tracking is the procedure of observing the duration of a completely successful TFT treatment to see if any part of the problem returns. It is extremely important that a client call the TFT-trained therapist immediately, should a problem that has been eradicated return. We find that generally, these rare occasions are due to the ingestion of or exposure to an exogenous substance. A therapist trained in TFT diagnostic procedures can usually determine the substance. After the substance has been absent for a period of two months, giving the person's system a chance to heal, a repeat treatment will usually hold. Then, after that time, the offending substance may no longer regenerate the psychological problem.

TRANQUILIZERS

A means of blocking awareness of anxiety without addressing the cause of the problem. Tranquilizers appear to help by temporarily masking or hiding anxiety from awareness. It is my thesis that all addiction is addiction to some form of tranquilizer, whether chemical or behavioural.

TRAUMA

A trauma is due either to a direct horrible experience leading to severe emotional upset (due to the generation of perturbations) and/or pain, or it is due to witnessing a terrible experience of another or others. Trauma entails certain sequalae, in addition to the direct pain and suffering. These sequalae consist of obsessive thoughts regarding the incident, as well as repeated bad dreams, nightmares or flashbacks. If one is familiar with Rupert Sheldrake's theory of morphic resonance, TFT proposes that these sequalae are the central source of relevant information fed into the morphic field (collective unconscious—Jung) that allows for the inheritance of what we call phobias (McDougall). The sequalae fulfill the dictum of Shannon, who introduced information theory, that a message will come across no matter how much background noise, as long as sufficient repetition of the information is carried out.

TUNING

(see Resonance) The process of bringing a particular thought associated with a problem into awareness. For example, a trauma victim will be asked to think about the trauma. Often, trauma victims and clients with obsessive-compulsive disorder, addictions, and anxiety have INTRUSIVE TF's that enter under their own power and require no attunement. There can be no diagnosis or therapy without appropriate tuning. Animals or infants who have no choice in tuning must be in a situation that generates the appropriate TF in order to be diagnosed and treated effectively.

VOICE TECHNOLOGY

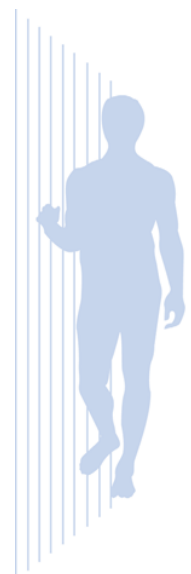
The proprietary technology that allows for the rapid and precise diagnosis of p's by telephone through an objective and unique voice analysis technology. The relevant (p) information can be demonstrated to be contained in holographic form within the voice. VT allows diagnosis to be done with only a fraction of a second of the voice available. Language, inflection, and content are totally irrelevant to the process. The encoded information is then decoded with precision, and the empirical effectiveness of the discoveries so obtained is quite easy to demonstrate. This is not stress analysis, since stress is too vague to be useful in this context and can be assumed when a client requires help. It is, rather, a rapid decoding process of the relevant p information in the attuned thought field and contained within the voice. The VT allows the TFT trainee a unique kind of experience wherein the trainee can obtain almost immediate consultation and help with difficult clients, in the trainee's office, through the medium of the Voice Technology. This on-the-spot availability of supervisory help that is offered as a part of training is unprecedented.

VOLTMETER

Harold Saxton Burr, a former professor at Yale Medical School, did interesting experiments using a voltmeter from the 1930's through the 1950's. One of his students, Louis Langman, went on to become a Professor of Gynecology at NY University Medical School. Prof. Langman used the voltmeter on his patients and found that cancer was highly associated with a negative polarity. This was a strikingly similar finding to mine in 1979. I discovered what I called "psychological reversal" and found a high correlation between this state and the presence of cancer. Interestingly, when surgery was carried out on the cancer patients, Langman found that the polarity went back to positive. Evidently, he and his colleagues knew of no way to correct the polarity reversal other than surgery. I believe that my methods of correcting reversal, which are supported by voltmeter readings, may prove very helpful in the treatment of cancers. We owe a great debt of gratitude to Ing Alvaro Hernández, TFT-Dx of Mexico City for discovering some voltmeters that work in the TFT context!

WITHDRAWAL

The acute anxiety experienced by addicts when deprived of their preferred tranquilizer. Withdrawal can be viewed as anxiety unmasked. Even heroin addicts may be totally relieved of all physiologic (and, of course, psychological) symptoms with the TFT treatment for addiction. A chain-smoking cigarette smoker may be entirely unaware of the anxiety that powers the need for cigarettes because the cigarette continually masks the anxiety. The chain smoker never has a chance to experience withdrawal; however, when deprived of a cigarette, the smoker becomes acutely aware of the underlying anxiety. One may, therefore, gauge the degree of an anxiety problem by the number of cigarettes smoked per day. The same reasoning applies to all addictions. The TFT algorithm for addiction withdrawal has a very high success rate. By this, we mean that the treatment eliminates the desire to consume a substance or engage in a behavioural addiction about 90% of the time. The TFT treatment is very effective in helping individuals who are addicted to prescribed tranquilizers; however, this should always be done under the supervision of a knowledgeable professional.



Levels of Thought Field Therapy®

TFT Algorithms

The general definition of an algorithm is “A sequence of instructions to be followed with the intention of finding a solution to a problem. Each step must specify precisely what action is to be taken, and although there may be many alternate routes through the algorithm, there is only one start point and one end point” (Youngson, R. M., 1994; The Guinness Encyclopedia of Science, Guinness, Middlesex. England, p. 232). The starting point in TFT is usually a SUD of 10, and the end point, hopefully, is a 1. In TFT, an algorithm is a recipe or formula for treatment of a particular problem discovered by TFT diagnosis that has been tested on many people and has been found to have a high success rate. An algorithm permits an untrained person to enter the domain of TFT treatment success without needing to learn the more complex diagnostic procedures that permit a higher success rate.

TFT Causal Diagnosis

The next higher level is what we call the diagnostic level where the individual is trained in the more complex TFT diagnostic procedures and becomes certified after completion of diagnostic training. At this level, the practitioner learns to diagnose and treat problems with greater success, and to address a much greater number of problems in the office than can be done with the algorithm level. The certified diagnostic level practitioner also gains a much higher degree of understanding of theory and is empowered to causally diagnose and treat most psychological problems with a high degree of success. They learn how to determine the specific tapping sequence needed for whatever the presenting problem/s for an individual.

Advanced TFT Voice Technology

The most effective level of TFT is Voice Technology, which requires training beyond the diagnostic level. This level is a significant advance above the previous two levels. The Voice Technology training is now accomplished in a three day live course and is open only to those who are certified at the diagnostic level. Voice Technology has the highest precision and success rate and allows one to treat effectively by telephone, which opens up world-wide potential markets for practice and consultations.



Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 2: Measures of Effectiveness

1. SUDS (Subjective Units of Distress) – importance and validity

Children's handout

2. Heart Rate Variability (HRV)

History of Use with TFT – Fuller Royal, MD

What Is A Good HRV Score – study / chart

Handouts

Article – Depression / HRV

Inner Balance Scan (IBS)

Heart Rhythm Scanner (HRS)

3. Voltmeter - handout

Recommended models

USA - Radio Shack Model 22-812

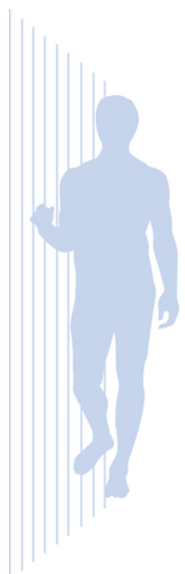
UK – Maplin's Model UNI-T

Use – how to / placement - handout

4. Radio Studies – Callahan and Leonoff handout

5. Research – handout

6. Demonstrations – submitted in advance with live interaction at the end of the class

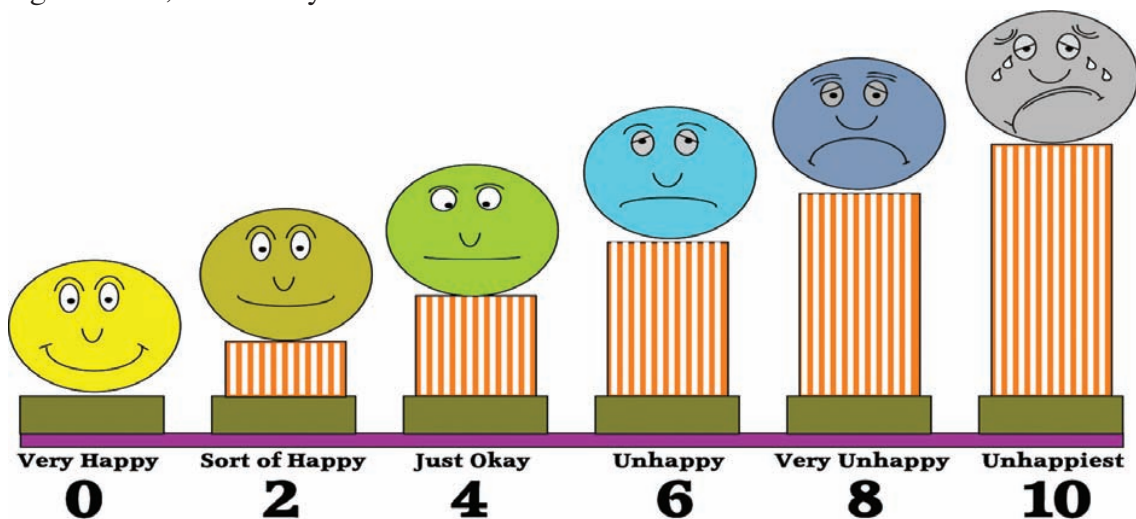


Using the SUD with Children

When working with children, make sure that they are in the thought field before treating them. If a child received a dog bite, you could show him/her a picture of a dog or have him/her draw a picture of a dog. You could also have the child talk about the dog bite. Avoid retraumatizing the child, however. As soon as the child is in the thought field, administer the treatment.

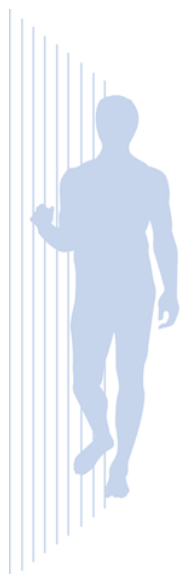
If you are treating a baby, you could hold or touch the baby and tap on yourself as a surrogate. Since you are forming a circuit with the baby, the treatment will go into the baby's body. You could also tap or rub the points on the baby's body. You could do the Nine Gamut Sequence on yourself while touching the baby.

For treating children, you could have them show with their hands apart how big the disturbance (fear, anger, hurt) is, or you could have them point to a chart like the one below. You could also use language such as, "How icky does this feel?"



Thought Field Therapy® (TFT)
SUD Assessment Chart for Kids
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It is best to have a parent or guardian present. You can also ask the parent or guardian if he/she notices any change in the child's behavior after the treatment.



WHAT IS A GOOD HRV SCORE?

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By Roger J. Callahan, PhD

In my study of the medical literature on HRV I find little or no reporting on what is a good score. I do not know why this is the case unless it is a result of a problem with the fact that the profession of heart care does not know how to dramatically improve HRV. In study after study and research after research HRV is properly lauded as the very best indicator of heart and also of general health. Most professionals do not wish to put into bold relief their glaring inability to improve low HRV by putting such skill to the tests. See, e.g., the HRV research on depression and Cognitive Behavioral Therapy.

In the HRV text book by Marek Malik and A. John Camm there is an illustration showing the length of survival after a heart attack by three groups of patients; this is from the original research by Kleiger and colleagues. It is summarized by Bosner and Kleiger in their chapter on HEART RATE VARIABILITY AND RISK STRATIFICATION AFTER MYOCARDIAL INFARCTION.

On page 331 they state “The absence of variability is a highly significant risk factor for adverse outcomes following acute myocardial infarction, including all cause mortality, arrhythmic, and sudden death.

They separated the research subjects into three groups – those with SDNN’s above 100, those between 50 and 100, and those below 50. To summarize the result, p 334,”... *those with SDNN BELOW 50 “had a mortality risk 5.3 times as high as those with SDNN above 100.”* This is a highly significant risk of death predicted by the SDNN.

Another clear source of the relative merit of having a high SDNN is the interesting quantitative study by Bilchick et al, who concluded:

“... each 10ms increase in SDNN results in a 20% decrease in the chance of death.”

Daugherty, CM and Burr, RL report in American Journal of Cardiology (1992), 70, Aug 25, pp 441-448, in an article titled, “A comparison of survivors and non-survivors of sudden cardiac arrests.”

There were 16 survivors and 5 deaths in their group. The HRV (SDNN) score breakdowns were as follows:

The 5 NON-SURVIVORS average score was SDNN = 52.3

The 16 SURVIVORS average score was SDNN = 78

It is very clear from these data that the higher the variability the safer one is, the healthier one is, and the farther from illness and death one is.

Experiment with HRV and toxic sweater: Joanne and I used HRV Live for this experiment which gives instant scores on HRV.

SDNN before sweater identified as a toxin: **SDNN=21.8** Test sweater and find it toxic.

HRV LIVE showed an immediate improvement to **SDNN 68.6**. In Bilchick's terms, the chances of death were decreased significantly by removing the sweater – in fact death was postponed, according to the Bilchick research (published in The American Journal of Cardiology) by 100%.

The difference in time between the pre and post sweater SDNN was a matter of the few seconds it took to remove the sweater from the body. HRV Live gives scores instantly rather than waiting for five minutes. Such findings as this as well as other TFT impacts on HRV is revolutionary in that in no place in the HRV literature, of which I am aware, does anything like this kind of improvement, in speed or quantity, exist.

CLIENTS WHO DIED AND WERE BROUGHT BACK

The first client who had died and was brought back in the hospital where he worked was a physician. I worked with him about ten months after his revival. His SDNN prior to TFT VT therapy was 16. After VT therapy his SDNN immediately increased to a very healthy 91!

The other client who came to my training a couple of months after being revived in a fire station near his home had an SDNN of 8. He was severely sensitive to his HIV- AIDS cocktail medication and using my recent discovery of treating toxins his SDNN immediately improved significantly and then with further time and treatments his SDNN score has gradually been restored to normal; i.e., above 100.

To illustrate the significance of this statement consider this physician who suffered from depression for 20 years and was not helped by the many medications or the numerous psychotherapies he tried. He attended one of my trainings and he volunteered to have me treat his depression with TFT. He took an HRV test before and after treatment. His depression prior to TFT treatment was a 10, meaning it was the worst it could be. The treatment took a matter of minutes and his depression completely disappeared. His SDNN before treatment was a very low 32 ms. Immediately after my brief treatment his SDNN increased to 144.4ms. Such dramatic improvements are unheard of in the HRV literature. As noted above, such an improvement will likely result in a profound decrease in the chance of death. If each 10 ms increase results in a 20% decrease in the chance of death, as Bilchick et al state, then it may readily be seen in the light of the of this study, that there is a dramatic decrease in the risk of death for this individual. How long will the treatment last? We never know until it lasts; however, I discovered in principle what can undo any successful treatment and this gives TFT a further important advantage over any other treatment.

It should be noted that although such improvements as this are commonplace with TFT, not everyone responds in this manner. I have learned that when SDNN does not respond immediately after stress removal, then toxins must be identified, treated and avoided. All cases needs to be followed in order to ensure that the dramatic gains hold over time. To understand how a highly successful treatment can be undone see Cure and Time in Stop the Nightmares of Trauma (Callahan and Callahan). In order to know what to do when a treatment is undone, see my recent important package The Identification and Treatment of Toxins.

A study carried out at a major hospital using only my depression algorithm (number of patients =106) found that depression was reduced from an average 7.3 (on a 10 point scale, where 1 means no trace of depression) to a 1.6 (Sakai, et al).

Professionals all over the world are now eliminating the stress of such psychological problems as trauma, anxiety, anger, and depression with great speed and alacrity unknown before my discovery of TFT. It seems highly likely that the people treated successfully will, in addition to being free of their specific problem, be less likely to expire prematurely.

Note: There were 50 men who were put on the “Aids Cocktail” at the same time David started and David is the only survivor living today (March, 2008).

Certain ordinary foods in some people act like a poison and can lower HRV, shorten life and cause serious illness. Since TFT is so powerful in eliminating stress of almost any kind, HRV typically responds immediately to an appropriate and correct treatment and the HRV will increase, often dramatically and immediately. Ingested toxins, however can take months to clear to the point where SDNN increases dramatically. It seems obvious that the difference in time is due to the greater inertia of the physical toxins as opposed to the psychological originated stress.

My Personal Standard

As I write this, I celebrated my 84 birthday. My health is excellent. I know that if it were not for the powerful treatments I discovered and developed, I simply would not be here.

I have had colon cancer and a triple bypass heart operation. Just before I made my discoveries, I suffered from severe chronic fatigue syndrome. I went to numerous physicians, chiropractors, (I even traveled to Detroit to see if Dr George Goodheart could help, numerous acupuncturists, etc. As my discovery of the role of toxins became more clear. I was able to cure this myself. It was wonderful that I could do it!!

Today, I take my HRV regularly and if it goes below 100, I find out what is wrong by means of my own objective self-testing procedure. My HRV typically increases to 100 or over as I address the problem whether it is toxic or psychological stress. Since my body is mainly free of toxic stress in recent years, it is possible for my SDNN to rise immediately.

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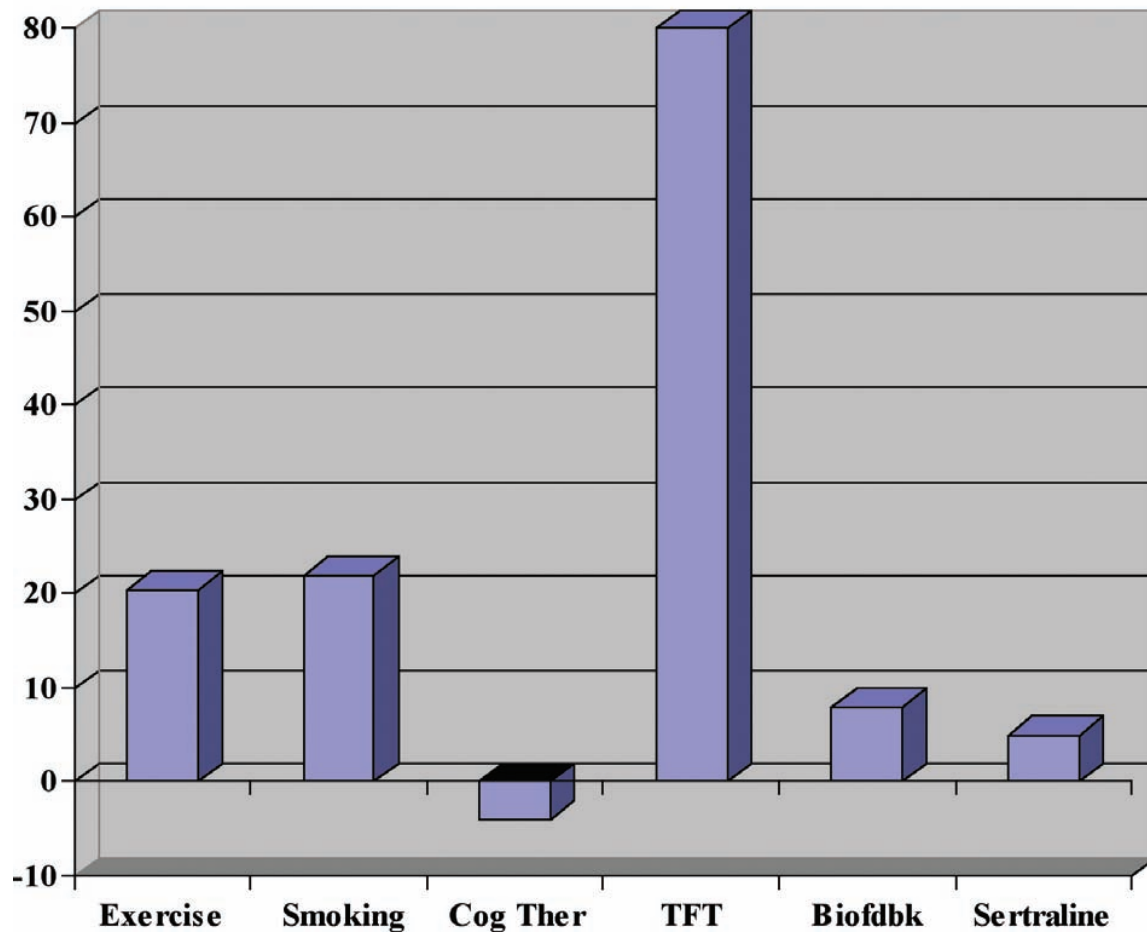
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% Increase in HRV (SDNN) with Different Therapies



Time Scale: Exercise and smoking cessation are after **one year**. Biofeedback relaxation training is after **two months**. Cognitive Behavioral Therapy for depression was carried out for **16 sessions**. Sertraline (Zoloft) was administered for depression for **22 weeks** in this study. Common side effects with Sertraline include nausea, diarrhea, tremor, insomnia, somnolence, and dry mouth. TFT for depression was done in **one session within minutes** (Callahan, 2002). Typically there is immediate elimination of depression and immediate increase in HRV averaging 80% in this sample. No harmful side effects with TFT.

I argue, along that HRV is an index of health - please see my article: Stress, Health, and the Heart: A Report on Heart Rate Variability and Thought Field Therapy, Including a Theory of the Meaning of HRV. <http://www.tftrx.com/download/index.php>

Some Statements From the Scientific Literature on SDNN (HRV)

First, a word on the ultra-conservative manner of scientific style: It is frowned upon in science, to express enthusiasm. Here is an exaggerated example of this mode of speech; Two academic scientists are riding on a train. One scientist looks out the window and seeing a field of sheep says. "Look, the sheep have just been

shorn.” The other scientist looks and replies, “They do appear to have been shorn on one side.”

When I published my trauma treatment in 1980, the title of my article included the word “amazing.” It was and still is amazing but I broke tradition by using the word in the title. My work with HRV is even still more amazing but I must stifle my excitement which has not diminished in my 80 plus years. To indicate my enthusiasm for certain scientific findings, I use bold type – all bold below is my addition.

Stress Test and HRV “Low HRV has been shown to be a powerful independent predictor of **all cause mortality** in the post-MI (heart attack) population, as well as **in patients with a number of non-cardiac disease states**. Indeed, low HRV may be a more powerful predictor than left ventricular ejection fraction, wall motion abnormalities, frequency and complexity of ventricular ectopy, **standard ECG and exercise ECG indices ...**” p440 [in HRV text book]

“We examined the specific role of HRV in relation to sudden death. 245 died suddenly. Those who had an SDNN of less than 25ms had a 4.1 fold higher risk of sudden death than patients with higher short-term variability scores.”

“HRV (SDNN) was also associated with cardiac death in subjects *without a history of myocardial infarction which may indicate that HRV is also a marker for sub-clinical disease*. Thus, HRV may predict sub-clinical conditions.”

“A reduced variability is a signature for disease and increased risk of mortality.”

“HRV is a powerful prognosticator of overall mortality.”

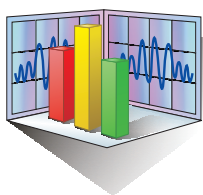
“The lower the HRV, the greater the probability of a greater risk of lethal arrhythmias.”

“In the Zutphen Study, a prospective study in middle aged and elderly dutch men, HRV was determined from 15 to 30 second recordings. **A strong association between low HRV and death from all causes, including cancer, was observed.**”

“Low HRV is an indicator of poor general health.”

“[Report] a progressive reduction of heart rate variability with eventual sudden death in two patients. These results suggest that sequential measurements of HRV may be useful in predicting sudden death”

“A Cox proportional-hazards model revealed that *each increase of 10ms in SDNN conferred a 20% decrease in risk of mortality (P=.0001)*.” Bilchick KC, Fetis B, Djoukeng R, Gross-Fisher S, Fletcher RD, Singh SN, Nevo E, Berger RD. (2002) Prognostic value of heart rate variability in chronic congestive heart failure. **American Journal of Cardiology.** 90(1):24-28



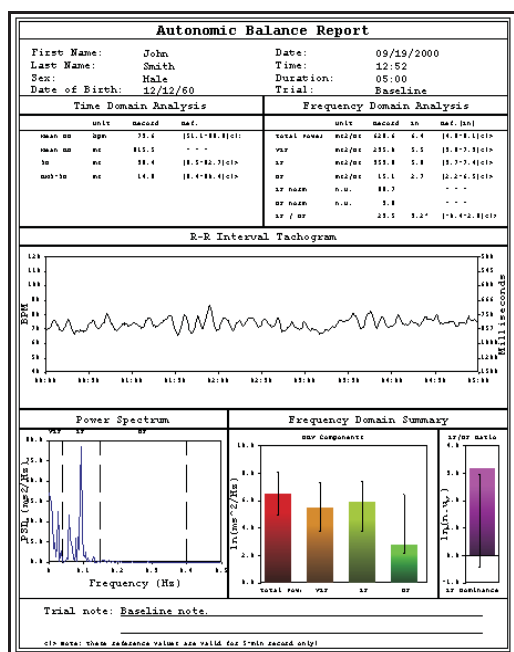
TFT Heart Rate Variability

Comprehensive Autonomic Assessment System



The **TFT Heart Rate Variability** system is a versatile instrument for measuring the heart rate variability (HRV). It performs recording of the electrocardiograph (ECG) or pulse wave signal and derives heart rhythm data off these signals for further heart rate variability analysis.

The **TFT Heart Rate Variability** system utilizes either an ECG recorder or an ear-clip pulse sensor connected to PC via a USB port. Either type of device is very simple to connect and use to obtain reliable heart rhythm data.



The **TFT Heart Rate Variability** software was developed to the standards and mathematical procedures for short-term HRV evaluation set by The European Society of Cardiology and The North American Society of Pacing and Electrophysiology (1996).

The **TFT Heart Rate Variability** system is a cutting edge technology that gives an ability to assess parasympathetic and sympathetic functions and assess the autonomic balance in the body. During or after session the system performs a comprehensive short-term HRV analysis and creates detailed reports. This allows for an easy comparison across numerous applications or procedures.

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OTHER INFORMATION

The Inner Balance Scan is a scientifically validated Windows software adopted to:

- **Evaluate your current overall health condition**
Simple 5-minute test at any time of the day using an ear-clip sensor will show you interpretative report about your health condition
- **Discover how your environment and lifestyle affect your health condition and inner balance**
Taking two 5-minute tests will help you to understand how any environmental factor (like pets, music, computer game, any exercise etc.) Influenced your health condition and inner balance
- **Reveal saddle health issues**
Daily usage of Inner Balance Scan allows you to see a progressive report of your overall health condition. This will allow you to estimate your health condition in next week, month, year and contact your physician if it is getting worse
- **Estimate the effectiveness of physical training**
Additional 5-minute test after recovering from your exercises will show you the difference in your regulatory systems and overall health condition. This will help you not to get over-trained or under-trained
- **Choose the right health improvement procedures**
Progressive report shows where your inner balance is moving, allowing you to choose procedures that lead you towards optimal inner balance state
- **Check how treatment works affecting your health condition**
Taking two 5-minute "before" and "after" tests will help you to understand how your treatment (like taking medicine, going to chiropractor or massage therapist, etc.) Influenced your health condition, to see effectiveness of any health improving procedure

Easy-to-use device with Windows software

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- Evaluate your current overall health condition
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- Reveal saddle health issues
- Choose the right health improvement procedures
- Check how treatment works affecting your health condition



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Depression, Grief, and Heart Rate Variability

By Howard Hagglund, MD

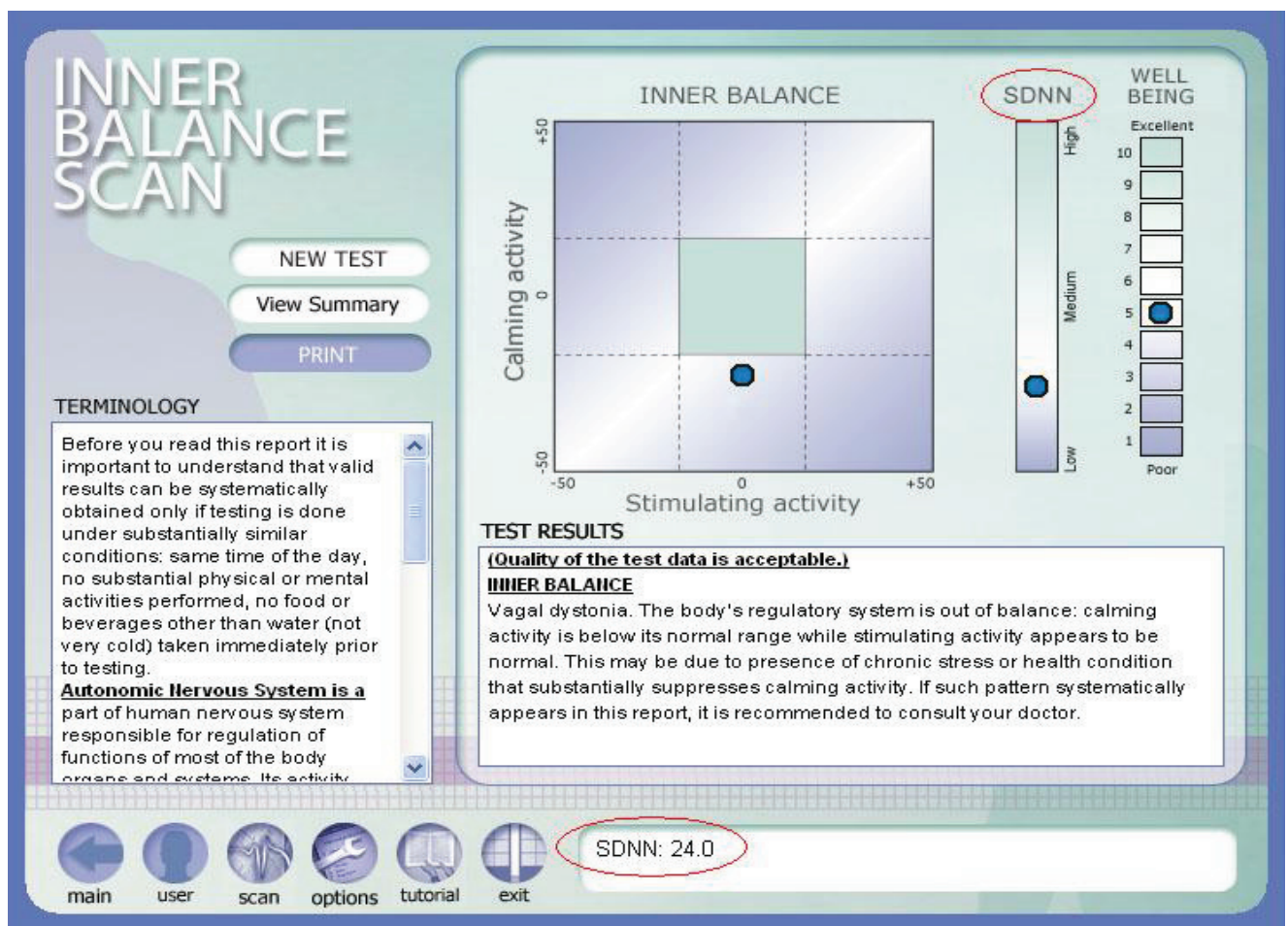
Part I – Depression and Heart Rate Variability

I am a family practitioner in Norman, Oklahoma. I have been using the Callahan Techniques® for about six months. I was at the causal diagnosis training seminar in June of 1999 and something interesting happened.

I have been very much involved in all the alternative therapies but as far as getting my own self well, it has never been a top priority. Indeed, I had a lot of despair about it. I volunteered to be treated using the Heart Rate Variability (HRV) Scanner along with the procedure so the effect of the Callahan treatment could be evaluated by this measurement.

What I had to confess to is that I had a lot of despair and a lot of depression because I never thought I would find a way that would make me well. Everybody else could be well, but not me. My HRV report reflected my poor status.

Dr. Callahan treated me and in less than five minutes, my depression of over seven years was gone and I had a bright outlook almost beyond belief. My HRV chart reflected this change. It was amazing.



Voltmeter & PR MEASUREMENTS

MEANING OF PR

- The meaning of PR is that the flow of energy in the body is reversed, i.e., the normal polarities are reversed.
- In such a state, normal healing and successful treatments are blocked from working.



Professor Harold Saxton Burr

Dr. Burr discovered that all living things - from men to mice, from trees to seeds - are molded and controlled by electro-dynamic fields, which could be measured and mapped with standard voltmeters.

These “fields of life,” or L-fields, are the basic blueprints of all life on this planet. Their discovery is of immense significance to all of us. Dr. Burr believed that, since measurements of L-field voltages can reveal physical and mental conditions, doctors should be able to use them to diagnose illness before symptoms develop, and so would have a better chance of successful treatment.



Professor Burr's Voltmeter

This is a Hewlett-Packard DC Vacuum Tube Voltmeter Model 412A Recommended by Burr to measure electrodynamic fields.



Control System and Direction

“In the growth and development of very living system there is obviously some kind of control of the processes.”

- Burr elaborates that control requires direction.
- One of the few things in the universe, which possess direction, is the electrical property of things.
- Even atypical growth (e.g. cancer) requires direction.
- Life requires energy but energy has no direction
- What Callahan calls **“PR”** and what Burr called the **“reversals of polarity”** appear to make sense from the standpoint of control forces operating within life.

Dr. Langman's Hypothesis

- **Langman had been a student of Prof. Harold Saxton Burr**
- **Was a professor of Gynecology at New York University**
- **Mention of Langman's study was in the Appendix of Burr's book**

Dr. Louis Langman hypothesized that cancer is fundamentally an alteration of field forces in the body.

To check the idea, he examined cellular diagnosed cases of cancer under blind conditions; that is, the pathologist and Langman did not know who was who. He compared these cases (in measurement of body polarity by Burr's method) to normals. [The measurement of body polarity was done with a sensitive voltmeter placing the electrodes on different parts of the body.]

Langman's Results

Those with NO GYNECOLOGICAL CONDITION

Positive Polarity	-----	74
Negative Polarity	-----	4

95% of the normal group showed the measured polarity to be POSITIVE.

Those with MALIGNANCY

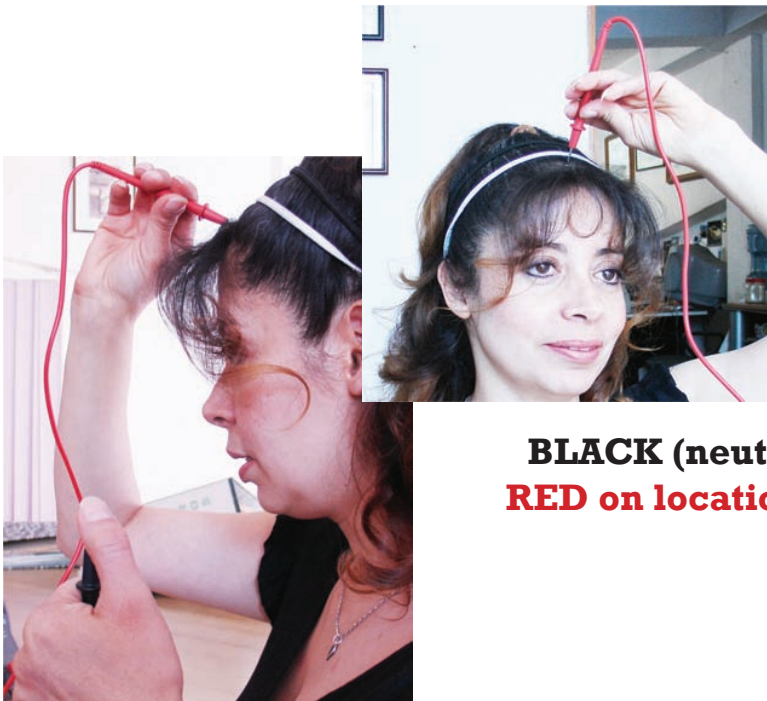
Positive Polarity	-----	5
Negative Polarity	-----	118

96% of this group showed the measured polarity to be NEGATIVE.

The cancer group has a striking preponderance of women showing a reversal of normal polarity. Dr. Callahan made the discovery of PSYCHOLOGICAL REVERSAL and found that the few cancer patients he had ALL showed PR. Dr. Shulman learned about PR in Dr. Callahan's first training. Shulman was a psychologist who specialized in treating cancer patients. On checking his cancer patients, he discovered they all had PR.

We can say that PR is a disrupted flow of energy caused by reversed polarity.

This reversed polarity can be measured (in millivolts) and corrected.



ELECTRODE PLACEMENT

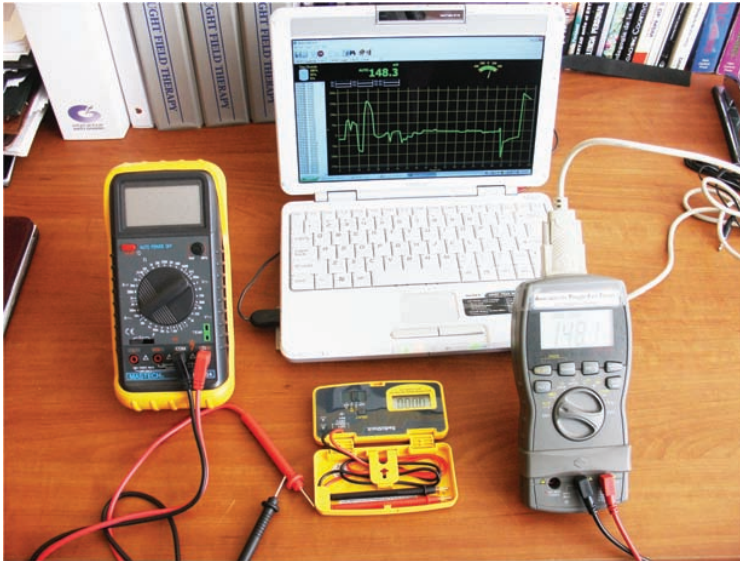
BLACK (neutral) on thumb or palm of hand
RED on location to be tested or back of hand

FOR BEST RESULTS

Electrode should make **DIRECT CONTACT** with skin



Examples of Voltmeters used to measure PR.



Using the Voltmeter

There are two leads coming from the voltmeter – a red and black one. After turning on the proper range, millivolts, take the black lead and place it on the fingerprint of your thumb.

Place the red lead on the part of the body you want to measure.

You should observe a rather steady movement of the voltmeter in a plus or negative direction coming to relative rest at a rather steady reading – some small variation is tolerable but the trend must be quite clear to be meaningful and the position of positive or negative should also be quite clear.

If you get sharp variations up and down, in a random sense, with the reading it is likely that you are in an area of great interference and must work in another more stable area. For example, in our first training in our building, my voltmeter worked great in my home but in my office the variation was extreme on the ground floor. Despite this on the second floor we saw amazing results with the vm reflecting the profound changes brought about by TFT and the various reversal corrections. What we have found is that fluorescent lights and wireless internet systems may interfere with stable readings. Try to select a location in natural lighting and without strong wireless systems near by.

BLUNT THE ENDS OF THE LEADS IF THEY ARE SHARP

We noted immediately that the points on the leads were very sharp. Ask the store to file off the sharp points so that no injury takes place – or get a a file and do it yourself.



PHOBIA AND ANXIETY TREATMENT BY TELEPHONE AND RADIO

The Final Results of a Replication of Callahan's 1987 Study

Glenn Leonoff, Ph.D.

The replication of Callahan's 1987 study has been completed and the final results reveal an astounding similarity in the findings of the two studies.

Radio listeners with phobias and anxiety states were invited to call radio programs in order to receive live-on-the-air treatment by the investigators. The proprietary Voice Technology(tm) pioneered by Callahan was used as the method of application of TFT treatment procedures by both Callahan and Leonoff in their respective studies. Each study included 68 subjects.

Consistent with the procedure of Callahan's initial study, the results of the present study include the data for all callers who were treated, including those whose treatments were interrupted due to programming requirements before optimal therapeutic results could be achieved. Callahan used this stringent procedure in order to minimize bias.

Treatment effectiveness was measured by the caller's own report about their experienced intensity of distress. Callahan used a ten-point (1 to 10) Subjective Units of Distress (SUD) rating scale while Leonoff used an eleven-point (0 to 10) SUD scale.

Despite the less than ideal conditions of treating psychological disorders on radio programs, a remarkable 97 percent success rate was achieved by both investigators. A successful treatment was defined as an improvement of two or more SUD points.

Callahan's mean (average) pre-treatment distress rating was 8.35 and his mean post-treatment rating was 2.01, representing a 75.9 percent improvement. Leonoff's mean pre-treatment distress rating was 8.19 and his mean post-treatment rating was 1.59, representing a 75.2 percent improvement. Callahan achieved his results in an average time of four minutes and thirty-four seconds. Leonoff required an average time of six minutes and four seconds.

As in Callahan's study treatment time represented the entire duration of talking to the caller until treatment was completed, not just the actual treatment time itself. Since treatment time entailed the entire time spent in talking with a caller prior to initiation of actual treatment, it is believed that personal interaction styles of the practitioners account for some of the difference in these measures. A greater willingness to engage in conversation with a caller prior to initiating the actual treatment would have resulted in a longer documented treatment time. A more exact measure of actual treatment duration would have been to measure only the actual treatment time. Such a procedure would have reflected the duration of actual treatment time more accurately.

COMPARISON OF RESULTS BETWEEN THE CALLAHAN AND LEONOFF STUDIES

Summary Table

	Callahan 1987	Leonoff 1996
Number of Radio Programs.....	23	36
Number of Subjects Treated	68	68
Successfully Treated	66	66
Unsuccessfully Treated	2	2
Success Rate.....	97%	97%
Pre-Treatment Mean (Average) SUD Level	8.35	8.19
Post-Treatment Mean (Average) SUD Level.....	2.01	1.58
Mean (Average) Improvement in SUD Level.....	6.34	6.61
Mean (Average) Improvement Percent.....	79.2%	75.2%
Mean (Average) Treatment Time (Minutes)	4:34	6:04

The fact that these incredibly similar results were achieved a decade apart by two independent investigators with dissimilar professional backgrounds and significant differences in their experience and knowledge of TFT procedures, provides strong support for the efficiency, effectiveness and reliability of the TFT treatment procedures.

Callahan was the pioneer and developer of these revolutionary treatment procedures.

He undertook his study after approximately six years of refining his methods. Leonoff embarked on his study during the course of his first year of study with Callahan. Thus, there was a distinct difference between the two investigators in their level of technical knowledge, experience and theoretical understanding of the TFT procedures. The virtually identical therapeutic success demonstrated by the two investigators is an indicator of the power and predictability of the TFT procedures despite the differing levels of expertise between the investigators.

All the research data of this replication study is preserved on recorded audio tapes and available for further scientific investigation.

The Callahan/Leonoff studies were not intended to investigate the duration of the achieved therapeutic gains. Duration of treatment results is an obviously important clinical issue for any psychotherapeutic procedure. Research concerning the duration of TFT treatment is an important next step in the establishment of an empirical basis for the efficacy of this procedure. Hopefully, the robust findings of the two studies will stimulate more extensive research which will address the issue of duration of TFT results.

Preliminary research data supporting the duration of successful TFT treatment is provided by the six-month follow-up data from the Figley and Carbonell study, "Active Ingredients in Efficient Treatment of PTSD," conducted at Florida State University in 1995. According to the report presented by of these two researchers at the International Society for Traumatic Stress Studies in Boston on November 3, 1995, TFT treatment gains were maintained on six-month follow-up. This research is expected to be published during

1996. The Figley and Carbonell data provide important corroboration to clinical observations of the enduring results of TFT. There is documented clinical evidence of TFT therapeutic gains holding for ten years or more.

A highly significant aspect of the Callahan/Leonoff research is that the demonstrated psychotherapeutic success was achieved through a procedure which is based on the diagnosis and treatment of the little known body energy system. The success of the TFT procedures represents a change in the psychotherapeutic paradigm of psychology.

The diagnostic and therapeutic procedures of TFT are founded on the identification of specific imbalances in the body energy system as identified through specific diagnostic assessment while the subject is engaged in thinking about or experiencing their particular psychological concern.

Briefly, it is hypothesized that the therapeutic results of TFT demonstrate that the body energy system is primary to human functioning and is the foundational basis for biochemical, hormonal, neurological and cognitive levels of human functioning. This theoretical formulation is based on the understanding in modern physics that complex energy fields and their interrelationships are the basis for all matter, including that of the human organism. It is theorized that the stimulation of specifically defined points along the meridian energy system transduces the physical energy generated by the TFT tapping procedure into a form of electromagnetic energy which has a direct and positive impact on the psychological thought field maintained by the individual undergoing treatment.

The body energy system is generally little known and un-mastered in western clinical practice, there are isolated recognized pioneers who have ventured to study this level of our organism's functioning and have reported findings with clear implications for the procedures and success of TFT.

In the 1940's Harold Saxon Burr of Yale University provided strong evidence that the body is an energy system and that the state of this energy system is critically significant to the development of living organisms.

Orthopedic surgeon, Robert O. Becker, M.D. (1985), determined the significance of electromagnetic energy fields to bone healing and developed successful treatment methods based on his findings. Through the application of electromagnetic fields he was able to restore natural healing ability in the human organism in terms of enabling bones which would not heal spontaneously to heal under the influence of governed energy fields. Another fascinating aspect of Becker's research with electromagnetic fields enabled him to unleash regeneration of amputated limbs in frogs. The extraordinary aspect of this work was that frogs normally do not naturally regenerate their lost limbs. Yet, treatments based on the application of electromagnetic energy fields actualized this healing potential.

The relevance of the body polarity state to human health is dramatically demonstrated in a study by Louis Langman, M.D., "The Implications of the Electro-Metric Test in Cancer of the Female Genital Tract." This study was published in the appendix of Burr's (1972) book, *Blueprint for Immortality: The Electric Patterns of Life* (1972), Langman's findings make a strong case for the relationship between the well being of the human organism and its polarity. In this study at the Department of Obstetrics and Gynecology, New York University, College of Medicine Langman found a dramatic difference in polarity between woman with cellularly diagnosed cancer of the genital tract and women with no diagnosis of such cancer. Woman

with diagnosed cancer had negative polarity in the genital tract 96% of the time as compared to woman with no known malignancy who showed negative polarity only 5% of the time. This dramatic difference offers further evidence for the importance of the energy system in the health of individuals. Unfortunately, there is no known followup research to these findings.

After twenty years of research the eminent radiologist and former president of Nobel Laureate nominating committee, Bjorn Nordenstrom (1983) of the Karolinska Institute in Sweden published, *Biologically Closed Electric Circuits: Clinical, Experimental and Theoretical Evidence for An Additional Circulatory System*. In essence, Nordenstrom postulated a circulatory energy system within the human body which he believes to be as vital to human health as the circulatory blood system. This is a profound statement from such a renowned western scientist. His research led him to believe that disturbances in the body energy system may be involved in the development of cancer and other diseases. Nordenstrom has been successful in producing complete remission from various types of cancers metastatic to the lung through the application of polarity in electrical currents.

Pierre de Vernejoul (1985) at Necker Hospital in Paris, France reported empirical evidence for the existence of the meridian (energy) system. His research team injected radioactive technetium 99m into acupuncture points and followed the isotope's uptake with gamma-camera imaging. Their findings indicated the radioactive substance migrated along the classical meridian pathways the Chinese had defined several thousand years ago. Injection of the substance into random locations in the body revealed they followed no determined pathway. The results suggested the meridian system is a separate morphological pathway.

Treatment procedures directed at the meridian system have been successfully applied not only by TFT but by the disciplines of acupuncture and applied kinesiology. The demonstrated effectiveness of TFT offers strong evidence for the significance of the meridian energy system relative to the rapid treatment of psychological disorders.

In this era of efforts to find cost-saving health procedures and practices, TFT provides the type of efficient and effective treatment procedures which can help to achieve such objectives in the field of mental health.

The three levels of training in TFT proficiency (Voice Technology(tm), Physical Assessment, Algorithm) allow for relatively rapid training of practitioners who are able to provide effective treatment in a variety of health service settings. TFT trained clinicians are able to have access to rapid telephone consultations for clients with complex disorders from practitioners trained in the use of the proprietary Voice Technology(tm). Such consultations provide for therapeutic support at the highest levels of proficiency for clinicians at all levels of TFT training.

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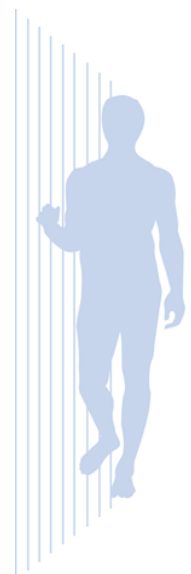
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Growing Evidence of Its Efficacy

The following studies have been done on Thought Field Therapy® (TFT).

- Blaich (1988) found that readers improved in their reading speed by 45% after using Dr. Callahan's treatment of tapping the side of the hand for Psychological Reversal.
- Yancey (2002) found that middle school students used Thought Fielding Therapy® to eliminate angry and violent feelings, to achieve at higher levels in school, and to overcome difficulties in relationships with friends and family. Adults used TFT with students to assist them in improving their scores on tests, relieve stress, get along better with family members and friends, overcome violent feelings, and grow in self-confidence. They also used it with themselves, their families, and their friends to overcome stress.
- In 714 participants who were treated by 7 therapists for 1,594 problems, paired-samples t-tests indicated significant reduction on the Subjective Units of Distress (1-10) self-report scale in 31 categories of distress from pretest to posttest (Sakai et al., 2001).*
- Thought Field Therapy® significantly decreased phobia of needles as measured prior to the treatment and a month later using the questions on the Fear Survey Schedule (FSS) related to blood-injection-injury phobia and the Subjective Units of Distress (1-10) self-report scale (Darby, 2002).
- Thought Field Therapy® significantly decreased fear of speaking in public as measured by the Subjective Units of Distress (1-10) self-report scale and the Speaker Anxiety Scale (Schoninger, 2004).
- Of 105 survivors in Kosovo who had 249 traumas, 103 reported complete absence of the trauma with 247 of the traumas. Presence or absence of the "bad moment" (p. 1238), or trauma, was used due to cultural taboos against the use of the Subjective Units of Distress (1-10) self-report scale. The results remained an average of five months later (Johnson, 2001).*
- Thirty-one immigrants to the United States showed a statistically significant decrease in posttraumatic symptoms as indicated by scores on the Posttraumatic Checklist-C, as well as on their Subjective Units of Distress (1-10) self-report scale from before the Thought Field Therapy® treatment to 30 days later (Folkes, 2002).



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Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 3: Application – Key Components of TFT

1. Structure – 9 gamut sandwich – handout

2. Psychological reversals – handout

- Massive Reversal
- Specific reversal
- Mini- reversal
- Level II Reversal
- Mini-Level II Reversal

3. Major treatment points – chart

4. Nine Gamut procedures – handout

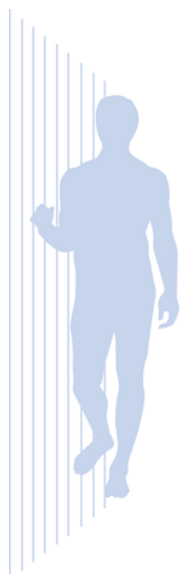
5. Collar bone breathing – handout

6. Floor to ceiling eye-roll – handout

7. Advanced procedures – toxin correction for reversals - handout

(just mention- 7 second and chakra)

8. Demonstrations – submitted in advance



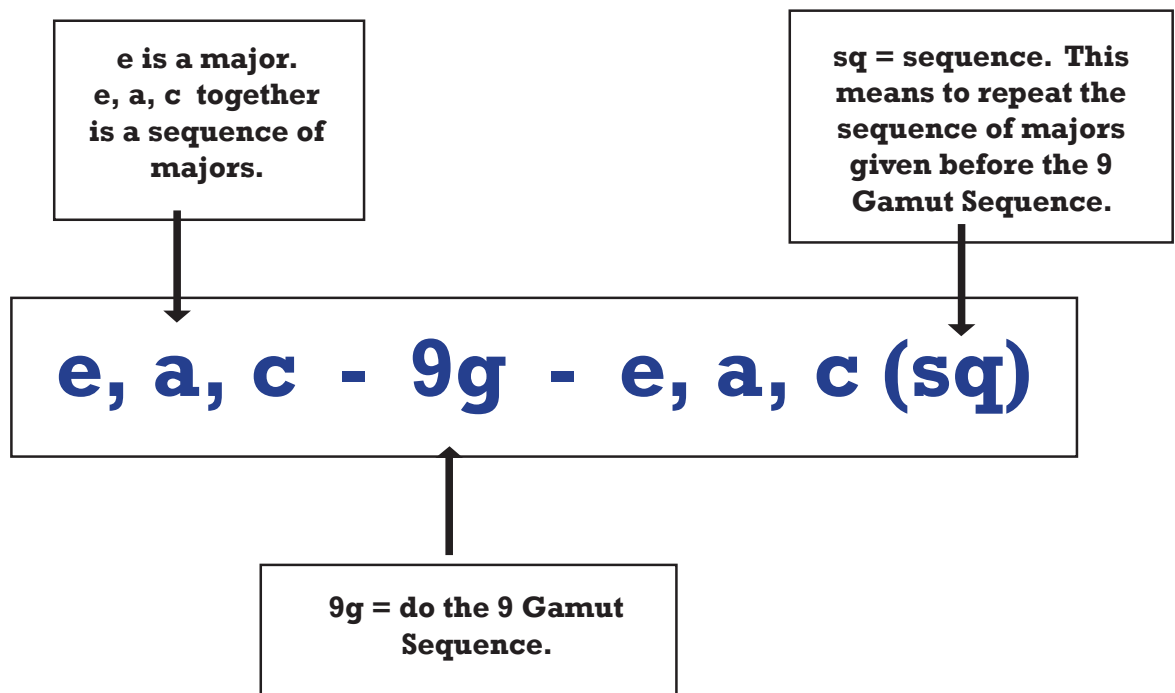
The Components of TFT Algorithms

The Architecture of TFT

Holons

Algorithms follow a standard pattern. By completing each step strictly in the order that they are prescribed, you will be performing effective TFT in the most efficient manner possible.

There is one standard protocol for all Algorithms, and it conforms to the architecture commonly present in TFT. To illustrate this, the TFT protocol for the treatment of a simple phobia is shown below:



In an abbreviated form, it can be written: e, a, c, 9g, sq.

The complete treatment sequence is known as a holon.

Each holon is a “9 gamut sandwich,” including majors (top bun), 9g (meat or vegetables), and majors (bottom bun).

The collarbone point often ends a sequence of majors, acting something like an exclamation point.

PSYCHOLOGICAL REVERSAL (PR)

A state or condition which blocks natural healing and prevents otherwise effective treatments from working. Evidence for the state of PR is revealed when an otherwise effective treatment does nothing - then after the PR is corrected the same treatment, which did nothing the moment before, suddenly works. A person may be fine in most domains of his life and be PR in just one or a selected few. The PR state is usually accompanied by negative attitudes and self-sabotaging behavior. A most interesting symptom of PR is that concepts are reversed 180 degrees; e.g., a person will say South when they mean North, but will not say East or West when they mean North. The implication of this reversal of concepts is quite profound and is in need of investigation. It seems to relate to a fundamental aspect of direction (chirality, polarized light, etc.) in elemental reality. A similar and related symptom of PR is getting numbers or letters out of order; a special proof reader's mark exists for this type of error which illustrates how common it is. The upside down and backward writing of dyslexia is due to the PR. PR in most of us is a temporary condition and when we are PR and reverse concepts, letters and numbers, PR may be viewed as a kind of temporary "dyslexia". Interestingly, a form of speed is sometimes given to hyperactive youngsters to slow them down. The paradoxical effect may be due to this reversal phenomenon. A research study (Blaich) showed that of a number of rather complicated and specialized treatments designed to improve human performance; the rapid (10 seconds) and simple treatment for PR was by far the most effective in improving performance in reading speed and comprehension. We find the presence of PR on treatment effect to be quite lawful and predictable. We have found a high correlation between presence of cancer and PR. In a highly significant study done at New York University back in the 1940's it was found that cancer patients had an overwhelming disposition to show a literal polarity reversal (as compared to normals) as measured by a sensitive instrument that measured body polarity (see Harold Saxton Burr, *Blueprint for Immortality: The electric patterns of life*; Neville Spearman, London, 1972). The concept of PR is relevant to all applied fields. PR is a vital phenomenon to successful treatment. The treatments would be significantly less successful (by 30 to 60%) if we could not correct this condition. MASSIVE PR is a reversal in most areas of life. MINI-PR is a block which kicks in during treatment and prevents the treatment from being complete. RECURRING PR is a reversal which returns as soon as it is corrected. Each of these variations of PR require their own special treatment.

**The following has been slightly modified and is taken from
Callahan and Callahan STOP THE
NIGHTMARES OF TRAUMA.**

PSYCHOLOGICAL REVERSAL (PR)

“We have met the enemy and he is us.”

Pogo (by Walt Kelly)

Revised 2006

What is Psychological Reversal (PR)? Psychological reversal (PR) is the single most important fundamental dynamic concept for health, human progress, happiness, and success that one may ever encounter. PR also blocks an otherwise powerful treatment from working. It is easy to learn how to treat for PR and to understand it. We also find that it is easy to take it for granted and to lose sight of its dynamic import for natural healing and for all kinds of various treatments. If it were not for the discovery of the PR, and how to correct the condition, in 1979, the success rate of TFT would be reduced by as much as 40 to 50%. Many people today who are quickly cured of intense psychological and other problems would be completely untreatable if we did not understand and know how to correct the important but seemingly simple phenomenon of psychological reversal.

Psychological reversal was the first discovery I made among the numerous discoveries that constitute TFT. Many people think of TFT as a unitary therapy but it consists of many quite separate parts, each one of which I proved to be effective and significant in helping people. The nine gamut treatments, for example, are nine separate treatments that I eventually combined into one since they were all treated on what has become the ubiquitous gamut point. In my first book, Five Minute Phobia Cure, these treatments were all listed separately and were not joined until later.

I knew and I know there is a terrible penalty for making radical revolutionary discoveries. I have sometimes thought, if I had quit with PR it would have been easy for conventional therapists to incorporate a simple procedure that would increase their success rate and I would have avoided a lot of the pain and difficulty I had to go through. For example, Dr Gary Emery, a prominent clinical psychologist who co-authored a book on Cognitive-Behavioral Therapy with Professor Aaron Beck, quickly saw and publicly proclaimed the value of my discovery of PR, calling it “one of the most important discoveries in clinical psychology.”

However, I would have missed the fun of it all and the fun and pleasure of discovery far out weighs the pain! I was reminded of this recently when I read the recent issue of the very interesting cancer newsletter (news@cancerdecisions.com) by Ralph Moss, PhD. One of Dr Moss’s mentors was the brilliant Albert Szent-Gyorgyi who was quoted as saying “It is fine to be one step ahead of everyone else – just don’t be two steps ahead.” Of course, he did not follow his own advice.

I first discovered PR as a real phenomenon before I found a way to treat it. Not until a number of months later, after intensive searching and clinical research, did I discover a therapy for correcting PR; as you may

see, in my original article on PR I found several ways to correct it. Prior to the discovery of the treatment for PR, it was clear that PR was an undesirable state; it was also clear that it was associated with chronic problems and that it carried with it a disposition toward destructive and self-destructive behavior.

Psychological reversal is a state of being which is caused by a simple polarity reversal within a system . All of us at times can be and are in this state. When we are in a bad, destructive mood, this is almost always a sign that the PR state predominates.

When a new discovery is made it is a formidable problem to select a name for it that will likely endure into the unknown future as further discoveries are made. The name “psychological reversal” was first chosen because the state appeared to reverse the usual motivational state of the person. PR appeared to turn the person against self-interest and toward self-defeat. I first viewed PR as a reward-punishment system that resulted in stress if the person wished to do good and no stress if harm or a self-destructive path was followed. This would be an obvious perversion within a system.

The term PR was first viewed as a metaphor. Years later it was exciting to find and discover that the term is much more than just a metaphor and actually refers to a concrete literal reversal of polarity. This was shown through the use of batteries and the hand on the head test – back vs palm. During the state of PR there is a literal reversal of polarity involved (see the work of Professor Harold Saxton Burr of Yale) who measured literal polarity in living things with a special voltmeter (Burr, H.S., 1972 *Blueprint for immortality: the electric patterns of life*, London, Neville Spearman. He points out that every cell is polarized and that the sperm polarizes the egg.

Once one grasps the fact of a literal reversal, I am sometimes asked, “Since the PR is literally a polarity block in a particular system, why do you still use the term psychological, why not just reversal?” This is a sophisticated question but the psychological part is an intrinsic factor when we wish to diagnose and or treat the PR. Having the person think of the problem is absolutely crucial in both diagnosis and in treatment. Tuning the problem is, of course, a psychological process and is an essential element in both the diagnosis (see *Causal Diagnosis*) and the treatment of the condition.

Types of PR

Specific PR is the most common form and is limited to a specific area or areas of a person’s life. For instance, a person who has a mental block to learning computers might be reversed only in the area of computers. This condition will make him appear inadequate in this one domain while in other pursuits he may be quite accomplished.

Massive PR is a reversal that affects most of a person’s entire life, rather than just one specific area. A person who is massively reversed needs to be treated for this condition in order for any treatment to work. Such people are often in a chronic bad mood and exhibit a negative attitude towards life. [I have found that not all systems are reversed even in what I call a massive pr, just most or many.]

Mini PR occurs when a treatment is partially, but not completely successful. For example, in doing the trauma treatment, the person’s level of upset goes from a SUD of 9 to a 4, but does not go any lower (without PR treatment). Several years after discovering how to correct for PR, I identified this partial PR.

Recurring PR is a psychological reversal that tends to return as soon as it is corrected. We have found that this is most often due to toxins (see “Cure and Time” chapter).

Behavioral Signs Which Reveal That PR is Present Here are some common signs in everyday life that a PR is present: Client shows no improvement after a usually effective treatment is administered. PR is corrected and then dramatic improvement takes place after a repeat of the very same treatment that a moment prior to the PR correction did absolutely nothing. This is a highly robust predictable observation and will be

easily observable if you refrain from correcting PR routinely prior to treatment.

Person reverses the correct order of letters or numbers. This effect is so commonplace that proofreaders have a special sign to indicate it. Whenever I find this or any other signs of PR in myself, I immediately correct my pr.

Person reverses directional concepts when in the PR state. For example, he will say “up” when meaning “down” or “right” when meaning “up” or “left;” “North” when “South” is intended. Interestingly, they will not say “West” or “East” when they mean “North” but only the opposite, “South.” Actions can be reversed also when in the PR state; e.g., person puts a cooked turkey in the oven instead of refrigerator that was intended or vice-versa. I find these reversals, correlated as they are to what I call PR, to be most interesting from a theoretical standpoint.

Some Examples of Quotations Which Feature Some Aspect of What I Call PR The phenomenon of psychological reversal can be readily inferred as expressed in the following quotes:

“Did you ever feel that life is an obstacle course and you are the biggest obstacle?”

Jack Paar, Original Tonight Show host

*“It’s a pleasure to be here on the Larry **Queen** show. ”*

Jerry Spence, Notable defense attorney, Guest host on the Larry King show

For the good that I would I do not: but the evil which I would not, that I do...s

I find then a law, that, when I would do good, evil is present with me.

For I delight in the law of God after the inward man:

But I see another law in my members, warring against the law of my mind,
and bringing me into captivity to the law of sin which is in my members.

Saint Paul, Romans 7:18; 20; 22; 23

An Incident of a Child’s PR A beautiful young 4-year-old girl whom we shall call Judy had spent a long day with her parents riding on a boat, mixing and playing with a number of older relatives. Unexplainably, she suddenly began crying intensely kicking and screaming. Surprisingly, nothing seemed to be able to relieve Judy’s apparent agony, not to mention the agony of everyone in her presence.

Her mother reported that Judy had been screaming and carrying on for almost a straight hour, for no known reason. Mother looked over at me and asked, “Is there anything I can do?” I suggested that she do the simple PR treatment. With nothing to lose, her mother gently tapped the side of her hand.treatment and Judy suddenly became transformed. She abruptly stopped crying and began observing her surroundings and interacting with the dozen or so people present in the large summer cottage living room.

PR as a Block to Healing The following is typical of the kinds of stories we hear all the time. I received a letter from Dr. John T. Hughes of Ashland Kentucky, a chiropractor and member of the International College of Applied Kinesiology. Dr. Hughes stated that in the 1980s, he was teaching a class of doctors and wanted to show them the phenomenon of PR that he learned from an article I had written (Callahan, 1981b). He used the TFT diagnostic procedure for PR with a volunteer, a wife of one of the doctors.

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The diagnostic test for massive reversal showed that she had no reversal (see Callahan Techniques® Causal Diagnosis Home Study Course). Her husband, who had heard of my notion of pr, asked Dr. Hughes to ask her specifically about her jaw. Dr Hughes then checked for specific reversal on her jaw by having her say: “I want my jaw to be healthy.” She then showed that she had a specific reversal that was mainly responsible for preventing an infection, as described below, from healing.

She had had a root canal performed on one of her teeth and developed a hole in her lower right jaw. This had continued to produce an exudate of pus for about a year and a half. She consulted another dentist but the condition continued for they did not know why she didn’t heal. Dr. Hughes then used my simple procedure for correcting reversal.

The treatment for PR occurred on a weekend and Dr. Hughes saw the doctor and his wife the following Thursday at a meeting. The doctor said, *“I want to tell you what happened to my wife after you corrected her . That very evening the hole in her jaw really started to run and produce more exudate than ever before. Then it just stopped. They had the dentist examine the area and he said all the tissue appeared clear and healthy.”*

Dr. Hughes saw the couple a few months later and she said, “Do you want to see my scar?” The jaw was totally healed. This story fits many experiences of many doctors. A PR can prevent normal healing and the simple correction can often bring about dramatic changes.

A Recent Experience I(RC) was flying home from the East Coast and I fell asleep with my right arm in a peculiar position. I awakened and the fingers in my right hand were all cramped. Rubbing the hand and arm and waiting for a time did nothing for this recalcitrant cramp. I tapped the PR point on the side of the hand, and immediately the fingers all relaxed and went to normal.

Fractures It is well known among those who work in the field of orthopedics that a person may break a leg and have it set, but in a small number of cases the fracture will not heal. This is quite serious for the unhealed leg may need to be surgically removed. Interestingly, experienced orthopedic surgeons will sometimes put a battery or a magnet on the site of the fracture and in some cases; this will result in healing. When this works it would seem that the battery or magnet does something that corrects the literal polarity reversal in the healing system associated with the fractured leg (see Robert O. Becker; and Basset, Pawluk, and Pila; and also Nordenstrom).

My theory is that a psychological reversal is responsible for the lack of healing just as in the case of the jaw, and of course this is an easily testable notion. The PR treatment takes but seconds as you will see, and it would be easy to check out the theory on this. If the leg still does not begin healing immediately then we suggest that a diagnostically trained TFT therapist be brought in to investigate why the PR was not correctable, which is a rare event but has a known cause for one properly trained in TFT. Often, in such cases, a knowledgeable TFT therapist can find the precise reason for the difficulty and once found the PR is usually corrected.

Incident A young man recovering from a severe case of paranoia for which he had been hospitalized is a member of a therapy group. His example is instructive because whenever he was psychologically reversed, it was obvious to all present from the expression on his face—this is not true of most people. When it is obvious, it is like neon sign reading—“I am psychologically reversed!” Members of the group would immediately urge him to correct his pr. The moment he did this, his face changed dramatically.

Evidence For PR In addition to the observations noted above, there are a number of different types of evidence supporting the concept of psychological reversal.

Dr. Robert Blaich is a leading Applied Kinesiologist (AK) practitioner. Applied Kinesiology is a method of diagnosis for chiropractic problems, which involves testing various muscles. AK was discovered and developed by Dr. George Goodheart, a genius chiropractor from Detroit. Dr. Blaich and his colleague, Dr. David Walther, jointly taught the 100 hour course in AK that I attended. I had discovered PR prior to taking the course. Drs Blaich and Walther were the first health care professionals to see the value of my discovery of psychological reversal.

In his superb presentation of Applied Kinesiology, Walther (1988) states:

“Most practicing physicians can recognize psychologically reversed individuals in their practices. These are often the individuals who respond poorly to treatment: when there is some improvement in a condition, they will dwell on the negative aspects. Even when the improvement is pointed out, they will immediately change the subject back to the negative aspects.”

Dr. Blaich, also an outstanding chiropractor, specializes in high level human performances and works with a number of elite world class athletes. He told me he found the PR correction to be invaluable in helping these athletes to break their own and other records.

Dr. Blaich (1988) did a most interesting research project wherein he attempted to improve the reading speed and comprehension of a group of professionals. The study used various treatment methods that might aid people, who were already high achievers, to improve their performances even more. He measured and demonstrated performance by using reading and comprehension skills. He found that the treatment for PR (which was by far, the most rapid and simple of the various treatments used) was the most effective of all the therapy methods used. Some required very high professional skills in order to carry the complex procedure.

He states:

“Reading #4, which provided a 45% improvement over reading #3 and a 119% improvement over reading #1, followed the treatment for Psychological Reversal and exhibited the greatest single change in reading rate of any of the steps done. Dr. Callahan’s procedure seems to have a very significant impact on human performance as evaluated here” (p12, my emphasis).

[The PR treatment as now used , takes less than five seconds; and although other treatments were used, the PR treatment was the only TFT treatment used in this study.

PR and Cancer Soon after I discovered psychological reversal I observed something interesting. My clients came to me because they had various psychological problems. During the period of 1981-83, I saw 8 clients who also happened to have cancer. I noticed that each of these clients showed massive PR. I thought this was an interesting finding but did not make much of it since the number of individuals was so small.

Around this time I gave a training on my procedures to some interested psychologists. One of these psychologists, Dr. Lee Shulman, specialized in working with cancer patients. When I reported my finding about cancer and psychological reversal he decided to check out my finding with his larger group of cancer clients. He was seeing more than 35 cancer patients at the time. Upon checking them for PR he reported that every

one of these clients also showed the presence of pr. Over a longer period of time, Dr. Shulman reported that he continued to find this relationship between cancer and PR.

What does this mean? I am no expert in cancer and I know that there are numerous people who show PR who do not have cancer. Nevertheless, this seemed a rather curious finding. No other diagnostic category stood out so emphatically as far as the presence of psychological reversal is concerned.

A few cancer clients appeared to surprisingly recover from their cancer but there was no way to know if any part of their recovery was helped by our treatments or not. It would make some sense if the treatments, including the treatments for PR, did help eliminate their cancer but there is insufficient evidence at this time.

Professor Harold Saxton Burr A few years ago, I was able to track down a book I had been searching for by Harold Saxton Burr. Professor Burr was a biologist at Yale University in the 1940's and did some very interesting work with a sensitive voltmeter. He demonstrated that all living things, even leaves, showed that they possessed a polarity on this meter (Burr).

In the Appendix of Burr's book, is a most interesting report of the findings of Louis Langman, MD, who had been a student of Dr. Burr. Dr. Louis Langman was a professor of gynecology at New York University and carried out a most remarkable study. He hypothesized that cancer is fundamentally an alteration of field forces in the body. To check this idea he examined cellular diagnosed cases of cancer under blind conditions; that is, the pathologist and Dr. Langman did not know who was who. He compared these cases (in measurements of body polarity by Burr's method, i.e., with a voltmeter) to normal individuals. [The measurement of polarity was done with a sensitive voltmeter placing the electrodes on different parts of the body.]

The startling results were (briefly) as follows: Those with no malignant condition

Positive polarity	74
Negative polarity	4

95% of the normal group showed the measured polarity to be positive.

Those with malignancy

Positive polarity	5
Negative polarity	118

96% of this group showed polarity to be negative.

The cancer group has a striking preponderance of women showing a reversal of normal polarity. This appears to correlate dramatically with what I found and was later found by Dr. Shulman with what I call psychological reversal which is a reversal of polarity measured with a muscle test.

Dr. Langman then studied an additional 737 patients who had a benign gynecological condition. He found that in this group 611 showed a positive polarity and 126 were negative; i.e., 83% positive and 17% negative.

A further strong confirmation of Langman's relationship between polarity and cancer received very strong support from the fact that when cancerous tumors were surgically removed the polarity changed from negative to positive (Langman, in Burr 1972, p144)

Statistical tests of significance are obviously not needed with differences as great as these.

Which comes first, cancer or PR? Langman believes cancer is caused by an alteration of field forces in the body. If future evidence supports this then it seems that PR, or the polarity reversal is primary in some important respect. We typically find that most chronic conditions, physical or psychological, have a PR associated with them. We know that most people who have a PR, we all do at times, do not have cancer but nevertheless the findings are strongly suggestive. More than this cannot be said with great confidence at this time. If any published researcher with access to cancer patients would like to investigate this I would be happy to contribute my understandings and experience to the research.

Since we find that psychological problems cannot be successfully treated when there is a PR, (the perturbations, p's simply will not show) perhaps something similar exists with at least some cases of cancer. If there is a PR then healing may be unable to take place. This may make the cancer more strongly established in the system insulated from the ordinary healing system.

Control System and Direction Burr (1972, p58) points out that "In the growth and development of every living system there is obviously some kind of control of the processes." He elaborates that control requires direction and points out that one of the few things in the universe, which possesses direction, is the electrical property of things. He elaborates that even atypical growth (e.g., cancer) requires direction.

Burr (1972, p 58) elaborates that life requires energy but energy has no direction. What I call the PR and what Burr called the reversals of polarity appear to make sense from the standpoint of control forces operating within life.

Sleep, Anesthesia, and PR Robert O. Becker reports a very interesting finding and that is living creatures show a polarity reversal when they sleep and also when they are under anesthesia. I know from long experience with PR that a condition cannot heal if there is a PR present. Sleep and anesthesia represent two different degrees of lack of general awareness. It has been shown that some people show evidence of awareness even under anesthesia; this has been known for many years and has prompted those in the operating room to be careful of what they say in the presence of an anesthetized patient.

On this basis, I would predict that patients in a coma would also show a general PR but this has not been tested as far as I know.

It is interesting that the PR is an electrical, and, more precisely, a polarity phenomenon. Many systems in the body take advantage of polarities in order to operate effectively. If the proper polarity is incorrect then there is a blockage of flow (just like two north poles on a magnet repel each other, instead of attraction there

is repulsion. When such is the case in a healing system then we run into potentially serious problems. But remember many of the serious problems are quite correctable with the simple correction of the PR that will then allow healing to properly begin.

The anesthesiologist, Stuart Hameroff, of Arizona State University, who along with the mathematical physicist Roger Penrose are major contributors to theories of understanding consciousness. Hameroff has pointed out the interesting fact that the gases used in anesthesia's are not from a common chemical category but rather seem similar in their electric effects on the system.

I find it especially relevant in this context that recent discoveries of the process of inebriation show that it is not the chemical effect of alcohol which results in drunkenness –the chemical effect is relevant, however, in understanding cell damage – but rather it is the electric effect of alcohol on the brain cells which causes drunkenness.

Alcohol's Electric Effects No one has understood how intoxication takes place. It is known that ethanol does not appear to affect brain cells until the concentration is deadly and begins to destroy cells. It has been found that the body begins breaking ethanol down into fatty acid ethyl esters, these changes, it is reported, results in changes in calcium which in turn affects the electric activity of the cells.

This landmark finding is reported in a Science News article which states that “In the Dec 20, 1996, J of Biological Chemistry, Richard Gross and Rose A. Gubatosi-Klug, of Washington University, School of Medicine, Gross says: Our report is the first to show ... these profound changes in the electrical functions of a [brain cell] at concentrations of alcohol which are present after people drink,”

For many years I have observed that it is difficult or impossible to treat someone who is inebriated. In the light of these recent reports, it seems that not only is such a person not in very high state of awareness, but it now seems that the electric effects of alcohol may render them somewhat “asleep” and the PR may be mainly responsible for the lack of responsiveness to treatments.

Taking a cue from this, I (RJC) have speculated that any system in a state of psychological reversal may be considered non-functional or even “dead.” When I told this view to Joanne, my wife and co-author, she said, “No, it is more like the system is in a coma.” I believe that this is a more precise expression of the condition.

The important news about the PR correction is that it will revive the system to proper functioning so that healing may begin.

Dr Werner Loewenstein, Director of the Laboratory of Cell Communication at the Marine Biological laboratory, Woods Hole, Mass has recently published some very important findings on the communication of cells. [The maintenance of life requires enormous constant communication within the living body.] All of Loewenstein's work is interesting and I recommend this work highly to scholars in this area, but one of his findings appears to cohere with my discovery of the effects of PR, which I found years ago.

Loewenstein says (p, 194-195):

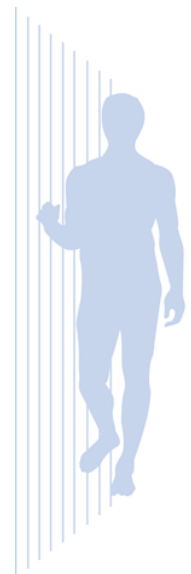
“Let us check briefly on the performance of [these units of information reception and transmission] to see how well they measure up to that promise. First, their directionality. To get a message through a communication channel, the information flowing through it must have a direction (see Burr above). In

of our technology, the direction is given by irreversible (one way) transmission stations. This is also true for the intercellular channels, though there may be an occasional reversible demon too along the line. But it's the irreversible ones who bring home the bacon – they are the ones who get the message through” (my emphasis).

[James Clerk Maxwell proposed the demon as an entity, which (in imagination) might overturn the most sanctified law of modern science, The Second Law of Thermodynamics. The demon was proposed as a device to help Maxwell understand the Second Law (Von Baeyer author of Maxwell's Demon). Maxwell, in the 1860's) is the famous scientist who created the theory of electromagnetism and Maxwell's equations, among other things.

I am suggest that PR may well be another meaningful name for a significant collection of “reversible demons.” When the PR is corrected , with my simple treatment, we then are in a position to witness the reversal being corrected and *“the bacon being brought home.”* Or, in other words, the healing system can now deliver the information required to heal a particular system.

Please do not allow the simplicity and ease of the PR correction mislead you to underrate its relevance and importance in all kinds of healing. Correcting PR can add to the success of any treatment that is generally successful.



Psychological Reversal Corrections

At any level, once PR has been corrected, begin the algorithm again from the beginning (See the Thought Field Therapy® Protocol in Section 4.4 for guidance).

Correction for Specific PR

Indication: Little or no change in SUD after the majors

Tap the Specific PR spot on the side of the hand (karate chop) about 15 times while focusing on the problem.

Repeat the majors. Check SUD. If SUD has not dropped 2 or more points, go to Recurring PR.

Correction for Recurring PR

Indication: Little or no change in SUD following repeat of the majors after correcting for Specific PR

Rub the sore spot on the left side of the chest while focusing on the problem.

Repeat the majors. Check SUD. If SUD has not dropped 2 or more points, go to Recurring PR.

Correction for Massive Reversal

Indication: *Little or no change in SUD following repeat of the majors after correcting for Specific PR and Recurring PR*

Rub the sore spot on the left side of the chest while focusing on problems and limitations in general.
(This is also a treatment for a person who is chronically negative or self-sabotaging.)
Repeat the majors. Check SUD. If SUD has not dropped 2 or more points, go to Level 2 PR (PR2).

Correction for Level 2 Psychological Reversal (PR2)

Indication: Little or no change in SUD following repeat of the majors after correcting for all previous forms of PR

Tap the treatment point under the nose (un) 15 times while focusing on the problem.
Repeat the majors. Check SUD.

Mini-PR

Correct for Mini-PR when the SUD has dropped by two points and is still not 2 or below. Then, repeat the entire treatment (majors, 9 gamut, majors).

Correction for Mini-Specific PR

Indication: SUD is still above 2

Tap the Specific PR spot on the side of the hand about 15 times while focusing on what remains of the problem.
Repeat the entire treatment (majors, 9 gamut, majors).

Check SUD. If still not 2 or less, go to Mini-Recurring PR.

Correction for Mini-Recurring PR

Indication: SUD is still above 2 after tapping for Mini-Specific PR and repeating the entire treatment (majors, 9g, majors)

Rub the sore spot while focusing on what remains of the problem.
Repeat the entire treatment (majors, 9 gamut, majors).
Check SUD. If still not 2 or less, go to Mini- PR2.

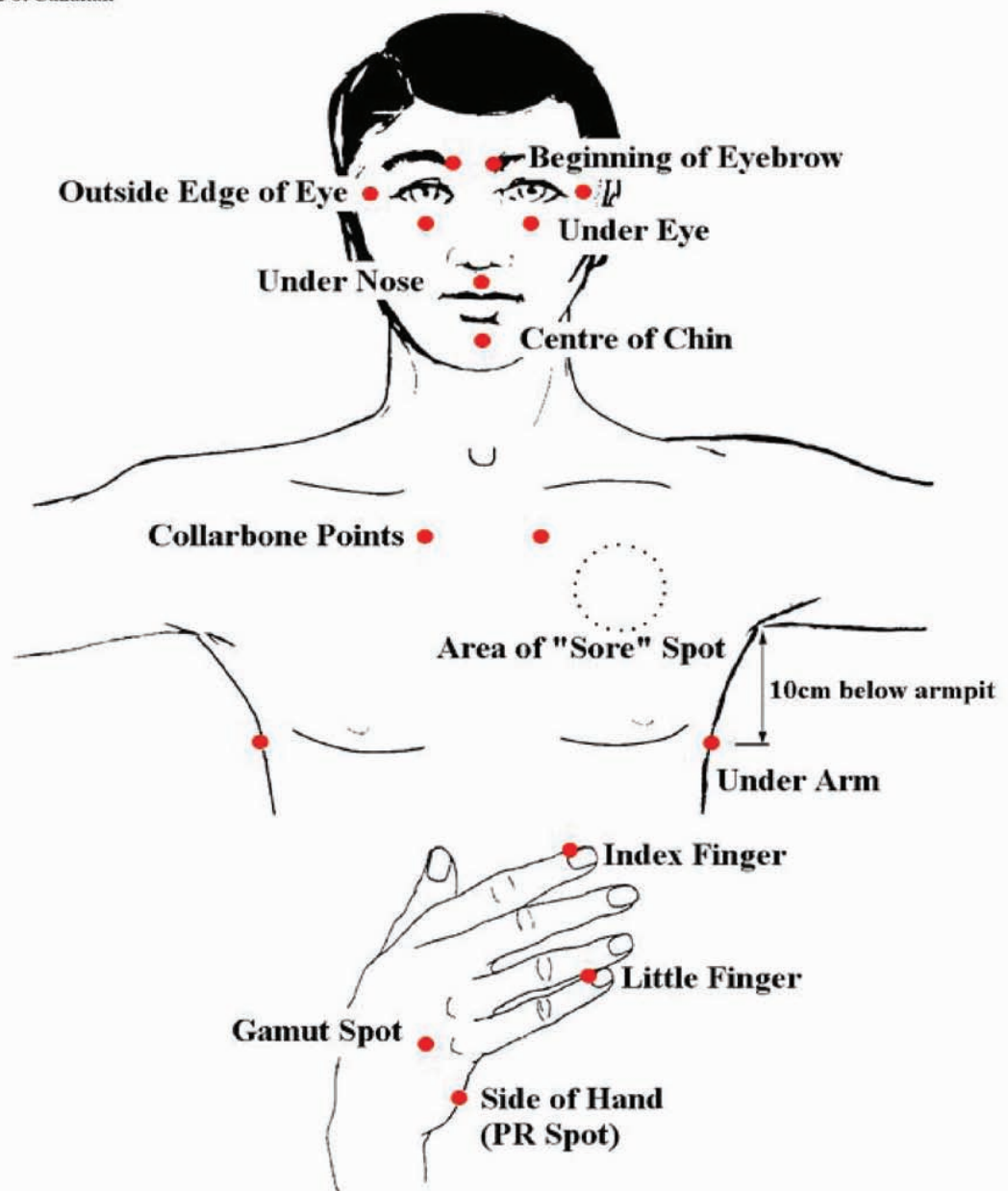
Correction for Mini-PR2

***Indication:** SUD still above 2 after the previous mini-PR treatments have been administered, including repeating the entire treatment (majors, 9 gamut, majors) after each treatment*

Tap the treatment point under the nose (un) 15 times while focusing on ***what remains of the problem.***
Repeat the entire treatment (majors, 9 gamut, majors).
Check SUD.

THE CALLAHAN TECHNIQUES®

Treatment Points
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The Nine Gamut Sequence (9g)

While continuously tapping the Gamut Spot (allowing about 5 taps for each step), do the following:

- 1. Close the eyes**
- 2. Open the eyes**
- 3. Move the eyes down and to one side**
- 4. Move the eyes down and to the other side**
- 5. Roll the eyes in a circle in one direction**
- 6. Roll the eyes in a circle in the opposite direction**
- 7. Hum a tune (about five notes) out loud, with mouth closed**
- 8. Count out loud from one to five**
- 9. Hum a tune again aloud, with mouth closed**

NOTE:

- Steps 1 to 6 of the Nine Gamut Sequence can be performed in any order (i.e., eyes down left first or eyes down right first; eyes in a circle to the left first or eyes in a circle to the right first).

Collarbone Breathing Treatment (CB2)

Collarbone breathing (CB2) is a treatment developed by Roger Callahan that will often allow a very resistant problem to respond to TFT treatments.

David Walther (1988) had developed a treatment that he called “Cross-K27.” Dr. Walther used it for what he called “neurological disorganization,” and it proved to be useful in the treatment of schizophrenics and dyslexics.

Walther’s (1988) treatment used cranial manipulation, which required special training. If not done correctly, cranial manipulation can cause harm. Dr. Callahan said the following about his discovery of the Collarbone Breathing treatment:

I discovered that rather than doing cranial manipulation, tapping the ubiquitous gamut spot would give the same result. It was a very thrilling discovery, for it meant that people were now able to do this important correction easily. I hence re named the treatment in a descriptive way, and now, we all do Collarbone Breathing. It never could have been the common and very helpful treatment it is now, were it not for my discovery of the simple way to apply it. I never would have been able to make this discovery, were it not for Walther’s prior discovery, with which I am still impressed.

When doing Collarbone Breathing in the context of a TFT treatment for a particular problem, the client must be tuned into the thought field of the issue being addressed.

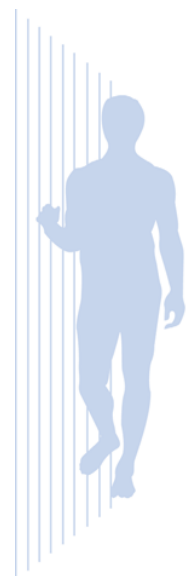
Dr. Callahan recommends that people working on addictions do CB2 at least three times a day, in addition to correcting their PR 15-20 times a day (side of hand, sore spot, and under nose). He also finds that clients with Anxiety and Panic Disorders and Obsessive/Compulsive Disorders (OCD) need to do Collarbone Breathing three times a day and correct their PR 15-20 times a day (side of hand, sore spot, and under nose) on a regular basis.

CB2 is also often useful in the treatment of Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), Learning Disabilities (LD), Dyslexia, Stuttering, Tourette’s Syndrome, and Schizophrenia.

In the Collarbone Breathing treatment below, when the knuckles touch the body, only they should touch the body. They are a negative polarity, and the palm of the hand, the thumb, and the elbow are a positive polarity. If anything other than the knuckles were to touch the body during this phase of the treatment, the treatment would not work. When a negative or neutral polarity touches the body at the same time as a positive polarity, it will short circuit the treatment.

Indications that Collarbone Breathing may be needed:

- TFT and / or PR Corrections won't work or won't hold.
- SUD is going down very slowly, i.e. 8, 7, 6, 5, 4, etc.
- Co-ordination is off, and the person is awkward.
- Person has unbalanced gait—arms don't swing evenly and smoothly when person walks (4% of people walk with one arm curtailed, and 2% of people walk with both arms curtailed).
- Person chronically reverses actions, concepts, and thoughts.
- Person is declining in performance and / or competence.
- Timing is off, and person is confused.
- Reading makes person yawn / feel sleepy.
- Person is hyperactive.



THE COLLARBONE BREATHING EXERCISE

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What I call the “collarbone points” are located in the following way:

Go to the base of the throat, about where a man might knot his tie. From that point, feel for the notch in the center of the collarbone. Go straight down about one inch, and the collarbone points are about one inch to the right and left of center (see treatment point diagram).

BREATHING POSITIONS

There are five breathing positions in this exercise:

1. Take a deep breath in fully and hold it.
2. Let half of that breath out and hold it.
3. Let it all out and hold it.
4. Take a half breath in and hold it.
5. Breathe normally.

THE TOUCHING POSITIONS

1. Take two fingertips and touch one of the collarbone points and tap the gamut spot on the back of that hand while going through the 5 breathing positions. Tap rapidly with about 5 good taps for each of the five breathing positions.
2. Move the same two fingertips to the other collarbone point and repeat above.
3. Now, bend the same two fingers in half and touch the knuckles to the collarbone point while tapping and going through the five breathing positions. Either tuck the thumb in or keep it in the air. Make sure that the elbows are in the air when you are touching the knuckles to the body so that only the knuckles are touching the body. The back of the hand is a negative polarity, so the treatment would not work if the thumb or elbow (positive polarities) were to touch the body.
4. Move knuckles to the other collarbone point and tap while going through the five breathing positions. Make sure that only the knuckles are touching the body.
5. Now, take fingertips of OTHER hand and repeat steps 1 and 2 above.
6. Now, take knuckles of that hand and repeat steps 3 and 4 above, making sure that only the knuckles are touching the body.

You have just done the 40 breathing and tapping exercises—20 with the fingertips, and 20 with the knuckles. You have done five breathing positions on eight touching positions. Please learn to do these well so that you are able to do them automatically.

Environmental Toxins

The following is a new treatment developed in early 1999 by Dr. Roger Callahan through Voice Technology. It has been confirmed by feedback from other VT-trained practitioners.

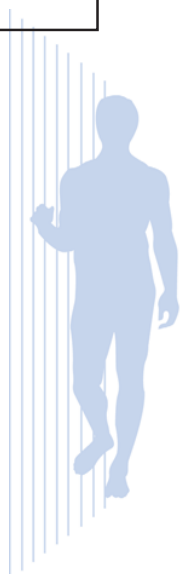
An environmental toxin is any toxin in the immediate environment, such as the person's clothing, hair spray, perfume, smoke, or any other airborne substance, that enters the body via the lungs. Dr. Callahan found that such toxins could completely prevent a treatment from working or holding, even in the short term. For an inhalant toxin, in the past, the clients would have to remove their clothing and put on a gown washed in a substance that was not toxic to them. They could also wear a surgical mask to prevent them from inhaling the toxic fumes. Another option was to have them shower and wash their hair before treating them with TFT.

Fortunately, the correction described below will work about 80% of the time, making removal of the offending clothing, showering, or other intervention unnecessary.

Dr. Callahan has recently determined that this correction will often work for an ingested toxin, as well. This treatment can be applied after the reversal treatment for PR2 (under the nose) and before Collarbone Breathing (CB2).

Environmental Toxin Correction

Tap the Index Finger 15 times.
Tap the Specific PR spot (side of hand) 15 times.
Then, repeat the treatment that hadn't previously worked.

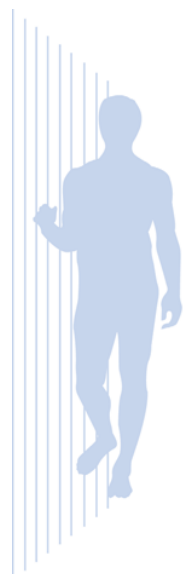


The Floor to Ceiling Eye Roll (Rapid Relaxation)

The floor to ceiling eye roll should be used at the end of all of the Algorithm treatments when the SUD is a 2 or lower. It will usually bring a SUD of 2 to a 1 (on a 10-point scale) or 0 (on an 11-point scale). If not, go back to where you were in the Protocol and do the next step.

- While tapping the Gamut Spot continuously, hold the head relatively level, starting with the eyes looking all the way down.
- Taking about 10 seconds while continuing to tap the Gamut Spot, *slowly* move the eyes in a vertical line from their downward position to as far up as they can go.

This treatment can also be done by itself for the purposes of stress reduction or rapid relaxation.



Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 4: Application – Trauma

1. Dr. Callahan's view of trauma and trauma treatments – handout/s

Kosovo letter

Definition and description

2 Case studies - handouts / discussion

Tapping Away the World's Traumas – elder Rwandan / child with fear of dark

Love pain / grief – Conrad Bain's video testimonial

Ildiko's testimonial video of child in car accident – www.YouTube.com/ThoughtFieldTherapy

Ugandan priests

War / IED's

Nairobi Embassy bombing

3. Key to Abbreviations

4. Trauma – algo handout

5. Complex trauma – algo handout

6. Anger – algo handout

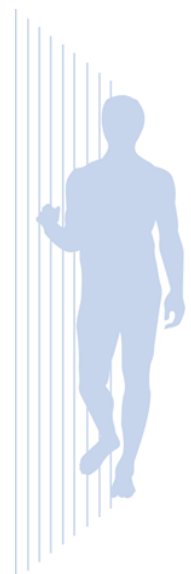
7. Guilt – algo handout

8. Different Kinds of Trauma - handout

9. Q & A's – submitted in advance

10. Demonstrations – submitted in advance

11. Join our TFT Trauma Relief Blog - handout





TRUPAT E MBROJTJES SË KOSOVËS
SHTABI I PËRGJITHSHËM
BATALIONI 40 I MJEKËSISË



Prishtinë me 01/11/2001
Nr. Prot. 03/2269

DR. ROGER CALLAMAN
CALIFORNIA
UNITED STATES OF AMERICA

Dear Dr. Callahan,

Many well-funded relief organizations have treated the post traumatic stress here in Kosova. Some of our people had limited improvement but Kosova had no major change or real hope until volunteer American Professor Carl Johnson came to help us with the method that you discovered, Thought Field Therapy.

We referred our most difficult trauma patients to the Professor. The success from TFT was 100% for every patient and they are still smiling until this day.

The Professor has been training our medical personnel in your amazing methods of psychotherapy and we are also having success now. Dr. Callahan, Kosova loves Thought Field Therapy.

As Chief of Staff of the Medical Battalion of K.P.C I have full, authority over all medical decisions in Kosova. I am revising this completely and starting a new national program.

The emphasis of the national program will be Thought Field Therapy.

Dr. Shkelzen Sylja

Chief of Staff



Trauma From a TFT Perspective

I, Dr. Callahan, believe that most of the treatments used to help trauma victims today, that entail suffering and reliving the emotional experience, are harmful and trauma inducing in their own right. It makes no difference that numerous so-called experts acclaim these outmoded procedures – they fail the scientific test; they are experiments that not only do not work but cause harm. Generations of suffering people have been wrongly taught that suffering is necessary and they must endure a process of suffering.

Those who do not wish to endure emotional suffering now have a choice. My belief is, that it is desirable to reduce or eliminate suffering as much as possible. Some professionals have criticized my work because they believe it is important for people to suffer. I do not agree.

When anesthesia was first discovered there was uproar among some factions (men) who objected to women not having pain in child birth. They cited the bible as an authority but of course the bible pre-dated the discovery of anesthesia. When I taught at Eastern Michigan University, a colleague, Professor David Palmer (Speech and Hearing) told me that when an operation first became available for cleft palate there were objections from some sources. Palmer jokingly paraphrased a part of the marriage vow: “What God has put asunder, let no man put together!”

In this class you will learn how to repeat some of the experiments based upon my discoveries relating to psychological trauma. Many professionals and volunteers have already successfully helped trauma victims many thousands of times all over the world, from Kosovo to Rwanda and here in New Orleans, after hurricane Katrina. You will learn to apply these simple yet very powerful self-help procedures for yourself and your family.

You will also learn how to eliminate the nightmares associated with past traumatic events and also the painful psychological after-effects of terrible and upsetting experiences.

Trauma refers to having a terrible experience. A phobia is an unwarranted fear. Trauma is different from a phobia. The upset in trauma is a normal upset in response to a terrible situation. A phobic person can have a traumatic experience due to his particular and unique, however unwarranted, fear. Most others do not share this unrealistic fear and hence would not be traumatized by the same fear event. However, everyone will be quite upset by a trauma

Traumas are commonly due to loss or negative event, e.g., losing a loved one, rape, mugging, robbery, accidents, war, industrial accidents, abuse, losing your job, school bombings, acts of terrorism, death of a loved one, getting a severe illness, and other negative events. Even witnessing or hearing about such events can have traumatic consequences, especially if the trauma happens to someone you know and care about.

Post-traumatic stress refers to stress that is delayed, perhaps for years. However, there is no difference in the way we view or treat trauma based on the time factor. Trauma is treated in the same way in TFT whether or not it is a problem right after the event or whether time passes prior to the upset. I once treated a concentration camp victim a half a century after the experience. However, his stress had been constant and not delayed.

Most psychological problems such as phobias are bewildering to people who have them. The central characteristic of a phobia is that it is an unrealistic fear. The person knows it is an absurd fear but neverthe-

less cannot help being afraid. If anything, this knowledge merely adds humiliation to the fear. Obsessions, addictions, distortions of reality, are all types of problems considered abnormal.

It makes more sense that an abnormal fear, say of bugs, should be curable rather than the severe upset over a terrible situation. Trauma is a unique class of problems, for it consists of a perfectly normal, appropriate emotionally disturbed reaction to an objectively terrible situation or event. There are people who overreact to trauma but this is an overreaction to a normally upsetting situation.

I find it especially interesting and intriguing that it is possible to banish all traces of emotional upset over a very real objective trauma. Until I made this discovery I thought that only time would partially heal traumas; sometimes taking many years of prolonged suffering.

Recently I treated a woman whose boyfriend committed suicide. She was naturally very upset, unable to function very well and was constantly in severe psychological pain. Immediately after the treatment she felt strong in the face of this tragedy and was again able to function and carry out her job. The simple recipe provided in your handout eliminated all traces of this poor woman's suffering.

The ease and power of this simple treatment suggests that we have a healing power within us which only awaits a simple correct procedure in order for the healing data to kick in and take us into a higher state of health or consciousness

Psychologists Carl Rogers and Abraham Maslow suggested many years ago that we all have this power within us and TFT supports their views by making this power clearly evident to any interested observer. If Rogers and Maslow were alive I am confident they would be shocked and pleased to see this power released with such ease and regularity through Thought Field Therapy® (TFT).

I interpret my therapy results, which you will be able to reproduce, as evidence that Nature gives us a license to be relatively free of intense emotional upset from very real, objectively horrible events; otherwise it would not be so easy.

Removing The Emotional Effects Of Trauma Does Not Change Reality TFT can now easily remove the emotional effects of trauma, however, the reality of a trauma, alas, remains. However, this reality can now be completely stripped of disruptive and disturbing emotional effects.

Though important, effective therapy cannot change reality. If, for example, parents lose a child, this reality must be lived with for the rest of their lives. There is no way to change the grim reality, and until recently there was no way to change the emotional hurt and pain. The loss will remain real, but one may become strong in the face of a grim reality.

Just yesterday, an acquaintance informed me of the recent loss of a much loved 19 year old nephew to suicide. The suicide was a response to love loss, his girl friend just broke up with him. Love pain is one of the most disruptive of emotions. Murder and suicides are not rare in this turbulent emotion. I helped the acquaintance who was suffering terribly from the grief of loss. It took only three minutes to accomplish this result. The extreme look of pain on her face was immediately gone. Of course, the loss is permanent but the severe emotional pain is completely gone. Perhaps, if the nephew had been aware of this simple treatment, it's quite possible his life could have been saved. There is an excellent example of how this trauma

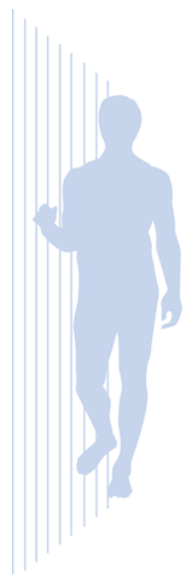
treatment helped a young man who had tried to commit suicide on our YouTube non-profit site, www.YouTube.com/ATFTFoundation.

This powerful trauma algorithm is so easy to do that everyone should know it for a psychological first aid procedure.

It is a common observation that severely handicapped people ought to be depressed over their situation but most, fortunately, are not. Depression and other emotions, as viewed by TFT, are not exclusively the result of a reality condition but rather the result of what we call perturbations in a thought field. When viewed this way we can understand how it is possible to treat severe traumas, not by changing reality, but rather by eliminating the fundamental cause of the suffering (see glossary on Perturbations).

The Ease of the Trauma Treatment Does Not Eliminate the Important Concept of Justice The fact that we can treat traumas with relative ease should not obscure the fact that victims are entitled to justice. One professional expressed concern to me that if no one was upset over a rape, then rape might become acceptable. Emotional upset should not be the relevant standard but rather the criminality of the act.

We can, and should, pursue justice without remaining unnecessarily upset. We can all be outraged over rape or other such crimes and pursue justice diligently without becoming personally devastated over the matter; in fact, we probably will do a better job of carrying out justice, the stronger and more resolute we can remain.



Tapping away the world's trauma

Interview with Caroline Sakai
by Michiko Ishikawa

The Association for Thought Field Therapy Foundation is a non-profit membership organization whose volunteers provide psychological help to people traumatized by wars, natural disasters, genocide and poverty. The group's Trauma Relief Teams, including psychologists, counsellors, doctors, and social workers, are trained in the Callahan Technique of Thought Field Therapy (TFT). They have assisted trauma victims in many parts of the world, including New Orleans and Mississippi in the aftermath of the Hurricane Katrina disaster; Tabasco and Chiapas, Mexico, after major flooding there; and in Kosovo, the Congo, and Rwanda to treat genocide survivors.

*Caroline Sakai, PhD., a psychologist and TFT practitioner, based in Hawaii, headed a team of therapists who worked with children in an orphanage in Kigali, Rwanda. The children survived the Rwandan genocide in 1994, in which 800,000 to 1 million people were slaughtered during the course of 100 days. Dr Sakai was interviewed by Michiko Ishikawa for *Share International*.*

Share International: How did you come to work with the genocide survivors in Rwanda?

Caroline Sakai: The idea came up when I was in New Orleans as part of an ATFT Foundation Trauma Relief Team working with Hurricane Katrina survivors and first responders – doctors, nurses and security people who were working with the survivors. One of the team members, Paul Oas, a psychotherapist and minister, asked me if I could work with the genocide survivors of Rwanda. His church has been helping to support the El Shaddai orphanage in Kigali, Rwanda, by providing necessities like food and shelter. He was seeing the effects of the genocide trauma among the children in terms of Post-Traumatic Stress Disorder (PTSD) – nightmares, flashbacks, insomnia, bedwetting, depression, withdrawal and rage. Reverend Oas wanted to take a TFT team there and work with the genocide survivors. Since I had headed the clinical team in New Orleans, he asked if I could do that in Rwanda.

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Caroline Sakai: "A year after the therapy, the children were really transformed."

SI: What is unique about your method of working with trauma?

CS: Thought Field Therapy is the most rapidly effective, and most gentle, treatment of trauma I have come across. I have worked as a clinical psychologist at Kaiser Hospital in Honolulu, Hawaii, for 31 years, and have used many other, more traditional treatments for PTSD. They usually involve some amount of abreaction (a re-living of the experience) as people work through the trauma, a lot of intensification of the feelings. That may be frightening for some people, who decide they don't want to continue with the treatment.

TFT does not create a lot of abreaction and distress. It is also empowering because it is actually a treatment that people use on themselves. From a feeling of being victimized, they are able to heal and help themselves. When results happen, when there is a lowered automatic emotional reaction, when the flashbacks and nightmares stop, when all the symptoms of PTSD remit, they realize the power that they've had to heal themselves.

SI: Does Thought Field Therapy work quickly?

CS: Yes. In fact we were amazed with the rapidity of treatment in Rwanda. We had only four therapists, and were faced with 400

orphans at El Shaddai orphanage. We found that 174 of them were genocide survivors. With the kind of atrocities they had experienced, we anticipated that it would take at least an hour per child, working individually. We thought we would need three consecutive days, working intensively. It actually turned out that most of them were treated in 15 to 20 minutes. We followed up in the next two days, checking to see if there were any more nightmares, returning flashbacks or other traumas because many of them had experienced multiple traumas during the genocide.

SI: What were some of the traumas they experienced?

CS: They may have witnessed the murder of their family, and subsequently saw or heard of other murders. Having had firsthand experiences, they re-experienced their own trauma vividly as they heard reports of others. Some of them are among only a few survivors of an entire village. They experienced the loss of many members of their community.

The severity of the Rwandan genocide in terms of traumatic impact was so intense because they were not distant killings with rifles or gunshots. The killings were done in close proximity, mainly with machetes. Many

7

victims were neighbors, friends and relatives of those who were the perpetrators.

SI: What were the ages of the children at the orphanage?

CS: The children ranged in age from 13 to 18, with most of them in their mid-teens. We also treated some adults from the village, whose ages varied.

SI: Who runs the orphanage?

CS: El Shaddai was created by Sylvestre Nzitukuze, a young teacher and coach. He started bringing homeless street children into his home. They were orphans surviving by doing drugs and prostitution, really victims of genocide, AIDS and poverty. When there were too many children for Sylvestre's home, he started El Shaddai in an old abandoned warehouse and had the children congregate there.

Sylvestre got a church congregation in Rwanda involved and then Reverend Oas' church in southern California. They work together to help the orphanage with necessary expenses for food and water, salary for the teachers, maintenance of the facility, and so on.

SI: What is Thought Field Therapy, the treatment that you used with the children?

CS: Thought Field Therapy is a self-treatment that involves the meridians used in acupuncture and acupressure. The treatment includes tapping on the meridian points, eye movement and other activities that activate different parts of the brain. The technique was developed by Dr Roger Callahan, a clinical psychologist in California. He made the discovery in the 1980s and has continued to develop and improve it.

SI: How did you begin working with the children at the orphanage?

CS: First we did some PTSD assessments. We had the assessment forms translated into Kinyarwanda, which is their language. The teachers, as guardians for the children, did the assessments. The students themselves also did their own subjective assessments. We compared, ranked and ordered them according to their assessments. The most severely traumatized children were seen individually and intensively. Because we were only there for three weeks and had only four therapists, we saw most of the children in small groups and then in larger groups, and saw the rest in class. We went through the treatment protocols with them.

There are different treatments for different problems. If they are dealing with PTSD, there is a trauma treatment involving tapping several meridian points. There were also a lot of people dealing with anger or guilt, so we would do those particular protocols which involve different meridian points. The tapping is done firmly but gently, about 5 to 10 taps, depending on the protocol.

SI: Did the children do the tapping themselves?

CS: We showed them the taps, and our interpreters would show how and where to tap. The children were very quick learners.

Let me give you an example. There was a 15-year-old girl who was three years old at the time of the genocide. Her family had taken refuge inside a church when the perpetrators started coming in and killing people. The girl related how her father had told her to run and not look back no matter what happened. She started to run as fast as she could and then heard her father yelling and screaming. He sounded like a crazy man, which was uncharacteristic of him. Even though she remembered that he had said not to look back, because she kept hearing him scream she turned to see why. A group of people with machetes were attacking her father.

Every day following the attack 12 years before, the girl had flashbacks of that scene; she called it a day-mare. She would have this day-mare of seeing her father being killed, and would have nightmares about it every night. As we were working it through and she was tapping the different meridians, she suddenly stopped and started to smile. She said she could remember her father playing with her, and that she had had no childhood memories before. The genocide was so much in the forefront of her memory that it blocked out everything else.

Then I asked her what she was feeling when she thought again about what had happened in the church. The interpreter, who was a pastor, looked at me hesitantly, as if to ask: "Why are you are bringing it back up again when she was doing fine?" But we need a complete treatment. The girl started crying and remembered seeing other people being killed. She recalled how she and another child who survived had escaped, and realized that her father had saved their lives by what he had done to distract the perpetrators' attention. She was crying as she remembered different scenes.

We continued to work through each of the traumatic events, and after about 15 or 20 minutes, she started laughing. We asked her what was coming up for her now, and she talked about her father. Her mother didn't want them eating very sweet fruits because they were not good for the children's teeth. But her father would sneak them home in his pockets and when her mother wasn't looking he would give them to the children. She was laughing wholeheartedly, and we laughed with her. Then I asked, now when you think about what happened in the church, what comes up? She paused and said without tears: "I can still remember it, but now it seems like a distant memory, like 12 years ago." She started to talk about other fond memories. Shortly thereafter, we ended her session for that day and made arrangements to see her the next day. She came in the next day looking much more cheerful. She told us that for the first time she had no nightmares and was able to sleep well. She started recounting many more happy memories.

SI: That story still moves you when you talk about it.

CS: Yes, it was very moving. We were very moved by the people in Rwanda and their wanting to be able to give back and show appreciation. They had a tremendous resilience, a tremendous capacity for forgiveness, an ability to experience and express their joy and appreciation of life.

One example was an elderly gentleman from the village. He was watching us work and asked if we could also work on him. He had been made to watch the slaughter of his wife and children and other villagers. Then the perpetrators started hitting him with machetes. Twelve years later we could still see the huge wounds on his neck and head. It was a miracle that he managed to survive. The wounds were healed but there were huge scars. He said he had constant flashbacks and nightmares.

We worked with him using TFT. The next day he came back and said he slept well for the first time in 12 years with no nightmares. He asked if we could help him with his dizziness, which caused him to fall frequently. We thought that he might need some medical or neurological help, but obviously the villagers don't have much access to, nor the money to pay for, medical services. So we thought we would try the diagnostic level of TFT, which provides an individualized treatment. Most of the treatments we provided in Rwanda were the standard prac-

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The teachers reported that the children had increased self-esteem and feelings of self-worth

tices found in Roger Callahan's book, *Tap- ping the Healer Within*.

SI: Those standard treatments worked with most of the people?

CS: Yes, for the traumas. There were only a few with unusual symptoms, where we had to use the diagnostic treatment.

After we did the diagnostic treatment with this gentleman to help with his dizziness, he walked around and said: "I am not dizzy any more." We were a little puzzled but thought perhaps the dizziness was related to the trauma. We've seen a lot of symptoms that are actually secondary to the trauma. Even after physical injuries are healed, there may be residual symptoms that are trauma-related, like depression and chronic pain.

The next day the gentleman came back and reported that he had no dizziness, no flashbacks and no nightmares. He told everyone in the village about it, and about 30 villagers followed him to El Shaddai asking for this Thought Field Therapy that had helped him.

Later in the week, he came to the Easter Sunday service at El Shaddai. During a sharing session at the end, he stood up and said he was now well for the first time in 12 years. He said he wanted to give back by taking in three or four orphans into his humble home. It was very touching.

SI: It's hard to believe that such deep traumas could be erased in such a short time by such a simple method. Do the traumas return?

CS: Most traumas and phobias don't come back. There may be some exceptions if it is not a complete treatment. There are some

other conditions that may have recurrences, like panic, obsessive/compulsive behavior and chronic pain. There may be the effects of other things such as toxins that can retrigger the symptoms. There are ways to figure out what those are and to treat them as well.

SI: You treated all 400 children and other local people in Kigali, Rwanda?

CS: Yes, we spent two weeks at El Shaddai. Then we spent a week giving training sessions on TFT to nurses, teachers, pastors and church members elsewhere before we left.

SI: I understand that you went back a year later.

CS: We went the next year on the anniversary of the genocide. We went deliberately at the worst possible time for their symptoms because we wanted to address any recurring or residual symptoms. The nation was in mourning. They were remembering the genocide with the hope and purpose of this never happening again. They were all focused on that and didn't have distractions like singing and dancing during that period.

When we did the assessments with the children, we were a little surprised to see that they were not showing signs of PTSD. As we interviewed the children and teachers, we discovered why. They had been treating themselves because they knew the self-treatment. The teachers had been able to treat the children and remind them of the treatment. Some children said that when the anniversary of the genocide began and they started thinking about it, they started having bad dreams. But they would just get up and start tapping on the meridian points.

One child would start tapping and soon there were seven or eight kids tapping together. They said that's why they didn't have the problems when we saw them.

SI: Is it important to remember the trauma to do this therapy?

CS: Yes it is. That is the thought field, the focus of the thoughts on the trauma. That is why we had the students concentrate on the traumatic scene and have them think about it while they are tapping to work it through.

SI: They focus on the trauma just for the few minutes that you are using the therapy?

CS: Yes. As they focus on the traumatic event during the therapy, the impact of the trauma seems to fade. It is common to have people say: "I can still remember it, but it is not vivid. It seems like a faded, distant memory now." Also, working on the meridians seems to reduce the physiological symptoms of the emotional reaction. That makes it a lot easier for people to think clearly and process things differently because our perspective is different when we are flooded with emotion.

SI: When you returned a year later, how had the children changed?

CS: It was amazing. They were really transformed. The teachers reported that the children had increased self-esteem and feelings of self-worth. Many who had felt victimized and had a sense of hopelessness, now had hope and more pride in their surroundings. They cleaned up around the orphanage, including the dirt on the floor, and asked to plant trees, flowers and vegetables. They also had large areas of land at the back of the orphanage where they were growing vegetables, which were starting to produce. So in addition to their usual diet of beans, rice and water, they had vegetables. In fact, they had so many vegetables that they were able to sell some for money to feed all the orphans.

SI: Did the children voluntarily do the work?

CS: According to the teachers, the children did the work very willingly. In fact, they initiated some of the projects. Also, some of the kids who had been depressed and withdrawn became more interactive. The ones who would never initiate any ideas would come up with ideas and share them without the impact of the traumatic flashbacks and

(continued on page 20)

THE VOICE OF THE PEOPLE

of Trade Unions. People are tightening their belts as the price of staple commodities like rice, bread, maize and dairy products increase. A trade Union spokesman said: "People are getting more and more angry. We felt we had to give expression to that anger in the form of mass action."

The **United States**, which traditionally celebrates Labour Day in September, has begun to mark 1 May along with the rest of the world, due to the large numbers of immigrant workers – they make up nearly half of the country's workforce. Thousands marched in major cities calling for a change in immigration laws. In Los Angeles about 8,500 took part in a march through the centre of the city, urging an end to work-site immigration raids. "A lot of people feel that nothing is being done," said Xochilt Pacheco, a 20-year-old Mexican American whose father is an illegal immigrant. She wore a dress bearing the slogans "We are workers, not criminals" and "Legalise me". Marchers included legal and illegal immigrants, one being Andres Rivas, 68, a former El Salvador city mayor, now a naturalized US citizen, having received amnesty in the 1980s. He said he marched to support those who are still fighting for legal status: "We have to stand up for those that don't have it today." There were also large demonstrations in New York, Chicago, Seattle and Washington, where the war in Iraq was a major grievance. (Sources: AFP; *LA Times*, US; www.deutsche-welle.net; BBC News; *International Herald Tribune*, USA; Reuters; AFP; *Daily News*, South Africa)

Rally in London for a Free Palestine

A crowd estimated by the organizers to be 15,000-strong marched in London to a rally in Trafalgar Square on 10 May 2008 calling for the end of the Israeli occupation of Palestinian land and the lifting of the siege of Gaza. The rally was organized by the British Muslim Initiative, Palestine Solidarity Campaign, Palestinian Forum in Britain and supported by many Trade Unions.

Many protestors wore black to commemorate Nakba, the 60th anniversary of the founding of Israel. Trafalgar Square soon filled up with waves of chanting marchers and a forest of placards and flags.

Speaker after speaker described the dire condition of life in Gaza: untreated sewage

from failing sewage treatment works, barely functioning hospitals the lack of safe clean drinking water, fuel, food or medical aid. They condemned checkpoints in the West Bank, the separatist wall, the policy of apartheid and collective punishment and called on supporters to boycott Israeli goods. British Politicians Tony Benn and George Galloway were among the speakers.

Prominent among the protestors were Jews for Justice for Palestinians, who call for an end to the siege of Gaza and the occupation of the West Bank, withdrawal of Jewish settlements and dismantling of the separation wall within Palestinian territory. They support the Palestinians' right to a viable state in the West Bank, East Jerusalem and Gaza, and want to redress the wrongs of the Nakba. Signatories include many eminent Jews who look to a future of peace and mutual co-operation between the Palestinian and Israeli peoples. (Source: palestinecampaign.org; jffp.org; nkusa.org; *The Observer*, UK)

Dockers refuse Zimbabwe weapons consignment

South African dockworkers refused to unload a shipment of arms from China destined for Zimbabwe, and the union's road freight members refused to truck the goods.

The Chinese ship, the *An Yue Jiang*, was carrying three million rounds of ammunition for AK47 assault rifles and machine guns, 3,224 mortar bombs and 1,500 rocket propelled grenades and launchers, ordered by President Mugabe's government at the request of army and police chiefs.

The dockers defied South African president Thabo Mbeki and his African National Congress (ANC) government, who said the 77 tonnes of weapons on board the *An Yue Jiang* were legal cargo.

Randall Howard, general secretary of the South African Transport and Allied Workers Union, warned that as far as the dockers are concerned, the containers would not be offloaded. The ship had to return to China.

"The dockers have good reasons for not unloading the ship," said Benzi Soko, spokesman for the Police and Prisons Civil Rights Union (Popcru). "We understand their objection."

Support for the action came from around the world. "This is the crucial role unions play in standing up for democracy in all

parts of the world," said Helen Kelly, president of the New Zealand Council of Trade Unions. "The workers thought it unconscionable to handle goods that were destined for the Mugabe regime, to be used against ordinary working people and the democracy movement. But for this stand, these arms would be in Zimbabwe now. History shows that the rights to free speech and to organise in unions, although guaranteed by international law, are among the first to go when democracy is subverted or overthrown." (Source: *The Sunday Herald*, Scotland, UK; thetimes.co.za, South Africa; CNN) •

Tapping away ...

continued from page 9

nightmares that were depressing and lowering their functioning level. They were more enthusiastic, more creative and more assertive. They were able to concentrate better and many passed their competitive exams to go on to regular secondary schools. The teachers also reported that there was a marked decrease in fighting behaviors and bedwetting. Many children who had been withdrawn and who avoided other kids because of their hurt and anger, reported getting along and playing with other kids and not having anger.

SI: *Do you have any other thoughts you'd like to express about your experience in Rwanda?*

CS: We would like to see more people able to benefit from this self-treatment. It was put very well by a number of teachers and students. They said that TFT needs to be made available to all sufferers of genocide, all sufferers of severe trauma, so they can experience relief from the traumatic symptoms and experience the joy of living again. The people of Rwanda expressed that very clearly. The treatment doesn't cost anything. As a number of people in Rwanda said. "It's free. You can do it on yourself."

Sylvestre Nzitukuze, a teacher and coach, of El Shaddai, said very eloquently: "It is like an answered prayer. These techniques have helped the children's lives. Their traumas have been set free so their eyes are set on the future."

For more information: www.atft.org •

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The Right Place at the Right Time

by Jenny Edwards, Ph.D., TFT-Dx

When I first heard about Thought Field Therapy, I knew that I wanted to learn it for my work in Africa. I give seminars there, and thought that people there would benefit from knowing a rapid way to eliminate trauma, physical pain, anxiety, addictions, phobias, and all of the other areas that Thought Field Therapy addresses. I didn't know just how much it might be needed.

In July, 1997, I received an invitation to conduct a two-week training sponsored by the Carmelite Community in Nairobi from August 3-14, 1998. I would be working with priests, nuns, brothers, students, counselors, educators, social workers, and others involved in helping professions. I accepted with pleasure, and made plans to teach a number of topics that had been requested, as well as a section on Thought Field Therapy.

The bombing of the U.S. Embassy in Nairobi occurred the morning of Friday, August 7. We were in the training at the time, which was about 25 minutes away from downtown Nairobi. Only during the afternoon did we begin to realize the devastation and the extent of the bombing.

All weekend, the Sisters in the training were at the hospitals serving people. Other activities had been scheduled for me, so I went along according to plan. On Monday, people in the training were starting to question Thought Field Therapy. We were just getting into the training, as it was one of several topics being addressed in the two-week seminar. They reasoned that, after all, people had just been in a bombing. Surely Thought Field Therapy wasn't powerful enough to help people with trauma that severe. I knew that I had to and wanted to go to the hospital and work with bombing victims.

The Sisters were going to the hospital after the training was over at 1:00 PM, and agreed to take me with them. As we went through police road blocks on the way there, I began to realize the severity of the situation. We arrived at Kenyatta Hospital and went directly to the wards. Doubts began to surface. Sure, I knew that Thought Field Therapy worked; however, these people had been in a bombing the previous Friday. Would it work with them? As I followed the Sisters from ward to ward, I asked myself questions like, "Who do you think you are?" "Fools rush in." "What if it doesn't work?"

In many of the wards that we visited, people's faces were filled with stitches. Eyes were bandaged. It would be unthinkable to ask them to tap on their eyebrows and under their eyes. [Note: In such cases there are equivalent points on the toes. RC] We went from ward to ward. The Sisters seemed to know what to do. Obviously, they had done this before. I thought I would just follow them around; however, I was praying and asking for direction. With whom, if anyone, should I use Thought Field Therapy?

We finally came to a ward in which people had mainly lower body injuries. I went up to a woman lying on her bed, staring into space, and began talking with her. She was in a great deal of pain - a "10." Her shoes had been blown off by the bombing, and she had walked out. She had a lot of glass in her feet, among other injuries, and was on strong pain medication. Since her injuries weren't quite as severe as others, the doctors hadn't had a chance to work with her yet. After building rapport, I said timidly, "I have something

that MIGHT help you. I'm not sure if it will work. It would involve tapping on these particular places on your body (I showed her), and would take about five minutes. I'm willing to try, if you would like me to." She said, "I'll do anything. I'm in so much pain. I also keep thinking that a bomb will explode any minute in the hospital. I know that it's probably not going to happen; however, I can't get the thought out of my mind!"

I decided to work with the pain first. After tapping the pain algorithm, the SUD came down from a "10" to a "5;" however, it wouldn't go any lower, even after tapping for reversal. It occurred to me that we needed to tap for trauma before the pain would go any lower. Of course, the trauma was a "10," and it came down to a "0" immediately. After that, we tapped again for pain, and it readily went down to a "0."

She blinked her eyes and looked at me, a little bewildered. She said, "I've played the pictures of what happened the day of the bombing over and over in my mind, almost without stopping, since Friday. It's really strange, but I'm not doing that any more. I think that I'll be able to get to sleep tonight." Then she looked straight at me, smiled, and said, "God saved me for a reason." "Yes, He did," I said. I told her that the pain probably would return, and wrote out what she could do when it did. I told her that the trauma probably wouldn't return; however, if it did, the directions were there for her to follow (including Psychological Reversal).

About that time, the Sister came to me and said, "The woman in the bed across the way says she wants to be healed, too." I went over to her. She was just staring into space. Her arm was bandaged, and her hand was limp. After talking with her for a few minutes, I asked her if it would hurt if she tapped on the hand that was limp. She said it might hurt a little; however, it would be worth it in order to be able to experience the changes that she had just seen the woman in the bed across the way experience. She was "10" on both trauma and pain. I decided to work on trauma first. It came down fairly quickly to a "0," with no Psychological Reversal.

Then, we worked on the pain, which had already gone down to an "8" after working on the trauma. As she tapped, it went down to "0," too. She was moving her hand all around, color was restored to her face, and she was smiling and laughing. I wrote down what we had done. Her husband, who had been watching, asked the Sister if it might help his neck pain. She said, "Of course." By now, the first woman was sitting up for the first time since the bombing, eating dinner and talking with her husband. They were smiling and laughing. Her husband told the Sister that usually she panicked when it was time for him to leave at night because she didn't want to be alone, for fear a bomb might explode. He reported that this evening, for a change, she felt fine about his leaving, and told him that she would see him the next day.

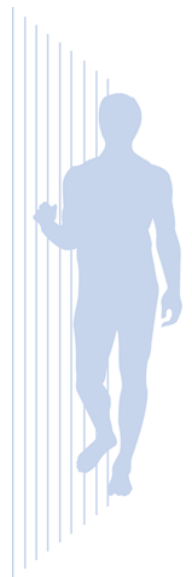
She then told the Sister that she had been on extremely high and frequent doses of pain medication, and was planning to use the tapping to lessen the amount and frequency of the doses. Then, I went to talk with a third woman in the ward. She was staring into space. I tried to build rapport; however, it was difficult. I made the determination that perhaps I wasn't supposed to work with her. The next day, the Sister said that the third woman had later told her, "Why did she heal the other two and she didn't heal me?"

The Sister's response was, "She wrote down what she did for the other two. Ask them to work with you."

The next day in the training, the Sisters shared what had happened in the hospital. People were amazed, and as I did demonstrations with people in the training around their trauma related to the bombing, they became believers and launched into the practice sessions with vigor. Furthermore, they sent their friends

with extremely difficult cases to me to work with in the afternoons for the rest of the week. I also had the opportunity to introduce TFT to therapists at a local counseling center. They were planning to follow up by ordering materials from Dr. Callahan.

Yes, I knew that I was supposed to share Thought Field Therapy with people in my seminar in Nairobi. I didn't know just how timely the training would be.



Using TFT Algorithms

Key to Abbreviations for TFT Algorithm Treatment Points

- SUD** subjective units of distress (a rating on a scale of 0-10 or 1-10 of how upset one is at the moment)
- e** under eye (under the pupil just below the rim of the bone—the inside of the second toe also works if the person is not able to tap on the face)
- a** under arm (about 4 inches down from the arm pit; in the middle of the bra line for women)
- c** collarbone (1 inch down from the V of the neck, and 1 inch over to either the left or right side)
- eb** eyebrow (at the point where the eyebrow begins, near the nose—the outside of the small toe also works if the person is not able to tap on the face)
- if** index finger (beside the nail on the side toward the thumb)
- tf** tiny finger (beside the nail on the side toward the thumb)
- un** under nose (below the nose on the upper lip)
- g** gamut spot (on the back of the hand in the indentation between the bones of the tiny finger and the ring finger about ½ inch back onto the hand—use 3 fingers to tap)
- 9g** 9 Gamut Sequence—Tap the gamut spot continuously while doing the following:
1. Close the eyes
 2. Open the eyes
 3. Move the eyes down and to one side
 4. Move the eyes down and to other side
 5. Roll the eyes in a circle in one direction
 6. Roll the eyes in a circle in the opposite direction
 7. Hum a tune (about five notes) out loud with mouth closed
 8. Count aloud from one to five
 9. Hum a tune again aloud, with mouth closed
- er** floor-to-ceiling eye roll (while tapping the gamut spot, hold head level. Look down to the floor, and slowly, to a count of 10, roll your eyes vertically up to the ceiling).

Stop the Nightmares of Trauma

Science is the belief in the ignorance of experts.

Richard Feynmann
Nobel Laureate in Physics

In a celebrated lecture to physics undergraduates at Cornell University, Professor Feynman elaborated on the quote above. He said, “If it [a new scientific law] disagrees with experiment; it’s wrong! In that simple statement is the key to science. It doesn’t make any difference how beautiful your guess is, it doesn’t make any difference how smart you are, who made the guess or what his name is, if it disagrees with experiment it’s wrong; that’s all there is to it.”

IMPORTANT!!! Please keep in mind that the tapping protocols given in this weeks class are for trauma and complex trauma with anger and guilt, not for other problems such as phobias, which are an irrational fear.

Incident: On the first day of one of my diagnostic training’s I asked the assembled group how many had tried TFT before coming to the training. Most hands went up. I asked if there was anyone who had been unsuccessful. It is unheard of to hear of no success with this powerful procedure. A high level professional person who had traveled from across the world to attend my training said that he had been unsuccessful with my trauma treatment.

I was quite surprised by this report and asked him to join me at lunch. I asked him to please tell me exactly what he was doing to treat trauma and much to my surprise he described to me, my phobia algorithm. I said, “No wonder you had trouble, that is not the correct procedure for trauma!”

All of the TFT algorithms have been found through what I call **Causal Diagnosis** (see glossary). Over three decades of treating thousands of patients with causal diagnosis, common patterns or algorithms have emerged. These algorithms have now been tested on many people both in self-help applications and with thousands of trained professionals throughout the world.

My first trauma victim was cured, believe it or not, by doing nothing more than tapping the beginning of the eyebrow. However, upon trying this same simple procedure on others with traumas, I quickly found that most were not helped this easily. I had to make further discoveries to increase the success rate. Each discovery was tested for efficacy on my trauma clients; this allowed me to quickly develop further treatments and allow me to help more people.

The algorithm for trauma presented in this class has been tested on thousands of people all over the world, young and old, and from many different cultures and the success rate is amazingly good. See, for example, the report on Embassy Bombing in this week’s handout.

We urge you to study the trauma tapping protocol and begin by applying it to yourself. We all have past

traumas of varying intensity such as being rejected, especially in a love relationship, failing a class, or any upsetting experience from the past. It is best to pick something that still causes a little upset so you can experience how the treatment causes the upset to disappear.

If you wish to practice on family or friends, it is good to know an important feature of TFT is the person guiding the treatment does not need any details or even know what specific trauma is being treated.

The Tooth, Shoe, Lump Principle (TSL) In a small number of complex clients a complication may take place which I call the tooth, shoe, lump (TSL) principle. Here is an illustration of this principle. Consider a person who has a terrible toothache: They call the dentist's office is called and rush over to the office. Although there is no opening in the schedule, the dentist will take care of the problem as soon as she can. The tooth was hurting so badly they had put on the first pair of shoes available, ignoring the fact these shoes hurt his feet. Due to the intense tooth pain, however, he doesn't notice the discomfort caused by the shoes.

When he gets to the office he sits on a couch directly upon a most uncomfortable lump. Again, this goes unnoticed due to the severe pain in the tooth. Just then the dentist comes out and indicates she will be able to attend to the problem in about an hour and a half, but seeing the severity of the pain, she injects a shot of Novocain to give temporary relief. The tooth is suddenly relieved of all pain and he now becomes aware he put on the wrong shoes and due to the Novocain effect he is suddenly aware his feet are quite uncomfortable. He removes the shoes and in a few moments he then begins to be aware of the uncomfortable lump upon which he has been sitting. He moves to a nearby chair and, at last, feels comfortable.

Something somewhat similar occurs in some severely complex clients who are only aware of a summation effect of their problems and do not, or are not able to, discriminate between say, trauma, anxiety and depression or mixtures of various other problems. There can also be different aspects to one traumatic event that might need to be treated separately, if the person does not fully respond to treating the trauma as a whole, though the necessity for this is rare. The person being treated might not be aware of this. All they know is they feel bad. We may completely remove all traces of the first problem in line, as confirmed by our tests and supported by the fact no complications such as PR or mini-PR show up on diagnosis. Often we are actually treating what the client may perceive as one problem but which may consist of a melange of problems.

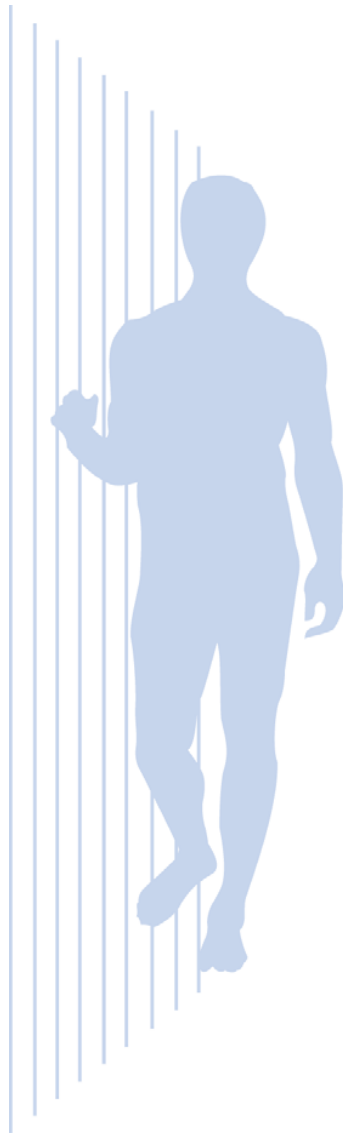
Inertial Delay In rare cases, there can be a delayed response to the treatment. This delayed response can occur anywhere from a few minutes immediately following the treatment to; in very rare cases, a few days later. Keep in mind, however, this type of delay is unusual and what we usually see are immediate, dramatic changes.

Is it Desirable to Eliminate All Upset Associated with a Trauma?

This question was a moot issue before there were powerful treatments to eliminate the bad effects of a trauma. I maintain it is desirable to eliminate all bad effects of a trauma. There are some therapists who have learned how to use TFT who believe they should not eliminate all suffering but leave some. They have the belief, quite wrong in my opinion, that leaving some measure of suffering will help protect the person against further trauma. I suspect this interesting notion likely became introduced through good treatments which were, nevertheless, not completely effective and that the residue which could not be eliminated be-

came rationalized as a desirable situation.

It is crucial to understand that although TFT can eliminate all traces of a problem the treatment does not make a person stupid or ignorant. I find a person can use more intelligence the less upset he or she is. This is the best protection one can have through treatment.



Post-traumatic Stress

The symptoms of Post Traumatic Stress can be resolved quickly. Unlike chronic anxiety problems (which are often caused by, perpetuated by, or aggravated by Individual Energy Toxins), these problems are a direct result of a traumatic event. Once the event is over, the associated perturbations can be resolved, and the symptoms will generally not return. If they do return, it is most often as a result of a new thought field with new perturbations. They can also return as a result of the person being exposed to a toxin.

Crisis Intervention

Crisis intervention applications are many. Use the TFT trauma algorithm at the scene of a trauma or immediately afterward to help people recover their functioning. When someone has just witnessed a life-threatening event affecting them directly, or a loved one has tears running down his/her face, has rapid shallow breathing, and is apparently in emotional distress, you do not have to ask for a SUD. Assume it to be a 10, and have the person mirror you in tapping for PR and the Complex Trauma with Anger and Guilt algorithm. As the person settles down, you can apply other TFT algorithms and other crisis intervention steps as required or as appropriate.

Acute Stress Disorder

In resolving Acute Stress Disorder symptoms, TFT is unparalleled in its effectiveness. As distress associated with telling the story about a trauma arises in a person, use the appropriate algorithm to eliminate it. When the person can think through the whole story with appropriate affect (feeling calm), other thought fields may need to be addressed. After getting the SUD for the initial trauma down to 1 (or 0), ask the person what other aspects of the trauma he/she is thinking about now. Complex traumas such as the sudden death of loved ones require more than a single TFT session, as many facets are usually involved.

Do not hesitate to refer clients to other specialists to assist them in making life changes as needed. Always make sure that you give a copy of the complex trauma algorithm to the person for future reference.

Post-traumatic Stress Disorder (PTSD)

Post-traumatic Stress Disorder is a diagnosis that is given to people 30 days after the precipitating event who have many severe symptoms disrupting their day-to-day functioning. Use TFT algorithms to resolve these symptoms as they present. Most often, a person will have little trouble getting to the thought field that needs attention. The core of the problem has to do with the ongoing, overwhelming thoughts, sensations, emotions, and memories associated with events that are out of the person's control.

After a trauma, people often develop avoidant or addictive behaviors to enable them to cope; however, these only cause more problems. In addition, feelings of rage, embarrassment, shame, depression, and pain related to the original trauma can and often do appear. You can address these problems with a variety of algorithms that you can combine, having the person think about the rage or embarrassment as he/she is tapping the rage or embarrassment algorithm. Some examples are below. The Tooth, Shoe, Lump principle is often apparent with traumas.

Trauma Algorithms

Simple Trauma

Eyebrow, Collarbone (using the Protocol)
(eb, c)

Complex Trauma

Eyebrow, Under Eye, Under Arm, Collarbone
(using the Protocol)
(eb, e, a, c)

Complex Trauma with Anger

Add Tiny Finger, Collarbone (using the Protocol)
to the end of sequence above for complex trauma:
(eb, e, a, c, tf, c)

Complex Trauma with Guilt

**Add Index Finger, Collarbone (using the Protocol)
to the end of the sequence above for complex trauma:
(eb, e, a, c, if, c)**

Complex Trauma with Anger and Guilt

**Add Tiny Finger, Collarbone, Index Finger, Collarbone
(using the Protocol)
to the end of the sequence for complex trauma:
(eb, e, a, c, tf, c, if, c)**

Complex and Complicated Disorders of Extreme Stress

Complex and complicated disorders of extreme stress are the result of many years of overwhelming physical, emotional, or sexual abuse. For both children and adults, exposure to violence (both threatened and actual) over extended periods of time can cause destruction of core functions and/or development of extreme coping mechanisms. These individuals may present as those with PTSD. They may also exhibit self-destructive behaviors, including suicidal symptoms.

You must use caution to assist these individuals in managing the overwhelming distress they are experiencing. Know your limits, and work within the scope of your education and license.

IMPORTANT

If the client has rapidly changing thought fields and/or signs of agitation or shutting down, you must ensure that both you and your client are in a position of safety before continuing.

Anger and Guilt

Clients can frequently expect TFT to generalize to all aspects of their life after one treatment. With complex problems, it is important to break the problem down and target its different aspects. For example, if you are helping someone with an anger problem, and you target the theme, “I get angry because no one listens to me,” the person’s anger regarding this will usually not generalize to the anger at someone laughing at him/her. That must be treated separately, albeit with the same algorithm (tf, c, using the protocol).

It is sometimes helpful to make a list of themes to be targeted. Be sure to check themes that you have already treated at subsequent sessions to make sure that the treatments held. Most importantly, teach clients to treat themselves at home!!!

Anger does not often extend to physical violence against objects or persons and can usually be controlled by an act of will.

Guilt can be seen as anger at oneself.

Algorithms for Anger and Guilt

Anger

Tiny Finger, Collarbone (using the Protocol)
(tf, c)

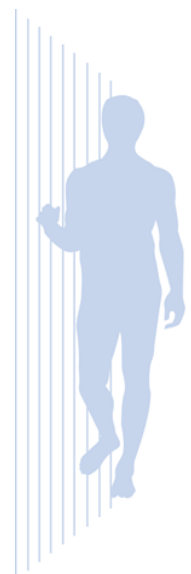
Guilt

Index Finger, Collarbone (using the Protocol)
(if, c)

When to Tap

Tapping can and should be done every day for situations that arise.

- When you first wake up and various times during the day (all points, including eb, e, a, c (thinking of any traumas), tf, c (thinking of any anger), if, c (thinking of any guilt), using the Protocol).
- When you are having trouble getting going in the morning, or you got out of bed on the “wrong side” (reversal treatments, including side of hand, sore spot, under nose, or collarbone breathing; then, tap for whatever the problem is, i.e., e, a, c for anxiety; eb, c for sadness; eb, e, a, c or eb, c for trauma, etc., using the Protocol)
- When you are reversing letters or numbers or words or having difficulty typing on the computer (reversal treatments, including side of hand, sore spot, under nose, perhaps collarbone breathing)
- When you are having difficulty focusing on what you are doing (reversal treatments, including side of hand, sore spot, under nose, an/or collarbone breathing)
- When you are procrastinating (e, a, c, focusing on the reluctance, using the Protocol)
- When you get angry, upset, or frustrated (tf, c, using the Protocol)
- When you feel guilty (if, c, using the Protocol)
- When something happens that you didn’t expect, and you are having difficulty calming down (eb, e, a, c—complex trauma, or eb, c—simple trauma, using the Protocol)
- When you feel extremely angry (tf, c, using the Protocol)
- When you have trouble sleeping (e, a, c for anxiety; eb, e, a, c for complex trauma if you are thinking about a trauma, using the Protocol; do the pulse test and track what toxin might be elevating the pulse and keeping you from sleeping)



How TFT Can Help With Different Types of Trauma

A wide variety of experiences come under the heading of trauma. I will give a few of the many examples of how the TFT trauma algorithm has helped people with different traumatic experiences. Your handouts will also give a variety of cases. As you will see, you can apply it to a large number of different types of trauma.

Love Pain and Grief Upset and loss from romantic rejection and disappointment, while not the most objectively horrible trauma, is often the most acutely painful to the person suffering. In my extensive therapy experience of almost half a decade, I would say that there is no more devastating emotional pain than romantic loss or rejection. There are many things objectively more terrible than romantic or love pain but for depth and severity of reaction, love pain is right at the top.

Many murders and suicides occur as a result of the devastating pain of lost romantic love. People experience such a loss as a rejection of who they are at the very core of their being and the hurt therefore goes very deep (Callahan, 1982).

These experiences not only happen to adults but children or adolescents as well. Such experiences are typically not taken seriously by the adults around them and written off as “puppy love.” However, these upsetting, often traumatic events may result in emotional devastation that is just as bad, if not worse, than it is for someone in a more mature relationship. Romeo and Juliet were only 14 years old.

The pain and trauma suffered as a result of romantic loss can be enough to affect a person’s ability as an adult to develop and sustain romantic relationships. Such people develop what I call Amouraphobia, the fear of being devastated in a romantic relationship.

Illness or the Illness of a Loved One Having a serious chronic or terminal illness, or observing the same in a loved one, is very traumatic and stressful. TFT cannot change the fact of the illness, but it can relieve extreme emotional upset and stress due to the illness and greatly enhance the quality of life. Decreased stress, improves Heart Rate Variability and increases the chance for healing.

At a recent conference, I publicly treated an 82-year-old woman who had endured several years of living and caring for her husband who suffered from Alzheimer’s disease, ending with his very slow and agonizing death. She had been with him at the time of his death and could not get the painful image out of her mind. Since her husband’s death, which occurred years earlier, she had not been able to stop visibly shaking and was unable to think about anything else. I treated her in front of about fifty professionals at the behavioral medicine conference where I was presenting Thought Field Therapy®.

She had come in hopes that something might help her with this acute suffering. After one very brief treatment of about two minutes, she stopped visibly shaking and her upset was completely eliminated. She and the group were shocked and thrilled with the relative ease of treatment and the elimination of her suffering. In some cases where there is trauma that has occurred over a period of several years as in this example, more treatments might be necessary. You may need to treat each upsetting event or different aspect of the situation. Fortunately, multiple treatments were not necessary in this case.

Job-related Stress and Trauma Whether an employer or an employee, there are many types of upsets and stresses that occur in connection with conditions of employment. The trauma treatment can help someone suffering from the trauma of being fired or laid off, as well as the many upsets that can occur during the course of a working day. One of the professionals I trained has specialized in consulting in the area of workplace violence and trauma. Large companies contract with him to treat employees who suffer from job-related upsets and problems including workplace violence, trauma and sexual harassment. TFT is very appealing to the businessperson because employees can be helped effectively and quickly. This simple but powerful treatment often results in increased harmony in the workplace and more productive employees. The anger algorithm can often quickly diffuse a potentially troublesome event before it escalates into a problem.

People who have jobs where they have to deal with trauma such as first responders, public service and disaster relief organizations – including police officers, fireman, paramedics, doctors, nurses, and other hospital workers - are often themselves very traumatized by what they witness in their day-to-day work. Regular use of the trauma algorithm can help relieve what has been termed compassion fatigue and prevent burnout for the workers. It has successfully helped the search and rescue dogs as well.

The TFT treatment for trauma is very effective in eliminating secondary trauma. One therapist I trained has worked in a hospital for 20 years and uses this treatment for herself on a daily basis. She reports that the treatment has helped her tremendously in dealing with the stress and upset she used to suffer as a result of what she is exposed to on the job.

Crime Victims Including Genocide This treatment is tremendously effective for people who have been victimized by crimes. It has helped many people to eliminate the fear, upset and nightmares that result from such an experience. One of the many people I have helped was a fourteen-year-old girl who was shot in the leg as the result of a drive-by shooting.

Her therapist was unable to help her and referred her to me. For eight months she had been traumatized and experienced nightmares due to the shooting. She couldn't get the frightening noise of the gunshots and the shattering glass out of her head. She suffered from nightmares in which she relived the shooting and would awaken terrified and very upset.

She came to me for help eight months after the shooting. When asked to think about the shooting she got very upset. The TFT treatment for trauma took less than ten minutes and removed all traces of her upset. The nightmares stopped. Even though this shooting was, in reality, a horrible event, she was no longer upset or bothered by it and was free to go on with her life without having to relive the event, over and over. Five years after this treatment, the client reported that she remained free of all upset and the nightmares were gone.

Child Abuse People who have suffered multiple instances of abuse, such as repeated child abuse, can be helped with TFT. Caution: Do not try the trauma algorithm on yourself if you are unable to even think about the event without severe, devastating upset. In that case, we recommend you call our office for a referral to a qualified therapist trained in these procedures who can work with you.

Sometimes, in the case of complex, multiple traumas such as prolonged child abuse, the person will need more than one treatment. Multiple treatments may be needed in order to address the different traumas that occurred, and the gamut of feelings and disturbances connected with them.

Shirley's mother claimed that, five years ago, Shirley, who is now eight years old, had been the victim of severe sexual and ritualistic abuse at her preschool. She also reported having been sexually abused in her home by a man with whom her mother used to live. Shirley had been in therapy for these traumas for five years, since the age of three, with a traditional psychologist at a well-known medical center and had shown no tangible improvement. She was still termed an elective mute. What had happened to Shirley was so upsetting that even after five years of psychotherapy she was not able to talk with her therapist or anyone else about what had happened. Talking about such an experience is, in and of itself, often re-traumatizing.

As a result of her experiences, Shirley had nightmares and many fears. She was afraid of strangers, going into dark places, going to the bathroom alone and going into certain rooms of her house. She also feared all kinds of windows because her abusers had told her she was being watched.

Her mother was referred to me by a friend in the law enforcement field. Although very skeptical, she first came to see me for help with her own fear of public speaking. She wanted to test out the treatment herself before bringing in her daughter. Since I was able to quickly eliminate her fear of public speaking, she brought her daughter in to see me.

Shirley had two sessions with me. I treated her fears and upset one by one. Fortunately, when being treated with TFT, the client does not have to talk about or relive the upsetting experiences for the treatment to be effective. By the end of the first session, she was visibly more relaxed. When asked if she would like to come back to see me, she readily agreed, which she had not done in her previous therapy sessions. Her mother reported that after the first session she was able for the first time, to talk about what had happened to her. She became more comfortable around people and was able to go into rooms that she had been afraid to go into before the treatment. Shirley did so well she was able to stop seeing the therapist she had been seeing regularly for the past five years.

She had one brief relapse, after the verdict was announced in the court case that set her alleged abusers free. This was quickly and successfully treated in one more very brief (minutes) session of TFT. She continues to do well.

Natural or Man-made Disasters People who suffer the traumatic after-effects of disasters such as hurricanes, earthquakes, floods, bombings, plane crashes and the wide array of other possible disasters, can benefit significantly from the -TFT trauma algorithm

When we had a major earthquake in the Palm Springs area where we live, I successfully treated several people who had been severely traumatized. Prior to treatment they were living in constant fear of another earthquake.

One woman I treated had been in an earthquake in the Philippines over twenty years ago. She still had nightmares about this frightening event. She now lived in Southern California and was in constant fear about the possibility of an earthquake occurring. The slightest rumble would typically send her into a panic.

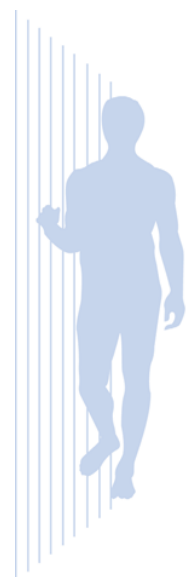
After I treated her and removed all traces of upset, nature provided us with a good test of the treatment. Three days later we experienced a minor earthquake and she showed no trace of fear. About a year later, she returned to the Philippines. Soon after her arrival a major earthquake occurred.

She told me that during the entire earthquake while other people were terrified and falling apart, she was able to remain calm and to be of assistance to other people who were panicking. Here was an acid test of the treatment.

Dr. Jenny Edwards, a marvelous and gifted therapist I trained in TFT, happened to be doing some therapy training in Nairobi, Africa at the time of the Embassy bombing in August 1998. She went to the hospital and helped a number of the victims who had been injured and severely traumatized by this horrible event. See your handout for the complete article.

This report, as well as the article published in Share International, Tapping Away the World's Trauma, provides dramatic examples of what is possible with the simple algorithms or recipes of TFT, even in severe disasters, wars and genocide.

As you can see from the above examples, our treatment for trauma is helpful for a variety of different types of traumas and life upsets. Thanks to TFT, it is no longer necessary for someone to have to live with the devastating after-effects of a trauma.



TFT TRAUMA RELIEF BLOG

<http://TFTtraumaRelief.wordpress.com>

Relieving Suffering--Creating Peace

Mary Cowley, PhD, TFT-VT

The ATFT Foundation's trauma relief blog has now been on-line nine weeks and there's been a lot of activity! As of July 5, we've had 2,100 total views! So far, we have 13 posts, including 8 videos, talking about TFT for the trauma of rape, car accident, genocide, violent kidnapping, prison, etc. More are added every week. These stories are strong testimonials to the power of TFT in relieving the suffering from trauma and ensuing grief, anger, fear, guilt, depression, and anxiety—for adults, children and even animals.

Sending your clients to the blog is an easy way to share these testimonials with them. Put a link to it on

Submitting your own stories of how TFT has helped relieve your clients—or yourself—from trauma not only helps get the word about TFT out to the world, but also provides a little

your web site for an instant connection! Submitting your own stories of how TFT has helped relieve your clients—or yourself—from trauma not only helps get the word about TFT out to the world, but also provides a little marketing for yourself. Testimonial videos are particularly effective for our visitors! You can submit a personal story or case study by sending it to me at drmary@thecel.com or Sheila Crouser at sheila@atft.org, but better yet, if you register on the blog as a contributor and then submit a testimonial post, your name on the post will link to your web site address, information that you write about yourself, and a list of all your posts on the blog. Even when you just comment on a post (click on title of post, then “Leave a Reply”), your name on the comment links to your web site!

What else do our visitors find on the blog? Besides the active home page of continually updated posts, we have a few permanent pages of information: 1) “About Us”—explaining what the ATFT Foundation is all about and why we created the blog; 2) “What Is TFT?”— in Dr. Roger Callahan's own words; 3) Written instructions for the complex trauma algorithm, including cb2 instructions; and 4) Video demonstrations of the algorithm.

So far we have algorithm instructions in English, Japanese (by Ayame Morikawa), and German (by Franz Ng). We will soon have them in French, Spanish and Italian (by Jenny Edwards). We have video demos of the algorithm in English, Chinese and Japanese. The plan is to add sub-titles to the video demo until we can get videos of the algorithm actually being done in other languages. We invite all of you who speak languages other than English to submit demo videos and/or the instructions (including cb2) in your language. As we have certain guidelines, please contact myself or Sheila if you can help out with translations. This will truly help TFT reach the masses world-wide!

Using TFT to relieve the effects of trauma can open people to peace, compassion and community.

You can help the ATFT Foundation blog make trauma relief available on a global scale!

See you there!

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Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 5: Application – Fears, Phobias and Anxiety Related Problems

Case studies

Whoopi Goldberg – trauma based phobia – fear of flying - video
Kelly Ripa - trauma based phobia – fear of flying - video

Common phobias

Snakes, bugs, birds, public speaking, planes, driving, etc.
En Vivo bird fear - handout
What is fear of heights – Acrophobia Study – FSU handout
What we think is really fear of public speaking
Common algorithm - handout

Other phobias

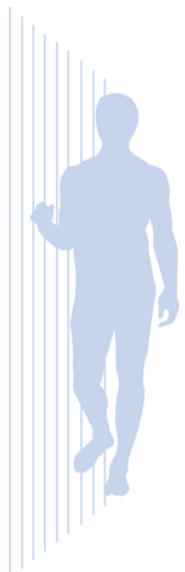
Claustrophobia, spiders, turbulence
Alyssa - tarantulas
Common algorithm - handout

Panic and anxiety disorders

Trauma and severe, chronic anxiety
Panic attacks - handout
Common algorithm patterns - handout
Role of collar bone breathing – Neurological Disorganization
Role of toxins – Coca/Pulse Test – panic attacks/pulse test

Q & A's – submitted in advance

Demonstrations – submitted in advance



In Vivo TFT of a Bird Phobia

Fred P. Gallo, Ph.D., The Thought Field, Vol. 2, Issue 3

Recently my wife and I had the occasion to visit the old section of San Juan, Puerto Rico, a beautifully preserved historical site near the ocean. We met a lady in her thirties there who reported a life-long fear of birds which she determined as beginning when she was a toddler. She reported that she was attempting to hold a “moth or butterfly” and it frightened her as flew into her face many times. As she recollects, she became afraid of flying creatures after that incident, birds being included in that category.

I told her that I might be able to help her eliminate or reduce the fear if she liked, and she was most agreeable if the process did not cause her undue distress. At this I briefly explained some TFT basics and then proceeded to treat her while we sat in a living room. At first I treated her for the painful memory (actually before I knew the details of the event). I then employed the basic phobia algorithm, and within moments she no longer felt discomfort while thinking about birds. I then pointed out that since only exposure to reality would tell if the treatment was through, we needed to encounter some birds. Since she and her companion as well as my wife and I were planning to tour the old section of the city, I figured that a test would be possible.

Talk about birds! There were birds all over the place in Old San Juan. While my “client” indicated some discomfort, it was in no way extreme. I then offered her some additional treatments, and within seconds she reported great relief. As she walked within the vicinity of literally flocks of birds she exclaimed, “I would never have been able to do this before! I could never walk this close to birds before.” She then noted with obvious calm and clarity that she was now much more aware of birds than she had ever been before. As she visually surveyed the area, pointing out the multitude of birds she realized, “I think I’ve tended to avoid paying attention to birds all these years!” While there were certainly a lot of birds to be aware of in Old San Juan at that moment, I seemed clear that she had previously shut down much of her awareness of birds as a kind of protective devise and now no longer required the distraction. Obviously, as Dr. Callahan has frequently emphasized, distraction is not all that powerful. While years of distraction may have helped this lady cope, it did nothing to resolve the bird phobia, which was successfully cured in moments with TFT.



An Experimental Study of TFT and Acrophobia

By Joyce L. Carbonell, PhD, TFT-Dx

As many practitioners of TFT are aware, Dr. Charles Figley and I conducted a Systematic Clinical Demonstration (SCD) study of four therapies, including TFT. This SCD study utilized clients who had suffered a trauma or who suffered from a phobia. All of the treatments tested were demonstrated to be effective, based on SUD ratings (subjective units of distress) and other paper and pencil measures. In order to further examine TFT, one of my students (Neta Mappa) and I decided to do an experiment to supplement the clinical demonstration. Although there has been a great deal of clinical support for TFT, there had been no true experimentation. The purpose of the experiment was to determine whether TFT would decrease the anxiety level of acrophobics more than a placebo control experiment.

We chose to do our experiment with acrophobics (height phobics) for several reasons. First, this is a fairly common phobia. In addition, there is a screening measure, the Cohen Acrophobia Questionnaire (Cohen, 1973), that can be used to screen people for acrophobia. And, we could also do a behaviour test of the subject's fear of heights both before and after treatment. Finally, there is a TFT algorithm for phobias. It was important to be able to use an algorithm to ensure that all subjects received the same treatment.

The subjects in the study were college students who identified themselves as having a fear of heights. There were 156 students who signed up for the experiment, indicating that they had a fear of heights. They were all given the screening measure and 49 of them reached the cutoff for heights phobics. These 49 subjects who reached the cutoff were then given a behaviour test. They were asked to approach and climb a four foot ladder. We hoped that the ladder was of sufficient height to provoke an acrophobic response, but not so high as to put the subject at physical risk. The floor in front of the ladder was marked off in one foot intervals for four feet. The subject was asked for a SUD rating at each mark, and then again on each step of the ladder. The subjects were free to stop ascending the ladder at any point.

After completing the behaviour test, the subjects were taken to a separate room and were met by another experimenter. They were then asked to give a SUD rating. They were requested to think of a situation related to heights that made them anxious and then rate their anxiety on a scale of 0-10. In order to assign the subjects randomly to either TFT or a placebo TFT, they were asked to draw a piece of paper from a box. All of the papers in the box were numbered 1 or 2. Those who drew the number one received the TFT algorithm for phobias and those who drew the number two received a treatment that consisted of tapping on various parts of the body that are not used in TFT. Before any treatment began, all of the subjects were treated for reversal.

Then, the experimenter treated them with either TFT or the placebo treatment. After treatment they were asked for a SUD rating. If the SUD was not zero, the treatment was administered again. After the second treatment, post-testing began, regardless of the SUD rating.

After the treatment, subjects were returned to the first experimenter who did post testing with the subjects. It is important to note that the experimenter who did the pre and post tests was unaware of which treatment the subject had received. At the post test, subjects were again asked to approach and climb the ladder, giving a SUD rating at each step, just as they had before treatment.

Before doing any analysis, the groups were compared on their pre-treatment measures to be sure the

groups were comparable. Given the random assignment to condition we did not expect the groups to differ on pre-treatment measures and they did not. Although both groups got somewhat better there was a statistically significant difference between those subjects who had received real TFT and those who had received placebo, with the TFT subjects showing significantly more improvement. There was a significant difference when all the SUD scores were averaged for each subject and the difference was more pronounced when examining the SUD scores of the subjects while climbing the ladder. Thus, those who were treated with TFT had less anxiety than those who received the placebo.

The study provides important data about TFT. While clinical trials demonstrate the usefulness of TFT, they do not have control groups, nor are subjects randomly assigned to condition. In this study, subjects were randomly assigned to condition and there was a placebo treatment. Unlike the SCD study, the goal was not necessarily to reduce the SUD to zero, but to determine if TFT, administered under controlled conditions, would differ significantly from a placebo treatment that was similar to TFT. The clinical study and experimental study, taken together, provide unique support for TFT. We plan to publish the full results of the study in the future.



A Letter From Canada

By Norma Gairdner, HD, The Thought Field, Volume 6, Issue 4

Hi Dr. Callahan,

I had the most amazing cure yesterday, with an algorithm, which I used on an anxious to near-hysteria, mother. This woman is the mother of a 16 year old homeopathic patient of mine.

The girl complained so much about her mother not trusting her, that I asked her to bring her mother with her (there is no active father) to her next appointment. The mother showed up wizened, bitter, ugly-looking, frantic and fraught.

We talked for awhile about the relationship between herself and her daughter who does no drugs, alcohol, or tobacco; no sex, no bad behaviour, has good grades, etc., and thinks that the mother is a "half-crazy".

After a while, I asked the mother if she would like a treatment for her fears about her daughter hanging around with the wrong friends, going downhill in school, not being prepared for life, being lazy, fighting with the mother, growing away from the mother (who has no one else), and suffering poverty in the cruel world alone (like the mother), badly prepared for real life (for which the mother feels guilty), etc.

She said ok, so I simply asked her to work up her issues and to lump all of them concerning the daughter together in her mind until they were unbearable...this woman is from Hungary and does not speak much English.

She got her SUD, after a bit of effort, up to a visible (with pallor) 8.5. I began the treatment without any muscle-testing, using the simple phobia Tx because she had had a lifetime of fear...not just about the daughter; and, I did not do PR first, though I was tempted. She was still at an 8.5, so I did the PR and then repeated the treatment. She went to a 5. Then I did the mini PR plus the affirmation (I don't know why I decided to use the affirmation, I just did.) and I could see the strength of the effect, right away. She then moved to a 2-3. I had her do the PR again, with another affirmation ("some of this problem"), and she went directly to a 1. Then, however, it was when I had her do the eye roll that she suddenly gasped with a shriek "Oh! What happened to me!?" she said.

"What are you feeling?" I said, calmly.

She said, "I feel a big warmth coming through my body". "I am dizzy," she said. (For a second she was clearly disoriented.) Then, she began to flush up really red and her whole face relaxed and her demeanor changed completely...like another person all together. She said, with her hands to her heart, "What have you done to me?"

I asked again, "What are you feeling?"

She said, "I feel, I feel, I feel completely relieved. Oh, thank you, thank you. Thank you so much!" and she wept.

I tell you Dr. Callahan, it was as though something dark had moved out from her body, and her healthy spiritual self showed up in full bloom. She looked beautiful.

I so appreciated the work....

Warm regards, Norma

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Phobias

A phobia is a persistent, irrational fear of a harmless object or situation. People who have a phobia are normally aware that the fear is irrational; nevertheless, they are unable to control the strong, fearful reaction they experience when they are confronted with the object of their fear. Their awareness of the irrationality of their fear often adds to their embarrassment about having the fear, which is exacerbated by the myths held by many people that people who have phobias lack “courage.” In reality, nothing could be farther from the truth, as it takes a supreme act of courage for people with phobias to function in the face of fears that they cannot help having.

What causes phobias? Some people erroneously believe that phobias always stem from traumas. While this might be true in some cases, it is more often the case that people are born with phobias. Biologist Rupert Sheldrake and others believe that the information in fields can be transmitted from our ancestors and passed down through the generations. In this way, phobias can be inherited, although not genetically.

All land-based chordates are born with a fear of heights. While most people outgrow this fear as a result of maturing, some people do not, and they continue to be afraid of heights. People who have a fear that they have never outgrown are said to have a neotenuous phobia.

Some phobias are atavistic, a term that refers to a throwback from an earlier ancestral form. In TFT, an atavism is a return of a psychological problem, within an individual's lifetime, that has been eliminated through therapy or subsumed naturally due to maturity (see TFT Glossary in *Stop the Nightmares of Trauma* for full definitions of atavism and neoteny).

When a phobia is clearly linked to a traumatic event, it is necessary to treat that trauma with the trauma algorithm before using the treatment for phobias; however, most phobias are not caused by trauma. It is much more common for people to be afraid of snakes or spiders, even though they have had no traumatic experience with them, than it is for people to have a phobia of something their parents might have warned them against, such as an electric socket or crossing the street.

It is also important to make a distinction between a simple phobia and complex anxiety disorder when trying to help someone. A simple phobia is a phobia that is limited to one area of a person's life. A person with a simple phobia will typically have no problem functioning in other areas of life that do not involve the object of the fear. For instance, if people have a phobia of dogs, they will normally be relatively free from anxiety and able to function in life until they encounter a dog. Simple phobias are usually easily treated in one treatment with the TFT phobia algorithm. Complex anxiety disorder will require more than one treatment, and Individual Energy Toxins will usually be involved.

Phobia Algorithms

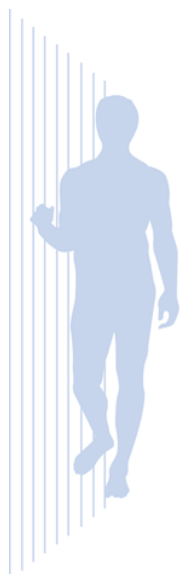
Most Simple Phobias

**Under Eye, Under Arm, Collarbone (using the Protocol)
(e, a, c)**



Spiders, Claustrophobia, Turbulence

**Under Arm, Under Eye, Collarbone (using the Protocol)
(a, e, c)**



OVERCOMING PANIC ATTACKS

By Christina Mayhew, TFT-Adv., ATFT UPdate, Issue 12, Summer 2009

Well, what if the anxiety doesn't go away. What if it gets worse? What if it gets out of control and becomes fully escalated into a full blown panic attack?

A friend of mine (Let's call him Art) was having trouble staying focused on his work, relating to others, sleeping at night, and was feeling very depressed and almost despondent. He called me and asked if I could help him. Art told me he had seen many doctors and had taken various drugs but nothing was working. In fact he was getting worse, not better.

He wasn't even sure he wanted to live any more because he felt there was nothing left in his life that he cared about. I immediately asked him if he was under a doctor's care. He said he was just released from a mental health facility and didn't have insurance so he had to keep going to a local clinic and would have to wait for hours to see a doctor. I asked him what happened. Art explained, "One day while driving to an appointment, I could feel the anxiety bursting at the seams. I was recently laid off from a large firm; I lost a long term relationship in a bitter break-up; I suffer from severe back pain from an auto accident a couple years ago, and now I don't have the money to pay my overdue rent."

Art had been looking for a job for months and was on his way to an interview, he said, when he looked in the mirror and saw his face swollen, red and very itchy. He was covered from head to toe in a rash. This was the final straw! The last thing he really remembered was stopping the car in the middle of the road and getting out. Two months later, he was released from a mental health facility, put on new medication, and sent back out into the world to deal with his challenges. He had no family locally and didn't have money to travel back home.

Art had done some pro bono work with my construction company so I agreed to see what I could do for him. When he arrived, he looked awful. His face and body were just covered in hives and he was shaking uncontrollably. I could see he was absolutely miserable and very distressed. The first thing I did was sit him down and take him through a relaxation exercise. Then I proceeded to walk him through the Thought Field Therapy Trauma Algorithm to help him overcome the trauma of the terrible rash. I then showed him tapping points for the trauma of his panic attack, then the loss of his job.

Each time, Art's shaking lessened and his body started to relax. I went on to treat him for the loss of his job and his broken relationship. Since I am new in using TFT, I was amazed to see how his demeanor changed to being more relaxed. Even his rash was starting to fade away! I tested him for some things that I felt may be toxic for him such as his anxiety medicine, foods he may have eaten, laundry detergent, etc. Because his body and immune system seemed so compromised, it didn't surprise to me to find that he was sensitive to many things. I started treating Art one by one for those sensitivities.

Two hours had gone by and I was still working on him, yet I felt the need to continue as he was showing great progress. It was truly amazing watching the rash disappear before my eyes and to see his horrible trembling almost stop. Art's big brown eyes looked up at me with tears flowing down his cheeks. I asked him if he was ok and if he wanted to stop. He took a deep long breath, closed his eyes and didn't say anything. I asked him again if he was ok or was this too much. He told me, "No, I just need a few minutes to take in what has happened." I left the room to give him some time to absorb it all. About five minutes later

Art asked me to come back into the room. I almost didn't recognize him. He wasn't the same person who walked in my door two hours before. He was smiling and almost completely free of the rash. He hugged me and said that this was the first time in several years he felt totally free, without pressure, and not anxious or nervous. He felt like he could make things work out. He didn't feel like the weight of the world was crashing down upon him.

Before Art left, I wrote the tapping sequences down for him so the next time he felt anxious, he could start tapping before he got out of control. He left a new man! I can't begin to tell you how being able to help people overcome their debilitating emotional states has changed my own life! Being able to empower people by teaching them this powerful, safe and non-invasive technique is truly a Godsend for me and them, and I know can be for you too!



Pulse Test Self-Discovery with Panic Attacks

By Caroline Sakai, PhD, TFT-VT, The Thought Field, Volume 7, Issue 1

A young adult professional male sought treatment for recurrent panic attacks. The panic episodes awakened him at night, and were most prevalent in the early morning upon awakening. He also occasionally had them while driving to work.

He worked with the panic algorithm with the addition of the middle finger, index finger and collarbone treatment points (by TFT-Dx) and could rapidly bring the panic symptoms down from SUD 10 to 0. He recalled not actually experiencing them on a trip which he attributed totally to being on vacation and not having to go to work, although he confessed he actually liked his job and had not considered that his job was too stressful until he started trying to figure out why he was having panic attacks. He even was beginning to suspect that maybe his wife was somehow making him anxious, although he reported a compatible and satisfying relationship, because he was trying to make sense out of why he had the attacks at home most, and in the bedroom especially.

He diligently did the pulse test (outlined by Arthur Coca, *The Pulse Test*, 1994). He found that in contrast to most people, his pulse rate was highest when he awakened (one-minute pulse was taken while still lying down upon awakening)—in the 95 to 105 range. It would decline while he was at work down to 65 to 80, with occasional spikes of twenty or more points after lunch or coffee break (pulse was logged 1 hour after ingestion of food or drink). He discovered energy sensitivities to his occasional decaffeinated coffee and diet decaffeinated coke through his pulse variations, and went on a trial taking those out of his diet for 8 weeks which eliminated the occasional daytime spikes. He realized after significant reduction in his pulse after washing all his bedding, that it could be his two cats, which he adored, and which slept or scampered on his bed, and with which he played before driving off to work. He called excitedly the morning after keeping his cats out of the bedroom, washing the bedding, and vacuuming the room and drapes, that he had a normal pulse and no panic episodes. He reported no panic attacks for a week, and then for a month, though it had been a daily occurrence. The panic episodes in the car stopped after he started lint-brushing his clothes and washing his hands before leaving the house and getting into his car. He told me it was a good thing he made the discovery through his own detective work with the pulse test, as he surmised that if I had suggested his beloved cats might be contributing to the firing of his symptoms, and he should consider keeping them out of his room as an experiment, he would have told me to go to hell!



TREATMENT PROCEDURES FOR COMPLEX PHOBIAS, ANXIETY STATES, AGORAPHOBIA, AND PANIC

By
Roger J. Callahan, Ph.D.

Complex phobias are defined as those phobias which are not eliminated within a relatively short period of time. Most delimited phobias, of course, are cured with the common algorithms in a brief time.

Complex phobias, anxiety states, agoraphobia, and panic disorders usually require persistent treatments, tracking and elimination of toxins over a period of time to assure a good and a lasting result. This follow up is vital to achieve complete and lasting results.

The following are the usual steps in the treatment of these problems.

I. Clarification of problem

Origin of problem (if known)

- Severity of problem
- How does it affect you?
- How long have you suffered from this problem?
- Treatment history: what treatments have you tried?
- Doctors, organizations or therapists; names and length of treatments with each.
- Your opinion on outcome.
- Conditions, places, circumstances and distances to which evoke problem.
- Medications taken in the past for this problem.
- Medications taken currently. How much, how often? Name and address of prescribing physician.

II. Treatment Procedure

- Upset thinking about a problem.

The majority of people get somewhat upset when they just think about their problem. The first step is to treat the feeling of upset while merely THINKING about the problem. It is a major step forward when you no longer can get upset thinking about a problem.

It's been known for years that when we think of a problem, our body and our mind reproduce exactly what happens to us when we are actually in the problem situation, but to a somewhat

lesser degree. This phenomenon allows you to treat the problem without you having to be in the real situation. All you have to do is think about it and then use the appropriate algorithm. In this way you can treat

in advance of being in the real situation. This can save you a lot of unnecessary pain and misery.

When you no longer get upset just thinking about a problem it doesn't necessarily mean you are cured of that particular problem, but it is a clear and encouraging development. The treatments have basically altered a fundamental aspect of your problem.

If you get upset merely THINKING about a problem you are most likely to be at least, or even more upset, if you actually engage in that problem. If you don't get upset after treatment it means something is now quite different. Many clients are significantly improved, if not completely better, after this.

• **Feel nothing while thinking about problem (before treatment)**

If you do not feel anything when you think about your problems, it is likely you are repressing, i.e., automatically keeping out of your conscious mind, an awareness of your emotions. You don't do this on purpose; you can't help it. It sometimes happens to people who feel they can't do anything about their problem. They just try to shut it out of their mind. Over time, this avoidance of awareness of emotion becomes automatic and there is no longer a choice in the matter; the awareness is simply gone. An emotion, in such people, is not perceived until it becomes overwhelmingly strong.

Repressors must be overwhelmed with an emotion before they are able to be aware of it. The repressor has become expert at not experiencing a feeling or an emotion, unless he is overwhelmed by it. The lower end of the emotional awareness scale is simply not available to this person.

The repressor can still be treated just as well as the more typical sensitive individual. The limitation is simply that the repressor doesn't know how he is doing until he is in the real situation. You will lack the immediate feedback and need to test the situation to know if you have had an improvement. In this instance you may need to repeat the procedure several times as you can only treat what you are actually tuned in to at the time of applying the algorithm. Without immediate feedback, you may not know until in the real situation that there is something else about the situation that also bothers you. If this is the case, simply repeat the appropriate algorithm at the time you begin to feel the upset.

• **Do the treatments last?**

We don't know for sure if you will be better in the real situation until you are ACTUALLY better in the real situation. Also, we don't know if it will last until it lasts. The treatments usually last over time. However, when they don't we begin the all important phase of tracking and identifying what brings back the problem. We have found that in certain complex cases, toxins of various types will cause a problem to return.

You should keep a diary or journal of everything that goes in or on your body and note when and how intense your symptoms are if they return. You can then begin to identify items that have aggravated your problem and address those items. You will also immediately treat the problem again. Note: a simple test for identifying ingested toxins is given in the book, *The Pulse Test*, by Arthur Coca. Some health food stores carry this book but it is out of print. You can download the book at: <http://www.soilandhealth.org/02/0201hyglibcat/020108.coca.pdf>

• **Treating the Underlying Problem**

The treatments are not wasted, even when a problem returns. Unlike drugs or other approaches that simply MASK the problem, TFT treatments are addressing and reducing or eliminating the basic underlying cause of the problem within the body and it's fields.

Most importantly, don't get discouraged if you don't get well right away. Some people naturally take a little longer to get better. If you run into any special difficulties or complications chances are good we have a treatment to take care of it.

• **Success Rate**

These procedures have an unusually high success rate, thanks especially to the discoveries about psychological reversal. Review the glossary on Psychological Reversal frequently. It is helpful for you to understand this important concept.

If you are having a panic attack, immediately, correct the psychological reversals, tapping the PR spot and under the nose, then do the collar bone breathing. That will often ease up the panic very quickly.

• **Objectivity needed**

Don't try to "help" the treatment by imagining you feel better if you actually do not. Conversely, don't hesitate to say you are feeling better if you ARE feeling better. Some people are afraid to admit they feel better for fear they will lose it. The gains from these treatments are very rarely lost.

You are the world's leading authority on how you are feeling, only you know for sure. Your reports guide the treatments and therefore, it is important for you to strive to be objective and accurate so you can be more effectively treated

• **One Problem At A Time**

It is impossible to treat more than one problem at a time. Keep your focus (your Thought Field tuned) on the immediate problem being treated as best you can. Don't shift your attention to the future or some other problem once you begin the algorithm.

Remember you can only treat one thing at a time. These treatments are remarkable, but they don't treat everything at once.

• **"I Can't Think About It Anymore"**

I hear this phrase a lot. It is an interesting and typical response from someone who has been successfully treated. Every time they have thought about their problem in the past, sometimes over decades; they have always gotten upset. Now, for the first time, they can think about their problem without getting upset and they wrongly conclude they must not be thinking about their problem. This is, of course, not precise. The reaction stems also from not believing this simple treatment could have had such a profound effect. It is hard to believe so they try to "explain" what happened by conjuring up the idea they must not be thinking

about it any more.

It is impossible to say the words, “I can’t think about my problem anymore” without actually thinking about the problem.

What is usually meant is: when thinking about the problem, for the first time since there was a problem, it is not possible to get upset.

A more precise statement would be, “Now, for the first time since I have had this problem, I don’t get upset when I think about it.”

III. Removing Traumas from the Past

This part is not critical for most people but it can smooth the path toward getting better and it is a crucial step for some clients. Try to recall the first time the panic or anxiety occurred or remember the absolute worst experience with it.

We can now remove the negative effects for all kinds of traumas from the past including war traumas, rape, robbery, accidents, grief, loss of a love, and other horrible experiences such as panic attacks.

Your first experience with your severe problem is similar to having been in a war or a horrible accident. These types of problems are called “post-traumatic stress disorders” and there has never before been an effective treatment for them. We can now remove these traumas quickly and effectively. Removing the effects of the trauma doesn’t cure the major problem (unless the major problem is a trauma) but it usually makes it easier to eliminate the problem.

One treatment is all most people need to eliminate the negative effects of past traumas forever. Should you ever again be able to get upset thinking about this trauma of the past it means you didn’t remove all of it. You should write a list of the things that still bother you about the past trauma and then address each one separately with the complex trauma algorithm.

IV. Pushing Yourself

Most people, including professionals, assume you have to push yourself; that you must experience anxiety over and over again in order to get better. Fortunately, that is rarely necessary and often creates additional trauma. I want you to feel relaxed and confident (which comes naturally with effective treatment) BEFORE you test the results in reality.

You will know when you are ready to test the treatment in reality. You will feel relaxed and confident thinking about it. That is the time to test it.

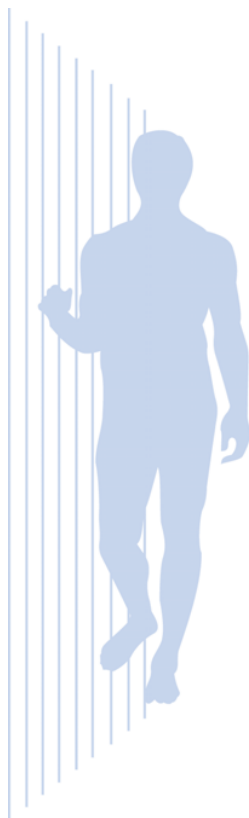
V. Medications

There are many problems with medications. First, even when drugs work they are only MASKING not curing the problem. There are side effects which are known and there are side effects which are NOT YET KNOWN with newer drugs. Then there is the addiction problem, which can create worse problems than you had before you started using the drugs. I have found that any drug, or even activity, which masks the awareness of anxiety, is likely to cause a serious addiction.

I am not opposed to drugs, but it's like major surgery; I recommend you try other, less toxic, approaches first. You will see that TFT usually works better than drugs and, most importantly, it eliminates the UNDERLYING CAUSE of your problems. You do not, therefore, risk addiction or side effects to the TFT procedures as you do to drugs. TFT actually eliminates the problem, not merely masks it.

If you are taking medication for your problem, discuss with your physician the possibility of weaning you off the drug. Withdrawal effects and severe anxiety connected with withdrawal can often be eliminated with TFT addiction treatments.

It is vital to follow the medical advice of your physician. Getting off any drug without medical supervision can lead to other problems.



Treatment for the Trauma of Panic Attacks

One of the most striking facts about panic is the consummate severity of it. Unless you work with victims of this disorder, or have experienced panic personally, it is hard to imagine how disruptive and terrifying the experience is. The state of panic represents the extreme acute intensity of what is possible in the realm of psychological suffering. There are objectively worse things that can happen to people, and there is suffering that can take a greater toll, but there is no suffering which is as acute or as disruptive as a severe panic reaction.

It usually strikes without warning and is a devastating experience. It has a severe negative impact to a person's confidence and self-esteem. Self esteem is affected because the victim usually and (unfortunately) blames himself for having an irrational "weakness". Self blame adds a very severe complication to the problem (see Psychological Reversal). Panic is a sharp intense and sudden attack of severe anxiety.

A panic attack is so severe that once it happens it has an extreme effect on how a person lives his life. Often, the sufferer is taken to the emergency room. The thought of having on of these attacks alone, and or, away from the security of home, or medical help is unbearable. In extreme cases, the person may become home bound, or has a limited territory beyond which he cannot go. The most poignant description of this horror was given to me by a young and devoted mother of a three year old child. She was unable to travel more than six feet from her front door. The worst part of the problem was, she told me, that if her child had to be taken to a doctor in an emergency she simply would not be able to take him. Knowing the truth of this made her feel more terrible.

Once this has happened to a person it creates a feeling of being psychologically crippled. The occasion of a panic attack creates a post traumatic stress disorder. It is similar to being in a war or a horrible accident. Therefore it becomes an important and central part of treating panic disorder to also treat the trauma of having the panic attacks.

Like most things panic exists in degrees. The most severe form is often underrated both by professionals and by relatives. Professionals are often quoted as saying that no one has ever died of panic.

Recently, a young Navy trainee who was severely phobic for water was taking training where he was supposed to submerge himself in a tank filled with water. He protested but the instructors, forced the young man to go in the water despite his pleas, and he died.

Panic Similar to an Earthquake

In certain respects panic is similar to an earthquake that happens inside oneself. Both severe anxiety (panic) and severe earthquakes are intrinsically horrifying experiences. One never knows when it will strike; both are unpredictable and may occur at any moment. Once someone has experienced either a severe earthquake or a panic it is unforgettable and the potential for more is a chronic source of intimidation.

We successfully treat people who have been in severe earthquakes and for whom the very thought of an earthquake is emotionally shattering and intolerable. After the treatment the formerly intimidated victim is typically one of the calmest people around in the next earthquake. We strive to do the same for panic victims.

When a panic victim knows how to neutralize a panic attack it dramatically reduces any former intimidation and leads to a growing confidence and sense of well being. Eradicating the effect of past panic attacks adds a great deal toward developing a calm and growing sense of confidence and a gradual elimination of intimidation.

Panic Creates a Post-Traumatic Stress Disorder

Post-traumatic stress disorder is a condition caused by a very upsetting, stress producing situation such as being in a war, a severe accident, victimized by rape, child abuse, or having a severe panic attack.

It doesn't do much good to diagnose the presence of post-traumatic stress disorder unless one knows what to do about it. The conventional treatments for post-traumatic stress, in my opinion, are usually worse than doing nothing. Having a victim relive emotionally, the agony of having gone through a horrible experience usually makes things worse. If you can't help someone with a problem, then it's better to do nothing at all.

Until I developed the treatment presented in your week 4 handout for post-traumatic stress, there has been no treatment which has significantly helped trauma victims. Mrs. W. had her first attack forty years ago. She has had no panic attacks for the last ten years. She would like help because she would like to travel with her husband and she just can't stand the feeling of being 'trapped' on the plane. We treated her of the upsetting thought and quickly got her from an 8 to a 1, just thinking about flying. She will be testing this out in the next few days and see how it holds up in the real situation.

We will check her, via telephone, the day before the flight and then will have a telephone appointment at the airport before she leaves.

After the brief treatment for flying, I asked her to think about her first panic attack forty years ago. She became visibly upset and went to an 8 on the 10point scale. I asked if any time during the forty years since the first attack, if she had ever been able to think about it without getting upset. She said, "No"; each time brings back almost the same horror of that first attack.

I asked her to think about her first attack while we carried out our rapid and treatment for trauma. Within a few minutes the 8 was reduced to a 1. We tell the client that if ever again they can get upset thinking about the trauma, to call us immediately, because that proves that we didn't get all of it. When it is thoroughly treated, the victim, will not get upset again.

We have had a lot of experience with this treatment, and it usually lasts, but sometimes it has to be repeated. The treatment goes very deep and, among other things, chronic nightmares about the trauma cease and the individual is able to recall and review the event with no trace of an upset.

We routinely check with each client, who has suffered from panic, and clear out the traumas associated with the frightening onset of the condition. The trauma treatment does not take care of all of the person's problems, by any means, but it is an important and often critical step in bringing about the eventual recovery from this problem.

Complex Anxiety Disorders / Panic Disorder

Complex Anxiety Disorders

Complex anxiety disorders are more complicated to treat than simple phobias. People with complex anxiety disorder have multiple phobias that affect their lives as a whole and interfere with their ability to function in major areas of their lives. An example would be agoraphobia. These clients can definitely be helped with TFT; however, it usually takes more than one treatment. Multiple aspects of the problem need to be addressed, as well as the traumas in their lives.

It is important for therapists using TFT to explain this information to clients with complex anxiety disorders so they do not become discouraged if they are not cured by one simple treatment. These clients also very often have Individual Energy Toxins that need to be addressed in order for the treatments to hold up over time (see “Cure and Time”). While an algorithm-trained person can help them by using the procedures to address different aspects of their fears, it is often necessary for them to have at least a few sessions with a person trained in TFT Causal Diagnosis or Voice Technology.

Complex Anxiety / Panic Attack Algorithms

First Use:

Eyebrow, Under Eye, Under Arm, Collarbone (using the Protocol)
(eb, e, a, c)

Alternative Algorithms:

Under Eye, Under Arm, Eyebrow, Collarbone (using the Protocol)
(e, a, eb, c)

Under Arm, Under Eye, Eyebrow, Collarbone, Tiny Finger (using the Protocol)
(a, e, eb, c, tf)

Eyebrow, Under Arm, Under Eye (using the Protocol)
(eb, a, e)

Under Eye, Eyebrow, Under Arm, Tiny Finger (using the Protocol)
(e, eb, a, tf)

Treatment for Neurological Disorganization **(collar bone breathing for anxiety and panic)**

The mind and body are obviously interconnected. Although there have been claims for many years, there is no solid evidence that the mind can exist apart from a living, functioning body. The brain and the nervous system are the parts of the body which are most intimately connected with the mind. It is artificial to separate the mind from any portion of the body; although we do it for convenience and simplification of communication.

Parts of the nervous system are developed and organized prior to birth and other parts become organized during the early developmental years. Early crawling activity and walking bring further refinements in the way the nervous system is organized and these activities are influential in the developing brain, including the ways in which the right and left brain are organized.

Problems can develop in the organization of the nervous system and such problems have many implications. For years, it has been known that there are children whose learning is affected by some kind of “neurological problem”. When I was a graduate student at Syracuse University and, later a research clinical psychologist at Wayne County Training School and, still later, at Eastern Michigan University, the workers in the field would refer to these children as “minimally brain injured children”. The most distinguishing characteristic of these children, apart from their perceptual, learning, and behavioral difficulties was that there was no evidence of ANY brain damage. I carried out a small campaign to change their name to “perceptually disturbed” which was descriptive of something they were, as opposed to something they were not.

Thanks to a number of other workers who shared my view, you rarely hear the term “minimally brain injured” anymore.

Among the many symptoms of such children; they often reverse figures and ground in their perceptual fields and were often hyperactive. Many of these youngsters were dyslexic in varying degree; that is, they were unable to read or if they could read it was with great difficulty and strain.

Signs of Neural Disorganization

The state of neural disorganization results in a state that those in applied kinesiology call “switching”. (Walther, David, Applied Kinesiology, vol 1, 1981, Pueblo, Co., p.139) Dr. Walther points out some of the body language that is often indicative of switching:

“An easily recognized sign of disorganization is the reversal of actions or thoughts. This is often seen as the patient does exactly opposite what the examiner requests, such as lying face down when asked to lie on his back, turning right instead of left, looking up instead of down, etc. Reversals are seen in the transpositions of letters in typing or doing mathematics, and in saying the opposite of what is meant.” (Note: we find these same phenomena in the state of psychological reversal which suggests that when we get reversed, among other things, our nervous system temporarily go out of organization. The “switching” phenomenon tends to be permanent before correction, while psychological reversal can be transient.)

“Poor coordination of the musculoskeletal system is evidence of possible switching. Numerous bruises on the legs or arms should alert the doctor to ask about bumping into coffee tables, door jams, etc., while moving about the house.”

Dr. Walther reports that some patients tell him that they repeatedly bump into the bed while they are making it and machinists who work with the same machine every day keep bumping into it. The severely switched child is the one who has trouble throwing a ball and has poor coordination in catching one; he is usually considered the “klutz” of the playground. He is the child who gets chosen last when the kids are choosing teams.

In World War II, in the Air Force Aviation Cadet Program, we would have a few candidates who could not get the basic maneuvers of left and right face consistently correct. I remember one fellow for the Ozark region of Missouri; he was unschooled, but he was obviously very intelligent and passionately wanted to be an Air Corps pilot. He washed out because of his confusion about right and left. Some of the training officers thought he wasn't too bright, but it was obvious to those of us who knew him, that he was probably brighter than those same officers. He had to achieve a high score on an intelligence test in order to enter the program in the first place. No one knew what the problem was, least of all him. Today, it is clear to me what was wrong with him. He had a problem with neural disorganization.

Dr. Walther also points out that the organized individual has a rhythmic movement while walking and running, whereas the switched patient is awkward.

Arm Swing When Walking

About twenty years ago, on TV, I saw a mugger in New York being interviewed about how he chose his victims. I remembered that he said that he watched how they swing their arms when they walked.

He said something about preferring a victim who didn't swing his arms because it seemed easier to surprise him and catch him off balance. Since that time, I have noticed how people swing their arms.

As is generally well known, normal people swing their arms when they walk. As the right leg goes forward, the left arm swings forward automatically. The nerves that control the relevant muscles are organized to promote that kind of heterolateral movement which is typical for humans.

I have observed that individuals who have a problem with their neurological organization will have a curtailed arm swing when they walk. Some have no arm swing at all when they walk while others have a curtailed swing of both arms or just one arm. It is interesting that these people are not aware of this until it is pointed out to them; and then they readily see it, but usually don't recognize that there is anything unusual about it until they observe other people walk quite differently.

A survey carried out on the street, yielded the following information about arm swing in the general population. The condition for observing will be spelled out incase you would like to check out the results for yourself.

Only count people who are in a full gait; meandering slowly doesn't count because there is no chance for the arms to swing. Only count people who have nothing in their arms and who are not obviously crippled. Using these criteria, we found that 2 out of a hundred do not swing either arm and 8 out of a hundred have a definitely curtailed arm swing in one arm.

Among difficult patients, the percentage of curtailed arm swing is far higher than the above figure. We

find a significant correlation between the degree of curtailed arm swing and the number of K27's (collarbone breathing treatments) that need to be done. We find that complex, non-responsive patients show the need for this kind of therapy. Dr. Walther (p.150), who works with physical problems states "It appears that all problem patients have neurological disorganization ...". We confirm that same finding in regard to panic, agoraphobic and chronic patients. When the correction for the disorganization is done, we find that most problem patients respond much more effectively.

K27 Therapy (Now referred to as Collar bone breathing exercises)

The K27 (collar bone) points are located at the junction of the sternum, clavicle and first rib. One is to the right of the center and one is to the left of center (see handout week handout). To find it, take your hand and place it at the bottom center of your chin and move it down the center of your throat until you touch the top of your collarbone. Now move down about one inch and then move about one inch to the right. You are now touching the right collar bone or K27 point. Move one inch to the left and you are touching the left collar bone or K27 point. If you are anywhere close to it; it will work.

The cross K27 treatments, or now simply referred to as the collar bone breathing exercises, which I have developed are based on some basic discoveries by Dr. George Goodheart and some crucial additional discoveries of Dr. David Walther. Dr. Walther has used his cross K27 treatments with success in treating some cases of schizophrenia and in cases of children with neural organizational problems.

The treatments are called K27 because the point touched during the treatment (see diagram) is the 27th point (the end point) on the kidney acupuncture energy meridian. This point is considered the home of all associated points.

The treatments developed by Dr. Walther require the service of a highly trained physician who is skilled in cranial manipulation. Some osteopathic and chiropractic physicians, skilled in applied kinesiology, are trained in this specialized procedure.

For our purpose, I found a far simpler way to make these corrections which appears to lead to similar results, as the involved and complex treatments. We have a considerable amount of clinical evidence that these simpler treatments help difficult and non responsive clients with complex psychological problems.

I have measured a number of severely disturbed clients, before and after these treatments, some of whom might be classified as ambulatory schizophrenic, using the HOD Test (The Hoffer-Osmond Test) which measures overt psychological, perceptual, and physical symptoms of schizophrenia. Definite, and in many cases, dramatic improvements were observe in the test results and in reduction of symptoms after these corrections were done.

Many people, apart from these severe cases, can benefit from the treatment. I have found it to be very helpful in many particularly difficult cases of any type of psychological problem. (We consider a case difficult, if the response to treatment is not immediate.) The cross K27 treatments, or collar bone breathing exercises, have proved to be especially helpful to some of the challenging anxiety and panic patients we have treated. Many people need to do the treatment only once but there are some people who need to repeat them daily, as I do for myself, or, after any significantly stressful event.

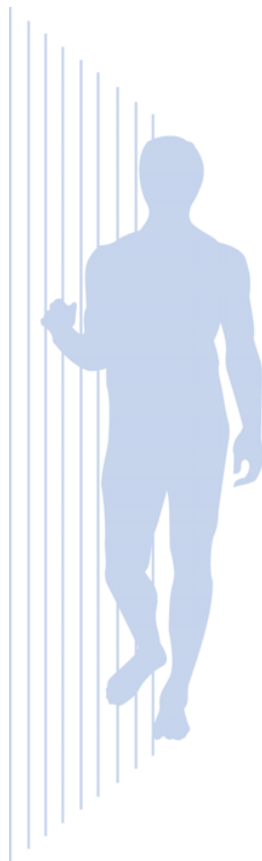
A theory about the treatment is that it is directed toward properly aligning the disorganized nervous sys-

tem. A person may be born with this tendency or it may be caused by traumas and perhaps may be perpetuated by the continuing trauma of body structural problems such as foot misalignment, spinal or pelvic distortions, or some other recurring cause such as continued exposure to toxins.

My own clinical experience suggests that people who are highly sensitive or susceptible to toxins, certain foods or substances are among those who repeatedly require correction of this problem. This includes those with anxiety and panic disorder and obsessive compulsive disorder.

Many people who were having difficulty responding to our anxiety treatments were able to respond after receiving the correction treatment described in your week three handout on collar bone breathing exercises. If you are having trouble responding to the treatments in the algorithms try the following procedure and then repeat the standard treatments three to four times daily. When you master these treatments you can carry them out in a matter of minutes.

We have found that if you do a treatment and it isn't needed it does nothing. Therefore, you can treat all forty, multiple times in a day, if you suspect you need it and it won't hurt. You can treat all of them faster than they can be tested, in any case.



Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 6: Application – Addictions and Obsessive Behaviors

1. What is Addiction? - handout

2. Case studies

- a. Radio and TV with shows with skeptical strangers –
- b. Addiction, Addictive Urge and TFT – handout article

3. Addictive cravings or urges - handout

- a. Explain and lead through algorithms
- b. Role of toxins

4. Other complicated addictions

- a. Underlying anxiety – masking
- b. Body image distortion – article handout

Anorexia and Bulimia

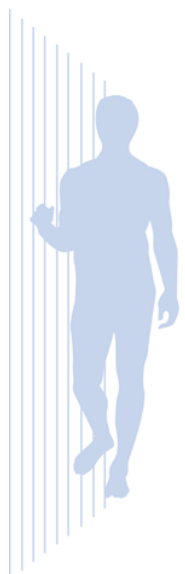
- c. Sexual addictions – case study - handout

5. Obsessive behaviors – handout

- a. Behavioral addictions – masking anxiety
- b. The Five-Minute OCD Cure – handout article
- c. Role of toxins
- d. Lead through algorithms

6. Q & A Submitted in Advance

7. Demonstrations – Submitted in Advance



WHAT IS ADDICTION?

Addiction is a dependency on some substance or activity which causes some degree of harm to, or interference with, a person's life. The dependency is powered by the tranquilizing (i.e., anxiety masking) effect of the substance or activity. Anxiety is a terrible emotion to experience and is worsened when there is no apparent cause for it. The anxious person not only feels bad due to the anxiety, but he also feels stupid for feeling bad, because he knows that the emotion makes no sense. If an anxious person takes something, or does something which blocks awareness of the anxiety, he feels tremendous relief.

The person feels calm, serene, tranquilized, temporarily free of the agonizing feeling of anxiety. The relief feels so good that it makes a profound impression on the body and the mind of the anxiety victim. Though many addicts are aware of this sequence of actions leading to addiction, not every addict is aware of the process. This sequence happens to each addict at a profound level of being, regardless of the level of conscious awareness.

The process of addiction creates a state of self-sabotage in the victim. This state makes it especially difficult to overcome the addiction because it drives the addict to engage in self-defeating and self-sabotaging activities and to become his own worst enemy, such as not doing a simple treatment which can eliminate the addictive urge. (See Chapter on Psychological Reversal for a fuller discussion of this problem.)

Why do certain substances or activities mask anxiety? This is an important question and the answer is not yet fully known. Some drugs appear to physically block awareness of anxiety, through the nervous system, or the brain, and some activities such as thumb sucking or hair pulling appear to be intrinsically soothing to some individuals, and the apparent comfort of the activity appears to block awareness of anxiety.

The term "addiction" is often used rather loosely and as a result there is considerable misunderstanding of the problem. For example, we may say that people are addicted to sports or books. But this meaning is not meant to indicate a problem. It is meant to indicate a strong or intense fondness for sports or books.

In a psychological or medical sense, the term "addicted" has the clear implication of indicating a problem. An addiction interferes with a person's life, functioning, health or well-being in some degree.

It is unreasonable to call natural, wholesome, and healthy good feelings an addiction. To feel good physically and mentally naturally, without drugs, is a sign and a consequence of good general health.

Everything that we feel or experience has physical consequences in our body. Each mental state has physical, electrical, structural and chemical consequences. Some of these consequences can easily be demonstrated in fine detail and more will become so as our abilities to measure these phenomena improve.

When we feel good naturally, there are some known chemical correlations to this feeling. Joggers, prize fighters, and other athletes in training, report that they feel good when they train. Some experts have pointed out that this good feeling is the result of endorphins being released. There is good evidence that the endorphins are being released but the use of the term addiction to refer to people who enjoy feeling good naturally is questionable and leads to unnecessary confusion in the already confused field of addictions.

Some experts on addiction believe that superior physical conditioning leads to the athlete being addicted to the release of his own endorphins, a kind of natural morphine released in the body. Other experts point out that daredevils, stunt men, test pilots, race car drivers, firefighters, and policemen get addicted to their natural adrenaline rushes. Addiction, by the definition used here, must cause some degree of harm or interference with a person's life.

I believe that it doesn't make sense to use the term addiction in this manner since it unnecessarily confuses the real problem of addiction. The training athlete feels good naturally and what he is doing promotes his physical and mental well-being. It seems absurd to call this an addiction.

There are many people in what may be called dangerous professions who very much enjoy their work and who find the mastery of this work thrilling and exciting. On the face of it, it makes no sense to call the love of their work addiction.

There are a small number of people in every line of work who may have a death wish or who show suicidal tendencies. There may be a few individuals in these objectively dangerous professions who also have a death wish, or who are self-destructive. Their work is intrinsically exciting, especially when they master it. The intense enjoyment of the mastery of difficult or dangerous work is not sufficient to label it a problem or an addiction.

Professionals in these fields are more aware of the dangers in their work than the addiction experts are, and they typically take appropriate precautions and usually balance the gains against the hazards. They take pride in their skills and the enjoyment of their work. The love of their work cannot, properly, be called an addiction.

Addictions, like other problems, can exist in degrees of severity. A severe addiction is when one's life is strongly and seriously disrupted and when there is an irresistible urge to take the addictive substance or engage in the addictive activity.

The lives of some addicts are severely threatened and disrupted by their addiction, but some are protected and sheltered by friends and relatives which, though helpful, also postpones the day of reckoning with the harsh realities of their addiction. Their lives may SEEM to be all right, but without the help and support of family and friends, the severity of their problem would be more quickly obvious to all.

PHYSIOLOGICAL ADDICTION

Most everyone is aware of what is called a physiological addiction. A classical case is addiction to heroin. Heroin and its derivatives are among the most physically addictive of drugs. Usage over time results in the body building a tolerance for, and a dependency upon the drug. When the person cannot get the drug for a period of time, he goes through withdrawal symptoms which include physical and psychological suffering. Even withdrawing from a mildly addictive drug, such as coffee, can result in mild withdrawal symptoms such as headaches.

Recently, the American Surgeon General announced that nicotine is a physiologically addictive drug. Professionals in the field have been aware of this fact for decades. The physiological aspects of addiction to nicotine are over with in about two or three days after withdrawal. Ask any heavy smoker if his problems with smoking are over with after three days of abstinence and most will tell you “no” Some smokers will suffer terribly from smoking for as long as one year or more after quitting. This withdrawal obviously cannot be due to physiological factors for they are over with rather quickly. What is going on is a crisis of anxiety caused by withdrawal of a favored tranquilizer. Often, other tranquilizers are found to substitute for the cigarette. For example, many former smokers gain weight after quitting smoking. They substitute food for cigarettes.

There is no question about the fact of physiological addiction to certain drugs. It is my thesis, however, that the purely physiological aspect of addiction is a relatively minor aspect in the whole problem of addiction and is overemphasized.

PHYSIOLOGICAL ADDICTION IS NOT THE MAIN PROBLEM

For years, the experts were befuddled and misled about cocaine. It was not a strong physically addicting drug and most experts considered it harmless. Today, it is well recognized that it is a powerful psychologically addictive drug.

Some purists would only use the term addiction for physiological addiction. But as we shall see, the serious problem of addictions are not primarily physiological, but rather psychological.

In England, it is legal to use heroin for patients who are suffering from severe and chronic pain. The interesting fact has been observed that when the patient stops taking the heroin there is no withdrawal problem. This can be explained by my theory; i.e., the patient was taking heroin for pain not for anxiety. Hence, when the pain is gone the patient shows no withdrawal which supports my idea that addiction and withdrawal is due to anxiety.

In the Vietnam war, a majority of American soldiers in combat used a number of illegal drugs. It is surprising to most experts on addiction that the vast majority of veterans who had used drugs, over long periods of time, simply gave up the drugs when they returned home. According to the prevailing theories about the importance of physiological addiction, this should not have happened. Most of the veterans, the theory goes, should have been addicts when they got back.

Only a small percentage of regular drug users continued using drugs after they left the stress of combat.

It seems likely that both the pain patients in England, and the veterans in combat, were using drugs primarily to help alleviate an unbearable objective situation in reality; physical pain in the case of heroin in England for pain and objective anxiety due to the war. When the reality situation no longer existed, there was no addictive problem, despite the physiologic dependencies that had been established.

The reports about the pain patients who used heroin and the war veterans who used hard drugs fit the theory presented here about the nature of addiction. The main difficulty in withdrawal is a crisis of anxiety. When the person cannot get his favored tranquilizer (which merely masks and does not eliminate anxiety or

its cause), he goes into a severe anxiety state. Although physiological addiction is real, the basic and serious problem involved in addiction is psychological. Withdrawal, I maintain, is an anxiety attack.

Some experts on addiction will have trouble grasping this new theory because they don't have an appreciation of the severity of the problem of anxiety. They wrongly believe, that because there are physical symptoms of withdrawal, the cause must be physiological addiction.

All emotions have physical consequences; an emotion is a PSYCHOSOMATIC (mind and body), or more accurately a unified response of the body/mind. When emotions are intense and severe, they have very strong physical consequences. That is why so many panic attack victims believe they are dying of a heart attack and it is not as reassuring as one might imagine when they discover that it is not a heart attack. Intense anxiety is certainly one of the worst feelings that anyone can experience.

An agoraphobic patient gave me a good example of how terrible and invasive the emotion of extreme anxiety can be. She was a young and devoted mother of a three-year old son and she said that if her son's life depended upon her ability drive him to a hospital in an emergency, she would not be able to do it. She couldn't walk, let alone drive, further than a few feet from her front door. This simple act, for most of us, was impossible for her. This is not an issue of a lack of courage, for I know personally and have treated heroic veterans who have shown enormous courage in combat, who could not tolerate this kind of anxiety. If you haven't seen or experienced very intense anxiety, it is hard to understand the sheer horror of it.

THE ANXIETY-ADDICTION CONNECTION

There are legions of people in the world who, although they are not in chronic physical pain, or not in combat, feel just as bad or worse, than if they were in combat or in chronic physical pain. We call these people "anxious."

Anxiety is the presence of fear when there is no objective external reason to be afraid. The uninformed may scoff at these people because their problem appears to be ridiculous but the victims of anxiety know, better than anyone else, how ridiculous it is. This knowledge only complicates their plight, for they suffer not only from anxiety, which is bad enough, but they also feel extremely foolish and stupid for having the problem.

THE CAUSE OF ADDICTION

All addiction problems are a result of the anxiety masking effect of certain drugs (legal or illegal); such as caffeine, tobacco, alcohol, cocaine, heroin, gasoline fumes, marijuana, Xanax, Valium, chocolate, foods; or the anxiety masking effect of certain activities, such as nail biting, hair pulling, thumb sucking, obsessive rituals such as counting or moving in prescribed manners, and many of the avoidance behaviors common to severe anxiety and panic disorders also may develop an addictive aspect.

The most commonly used drug is aspirin. Yet, in forty years of practice, and having treated many forms of addiction over those years, I have never seen a case of addiction to aspirin. A few people in chronic pain may use aspirin regularly, but it is not meaningful to talk about being addicted to relieving physical pain. When the pain is gone, there is no further need for the aspirin. If aspirin had anxiety masking properties, then we would see many people addicted to aspirin. The mere use of a drug doesn't result in an addiction.

The drug must have anxiety masking effects for a highly anxious person before an addiction will take place. It is this reason that I believe any effective tranquilizer will become an addictive drug.

My theory is that the small number of veterans who continued drug use after they left the stress of combat and returned home, were chronically anxious people who needed the drug for relief and who discovered the anxiety masking properties of their favorite drug while they were in combat. They continued using the drugs after the war because they were under the great stress of anxiety though they were out of the war. It could even be a relief to such a person to have a reason to be anxious, such as war; it would help them to make some sense of their strange and terrible pervasive feeling.

Because anxiety is such a common psychological problem, many soldiers were probably under great stress before they got in combat. Some of them would have been under the great stress of anxiety even if there were no war. Some of them suffered from post-traumatic stress disorder due to the horrible experiences of the war. All of them needed relief from their suffering after the war. The drugs that they used seemed to provide that much needed relief. Note: the drug didn't actually provide relief; it merely SEEMED to give them the much needed relief that they desperately needed.

The majority of combat veterans did not need the drugs after the war was over and, therefore, it was easy for them to give the drugs up. The source of anxiety, the war, was over for these veterans, but for the chronically anxious veteran, the stress was still there as it was before exposure to the war.

Many people say that they use drugs in order to feel good. Actually, what many of them (those prone to addiction) call "feeling " is the temporary illusive feeling of the freedom from anxiety. The anxiety may be so chronic that they might not even be aware that they are feeling so bad until they try a drug and find that they are capable of feeling much better than they ever imagined.

An addict, or one who is prone to addiction (addictive personality), is one who suffers from chronic or situational anxiety which can be almost unbearable. He finds, perhaps accidentally, that a substance or an activity gives him APPARENT relief.

It is important to understand that he does not actually get any relief. What he gets is a tranquilizing or masking or blocking effect. The anxiety is temporarily masked. This masking effect carries a danger because it sets up the situation where an addiction can take place. He receives much needed, but only apparent relief from the anxiety. An addiction may begin with whatever substance or activity it is that provides the much needed relief.

If the drug or activity actually reduced anxiety, or contributed to eliminating the cause of the anxiety, there would be no addiction problem. In that unlikely case, the problem would be receiving a treatment and the problem would be diminished or possibly eradicated.

In fact, what happens is that the anxiety usually and typically gets worse as the addiction builds up. The serious crisis in withdrawal from an addictive drug or activity is a crisis of anxiety. Unless you are familiar with anxiety patients, or with addicts who are undergoing withdrawal, you may not appreciate how difficult and excruciating a problem this anxiety of withdrawal can be.

Also, an addict who has been successful in quitting may go through a renewed crisis if something stressful

happens, such as losing a job, or a family member getting ill. Any upsetting event may trigger an extreme renewed intense need for the favored tranquilizer.

ALL ADDICTIONS ARE, MAINLY, ADDICTIONS TO A TRANQUILIZER

A tranquilizer, in this context, is any substance or activity which masks or hides anxiety. It can be a drug, alcohol, food, cigarettes, gambling, nail biting, pulling hair out, or any number of substances or activities.

A heavy user of any tranquilizer is usually not aware of the underlying anxiety problem because he is continually masking the anxiety. A simple experiment can reveal the existence of the underlying anxiety. Let any addict, of any sort, be without his favorite tranquilizer, whether it is a substance or an activity, and intense anxiety will overwhelm him. He will then be very much aware of the anxiety, which is ever present, but usually is obscured from awareness.

The addict, in withdrawal from his tranquilizer, will become acutely aware of the anxiety that is lurking there all the time but is never thought about because it is constantly being masked. At the first sign of anxiety, the addict typically will indulge in his favorite tranquilizer and, therefore, he does not get much chance to become aware of the anxiety.

A heavy smoker who runs out of cigarettes and finds that all the stores are closed and all the cigarette machines are empty will know the anxiety that he is simply not aware of when he is smoking cigarettes one after the other.

If this theory about the basic nature of addiction is correct, then it should be possible to eliminate even the most powerful addictive craving by treating and removing (not masking) the underlying anxiety which powers the addictive urge.

As you read on, you will see that we can now indeed rapidly eliminate the most powerful addictive craving by removing (not masking) the underlying anxiety. This gives us a powerful tool to eliminate not only addictions, but to eventually eliminate the underlying cause of addictions. When you study and apply the procedures presented here, you will find that you will be able to do this for most addicts with ease.

HABIT AND ADDICTION

Many people confuse habits and addictions. There is a great deal of difference between the two.

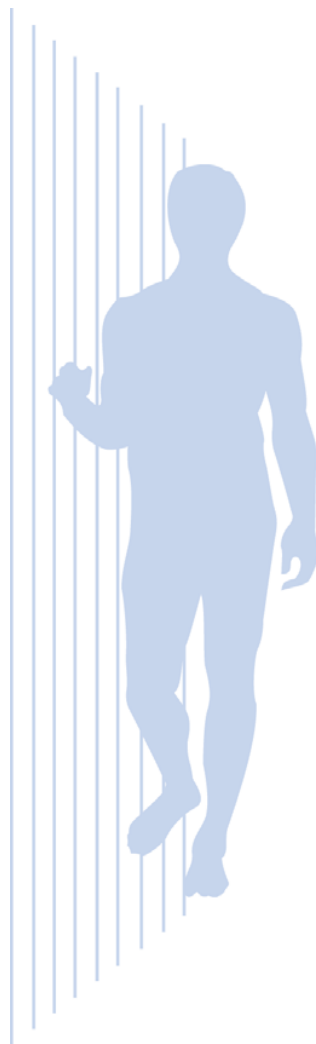
A habit is a behavior pattern that is done regularly and is so established in our behavioral repertoire that it is usually done or carried out without conscious effort. Since a certain amount of effort went into establishing a habit, a certain effort is required for changing a habit.

A good example of a habit is how we train ourselves to automatically remove our car keys when we leave our car so that we don't lock ourselves out. When we go to a car wash, a car repair, or leave our car with a valet or parking service, a special conscious effort is required in order to not walk off with the car keys when we shouldn't. When we make the conscious effort, it is not that difficult to change the habit; the difficulty is remembering to be conscious about it. People think that habits are like addictions. They are not. In addiction, no matter how conscious you are, you will find your addictive urge to be rather compelling or

overwhelming, depending upon the severity of the addiction.

We all have a habit of brushing our teeth regularly. If a new discovery in dentistry proved that it was better if we did not brush our teeth (an unlikely event!); it would not be that difficult to quit. A certain amount of work is required in habits and addictions. All animals from the amoeba on up strive to minimize work or effort in carrying out activities. An earthworm will learn the shortest path to this goal in a simple maze. There is a natural repugnance to unnecessary effort. We would, for the most part, find it rather easy to give up the habit of brushing our teeth.

Addictions, unlike habits, as everyone knows, are extremely difficult to give up. If its very difficult to quit, then it isn't a habit, it is an addiction. In an addiction, one is driven and compulsive; habits are just highly learned activities.



Addiction, Addictive Urge and TFT

Fred P. Gallo, PhD, The Thought Field, Volume 1, Issue 3

About four years ago I read an article in a national newsletter that described a treatment that described a treatment for neutralizing addictive urges. The author, a psychologist, proffered the position that addiction is essentially an anxiety disorder and that the addicted person was attempting to mask the anxiety by using a substance. While I readily concurred with

the author, based on my own 21 years of working with addiction. I had a difficult time swallowing the treatment procedure. He recommended that one have addicts pay attention to the urge while tapping various points! I remember thinking at the time that most likely the psychologist had lost his proverbial marbles! I shoved the article aside.

Months later I was treating a person who was dependent on opioids. During one of our sessions she evidenced a strong urge, becoming quite pale tremulous after discussing her affinity for the drug. I attempted to assist in settling the urge by using cognitive technique referred to as rational Emotive Imagery (REI). While we were able to reduce the craving somewhat, the intensity returned moments later. Then I recalled the strange procedure I had read about. At first I was a little embarrassed to suggest it to my client, but then I figured we had nothing to lose. I simply told her that there was another technique that might help, although I could not promise that it would. I pointed out that it did not seem that it could do any harm, but then again it might do nothing at all. Talk about setting the stage for positive expectations! My client shrugged her shoulders and agreed to give it a try. We had reasoned at the time that if she had a means of settling addictive urges without using drugs, she would ne inclined to do so.

I asked her to tap under her eyes, then about four inches under an armpit, and finally under her collar-bones. Repeating this treatment several times brought the urge down to a four. While we were unable to dissipate the urge any further, she was unable to intensify the urge either, even though I had her think about “how good it would feel.” While I realized at that moment that I had more to learn, needless to say both my client and I were quite impressed.

I could not recall who wrote the article, but I was fairly sure that I had kept it. In desperation I rooted through huge stacks and files of papers at my office and at home. Eventually I found the newsletter. “Let’s see, who wrote that article?” I mused while turning the pages, “Here it is, Dr. Roger J. Callahan, Indian Wells, CA.” After reading the article again, I wondered if there might not be more to this method. I decided to give Dr. Callahan a call. While I was unable to make contact at first, since he was out of town, before long I was reviewing his materials and we were talking to each other regularly. What a delight! I had been looking for something new and exciting, something truly effective in helping people, and know I had found it with a gentleman psychologist who lived and working in the luxury of a desert. This was a whole new dimension in understanding and treating psychological problems. I was inspired once again.

But I’m getting away from my original story. Shortly after contacting Dr. Callahan, I learned more about treating addictive urges. I saw my client with the optiod problem and treated her again with more detailed Callahan Techniques®. By this time I understood more about treatment points, psychological reversal, etc. Easily we were able to alleviate addictive urges within moments. She was equipped to treat herself at will. I felt quite happy about this.

Then one day she returned to the office for a session and I asked her process. She reported that she was still using drugs at times. Amazed, I asked if perhaps the “tapping technique” was not helping. Her response: “Oh... I don’t use IT all the time; IT WORKS!” Initially I couldn’t believe my ears. But then it all made sense. There is an elusive obvious difference between addiction and addictive urge. As Dr. Callahan rightly elucidates, there is seldom a psychological reversal for alleviating an addictive urge. Not so with addiction, which is a more pervasive process. It makes good phenomenological sense. Of course the addicted person wants to get rid of the urge; that’s why he/she takes the drug. The drug alleviates the urge. The urge is the anxiety, the somatic manifestation of specific perturbations in the thought field. But after the urge is settled, there is something else present: the effects of the drug itself. This includes the “high,” the camaraderie, and certainly the self sabotage (to mention a few). A pervasive psychological reversal is often present in conjunction with a wide array of issues or holons in need of treatment.

We’ve always known that addiction has many facets, momentarily I had overlooked this point in my fervor to neutralize one of its components, the urge. The beauty of TFT, however, is that it assists the therapist in clearly mapping out the various components of a problem, while providing a precision technology for unraveling and alleviating the energy configuration at the core of each of the facets of addiction. Another beauty of TFT, especially when working with one of its diagnostic methods, is that if we start with treating the urge and have enough good sense to stay with the program even after the urge has disappeared, other layers of the problem will present themselves for treatment in logical order. It’s like a cafeteria tray dispenser; after you take the top one off, the next one in line pops right up. How much more simple could it be? How much simpler could nature have made it? As Sir Francis Bacon stated, “Nature, to be commanded, must be obeyed.”



Addictive Urges and the Anxiety / Addiction Connection

Dr. Callahan, in his book, *The Anxiety Addiction Connection: Eliminate your Addictive Urges with TFT* (1995), explained that the growing problem of addiction is due to the prevalence of the problem of anxiety. He proposed that all addictions are attempts to reduce anxiety, although the addictive substances and behaviors actually only serve to mask the anxiety and do nothing to eliminate it.

Therefore, addiction is tied to anxiety as an associated response. In fact, it is often the only conscious response. The anxiety itself is apparently out of the addict's awareness. Rather than consciously feeling the anxiety, the person becomes aware of a craving for the addictive substance (or behavior).

It is important to teach clients to use the algorithms for anxiety on their own. When clients are experiencing anxiety, they can eliminate or dramatically reduce it within two or three minutes. Imagine the benefits! In fact, don't just imagine them. Experience them! The best way for you to realize how important this can be for your clients is to use it yourself. Anytime you feel anxious about anything, treat it, and notice how much more smoothly your life goes. You may notice health benefits and an improved quality of life, as well.

The Trouble with Repression

Anxiety is so pervasive in our society that people are often not overtly aware of experiencing it. Many times, it manifests instead as a reluctance to do something. In this case, you can target the client's degree of reluctance and get a SUD level specifically for the degree of reluctance. For example, you can target your client's degree of reluctance to search for a job, although he/she may not actually consciously feel anxious about looking.

Often, people will not experience anxiety but will instead be aware of an urge to use an addictive substance or engage in an addictive behavior. For example, have you ever felt like you needed a drink or a piece of chocolate at the end of an especially stressful day? In these cases, by targeting the urge, you are targeting the underlying anxiety, as well. You can tap for the stress of the day.

When a person has intense anxiety, this sets in motion a search for a tranquilizer to mask the anxiety. The usual addictive substances generally are good masking agents for awhile. Whether treating for addiction or anxiety, the algorithms are consistently the same for both. Dr. Callahan has found that the TFT algorithm for simple anxiety (e, a, c, using the Protocol) is also extremely effective in eliminating the addictive urge, regardless of the addictive substance.

When treating addictive urges with TFT, we regularly observe an interesting phenomenon. It is often the case that people are willing and eager to be treated with TFT so that their addictive urge will go away; however, they are usually psychologically reversed when it comes to giving up the addictive substance (i.e., cigarettes, chocolate, etc.) permanently. In other words, they may sabotage themselves when it comes to the desirable long-term result of giving up altogether the substance to which they are addicted. While they are motivated to get rid of the anxiety beneath their addiction by using TFT, they may not be as willing to let go of the substance that they have been using to alleviate that anxiety.

When you have clients think about giving up the addiction itself, you will generally find that they will need to have their PR corrected.

It is necessary for people to be actually experiencing the urge in order for it to decrease with TFT treatment. When you work with a client, ask him/her to come to the session without having indulged in the substance so that he/she is experiencing the urge.

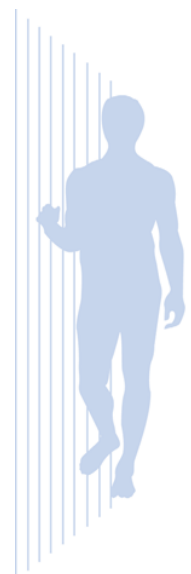
We recommend that our addiction clients perform the reversal correction (tapping the side of hand 15 times, rubbing the sore spot, and tapping under the nose) about 15-20 times per day while thinking about their addiction. You might suggest that they think about doing it approximately every hour. This helps keep them out of the state of reversal or self-sabotage. They will also benefit from doing Collarbone Breathing three times a day. You could suggest that they do it before or after each meal in order to link it with something they are already doing. As a result of staying out of reversal during the day, they will be more likely to use the addictive urge algorithm when they need it.

VERY IMPORTANT...

Continue to remind the client that it is essential to correct for PR about 15-20 times a day (side of hand, sore spot, and under nose) and to do Collarbone Breathing three times a day in order to avoid entering into a self-sabotaging state. If addicts are reversed, they will not treat themselves when they have an urge to indulge.

By treating for PR consistently throughout the day and treating the urge each time it arises, clients will find that the urge will begin to diminish in frequency and intensity. What is really happening is that the perturbations for the underlying anxiety are being treated each time they treat the urge. Eventually, enough aspects of the underlying anxiety will have been eliminated so that the addiction will no longer be necessary to mask the anxiety.

The algorithm for addictive urge has a high success rate; however, like any other successful treatment, a toxin can undo the cure. Addictive substances are generally Individual Energy Toxins and will tend to put the addicted person into a state of reversal. If the client chooses to have the addictive substance, have him/her immediately tap for reversal. Difficult cases are best referred to a person who is trained in TFT Diagnosis or Voice Technology to identify toxins.



Algorithms for Eliminating Addictive Urge

First Use:

Under Eye, Under Arm, Collarbone (using the Protocol)
(e, a, c)

Alternative Algorithms:

Collarbone, Under Eye, Collarbone (using the Protocol)
(c, e, c)

Under Arm, Under Eye, Collarbone
(using the Protocol)
(a, e, c)

Under Eye, Collarbone, Under Arm, Collarbone
(using the Protocol)
(e, c, a, c)

Obsessive-Compulsive Disorder (OCD)

Obsessions are negative persistent ideas, thoughts, impulses, or images that repeatedly come to mind. People who have them experience them as being intrusive or inappropriate, and they can cause anxiety or distress. Compulsions are repetitive behaviors in which people engage in order to prevent or reduce their anxiety or distress, often to manage obsessive thoughts. People recognize that these thoughts and behaviors are excessive or unreasonable. They are time consuming, and they can cause impairment in one's life.

The negative and out-of-control aspects of Obsessive-Compulsive Disorder make it different from normal worries about problems in life or attempts to establish positive habits and repeat pleasurable activities. A classic example is checking to see if the door is locked or the stove is turned off. An example of obsessions

and compulsions occurring together is hand washing to deal with an obsessive thought that one is being contaminated by touching others or by touching things that have been touched by others. This condition is different from an intrusive thought related to a traumatic stress event. Most of the time, people will tell you that they know these things are not worth worrying about. They will say that most reasonable people would know that they have taken adequate precautions.

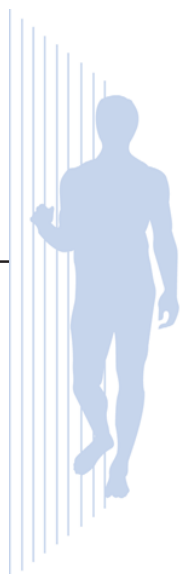
Invite the person to tune into the obsessive thought that is causing the distress and rate the difficulty of letting go of that thought or image on the SUD. Another way is to ask clients how much distress they feel when the thought is present. If they feel an urge to carry out a compulsive behavior, have them rate that urge on the SUD. Using the OCD algorithm will help to reduce the SUD. Once you have eliminated the symptoms, be sure and ask about other aspects of the problem and treat as needed (trauma, etc.). Suggest that the person do collarbone breathing three times a day and treat for reversal 15-20 times a day (side of hand, sore spot, and under nose). As with all chronic conditions, consider the impact of Individual Energy Toxins. Clients will need to repeat this algorithm, as they do with the addiction algorithm.

Obsessive-Compulsive Disorder

Collarbone, Under Eye, Collarbone
(using the Protocol)
(c, e, c)

Under Arm, Under Eye, Collarbone
(using the Protocol)
(a, e, c)

Under Eye, Under Arm, Collarbone
(using the Protocol)
(e, a, c)



Volume 8, Issue 1
The “5 –minute OCD Cure”

Dr. Colin Barron

Obsessive - compulsive disorder (OCD) is a distressing condition which affects 1 in 50 of the population. It can destroy marriages and lives and sufferers have been known to commit suicide to escape the distress caused by the condition. Unfortunately conventional medical treatment is of little value. Drugs, merely damp down the symptoms while cognitive behaviour therapy is virtually useless. Indeed many psychologists regard OCD as an “incurable” condition.

Recently I treated a patient with OCD using Voice Technology. What was astonishing about this case was not the fact that a cure was obtained (which is often the case with VT) but that the treatment time was very short ,measured in mere minutes.

A 57 year-old lady contacted me after hearing me talk about VT on a BBC Radio show. She had suffered from OCD since the age of 8. This caused her to check things excessively and to count numbers repeatedly.

Her initial SUD was 10. VT diagnosis revealed two short holons, a level 2 reversal and the need for collarbone breathing. She was found to have a few toxins namely wheat, tomatoes, vinegar and chocolate.

At a follow- up appointment a week later she reported that she had had no recurrence of her symptoms since the initial treatment. Her SUD was 1 and she found it hard to believe that she was now cured after years of unsuccessful conventional therapy.

One factor that contributed to this very successful outcome was that the client agreed to avoid all toxins totally. The short treatment time of just a few minutes was astonishing, even by the standards of VT. TFT was once described as the “Five Minute Phobia Cure”. In this instance it was also the “Five Minute OCD Cure!”



The Importance of Toxins, Personally Witnessed

Robert Grant, TFT Dx, The Thought Field, Volume 12, Issue 2

I remember having a skeptical client who was suffering from severe panic attacks, OCD and very bad anxiety. He had tried various different forms of therapy most of which made zero difference, but he had tried NLP, hypnosis and TFT with 3 different practitioners which had made some difference during the sessions but he said shortly after leaving, the anxiety and thoughts returned.

He came to me and I used TFT to relieve his symptoms of OCD, whereby he could not stop thinking about a time that he had entertained the thought of doing a very severe crime, although he didn't follow through. Now a man of 34 he was sometimes suicidal and permanently anxious coupled with these OCD thoughts. After my session with him and he left, his symptoms returned 10 minutes later. This was during my step C training, so I called Roger and Roger said to me I bet you he's a smoker and that its a toxin for him causing the return of his symptoms.

I asked him if he was a smoker and he confirmed Roger's suspicion. The man thought that I was mad and said he didn't believe in the effects of toxins. But he agreed to do some VT work. I told the client not to smoke the day of the session. I phoned Roger and began to proceed with the session. There were recurring reversals and Roger went through a list of foods and washing powder to try and identify the offending toxins. But nothing would shift the reversals. Then I suddenly noticed the client's cigarette pack in his shirt pocket. I told Roger who instructed me to take them out the room. Immediately the reversal went and Roger proceeded to eliminate the perturbations. At that point someone else walked into the room mid session, he had seen the cigarette pack on the floor and brought them back into the room and placed them on the table next to my client, without my client noticing. Immediately the reversals returned along with the symptoms. Roger was busy talking to the client and I didn't want to interrupt, so without saying anything I took the cigarettes out the room. When I returned seconds later. I asked the client how his symptoms were he reported that his suds had mysteriously dropped back down. Roger then diagnosed that the reversals were gone and he proceeded to bring down the suds. I then sneaked the cigarettes back into the room, placed them near the client and asked him how he felt he said his suds had gone up again. I showed him the cigarettes and took them away from him and the suds went down again. I then told him what had just happened. He was surprised. This man had been wasting his time in conventional therapy for over 6 years with zero results.

The day I woke up and realized the full extent of toxins and their contribution to anxiety disorders was when I treated a relative for fear of her car door opening whilst driving and of getting lost whilst driving. She reported a constant feeling of anxiety in the pit of her stomach, ALL and I mean literally ALL the time (I have found this to be an almost sure sign of toxins, unless there is an imminent danger looming e.g. being attacked or something of that nature). I wasn't aware of this at that point. So I ignored the permanent anxiety and toxins and instead with a great struggle brought down the Suds for her fear of driving an etc. The suds only came down half a point at a time (Roger told me this was an indicator of toxins). With her suds at a zero I went home leaving my relative happy.

Two days later I got a visit from my relative. I opened the door and she was sobbing hysterically. She said she had just had a panic attack whilst in the car park of her local shopping center terrified that she would get lost in the new car park wing.

The first thing I noticed after she walked in was a very powerful smell of her husband's aftershave. I asked her husband to wait in the lounge and took her into the garden.

Immediately her SUD dropped to a 3. I brought her into the living room to test my suspicion that it was the aftershave. (I didn't tell her my theory yet). In and out of the room 4 times, each time the suds would come back up to an 8 or 9 when she went near her husband. I then realized that the toxin really was causing problems. I took her outside treated her for breathing the toxin and immediately she was calm. I got her husband to wash off his aftershave and they both went home smiling. He doesn't wear aftershave anymore near her. Her doctor told her that an overly sensitive sense of smell is a possible indicator of liver toxicity. She was recently diagnosed with liver problems.

People really underestimate Roger's work regarding the HUGE role of toxins contributing to so so so many unnecessary illnesses today. I have now personally witnessed recoveries from cancer in three cases by identifying toxins and eliminating them from the diet.

Roger's discovery of reversal is so very important with relation to toxins because it makes the accuracy of diagnosing the toxins so high as opposed to those in the kinesiology world who choose to ignore this and come up with a high margin of error from ignoring reversals.

Toxins can and do KILL people. Eliminating a toxin in ill people can literally save a life if it's caught early enough.

One client of mine had suffered from severe depression for three years after having prostate surgery and losing his business. He had been in conventional therapy for 3 years and had many times contemplated suicide. I was his last resort. After 7 sessions of trying everything I had ever learnt from TFT to NLP, Hypnosis, Life Coaching nothing at all worked. I was about to give up and decided to contact one of our UK VT practitioners for some VT toxin diagnosis. He told my client to get rid of his laundry powder and change it. I got a call from the client a week later and he said he was fine no more depression gone just suddenly. I asked him what changed if he had started a new business perhaps. No he said, nothing changed. I asked him if he changed his washing powder he said he didn't know as his wife does the washing. He asked her and she had changed the washing powder 4 days after our session. That day his depression just disappeared. 3 years later he is still symptom free and tells everyone he knows to try TFT as a choice of treatment.



Child Molester Treated with TFT

J. Schleimer, MD, Psychiatrist, Neurologist, The Thought Field, Volume 10, Issue 2

When the Treatment started, my patient was 29 years of age. He has been working as a Chief Controller in a big company and was married just 4 months ago. He reported that his problem started in 1998, without any relation to events at the time, he felt the urge to expose himself to others – by showing his private parts. This behavior had no legal consequences at the time.

Then he started cruising in his car in the daylight and driving to nearby schools (especially girls schools) or playgrounds and masturbating. This gave him an additional sexual thrill because of the possibility of being discovered by others.

A lawsuit was opened against him when the father of one of the molested girls went to the police. Because of Germany's comparatively liberal laws the lawsuit was played down and no legal consequences took place.

Nevertheless, he suffered from his problem and contacted a psychotherapist who treated him with behavior therapy for about a year and a half. Then "it" started again.

He reported that he felt physically well. His sexual performance being extraordinary but he suffered from oligospermia (deficiency of sperm in the semen). The reason for this dysfunction is not etiologically clear. Otherwise, he had not been ill for a long time.

The treatment started in the spring of 2002. First remedies were administered but nothing really remarkable happened.

To discover the history of his problem I started hypnoanalysis using Transforming Therapy of Boyne. It revealed only that he was sexually immature and that he discovered his father's pornographic literature when very young. But nothing of therapeutic value came of it.

Meanwhile, another incident had taken place and an especially ambitious female district attorney had decided to fight it out. It happened at the time I started to use TFT in my practice.

The TFT treatment started on March 3rd, 2004. Using causal diagnosis the following sequence was revealed and applied: c, e, c, oe, if, 9g, sq. This treatment reduced his obsession and craving to engage his perversion from a SUD of 9 to 1, within a few minutes.

On April 23rd he reported that he had repeated the treatment I found for him and he felt no further urge at all. He stopped treatment for about a month while training for the Munich marathon.

On June 3rd he reported the urge suddenly getting stronger. This time the following sequence showed on causal diagnosis - eb, e, if, G, oe, 9G, sq.

Up to now, June 24, the urge to expose himself has not returned. Only one treatment was necessary to relieve him from the stress of the threatening trial. The SUD was 8 being reduced to 1 by eb, e, a, c, tf, c, 9G, SQ.

TFT Treatments for Body Image

Robert Gairing, PhD., TFTdx, The Thought Field, Volume 10, Issue 1

Here are two cases that I found interesting and the fact that I was able to help them substantially was most gratifying. The first involves a gentleman who had stomach reduction surgery due to obesity with its related health issues. He explicitly told me that he was not interested in body image or in improved energy. The surgery was extremely successful in that he lost an enormous amount of weight, which was clearly visible even in just his face, and he was not at all disgruntled with the necessary restrictions. However, he did not feel any better in terms of increased energy and more surprising, he thought that there was no improvement in his appearance. In fact, he typically became angry when someone complimented him on his improved looks.

Having treated several anorexic clients, I was familiar with how intractable such delusions can be. However, I was not dismayed by this one recalling Dr. Callahan telling us somewhere that delusions could be eliminated via TFT-Dx procedures. If memory serves, he mentioned that regarding an anorexic client. Anyway, there were more pressing problems in this gentleman's presentation, so I took off on toxin detection and elimination as the wisest initial move. He was highly motivated making toxin elimination very successful. Finally, at the third meeting, I decided to launch into that delusion. At that juncture, I had an insight: examine him for pr in this area. While he was not globally pr, pr was hiding out in the sentence, "I have lost a lot of weight". – weak and "I am as fat as ever". – strong. This was readily corrected. Next I took him into the men's room where there was a large mirror. I had him stand in front of it and acknowledge that he had in fact lost weight and looked it. In approximately 30 minutes, I retested the two sentences to make sure the correction held; it did. The following week the correction was still in place and he reported the in vivo experience of being complimented by someone and genuinely receiving it graciously, i.e., without hostility. To date correcting the pr was all the treatment required. He reported an additional benefit as a result of a hike he took, which he readily acknowledged he could not have done at his previous weight.

My next case was a woman, who had undergone a double mastectomy approximately a decade ago. I have forgotten the specifics, but the prosthesis or substance used for reconstruction was not as "natural" as is used today. The net result of this was that she felt alienated from her breasts and could not image anyone finding her attractive in the nude because of them. This consciousness became exacerbated as she was facing a divorce and could not imagine a new partner finding her attractive. This was not her initial presentation, but as our relationship developed across two or so sessions she disclosed it. Using our TFTDx procedures, I took off on this with her enthusiastic cooperation and within a few minutes we had eliminated "the feeling" associated with her breasts. Of course, the ultimate test was to occur that evening when she disrobed prior to retiring for the night. At the next session, it was so wonderful to hear her tell me that seeing herself that night confirmed that "the feeling" was gone and that her breasts "felt warm".

After 30 years of clinical work, TFT is enabling me to realize a dream that I have held since my doctoral studies in 1974: to be able to heal people quickly and completely with precision and extraordinary efficacy. Thank you, Dr. Callahan, for this marvelous therapy. I cannot imagine how painstaking its development must have been.

Obsessive-Compulsive Disorder (OCD)

Obsessions are negative persistent ideas, thoughts, impulses, or images that repeatedly come to mind. People who have them experience them as being intrusive or inappropriate, and they can cause anxiety or distress. Compulsions are repetitive behaviors in which people engage in order to prevent or reduce their anxiety or distress, often to manage obsessive thoughts. People recognize that these thoughts and behaviors are excessive or unreasonable. They are time consuming, and they can cause impairment in one's life.

The negative and out-of-control aspects of Obsessive-Compulsive Disorder make it different from normal worries about problems in life or attempts to establish positive habits and repeat pleasurable activities. A classic example is checking to see if the door is locked or the stove is turned off. An example of obsessions and compulsions occurring together is hand washing to deal with an obsessive thought that one is being contaminated by touching others or by touching things that have been touched by others. This condition is different from an intrusive thought related to a traumatic stress event. Most of the time, people will tell you that they know these things are not worth worrying about. They will say that most reasonable people would know that they have taken adequate precautions.

Invite the person to tune into the obsessive thought that is causing the distress and rate the difficulty of letting go of that thought or image on the SUD. Another way is to ask clients how much distress they feel when the thought is present. If they feel an urge to carry out a compulsive behavior, have them rate that urge on the SUD. Using the OCD algorithm will help to reduce the SUD. Once you have eliminated the symptoms, be sure and ask about other aspects of the problem and treat as needed (trauma, etc.). Suggest that the person do collarbone breathing three times a day and treat for reversal 15-20 times a day (side of hand, sore spot, and under nose). As with all chronic conditions, consider the impact of Individual Energy Toxins. Clients will need to repeat this algorithm, as they do with the addiction algorithm.



Obsessive-Compulsive Disorder

Collarbone, Under Eye, Collarbone (using the Protocol)
(c, e, c)

Under Arm, Under Eye, Collarbone (using the Protocol)
(a, e, c)

Under Eye, Under Arm, Collarbone (using the Protocol)
(e, a, c)

Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 7: Application – Miscellaneous

1. Physical pain – handout

- Thought Field Therapy and Pain – study, Vol. 11, Iss. 2, The Thought Field – handout

2. Depression – handout

- Depression, Grief and Heart Rate Variability – article, Vol. 5, Iss. 1, The Thought Field
- Objective Evidence of the Superiority of TFT in Eliminating Depression

3. Shame – handout

4. Embarrassment – handout

5. Jet lag – handout

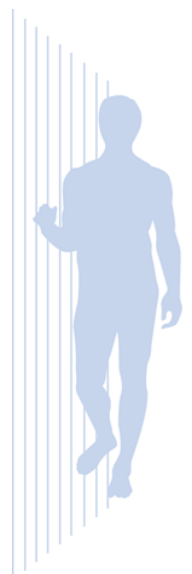
6. Visualization and peak performance – handout

- Visualization Made Easy – article

7. Research – handout of study demonstrating many of the problems discussed in weeks 1-7, Thought Field Therapy Clinical Applications

8. Q & A's – submitted in advance

9. Demonstrations – submitted in advance



Physical Pain

TFT can only be successful in clearing inappropriate pain. Pain arising from actual injury or illness cannot be resolved, as this is the body's warning mechanism. For example, the pain that arthritics feel when sitting quietly in a chair can usually be reduced or eliminated; however, the pain that they feel when moving may be reduced slightly but may not be able to be eliminated, as actual damage to the joints is occurring.

Clients should have consulted their General Practitioner prior to working with you in order to have their pain and its origin assessed. Functional pain, such as pain caused by a broken arm or appendicitis, will generally not go away. If you happen to be working with a client before he/she has consulted a GP and the pain will not go away, the client should definitely consult a doctor.

Researchers at Oxford University in the United Kingdom (Plonghaus et al., 1999) have found that the anxiety caused by the anticipation or experience of pain makes the perceived level of pain much worse. Therefore, it is good practice to treat the client for the past trauma of the pain experience before using the pain algorithm itself. An initial thought field could be elicited by asking the client to think about "the distress the pain has caused."

When the pain was caused by a trauma, it is necessary to treat the trauma first. Have the client think about the trauma and tap for that.

At times, the pain may move to a new place. Ask for the SUD for the new place, and treat that. After doing so, ask the client about the places where the pain was previously located in order to make sure that they, too, have diminished.

While SUDs of 0 or 1 can be obtained for thought fields such as trauma, when working with pain, the treatment has to go through the body. As a result, inertial delay can occur, in which the SUD goes down, but it doesn't go down to 0 (on an 11-point scale) or 1 (on a 10-point scale). If the pain does not come down to a 0 or a 1 during the treatment, let the client know that the pain will probably diminish in the next 2 hours to 24 hours. Be sure that you have treated for all levels of reversal. Toxins can also cause inertial delay.

Plonghaus, A., Tracey, I., Gati, J. S., Clare, S., Menon, R. S., Matthews, P. M., & Rawlins, J. N. (1999). Dissociating pain from its anticipation in the human brain. *Science*, 284(5422), 1979-81.

Physical Pain Algorithm

**Gamut Spot (50 times), Collarbone (using the Protocol)
(g50, c)**

Volume 11, Issue 2

Thought Field Therapy and Pain

Robert Pasahow, PhD

Diplomate, American Board of Medical Psychologists

Director, Affiliates in Psychotherapy

Chronic pain is such a prevalent problem that a sub-specialty for anesthesiologists, Pain Management, is a relatively new development in medicine. Multi-disciplinary professionals have worked on the deleterious effects of pain; it is now being reconsidered as a disease in and of itself. (Basebaum, A., 1998; Cousins, M.J., 1999; Leibeskind, J.C., 1991).

I have used numerous psychological techniques in working with chronic pain patients, a large part of my patient population. Thought Field Therapy (TFTdx) is one of a number of procedures that I have used to help people with the psychological difficulties posed by chronic pain. TFTdx has decreased patients' frustration about their pain, their sense of helplessness, and depression in reaction to or part of the chronic pain syndrome. When communicating these results to a fellow TFTdx clinician, he suggested that I treat the pain directly. My first reaction was to think that this is not possible since pain is largely organically based. However, since I have been pleasantly surprised in the effectiveness of TFTdx for other problems, I decided to try to use it to reduce pain.

My first treatment was with a fifty-five year old obese woman who suffered from bilateral carpal tunnel syndrome. Braces were always on both wrists. Physical therapy only provided slight and temporary relief. The TFTdx treatment went smoothly. To the surprise of all, her pain went from a 6 down to a 0.

During the next two years, I continued to use TFTdx to try to reduce patients' pain. The vast majority of patients received temporary relief with one TFTdx treatment session. The results were sufficiently impressive that I thought a study should be conducted on the effectiveness of TFTdx in relieving muscular, skeletal, nerve, and spinal pain.

Subjects (Patients): The next twelve patients from my practice suffering from pain became the subjects of this study. There were seven females and five males. The age range was twenty-eight to sixty-six years of age. Seven were injured in an automobile accident. Collectively, they had received treatment from family physicians, physiatrists, anesthesiologist-pain management physician, neurologists, neurosurgeons, and chiropractic doctors. Most have received physical therapy and almost all have received pain related medication at some point in time. Two had prior surgery in the lumbar region, one had prior surgery in the cervical area, and one patient had surgery in both areas. Diagnoses included herniated, bulging and ruptured discs, stenosis, carpal tunnel syndrome, radiculopathy, pinched nerves, and muscular strain/sprain syndromes.

Procedure: Once starting the study, the next twelve pain patients who came in with a disturbing level of pain were offered the opportunity to have TFTdx treatment to attempt to reduce pain. The procedure was explained to them, especially since the therapy would not have face validity as being the treatment to likely reduce pain. All twelve subjects

gave their informed consent. Ratings of pain levels were done before and after the patient received TFT-

dx. To determine the duration of the pain relief, all those who experienced relief were instructed to record when their pain increased to a disturbing level. A rating of their overall pain levels was obtained at the patient's next session, which generally was one or two weeks after the TFTdx treatment was administered.

Results: Table 1 lists all 12 subjects' pain levels before and after the TFTdx. Pain level were rated from 0 – 10. The last column in table 1 represents the degree (or percent) of pain relief from TFTdx. Percent of pain relief was calculated by a fraction. The numerator was the pain rating before TFTdx subtracted by the pain rating after having TFTdx. The numerator was then divided by the patient's pain rating before receiving TFTdx. For example, subject #3's pain relief was $8-1 = 7$. Thus, the fraction was $7/8 = 87.5\%$ pain relief. Note that nine had complete relief reporting no pain after TFTdx. Two did not experience any improvement at all, and one almost had complete pain relief from TFTdx. In grouping the data, the average pain reduction was 82% (SD=39%).

TABLE 1
PAIN LEVELS BEFORE AND AFTER TFTdx TREATMENT

Patient	Pain Level Before TFTdx	Pain Level After TFTdx	% of Pain Relief
1	7	0	100
2	6.5	0	100
3	8	1	88
4	6	0	100
5	6	6	0
6	5	0	100
7	9.5	0	100
8	8	0	100
9	8.5	0	100
10	8	0	100
11	8	0	100
12	8	8	0

Patients who had pain relief were asked to note when the pain increased by at least a moderate degree. Although not a perfect measure, data regarding the duration of pain relief was obtained. TFTdx engendered pain relief that lasted from 4 – 96 hours for the ten patients who experienced pain relief from TFTdx. The average duration of the pain relief was 33.2 hours (SD = 37.3 hours).

Patients were seen for their normal therapy sessions approximately one to two weeks later. Pain levels on the same 0-10 scale were obtained. Ten of these patients were seen

six to eight days later and two were seen fourteen days later. Of the ten patients that I saw six to eight days later, two had not experienced any pain relief immediately after the TFTdx. They also did not experience any lower pain levels when seen in the follow-up session. They are included in the following data. The degree (or percent) of pain relief the patients were experiencing six to eight days later was calculated as was done in the last column in Table 1. A fraction was made where the numerator was: the patient's pain level before TFTdx, subtracted by the pain level at their next visit with me. This numerator was then divided by the initial pain level before receiving the TFTdx. For instance, one patient's pain level before

TFTdx was 8. One week later the pain level was reported to be at 6. Thus, the percent of pain reduction experienced one week later could be calculated: $8-6/8 = 25\%$ lower pain level. Even including the two unresponsive patients, follow-up pain levels were 30% less (SD = 29%). The large standard deviation reflects the varying amounts of pain alleviation experienced one week later by these patients.

Two patients were not seen until two weeks later. Both had experienced substantial pain reduction immediately following TFTdx. These two patients were reporting pain levels that were 49% less (SD = 16%) two weeks after having received TFTdx.

Discussion: TFTdx reduced muscular-skeletal, nerve, and spinal pain in ten of twelve patients treated in an outpatient psychology private practice. A comparison of pre and post pain rating showed an 82% reduction in patients' pain ratings immediately after the procedure was administered. Ten of the twelve patients had complete pain reductions immediately after the procedure, experiencing pain relief of 88% or greater. The other two patients had no pain reduction.

It was impressive to patients and myself that ten experienced pain relief, especially since the procedure of TFTdx does not appear to logically have pain reduction properties. It is not consistent with other conventional medical and chiropractic treatment methods. There is nothing like the application of electric stimulation, ultrasound, exercises, and spinal adjustments. Furthermore, the TFTdx treatment generally does not elicit expectations of pain relief and yet it occurred in ten of the twelve patients treated. Two patients did not experience pain relief. For these two patients, massive and/or polarity reversals could not be corrected. Four others had similar energy reversals that were helped by oral neutralization to ultimately be effective. I was not aware of the toxin neutralization technique when treating this patient population.

To be able to relieve pain is important, but the duration of the analgesic effect is also paramount to the patient. For those who had pain relief, instructions were given for them to notice when the pain significantly increased. TFTdx resulted in relatively long pain reductions for some (20-96 hours) and lost its effect within six hours for others. The average duration of pain relief for the ten patients who experienced pain reduction from

TFT and Pain

TFTdx equals 33.2 hours (SD = 35.41 hours). TFTdx obviously provided longer relief than what patients experienced from pain medications.

Even with including the two patients who did not experience relief after TFTdx and who continued not to have any lower pain levels, the ten patients who saw me 6-8 days later reported a pain reduction of 30% (SD = 29%). Only two of the twelve patients were seen at follow-up two weeks later. Their pain levels were decreased an average of 49% (SD = 16%).

Although most patients complained of pain at multiple sites, all reported having lower back pain. Any method that would help lower back pain would be helpful given this disorder occurs in four of five people during their lifetime, is a most frequent cause of disability for workers aged nineteen to forty-five, and is the second most common cause of missed work days. A number of these patients not only had muscular-skeletal injuries, but had spinal injuries (herniation, herniated and bulging disc). Information from their medical reports is illustrative. For instance, a sixty-five year old woman had a seven year history of active treatment for her pain. Herniations were noted at the L5-S1, L3-4, and L4-5 levels. Two different pain management-

anesthesiologists collectively had previously administered injections in her cervical and lumbar region about ten different times. She was patient #6 and experienced a reduction of pain of 5-0 that lasted for four hours. A forty-four year old man had been in two car accidents since 1995. Radiology studies indicated “scattered degenerative changes of the cervical spine are noted with more severe focal changes seen at C3-4 and C5-6. At C3-4, spurring is noted predominantly in the left lateral recess. AT C5-6, spurring is noted predominantly centrally and to the left. A tiny herniation to the right of midline is present as well at C6-7... At L3-4, a bulging annulus has combined with facet and ligamentous hypertrophy to cause a slight spinal stenosis”. His neurosurgeon writes that he was “involved in a second motor vehicle accident in August of 1996, in which he had worsening of his symptomatology, as well as changes in the workup, consisting of a disc herniation at the C5-6 level. This was complicated by the development of cervical radiculopathy secondary to disc herniation at that level, for which the patient was managed with surgery”. This patient had a pre-TFTdx pain level of 8 which turned into a 0 and he had pain relief last for six hours. A thirty-eight year old man received TFTdx after he had cervical and lumbar surgery. His orthopedic diagnosed him as “post-traumatic cervical sprain and strain with herniated nucleus pulposus at C3-4, C4-C5 and C6-C7, with right upper radicular symptoms...Posttraumatic lumbosacral sprain and strain with herniated nucleus pulposus at L5-S1 with left lower radicular symptoms”. An MRI of his lumbar spine showed “broad disc herniation at L5-S1, which has combined with facet/ligamentous hypertrophy to cause a mild spinal stenosis”. He had an initial pain rating of 8 which TFTdx brought to a 1 and this relief lasted four hours. These are three of the twelve patients in this study and indicate that serious spinal injuries were involved.

These were the more seriously injured patients. Less injured patients had reported pain relief of 96 hours following TFTdx.

The nature of the treated patients makes these findings that much more interesting. Seven of the patients were involved in a lawsuit against a “negligent party” whose actions

caused their injuries. If a bias exists for these litigants, one would wonder what their likely response would be to TFTdx. It would likely be to not exaggerate that TFTdx works. How would their legal case about their injuries appear if this unusual procedure that does not appear to directly treat their injuries ends up reducing their pain? How serious would their injuries appear to be to others? Not very severe. On the other hand, it would be hypothesized that the bias would be to resist the pain reduction as that would make the injuries seem more serious and treatment resistant. More severe injuries generally lead to higher monetary settlements. However, my distinct impression was that these patients were accurate in their verbal reports and in their muscle testing. All were interested to see if a different procedure might help in their struggle against pain.

There was no control group utilized to assess for placebo effects. That would be unethical in a clinical private practice population. This study clearly was not a double blind experiment nor even a single blind study. However, this investigation was never intended to be that, but to be a systematic collection of data on the effects of the TFTdx treatment on reducing pain. Since numerous patients have responded to this treatment before, the study was attempting to collect data on patients in a clinical setting.

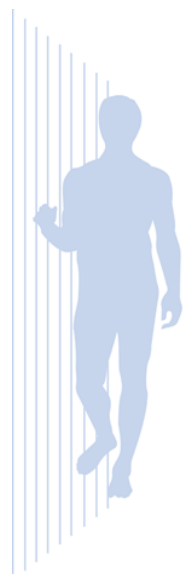
Future research is needed by clinicians in the areas that TFTdx have been helpful. Reports on the usefulness of TFTdx on one person have been the predominant type of article published in “The Thought Field”. Greater acceptance of TFTdx into general health care will be facilitated by research. Although this study does not adhere to strict research design requirements, a collection of similar studies may eventually interest researchers to examine TFTdx’s usefulness for pain management in a systematic manner.

Comment by Dr Callahan

Dr Pasahow has carried out a very interesting and important study. My treatments for pain have been known to be effective for about 23 years. In addition to demonstrating the power of my pain treatments Dr P's data shows the power of Psychological Reversal to completely block otherwise effective treatments from working. Dr P wisely notes that he was unfamiliar with my toxin corrective treatments at this time and with the addition of these treatments it is likely that all of the patients might have been helped. In addition, the duration of the treatments can be extended with my toxin treatments (see the chapter Cure and Time from Stop the Nightmares of Trauma, for an explanation). For students of TFT it will be interesting to note that HRV results lend strong support Dr P's findings (see Callahan, R and Sakai et al in J Clinical Psychology, Oct, 2001). Also, see Dr McKoy's comment over a decade ago: "When I observe a number of suffering patients who did not respond to our usual treatment modalities, suddenly get better after TFT treatments are given, I don't need a double-blind controlled study to tell me the value of Callahan Techniques® TFT."

James McKoy, MD

Chief, Pain Clinic, Chief, Rheumatology Service, Assistant Chief, Neuroscience Department
Kaiser Permanente.



Depression

Always address issues of depression with great care, especially if the client has a history of:

- **self-injury**
- **suicide attempts**
- **alcohol or drug use**
- **mania**

In every case, the client must have consulted his/her General Practitioner (GP) first, and all cases must be monitored carefully and regularly, with referral back to the GP, as required.

Numerous things can cause depression, and numerous thought fields may need to be treated. “I am not worthy” is a different thought field from “I don’t have any money for the holidays,” etc. Traumas can often be associated with depression. Individual Energy Toxins are also often involved. Again, persistence is the key. Be sure and provide your client with the appropriate algorithms to use at home when depressing thoughts surface.

IMPORTANT—When the depression shifts, anger and/or rage that the client may have been suppressing may surface. This can be treated using the anger and/or rage algorithms.

Clients with complex problems such as depression or anxiety may become discouraged that they “did the tapping and are still depressed / anxious / angry.” Be sure and remind them of the different thought fields involved, as well as the Tooth/Shoe/Lump principle. At each session, it is important to check what you worked on in the previous session. Usually, the client will have noticed a subtle but distinct shift in that particular aspect, and another thought field will have bothered the client this week. Then, you can treat that.

Remember—Be patient, and help clients to be realistic about the changes that they can expect!

Depression Algorithm

**Gamut Spot (50 times), Collarbone (using the Protocol)
(g50, c)**

Volume 5, Issue 1

Depression, Grief, and Heart Rate Variability

By Howard Hagglund, MD

Part I – Depression and Heart Rate Variability

I am a family practitioner in Norman, Oklahoma. I have been using the Callahan Techniques® for about six months. I was at the causal diagnosis training seminar in June of 1999 and something interesting happened.

I have been very much involved in all the alternative therapies but as far as getting my own self well, it has never been a top priority. Indeed, I had a lot of despair about it. I volunteered to be treated using the Heart Rate Variability (HRV) Scanner along with the procedure so the effect of the Callahan treatment could be evaluated by this measurement.

What I had to confess to is that I had a lot of despair and a lot of depression because I never thought I would find a way that would make me well. Everybody else could be well, but not me. My HRV report reflected my poor status.

Dr. Callahan treated me and in less than five minutes, my depression of over seven years was gone and I had a bright outlook almost beyond belief. My HRV chart reflected this change. It was amazing.

Part II – Extreme Grief

I am particularly interested in having others know about the treatment for my own grief reaction that followed a terrible tragedy. While at the advanced seminar, I learned of my daughter's sudden and unexpected death. This was my oldest daughter, obviously my pride and joy. We have walked together four nights a week for five or six years. She was a stunning individual. We had been soul mates for quite a long time. She had suffered from chronic connective tissue disease, etc. but died suddenly while I was at the conference. I was devastated.

I wanted to feel the pain and stand into it and was surprised when I spoke with Roger and he told me that it was not necessary to experience such suffering. But he spoke to me most reassuringly that I wouldn't have to endure that degree of suffering and it was not part of the therapy to suffer (as it so often is in conventional therapies).

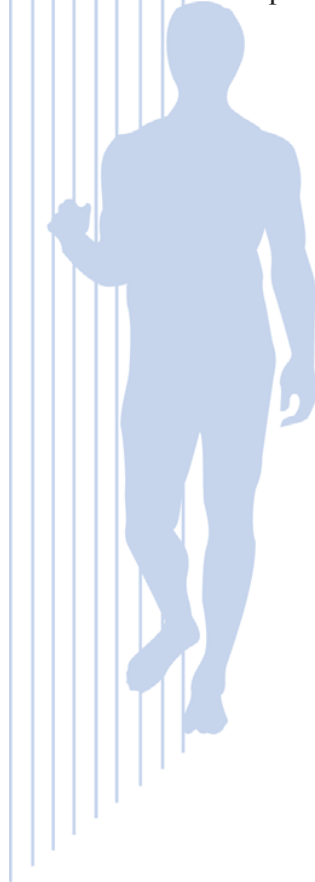
I began working with Roger with the Voice Technology and there were eight or ten issues we covered in that first post trauma session. We covered these particularly upsetting issues and to my surprise all of that intense pain was wiped down to just sweet memories and an enormous amount of compassion. I did a whole turn around on my approach to Ann's death. Because she is gone now, she doesn't have to suffer anymore from all the physiologic problems that she had. Believe me, I am not just using that thought so I can make all the pain and sadness go away. It really doesn't work during those lonely long nights. What I did find was that all of the thoughts that we worked on were safe from that time on. Now to show you that for each level of the loss of a child like this, unless I know what it is and that it has been treated can still be very painful. One example is the lady who sold her a horse last year had some photos of her and asked if I

wanted them. Of course I did – it was a treasure beyond belief. On seeing them it was like being stabbed in the heart.

I called Roger immediately and the VT eliminated all traces of pain within minutes. What I am finding is that each aspect of a loss, or thought field has its own specific problems (or perturbations) and they need to be treated in turn. If these aspects are treated they become compassionate memories within minutes instead of a devastating arrow right in the center of my heart.

I am also aware that the most compassionate advice I get from friends and professional colleagues who are unfamiliar with TFT all say to go into my pain, feel it, and that it will take a year. Well, I found that it doesn't take a year. It can take only minutes, in fact. At times I wonder, "Maybe I am not being loyal as I should to my own daughter's death and to her loss, and yet, at the same time, I really believe that people suffer way too long because they have not been exposed to TFT. I offer this in compassion and truth. I know that it goes against the common philosophy of the day. I know that people who offer you these compassionate bits of advice about the necessity of suffering over time, are very well meaning. But, I am here standing in a position to say that I see no need, and no desire to continue to have such pains eating away at me, especially when all of this, I mean all of this, is so easily treated.

Anyone who would care to discuss this may get touch with me. I am on the web at www.doctortalk.com. I am certainly up for as is Roger and the other practitioners to have you understand this. What a gift to humanity that we could pass through this life, taking a course of caring deeply for whatever treasures you would without having to suffer intensely for years at the loss of such precious irreplaceable treasures.



Objective Evidence of the Superiority of TFT In Eliminating Depression

by

Roger J. Callahan, PhD

Experts in the field of Heart Rate Variability (HRV) present evidence that it is an objective, reliable, placebo-free measure. It is, I believe, the very best measure to assess the effects of psychotherapy as well as other treatments. Although many have not heard of HRV, interest is growing. The October issue of The American Psychologist featured an ad on the back cover for HRV.

Our work with HRV demonstrates that we can make improvements never before dreamed possible in this objective and placebo-free measure. Since HRV is the best predictor of mortality, and an index of general health, it is very important to be able to improve poor HRV scores.

The most stable score in HRV, and the measure of variability itself, is what is called SDNN (standard deviation of normal to normal intervals). SDNN is the score used to predict mortality.

Nolan and others (see below) carried out a very elaborate study on predicting death with various medical indices. **They found: “A reduction of SDNN was the most powerful predictor of the risk of death due to progressive heart failure ... and (SDNN) is a better predictor of death ... than other conventional clinical measurements.”** Many others report the same finding.

Within a few years, as more people become aware of the importance of HRV measurements for health, and the fact that dramatic improvement is possible with TFT, HRV will likely become far more common in homes than blood pressure machines.

As far as we can determine, in our reviews of the literature, no one has ever made the kind of dramatic improvements in SDNN that we are able to make. Here are some examples of positive improvements in SDNN in the literature:

- quitting smoking, which is known to contribute greatly to health, improves SDNN, over time, by about 20%
- exercising for six months or more, another very positive health contributor, increases SDNN by about the same amount

These are very good improvements in SDNN. Almost all drugs have a negative effect on SDNN. Typical SDNN improvements after TFT are greater than those obtained by exercising for six months or after quitting smoking! This suggests that successful TFT is accomplishing something very deep, very powerful, and biologically restorative.

In our files we have SDNN scores that verify the astonishing power of TFT. It is not unusual to get improvements in SDNN, within minutes, much greater than 20%

It is a highly desirable goal to improve SDNN so that people may have a better chance to live a longer and a more enjoyable life. A growing number of psychotherapists are using HRV but it is rare to find a report on SDNN changes. This may be due to the fact it is very difficult to improve SDNN since it is a highly stable score. We finally found in the literature a report that actually gives some SDNN scores obtained by a conventional psychotherapy. This information gives us a basis to compare results of TFT with cognitive-behavioral therapy (CBT), a widely accepted psychotherapy. I was a pioneer in CBT many years before it became accepted.

Carney and others (see below) give a report on CBT in the treatment of depression for patients with heart disorders. [We can improve SDNN in heart patients and this will be the subject of a future report.] They used HRV in the study and reported various HRV scores including SDNN. It is known in cardiology research that depression can be especially dangerous for patients who suffer from heart disorders and this is one reason why work in this area is so very important.

As a result of up to 16 CBT therapy sessions the patients report some improvements on a questionnaire and on one measure of HRV. However, the very stable, and difficult to improve SDNN score did not get better but declined somewhat after the CBT. The SDNN average for the severely depressed patients treated with CBT in this study declined from 103.4 to 98.9 as a result of “up to 16 CBT sessions.” In evaluating their results, the authors posit that perhaps severe depression does something physiologically damaging to the person through deep negative and permanent biological change making it impossible to obtain improvement in SDNN. The authors’ state (p645-646), “It is possible that heart rate and HRV never return to normal once there has been an episode of major depression.” If correct, this information is terrible news for anyone who ever suffered from depression. Here is a summary of the HRV results that led to this pessimistic position.

Cognitive-Behavioral Therapy [up to 16 treatment sessions]

Pre-therapy SDNN = 103.4
Post-therapy SDNN = 98.9

**A slight worsening or decrease of 4.5%
after up to 16 CBT sessions.**

TFT experience with HRV counteracts this pessimism regarding the effect of depression on HRV. We have a growing amount of data on TFT and HRV. I selected eight cases from our files of people who suffered from severe depression and for whom we had pre and post-therapy SDNN scores. The pre-therapy average SDNN was 57.5 (much worse than the CBT group average). After treatment with TFT, the average SDNN shot up to 105.7. Such improvements in SDNN are unprecedented. It is also noted in the HRV literature that lower SDNN scores are even more stable than higher ones and more resistant to change. In each case with

TFT, the depression was completely eliminated. This improvement was accomplished with only one TFT session taking minutes rather than weeks or months.

Thought Field Therapy

Average Pre-therapy SDNN = 57.5
Average Post-therapy SDNN = 105.7

The average increase in SDNN after TFT for depression was 84%

Although further research is needed, our results are nevertheless strong and important. Our findings are quite contrary to the CBT pessimistic notion of permanent biological damage caused by depression. When depressed people are treated with TFT we show that it is definitely possible, not only to rapidly eliminate the depression, but also to improve HRV.

We strongly urge that other scientists with HRV replicate our work with depression. I developed an algorithm or recipe for the treatment of depression (Callahan and Trubo, 2001) that makes it easy for others to explore the powerful effects of TFT.

The results of the comparison presented here between CBT and TFT strongly agree with my own pioneering experience of doing CBT for 27 years prior to my discovery of TFT 20 years ago.

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In much – even most – research in social and physical sciences, statistical testing is not necessary. This is because where there are big differences between different sorts of circumstances – for example, if one medicine cures 90 patients out of 100 and the other medicine cures only 10 patients out of 100 – then we do not need refined statistical tests to tell us whether or not there really is a difference. And the best research is that which shows big differences, because it is the big differences that really matter. If the researcher finds that she/he must use refined statistical tests to reveal whether there are differences, the differences do not matter much. (p19)

Julian L. Simon

Resampling: The New Statistics

A Mini Study on Depression (excerpted from Journal of Clinical Psychology, October, 2001; pp1257-8)

Low and hazardous HRV scores, as I documented (Callahan, a, in this issue) and as investigators have shown, Van Hoogenhuyze et al), are among the most stable and most difficult to improve. The Van Hoogenhuyze et al study is illustrative for it shows the individual scores of 55 men and the exact changes in retest may be examined. The authors comment that “Heart rate variability values in the range associated with increased risk of mortality showed less day-to-day variation (i.e., were more reproducible) than the high heart rate variability values in normal subjects (my emphases). (Van Hoogenhuyze, 1996, p1672).

Lohr is quite correct in stating that “other effective treatments” are not cited for improving HRV. In all of the literature we have searched on HRV, we find nothing that compares to the improvements in HRV generated by TFT. Please also consider the roles of “mere passage of time” and “regression to the mean” in the recent important study done on depression with heart patients (Carney et al, 2000). Depression can be a serious problem for heart patients. Cognitive Behavioral Therapy (CBT) was administered to the patients. The post-therapy measures of HRV were taken after up to 16 CBT sessions. The exact amount of time is not mentioned but it takes considerably more time to do 16 CBT sessions than the minutes it takes to do TFT. Despite this passage of time as well as the possibility of regression to the mean in this study, the SDNN got slightly lower after 16 CBT sessions. The impact of CBT, plus the passage of time, and the regression toward the mean had little or no effect on SDNN. The SDNN was so poor (minus 4.5%) after CBT treatment as to lead the authors (after Nolan, 1998) to speculate that depression may generate a deep, permanent and harmful biological effect on the mechanisms responsible for the variability of the heart.

To informally check the alarming idea that depression can cause permanent and irreparable biologic harm, I looked at 8 cases of severe depression treated with TFT and for whom HRV scores were taken before and after TFT. The average change in SDNN after TFT for depression was plus 85% compared to a minus 4% with CBT (Callahan, 2001,c). Please note that we are not comparing the 24 hour scores used by Carney et al to our 5 minute scores; we are comparing the % of change in SDNN as a result of treatment. Naturally, our informal work must be repeated and we most emphatically encourage others to do this since if our results are replicated it could have profound implications for people with depression, heart problems, and most especially for those who have both.

Algorithms for Embarrassment and Shame

Embarrassment

**Under Nose (using the Protocol)
(un)**

Shame

**Chin (in the cleft between the chin and lower lip)
(using the Protocol)
(ch)**

Jet Lag

The feeling of disorientation as a result of flying into new time zones can be resolved by tapping the appropriate algorithm every waking hour. Don't specifically wake up during the trip, however, to tap.

Algorithms for Jet Lag

West to East:

Under Eye, Collarbone (using the Protocol)
(e, c)

East To West:

Under Arm, Collarbone (using the Protocol)
(a, c)

For some people, application of the opposite treatment may be required, i.e., you may need to do the “east to west” algorithm for traveling “west to east.” Feel free to tap both (e, c, a, c, using the Protocol). It may be helpful to treat for reversal first (side of hand) because often, no SUD will be evident. After you arrive at your destination, keep tapping as long as you need to. It is also helpful to differentiate between jet lag (waking up in the middle of the night) and tiredness from not getting enough sleep on the trip.

Visualization for Peak Performance

In *The Anxiety Addiction Connection* (1995), Dr. Callahan explained that many people find it impossible to visualize themselves being over their addiction or other problem. Others may report that they cannot see themselves performing at the peak level they desire. Even if people are able to visualize other things very well, they may have trouble visualizing their own desired state. They may say, “I just can’t see myself doing it, achieving my goal, being smoke-free, avoiding toxins, etc.”

He explained the following steps to help people overcome their inability to visualize being over the problem. After this treatment, clients can use positive visualization as part of a full therapy regime.

Ask the client to visualize something in detail (like an apple). Then, ask the client to visualize it in some unrealistic situation (such as flying through the air like a bird). Then, ask the client to visualize him/herself in an unrealistic situation (like flying through the air him/herself).

Once it has been established that the client can visualize even unrealistic things, ask him/her to visualize him/herself indulging in the addiction, performing the dysfunctional behavior, or otherwise being involved in the undesirable state. Usually, the client will be able to do this easily.

Then, ask the client to visualize him/herself in the desired state. Often, the client will find it impossible or will be able to do so only vaguely.

Ask the client to rate the level of difficulty of visualizing the desired state on a 10-point scale, with 10 being impossible, and 1 being easy. (Feel free to use an 11-point scale, should you prefer to do so.)

While the client strives to imagine the desired state, have him/her tap the algorithm, which is:
under arm, collarbone (using the Protocol)

Follow the protocol, using the necessary PR corrections, until the client can easily visualize the desired state and arrives at a level of 0 or 1 (extremely easy to visualize).

This algorithm has been found to be therapeutic in a range of situations, including overcoming addiction, recovering from cancer, eliminating toxins, reaching sales quotas, eliminating toxins, breaking records in athletics, losing weight, etc.

Visualization Made Easy (step-by-step)

A person who suffers from panic, anxiety, agoraphobia, complex phobias, addictions, depression, and many physical diseases may benefit from what is called visualization.

Studies have shown visualization to improve healing, performance and achievement in many areas of life. The patient attempts to picture or imagine, in some detail, being over his problem. The more vividly the scene can be pictured in the mind's eye, it is believed, the more the process may contribute to a greater degree of success in reality.

The technique has been used in the treatment of cancer patients where the patient visualized his cancer, cancer cells, being destroyed by the “warrior” cells of the immune system. At the very least, this procedure provides a patient who feels helpless, something to do toward the process of healing. At most, and there are reports from professionals which support this idea; the immune system may even be aroused to more vigorous action and the patient may even heal himself.

Visualization is frequently used in sports and there is evidence that the procedure helps the athlete perform better after visualizing in detail, a successful performance.

“The Ball Won’t Go In The Basket”

Many years ago, an engineer renewed my interest in visualization by presenting an interesting problem. After we had cleared up a number of his major life problems, he said that it might sound trivial compared to what we have been working on, but he wondered if I might be of some help in this concern of his.

He enjoyed going to the gym by himself and shooting baskets. He has been doing this for twenty years; ever since he was in junior high school. He is terrible at it, he reports, always has been, but still enjoys the challenge of it.

He said that in an effort to improve his rather poor skills he tried the technique of visualization. Although he was able to visualize anything else with ease, in his visualizations attempts to shoot the baskets, the ball just wouldn’t go near the basket. He said, “In my imagination, I would shoot the basket and the ball would just go off to the side; every time!” No matter how hard he tried or how often, he could not, for the life of him, picture or imagine that ball going through the hoop. It would always bounce away from the basket; even in his imagination!

Most people, I should add, have no problem in imagining a basketball going into a basket, or anything else for that matter as long as there is no psychological problem involved. This man had a specific psychological problem, or a block, in regard to shooting baskets.

I was intrigued with his special problem and asked him to quantify the degree of difficulty imagining the ball going into the basket. Since he couldn’t come even close to picturing the ball going into the basket he gave it a ten, on a ten point scale of difficulty.

The difficulty in imagining the ball going into the basket was matched by an actual difficulty. He was a terrible basket shooter. He had been failing for years despite his frequent practices and his obvious love for the activity. This man was not easily discouraged!

We usually think that if a person loves something, will work diligently to achieve his goals, and will persist over time, he is bound to succeed. Obviously, one has a better chance with all the foregoing virtues working for him, but if there is a psychological problem blocking success, it is very difficult to succeed.

We developed a special treatment to help him with his visualization problem. After the new treatment was given, he was immediately able to see the ball going into the basket (the treatment is provided below). He was thrilled with this development and I asked him to let me know how he did in the gym when he actually shot baskets.

He called the next day and reported a definite and immediate improvement in his basketball skill. He didn't suddenly become a Wilt Chamberlain, but he reported a distinct and thrilling improvement after all these years of trying so hard. It seemed as if the years of practice could now be integrated, in some degree, into his actual performance; which could not take place before.

Psychological Problem Makes It Hard To Visualize Success

A survey of my clients revealed that although most of them could visualize the most fantastic things, most of them were unable to clearly visualize themselves being over their problem.

Why is this? It may be because there is no emotional obstacle to visualizing fanciful things like flying through the air like Superman. There has never been an emotional investment in flying through the air, no expectation that one should be able to do it, no failure in the attempt which hurt emotionally. In short, there are NO emotions connected with fanciful imaginings. Emotions go deep in to a person. The emotions connected to a psychological problem are just as deep as emotions connected with rational interests. Psychological problems, in this context, consist of failure when the person knows he ought not to have failed. The emotional reality of the failure goes deep.

Have you ever noticed that when you are ill, for example with the flu, it is difficult to imagine what it feels like to be feeling good and conversely, when you are feeling good, it is difficult to imagine what it feels like to be ill? Emotions lend a reality to a moment that is sometimes difficult to get around. It seems that the emotions that are aroused when one attempts to imagine being over a psychological problem makes the visualizing process difficult.

Though visualization can be helpful some advocates of therapeutic visualization tend to overemphasize the benefits of this procedure. Exaggeration is evident in the positive thinker's slogan of "Anything the mind can conceive the mind can achieve".

I am able to conceive, imagine and visualize myself flying through the air like Superman but I will never, alas, be able to do that. Although my mind can conceive it, I will never be able to achieve it.

I find that the treatment that allows clients to visualize success helps them in certain ways to improve,

but they usually still need to be treated to overcome a particular problem. The visualization treatment is rarely sufficient unto itself to bring about radical changes, though it helps. The basketball shooter quickly achieved a higher degree of success, because he had many years of practice behind him. The new ability to visualize helped him to better capitalize upon and integrate his previous years of practice.

The vast majority of people visualize almost anything. Here is what I found to be a major problem; when you ask someone to visualize overcoming a psychological problem they run into trouble.

I started checking with all my clients and I found that most all of them had trouble picturing themselves being over their problems. They had no trouble imagining anything else, but they could not imagine or visualize themselves being over their psychological problem. They could imagine or visualize themselves doing all sorts of fanciful or impossible things, but it was very difficult or impossible for them to imagine or picture themselves being free of their problem.

Visualization Treatment

Before beginning the treatment for a specific visualization problem it is necessary to establish that one is generally able to visualize. We ask the client to carry out the following mental exercise: we first ask him to visualize an apple and if he can; and almost everyone can with great ease, we then proceed to check out more difficult levels of visualization, like can he visualize in color. We then check his ability to visualize something which he knows is actually impossible; his ability to fly like Superman.

Following is a sample of a typical dialogue:

“Can you see an apple in your imagination?”

“Yes”

“What color is it?”

“Red”

“Can you see the apple flying through the air like a bird?”

“Yes”

“Can you see yourself?”

“Yes”

“Can you see yourself flying through the air like Superman?”

“Yes”

Now that we have established that the client can visualize and furthermore, he is even able to visualize fanciful and totally unrealistic phenomena, such as himself engaging in flying, which he knows he really couldn't do; we are ready to go forward.

Next, we move into their psychological problem. “Can you see yourself (indulging in particular addiction, or feeling chronic pain)?”

“Yes”

The next step is the key one because it is the crucial step in therapeutic visualization.

“Can you see yourself confronting your most feared situation and see yourself as being calm, confident

and relaxed, or being completely pain free?

At this point, it is necessary to clarify that we are not asking them if they are now over their problem, but we just want to know if they can IMAGINE and visualize themselves being over the problem. We may remind them that being able to visualize themselves flying through the air doesn't mean that they can really do that.

“No” (The typical answer)

Sometimes at this point a response occurs that indicates that they can dimly or somewhat see themselves doing this with no problem. In order to clarify the degree of difficulty, we ask them to quantify it on a ten point scale where 10 represents impossibility to visualize and 0 represents no problem at all in visualizing themselves being completely over their problem.

“It's difficult but I can sort of see myself that way”

“Give me a number 0 to 10, 10 being impossible and 0 being easy, to indicate how difficult it is for you to see this clearly”

“8”

Now that they can quantify the level of difficulty we have a means to monitor the progress of treatment, and to guide us in giving the treatment effectively.

Treatment

We tell the client to strive to imagine being relaxed and confident while confronting a situation where his anxiety is likely to be highest, or similar means of testing his problem, like being with a group who are smoking and he is calmly enjoying himself with no desire to smoke.

Tap the spot underneath the arms and then tap the collarbone spot (see diagram of treatment points).

After tapping under the arm and the collarbone spot about ten times it should be significantly easier to visualize success in this problem area. If it is no different, or if the client was an 8 and now reports a 7, we suspect the presence of a psychological reversal.

We have to be careful of positive thinking or positive distortion intruding into the picture because it will make us wrongly believe that positive change has occurred when it hasn't. Some people mistakenly think that they have to help the treatment along by imagining or pretending that there is improvement where there actually has been none.

The client needs to be instructed not to escape in positive thinking but to report everything as accurately and objectively as possible.

When a patient is in the high range of difficulty (7 or above) he should notice at least a two point drop after the first step in treatment; often there will be more than a two point improvement. If the drop is less than two points, it is suspect.

In a very small number of people, in the neighborhood of 1%, they may be reporting accurately. There are a very small number of people who actually go down by just one point. Usually, however, a one point change means that the person is psychologically reversed and hence cannot respond to the treatment at all until the absolute block is removed.

These treatments do not work by positive thinking, suggestion, faith healing, self delusion or anything of that sort. You do not have to believe in these treatments in order for them to work. You don't have to believe in the power of penicillin in order for it to work, it has nothing to do with your beliefs. These treatments usually work, much like penicillin, even if you are highly skeptical of them.

The treatments are so unusual that when one first encounters them, there is an almost instantaneous doubt and skepticism which occurs.

In treating thousands of skeptics, including a good number of militant ones, I can assure you that belief in the efficacy of these treatments is no requirement for successful treatment. In fact, because of this, we don't even get our fair share of placebo cures.

So called placebo cures presumably work because the patient, the doctor, or both have such a high confidence in a treatment that many people report getting better even when nothing significant was done.

There are placebo cure treatments on record where the person had major exploratory surgery, but nothing was found, the patient was sewed up and reports a marvelous cure of his problem. Why? Because the patient had the mistaken belief that the cause of his problem was removed in surgery.

If the client doesn't respond to the visualization treatment; he is given the treatment for psychological reversal to unblock him and the basic treatment is repeated. His ability to visualize himself performing successfully should now be significantly enhanced.

If the client has shown a definite improvement in his ability to visualize his success he is now given the nine gamut treatments and repeats the under arm and collarbone tapping in order to further improve the visualization.

If Your Visualization Does Not Improve

If you do not respond at all to the treatment, the treatment for psychological reversal needs to be done. Tap the reversal correction spot, say, "I accept myself even though I have trouble visualizing being over my problem". Tap while you say this three times. Repeat visualization treatment. You should notice an immediate improvement when you tap under your arm and collarbone.

Mini-Psychological Reversal

If you responded well to the visualization treatment but you did not progress to a COMPLETE ability to visualize being over your problem; say you progressed from an 8 to a 4, but you cannot see yourself as clearly as you would like; then the mini-psychological reversal treatment will often clear the block to complete visualization clarity.

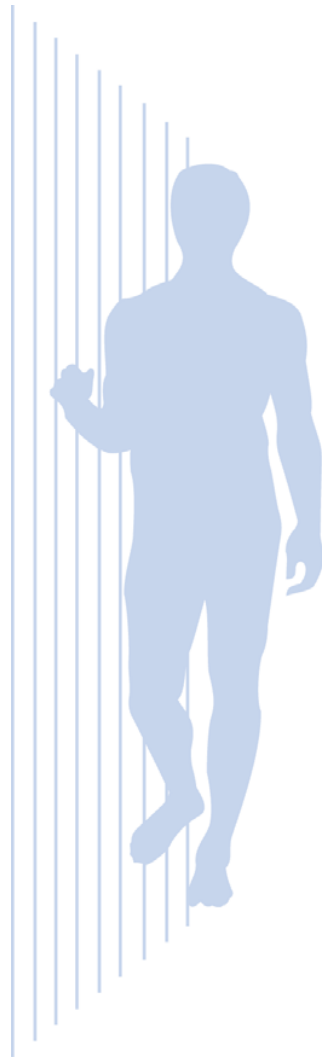
Tap the PR spot on the outer edge of the hand (see drawing) and say "I accept myself even though I STILL

have some difficulty in seeing myself being completely over my problem”. Now repeat the visualization treatment again and there is a good chance that you will clearly see yourself being over the problem.

The ability to see yourself being over the problem, remember, does not mean that you are over the problem. It just means that it is possible for you to use a therapeutic aid (visualization) that was not available to you before.

It is emphasized that we don’t consider visualization a treatment for a problem, but we see it as a possible significant contribution to eliminating obstacles to overcoming a problem. It appears to smooth the path toward successful treatment.

For many people the visualization treatment can be quite helpful in developing and establishing healthier and more accurate body images.



THOUGHT FIELD THERAPY CLINICAL APPLICATIONS:

Utilization in an HMO in Behavioral Medicine and Behavioral Health Services

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Abstract

Thought Field Therapy (TFT) is a self-administered treatment developed in 1980 by psychologist Roger Callahan. TFT uses energy meridian treatment points and bilateral optical-cortical stimulation while focusing on the targeted symptoms or problem being addressed. Clinical applications of TFT in Behavioral Medicine and Behavioral Health Services in an HMO are summarized. The applications included anxiety; adjustment disorder with anxiety, depression, and both; alcohol abuse; anxiety due to medical condition; anger; acute stress; bereavement; chronic pain; coping style affecting medical condition; depression; neurodermatitis; fatigue; major depression; maladaptive health behaviors including eating patterns in diabetic or high cholesterol patients; nausea; nicotine dependence; obsessive traits; OCD; OCPD; panic disorder without agoraphobia; parent-child stress; PTSD; relationship stress; social phobia; specific phobia; trichotillomania; tremor; and work stress. Paired t-tests of pre- and post-treatment SUD were statistically significant in the 31 categories reviewed with 1578 applications of TFT. Illustrative case and heart rate variability data are presented.

THOUGHT FIELD THERAPY CLINICAL APPLICATIONS

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Introduction

Thought Field Therapy (TFT) is a self-administered brief treatment that uses energy meridian treatment points and bilateral optical-cortical stimulation while focusing attention on the targeted negative emotion or symptom. TFT was developed in 1980 by psychologist Roger Callahan who treated 97% of 68 phobic patients successfully in an average treatment time of 4.34 minutes (Callahan, 1985). Callahan's study was replicated by Glenn Leonoff with 97% success reported with 68 phobics in an average treatment time of 6.04 minutes (Leonoff, 1995).

Charles Figley and Joyce Carbonell noted that all of the new therapies of Post-traumatic Stress Disorder (PTSD) that they studied accelerated the process of therapy of trauma, in contrast to the lengthy traditional therapies. However, TFT was the most rapid treatment with comparable treatment success to the other new therapies: Traumatic Incident Reduction (TIR) treatment duration mean was 254 minutes, Eye Movement Desensitization and Reprocessing (EMDR) 172 minutes, Visual Kinesthetic Dissociation (VKD) 113 minutes, TFT 63 minutes. More traditional therapies are estimated to take 1200 to 18,000 minutes (20 to 300 hours of therapy). (Carbonell & Figley, 1999; Wylie, 1996)

In addition to phobias and traumas, TFT has been used in the treatment of anxiety, addictions, anger, stress, obsession, depression, jealousy, and other negative emotions. In addition to psychological diagnoses, TFT is now being applied to many other problems by physicians, naturopaths, chiropractors, dentists, massage therapists, acupuncturists, and other healing professionals (Callahan, 2000).

Heart rate variability (HRV) (Task Force of the European Society of Cardiology and the North American Society of Pacing and Electrophysiology, 1996) and power spectral density analyses (Cohen et al., 1999) have been used to monitor a number of pathological states, including predicting mortality after myocardial infarction (Bigger et al., 1993; Kleiger & Miller, 1978; Rottman et al., 1996, Stein et al., 2000) and congestive heart failure (Saul, et al., 1988). The effects of emotions on short-term power spectrum analyses of heart rate variability has been studied more recently (McCraty, et al., 1995). Psychiatric research implications of HRV for anxiety and depression are pointed out by Yeragani (1995), who noted the variability of heart rate between 0.15 and 0.5 Hz is related to respiratory sinus arrhythmia, and is modulated by cholinergic activity, while the variability between 0.04 and 0.15 Hz is dually influenced by cholinergic and adrenergic mechanisms which can be used as a relative measure of sympathetic activity. Analysis of HRV provides a window into autonomic control of heart rate which is valuable in elucidating the autonomic underpinnings of panic disorder (Friedman & Thayer, 1998; Yeragani et al., 1998, Middleton & Ashby, 1995), phobic anxiety (Kawachi et al., 1995), anxiety (Watkins et al., 1999), ADHD (Borger, et al., 1999), type A (Kamada et al., 1992), and depression (Balogh et al., 1993; Carney, et al., 1995; Lehofer, et al., 1997; Yeragani, et al., 1991). Lower cardiac vagal component of HRV was found with recent experience of persistent emotional stress, regardless of a person's level of physical fitness, heart rate, mean arterial blood pressure, respiration rate, age, gender, and disposition toward experiencing anxiety (Dishman, et al., 2000).

Method

Seven TFT trained therapists at Kaiser Behavioral Medicine Services and Behavioral Health Services applied the symptom- or problem-specific TFT treatments for 1578 conditions. In some situations the same patients were treated for more than one symptom or problem, but a patient was only listed once for the same condition. The therapists were three social workers, two clinical nurse specialists, one master's level clinician, and one psychologist. Behavioral Medicine Service serves patient referrals from primary care physicians, nurse practitioners, diabetes educators, dieticians, clinical pharmacists, and other staff, right in the primary care setting. Behavioral Health Services are the traditional psychiatry and mental health services offered in a specialty clinic. Behavioral Medicine Services sessions typically were 30 minutes in length, whereas Behavioral Health Services sessions were usually 50 minutes long.

Therapists noted the problem treated and disorder, and then obtained a pre-treatment Subjective Units of

Distress (SUD)(Wolpe, 1969) rating of the severity of the symptom or problem from the patient. Therapists then guided the patient through the TFT treatment for the particular symptom or problem, and then obtained a post-treatment SUD in the same session. Data were recorded on standardized forms by the therapists. Pre-treatment and post-treatment SUD for problems or symptoms for which at least 5 patients were treated were compared by paired t-tests using SYSTAT 7.0.

Heart rate variability short-term recordings of 5 minutes pre-treatment, and 5 minutes post-treatment were obtained using Biocom Technologies Heart Scanner Version 1.00 Beta in a few cases where it was feasible. This module was connected to a computer with at least 150 MHz, 32MB RAM, 800x600 hi-color resolution. The Heart Scanner utilized three electrocardiograph (ECG) leads attached on the palm side of each of the patient's index fingers. Velcro strips with the embedded ECG leads were wrapped around the index fingers.

Results

Statistically significant results were obtained with all problems and symptoms treated with TFT (see Table 1). These included anxiety, adjustment disorder with acute stress, adjustment disorder with anxiety and depression, adjustment disorder with depression, alcohol abuse, anger, anxiety, anxiety due to medical condition, bereavement, chronic pain, coping style affecting medical condition (including Type A and histrionic styles), depression, neurodermatitis, fatigue, major depression, maladaptive health behavior (including problematic eating pattern in patients with diabetes or high cholesterol), nausea, nicotine dependence, obsessive traits, obsessive-compulsive disorder, obsessive compulsive personality disorder, panic disorder without agoraphobia, parent-child stress, partner relational stress, post-traumatic stress disorder, relationship stress, social phobia, specific phobia, trichotillomania, tremor, and work stress. All paired t-tests of pre- and post-SUD were significant at the .001 level of probability, except tremors, which was significant at the .01 level. The number of patients (N) treated for that diagnostic category or symptom (Dx or Sx), mean pre-treatment SUD (SUD-Pre), mean post-treatment SUD (SUD-Post), mean difference (Mean Diff), standard deviation of the mean difference (SD), t value (t), and probability (p) are summarized in Table 1.

Additionally, four or less patients were treated with the following diagnoses or symptoms with positive results: Bipolar II mood swings, ADHD, Cannabis Abuse, Impulse Control Disorder NOS, Polysubstance Abuse, Dissociative Disorder NOS, and Dysthymia. Small improvements were noted for Amphetamine Abuse (N=4), and Stuttering. Minimal changes were noted for Body Dysmorphic Disorder, Tinnitus, and Generalized Anxiety Disorder (N=4). Results for enhancing Peak Performance were very positive (N=4).

Case Presentations

Case 1 was a female in her 30's who was referred for depression, flashbacks, insomnia, hypervigilance, avoidant behaviors, hyperstartle, and smoking one pack of cigarettes a day. Center for Epidemiological Studies of Depression scale (CES-D--a 20-item commonly used patient report of depression symptoms, Radloff, 1977) score was 49, which was in the extremely depressed range. By history, her depression appeared secondary to trauma, so she was treated with the algorithm for complex trauma with TFT. After treatment her Subjective Units of Distress (SUD) dropped from 10 to 0. She no longer appeared tense, fatigued, irritable, sad, and feeling hopeless, but instead appeared animated, more energetic, relaxed, and future-oriented. She repeated the CES-D at the end of that same session, and attained a normal range score of 14 (a 35 point drop, and 71% improvement). All of her presenting complaints were gone, except she still wanted to smoke. A followup session one week later was cancelled by the patient, who called to ask if she still needed to come in since she didn't have complaints, but wasn't motivated to quit smoking at that time. In followup calls 1 month, 3 months, and 6 months later, she reported no further symptoms of depression nor of post-traumatic stress disorder.

Case 2 was a female patient in her 50's referred for depression, weight loss, loss of appetite, difficulty sleeping, tightness in chest, anxiety and distress about her relationship with her partner. She had a CES-D

score of 50, in the extremely depressed range. After treatment for depression and lack of appetite, patient reported feeling more energetic, less depressed, no chest tightness, and she felt hungry. Her post-treatment CESD at the end of the session was 30 (a 20 point drop, and 40% improvement). On one week followup, her appetite continued to improve, and she was regaining weight, as well as sleeping better. Her CES-D score continued to improve to 18 (a 32 point drop, and 64% improvement), just above the normal range.

Case 3 was a female in her 40's with consistently high cholesterol in the low to high 200s range over several years. With no other interventions, after TFT treatments for food cravings, stress, and chronic pain, her cholesterol level dropped to 160, from a prior 297.

Case 4 was a male in his 30's referred for panic attacks and chronic pain, who reported feeling "100 times better" at the followup session three weeks after his initial session and treatment with TFT. He reported zero panic attacks, and marked decrease in aches and pains.

Heart Rate Variability Data

Included in this report are three patients for whom heart rate variability (HRV) data were obtained before and after TFT treatment in the same session (Sakai & Paperny, 1999; Paperny, Sakai & Callahan, 2000).

The first case is a male in his 50's presenting with sciatic pain, fatigue, and low mood (Figure 1). Pre-treatment 5-minute Total Power (the total variance of normal-to-normal heartbeat over the course of the sample period of 5 minutes) was 312, post-treatment Total Power was 1462, a 469% improvement. SDNN (standard deviation of the normal-to-normal heartbeats) improved from pre-treatment 28 to post-treatment 54. Autonomic balance between the sympathetic and parasympathetic activity was at low levels of regulatory activity at pretreatment (small black square in relationship to the normal level in the central square marked with an X), and improved to normal level of regulatory activity at post-treatment. SUD dropped from 7 to 0. Electrocardiograms of his heart rate for 5 minutes pre-treatment, and 5 minutes post-treatment demonstrate marked improvement, and are shown in Figure 2.

The second case is a female in her 50's presenting with anxiety and stress (Figure 3). Pre-treatment spectral analysis Total Power was 350, and post-treatment Total Power was improved 216% to 757. Pre-treatment SDNN was 28, with a post-treatment improvement to 40. At pre-treatment, she had moderate dominance of the parasympathetic nervous system with low levels of sympathetic and normal levels of parasympathetic regulation, and attained an improved balance between sympathetic and parasympathetic activity at a normal level at post-treatment. SUD dropped from 8 at pre-treatment to 0 at post-treatment. Her 5-minute electrocardiograms at pre-treatment, and post-treatment show substantial improvement (Figure 4).

The third case is a female in her 50's suffering from anxiety secondary to premature ventricular contractions and esophageal reflux (Figure 5). The middle data is from a control treatment which involved tapping on points which were not energy meridian points but included the bilateral optical-cortical stimulation. Her pre-treatment Total Power was 807, control treatment Total Power was 1007, post-treatment Total Power was 1246. Her pre-treatment SDNN was 43, control treatment SDNN was 44, and post-treatment SDNN was 51. She had moderate dominance of parasympathetic activity with low levels of sympathetic and normal levels of parasympathetic regulation at pre-treatment, no change with the control treatment, and attained a balance between sympathetic and parasympathetic activity at normal levels of regulatory activity at post-treatment. SUD was 8 at pre-treatment, remained at 8 after the control treatment, and improved to 0 at post-treatment. Her electrocardiograms for the pre-treatment, control treatment, and post-treatment demonstrate a marked improvement post-treatment (Figure 6).

Discussion

TFT treatments of the broad spectrum of diagnoses and symptoms presented here showed significant improvements in patients' ratings of subjective units of distress after one session of treatment. These results are supported by CES-D data, heart rate variability and autonomic balance changes noted at the session, or cholesterol levels taken one to two months later in the few cases in which such measures were obtained.

The results obtained by seven different providers with different training backgrounds suggest the utility of this modality across disciplines. It is effective in the brief treatment services provided in Behavioral Medicine Services in primary care with its shorter treatment sessions, as well as in mental health and psychiatry services.

Further research is needed to evaluate the long term effects of TFT over time for various diagnoses and symptoms. Treatment of phobias (Callahan, 1985) and post-traumatic stress disorder (Callahan, 2000) are reported to sustain over time without additional treatment in most cases. Treatments of recurrent conditions which require additional treatments call for study of the more complex treatments, and protocols for discovering and eliminating the retriggering stimuli (Callahan, 2000). Physiological data such as HRV on a larger number of patients with different diagnoses or symptoms could be illuminating in comparing the effectiveness of different treatment modalities with this promising broad spectrum yet very specific treatment.

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Table 1. Pre- and Post-SUD Paired t--Test Data for TFT Applications

Dx or Sx	N	Mean SUD-Pre	Mean SUD-Post	Mean SUD Diff	SD	t	p
Acute Stress Adjustment Disorder	13	7.69	1.19	6.50	2.25	10.44	.001
with Anxiety Adjustment Disorder	27	7.65	1.00	6.65	2.46	14.02	.001
w/ Anxiety/ Depression Adjustment Disorder	8	7.37	1.37	6.00	2.62	6.48	.001
with Depression	12	6.50	0.83	5.67	2.35	8.36	.001
Alcohol Abuse	5	6.80	0.40	6.40	2.51	5.70	.001
Anger	162	8.18	1.02	7.16	2.42	37.67	.001
Anxiety	216	7.54	0.86	6.68	2.25	43.53	.001
Anxiety Due to Medical Condition	78	7.83	1.46	6.38	2.72	20.69	.001
Bereavement	16	7.00	1.41	5.59	2.25	9.97	.001
Chronic Pain	234	6.82	2.24	4.58	2.55	27.42	.001
Coping Style Affecting Medical Condition	10	8.70	2.95	5.75	3.54	5.14	.001
Depression	106	7.35	1.59	5.76	2.55	23.26	.001
Fatigue	47	7.23	1.91	5.32	2.37	15.39	.001
Major Depression	6	8.50	2.50	6.00	2.45	6.00	.001
Maladaptive Health Behavior	142	8.14	0.67	7.47	2.18	40.84	.001
Nausea	15	6.40	0.67	5.73	2.63	8.44	.001
Neurodermatitis	8	6.50	0.0	6.50	2.73	6.75	.001
Nicotine Dependence	29	7.45	0.28	7.17	2.28	16.91	.001
Obsessive Traits	29	8.06	1.17	6.89	2.26	16.42	.001
OCD	9	8.39	1.61	6.78	2.40	8.47	.001
OCPD	12	6.67	0.83	5.83	2.72	7.42	.001
Panic Disorder w/o Agoraphobia	29	7.76	1.50	6.26	2.45	13.75	.001
Parent-Child Stress	12	8.13	1.75	6.37	2.51	8.81	.001
Partner Relation Stress	16	7.81	1.69	6.12	2.69	9.12	.001
PTSD	142	8.71	1.22	7.49	2.27	39.37	.001
Relationship Stress	55	7.71	0.84	6.87	2.32	21.93	.001
Social Phobia	22	8.41	1.07	7.34	2.22	15.50	.001
Specific Phobia	49	8.15	1.45	6.66	2.41	19.39	.001
Tremor	7	5.86	1.50	4.36	2.84	4.06	.01
Trichotillomania	11	7.36	0.91	6.45	2.11	10.12	.001
Work Stress	67	7.66	1.45	6.21	2.47	20.58	.001

Program Outline

TAPPING THE HEALER WITHIN

Using Thought Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress

Week 8: Troubleshooting

1. Toxins – handout

- Toxin – handout

2. Products that support toxin identification and elimination – handout

- Sensitivities, Intolerances and Toxins – Self-Study course
- Pulse Test – link provided previous handout
- Waiora Natural Cellular Defense
- MSM (best with natural Vitamin C)

3. Chronic problems – discussion

4. Recurring Reversals - discussion

- Sore spot versus toxin identification, elimination or treatment

5. Products that support psychological reversal corrections

- Rescue Remedy – cream, spray, drops, pastilles
- Homeopathic salts – Mag. Phos., Calc. Fluor.

6. Apex problem – handout

7. Further support materials – handouts

- Algorithm Wall Chart – color coded – handout
- Algorithm Description and Sequence chart - handout

8. What can you do next – handouts

- Tapping The Healer Within – Case Study Assessment - handout
- Training and Practitioner Paths

9. Q & A's – submitted in advance

- Bonuses – handout with follow-up letter after last class

<http://www.rogercallahan.com/Bonus-Materials.php>

1. Voltmeter and PR book – download

2. Using TFT to Stop Smoking Now – book download

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3. **Eliminate Addictive Urges – MP3 audio file**
4. **Love Pain and Grief – download and MP3 audio file**
5. **TFT and Cancer – MP3 audio file**
6. **15 minute private phone consultation with Roger – schedule via e-mail, Roger@tftrx.com within the next 90 days**
7. **Bonus 60 minute open Q & A with Joanne, including MP3 file – August 13, 2009, 6:00 PM PDT. Questions to be submitted in advance, via e-mail to Joanne@tftrx.com by Wednesday, August 12, 2009, to keep the noise factor down during the answers. There will be a live interaction at the end of the call.**

10. Demonstrations – submitted in advance

Disclaimer

This course material is intended for informational purposes only. Nothing presented in this course is intended to be a substitute for professional medical advice. In fact, we strongly recommend that individuals with health problems see a licensed medical doctor or their health care specialist.



Sensitivities, Intolerances, and Individual Energy Toxins:

By Roger J. Callahan, PhD and Joanne M. Callahan, MBA (Health Care)

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INTRODUCTION

Toxins, especially those I call, Individual Energy Toxins (IET's), have been identified as the proximate cause of the common cold (Coca, 1956), a possible cause of heart attacks and death (see Appendix, Return From Death), as well as a long list of numerous problems including psychological problems such as depression, anger, and anxiety.

Many professionals are aware of the role that toxins play in illness and in the generation of psychological problems (Randolph and Moss, Rapp; and Coca). There remained, however, one important unknown issue, for it would take a very high success rate treatment to permit the discovery to be made. The issue: "What causes some cures to become undone?" My discovery of this very important principle, which is described in, *Cure and Time*, is an extremely relevant and important contribution to obtaining higher success rates with all potentially successful treatments, in all the fields of the healing arts. This discovery has allowed many who could not be cured for any length of time, finally to be completely and totally cured.

Since TFT is a very high success treatment, this allowed me to discover something that has applicability to any and all successful treatments. I discovered that after a cure is established, in some cases, the cure can be undone by a toxin. *Cure and Time*, detailed later in this article, spells out in detail this important principle. It is important to understand that this is relevant to any and all effective treatments of any kind, for any purpose. The information about toxins and cure and time will help you improve the effectiveness of the procedures you use in your practice for you can identify the toxins that might undo some of the cures you are able to generate. By treating and then avoiding the toxin this makes it possible to have a much higher success rate and a much more stable cure.

WHAT IS AN IET?

IET stands for Individual Energy Toxin. Unlike universal toxins such as mercury, cadmium, lead, IET's are specific to certain individuals who are often called or considered "difficult, complex or recalcitrant patients. I use the word toxin for the IET is a toxin for such individuals but only for these individuals. The term "energy" is used for it will be seen that an aspect of the body's energy system is the first system affected by a toxin - IET, or otherwise. One characteristic of most IET's as opposed to conventional toxins is that they are, for the most part, in the domain of choice. For example, an IET may be a nutritional supplement, even though it may be fine and even helpful for many others, or wheat, corn, eggs, perfume, laundry soap, etc.

Checking For Toxins; Not For Nutritional Value

Many people understandably confuse this matter. When we test we are not checking for nutrition but for energy toxin impact. Refined sugar tastes good but is not particularly nutritious. Health and organic foods are good but that is not what toxin testing is about. Ironically, sugar may test OK, but an organic carrot may be toxic for some people. A healthy supplement may be a toxin for some individuals (see HRV Chapter). The only way to know what is an IET for the person, is to test.

Many otherwise good supplements will test as a toxin for some people. For example, even the best and

purest MSM will test as bad for a small group of people. I find various herbs, which may be very helpful to some, are often extremely toxic to some sensitive people. It is interesting to observe the reactions of some health care professionals who cannot imagine that a good nutritious or herbal product may be a problem for some people. I have demonstrated that Heart Rate Variability (HRV) is adversely affected by identified toxins.

Toxins are a major cause of illness. We are not testing nutritional needs. We test for IET. We do not test for the health value of the food or supplement in the ordinary sense; our test reveals whether the item is an IET (i.e. toxin, poison) for this particular individual.

Individual Differences

It is important to grasp the relevant fact of individual differences. Although we humans have very much in common, we also differ in many important respects. For a good review on this important subject, please see Roger Williams (1967) classic book, *You Are Extraordinary*. It is a clear and obvious fact that some people cannot tolerate wheat for example, while others cannot tolerate corn, and still others cannot tolerate eggs – such issues are highly individualized and this fact is central to the information in this book.

What is a Toxin?

What do I mean by a toxin? I mean by a toxin, the usual literal meaning of the word which is a poison. The usual obvious poisons include mercury, cadmium, lead, arsenic, etc. However, when I speak of toxins, I refer to such things as ordinary foods, drinks, soaps, perfumes, toothpastes, etc; such common items are not a problem for most people, however, some of us have special sensitivities to these common items. The technical name I use to distinguish what I mean in this domain is “Individual Energy Toxin.” My use of “individual” is crucial and incorporates the broad differences that will be obvious as one pursues these tests. You will learn in this book, the word “toxin” has a special meaning. It refers to a substance, harmless to most people, that has a deleterious effect on some individuals but not all or even most.

Why do we have such sensitivities? Some experts believe that it is due to inheritance in the domain of missing certain enzymes that can neutralize toxins.

One theorist believes that it is due to stressful psychological traumatic events. Although I know that stress can lower one's threshold I do not believe that this explains these sensitivities. My doubts as to the accuracy of this theory stem from the fact that TFT can make it so easy to remove all sorts of terrible stress. It is so easy for us to remove traumas with TFT. Since we can cure the very worst traumas, we could cure toxins with our powerful trauma treatments. We do not hold that we can cure toxins. My finding is that when a person is strong and healthy she tends to show fewer toxins than when ill or not in the prime of health.

Awareness of the Toxin

If you get a very strong and dangerous reaction to a substance, such as peanuts, and you get this every time you have peanuts and have to rush to emergency in order to have an injection in order to be able to breathe, then you do not need some test to tell you that you have a problem with peanuts.

The literal meaning of “toxin” is poison and that is precisely what I believe these items are.

IET Not an Issue of Nutrition

Many people, especially knowledgeable professionals often misunderstand IET. We are not testing for the nutritional or health value of a substance, we are testing only if the person has, at this time, a special sensitivity to the substance.

BACKGROUND

The following tragic event helped prepare my mind for appreciating the role of toxins in human (as well as animal) behavior and health.

Alive!

This book, and later movie, told the true dramatic story of a soccer team returning from European competition back to South American. The plane crashed high in the Andes in the snow, killing some of the team and they did not know whether they would ever be found.

In order to survive, the athletes had to eat the flesh of their dead comrades; this was very difficult to do but it was necessary. Here is the part that made an unending impression upon me. Despite the fact that these young persons did not know if they would ever be found they reported a phenomenon that I shall never forget. They reported that despite the uncertainty of their future and the horror of necessary cannibalism they felt better than they had felt in years! As a psychologist very interested in feelings of well-being and possible causes, I began to wonder about what might be causing this strange increase of well-being under such horrible psychological circumstances.

Could it be that their diet could have something to do with it? Probably I reasoned, but not because of what they were eating but rather because of what they were not eating.

**It was not what they were eating, but rather
what they were NOT EATING that
made the difference.**

Having no food supply severely limited their diet to the only grotesque food available - their fallen comrades. This left out many foods of course that they ordinarily would be having daily such as wheat, milk, potatoes, tomatoes, and corn. Is this why, under such grueling circumstances, that they admitted feeling good and full of energy? I believe it is.

As a psychologist I was extremely impressed with the fact that the horror entailed in this diet did not overrule or cancel out the good physical feelings that were so evident. This suggests an important role indeed for diet in the feeling of well being and good energy levels. They were not filled with fear and depression but rather with energy. The lesson to be learned here is very important.

So this held my interest but did not at all suggest to me the role that I would discover for toxins as an important factor in psychological problems and especially for maintaining the cures which I would later discover how to carry out.

My interest level in toxins was further reinforced when I became a member of the two professional groups started by the influence of Linus Pauling (double Noble Prize scientist); Orthomolecular Medicine and Orthomolecular Psychiatry. At the professional meetings of this group I met some of the leaders in the field of toxins. However, I never got seriously involved until some years later when I was developing the highly effective Callahan Techniques® Thought Field Therapy.

Invasion of Client's Preferences and Addictions

Clients understandably get upset if you find some of their favorite foods, drinks, or nutritional supplements toxic and then you add insult to injury by suggesting that they stay away from them. Complicating this is the common observation that some of our favorite foods, etc tend to be toxic. This coheres with the finding that addicts tend to be sensitive to the very items that are addictive. Such items as pot, heroin, nicotine, certain alcohols, cocaine, pain pills, coffee, etc are often toxic to the addict.

Plant Defense

Not all toxins are derived from plants but a large number of them are. It is important to understand that plants have only one major defense against predators – the use of toxins or the ability to mimic a toxic plant, to discourage animals from eating them (until it is desired for propagation purposes.)

Although genetic alteration or pest sprays may be the source of toxins in some cases, it is definitely not the main source; it is rather something in the plant with which our system is unable to cope. Especially if our system is severely stressed; though it is not stress that causes the problem but the other way around.

Unripe apples are sour - this is due to a toxin which changes when the seeds are ready to be propagated. This protects the seeds until they are ready to be propagated; this is when the apple tastes good - encouraging propagation. This is an evolutionary device to encourage the spread of seeds and the plant or tree. The cashew nut has hydrogen cyanide on the fleshy fruit and coats the nut which makes it taste bad. It is roasted off.

“You don’t catch a cold, you eat it.”

Arthur F. Coca, MD

Pulse Test, page 150.

In the chapter of the same title, Coca explains that colds happen to people who have toxic sensitivities and whose system is weakened by the toxin and makes the person vulnerable to the virus.

My experience suggests Coca is quite correct about this. As people have their sensitivities identified and avoid them, they become significantly less sensitive to colds and flu. This may help explain why in the face of epidemics many people do not get ill.

TFT is very powerful in eliminating all symptoms of colds as well as flu and we find much success in this endeavor. We have had potential trainees call after getting (eating) the flu and we treat them with Voice Technology (VT) and eliminate all symptoms within minutes. It is often surprising to the trainee who had no idea that a therapy could help this type of problem. Today, as soon as possible, I like to discover the toxin that caused the cold or flu and then treat the person for the toxin. If we find and treat all the relevant toxins, we are likely to be successful.

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SYMPTOMS OF TOXICITY:

Some of the more common symptoms are:

Fatigue; worsening of ANY symptom; headache; panic attack; obsessive compulsion disorder; complexity of treatments; holding of water; constipation; diarrhea; depression; physical pain; red ears; jumpiness; rapid leg movements, excessive finger and hand movements; the “heebie jeebies;” Tourette’s Syndrome, rapid pulse; sticky feces - the amount of toilet tissue required may be a direct index to toxic sensitivity; a problem which has been cured, returns; lower than normal temperature; lower than normal blood pressure; high blood pressure (not due to temporary stress); increased heart rate; heart fibrillation; heart pains; always hungry; excessive fat and extreme obesity (it is said that this is genetic but the interesting question is: Exactly what is it that is inherited? Among other things it may very well be a wide ranging sensitivity to various toxins;

Chronic Fatigue

This morning, I treated a man who suffered from chronic fatigue for 15 years. Visiting a large number of different health care specialists did not help. It is commonly believed that this cannot be successfully treated – it now can be treated successfully with TFT and with my toxin treatments. Two days earlier, I treated (with Voice Technology (VT) and eliminated every trace of fatigue. Knowing that toxins are behind this common problem, I asked him to phone me the moment he was aware that any trace of fatigue returned.

Three hours later he called and said his fatigue was a 9. I checked everything he ate and found two culprits – a nutritional product that I had tested and found to be bad – he had mistakenly taken this. Diagnosing and treating this brought the fatigue down to a 4. I also found that a carrot was toxic. Treating the carrot took him down to a 1 – meaning no trace of fatigue. Such experiences help your client have faith in your procedures.

Obesity

Toxins play a major role in common obesity in that they propel the desire to eat when one does not need food. I once wrote a book called “Why Do I Eat When I’m Not Hungry?” and the answer that the book gave, along with a highly successful treatment solution, was accurate in that it spelled out that any addiction is propelled by anxiety. Later, I learned that the anxiety is almost always propelled by toxins.

I can almost always tell if I ingested a toxin because I will feel hungry when I know I ought not to be. For example, this morning, I got obsessively hungry after a breakfast that usually is satisfying and can typically last me past my usual lunch time. This morning, however, I noticed a powerful urge to eat. My identification of the toxin and the 7sec+ treatment eliminated this urge immediately.

Unusual Toxins

It is not always obvious what toxin is the problem. Here are a couple of examples that illustrate the issue.

Recalcitrant Depression- Consider this experienced psychotherapist who suffered from severe depression for a twenty years and who was non-responsive to psychotherapy as well as various medications. In about five minutes I was able to completely eliminate all traces of depression with Voice Technology (VT). It was the first time in two decades that he was free of depression and he felt wonderful. I knew that the problem could be brought back during the early stages of treatment by a toxin so in order to have the treat-

ment endure, I checked for a number of common toxins. I found corn to be a toxin and told him to not have one molecule of corn or any corn products such as corn syrup or corn starch. I made an appointment for him to check in with me in three days but told him to phone me at the first sign of even the slightest degree of depression.

Several hours later I received a phone call and he said the depression returned. I asked what he had to eat. “Nothing,” he replied. I then asked what he had to drink. Again, he replied, “nothing.” A mystery, but I knew from experience that it had to be a toxin but I did not yet know what the toxin was. I asked him to tell me everything he did since we last spoke. He told me all the details of his actions in his office and then he said something that got my full attention. He said that he wrote some letters. I then asked if he had licked a stamp or an envelope and he said he had. I then explained that they often put corn syrup in the glue in order to make it sweeter to the taste. I treated him again and he was relieved, as was I, to find the answer to the return of the depression. I did not yet have the 7 sec and the 7 sec + treatments and so I simply diagnosed and treated the problem again.

Recalcitrant OCD- I once treated a severe case of Obsessive Compulsive Disorder (OCD) who did not respond to any treatment, whether drug or psychotherapy. He then made it his business to track down several major professionals in the field who had written books on OCD. He ended up traveling to the city where each expert worked and tried the procedures advocated by each authority in turn. One of the experts, he told me, was able to help him with something he called “energy therapy” but the problem was that the next morning the problem would always return. The therapist was as puzzled by this unfortunate result as was the client. I took great interest when I heard this for I had a good idea in a general way what must be happening.

He was pleased that he did not have to have the added expense of traveling to see me although he lived in the same state, it was still quite far. I helped him, as did the last therapist (who was using a spin-off of my treatment) and I checked all his foods and supplements and found wheat to be a problem. He phoned me later in the day and reported he was free of the problem.

The next day he was discouraged for the problem returned soon after he had his morning coffee. After making sure he had no wheat, I naturally checked the coffee and found that it tested OK. He mentioned also that he read the morning newspaper and when I checked that I found the newsprint to be toxic for him. He was sensitive to the formaldehyde in the newsprint. I have found numerous individuals with this sensitivity since that first finding.

I suggested that he either get his news on television or his computer and if he had to read a particular newspaper that he get a large piece of glass to protect him from the ink. (I have found a few people who have this particular sensitivity.) He was thrilled and at the same time a bit outraged that none of the experts he consulted, big names in the field, knew nothing about what might cause a cured problem to return.

TOXINS WILL NOT REMAIN CONSTANT

It is quite difficult for people to suddenly stop eating some of their favorite foods. One expert, Environmental Allergist and Pediatrician, Dr. Doris Rapp, said that she always asks what an individual’s favorite foods are and usually three or more are sure to be toxic. TFT can make it easier to avoid toxins if addiction is involved. See your handout from week 6 for a simple but very effective treatment. To add to client frustration over toxins, it is well known that they may not remain constant, static, and forever the same. Some

toxins can be dependent on the state of the individual and their overall stress; the more stressors such as allergies, mold, dust, perfumes, work load, fears, traumas, etc., the lower the threshold for toxins. We do not remain constant but are constantly changing and dynamic. Dr. Rapp refers to this as the barrel effect. When our barrel is full to the brim with many physical and emotional stressors, our barrel overflows and we experience negative emotions and poor health.

**Some things will never be toxic; some things will always be toxic;
and some things will sometimes be toxic and sometimes not.**

Typically, at the beginning of a severe complex problem a person will show many items to be toxic and as the person gets stronger as therapy progresses, through the regimen of treatment and avoidance of known toxins, they typically begin to get much stronger and less sensitive to numerous items.

CURE AND TIME

In addressing the non-hard fields of science, the famous physicist Richard Feynman states (p 202, in Davies and Brown):

“You see we in this field (physics) have a tremendous advantage over people in some other fields because we experiment to check our ideas.”

A more concise expression of how TFT was developed is not possible. TFT has experimental advantage over all other treatments. In fact, I have often observed that the great advantage I have had in developing both my causal diagnosis and my treatments is that I was guided totally by the immediate results of the therapy experiments I carried out over decades. The fact that I did my best to ignore all my prejudices and expectations based upon my many years of clinical experience and previous misunderstandings gave me the powerful edge which made the development of TFT possible.

Every single aspect of TFT was developed, by the clinical experiments that I carried out over a period of two decades and extending into the future. Many kinds of modifications were dropped because they had little or no impact on the results as measured by the client report, which was my bottom line. Since the results of my treatments are immediate, an unprecedented speedy feedback took place that immediately informed me of the impact of any particular treatment I was investigating. (TFT consists of many different highly specific treatments that are integrated into the whole procedure.)

In Causal Diagnosis (see Chapter, Causal Diagnosis, especially pp59-62, in *Stop the Nightmares of Trauma*, Callahan and Callahan, 2003) I present evidence that TFT is actually hard science. A glance at the kind of predictions given by TFT will quickly show that this work is nothing like social science or conventional therapies but is similar to physics and chemistry in terms of predictive power.

When TFT is done correctly, no other form of help can come close to our success rate. This success rate has been climbing through the years thanks to the continuing new discoveries I have made. Each of these discoveries through the last three decades contributes to the growing success rate. Our more recent discoveries with toxins and advanced treatment points have increased our success rate even more. Some of our VT trainees have participated in the testing of our more recent discoveries.

The high success rate of TFT has allowed me to reasonably introduce the concept of “cure” to the field of mental health over the last 30 years. Cure was not listed in the dictionaries of psychiatry and psychology that I consulted in the 1980’s and 1990’s.

In 1993 Adler wrote an article for the American Psychological Association Monitor, quoting a number of experts from the Science Directorate who proclaimed that cure was impossible! Well, to again quote one of my favorite scientists, Feynman, he said, “Science is belief in the ignorance of experts.” Feynman is speaking here not of humdrum everyday stuff that comes under the name of science, he was referring to creative science, the startling new discoveries which the hum drum every day world of the conventional science technician knows nothing about.

Orville Wright offered a similar notion to Feynman’s when he said:

If we all worked on the assumption that what is accepted as true is really true, there would be little hope for advance.” Orville Wright

Interestingly, even after he and his brother successfully were flying for several years, the experts were still contending that man would never fly (Milton).

Definition of Cure- Cure is a term that is rarely, if ever, mentioned in psychology. I never used the term myself until my discovery of the “Five Minute Phobia Cure” nearly thirty years ago. Dr. Joseph Wolpe, a pioneer in behavior therapy used “cure” in the subtitle of a book he co-authored with his son (1988), though I could not find the word in the index or anywhere inside the book.

My usage of “cure” was necessitated by the fact that all traces of a phobia, as well as sequelae, such as nightmares, were gone after the TFT treatment. The usual definitions of cure contain several different meanings:

*1. Recovery or relief from disease; 2. a course or **period** of treatment; 3. to restore to health; 4. something that corrects, heals or **permanently** alleviates a harmful or troublesome situation; 5. to free from something objectionable or harmful; 6. to rectify an unhealthy or undesirable condition; 7. successful remedial treatment; 8. to relieve or rid of something troublesome or detrimental, as an illness, a bad habit, etc.*

A cure for a psychological problem is herein defined as the complete elimination of all subjective units of distress (SUD) as well as all other symptoms associated with the problem, such as nightmares. In TFT diagnosis, the Cure State, as reported by the client, is almost perfectly correlated with the complete absence of perturbations as revealed in causal diagnosis.

Later in this paper, pg 15, I give the definition of cure for cancer. It is a much looser definition than mine.

Cure Vs. Help- The word “cure” can mean “to relieve” or reduce a problem although I use the term “help” in order to distinguish this lesser effect from the more complete implication of the term “cure”.

“Help” means “to relieve”; “to change for the better”; “a source of aid”; and should be used when a treatment or series of treatments produce improvements which, though quite definite, are not quite complete.

I studiously avoided the term “cure,” for decades, but was forced to change by the evidence of my new discoveries. For example, most simple phobias treated with TFT showed no trace of the phobia after the brief treatment. Following my discoveries, there have been thousands of acid tests of the robustness and endurance of the treatment. Clearly, here was indeed a cure in the fullest sense of the word. The fact that the term had hardly if ever been used in psychology was irrelevant to the startling new and easily repeated facts revealed by the TFT treatments.

How Cures are Undone- Since we typically eliminate all traces of a problem as well as sequelae (such as nightmares and obsession) we may legitimately use the term “cure” in the strict sense as I have defined it. Our definition of cure puts a focus on the very important fact of eliminating all symptoms of a problem. After the cure has been established, it then **and only then**, becomes possible to observe the undoing of a cure. The next relevant stage in complete treatment is to evaluate the endurance of the cure over time -- in TFT we call this stage of treatment “tracking.” If the problem should return, a rare event, we then re-treat it in minutes but more importantly we find the cause of the return so relapse may be prevented in the future.

Margie Profet offers a new view of allergies, which makes good sense from an evolutionary standpoint. She maintains that allergies are due to toxins, i.e., poisons, and that the typical allergic response is defensive and an attempt to minimize or rid oneself of the toxin. Many experts for years have maintained that most allergies are a result of the immune system gone haywire since the person is reacting badly to something that is presumably not harmful. Interestingly, this change in view parallels my own change in the phobia domain. Earlier (Callahan, 1985), I drew a comparison between an allergy (reaction to a “harmless substance”) with a phobia (fear reaction to a harmless situation or object). I thought that a phobia was analogous to an allergy; the difference is that it was the fear system instead of the immune system that was haywire. I later changed my view on this matter and I now believe that all phobias were at some time of something actually harmful, usually in the far distant past.

The major point of Profet’s brilliant work is that food toxins (or sensitivities) are actually due to poisons even though some people, perhaps most, can handle them with ease – some people cannot. This is a very important fact for those who believe that they can cure allergies or food sensitivities. Even though the person may no longer react it should not be forgotten that the real toxin might possibly cause harm in the future.

Williams and Nesse point out that plants and vegetables main defense against predators is to make a toxin that will discourage predation. Some of the toxic like chemicals become neutralized when it is an advantage for the plant to have the fruit eaten. For example, some nuts are terribly poisonous until ripe, and even apples taste very sour until they ripen. This process ensures maximum spread of seeds while protecting the unripe seeds.

C.W. Smith, said *“When biological systems are under good control (homeostasis) the effects (of toxins) do not get larger as stress is raised they become more complicated.”*

Contained within this simple eloquent statement is an explanation of the role of toxins in psychological problems and specifically, why some people show complex problems.

A possible description of how toxins might create disorder is the following (Yin, p253):

“The really startling thing here is that manipulating just one molecule can perturb such complicated behavior,” Yin [Jerry C. P. Yin of Cold Spring Harbor NY] says “There are a million ways you can muck something up ... (but) if you can improve a process, you’re probably looking at something that’s crucial.” [I believe a similar type of process is also relevant for our treatments.]

Incident: You treat a severe phobia.. No symptoms remain. It looks like a complete cure. However, after the client leaves your office, only a few minutes later, you hear a knock on the door. The client says: “A terrible thing happened; when I approached my car, the problem came back!” This is not a commonplace occurrence in TFT; (it is especially rare with trauma treatment), but it can happen. Of course, there can be no such thing as the return of a problem unless it had first been eliminated. We must wonder about any treatment that ignores the undoing of a cure – it seems likely that they are unfamiliar with the fact of cure.

What might have caused this unusual situation where all symptoms of a problem are gone and then suddenly they reappear? Understanding the details of what is going on require diagnostic training but a general understanding is possible without that specialized knowledge. The following is a good example of the undoing of a cure.

Years ago I was invited on the Tom Snyder television show to demonstrate my therapy. Tom had a very severe fear of heights and the simple phobia treatment did not work. I corrected the PR and this allowed the treatment to work. After the brief treatment (he only allowed me two minutes before the show would be over!) all traces of his severe fear were gone. He climbed the ladder with ease, which he could not do earlier. He was very pleased.

Three years later, a colleague appeared on Tom’s show and asked him about the ladder. Tom said that it worked for that day but the next day the problem returned. I had asked Tom to call me if his fear returned but he didn’t. Here is another early relevant experience which led to my discovery of the role of toxins in undoing a cure. [Tom Snyder was a heavy smoker.]

I attended a meeting where an author I knew was going to lecture on her book that had just been published. I could see that she was a nervous wreck while waiting for her talk to begin. I saw her get up to go to the wash room and I went over to her. I told her I had a new discovery and asked if she would like to experience it. I explained that we might be able to quickly help her with her obvious fear. She did not seem interested but complained that she deeply regretted agreeing to give this talk; she would rather, “be boiled alive in oil.”

I treated her, in less than two minutes, and asked how she felt; she appeared much more relaxed; she appeared to “forget” about her problem after the brief treatment. She went to the bathroom and then returned to her place at the head of the table. I was pleased to see that she looked even more relaxed. When it came time to speak she said that she really enjoyed being at the meeting and she was looking forward to giving more talks because it was such an enjoyable thing to do.

Quite a switch! I expected her to say “and thank you, Dr. Callahan, for your marvelous help.” After the meeting, I went up to her and commented, “That treatment really helped, didn’t it!” She said, “What treatment? You didn’t do anything!” This is yet another example of what we call the apex problem.

In any case, recalling what I said after her talk, she called me two weeks later because she had a scheduled talk and was a nervous wreck. I cured her again but later the same thing happened. [She too was a heavy smoker.]

Later, I realized that most of the people I treated stayed treated but there was one common feature shared by the author I treated for the fear of public speaking, and Tom Snyder with the fear of heights. They smoked. I was not aware of the problem at that time but I now know that this was exactly what undid the powerful cure of the treatment.

Cigarettes are a common toxin for most people but we also occasionally find that there is a very small number of smokers whose treatment is not undone by smoking a cigarette. This was the case when I recently treated Whoopi Goldberg for her fear of flying. Toxins are a very important and neglected aspect in psychotherapy and we find that knowledge about toxins is vital to successful any psychotherapeutic work; indeed, I believe this knowledge is applicable to all the healing arts.

Any truly successful treatment, for any type of problem, must incorporate this knowledge of toxins and their treatment into the program in order to establish optimum performance and endurance of the treatment.

See the article by Martha Miller (1995), and also see the book put out by the American Psychological Association on toxins (Travis, et al, 1989); see also the work of Doris Rapp, MD (1991) pediatric allergist. These works, however, do not mention psychotherapy and toxins, but it is important based upon my discovery of the crucial role of toxins in successful psychotherapy or indeed, in any successful treatment in all healing fields.

The concepts are extremely important for a therapist who practices TFT or any other effective therapy such as EMDR or NLP. Less successful therapies do not get cures with the regularity found in TFT and these other two therapies, and are, therefore, not in a comparable position to observe the undoing of a cure. The knowledge of the role of toxins allows us to help people who couldn't be helped before and increases the endurance of our cures. So when someone asks, "How long will this last?" We can reasonably reply, "We do not know, however, if it does not last, we know where to look and how to fix it."

When the undoing of a cure takes place, we investigate the important and neglected issue of exogenous causes, which can regenerate a problem. If one could not eliminate all symptoms of a problem, the recurrence and the power of tracking or searching for the causes for the recurrence would not be apparent. Rapid effective treatments, therefore, serve as a new scope into the workings of the mind and body and open new vistas of great potential understanding in all fields of healing.

Investigating the role of toxins in undoing a cure has been a fruitful new way of examining our data in TFT. It has led to generating continuing improvements in the power and enhancing the understanding of the treatments. This same model could well offer similar help in other fields than psychotherapy.

For example, in this light, someone might discover a cure for cancer. If after a successful treatment there remains no trace whatsoever, in careful biopsies and analyses of cells, formerly cancerous, it seems reason-

able to call the treatment that removed all traces of cancer, a cure, even though the time span may only be minutes rather than years. This leaves open the *important but quite separate notion* associated with the concept of cure: how long will the cure endure? Some cures now being discarded or overlooked might well be appreciated with this new insight into what can overturn any cure in any field.

This step recognizes the fundamental fact that *any cure must begin at some point in time* and the endurance of the cure over time must be seen as an important but quite separate issue from the fact of the cure itself. In other words, *if a cure does not begin at some point in time, it cannot be a cure.*

Specific to the field oncology and cancer, “cure” is defined as the following: The current cancer authorities, such as the ACS, NCI, and FDA have all chosen to define “cure” as alive five years after diagnosis. This official definition does not mean “cancer free,” nor does it mean “healed of your disease,” which is what most people think the word “cure” means. (Outsmart Your Cancer, Alternative Non-Toxic Treatments *That Work*, by Tanya Harter Pierce, pg 8)

Forever? -- An obsessive colleague once told me that a cure should last forever. However, that perfectionist description is useless. Even if we modified the notion of cure to mean that it had to last for a person’s lifetime, we would have to wait until all our clients died before “cure” could be used. Even then, we never know for a certainty whether the cure might have been undone if the client had lived just one more minute! I believe that my proposal for the usage of cure is highly practical and meaningful and could well open up cures in other fields than psychotherapy. Undue perfectionism can be a problem in science as well as in life.

If we have a person who gets quite upset when *merely thinking* of a situation and then, after the treatment, *under the same circumstances (i.e., merely thinking about the problem)* the person is unable to generate even the slightest upset, then I propose, we are entitled to call this a cure. How long it lasts is an entirely separate but highly relevant issue. Once, we only had the client report to check the power of our treatments but today we have added the Heart Rate Variability (see Chapter) to our repertoire and this objective, placebo-free measure lends very strong support to my observations..

There are at least two pertinent issues that immediately follow after all traces of a problem and its sequelae are removed: 1/ the endurance of this cure over time; 2/ the testing or “proving” of the cure under various stringent circumstances or exposures; especially when treating traumas, depression, addictions, phobias, panic, and anxiety disorders.

Calling such an achievement a cure has the advantage of bestowing special significance upon a treatment, which can quickly eliminate all traces of a symptom. The use of the term “cure” boldly claims a vital result of treatment and marks the beginning of time when the symptoms are gone. This allows practitioners to be on the look out for, and to undertake an investigation into the possible specific factors, which can undo a cure. These precise procedures have been responsible for a dramatic increase in our success rate. No longer does a client need to be discouraged if a problem returns because it is now known, *in principle*, what the cause is. The underlying assumption governing this work is that the undoing of a cure, as the cure itself, is caused. The job is to find the cause of the undoing.

If a person is pronounced free of cancer today at 3:00 PM, by expert medical testing of all relevant involved tissues and there is no longer any discernible trace of cancerous cells, I propose that the term “cure” be used. However, if the next day cancerous cells recur, instead of merely despairing that the treatment did

not last and perhaps dismissing the important though briefly enduring cure, an intense investigation should be carried out to discern why the cure was undone. Among other things, this process recognizes the important fact that nothing can last or endure unless it first is. ***It is now clear that it is not a necessary weakness of a cure if a cured problem returns.*** This rather, is an index of a client's susceptibility and vulnerability to various toxins.

How Long Will it Last? Many skeptical observers will disparagingly ask, after a cure "Yes, but how long will it last?" The question is fundamental, of course, but needs to be seen objectively and not as a criticism of a treatment that can do something that previous treatments could not do (i.e., the complete elimination of all symptoms of a problem). Although I treated patients for over three decades prior to my discoveries called Thought Field Therapy (TFT), I never once heard the question, "How long will it last?" Since the discovery of TFT I have heard this question thousands of times. Whether intended or not, it is a supreme compliment to ask this question. It implicitly acknowledges that something of significance happened in order to wonder about the duration of this something. In TFT we carefully track our successfully treated clients and should the problem return, which is an uncommon event, we then set out to find the exogenous cause for this event.

Endogenous causes such as toxins due to infection are, fortunately, rare but in such cases appropriate medical or dental referral is required. A possible endogenous cause of the return of a problem is an unknown, and hence untreated chronic infection of some kind. Infections create by-products of toxins that can make a very small number of people extremely complex to treat and the condition may also undo a cure whose source may be more difficult to track down than exogenous sources such as described in this book. Based on my experience, I estimate such endogenous cases to be less than one in a thousand.

In TFT it is empirically known from wide clinical experience over the last two plus decades, that the treatment effect usually lasts. Further, it is known that this endurance will usually persist even in the face of harsh acid tests carried out in reality. For example, one anxiety client could not drive on highways because he was afraid of getting trapped in traffic. He had two acid tests: the first was a great fire which caused a huge traffic jam that trapped him for hours. The second, which took place two years later, was the San Francisco earthquake which created an even longer delay in traffic. These were instances of his worst nightmares come true and he showed no trace of anxiety during these *two* acid tests after his successful treatment. He may be heard on the audiotape "Telephone Therapy", which is available from our office. Regardless of endurance, however, any cure must begin at some point in time and the present discussion highlights this important and neglected consideration.

Successful Prediction- The relevance of this acknowledgment is two-fold. First, it recognizes and emphasizes the profound significance of purposively and predictably removing all traces of a former intense discomfort (or other symptoms) in a treatment situation. The prediction supports the idea that the achievement is no accident. Second, the emphasis highlights and encourages an exploration of causes that may undo a successful cure. Since cures are uncommon in psychological treatments, the problems of endurance and recurrence have accordingly not received attention in psychotherapy. Most psychologists, at this time are so unfamiliar with cure for psychological problems that they don't know how to receive the startling news that it is now, at last, possible to speak of cure in psychology.

Also, successful prediction is so rare in the social sciences that when it takes place in the dramatic fashion afforded by TFT, the scientists have no idea how to greet this dramatic new finding. Usually denial of some

sort is attempted--see apex problem. I have had a number of discussions with professionals who appear to conveniently forget what they observed when they see dramatic cures taking place before their eyes, sometimes even on themselves. They forget and compulsively ignore the bold studies in public treatments carried out and repeated a decade later with almost identical high success rates.

To repeat, once a treatment results in the complete elimination of all symptoms, when prior to treatment these symptoms were intense, we may reasonably call this treatment a cure; even though the treatment took but minutes. The next step is to track the cure over time and different exposure situations. We tell our clients, to call us the *moment* that even slightest sign of return of symptoms, take place. Of course, we then can re-treat the person in minutes but that is almost trivial in this context. The main issue is to discover precisely why the problem returned. This discovery is the most important element in treatment for then through care, the person's cure will remain.

A Terrible Misunderstanding- Some therapists have wrongly concluded from this information about toxins, that TFT is unique among therapies in that it has to be concerned about the return of a problem. This is a serious perversion of the actual facts. . TFT, when done properly, is unique in that it has the highest success rate; we eliminate more problems than anyone else. Therefore we who do TFT are in the unprecedented position to observe the undoing of a cure; and what it is that might make a previously cured problem return.

The most common reason for the return of a problem is *not*, as many therapists and clients assume, due to psychological incidents but is rather almost always (there may be very rare exceptions) due to a toxin in the form of a particular food sensitivity, exposure to heavy doses of chemical toxins, radiation exposure, and anesthesia's or certain medications may also cause a problem to return. When the reason(s) for the return of a problem is discovered and another successful treatment is administered, the new treatment will have a good chance of being sustained over time as long as the identified food toxin is avoided for at least two months.

No Toxins for Two Months- This period of abstinence gives the treated system a chance to heal with no toxic interference. I am often asked, "Do I have to stay away (from the toxin) forever? We find that two months free of the damaging toxin is usually adequate to ensure that the problem does not return. However, I tell all my clients that they would do well to be cautious about the toxin in the future for even though the treated system is now healed and the problem will not likely return, there are other consequences regarding toxins (see, e.g., Rapp).

The undoing of a cure has naturally received little or no attention in psychotherapy due to the rare nature of cure itself. *If one cannot cure a problem then it is meaningless to discuss the undoing of a cure.* The focus on undoing a cure, a rare but definite event, has allowed us to increase our general effectiveness by identifying and avoiding exogenous causes of the major factors, which interfere with successful treatment.

Atavisms (throwbacks) Interestingly, we see the undoing of a cure, which represents a higher developmental state to be similar in principle to what in biology is called an atavism. An *Atavism* is a term used in biology that refers to a throwback to an earlier ancestral form. An example is a human born with a tail or extra nipples. Atavisms can be created in the laboratory *by exposing an organism to toxins such as radiation or chloroform.* We believe that something quite similar takes place when the previously cured state of a psychological problem is overturned. I think of a problem whose cure has been undone as a

biological atavism that takes place within the same generation. The difference is that we can again treat the problem, treat the toxin, and then avoid the toxin and then the cure remains.

Cases and Examples

Here are some interesting and unusual cases where with just one TFT treatment for the toxins, the medications which were helping the medical problem were also causing the most severe symptoms. The effects were achieved by just one treatment but when he observed that his weight loss slowed down, the meds were again treated with the treatments described herein.

This case demonstrates what is possible with these toxin treatments. We have had similar good results in treating cancer patients who had to undergo radiation and chemotherapy. One of our common results is to restore the desire to eat in patients made anorexic by their necessary treatments.

RETURN FROM DEATH

(reprinted from the Thought Field newsletter)

My name is David Hanson and I have serious doubt that I would be alive today without Dr. Roger Callahan and THOUGHT FIELD THERAPY. What follows here is a true account of my personal experience with TFT and how it has returned me to a state of vibrant good health. All of what you will read here is verifiable and reliable witnesses are available to attest to the validity of all facts included here.

I met Dr. Roger Callahan in May of 2002 when I attended the TFTdx training in Palm Springs but that's not where this story starts. In telling a story like this, it's always best to start at the beginning. So, here it goes.

In 1990, I was diagnosed with HIV infection. I became disabled in 1995 when testing revealed that my T-cell count (T-cells are lymphocytes that fight viruses and infections) had plummeted to just 30. A normal person has between 800 and 1100. I had only 30 - - so few, in fact, that I could have given each of them names! I was terribly depressed and talk therapy was unsuccessful in relieving the problem.

In 1997, my physicians put me on the famed AIDS "cocktail", a mixture of noxious chemicals that would stop the forward progress of the virus. Through this ordeal, I have learned the implacable universal law of "price paying." In other words, for everything there is a price. The price I paid for avoiding a journey across the river Styx was many faceted.

I was beset with ALL of the much publicized side effects of the AIDS medications which included: *nausea and vomiting, chronic fatigue, daily bouts of diarrhea and severe stomach pain, a sharp increase in cholesterol and arterial plaque, and a thing called "lipodystrophy"* which is a fancy word that means you body starts redistributing fat in the oddest ways. My body soon learned to despise the "cocktail" and would not allow me to take my twice a day dose without gagging violently.

The only thing I did NOT suffer from was wasting syndrome. Instead, I experienced exactly the opposite effect. I started to gain weight at a tremendous rate. Among my friends, I used to laughingly call it "ARF" - AIDS Related Fat. My weight quickly climbed to 320 pounds. That's really bad when you're only 5' 8".

So, here I was. Sick, tired, and fat. I had one foot in the grave and the other on a banana peel - *and it was raining!*

In the meantime, I had become interested in Reiki, a form of Japanese energy healing. As a student of Reiki I soon learned that most of the dis-eases the body encounters are the result of an impairment to the orderly flow of “Chi”, the body’s life force energy. I completed my Reiki training with Master and Teacher certifications. Between the daily Reiki treatments that I gave myself and the medical “cocktail” I started to gain T-cells. My labs showed my T-cell numbers increasing to about the same number as my weight, 320.

Now fast forward to the week before Thanksgiving of 2001. The AIDS meds and lypodystrophy had increased my cholesterol and arterial plaque to the point where I was having angina. My cardiologist determined that I needed to have an angioplasty and stent implant. Angioplasty opens the blocked artery and the stent is a small internal brace that is supposed to hold it open and allow a restoration of the blood flow to and through the heart. I underwent this procedure three days before the Thanksgiving holiday and was released from the hospital the very next day. I was sore but no longer had the chest pain. The holiday came and went. On the following Tuesday morning, I was sipping my decaf coffee and nibbling my morning toast when I felt the worst pain I have ever known come into my chest. I was having a heart attack.

The paramedics rushed from the fire house across the street, they put me in the aid car and off to the cardiac care center we went. I don’t remember much after that because I died in the back of the ambulance. The paramedics were able to restart my heart, but the attack was serious enough to keep me in the hospital for nine days.

Between December of 2001 and May of 2002, I continued the AIDS meds - still experienced the nasty side effects and found my recovery to be slow. Very slow.

Tired of reading yet? Don’t quit! Please continue because this is where the story really gets good!

I attended Suzanne Connolly’s Algorithm training in May of 2001. It was my first exposure to the miracle of TFT. I watched a girl (one of my Reiki students) who was so frightened of heights that she would break into a sweat at the thought of standing on a chair. After application of the appropriate algorithm, she was able not only to stand on a chair, but also to ascend to the top of a nearby desk without a wince of hesitation. Her fear of heights was GONE! I knew right then that I had just stumbled across something big.

I started using TFT with everyone I could find. I became what Bob Bray calls a “shameless tapper.” It wasn’t just that it was so effective that prompted me to use the technique on everyone I could find. It was FUN! I used TFT with my Reiki patients, my neighbors, friends, family, students. EVERYONE!

My growth in TFT was going great but my health was not. By May, 2002 I was having chest pain again. My doctor was suggesting quad bypass surgery and my t-cells were hanging in there at about 420. I was continuing the Reiki treatments which I believe contributed to my stabilization, but I seemed not to be progressing and my weight was as bad as ever. I was still sick, tired, fat and never without a pocketful of nitro tablets.

But chest pain or not, I decided to take the TFTdx training in Palm Springs that started May 20, 2002. With fellow Reiki Masters Sharron Kanter and Michael Gross, I flew from Seattle to Palm Springs. The weather in May is lots cooler in Seattle than it is in Palm Springs. It was over 100 degrees. I was sick to my stomach from the AIDS meds and my chest began to hurt the minute I got off the plane and into the desert.

heat. ***Over that weekend, I used over a dozen nitro pills. They tell you to go to the hospital after the third one,*** but I'm stubborn. I recall having to leave the training room numerous times because of the medication-related diarrhea.

I quickly became the class "project" when, on the first day of class, ***my HRV (SDNN) score turned up as an alarming 6!*** This was clearly disturbing considering that we (the class) had just learned that the lower the HRV score the greater the prediction of mortality. My traveling companions were becoming visibly agitated and Dr. Callahan was having trouble disguising his concern with my low score. He and Bob Bray were pleasant but firm in their invitation to step outside the training room for a quick diagnostic session out in the hall.

Drs. Callahan and Bray worked with me for twenty minutes more or less. There was no surprise in finding that the ***AIDS meds tested toxic. The meds were treated by Callahan's 7 sec procedure*** and we worked on the nausea and diarrhea. We worked on the chest pain. We worked on the abdominal pain. I was led back to the HRV scanner and I improved only slightly to an eight point something. Not much, but still an improvement. I did not know how important this day would be in my current life.

The next day, we worked at building on the prior day's successes. But with one important difference: ***I woke up the next morning without the diarrhea or abdominal pain that I had grown so accustomed to and I was able to take my morning meds without the usual gagging. After my morning TFT treatment, I scored better on the HRV scan.*** We continued this throughout the four day training and I eventually got my ***HRV score up to 18 (a three hundred percent increase)*** but my autonomic balance was still way out of kilter. But that doesn't matter because that Dx training was a life-changing event for me.

Since then, ***I have not been troubled AT ALL with medication sickness or the nausea, gagging, abdominal pain, or fatigue that comes with it.***

I took advantage of the information we discovered about the foods that are toxic for me and have modified my diet accordingly. Since May 20, 2002, ***I have lost a total of sixty-five pounds and ten inches around my waist without hunger or depression.*** As a matter of fact, I started a weekly TFT weight loss program to help others with food addictions.

I was HRV scanned again in October and my ***HRV (SDNN) has improved to a robust 87.3 and my autonomic balance is nearly perfect.***

My T-cells have jumped miraculously to over 690 and my viral load had dropped to undetectable levels. For all purpose and intent, the AIDS is in total remission. And my medical doctor discovered that my cholesterol dropped to completely healthy levels.

Thanks to Dr. Callahan and TFT, I have been getting healthier and healthier. I have my life back. And the best part of this story is yet to be written because next Tuesday morning, I leave the disability dole (after seven years on disability) and am starting a new, full-time job as a counselor with one of the Puget Sound's largest cemetery/funeral home combinations working with families who have lost a loved one.

My new mission is to spread TFT through the grief-counseling community.

As I said before, there is no doubt in my mind that I would not be alive today without TFT. I want to take

this opportunity in print to publicly thank you, Roger, for your help. The gratitude I feel in my heart is not easily translated into words. Just know that I will forever be in your debt.

David Hanson, DEH, TFTdx

8-15-03 Update: Latest medical report. T cell count (immune system) 903; no viral load; if he continues to hold these gains for six more months his doctors have told him he will be considered Aids free!

A Toxic Shirt

Dear Roger,

When I was in Nairobi presenting TFT in Summer, 1999, one of the participants asked me to work with him after the training was over in the afternoon. We worked one day using diagnostics, and everything came down quickly to a zero.

The next day, we continued working; however, the SUD would not come down. He was wearing a new African shirt. I asked him about it, and he had just received it as a present.

It was stiff and had not been washed.

Since he was wearing a t-shirt under it, I asked him to remove the shirt and put it on the other side of the room. Immediately, everything we worked on went down to a zero! That early experience truly demonstrated the power of toxins to me!

Jenny

Healing From Eye Surgery

August 19, 2003

On Saturday, July 19, I treated a woman who had had surgery for detached retinas in both eyes in early June. The right eye was healed. The left eye was a 7 in terms of ability to see (0 = perfect sight). She had been having difficulty doing her job as a university professor, reading students' work, since the surgery. I treated her with algorithms, as I was not in a position to do Voice Technology. After collarbone breathing, she improved to a 5, but no more.

On Monday, July 21, Dr. Callahan did VT with him and diagnosed the toxins that were preventing the eye from healing. Toxins included Molding Mud that she used on her hair, her cologne, and milk thistle.

After doing the 7-second treatments for the toxins, diagnosing points for the eyes, and instructing her to eliminate the toxins, I spoke with her on Thursday, July 24. She said that on Wednesday, July 23, the doctor said that her eyes were both totally healed. She has been able to read since then. She needed to have glasses, and she had glasses before. Without glasses, prior to the surgery, her eyes were 3.

I spoke with her on August 19. She said that the doctor discovered a wrinkle in the left eye that was scar tissue from the detached retina. It did not have anything to do with healing. The eyes had healed 100% from the surgery.

Jenny Edwards, PhD, TFT VT

Hi Roger,

A short toxin story involving myself:

About a month ago I decided to try brushing my teeth with baking soda. I haven't used tooth paste for a couple years, as they all test toxic to me. I've heard of using baking soda before, but I was prompted this time by a message on the TFT list serve re the caries bacteria not liking bakingsoda.

About a week later I started having pain on the right side of my throat (a canker sore-type pain), a sore developed inside my nose, and my skin started to break out near my mouth. All of these symptoms are now rare for me, so I suspected a toxin--and remembered that I had recently started using baking soda in my mouth. Sure enough, it tested toxic. Don't ask me why I didn't test it before using it(!), but at least it was more good evidence of the trouble a toxin can cause. What's even more significant to me is that now whenever I feel ANY bothersome symptom, I can usually trace it to a toxin.

By the way, as you would expect, the symptoms went away almost immediately after I stopped using the baking soda.

Mary

Mary L. Cowley, PhD, TFT VT
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(858) 756-7131
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Dear Roger,

I had an interesting experience with the 7 second Tx a few months ago. I was treating a lady in the UK for agoraphobia. She required treatment in the actual situation using a mobile 'phone. I couldn't get her SUD down immediately. Then I tested with the Voice Technology (VT), and her scarf was toxic. After treating this with the 7 second Tx her SUD immediately went down to 1 and the problem has not returned.

Colin Barron, MD

APEX PROBLEM

The apex problem is when a treated client accurately reports that the problem is gone but is unable to see that the therapy did the job. It is a robust tendency—it could be called a compulsion—for treated clients or even scientific observers of therapy to give “explanations” of the treatments that careful thought reveals to be totally inappropriate and irrelevant. The common “explanations” are “distraction,” “hypnosis,” “exposure,” or “placebo.” Many therapists who observe TFT will say that the treatment works by suggestion, placebo, or hypnosis, even though there is no basis in reality for such a claim. Typically, professional observers of the phenomenal demonstrated results of TFT will not ask but rather will compulsively tell the therapist their (usually totally irrelevant) version of what took place. A good example was a host of a radio show that had a riverboat theme. He called himself “Captain Andy.” He asked me to demonstrate my treatment with his teenage daughter who had been quite bothered about something for some years, which we did not go into. I guided her through some treatments and took her from a SUD level of 10 to a 1. She was, quite naturally, pleased by this result. Captain Andy then accused her of lying. Many TFT-trained therapists record therapy sessions because some clients “forget” that they had a problem after the rapid successful therapy. We call this phenomenon the “apex problem” since the mind is not operating at the apex or top level. When confronted with something as strange and revolutionary as TFT, the mind has trouble shifting out of the inertia gear. Mental work at the apex of the mind is required to grasp and understand these new treatments. Most of us attempt to avoid such work and mistakenly attempt to fit our observation into something we believe we understand. As mentioned, many therapists who witness dramatic, rapid changes appear to be compelled to give an “explanation.” It is the rare and, we must add, wise therapist who asks, “Why?” The identification of the apex problem has scientific utility in that it refines prediction, i.e., we predict that the client will report improvement, and we further predict that the client is not likely to credit the therapy for the improvement. The apex problem is a form of cognitive dissonance, or “left-brain interpreter,” which is common in split-brain research.

Algorithm Chart		
Abnormal clumsiness or awkwardness	1	CB2
Addictive Urge	2	e - a - c
	3	c - e - c
	4	a - e - c
	5	e - c - a - c
Anger	6	tf - c
Complex Trauma / Rejection / Love Pain / Grief	7	eb - e - a - c
Complex Trauma with Anger	8	eb - e - a - c - tf - c
Complex Trauma with Guilt	9	eb - e - a - c - if - c
Complex Trauma with Anger and Guilt	10	eb - e - a - c - tf - c - if - c
Depression	11	g50 - c
Embarrassment	12	un
Environmental Toxin Correction	13	if-repeat PR corr. (side of hand 15x)
General Anxiety / Stress	14	e - a - c
Guilt	15	if - c
Jet Lag (East - West)	16	a - c
(West - East)	17	e - c
Obsession / OCD	18	c - e - c
	19	a - e - c
	20	e - a - c
Panic / Anxiety Disorder	21	eb - e - a - c
	22	e - a - eb - c
	23	a - e - eb - c - tf
	24	eb - a - e
	25	e - eb - a - tf
	26	c - e - a
Physical Pain	27	g50 - c
Rage	28	oe - c
Reversal of concepts, words or behavior		
Self sabotage / Negativistic behavior	29	Correct for PR at appropriate level
(PR / RPR / MPR / PR2 / CB2)		
Shame	30	ch
Simple Phobias / Fear	31	e - a - c
Simple Trauma / Rejection / Love Pain / Grief	32	eb - c
Spiders / Claustrophobia / Turbulence	33	a - e - c
SUD report of 2 or less / Rapid Relaxation	34	Floor-to-Ceiling Eye Roll (er)
Visualization for overcoming addictions	35	a - c
or achieving peak performance		



Thought Field Therapy Algorithm Chart

Simple TRAUMA / GRIEF / REJECTION

EB C 9G SQ ER

Complex TRAUMA

EB E A C 9G SQ ER

Complex TRAUMA with ANGER

EB E A C LF C 9G SQ ER

Complex TRAUMA with GUILT

EB E A C IF C 9G SQ ER

ANGER

LF C 9G SQ ER

GUILT

IF C 9G SQ ER

ANXIETY / STRESS / FEAR /

E A C 9G SQ ER

SPIDERS / CLAUSTROPHOBIA

A E C 9G SQ ER

ADDICTION / ANXIETY

1 E C A C 9G SQ ER

2 C E C 9G SQ ER

3 A E C 9G SQ ER

OBSESSION / OCD

1 C E C 9G SQ ER

2 E A C 9G SQ ER

3 A E C 9G SQ ER

PANIC / ANXIETY DISORDER

(may require TFT Causal Diagnosis)

1 EB E A C 9G SQ ER

2 C A EB C 9G SQ ER

3 A E EB C 9G SQ ER

RAGE

OE C 9G SQ ER

DEPRESSION / PHYSICAL PAIN

G50 C 9G SQ ER

SHAME

CH 9G SQ ER

EMBARRASSMENT

UN 9G SQ ER

AIR TURBULENCE

A E C 9G SQ ER

JET LAG (West to East)

E C 9G SQ ER

JET LAG (East to West)

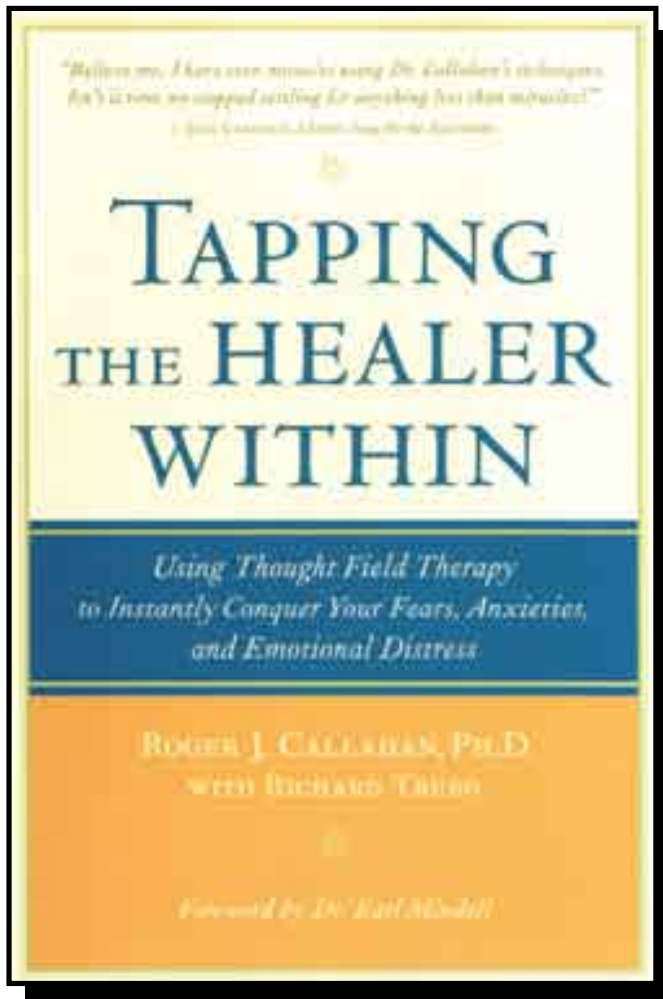
A C 9G SQ ER

INABILITY TO VISUALIZE

A C 9G SQ ER

ABNORMAL CLUMSINESS

CB2



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Course:	Designation	Required for Practitioner	Req. for Trainer
Algorithm \$299-\$399 2-day	TFT Algo	yes (or Dx level)	yes
Diagnostic \$1750 (A & B) 3-day	TFT Dx	yes (or Algo level)	yes
Trainer's Program \$4000 (C) All trainer supervision is over telephone – includes 6 months unlimited VT support	TFT Dx (licenses/training materials/guidelines, etc)	no	yes
Optimal Health \$5000 3-day	TFT Adv (beneficial to provide unparalleled support to trainees/clients)	optional	no
Voice Technology \$100,000 5-days	TFT VT	optional	optional
TFT Boot Camp \$997 2-day	TFT	yes (Algo or Dx level)	no
ATFT RCT \$469 2-day	TFT RCT (continuing education offered by ATFT)	no	CE title

One may become a practitioner at any level from Algorithm on up through the most effective level of TFT, the Voice Technology.

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Brown – Association for Thought Field Therapy instructor, Jennifer Edwards, PhD

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