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Thought Field Therapy and Trauma Recovery

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ABSTRACT: People who have been repeatedly exposed to traumatic events are at high risk for Post Traumatic Stress Disorder (PTSD). Refugees and immigrants can certainly be in this category, but seldom seek professional therapy due to cultural, linguistic, financial, and historical reasons. A rapid and culturally sensitive treatment is highly desirable with communities new to Western-style healing. In this study of 31 clients, a pre-test was given, all participants received Thought Field Therapy (TFT), and were then post-tested after 30 days. Pre-test and post-test total scores showed a significant drop in all symptom sub-groupings of the DSM criteria for PTSD. The findings of this study contrast with the outcomes of other methods of treatment, and are a significant addition to the growing body of data on refugee mental health. [International Journal of Emergency Mental Health, 2002 4(2), pp 99-103].

KEY WORDS: posttraumatic stress, refugees, non-traditional, culturally-sensitive

Introduction

This study examined the effectiveness of a non-traditional approach to reducing emotional overwhelm resulting from traumatic experiences in a population of culturally diverse people. The study utilized a therapeutic practice known as Thought Field Therapy (TFT). TFT is an approach developed from a blending of three modalities and theories: acupuncture, chiropractics, and psychotherapy. Despite scientific advances recognizing subtle energy fields, and the increasing use of subtle energy practices such as TFT worldwide, questions have been raised over the validity this therapeutic tool. Much has been learned about subtle energy and energetic approaches to healing in the last decade that makes "techniques" like TFT seem less alternative and more mainstream.

TFT is both rapid and non-invasive, requiring clients to disclose to the facilitator only as much of their "story" as they feel comfortable or able to tell. Traditional "talk therapies" require lengthy disclosure. Due to varying cultural norms and the nature of trauma, TFT is an appropriate treatment choice for any client who is new to counseling, or who has difficulty telling their trauma story. Eighty to ninety percent or more of individuals treated with simplest form of TFT report benefit (Callahan, 1996; Ignoffo, 1998).

TFT is a therapeutic tool. Although TFT is used by laypersons to help manage anxiety and other emotions, trauma recovery work can be extremely sensitive and must be done responsibly. Experienced and reliable cultural and clinical supervision is always advised (Gonsalves, et al, 1993; van der Kolk 1999). Consistent, gentle, and professionally guided discussion of the trauma sequelae and the recovery process is necessary to help the client integrate the new state. TFT does not replace the therapeutic relationship, but helps empower clients to move towards balance and mindful self-regulation. Reduction of the overwhelming emotional states of trauma allows for an increase in personal control and confidence, two attributes often lacking in trauma survivors. Clients who use TFT report they suffer less, feel more in control, and can be more relaxed and ready to move into an active integration of life events.

In short, with TFT a facilitator directs the client to tap in a specific sequence on meridian treatment points (synonymous with acupuncture points), creating changes in the subtle energy system of the Body-Mind. These changes are purported to result in immediate and lasting relief from
emotional overwhelm. Lambrak and Pratt (1999) do an excellent job of explaining this subtle energy system and the historical time line that belatedly brings it to the Western canon.

Mental health literature on the bio-psycho-social effects of trauma for the general population is extensive. Survivors of repeated trauma, such as war trauma, are often left with decreased abilities to thrive. It is well known that exposure to a single traumatic event does not always result in a diagnosis of PTSD. However, the prevalence of posttraumatic stress in the refugee population has been documented as high as 83% due to the severity and repetition of traumatic stressors. (Michultka, et al, 1998; Ferrada-Noli, et al, 1998) It is generally accepted that exposure to repeated traumatic events may put a person at a higher risk for ongoing emotional overwhelm and evidence of traumatic symptoms (Friedman, et al, 1993).

As is the case in many areas of the nation, refugees are becoming more and more commonplace. The United States admits about 70,000 refugees each year. Studies of recovery from repeated exposure to traumatic events may help therapists to better serve survivors of many types of trauma. This study may have more relevance for some readers as demographics in their area change, or as their professional practice shifts to serve more clients, like refugees, who endured years of repeated trauma or were forced to flee their native homelands.

Historically, refugee mental health research has focused on Southeast Asians and Cubans. Little has been documented about the more recent refugee groups such Somalis, Eritreans, and Ethiopians. Due to the demographics of the study region, Latino participants from various backgrounds and varying lengths of stay in the United States were also included although they are not classified with the legal term “refugee.” In this study, TFT was used as a therapeutic tool to reduce emotional overwhelm reported by individuals from groups which are often overlooked and under-served by mainstream counseling services. It is hoped that this study will add to a base of knowledge about the lives, needs and strengths of people from these more newly arrived groups.

Participants were drawn from an area around a large, urban elementary school with a population of 1,165 students in Southern California. The area is the first home to most recent arrivals, with a higher foreign-born rate than anywhere else in the city. It encompasses neighborhoods well known for their concentration of recent arrivals, such as “Little Mogadishu”. The school that served as a base for this study, like the surrounding area, has a dramatic profile. Ninety-seven percent of the school’s students qualified economically for free breakfast and lunch at school. At least 800 of the students and their parents are Limited English Proficient (LEP). These families are unlikely to have medical insurance, and are the least likely groups to seek out recovery assistance in general, especially mental health counseling, from anyone outside their cultural group. It is most common for such families to seek advice from their faith leader, a traditional healer, or an elder. Discloser of personal information to a “stranger”, such as a mental health counselor, is considered taboo and a breech of familial confidence. These demographics helped to guide the study design and the conduct of the community facilitators.

Methodology

Funded in part by the U. S. Department of Education (R215s50187), this study encompassed a four-month period. Bilingual/bicultural facilitators were carefully chosen for their recognition in their communities, leadership abilities, and training in multi-cultural counseling. The project served clients in English, Spanish, Amharic (Ethiopia), Tigrinin (Eritrea), and Somali. The facilitators were responsible for participant recruitment and community education, as well as for direct therapeutic service. They conducted the community education, initial interviews, and treatment sessions in the five target languages. Each facilitator completed only the basic two-day training in TFT. The facilitators recruited participants through word of mouth, public workshops, and home visits. Also, a workshop on how to recognize trauma symptoms and the basic uses of TFT was offered to 15 bilingual-bicultural nonprofit agency representatives. These professionals and paraprofessionals served as competent cultural brokers throughout the study. They informed facilitators about potential candidates, and informed participants about the study being done by trusted facilitators. There was value in giving to the communities first before asking that participants trust the investigators with their most intimate pain.

It is important to note here that facilitators made no attempt to take a complete trauma history. Recounting traumatic events in detail often triggers intense reactions. This often discourages refugee trauma survivors from entering a therapeutic relationship, and also from returning for treatment. Culturally speaking, requesting that a participant
share intimate information is not advised. Facilitators brought both knowledge of trauma dynamics and these cultural norms into their interactions with participants, and kept their interactions focused on reduction of the overwhelming emotional symptoms.

As is typical for TFT sessions, facilitators only asked participants to state their problem in simple terms, then to rate their current level of discomfort on a 1-10 scale. They were asked to think about their problem while following a tapping sequence. A sequence typically lasts 1-3 minutes and involves tapping on designated points while thinking of the emotional overwhelm or traumatic event. One session usually covered a number of related topics around a single traumatic event, and lasted 60-90 minutes. The majority of participants reported that after only 1-3 algorithm sequences they experienced measurable relief.

For example, if a participant was experiencing emotional overwhelm related to involvement in a bombing attack, the person may have traumatic memories of those sounds, smells, and sights. The person may also have overwhelming feelings and thoughts about why the event occurred, who was responsible for the terror, the loss of loved ones, and the effects of the event, and the loss for themselves and their community. Each of these aspects is treated as a unique item requiring a separate TFT algorithm.

All of the study participants completed a short intake form, were educated about confidentiality, and the research process was made explicit. As both pretest and post-test all participants completed a checklist developed by Weathers, et al., (1994) known as the posttraumatic checklist-C, or “PCL-C”. The PCL-C and consent form were professionally translated into Amharic, Tigrinian, Somali and Spanish, and back-translated for reliability. The written translations, verbal explanations, and culturally-competent rapport were extremely important to establishing credibility in the communities served in this study.

Validity and Reliability of the Instrument

The 17 question checklist known as the “PCL-C” for adults and the “PCL-Child” for children, were adapted from the DSM-IV PTSD diagnosis criteria B - D, by Weathers, et al., (1994) at the National Center for PTSD in Boston. With this instrument, participants rated their level of current distress on a Likert-scale. The checklists measure three trauma symptom subcategories, a) intrusive thoughts, b) avoidance of stimuli related to the traumatic event, and c) hyper-vigilance. The PCL-C has been found to have test/retest reliability, and convergent validity with other PTSD scales, such as the MMPI-2 and the Keane PTSD Scale (Weathers et al., 1993 in Andrykowski, et al., 1998). The PCL-C correlates with the professional “gold standard”, the Clinician Administered PTSD Scale, known as “CAPS”, on all 17 items with .70 or higher diagnostic efficiency (Blanchard, et al., 1996). There is some controversy over the cutoff score, and the validity of setting one score for all of the 17 items. The symptom criteria for PTSD are complicated, and validation studies on the PCL-C have shown varying degrees of diagnostic efficiency and sensitivity when items are analyzed at cutoff scores between 30 and 50. (Andrykowski, et al., 1998; Blanchard, et al., 1996) Therefore, in this study, a cutoff score of 40 was chosen.

Results

Sixty-one participants from five language groups completed the intake interview and consent form, the PCL or PCL-Child as a pretest, and were then treated with the appropriate TFT sequences. Thirty days after treatment, participants completed the checklist again as a post-test. Sixty-nine percent of the participants were female, and 31% were male. Participants ranged in age from 5 to 48 years, resulting in an average age of 27.7 years. Only five of the participants were minors. Of the 61 total participants, only 31 participants completed both pre- and post-tests due to high mobility and what the researcher will call a poor understanding of the research protocol. Many participants expressed the belief that because they were feeling better, they simply needed no further contact with the project. Total scores of the 31 data sets were pretest (mean=51.3, SD=14.1), and post-test (mean=31.23, SD=13.5). From those 31 complete data sets, 29 participants met the established criteria of a pretest score of 40 points or higher. Pre- and post-test total scores on only the 29 sets scoring above the 40 point cutoff were slightly higher, pretest (mean=53.74, SD=12.1) and post-test (mean=32.29, SD=13.6). This 21.45 point drop between the pre- and post-test mean scores was significant at the .05 level using a two-tailed T-test. A one-way ANOVA measured at the .05 significance level showed no significant differences in the gains experienced between ethnic groups, or between males and females.

To explore the possibility that the treatments reduced the effects of trauma in only one of the three subgroups
identified by the PCL-C (anxiety, avoidance, and hyper-vigilance), a two-tailed T-test was used to pair the pre- and post-test items within the sub-groupings. Each of the three subgroups showed significant differences at the .05 level. Eighteen of the 29 individuals, or 62% of participants, who had scores on the pretest above the 40 point cutoff for a PTSD diagnosis had post-test scores below the diagnostic threshold. Another five of the 11 individuals with pretest scores above the threshold reported symptoms reduced by at least 20%. In the end, 79% of the participants reported significant improvements in the frequency and intensity of their original traumatic stress symptoms.

Limitations of the Study

Because of the need for an extremely gentle and culturally sensitive approach, and the limited scope of financial resources, this study was quite small. It does not attempt to make any generalizations as it lacks the methodological specificity to account for variables such as facilitator differences, traumatic stress histories, multiple diagnoses, life events between pre- and post-tests, the impact of referral and information services, or any previous treatment experiences. The self-report instrument had not been previously used with these specific groups or in these languages. The author acknowledges the many limitations of the study, and recognizes that these limitations may raise significant questions. The purpose of the study is to add to the data relating to approaches for reducing trauma symptomology in a population new to the North American research base.

Discussion

In a very short period of time, and with little discomfort for the participants, TFT reduced the reported symptoms at rates greater than would be expected by traditional approaches (Sherman, 1998), and were much greater and more rapid than one would expect due to random change over a 30-day period (Callahan, 1996). The changes reported, and validated through the use of the PCL-C, were consistent with observations of the facilitators, and the verbal and physical responses of the clients. This study suggests that TFT significantly reduced the overwhelming emotions resulting from traumatic life experiences of men and women of various ethnicities and histories.

As trauma survivors are freed from overwhelming emotions, less prominent emotions often began to surface, just as in traditional "talk therapy". With TFT, these layers are peeled away quickly. Through the reduction of overwhelming emotions, the culturally and linguistically competent introduction to healing trauma, and the gentleness of TFT, participants reported that they felt more able to seek on going therapy. The traumatic events are not forgotten or minimized with TFT, but the overwhelming and often paralyzing emotion is released. It is as if a crumpled photo is laid smooth again, and the scene is clearer and can be more easily remembered and reflected upon for deeper meaning. Natural ranges of emotional responses to traumatic life events can be normalized and neutralized in the course of only one to three therapeutic sessions.

It is anticipated that the interest in this healing treatment will increase. Further research in this approach using an experimental design is recommended. Similar studies with trauma survivors and new Americans in other communities are strongly encouraged. Documentation of every approach which contributes to a collective data base of effective ways to support survivors of severe and repeated trauma regain balance for themselves and their families ultimately affects the health of all our American communities.

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References


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