Thought Field Therapy

Background/Definition

Thought Field Therapy (TFT) is a form of self-administered psychotherapy that uses a combination of physical stimulation–usually a specifically ordered range of tapping movements–of acupuncture points in conjunction with a focused attunement to specific psychological symptoms and/or psychological trauma (i.e. traumatic memories) (Connolly, Sakai, & Oas, 2010). As a whole, TFT involves an integration of methods drawing on psychology, acupuncture and applied kinesiology (Schoninger, 2004).

Proponents assert that the therapy is rapidly effective, claiming that patient improvements can occur within minutes (Callahan, 2001b; Sakai et al., 2001). Anecdotally, TFT has been reported to have been used by mental health professionals worldwide in the treatment of phobias, anxiety, trauma, obsessions, compulsions, depression, addictive urges, etc. (Pignotti & Steinberg, 2001).

Dr. Roger Callahan, a psychologist with training in applied kinesiology and an interest in acupuncture theory, began developing TFT in the early 1980s. Initially he used this technique to treat phobias and he eventually began treating individuals experiencing the debilitating and ongoing psychological effects of trauma (Pignotti, 2000).

TFT as a treatment tool was further refined, particularly with the development of "TFT algorithms," or specific tapping sequences, for certain psychological conditions (i.e. phobia). For patients that don't respond to these algorithms, or for other psychological conditions, a TFT therapist develops specific sequences based on their own diagnosis of a patient's condition (Pignotti, 2000).

According to Schoninger (2004) TFT training often consists of three levels. First, trainees learn the basic theory behind TFT, including frameworks for understanding thought fields, the cause of psychological distress, and the general process and techniques used in removing emotional disturbances. Next, they learn how to determine which meridians are correlated with a patient's emotional distress, and the corresponding acupressure points needed to treat those meridians. Thirdly, trainees learn a technique, developed and named by Callahan for TFT, called voice technology (VT), which can be used in the diagnostic process. This will be discussed further in the *Procedure* section.

Theory

TFT operates under the basic idea that emotional disturbances (i.e. anxiety) are related to patterns of energy, and that tapping specific sequences of acupuncture points while mentally engaged with the problem will eliminate this disturbance (Schoninger, 2004).

Fundamental to TFT is the theory developed for thought fields themselves. This model holds that thoughts are energy present in an information field which is a part of the mind-body system (Callahan & Trubo, 2002). According to Diepold et al. (2004) these fields contain information related to one's experience (i.e. memories) and have a direct effect on a person's physical,

emotional and energetic state of mind. They define a thought field as: "an energetic bridge between thought, memory and emotional experience that reaches beyond conscious awareness."

According to Pignotti (2000) the most important aspect of thought field activity as it relates to one's health are "perturbations." TFT theory states that the root cause of emotional distress is a perturbation**,** a term Callahan used to describe the subtle aspect of a thought field which triggers negative emotion. The perturbation is the seed from which the chemical, cognitive, hormonal, etc. characteristics of a negative emotion take form. From this framework, it is not brain chemistry that is the primary cause of negative emotion, but the perturbation that then gave rise to that chemical manifestation.

Pignotti further explains that isolating and eliminating a perturbation removes the cause of the negative emotion and distress, therefore resulting in successful treatment. Since these perturbations lie in thought fields and can be isolated, erasing them do not also destroy other memories associated with that certain event. Instead, it is only the "emotional charge" behind the distress which is removed.

TFT operates under the belief that a one-to-one relationship exists between the body's energy meridian points and thought field perturbations. In other words, a practitioner must address a certain energy meridian point on the body which corresponds to a specific perturbation (Callahan & Trubo, 2002). The energy meridian system "governs, controls, and heals the disturbing emotions" (Yancey, 2002).

Another important aspect of TFT theory involves its cognitive component, specifically the idea of "psychological reversal" (PR). Upshaw (2005) defines PR as: "a state that blocks what would otherwise be a successful treatment. The blocking effect of psychological reversal may be witnessed when treatment is given and a participant reports no improvement." Yancey (2002) describes PR succinctly as a "block that prevents a normally effective treatment from working." A person can experience PR in certain dimensions of their experience (i.e. related to a specific symptom) and not others; it is often characterized by negativity or other self-destructive behavior (Callahan & Callahan, 1996). It's important to understand that correcting PR is not synonymous with treatment of the source problem, but a step in doing so since it eliminates barriers to eventual successful treatment (Callahan & Trubo, 2002). Callahan claims that correcting PR enables TFT to be 40% more effective (Callahan, 2001b).

Procedure

TFT practitioners use several techniques to diagnose a patient. At the outset of TFT treatment, practitioners instruct patients to think about the problem or condition to be addressed. This tuning in process causes the energetic element of the problem, which is encoded in the thought field, to become more readily apparent (Schoninger, 2004). Schoninger adds that during this attunement process, patients are instructed to rate their symptoms on a subjective units of disturbance (SUD) scale (from 0-10 or 1-10), a scale originally named by Wolpe (Wolpe, 1973). TFT treatment is measured based on how the client reports their discomfort on this scale (Yancey, 2002). Callahan and Trubo (2002) note:

> Once you've tuned the thought field, you'll be asked to rate your psychological turmoil on the subjective units of distress (SUD) scale. The SUD ... is a widely accepted psychological tool. It is a simple 10-point scale, with 10 being the worst you could possibly feel, and 1 indicating absolutely no trace of upset The SUD can be used for any kind of human problem as a way of quantifying the intensity of your feelings, emotions, stress, or pain.

Voice technology (VT), a technique also developed by Callahan, can also be used to assess the patient's condition during this initial stage, and more specifically, to begin to ascertain the causal nature of the disturbance. Since it is believed that the patient's voice holds information related to the fundamental nature of a problem (the perturbation), patient's are sometimes instructed to talk or to count while attuning to the issue. Practitioners trained in this technique glean information from the patient's voice and use that information to develop a treatment protocol for that particular problem (Schoninger, 2004).

Another method used to ascertain the "code" which has produced and can be used to heal a psychological problem is causal diagnosis (Callahan & Trubo, 2002). Practitioners test points along the body's meridian pathways (while the patient is attuned to the psychological problem) and identify locations with blockages. Since perturbations are the source of the disturbances, and each meridian point location associated with a perturbation, causal diagnosis allows the practitioner to determine the specific series of locations needed for tapping to eliminate perturbations (Schoninger, 2004).

Callahan's algorithms (a set order of acupuncture tapping points) for specific conditions were developed over many years using causal diagnosis and discovering sequence patterns that reoccurred (Callahan & Trubo, 2002).When no known algorithm proves effective for a treatment, practitioners use causal diagnosis to uncover the "specific casual constituents (perturbations) that cause a particular psychological problem" and utilize a unique algorithm for that particular case (Yancey, 2002).

After a tapping sequence is established, the patient is directed to perform the sequence. Once the SUD level reaches zero the treatment is over. Patients can also repeat the sequences later individually if/when another thought field is accessed and disturbance arises (Schoninger, 2004).

Review

Survey reports and case studies, of which there are many in the TFT literature, will not be reported on in this review. Focus instead will be given to dissertation work and other experimental research which provide precedents, standards and critique opportunities for methodological frameworks and efficacy measures.

In an early study testing TFT treatment for phobias, Wade (1990) used a design that called for pre and post tests for both treatment and control groups, and used the "Self-Concept Evaluation of Location Form" and the "Tennessee Self Concept Scale" as pre and post treatment measures. A 10 point Subjective Units of Distress scale was also used for subjects to rate the intensity of the anxiety brought on by their phobia. Treatment involved self-administered tapping by the

participants in a group setting. The control group did not receive any form of treatment. Wade reported that in addition to improved self-acceptance and self-esteem "eighteen of the twenty-eight experimental participants reported a decrease of three or more points (on the SUD scale) following treatment, while two participants in the control group reported such a change." No statistical analysis of the data was conducted.

Carbonell (1996) tested TFT's effectiveness in reducing anxiety levels of individuals with acrophobia (fear of heights). Participants rated their SUD level near to or on a ladder and were randomly placed in a treatment or a placebo group. Both groups received treatment for reversal. TFT was administered twice to the treatment group, with the placebo only experiencing the reversal. A post-treatment assessment was undertaken by an individual blind to which group a participant belonged, and all participants were assessed regardless of SUD score. Carbonell reported a statistically significant difference in improvement between the two groups, although both showed a reduction in anxiety. SUD scores were averaged for each participant and results also showed a significant difference, with an even greater difference reported during the ladder climbing condition. One limitation of this study is a possibly ambiguous placebo group, since psychological reversal could reduce symptoms as well (Schoninger, 2004).

TFT's effectiveness for PTSD treatment was explored as part of a dissertation thesis by Kessler (2002). Administration of treatment occurred in a group setting as opposed to individually, and Kessler ultimately reported no reduction in any of the outcome measures (anxious arousal, intrusive thoughts, defensive avoidance). Schoninger (2004) notes that perhaps these results speak to TFT being more effective in individual treatment scenarios.

For another dissertation, TFT's efficacy was tested on individuals who had a fear of needles (Darby, 2002). The Fear Survey Schedule and the SUD were used as measures (both pre and post) for the 21 participants. Treatment using causal diagnosis was performed by the author and one month after the treatment participants were instructed to complete the post assessment. Darby reported a significant difference between pre and post levels on both measures. Among other acknowledged limitations, the protocol lacked a control group, utilized a post treatment interval (1 month) that left the assessment measures open to confounding variables, and—due to the experimenter performing the treatment himself—may have introduced a conscious or unconscious desire in the participants to please the experimenter.

A preliminary study examining TFT's effects on public speaking anxiety was undertaken by Schoninger (2004) for dissertation research. The 48 participants were randomly assigned to a treatment group or a delayed treatment group. After a brief self-written speech given in front of an audience, the treatment group had their anxiety assessed, then received one hour of TFT, gave another speech, and had anxiety assessed once more. The delayed treatment group was assessed post speech but did not receive treatment after the first speech. They returned to give a second speech one month later, at which point they received their first TFT treatment, gave another speech, and then met with an independent assessor. In both groups the assessor used the Speaker Anxiety Scale (SA Scale) and the SUD scale. Schoninger reported statistically significant improvements on both scales, for both treatment groups, and concludes that "all of the null hypotheses were rejected." The use of a delayed treatment group, and subsequent data showing minimal differences between pre-treatment time 1 and pre-treatment time 2 for this group,

suggests possible limiting factors for both groups like desensitization, un-intimidating audience and/or changes in anticipatory anxiety were negligible.

In the last dissertation research to be reported on in this review, Upshaw (2005) investigated TFT as an adjunct treatment with cognitive behavioral therapy for the negative affect associated with witnessing family-of-origin violence. Outcome questionnaires for both groups, standard treatment and standard treatment plus TFT, were completed at 90 day intervals during the 36 week treatment period. Outcome measures included Symptomatic Distress, Interpersonal Relations, Social Role Adjustment, and Well-Being. No statistically significant differences were found between the two groups on any of the outcome measures. A small sample size (n=40) lacking in statistical power, non-randomization of treatment and control groups, possible variability in therapist treatment process, and short course of treatment were cited as potential limiting factors of this study and its results.

In 2001 the *Journal of Clinical Psychology* dedicated a special issue to Thought Field Therapy. The journal's editor invited Callahan and colleagues to submit papers on TFT after Dr. Callahan expressed criticism that the journal review process was biased against non-traditional therapies (Beutler, 2001). The issue also included reviews of the studies by scholars individually selected by the journal. The research papers submitted did not undergo peer-review prior to publication in this edition of the journal.

In one of the papers, Callahan (2001a) reviews the scientific literature on heart-rate variability (HRV), and how this research purportedly shows that very little can be done to improve HRV, and that the effect of placebo on HRV is negligible. Using a non-random sampling of data from TFT therapists, and from his own practice (all therapists used the same protocol), Callahan then reports on the effects of TFT on HRV. Subjects had HRV assessed for five minutes before TFT treatment, then received the treatment, and again had HRV measured for five minutes immediately following treatment. During the HRV testing, subjects were asked to think about the problem for which they were being treated. SUD scales were also completed at both intervals. The results showed a marked improvement in SDNN (standard deviation of all normal-to-normal intervals) for all patients who reported a SUD score. Overall, the mean percent change of SDNN more than doubled after TFT treatment. Callahan calls these results "unprecedented" and notes that for such improvement in HRV he "has been unable to find any studies or even a single case that showed the degree of change documented here with TFT."

In the same journal issue, McNally (2001) provided a critical review of this paper by Callahan. His critiques revolved around: 1) the highly selected sample used for data, 2) a diverse and poorly characterized list of ailments for treatment, 3) no controls for demand characteristics, 4) therapist expectancy, 5) nonspecific (placebo) effects, 6) lack of clarity as to why HRV was used as a measure (i.e. why changes in HRV would reflect recovery/improvement of the problem), 7) lack of a wait-list control group to ensure passage of time was not a factor, 8) no sham TFT group, and more. Ultimately, he emphasizes that TFT must be subjected to more tightly controlled research and that given his perception of the existing state of the research, "psychologists are not obligated to pay any attention to TFT."

A second paper by Callahan also reported on TFT and HRV, this time through a variety of case studies that described examples of treatment (i.e. procedure, reducing the impact of toxins, PR, TFT for illness brought on by certain foods) and were meant to demonstrate TFT's effectiveness and that it can be beneficial for a variety of conditions (Callahan, 2001b).

Kline (2001) reviewed this second paper by Callahan and made these summarizing remarks:

> My criticisms center around a) inappropriately strong inferences given exclusive reliance on case reports, a potentially biased sample, and lack of appropriate controls, b) misinterpretation of statistical artifact as systematic effect, c) lack of systematic evaluation of HRV changes and d) erroneous interpretation of HRV. Callahan's article provides no evidence for the efficacy of TFT nor does it provide evidence for the credibility of TFT's rationale.

Essentially, Kline dismisses HRV as a reliable outcome measure in Callahan's cases not because of the qualities of this condition as a measure, but because of the way data collection and reporting were done—as case studies. Since no controls, statistical analyses or general information on methodology were reported, he refuses to recognize Callahan's reporting as indicative of TFT efficacy from a scientific standpoint. He specifically notes that regression to the mean could account for the raising and/or lowering of HRV, and asserts this is the most parsimonious explanation (if, at Time 1, a subject has a very low HRV, one would expect Time 2 to result in a higher HRV regardless of any intervention being implemented). Also, Kline takes issue with the idea that Callahan views HRV as "isomorphically related to better health" when HRV could have many different correlates.

Within the same issue of the journal, Callahan responded to much of the criticisms leveled at his publications (Callahan, 2001c). With regard to the case study reports not being evidentiary avenues to indicate efficacy, he stated frankly that such reports are vital to further the science of clinical psychology. He also emphasized that while he still views HRV as an appropriate evaluation tool, it is not a substitute for SUD since TFT treatment must be tailored to an individual and the process of an effective treatment procedure itself involves self-reporting.

He also states his uncertainty whether placebo is a real phenomenon and that control groups have relevance only when researching phenomena with ambiguous outcomes (meaning that TFT's treatment effects are so apparent that control groups are not needed). Citing a paper from a "conservative group of neurologists," Callahan proposes that for any therapy with a 75% success rate or higher, a control group is not required to indicate something is happening.

Addressing criticisms of demand characteristics, Callahan asserts that in his experience clients paying for treatment are not disposed to pleasing a practitioner and that "TFT is successful with horses, dogs, cats, infants, and very young children, and it does not seem likely that demand characteristics operate in these domains either." He doesn't cite evidence for TFT research in these domains.

Acknowledging McNally's concern that the changes in HRV could have occurred naturally with the passage of time, Callahan remarks that this would only be relevant if the passage of time had

been longer—in the cases presented the time intervals were "but a matter of minutes." In terms of regression to the mean, Callahan references research showing HRV extremes, low or high, to be very stable and very difficult to improve, which is why they are seen as hazardous. In other words, at the low or high ranges, day-to-day variation is minimal so a regression to the mean effect cannot be expected to occur.

In another paper submitted to this special issue, the effects of TFT on widespread PTSD from a range of traumatic experiences were reported (Johnson, Shala, Sejdijaj, Odell, & Dabishevci, 2001). The ethnic Albanian majority of Kosovo, a province of Yugoslavia, were tortured or killed en masse by the invading Serbian military in 1999. A group of clinicians trained in TFT joined physicians in Kosovo to treat 105 trauma victims. Five trips were made in the year 2000, each lasting two weeks. The authors state that 249 traumas were treated, varying from witnessing the murder of relatives to rape. Due to cultural taboos, treatment outcome was not measured using the SUD scale but in "absolute terms—it's presence or absence," and treatment success achieved in the "absence of both unwelcome emotion and related somatic discomfort, when recalling the bad moment."

Of the 105 patients, the authors reported successful treatments for 103 of them, and of 249 traumas, 247 were successfully treated. Follow up data was collected from 81 of the 103 successful cases, with the follow-up interval ranging from 1 to 9 months (mean and median of 5 months). The authors found that no relapse occurred in any of the 103 cases. All data during the study came from self-report accounts of the subjects.

Rosner (2001) critiqued this study on a number of points, initially acknowledging that research in postwar conditions can introduce methodological difficulties. She noted that diagnostic characteristics of the methodology are either very vague or not mentioned at all. For example, it is unclear how the authors define traumatic experiences since the "description provided in the article is more journalistic than oriented on the scientific literature on traumatic experiences."

In Rosner's view, validation of the results is also compromised because, prior to treatment, no attempt to perform a standardized PTSD diagnosis was made. If used, a PTSD measure could have been implemented post-treatment as well, and provided a more reliable efficacy measure than the "crude and superficial" closed question procedure utilized in the study. Since PTSD is often characterized by more than one symptom, a PTSD diagnostic tool could also shed light on which symptoms were affected (if any).

Treatment conditions and procedure were also quite ambiguous, with little to no information given on this process. Rosner comments that the overwhelming probability of expectancy effects limits any effect from being specific to TFT since such effects are "regarded to be one of the common factors contributing to therapeutic effectiveness." She notes that ideally in future studies, a second treatment group should be used as a control condition with the group receiving a PTSD therapy already backed by sound efficacy research. This would provide a valuable comparison to the TFT group, of which there was none in the Kosovo study.

The journal also published a paper from an uncontrolled study which used TFT-trained therapists (with varying professional backgrounds) at Kaiser Behavioral Medicine Services and Behavioral

Health Services (Sakai, et al., 2001). A total of 1,594 applications were treated for on 714 patients using symptom-specific or problem-specific treatments. SUD scale ratings were obtained before, during and immediately following treatment. HRV recordings five minutes pre-treatment and five minutes post-treatment were also obtained. The authors found a statistically significant within-session decrease in self-reported distress for each of the 31 problems. A series of case reports from these sessions are also included in the paper. HRV data were only reported for three patients, all of which showed moderate positive changes to SDNN. It is unclear whether more patients had HRV recorded.

Lohr (2001) wrote a critique of this study, highlighting a number of perceived issues with its methodology. He preliminarily asserts that the existing TFT efficacy research is not sufficient to justify the publication of an effectiveness study like the one performed by Sakai, et al. He also dismisses the SUD scale as an appropriate measure of efficacy, citing initial research in which SUD ratings were used only to assess patient emotional state during treatment, and subsequent research on Eye Movement Desensitization and Reprocessing which demonstrated why SUD ratings cannot be used to measure effectiveness for such a therapy. In his view, the same applies to TFT, and he suggests the use of normative, validated measures that are symptom or disease specific.

Lastly, and resulting in a later retraction by one of the authors, Pignotti and Steinberg (2001) provided data from a non random sample of 39 cases in which the effect of TFT was measured by recording HRV and SUD pre and post treatment. As with the other papers published in this journal, almost all the cases showed marked improvement in SUD and HRV measures. Herbert and Gaudiano (2001) reviewed the article by Pignotti and Steinberg, ultimately remarking that the paper "falls dreadfully short at demonstrating the efficacy of TFT or the efficacy of using HRV as a treatment outcome measure." They cite lack of control for experimental confounds (i.e. statistical regression, passage of time, non-standardized methods and procedures, expectancy effects, and demand characteristics), a highly heterogeneous sample, and failure to use standard symptom measures.

Callahan (2005) responded to critiques of using HRV as a short-term measure by stating that Herbert and Gaudiano (2001) are not experts on HRV and that the other study cited as proof actually does not identify problems with short-term HRV as a measure. Callahan also stands by his view that HRV can be used as an index of health, citing two studies (Dekker et al., 2000; Dekker et al., 1997) that reached such a conclusion. He maintains that the use of the SUD scale is appropriate because "there will never be a substitute for the first-hand report of how a client feels. A problem…with some of the 'valid assessment measures' is that they are not designed to accommodate one-session treatments."

Four years after the publication of her paper in the special issue of the *Journal of Clinical Psychology*, the same journal published Pignotti's retraction of the conclusions reached in that study (Pignotti, 2005b) and also published her critique (Pignotti, 2005a) of Callahan's response to criticism (Callahan, 2005) of the TFT papers. Pignotti states her acceptance of the points made against her article and others by the critical reviewers mentioned above, reaches the conclusion that efficacy had not been demonstrated and that future research must focus on randomized controlled studies with standardized assessment measures.

In an effort to improve objectivity in TFT outcome measures, Diepold and Goldstein (2009) performed a pilot test study on one subject using quantitative electroencephalography (QEEG). A set of conditions were established to provide comparisons for brain activity. These conditions measured brain activity while thinking neutral thoughts (baseline), while thinking about the trauma, during the TFT treatment, thinking neutral thoughts post treatment, and thinking about the trauma post treatment. The pre treatment and post treatment results for the neutral category showed minimal changes. In the "thinking about the trauma" condition, the authors report a significant difference between the pre and post sessions with the post treatment condition showing some normalization as it was more closely aligned with the "thinking neutral thoughts" condition. As a case study with only one subject (of which, the authors note, was on a variety of medications) the results cannot be generalized, but the authors suggest further research using this methodology is warranted.

A later study investigating TFT and PTSD amongst child survivors of the Rwandan genocide utilized standardized assessment measures of PTSD (Connolly, et al., 2010). The Child Report of Post-Traumatic Symptoms (CROPS) and the Parent Report of Post-Traumatic Symptoms (PROPS), in addition to the SUD scale, were used to collect data from 50 children who had scored in the PTSD range on the PROPS scale. Treatment involved meeting with a therapist for three consecutive days for one of three types of treatment (randomized order) including TFT, a progressive relaxation training in conjunction with supportive counseling, and training in a diaphragmatic breathing technique in conjunction with supportive counseling. The authors note that this study is "properly understood as a systematic investigation of clinical outcomes without a comparison condition." Both the PROPS and CROPS inventories showed significant improvement post treatment, and at the long-term follow-ups. Given the nature of the design, it is difficult to isolate TFT as the causal factor. The authors offer a direction for future research: "A randomized controlled trial that compared TFT with a wait-list control and a recognized PTSD treatment such as CBT, using the same measures, would be a next step for future investigations."

Three years later a randomized controlled trial was conducted with a separate population of Rwandan genocide survivors suffering from PTSD (Connolly, Roe-Sepowitz, Sakai, & Edwards, 2013). A total of 164 participants, divided into a treatment group (n=85) and a waitlist control (n=79), completed pre and post tests using the Modified PTSD Symptom Scale and the Trauma Symptom Inventory. Treatments were administered by locals who had been trained in the procedure. The authors reported significantly greater trauma symptom reduction in the treatment group compared to the control for PTSD-specific trauma symptoms and the frequency and duration of those symptoms. Upon receiving treatment the waitlist group also experienced significant improvement in these areas. Since post measures were taken once at seven days after treatment, future studies may be improved by using additional post measures at longer time intervals to assess whether the treatment endures. Controlling for confounding variables between pre and post tests, and utilizing placebo treatments and/or traditional PTSD treatments as comparative aspects of future studies would also improve the quality of reported data.

References

Beutler, L. E. (2001). Editor's introduction. *Journal of clinical psychology*, 57(10), 1149-1151. doi: 10.1002/jclp.1081

Callahan, R. J. (2001a). The impact of Thought Field Therapy on heart rate variability. *Journal of clinical psychology*, 57(10), 1153-1170.

Callahan, R. J. (2001b). Raising and lowering of heart rate variability: some clinical findings of Thought Field Therapy. *Journal of clinical psychology*, 57(10), 1175-1186.

Callahan, R. J. (2001c). Thought Field Therapy: Response to our critics and a scrutiny of some old ideas of social science. *Journal of clinical psychology*, 57(10), 1251-1260.

Callahan, R. J. (2005). Unprecedented improvements in short-term heart rate variability due to Thought Field Therapy: Response to the Pignotti retraction. *Journal of clinical psychology*, 61(3), 367-372.

Callahan, R., & Callahan, J. (1996). Thought Field Therapy (TFT) and trauma: Treatment and theory: Thought Field Therapy Training Center.

Callahan, R., & Trubo, R. (2002). *Tapping the healer within: Using thought-field therapy to instantly conquer your fears, anxieties, and emotional distress*. McGraw Hill Professional.

Carbonell, J. (1996). An experimental study of TFT and acrophobia. *The Thought Field*, *2*(3), 1-6.

Connolly, S. M., Roe-Sepowitz, D., Sakai, C., & Edwards, J. (2013). Utilizing Community Resources to Treat PTSD: A Randomized Controlled Study Using Thought Field Therapy. *African Journal*, 24.

Connolly, S. M., Sakai, C. E., & Oas, P. (2010). Treatment of PTSD in Rwandan child genocide survivors using thought field therapy. *International Journal of Emergency Mental Health*, 12(1), 41-50.

Darby, D. W. (2002). The efficacy of thought field therapy as a treatment modality for individuals diagnosed with blood-injection-injury phobia. 3085152 Ph.D., Walden University, Ann Arbor.

Dekker, J. M., Crow, R. S., Folsom, A. R., Hannan, P. J., Liao, D., Swenne, C. A., & Schouten, E. G. (2000). Low heart rate variability in a 2-minute rhythm strip predicts risk of coronary heart disease and mortality from several causes The ARIC Study. *Circulation*, *102*(11), 1239-1244.

Dekker, J. M., Schouten, E. G., Klootwijk, P., Pool, J., Swenne, C. A., & Kromhout, D. (1997). Heart Rate Variability from Short Electrocardiographic Recordings Predicts Mortality from All Causes in Middle-aged and Elderly Men The Zutphen Study. *American Journal of Epidemiology*, 145(10), 899-908.

Diepold, J. H., Britt, V., & Bender, S. S. (2004). *Evolving Thought Field Therapy: The clinician's handbook of diagnoses, treatment, and theory*. Norton.

Diepold, J. H., & Goldstein, D. M. (2009). Thought Field Therapy and qEEG changes in the treatment of trauma: A case study. *Traumatology*, 15(1), 85-93.

Herbert, J. D., & Gaudiano, B. A. (2001). The search for the holy grail: Heart rate variability and Thought Field Therapy. *Journal of clinical psychology*, 57(10), 1207-1214.

Johnson, C., Shala, M., Sejdijaj, X., Odell, R., & Dabishevci, K. (2001). Thought field therapy-soothing the bad moments of Kosovo. *Journal of clinical psychology*, 57, 1237-1240.

Kessler, R. A. (2002). The differential impact of thought field therapy as a treatment modality for male perpetrators of domestic violence diagnosed with posttraumatic stress disorder. 3076568 Ph.D., Walden University, Ann Arbor.

Kline, J. P. (2001). Heart rate variability does not tap putative efficacy of Thought Field Therapy. *Journal of clinical psychology*, 57(10), 1187-1192.

Lohr, J. M. (2001). Sakai et al. is not an adequate demonstration of TFT effectiveness. *Journal of clinical psychology*, 57(10), 1229-1235.

McNally, R. J. (2001). Tertullian's motto and Callahan's method. *Journal of clinical psychology*, 57(10), 1171-1174.

Pignotti, M. (2000). Helping Survivors Of Destructive Cults Applications of Thought Field Therapy. *Traumatology*, 6(3), 201-235.

Pignotti, M. (2005a). Callahan fails to meet the burden of proof for Thought Field Therapy claims. *Journal of clinical psychology*, 61(3), 251-255.

Pignotti, M. (2005b). Regarding the October 2001 Journal of Clinical Psychology special issue on Thought Field Therapy: Retraction of conclusions in the article “Heart rate variability as an outcome measure for Thought Field Therapy in clinical practice”. *Journal of clinical psychology*, 61(3), 361-365.

Pignotti, M., & Steinberg, M. (2001). Heart rate variability as an outcome measure for Thought Field Therapy in clinical practice. *Journal of clinical psychology*, 57(10), 1193-1206.

Rosner, R. (2001). Between search and research: How to find your way around? Review of the article “Thought Field Therapy—soothing the bad moments of Kosovo”. *Journal of clinical psychology*, 57(10), 1241-1244.

Sakai, C., Paperny, D., Mathews, M., Tanida, G., Boyd, G., Simons, A., ... & Nutter, L. (2001). Thought Field Therapy clinical applications: utilization in an HMO in behavioral medicine and behavioral health services. *Journal of Clinical Psychology*, *57*(10), 1215-1227.

Schoninger, B. (2004). Efficacy of Thought Field Therapy (TFT) as a treatment modality for persons with public speaking anxiety. 3149748 Ph.D., Union Institute and University, Ann Arbor.

Upshaw, R. (2005). The efficacy of thought field therapy as an adjunct treatment modality for male domestic-violence perpetrators with domestic abuse in their family of origin. 3187234 Ph.D., Walden University, Ann Arbor.

Wade, J. F. (1990). The effects of the Callahan phobia treatment techniques on self concept. *Unpublished doctoral dissertation. The Professional School of Psychological Studies, San Diego, CA*.

Wolpe, J. (1973). The practice of behavior therapy: Pergamon.

Yancey, V. (2002). The Use of Thought Field Therapy in Educational Settings. PhD, Fielding Graduate Institute.