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PROJECT DEMONSTRATING EXCELLENCE

Efficacy of Thought Field Therapy (TFT) as a Treatment Modality for Persons with Public Speaking Anxiety

by

Beverly Schoninger

Submitted in partial fulfillment of the Requirements for the Degree of Doctor of Philosophy with a concentration in Psychology

July 9, 2004

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Cincinnati, Ohio
Dedicated
To my beloved son, Kenneth,
Whose life was my inspiration;
Whose spirit was my joy;
And whose courage gave me the strength
To reach for the stars.
Acknowledgements

I am profoundly grateful to the many people who have helped me complete this research study. Their support, encouragement and love have provided me with the strength and endurance needed to see this project to its fruition.

To my children Melanie, Chuck, Loni, Stacey and Shaun who have been by my side during some very dark times, I thank you. To my wonderful companion, Alan, who has provided light, hope and love, I am forever grateful. I do not think I could have made it without you.

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Abstract

This study investigated the effects of one 60-minute Thought Field Therapy (TFT) session on 48 participants with public speaking anxiety. Within that group, 38 were women and 10 were men, ranging in age from 27 to 59. Their education varied from some high school to individuals who had doctoral degrees. Participants were randomly assigned to a treatment group or a delayed treatment group. There were 28 participants in the treatment group (5 males and 23 females) and 20 participants in the delayed treatment group (5 males and 15 females). They were randomly assigned to one of 11 therapists (3 men and 8 women). All therapists were licensed and trained in TFT, level II. The measurements administered by an independent assessor were subjective units of disturbance (SUD), (Wolpe, 1958), Speaker Anxiety Scale (SA Scale), (Clevenger & Halvorson, 1992) and The State-Trait Anxiety Inventory (STAI) (Speilberger, 1983). Post-treatment SUD scores decreased significantly ($p \leq .000$). In analyzing the 9 dependent measures of the SA Scale for both groups, post-treatment scores showed a significant decrease in anxiety ($p \leq .01$) and an increase in positive factors significant at the ($p \leq .000$) level except for “Wants More” ($p \leq .03$). Despite the brevity of the treatment, treatment effect sizes in this study range from .71 to 1.58. The mean effect size on overall anxiety was 1.75. Results support the effectiveness of TFT in reducing public speaking anxiety and increasing participant’s positive anticipation of future public speaking experiences.
Chapter I—Introduction

This chapter presents the purpose and background of the study; a brief description of a new, unconventional treatment called Thought Field Therapy (TFT); a condensed overview of the research to date; a statement of the problem; the null hypotheses; the significance of the study; and the summary.

Purpose and Background of the Study

Thought Field Therapy is a self-administered treatment, based on the disciplines of Applied Kinesiology (AK) and acupuncture. It is used for variety psychological complaints, including anxiety, phobias, traumas and depression. In this study, it is used specifically for the treatment of public speaking anxiety. Each participant received one 60 minute treatment from a licensed TFT-trained therapist. Thought Field Therapy is innovative in two ways: first, because a decrease in symptoms can be accomplished very rapidly, and second, because change occurs as a result of tapping on various locations of the body.

In the psychological literature, the constellation of symptoms that characterize communication apprehension is identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition- Text Revision (2000) under Social Phobia or Social Anxiety Disorder. The manifestations of this disorder are: “A marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing” (American Psychiatric Association, p.456). Other criteria deal with the anxiety that results from the exposure, or the anticipated exposure, the avoidance of these situations, and the realization by the individual that the fear is excessive or unreasonable.
In the communication literature public speaking anxiety is defined under the broad rubric of communication apprehension. J. C. McCroskey, a leading scholar in this field, discusses the evolution of the definition of communication apprehension in his book *Avoiding Communication: Shyness Reticence, and Communication Apprehension*, (1984b). He reports, in the early seventies, he conceptualized CA as "a broadly based anxiety related to oral communication" (p.13). He expanded the definition, later, to include the anxiety related to real or anticipated communication of all kind.

During an initial interview participants were asked to rate their anxiety regarding public speaking based on the subjective units of disturbance (SUD) scale developed by Joseph Wolpe (1958). This scale was originally designed with 0 representing no anxiety and 100 representing the most severe anxiety. It has been modified as a ten or eleven point scale with 1 or 0 representing no anxiety and 10 representing the most severe anxiety. In this study we used the 0 to 10 scale. Those reporting a distress of 6 or more met the criteria for inclusion.

In 1980, after working unsuccessfulty for over a year with a patient named Mary, who was so terrified of water that she had difficulty taking a bath, psychologist Roger Callahan, tried an application of acupuncture, which he had been studying. Acupuncture postulates that energy flows along meridians and healing can occur by stimulating specific points on the body.

When Mary identified that she felt anxiety in her stomach, Callahan directed her to tap under her eye, the meridian point which corresponds to the stomach meridian and to the emotion of fear. After following his directions, Callahan reported that her lifelong fear was gone. He said she was so relieved, she walked over to the pool outside his home office and
splashed water on her face. He stated her phobia had disappeared, and she would no longer be troubled by fear of water (Callahan with Perry, 1991). Mary’s treatment has held for 20 years (Pignotti & Steinberg, 2001).

Callahan studied with John Diamond (J. Diamond, 1979), a psychiatrist who was combining AK and meridian work with his patients. Using these theories, Callahan began to develop his own diagnostic procedures to determine which acupuncture points needed to be stimulated to eliminate a particular emotional disturbance. Through experimentation, he found each condition usually required tapping on acupuncture points in different sequences. This discovery enabled him to develop treatment protocols which he called “algorithms.” Each algorithm addressed a specific problem (as an example, there is one algorithm for phobias, for trauma and so on). He reported that he treated thousands of clients whose emotional disturbances were reduced by this procedure.

_A Brief Description of TFT Treatment_

In treatment, clients are asked to think about, or attune to, their distress and rate their symptoms on a subjective units of disturbance (SUD) scale, a protocol based on earlier work by Joseph Wolpe (1958, 1991). Wolpe’s original scale went from 0–100. Subsequent adaptations have ranged from 0–10 or 1–10, where zero is no disturbance and ten is the highest disturbance. Callahan used 1–10. In this study, we used the 0–10 scale. Treatment is initiated by the client who taps on various acupuncture points in a specific sequence, while attending to disturbing thoughts. The tapping sequence or algorithm is tailored to correct the problem the client reports. This process is designed to eliminate the negative emotions associated with the presenting problem. There will be more about the methods and the different components of this treatment in Chapter II.
A Condensed Overview of Current Research

In 1987, Callahan completed an informal survey. Between July 1985 and June 1986, 68 participants were solicited, via the radio, to call in and be treated for phobias and other anxieties. Callahan used an advanced diagnostic procedure he called voice technology (VT). (This process will be discussed in Chapter II.) This can be done over the telephone by sampling the client’s voice and diagnosing which points need to be tapped and in what order. Sixty-six out of the 68 participants had a reduction in their SUD score. Reported pre-treatment average distress/anxiety level was 8.35. Reported post-treatment average distress/anxiety level was 2.01. Average improvement was 6.34 points. Average treatment duration was 4.34 minutes. Four of the participants dealt with public speaking anxiety. The average reported pre-treatment distress for this sub-group was 8.75, and the average reported post-treatment distress was reported at 1.25. The average pre-test to post-test difference was 6.50. The average duration of the treatment was 3.58 minutes. Ten years later, psychologist Glenn Leonoff replicated Callahan’s survey (1995) with similar results.

In addition to these surveys, there has been a plethora of claims by practitioners reporting on the power of this rapid, unorthodox treatment. Numerous case studies, as well as research studies, have attempted to document its effectiveness. A brief synopsis of some of these current case reports and critiques follow. A more detailed description of the literature will be found in Chapter II.

The case studies suggest that TFT is extremely effective for treating trauma as well as anxiety and phobias. Psychologist Fred Gallo reports on a successful treatment for posttraumatic stress disorder (PTSD) in The Family Therapy Networker (1997). Of the many
reports published in *The Thought Field*, a newsletter produced by the Callahan Techniques, Inc., two are by psychologists Dick Brown (1996) and Jeffrey Santee (1996). Brown informs us about a client whose dog phobia was cured and Santee discusses successfully treating his son for social anxiety. Three compilations of case studies were reported in *The Journal of Clinical Psychology (JCP)* (2001): Thought Field Therapy Clinical Applications: Utilization in an HMO Setting (Sakai, Paperny, Matthews, Tanida, Boyd & Simons 2001); Heart Rate Variability as an outcome Measure for Thought Field Therapy in Clinical Practice (Pignotti & Steinberg 2001); as well as an outcome study testing the results of TFT in a war torn country with traumatized individuals called Thought Field Therapy-Soothing the Bad Moments in Kosovo (Johnson, Shala, Sejdijaj, Odell & Dabishevc, 2001).

Experimental studies on TFT have been done at Florida State University. The first was a comparison of four new therapies treating trauma called, The Active Ingredient Project (Figley & Carbonell, 1994), which was reported in *The Family Therapy Networker*, (Wylie, 1996). In the second study, Joyce Carbonell and Neta Mappa treated acrophobia with TFT. This study was reported in the TFT newsletter (Carbonell 1996). Other studies have been reported by Callahan in his book, *Tapping the Healer Within* (Callahan 2001). These include research done by psychologists Stephen Daniels, Robert Bray and Ian Graham.

Three doctoral dissertations which have not been published include: *The Effects of the Callahan Phobia Treatment Technique on Self-Concept* (Wade 1990) and studies by Dale Darby (2001) and Ray Kessler (2002).

Thought Field Therapy comes under the broad rubric of a new model called energy psychology. Diepold, Britt & Bender (2004) report:
The seeds planted by Diamond and Callahan, in the use of the acupuncture meridian system to treat psychological problems, have begun to germinate into other alternative and complimentary models of energy psychotherapy. These new techniques and fresh approaches in energy psychology have found their way to interested therapists and to the general public via the Internet, conferences, training workshops and publications. (p. 6)

Thought Field Therapy differs from most therapeutic approaches in that the relationship is not the central change mechanism, and very little client-therapist interaction is necessary to produce results. Change, which can happen quickly, is said to be accomplished by tapping on meridian points. Because of the nature of these differences, there has been skepticism in the psychological community.

In reply to Gallo’s case study, “A No-Talk Cure for Trauma,” in The Family Therapy Networker (1997), noted psychologist Lawrence LeShan writes:

Either this is a new contribution of tremendous importance (in which case this report should have been sent back for supporting details and facts), or it is one of those wild therapies that depend on the therapist’s personality and belief. (1997, p. 71)


A review of the theory and research on TFT efficacy indicates that the theoretical basis for the specific treatment is unfounded and that adequately controlled efficacy research has yet to be conducted.” In this same journal, psychologist Richard McNally (2001)
responds to Callahan’s article, *The Impact of TFT on HRV*, by saying, “Lacking any credible theory or convincing data, TFT therapists nevertheless continue to tell their patients to tap and hum their troubles away.

**Statement of the Problem**

This study investigated the efficacy and efficiency of TFT treatment on 48 participants who suffered from public speaking anxiety. Because case reports and clinical claims have been so dramatic, it is important to address this method in a more scientific manner. In addition to testing the TFT protocols, this study attempted to address criticisms of previous TFT research. For example, lack of random assignment to treatment and control groups, independent and blind assessor, standardized test measures, statistical analysis and treatment fidelity.

**The Null Hypotheses**

The study investigated the effects of TFT on public speaking anxiety. There were two null hypotheses:

Ho 1: There will be no statistically significant reduction of anxiety regarding public speaking, as measured by the subjective units of disturbance (SUD) score on the part of participants, as a result of TFT treatment.

Ho 2: There will be no statistically significant reduction of anxiety regarding public speaking as measured by the Negative sub-scales of the Speaker Anxiety Scale (SA Scale) on the part of participants as a result of TFT treatment.

Ho 3: There will be no statistically significant increase in positive responses regarding public speaking as measured by the Positive sub-scales of the SA Scale on the part of participants as a result of TFT treatment.
Significance of the Study

This author is unaware of any controlled TFT research, to date, that has been published. This study is an attempt to inquire, in a controlled environment, if this method lives up to the many positive case studies and reports of clinical efficacy and efficiency.

Public speaking anxiety is as old as the human race. In Cicero’s rhetorical treatise *De Oratore* “On the Orator,” written in 55 B.C., he writes, “I turn pale at the outset of a speech and quake in every limb in all my soul” (1942, p. XXVI). In a survey of the worst fears published in *The Book of Lists* (Wallechinsky, Wallace & Wallace, 1977), speaking in public was rated higher then the fear of death, in a survey of 3,000 Americans. In this hierarchy, the fear of death was sixth. James McCroskey (1972), a noted scholar in the communication field, estimates that at least 20% of the students enrolled in public speaking class suffer from speech or communication apprehension (CA).

In addition, the ability to speak in public has far-reaching implications. Studies indicate that students with high CA are less motivated to study (Frymier, 1993) and do not perform as well in school (Comadena, 1988). In a four-year longitudinal study of university students, McCroskey, Booth-Butterfield and Payne (1989) found a positive relationship between high CAs, low grade point average and high drop-out rate. Comedena (1988) correctly observes this correlation exists because most learning is communication-based and students with high CA simply do not participate as much as students lacking that difficulty. Henrikson (1943) points out in his research that negative speaking experiences lead to a desire to avoid circumstances in which public speaking is expected.

Personal relationships and self-esteem also appear to be affected by a more general kind of speech anxiety that appears more related to Overall Trait-Anxiety. Ayres (1989)
observed dyadic relationships between males and females. He discovered that high CAs were less satisfied with their partners than low CAs. McCroskey and Sheanan (1978) reported that, “High communication apprehensives, as compared to lows, were found to interact less with peer strangers, to be less likely to accept a blind date, to have fewer dates...to be less satisfied with the college environment” (pp. 44–45). Another study by Paulson (1951) points to the clear relationship between positive speaking experiences and high self-esteem. In the book, Avoiding Communication, (Daley & McCroskey, Eds., 1984), Daly and Stafford describe numerous studies in which there is an inverse relationship between high CA and self-esteem, achievement and assertiveness, and a direct relationship between CA loneliness and a tendency to be withdrawn. Daley and Stafford (McCroskey, Ed., 1984) also report that the inability to speak in public also reduces one’s effectiveness at work. Because employers evaluate their staff by their ability to communicate what they know, people who are disabled in this area might be limited in career options.

In addition to examining public speaking anxiety, this author believes that investigating the efficacy of TFT has a great deal of social relevance. If this method is as rapid, as effective and as painless as case studies and practitioners suggest, it is a breakthrough with profound implications for the field of psychotherapy.

Summary

This chapter contained the purpose and background of the study; a brief description of TFT treatment; a condensed overview of current research; a statement of the problem; the null hypotheses; and the significance of the study.
Chapter II—Review of the Literature

Introduction

This chapter will cover the communication apprehension (CA) literature and how public speaking anxiety is conceptualized; the possible causative factors for public speaking anxiety; current treatments in the communication literature; treatment models in psychology and psychotherapy; Thought Field Therapy (TFT) theory and methodology including: energy, subtle energy and energy fields; evidence that energy can be used for healing; acupuncture and the meridians; research describing the existence of the meridian system and how it can be used for healing; applied kinesiology (AK) and manual muscle testing; thought fields; perturbations, attuning to the thought fields; causal diagnosis; algorithms; psychological reversals and neurological disorganization; nine gamut treatment (9g); floor to ceiling eye roll; energy toxins; voice technology (VT); subjective units of disturbance (SUD); treatment session components and Thought Field Therapy components; and Thought Field Therapy training. The chapter concludes with Thought Field Therapy Research which includes: surveys, case reports and experimental designs; and the summary.

Communication Apprehension Literature

In the psychological literature, the constellation of symptoms that characterize CA is identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, under Social Phobia or Social Anxiety Disorder. According to this manual, the manifestations of this disorder are:

A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The
individual fears that he or she will act in a way (or show anxiety symptoms) that will
be humiliating or embarrassing. (American Psychiatric Association, 2000, p. 456)

Other criteria include the anxiety that results from the exposure, or the anticipated
exposure, the avoidance of these situations and the realization by the individual that the fear
is excessive or unreasonable.

In the communication literature, James C. McCroskey, a leading scholar in the field,
discusses the evolution of the definition of CA (McCroskey & Daly, Eds., 1984b).

He reports that in the early seventies he conceptualized CA as “a broadly-based
anxiety related to oral communication” (p. 13). He later expanded the definition to include
the anxiety related to real or anticipated communication of all kinds. Public speaking anxiety
falls under the category of generalized-context CA.

McCroskey conceptualizes CA on a continuum with trait characteristics at one end of
the continuum and state characteristics at the other end (1997b). There are four points along
the continuum, each representing a distinct type of CA: trait-like, generalized context,
person-group and situational.

Trait-like is the first point on the continuum and is viewed as an unvarying
characteristic. McCroskey says, “Trait-like CA is viewed as a relatively enduring,
personality-type orientation toward a given mode of communication across a wide variety of
contexts” (p. 85).

Generalized context, the second point on the continuum, is defined as, “a relatively
enduring personality-type orientation toward communication in a given type of context” (p.
86). Public speaking anxiety, speaking in small groups or classes, group discussions and
dyadic interactions are in this category.
Person-group CA is the next point on the continuum and can vary with the interaction. McCroskey defines it as, “a relatively enduring orientation toward communication with a given person or group of people” (p. 86).

Situational CA is the last point on the continuum. It is defined as, “a transitory orientation toward communication with a person or group of people” (p. 87).

Possible Causative Factors for Public Speaking Anxiety

In their analysis of the field, Ayres & Hopf (1993), report that “cognitive, affective, and behavioral explanations...have been advanced to account for the existence of public speaking anxiety” (p. 5).

Theorists who support the cognitive explanation, like McCroskey (1984), believe that communication apprehension is caused by irrational or illogical thinking about the communication process. McCroskey says:

When no appropriate expectations can be developed, anxiety is produced. When expectations are produced that entail negative outcomes, that are seen as difficult or impossible to avoid, fear is produced. When applied to communication behavior these last two cases are the foundation of CA. (p. 27)

Those who support the affective explanation for CA theorize that experienced feeling is the most important element in CA and the rationales for these feelings are unimportant. Buss (1984) and Zimbardo (1977) point to the importance of shyness and fear as they relate to the feelings responsible for CA.

Gerald Phillips, a leading communication scholar, defines the behavioral component of CA as reticence (1997). He says, “Rather it is characterized mainly by avoiding
communication situations, when possible, and inept performance in situations that cannot be avoided” (p. 129).

Recently, however, scholars in the communication field theorize that CA is physiologically mediated. In an article called “Communication apprehension as a temperamental expression: A communibiological paradigm,” Beatty, McCroskey and Heisel (1998) state that CA “represents individuals’ expression of inborn, biological functioning, which has been shown to be antecedent to social experience and therefore, independent of social learning processes” (p. 197). They report the rationale for this conclusion is the result of a growing body of research which hypothesizes that personality traits are the result of neurobiological configurations which are genetically transmitted. They describe the foundation for this new theory:

Adapted to the theoretical treatment of communication apprehension, the basic propositions are: (1) All psychological processes including cognitive, affective, and motor involved in social interaction depend on brain activity, which thereby necessitates a neurobiology of communication traits; (2) brain activity precedes psychological experience; (3) the neurobiological structures underlying temperament traits and individual differences, such as those associated with communication apprehension, are mostly products of genetic inheritance; (4) environment has only a negligible effect on trait development; and (5) differences in interpersonal behavior are principally a consequence of individual differences in neurobiological functioning. (p. 197)

In agreement are Kelly and Keaten (2000), Keaten (2001) and Sawyer and Behnke (2002). Kelly and Keaten (2000) say, “Given the compelling evidence, scholars in the field
of communication are engaging in a discussion regarding the implications of a biological view of communication anxiety” (p. 45).

Condit (2000) believes that this theory is not broad enough. She argues that:

In place of a ‘communibiological’ paradigm for communication a multicausal model is suggested in order to attend to the complex and variable interactions among the many factors contributing to communication behaviors, including genes, gene products, physiological and environmental inputs, developmental processes and inputs, cultural processes, social structural inputs, and codes. (p. 7)

Current Treatments in the Communication Literature

Treatment is dependent on how CA is conceptualized. Some of the scholars who believe that CA is caused by irrational or illogical thinking have supported the use of cognitive treatments such as Rational-Emotive Therapy (RET). This approach is based on the work of Albert Ellis (1957). Fremouw (1984) says that these beliefs or expectations “directly mediate change in the other physiological and motoric response channels of anxiety” (p. 210). Watson and Dodd (1984) have developed a treatment approach in which they use RET based on Ellis’ theory that “it is the view people take of things that disturb them, not the things themselves. CA may be an emotional reaction associated with communicative performance” (p. 258). This approach encourages identifying irrational thoughts and uses positive self-talk to express a more accurate appraisal of the experience.

Allen, Hunter and Donohue (1989) reviewed the communication literature and reported on current treatments being used to reduce CA. The most successful techniques include systematic desensitization, cognitive modification and skills training, or a
combination of the three. Ayres and Hopf (1985) report on a treatment they have developed using visualization, which is proving to be a promising alternative.

Other treatments that have produced positive results include the following: cognitive restructuring with exposure-based procedures (Macri, 2003); hypnosis combined with a cognitive behavioral treatment (Schoenberger, Kirsch, Gearon, Montgomery & Pastynak, 1997); programs designed to decrease reticence (Kelly & Keaten, 1992); impromptu speech exercises (Rumbough, 1999); and watching a videotape specially designed to decrease public speaking anxiety (J. Ayres, F. E. Ayres, Baker, Colby, De Blasi, Dimke et al., 1993).

Behnke and Sawyer (2001), Dwyer (2000), Whitworth (1996), Hopf and Ayres (1992) see CA as a unique combination of anxiety patterns. They argue that combinations of different treatment modalities like systematic desensitization, cognitive, affective and behavioral interventions, skills training and visualization are the most effective.

However, Mc Croskey and Beatty (2000) argue that the research in CA does not support the methods which have been previously chosen to remediate this condition. They say, “When empirical research is conducted little evidence, except for studies with very small effect sizes or seriously flawed designs can be marshaled to support the effect of instruction on students’ communication behavior…” (p. 5). They hypothesize that the reason these methods are no more than marginally effective is because the etiology of CA is biological.

_Treatment Models in Psychology and Psychotherapy_

Historically, theorists and clinicians in the field of psychology and psychotherapy have attempted to unravel the etiology of psychological conditions and the explanations for therapeutic change. Corsini (2000) tells us there are between 250 and 400 different theoretical models which have been proposed to answer these questions. These models are an
incomplete attempt to explain complex states. While it is important to evaluate new theories with a critical eye, we must also view them with an inquiring and open mind and place this process in perspective. Physicist William A. Tiller (1997) says:

In this quest for understanding and its utilization, we generate models or ‘visualizations’ of the phenomena as aids to our efforts or, rather, as temporary vehicles via which we gain fuller understanding. In fact the models generally become targets against which we throw experiments in order to test the accuracy of our reasoning and our understanding. They are like the rungs of a ladder via which humankind climbs from one state of understanding to another. In any new area of inquiry, it is valuable to have a model with which to make prognostications that may be compared with the reality of experimental results. It is also important to remember that any model, no matter how seemingly successful, will eventually be proven incomplete in detail and that its primary purpose is to act as a vehicle which gives a sense of understanding that triggers the proper set of questions or experiments needed to probe deeper. Just as the classical Newtonian model had to give way to the classical Einsteinian model, the latter had to give way to the Relativistic Quantum model—and so it goes as we ride the river of life onward into our future. (pp. 41–42)

Our inquiry then takes us to models that have been used to explain the phenomena of human behavior, understanding that in these methods we do not know by what mechanism change occurs. We will explore three of the most influential movements: psychoanalysis, behaviorism and the cognitive behavioral approach.
In the twentieth century, the psychoanalytical model used by Sigmund Freud hypothesized that psychopathology was caused by the interplay of the conscious and unconscious mind as it deals with intra-psychic and interpersonal issues. The term psychoanalysis refers to a system of psychology, as well as a therapeutic approach to deal with emotional issues. In *An Outline of Psycho-Analysis*, Freud (1938/1964) states that the principal goal of therapy is to give back to the ego, "It's mastery over the lost provinces of...mental life" (p. 173). Some of Freud's groundbreaking contributions included focusing on the stages of human development; especially the needs associated with childhood, as well as the development of a new model of psychotherapy.

Additionally, Freud's theories have influenced many forms of modern psychotherapy and thought from Jungian analysis, to Adlerian therapy, to the work of Carl Rogers. Physician Jacob Arlow in *Current Psychotherapies* (2000) speaks about the similarities of these models. He says the commonality of these approaches is the analyst or therapist listening "patiently, sympathetically, uncritically and receptively" (p. 19), while the client verbalizes emotions in an effort to help clarify and resolve internal conflicts.

A very different point of view was taken by the behaviorists who were formulating their theories at about the same time. In Russia, Ivan Pavlov was working on research on the psychology of learning, while in America, E. L. Thorndike was showing the results of reward and punishment on animal learning. This was to be the foundation of classical conditioning in which behaviorism is based. It explains behavior as generated by external factors and sees stimulus-response and other kinds of conditioning as the significant determinant for behavioral change. According to G. Terence Wilson in *Contemporary Behavior Therapy*, (1982) both J. B. Watson and by B. F. Skinner believe that the only acceptable subject of
scientific investigation is behavior that is observable and identifiable. The cognitive approach explains human behavior by examining how internal and external language affects and influences emotions and behavior. Albert Ellis (2000), the father of rational emotional behavior therapy (REBT) says:

From the beginning REBT considered the importance of both mind and body, or thinking/feeling/wanting (contents of the mind according to psychology) and of behavior (operations of the body). It has stressed that personality change can occur in both directions: therapists can talk with people and attempt to change their minds so that they will behave differently, or they can help clients to change their behavior and thus modify their thinking. (p. 169)

This model confronts clients with their “irrational thinking, self-damaging habituations and intolerance” (p. 169). Ellis does not believe that a warm relationship is necessary for change to occur, and in this regard REBT is similar to TFT and Eye Movement Desensitization and Reprocessing (EMDR).

These models deal with thoughts, feelings and behaviors. However, increasing scrutiny has been given to how we process trauma neurobiologically and how that impacts how we think feel and act.

Harvard psychiatrist Besel van der Kolk (1994) discusses how neuroimaging provides a visual representation of the mechanism of the brain when patients remember a traumatic memory. During these periods, the area of the brain, which is the center of speech called Broca’s Area, shuts down and the area around the amygdala (thalamus, hippocampus, hypothalamus and brain stem) shows activity. Van der Kolk says: “The inability of people with PTSD to integrate traumatic experiences and their tendency, instead, to continuously
relive the past are mirrored physiologically and hormonally in the misinterpretation of innocuous stimuli as potential threats” (p. 243). These responses have a biochemical consequence which impacts human behavior. Van der Kolk explains the barrage of chemicals (cortisol, oxytocin, vasopressin, endogenous opioids, epinephrine and norepinephrine) that course through the body when one thinks about a traumatic event.

Additionally, it appears as if low levels of serotonin have been implicated in increased startle response, impulsivity and aggression, involuntary fixation with a traumatic memory, as well as depression, and obsessive-compulsive disorder (Gallo, 1998). In an effort to remediate the effects of these chemicals, psychiatrists treat depression, PTSD and other anxiety-based pathologies with neurotransmitters, such as serotonin and norepinephrine, as well as benzodiazepines, beta-blockers, MAO inhibitors and many other substances (Kaplan & Sadock, 2000).

In Kaplan and Sadock’s *Synopsis of Psychiatry* (2000), they report:

The use of pharmacological agents or psychotherapeutic drugs can be defined as an attempt to modify or correct pathological behavior by chemical means. The relation between the physical state of the brain and behavior is highly complex and imperfectly understood. Clearly, however, various parameters of both normal and abnormal behavior, such as perception, consciousness, affect and cognitive functions may be profoundly affected by certain changes in the central nervous system. (p. 999)

We can see then, the connection between all of these systems. All of these models, including disciplines that concentrate on neurobiology and biochemistry, provide answers to the same questions from different perspectives. However, they are all intrinsic to the Western
paradigm, which investigates cause and effect (Diepold, Britt & Bender, 2004) and strives for homeostasis (Lambrou & Pratt, 2000). Traditional Chinese medicine, which has been increasingly examined and used in the United States, looks at pathology in a more holistic fashion. Diepold et al. (2004) state, “For the Chinese, illness occurs simultaneously on all levels of a person’s being, including physical, mental and energetic” (p. 31). This energetic force is known as chi and is accessed through the meridian system. Balancing these energies is the goal, because imbalances in this system make one susceptible to illness. It is this theoretical construct that we use in TFT and other energy psychology models.

*Thought Field Therapy (TFT) Theory and Methodology*

Thought Field Therapy signals a paradigm shift in the way we conceptualize psychological disturbances because its developer, psychologist Roger Callahan believes, like the Chinese, that all emotional distress emanates from imbalances held in the energy field of the body. His protocols integrate information and methods from psychology, acupuncture and applied kinesiology. Treatment is initiated by the patient who taps on designated acupuncture points while thinking about the problem to be resolved.

The theories of Roger Callahan and John Diamond have stimulated a developing body of work in psychology and psychotherapy called energy psychology. Psychologist David Grudermeyer (2000), founder of The Association for Comprehensive Energy Psychology (ACEP), says:

Energy Psychology is the generic name for an emerging family of experimental rapid-effectiveness tools that utilize the body’s energy pathways (meridian acupoints system), energy centers (chakras), and biofield (aura), to assist in addressing psychological, spiritual, mind body and peak performance goals. (p. vi)
Grudenmeyer also reports that many different protocols flow out of this model. One of the protocols developed by chiropractor James Durlacher (2002) is called Acu-POWER. Durlacher describes energy psychology this way:

Energy psychology is basically a physiological treatment for an emotional problem. There are several areas within the brain—specifically the limbic system—that are involved with the body’s survival. The hypothalamus and the amygdala, which are part of the limbic system, work like a computer....The functioning of the limbic system gives us an ability to react appropriately to particular conditions. These physiological structures are all tied to the meridians that go through the body. When we change the physiology of the body by altering the electromagnetic system via the meridian system, then we are able to effect physiological changes, which in turn cause changes in emotion. (p. 390)

Because this is such a departure from traditional psychotherapy, it is important the reader understand the theoretical constructs on which these theories are based. To that end, this researcher will paint, in broad strokes, the historical perspective in which energy psychology is placed, and will define energy, subtle energies and energy field, acupuncture and meridians, applied kinesiology and manual muscle testing. In addition, we will discuss terms specific to Callahan’s work: thought fields, perturbations, attuning to the problem, psychological and neurological reversals, causal diagnosis, algorithms, nine gamut treatment (9g), floor to ceiling eye roll (er), toxins, and voice technology.

Finally, we will define Wolpe’s term subjective units of disturbance (SUD) as it relates to TFT. We will then discuss how all these are applied in a treatment session.
Energy, subtle energy and energy fields. Webster defined energy in physics as “the capacity for doing work” (1988, p. 449). Energy can manifest as heat, chemical energy and mass. It is transmitted through light, sound and electricity (Diepold et al., 2004). Other forms of energy that we are familiar with are magnetism, electromagnetism, kinetic energy of motion, gravity, vibration, elastic energy, nuclear energy, etc. (Oschman, 2000).

What do we mean by subtle energy and how do we know it is there? By definition, subtle refers to an energy that is not easily detectable by the measurement devices that are presently available. Hence, the very existence of this energy has to be hypothesized on the basis of its presumed effects.

Subtle energy is defined more specifically by Gerber as “a general term denoting energy that often exists in the high frequency octaves beyond the ordinary time/space frame i.e. magnetoelectric (ME) energy which moves faster then light” (Gerber, 1988, p. 541). He comments that “these subtle energies influence cellular patterns of growth in both positive and negative directions” (p. 43) and, therefore, can affect our health and well-being. Historically, subtle energy has been thought to be an Eastern concept; however, numerous scientists and researchers in our Western scientific world are involved in attempting to observe, measure, and document its existence.

The electrical fields generated by our tissues and organs, which we access for medical evaluations, are thought to be examples of this subtle energy (Hartung & Galvin, 2003; Oschman, 2000; Becker, 1985). The electrocardiogram (EKG) and the electroencephalograph (EEG) are some commonly used tests that use subtle energy to diagnose pathology. These tests measure the electrical currents present in our bodies. The magnetoencephalograph
(MEG) produces images of the human brain from magnetic fields and measures the currents due to neural activity.

In James Oschman's *Energy Medicine: the Scientific Basis* (2000), he reports that our biological electrical fields are accessed when we evaluate heart function in the EKG and brain electricity in the EEG. Both of these tests measure electrical energy on the skin. However, the electrical current becomes distorted and weakened as it passes through tissue and bone. To resolve this problem, scientists have turned their attention to biomagnetic signals which, when observed with the MEG, give us more information about what is occurring inside the body (Oschman, 2000; Becker & Seldon, 1985).

Candace Pert, a neuroscientist and professor at Georgetown University, discusses subtle energy in her book, *The Molecules of Emotion* (1997). Pert describes the fact that there are neuropeptide receptors in every part of the body, not just in the brain, as was previously thought. In her discussion regarding the mechanism of action of these chemicals and molecules she says:

My own hunch is that these energy emanations get created as ligands bind with receptors in the body, doing their own intricate humming dance with each other. Now these energies have not been convincingly measured by objective devices, although a few physicists have worked at devising more sensitive means of measuring quantal events. (p. 224)

One such instrument, which comes out of the research done on quantum physics, is the superconducting quantum interference device (SQUID) (Hartung & Galvin, 2003; Becker & Seldon, 1985; Oschman, 2000). It is a sensitive and sophisticated magnetic imaging mechanism which assesses extremely weak magnetic fields around the body. It produces
three dimensional maps of the energy fields around the body by screening out other stronger fields that might interfere. It measures magnetic waves in the body and can not only determine the number of nerve cells in specific cortical regions of the brain and their function, but can also detect tumors that are not observable with computed axial tomography scans (Hartung & Galvin, 2003; Oschman, 2000).

There has also been some interesting research on the existence of energy fields. Harold Saxon Burr (1972), a Professor of Neuroanatomy at Yale University, became interested in the energy field or aura. Burr and his colleagues began measuring electrical fields and electrical potential around hydras, molds, worms, salamanders, humans and other mammals (Oschman, 2000). Burr and Elmer J. Lund, a researcher at the University of Texas, developed theories of an electrodynamic field which they called the “fields of life or L fields.” These fields “hold the shape of an organism just as a mold determines the shape of a gelatin dessert” (Becker & Seldon, 1985 p. 83) and by surrounding living beings, serve as a blueprint for their ultimate form. Burr demonstrates that a baby animal has an energy field around it which is the same size as an adult (Burr, 1972).

The presence of energy fields are discussed in the works of the physicist David Bohm (Bohm & Hiley, *The Undivided Universe and ontological Interpretation of Quantum Theory*, 1993), the Stanford physicist and researcher, William Tiller (*Science and Human Transformation: Subtle energies, Intentionality and Consciousness*, 1997), the physician Richard Gerber (*Vibrational Medicine*, 1988), and the physician and researcher Robert Becker (*The Body Electric*, 1985). These authors postulate that energy permeates our universe and connects us to each other and everything in our world.
Gerber hypothesizes that disease begins at an energetic level. It is his contention that disease can be prevented if we can intervene energetically before it is detected in our physical body. He states, “By realizing that humans are beings of energy, one can begin to comprehend new ways of viewing health and illness” (Gerber, 1988, p. 43). He continues by commenting that these energy systems are affected by our emotions.

Gallo (1999) cites the theories of quantum physics as a basis for his beliefs about the mechanisms of energy psychology. Gallo says Einstein’s formula E=mc² informs us that everything is energy. He concludes matter and energy are interchangeable manifestations of the same reality and that matter is condensed energy, but appears motionless because it moves so slowly. Gerber concurs, writing that:

Quantum physics and experiments in high energy particle physics have shown us that, at the particle level, all matter is essentially energy. Einsteinian medicine is a viewpoint that tries to put the Newtonian picture of biomachinery into the perspective of dynamic interactive energy systems. (Gerber, 1988, p. 34)

Gallo hypothesizes that, “If all is essentially energy, it follows that this holds true for our nervous system, the neurochemistry, and even thought and cognition.” He continues by saying, “While therapy can be conducted at more material levels, it is hypothesized that if it can be directed precisely at an energy level it will prove more thorough and immediate in its effects” (1999, p. 10).

_Evidence that energy can be used for healing._ Gerber believes that because we are energetic beings, it is natural to assume that we are affected by energy. He states: “Even orthodox medicine has begun its evolutionary progression toward the development of energy methods of treatment” (1988, p. 34). He cites the use of therapeutic radiation to treat cancer,
electricity to deal with pain and electromagnetic fields to heal fractures. Oschman agrees, reporting that Western medicine is now becoming interested in energy medicine. He says, “Two areas of research are being extensively investigated: the study of magnetic fields produced by living things—biomagnetism—and the study of the effects of magnetic fields on living systems—magnetobiology” (Oschman, 2000, p. 73). Magnetic fields are considered to be a better choice for healing than electrical fields because they are less invasive and they are able to treat both soft and hard tissue injuries simultaneously.

One of these devices is the pulsed electromagnetic field (PEMF). Andrew Bassett and electrochemist Arthur Pila developed what is described by Becker and Seldon (1985) as “a pair of electromagnetic coils sheathed in plastic pads, connected to a book sized generator that plugs into a wall socket” (p. 176). This is applied on either side of the fractured bone 8–10 hours a day. It produces a varying magnetic field that induces millions of minute currents which act to jump-start the healing process in bone fractures (Oschman, 2000). Becker and Seldon report that these “artificial time-varying magnetic fields directly activate the cells by speeding up their mitotic rate” (p. 177). Hartung and Galvin (2003) report that Bassett, one of the developers of this device, who states that clinical trials have demonstrated that fractures that have gone unhealed for as long as 40 years have been improved by using the PEMF.

Acupuncture and meridians. Many cultures throughout history have conceptualized energy systems (ch’i or qi in China, prana in India and Tibet, Ki in Japan), but it was not until 1971 when the journalist James Reston traveled with Henry Kissinger to China, and he required an emergency appendectomy that the Western world took notice. Acupuncture was used to reduce his post-operative pain. He reported his findings after observing the benefits of his procedure, as well as surgery in which acupuncture was used as an anesthetic. This
news generated research by the army and the National Institute of Health (NIH) (Decker & Seldon, 1985). Over time, practitioners of the healing arts began exploring some of the uses of this approach and integrating it into their practices. The NIH now recognizes acupuncture as a valuable treatment for an increasing number of medical conditions (Lambrou & Pratt, 2000; Hartung & Galvin, 2003).

The earliest use of the human energy system for healing probably occurred in China approximately 5 thousand years ago. Traditional Chinese medicine (TCM) is a distillation of the world view of the Chinese incorporating culture, language and their philosophy of life (Diepold et al., 2004). Pulos (2002) reports: “In Eastern or Chinese health practices, upon which energy psychology is based, the individual is viewed as a microcosm of nature, a universe in miniature, a fusion of seen and unseen energies” (p. 168). In this system, balance is important.

The concept of ch’i (life force) is basic to TCM. Diepold et al. (2004) define ch’i as the “energy that supports and influences life and all of its manifestations” (p. 34). Traditional Chinese Medicine holds the belief that any illness or symptom in the body, mind or spirit, can be associated with disharmony in a person’s vital energy or ch’i. It is believed that ch’i flows through meridians, which are unseen channels (like blood vessels) in the body. There are 12 paired major pathways (one channel flows close to the skin and is accessed with needles or pressure, and the other channel is internal). Each of the meridians also passes through a specific organ in the body and the system is connected so that life energy, or ch’i, flows from one meridian to the next (Gallo & Vincenzi, 2000). The uninterrupted, balanced flow of ch’i along these meridians creates good health. In TCM, the belief is that stimulating acupuncture points on the surface of the body will affect internal functions. This is the way
balance is restored. Acupuncture and acupressure utilize the same points, but acupuncturists use needles instead of using the hands to apply pressure (Gach, 1990).

_Research describing the existence of the meridian system and how it can be used for healing._ When the NIH requested proposals for research on the technique, Robert Becker, an orthopedic surgeon, who had previously been interested in the method, applied for a grant (Becker 1985, 1990). Initially, he writes that most of the researchers thought it operated as a placebo and placement of the needles was not important. This theory was quickly disproved and Becker was given a grant to study it more fully. Becker says he hypothesized that “acupuncture meridians were electrical conductors that carried an injury message to the brain, which responded by sending back the appropriate level of direct current to stimulate healing in the troubled area.” He writes:

I also postulated that the brain’s integration of the input included a message to the conscious mind that we interpreted as pain. Obviously, if you could block the incoming message you would prevent the pain, and I suggested that acupuncture did exactly that. (Becker & Seldon, 1985, p. 234)

He theorized that the farther you get from the energy source, the weaker the signal becomes and acupoints worked as booster amplifiers situated along power lines. He continued to reason that, “if the lines and points were conductors and amplifiers, the skin above them would show specific electrical differences compared to the surrounding skin” (p. 234). To prove this theory, he and his colleague Maria Reichmanis developed an electrode which would roll along the meridians to measure electrical characteristics at each point. After completing this experiment, Becker concluded: “It was obvious by then that at least the
major parts of the acupuncture charts had, as the jargon goes ‘an objective basis in reality’” (p. 236).

More proof of this has been sought by Hiroshi Motoyama, Ph.D., a Japanese researcher and founder of the California Institute for Human Sciences in Encinitas, California. He developed a machine called The Apparatus for Measuring Meridian Identification (AMI) (Diepold, 2002). Collinge (1998), a teacher and researcher in the field of subtle energy, reports that researchers have successfully used the AMI to measure energy flowing through the meridians by calibrating the flow of ions in the interstitial layer of tissue beneath the skin’s surface. It has been found that these patterns of flowing ions are consistent with the blueprint of the meridians.

The AMI works by attaching electrodes which transmit calibrated low-voltage impulses into acupuncture meridians to determine whether ch’i is flowing normally (Lambrou & Pratt, 2000). Collinge (1998) explains that in a 10 minute session it can produce an extensive evaluation of a person’s meridian system and the organs which are fed by those meridians. Motoyama studied over 5,000 people with the AMI and identified ch’i as electromagnetic energy with accompanying infrared and infrasonic energy. He and others using the AMI as a diagnostic tool have discovered strong correlations between the meridians that are out of balance electrically and disease in the organs systems (Gerber, 1988).

It has also been used as an educational diagnostic tool by measuring the nervous system to identify gifted children, and compare them to average children (Borg, 2003). It found “on average, boys in the gifted group had statistically calmer nervous system measures than boys in the average group” (p. 861).
University of California physicist Zang-Hee Cho, who has been credited with developing the prototype for the positron emission tomography (PET) scan and was one of the early investigators of magnetic resonance imaging (MRI), has begun to use the MRI to explore the effects of acupuncture. After a back injury, which was treated successfully with acupuncture, Cho became curious about acupuncture’s mechanism of action (Lambrou & Pratt, 2000; Hartung & Galvin, 2003; Diepold et al., 2004). The MRI helped him chart how acupuncture treatment to the little toe altered blood flow to the brain even though no known nerve, blood or other direct connection exists (Cho et al., 1998).

In the article, “Subjective Evidences and Propagated Sensation Transmission (Proof of the Power and Arousal of Ch’i)” published in the Journal Clinical Acupuncture and Oriental Medicine, Eachou Chen (2002) provides concrete evidence of the meridian system. He reports the effect that ch’i transmission has on skin temperature, local blood flow, electrical muscle reaction and phantom limb pain. He states: “The routes of ch’i transmission described by people who are sensitive to propagated sensation occur with meridian routes described in classic Chinese acupuncture textbooks” (p. 161). He also reports that ch’i transmission can be blocked for a number of reasons, but once the obstruction is removed then ch’i can pass freely through the meridian.

Even though there is no decisive scientific support for the exact mechanism of operation, it is clear that acupuncture is widely practiced. In addition to endorsements by the World Health Organization (Burton, 1993) and the National Institutes of Health (Lambrou & Pratt, 2000; Hartung & Galvin, 2003), there have been controlled studies documenting the successful use of acupuncture for nausea (Ferara-Love, Sekeres & Bircher, 1996), motion sickness (Hu, Stritzel, Chandler & Stern, 1995), hypertension (Yu, Li, Wei, Wu & Fu, 1991),
pain management, (Felhendler & Lisander, 1996) and physical ailments caused by stress, such as tension headaches and neck pain (Stone & Wharton, 1997). Hartung and Galvin remind us that: “Many insurance companies reimburse acupuncture not necessarily because all of the theoretical components are endorsed but because treatment consistent with the theory is effective” (2003, p. 58).

*Applied kinesiology and manual muscle testing.* Callahan’s theories were influenced by the work of the chiropractic physician George Goodhart (1965, 1988) who developed applied kinesiology (AK), and psychiatrist John Diamond (1979). Goodhart’s work expanded on the knowledge of manual muscle testing (Kendall & Kendall, 1949). He found that when one applied neutral pressure to a muscle it tested strong (or stayed stable when pressure was applied) when the subject thought about something pleasant or true.

The muscle would test weak (the muscle would not hold, or would collapse when pressure was applied) when one thought about something unpleasant or untrue. This procedure is done by “exerting a small amount of physical force against a resisting muscle, or group of muscles, to make a diagnostic determination” (Diepold et al., 2004, p. 53).

Goodhart theorized that this puzzling phenomenon might have something to do with the meridian system and discovered that by applying pressure to certain acupuncture points he could restore strength to muscles which had previously tested weak. Diamond (1979) who was trained in AK, began combining meridian work with manual muscle testing to treat psychological problems by correlating the meridians with certain emotions. Building on their work, Callahan experimented with his patient Mary, who was terrified of water. (Callahan had been working with Mary regarding this problem for over a year with little or no results.)
Testing meridian alarm points using muscles as an indicator is the foundation of TFT diagnostic procedures.

Callahan studied applied kinesiology with chiropractors David Walther and Robert Blach (Diepold et al., 2004) after his introduction to muscle testing by a psychiatrist colleague, Harvey Ross, who “had me extend my arm horizontally to the side as he tried to push it downward.” He said:

I was able to resist his effort, feeling quite strong despite the pressure he was applying. But then he asked me to think of something upsetting. I chose to focus on the image of my home being destroyed by fire. As I did Harvey pushed my arm using the same force as before. This time with the negative thought prominent in my mind, I could not keep my arm up. I felt powerless. At that moment I realized that this was the best demonstration of the mind/body interaction I had ever experienced. (Callahan with Trubo, 2001, pp. 21–22)

However, AK is controversial. Physician Stephen Barrett (2004) reported about “bizarre claims” that AK makes in which muscle testing is used to determine if there are allergies or nutritional deficiencies present. He wrote:

The concepts of applied kinesiology do not conform to scientific facts about the causes or treatment of diseases. Controlled studies have found no difference between the results with test substances and with placebos. Differences from one test to another may be due to suggestibility, distraction, variations in the amount of force of leverage involved, and/or muscle fatigue. If you encounter a practitioner who relies on AK muscle testing for diagnosis, head for the nearest exit. (p. 6)
While Barrett's article quoted some research articles that do not support the use of AK as a diagnostic tool he dismissed other studies which validate AK for these purposes. Of particular note, is a study completed by Monti, Sinnott, Kunkel & Greeson (1999) which investigated using muscle testing as a tool with participants who made congruent and incongruent self-referential statements. These tests were compared with results from a dynamometer. They report: “Over all, significant differences were found in muscle test responses between congruent and incongruent semantic stimuli” (p.1019).

Another article completed by Lawson and Calderon (1997), examined reliability between different practitioners using muscle testing. The authors conclude: “This study demonstrated significant interexaminer reliability of individual tests of the pectoralis major and piriformis muscles but not for the tensor fascia lata or hamstring which are essentially tests of groups of muscles at once” (p. 539).

Thought fields. Callahan conceptualized thoughts as energy bound up in a field (Callahan with Trubo, 2001). He believed that thought fields are information fields which are held in the mind-body; they contain cognitions and affect. Diepold et al., (2004) state, “A thought field is conjectured to contain energetic information about real, imagined or remembered experience that has a direct effect on an individual’s physical, emotional, and energetic state of mind” (p. 116). Callahan explained: “When you are terrified of snakes, devastated by a marital breakup or depressed over the loss of a job, the cause of this disturbance is contained in a thought field” (Callahan with Trubo, 2001, p. 24). Diepold et al., (2004) hypothesize, “a thought field is an energetic bridge between thought, memory and emotional experience that reaches beyond conscious awareness” (p. 116).
As to the etiology of psychological distress, Callahan’s thinking is unconventional. Many of his colleagues believe that the information which causes negative emotions is hardwired into the brain. This means that eliminating it is a long arduous process which may include drugs or a long course of therapy. Callahan, on the other hand, is of the opinion that the information that causes negative emotion is software rather than hardware and that it can be eliminated rapidly by stimulating designated acupuncture points (Callahan with Trubo, 2001).

*Perturbations.* Acknowledging the meridian theories and the work of Bohm and Hiley (1993) on thought, Callahan further postulates that emotional disturbances are caused by blockages, or minute “microstate” energy forms in a thought field, which he calls perturbations (Callahan & Callahan, 1996). In his newsletter *The Thought Field* he states that “perturbations in the thought field contain the active information which triggers and forms the sequence of activities, neurological, chemical, hormonal and cognitive which result in the experience of a negative emotion such as fear, depression, anger, etc.” (1995, p. 3).

Pignotti (2000) explains that although the thought field perturbations are isolable; they can be deleted while the rest of the information in that field remains. She relates, as an example, the case of Mary who lost her fear of water, but did not lose the other information as it relates to the thought field. Mary no longer has a phobia, but she remembers that she cannot swim. In the case of trauma, the memory (or thought field) is intact without the disturbing emotions.

Writing about Callahan’s theory of perturbations, Diepold et al. (2004) state that, “The origin purpose of perturbations, as the hypothetically fundamental causative agent for negative emotions, is open to speculation and verification” (p. 119). However, they say we
do know that when people experience trauma or painful emotions there is some trigger mechanism in place which warns them of impending danger. They postulate that even thoughts or memories can precipitate this reaction and that this may be encoded energetically.

*Attuning to the thought field.* To begin TFT treatment, patients are required to tune into, or think about, the problem to be addressed. Attunement brings up the energetically encoded information in the thought field. Pignotti (2000) notes that TFT treatment is different from other medical attention, because their treatment does not require thinking about anything.

*Causal diagnosis.* Callahan employed muscle testing to determine what points needed to be treated and in which order. He found that emotional disturbances could be eliminated by testing points along the meridian to determine where blockages occurred while the patient was attuned to it. Since the fundamental ingredient of the disturbance, according to Callahan, was the perturbation, TFT diagnosis uncovered the exact perturbations in the specific order in which they occurred. Callahan said causal diagnosis, "is a method by which we can determine with precision the 'code' responsible for producing and healing a particular psychological problem" (Callahan with Trubo, 2001, p. 29).

In the energy psychology community there is disagreement as to Callahan's concept of "specific order" and the need for causal diagnosis. Gary Craig (2004), an engineer who has studied with Callahan, disputes the theory of order and causal diagnosis. He uses a protocol incorporating all of the treatment points in Thought Field Therapy. He says: "Where I have a serious scientific question is in the idea that muscle testing will allow a therapist
(even a beginner) to find the appropriate sequence for a client’s problem out of the 87 billion possibilities” (p. 5).

Monica Pignotti, a social worker and former close collaborator of Callahan, also has questions in this regard. In a posting to the TFT listserv titled “Why Roger Callahan and I have Split,” Pignotti reports on data she collected from a single-blind study in which she used random sequences (for which she did not perform diagnosis) on some participants and VT on the control group. She reluctantly reports there was no difference between the group that got VT and the group that got a random sequence of treatment points. She says:

The results I got from this experiment stunned me. It turned out that I had identical results for each group – a 97% success rate, success being defined as it was in the 4 other VT studies cited by Roger Callahan on p. 51-52 of Stop the Nightmares of Trauma (Callahan, Leonoff, Daniel & Pignotti, a SUD of 1(using a scale of 1-10) – complete elimination of all subjective units of distress (p.2).

While Pignotti’s article acknowledges the effectiveness of treatment she appears to question the use of prescribed sequences as opposed to random sequences, causal diagnosis and VT. In this study the therapists did not utilize VT, causal diagnosis, or muscle testing; they employed algorithms instead.

*Algorithms.* Using causal diagnosis, Callahan found emotional disturbances, such as phobias, anxiety and traumatic stress, had patterns of energy disruption. When the relevant sequences of acupuncture points were tapped while the patient was attuned to the problem, the disturbance would be eliminated. These patterns helped him develop what he called algorithms or formulas.
Algorithms refer to that prescribed sequence of acupuncture points (Callahan, 1997).

Callahan arrived at these algorithms after many years of experimenting, using causal diagnosis, by finding sequences that recurred (Callahan with Trubo, 2001).

The algorithms used in this study were:

Trauma algorithm: (PR, cb, e, a, cb, 9g, cb, e, a, cb, er)

Fear, phobia and anxiety algorithm: (PR, e, a, cb, 9g, e, a, c, er)

Embarrassment algorithm: (PR, un, cb, 9g, un, cb, er)

Perspiring and other physical symptoms: (PR, e, a, cb, 9g, e, a, cb, er)

Claustrophobia algorithm: (PR, a, e, cb, 9g, a, e, cb, er)

All eyes upon me: (PR, a, e, cb, 9g, a, e, cb, er)

Complex problems: (PR, cb, e, a, cb, if, cb, if, cb, 9g, cb, e, a, cb, if, cb, if, cb, er)

  On if you may say 3x’s: “I forgive _____/she/they did the best they could, or I reach out with forgiveness and love.”

  On if you may say 3x’s: “I forgive myself, I did the best I could.”

Rapid stress reduction protocol: (PR, er, 9g, er)

Anger algorithm: (PR, if, cb, 9g, if, cb, er).

  On if you may say 3Xs: “I forgive _____he/she/they did the best they could or I reach out with forgiveness and love.”

Guilt Protocol: (PR, if, cb, 9g, if, cb, er).

  On if you may say 3Xs: “I forgive myself, I did the best I could.”

Rage algorithm: (PR, oe, cb, 9g, oe, cb, er).

  On oe you may say 3Xs: I forgive _____he/she/they did the best they could, or I forgive for my own healing or I reach out with forgiveness and love.”
Abbreviations:

eb: inside corner of eye brow at eyebrow
a: under arm
e: under eye
oe: outside eye
a: arm
cb: collarbone
lf: little finger
if: index finger

er eye roll: (slowly roll the eyes from floor to ceiling while tapping the gamut spot)

9g (nine gamut): The 9g treatment is accomplished by tapping the gamut spot, which is on the back side of the hand between the ring finger and the little finger (the third acupoints on the tri-heater meridian), while at the same time opening and closing the eyes, looking down to the right, down to the left, circling the eyes in both directions, humming, then counting and humming.

*Psychological reversals (PR) and neurological disorganization.* In this matter, Callahan’s theories had been influenced by the work of Becker and Diamond. Becker was a pioneer in the field of amphibian regeneration and its relationship to electrical current. Becker also studied the effects of polarity reversals in unhealthy people. He hypothesized that these reversals prevented healing (Becker & Seldon, 1985; Becker, 1992).

Diamond is a psychiatrist who believes that when people test weak while thinking of something positive and strong while thinking about something negative healing cannot take
place because their life energy is being diverted. He calls this a “reversal of the body morality” (Diamond, 1988, p. 15, 1995d, p. 5).

Building on their work, Callahan postulated that intent could be reversed on an unconscious level. He continues to believe some people exhibit behavior which is self-sabotaging or chronically negative and calls this psychological reversal (PR). In his book Why Do I Eat When I am Not Hungry? (1991) he defined PR as “a state of the body and the mind that blocks the natural healing (energy) force within and prevents effective therapeutic intervention” (p. 42). Callahan suggests that this reversal must be corrected before treatment can be effective and has developed techniques to remediate PR.

The reversals are broken down into three categories: massive, specific and mini. Different remedies are prescribed for each of these reversals (Callahan with Trubo, 2001). A massive reversal is indicated when one tests weak with the statement “I want to be happy” and strong with “I want to be miserable.” A specific reversal is present when one tests weak with the statement “I want to be over this problem” and strong with “I want to keep this problem.” A mini reversal is indicated when the statement “I want to be completely over this problem” tests weak and “I want to keep some of this problem” tests strong. If muscle testing is not used, as it was not in this study, reversals can be assumed and treated if the SUD does not decrease or appears stuck.

A massive psychological reversal is treated by having the client stimulate a point on the left side where the lymphatic drain is located while stating a positive affirmation such as, “even if I have this problem (or anxiety, anger, etc.) I completely and profoundly accept myself.” A specific reversal is treated by tapping continuously on the little finger side of your hand while making the following statement three times: “I accept myself even if I still have
some of this problem (or anxiety, anger, urge, etc). (See Appendix A for illustration of these points). In the last few years, Callahan has deleted the affirmations believing the physical technique alone, rather than the words, engender the shift.

Neurological disorganization is another condition that interferes with treatment and natural healing. This concept, again, flows out of the discipline of AK (Walther, 1988) which views this phenomenon as polarity switching. This constellation of symptoms is characterized by unusually awkward and clumsy behavior, confusion with right and left, and language which is opposite from that which was intended. It is believed that it involves right brain/left brain disorganization and may be caused by anything which impedes the energy flow, such as exposure to irritating substances or conditions, preexisting neurological trauma or imbalances caused by chemical or nutritional substances. Callahan has developed a treatment for this called collarbone breathing (CBB) (Callahan with Trubo, 2001).

Using two collarbone points (See Appendix A for illustration), Callahan describes this procedure:

There are five breathing positions in this exercise, to be followed in this order:

1. Breathe normally.
2. Take in a deep breathe, and hold it.
3. Let out about half of that breathe, and hold it.
4. Let out the remainder of that breathe, and hold it.
5. Take in a half breathe, and then release it.

The Touching Steps

These touching steps should be performed while moving through the breathing techniques above, start with either hand.
1. Using two fingertips, touch one of the collarbone points. As you do, tap the gamut spot of that same hand with two fingertips of the opposite hand. Simultaneously, proceed through the five breathing techniques. Tap rapidly about five good taps for each of the five breathing steps.

2. Move the same two fingertips from the original collarbone point to the other collarbone point. Then repeat the tapping and breathing maneuvers in step 1.

3. Bend the same two "touching" fingers at the knuckle (as though you were making a fist with them), and place these knuckles so they are touching the first collarbone point. At the same time, tap the gamut spot of that hand and proceed through the five breathing techniques described in step 1.

4. Move the same knuckles to the other collarbone point and tap the gamut spot of that hand while going through the five breathing steps. (pp. 87–88)

Repeat this procedure with the other hand and continue the treatment using steps 1, 2, 3 and 4.

_Nine gamut treatment (9g)._ The nine gamut treatment (9g) had been devised by Callahan to balance energy flow by stimulating the right and left hemispheres of the brain. Callahan commented:

The theory behind the gamut treatments is that we are balancing various functions of the brain with each treatment in regard to the particular problem we are treating....It is as if the brain must be tuned to the right frequency for each problem for the treatment to work. (p. 15)

Callahan believes, based on his study of AK, neurolinguistic programming (NLP) and the work of Moishe Feldenkrais, that:
Certain eye movements allow access to certain memories....I recognized that the position of the eyes could diagnostically reveal a hidden perturbation. I also discovered that tapping the gamut spot while moving the eyes in particular ways could contribute to the collapsing of a perturbation. (Callahan with Trubo 2001, p. 81)

The 9g is accomplished by tapping the gamut spot, which is on the back side of the hand (the third acupoints on the tri-heater meridian), while at the same time opening and closing the eyes, looking down to the right, down to the left, circling the eyes in both directions, humming, then counting and humming. (See Appendix A for illustration for the gamut spot.)

*Floor to ceiling eye roll (er).* The floor to ceiling eye roll (er) also utilizes the gamut spot. It is generally used at the end of treatment when the SUD scale is at a one or two. Gallo (1999) describes it as a “rapid relaxation procedure reminiscent of the work of Moishe Feldenkrais” (p. 110). Callahan reports that it is one of his newer discoveries and believes that it solidifies improvement (Callahan with Trubo, 2001). It is accomplished by tapping the gamut spot while slowly (to a count of 10) raising the eyes from the floor to the ceiling.

*Energy toxins.* Callahan believes energy toxins are a negative reaction to substances such as alcohol, tobacco, caffeine, laundry detergent, as well as a host of other substances can disrupt the energy system so that healing cannot occur. These agents can also affect the duration of the positive effects of TFT so treatment must be repeated to be effective if toxins are a factor (Callahan with Trubo, 2001).

*Voice technology.* Voice technology (VT) is viewed by Callahan as the most sophisticated method of arriving at a diagnosis. Utilizing this technology, treatment can be done over the telephone by assessing the client’s voice. Gallo (2002) says, “In this regard, the
voice which also involves muscles, carries the information about the structure of the problem (i.e., the perturbations in the thought field) while the client speaks or is directed to count while attuning to the problem” (p. 102). Callahan considers VT proprietary. Only those trained in the technique know the details about how it operates. This training is quite expensive; however, the trainees are supervised by Callahan for two years. Voice technology was used by Callahan and Leonoff in the research done over the radio (Callahan, 1987; Leonoff, 1995).

In the listerve posting titled, “Why Roger Callahan and I have Split” Monica Pignotti (2004) reports on data she collected from a single-blind study in which she used random sequences (for which she did not perform diagnosis) on some participants and VT on the control group. She reluctantly reports there was no difference between the group that got VT and the group that got a random sequence of treatment points. She says:

The results I got from this experiment stunned me. It turned out that I had identical results for each group—a 97% success rate, success being defined as it was in the 4 other VT studies cited by Roger Callahan on p. 51–52 of “Stop the Nightmares of Trauma” (Callahan, Leonoff, Daniel & Pignotti), as a SUD of 1 (using a scale of 1–10)—complete elimination of all subjective units of distress. (p. 2)

The therapists in this study employed algorithms not VT.

*Subjective units of disturbance (SUD).* This scale was originally developed by Joseph Wolpe (1958) to measure distress with 0 representing no anxiety and 100 representing the most severe anxiety. It has been modified as a 10 or 11 point scale with 1 or 0 representing no anxiety and 10 representing the most severe anxiety. The higher the number the more distress there is. When tuning into a thought field, patients subjectively rate their

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disturbance on a 0–10 or 1–10 scale. In this study, we have used the 0 to 10 scale to assess treatment outcome.

Treatment session components. Treatment sessions begin with the client tuning into the thought field and evaluating the SUD scale. The therapist then assesses for psychological and/or neurological reversal and treats for them, if necessary. In this study we did not employ muscle testing and began with PR treatments working under the assumption that there might be reversals present.

If the practitioner is trained in causal diagnosis, he could use manual muscle testing to determine which acupuncture points need to be stimulated. If not, he could choose the specific algorithm needed for treatment. Treatment begins by tapping on designated acupoints and includes the (9g) technique. When the SUD is at a one or two, the eye roll (er) technique is employed. The client tunes into the subject that is being treated and when the disturbance is down to zero, treatment is concluded. At this point, as the participant thinks about the disturbance, another thought field may be accessed. If this happens, the procedure is repeated with this new information. Clients are usually given the protocols that would be most helpful so they could repeat them by themselves at a later date, if necessary. This was done in our study.

Thought Field Therapy Training There are three levels of TFT training. In the first level, trainees learn thought field theories, how perturbations cause psychological distress and how psychological reversals can block treatments (Callahan, 1995a). They are also taught how emotional disturbances can be eliminated using the algorithms and the treatments for PR. During the second level of training, practitioners are introduced to the causal diagnosis. At this level, students learn how to discover which meridians are being affected
when clients experience emotional distress and the appropriate acupressure points necessary to treat that meridian. The third level of expertise involves the use of equipment called VT which has been discussed previously.

Thought Field Therapy Research

Surveys. Callahan (1987), reports on an informal survey. Between July 1985 and June 1986, 68 participants were solicited via the radio to call in and be treated for phobias and other anxieties. Callahan used an advanced diagnostic procedure he called voice technology (VT). This can be done over the telephone by sampling the client’s voice and diagnosing which points need to be tapped and in what order. Sixty-six out of the 68 participants had a reduction in their SUD score. Reported pre-treatment average distress/anxiety level was 8.35. Reported post-treatment average distress/anxiety level was 2.01. Average improvement was 6.34%. Average treatment duration was 4.34 minutes. Four of the participants dealt with public speaking anxiety. The average reported pre-treatment distress for this sub-group was 8.75, and the average reported post-treatment distress was reported at 1.25. The average pre-test to post-test difference was 6.50. The average duration of the treatment was 3.58 minutes.

In the second TFT survey, Leonoff (1995) worked with 38 participants. All participants reported a decrease in SUD level. Leonoff’s treatment duration was longer than Callahan’s at 6.48 minutes—and his success (again computed by average improvement percent) was 87.3%.

The limitations of these surveys are apparent: there was no control group, no consideration of confounding variables, no random assignment, no assessment beyond the client’s reported SUD and no follow-up. The possibilities of bias, e.g., demand
characteristics, also exists in both surveys. In the Callahan survey, the researcher both
developed and performed the treatment, and in the Leonoff survey the researcher performed
the treatment.

*Case reports.* There have been many case reports described by practitioners of TFT,
in addition to Callahan’s first patient, Mary.

In an article titled “A No-Talk Cure for Trauma” psychologist Fred Gallo (1997),
reports of a patient suffering from a trauma in which her inebriated husband put a gun to her
head and then went into another room and killed himself. This event occurred 10 years before
her visit with Gallo. Subsequent to her husband’s death she had been suffering from
“generalized anxiety and frequent severe panic attacks, often several times a day, involving
tension, tachycardia, difficulty breathing and fear of losing her mind or even dying. She was
phobic about driving and was anxious as a passenger” (p. 65). Gallo used the algorithm for
trauma. Her acknowledged SUD level on a 0–10 scale was a 10. Gallo first asked her to
focus on a picture of the worst part of the trauma, which for the patient was seeing her
husband lying in a pool of blood. After using the trauma algorithm, which took around 10
seconds, her SUD level went from a 10 to a 5. She said, “I can see it, but I don’t have any
fear” (p. 66). They repeated the algorithm, and she reported, “It’s gone, it’s a one” (p. 67).
Then Gallo worked on her anger at her treatment by the police, which was another aspect of
the trauma. After completing the algorithm with a slight modification to address her anger,
she reported to Gallo, “The anger is gone they were just doing their job” (p. 68). Follow-up at
1 week, then 4 months after treatment revealed that she was no longer bothered by the
traumatic memories. Her anxiety as a driver and a passenger was gone and she no longer had
nightmares or panic attacks.
Enthusiastic TFT practitioners report that these techniques are extremely useful for treating phobias. Two cases appeared in The Thought Field, a newsletter published by the Callahan Techniques. The first case is reported by psychologist Dick Brown (1996) and concerns a 10-year-old boy, Jimmy, who has a dog phobia. He reported:

When I was little a great big Doberman Pinscher attacked me. He bit me on the inside of my leg. I went to the hospital and got stitches. I looked at his eyes and saw that he was mad and hungry. I ran but he got me. (p. 1)

When he was asked to rate his fear of dogs on a one to ten scale, he reported assertively that it was, “a million” (p. 1). After using the trauma algorithm, which includes the 9g (humming a tune while tapping on the back of the hand) Jimmy remarked, “I know why you had me hum ‘happy birthday,’ because I’m happy, I don’t have fear anymore” (p. 1).

The second case report is particularly relevant because of its focus on communication apprehension. It is presented by psychologist Jeffrey L. Santee (1996), who reports that his 5-year-old son, Matt, was so frightened about getting up in front of his class on “sharing day” that he refused to go to school. He told his parents that “talking to his class was stupid” (p. 6). Santee relates this was his son’s favorite excuse anytime he was afraid. Matt was persuaded to try the phobia algorithm. Santee decided to use a bar graph with a happy face at one end and a tearful face at the other, instead of a SUD scale because of his age.

Initially, Matt identified his fear at the end of the scale that corresponded to a 10. Santee reports that the algorithm worked quickly and soon his son was down to a one. This treatment occurred the night before sharing day. The next morning, Santee’s wife repeated the algorithm. Matt did not complain about going to school that day, and when he returned he
was so happy about his performance that he said that he couldn’t wait for the next “sharing
day.” Santee reports that this event happened a year before he wrote his article. Since then,
they have not heard any complaints from Matt about sharing. Teacher’s reports compliment
his social confidence.

While these case reports are interesting, it is important to recognize that they have
been published in Callahan’s newsletter, rather then in a peer-reviewed scholarly journal. In
addition to Callahan’s report of a 90% success rate in his private practice (1994) and a report
by Durlacher (1995) of a 95% success rate, at this time there are few controlled studies on the
efficacy of TFT.

Experimental designs. The first report of an experimental design—a study titled “The
Effect of the Callahan Treatment Technique on Self Concept”—was done by psychologist
Joel Wade (1990). The study employed a pre-test/post-test control group design, with eight
measured variables. There were 27 participants in the treatment group and 24 in the delay
treatment group. All of the participants reported having phobias.

The questionnaires used were The Self-Concept Evaluation of Location Form, and
The Tennessee Self Concept Scale. Participants were solicited from a newspaper
advertisement. Those who agreed to participate were sent both questionnaires and a 10-point
scale to rate the intensity of their phobic anxiety. Treatment was performed one month later
in a group setting with the participants self-treating, after an explanation by Callahan.
Participants for whom group treatment was ineffective or insufficient were, subsequently,
treated individually. The TFT treatment session lasted for 3 hours. Five participants who
were unable to attend were treated individually with TFT by Wade. Approximately 3 months
after receiving the initial completed questionnaires, the participants received a second set of
questionnaires. The control group received questionnaires at the same time intervals.

Wade reports that “…these data indicated that as a result of the Callahan intervention
subject’s self-acceptance and self-esteem were enhanced and self-incongruence was
decreased” (p. 78). He reports there was a clinical, as well as a statistical difference. What is
more important, for our purposes is that “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” (p. 79). Wade
did not do a statistical analysis on these data. This study is also limited by the fact the
researcher, Joel Wade, and the developer of the technique, Roger Callahan, both performed
the treatment which placed demand characteristics on the participants.

Two studies were conducted at Florida State University. The first, The Active
Ingredient Project (Figley & Carbonell, 1994), was reported in The Family Therapy
Networker (Wylie, 1996). This study was designed to evaluate the effectiveness of four brief
treatments for Post Traumatic Stress Disorder (PTSD). The treatments selected were
Traumatic Incident Reduction (TIR), Visual Kinesthetic Disassociation (VK/D), Eye
Movement Desensitization and Reprocessing (EMDR), and Thought Field Therapy (TFT).
The history of the study began in 1993, when Figley and Carbonell contacted 10,000
members of an Internet consortium, as well as other therapists who were experienced in
PTSD, inviting them to submit possible treatments. These treatments required endorsement
by other professionals who regularly treated trauma. Though many nominations were
received, only the four mentioned above were selected (Gallo, 1998).
Fifty-one participants were solicited from clinicians in the community, radio and newspaper advertisements. They were required to exhibit symptoms of PTSD or phobias which interfered with their daily functioning. They were pre-tested and post-tested with the Brief Symptom Inventory, and The Impact of Events Scale. They self-reported their symptoms on the SUD scale. Of the 51 participants, 39 took part in the study. Twenty-two completed the 6-month follow-up. The pre-treatment SUD averaged 5.9 while the post-treatment SUD averaged 3.3. At the 6-month follow-up, SUD averaged 3.5 for all the treatment groups. Although the investigators have not formally supported one therapy over another, Wylie (1996) reported Figley and Carbonell’s observation that even though all of the therapeutic interventions were successful at decreasing symptoms, participants treated with TFT reported relief in a shorter period of time. “Requiring virtually nothing in the way of personal interaction, TFT can by-pass all that tedious therapeutic business of joining, empathy, history taking, reprocessing and the like and zero in on the problem immediately at hand” (p. 34).

Carbonell and Mappa completed another study at Florida State University. In an article published in the Callahan Techniques newsletter, The Thought Field, (1996), Carbonell writes, “The purpose of the experiment was to determine whether TFT would decrease the anxiety level of acrophobics more than a placebo control group” (p. 1). The participants were given the Cohen Acrophobia Questionnaire. Of the 156 who signed up for the experiment, only 49 reached the predetermined cut-off score for height phobics. Participants were also given a behavioral test and asked to evaluate their SUD level at different points near or on a ladder. They were randomly assigned to a treatment and placebo group. Both groups were given the treatment for reversal, consisting of rubbing the chest at
the neurolymphatic reflex spot on the chest and repeating a positive statement. Thought Field Therapy was given two times. At that point, regardless of SUD rating, a post-test was performed by an assessor who was blind to whether the individual received treatment or PR correction alone. Each participant was then asked again to approach the ladder, climb it and rate his SUD level. Carbonell reports:

Although both groups got somewhat better, there was a statistically significant difference between those participants who had received real TFT and those who received placebo, the TFT participants showing significantly more improvement. Furthermore, there was a significant difference when all the SUD scores were averaged for each participant and the difference was more pronounced when examining the SUD scores for the participants while they were climbing the ladder. (p. 1) (i.e., at a time when their fear was the most heightened.)

Limitations to the study include questionable methodology in defining the placebo group. In reality, the subjects in this group were treated for PR, which in the view of some produces a reduction in symptomatology (Hartung & Galvin, 2003).

Two dissertations on TFT have recently been written by Raymond Kessler (2002) and Dale Darby (2002). For his study, Kessler recruited 50 participants, who were perpetrators of domestic violence and who were diagnosed with post-traumatic stress disorder. They were treated with TFT in a group setting. The treatment did not reduce anxious arousal, intrusive thoughts or lessen defensive avoidance. The one concern regarding the validity or generalizability of these results is that the TFT treatment was done in a group setting, rather than done individually. This population is extremely fragile and results might have been different if participants were treated individually.
Darby’s (2002) TFT research was completed with participants who were having difficulty accessing medical treatment because of their fear of needles. Twenty-one participants diagnosed with needle phobia were enrolled in this study. Pre-treatment and post-treatment measures were taken using the Fear Survey Schedule and the SUD measurement. Post-treatment tests were taken one month after treatment. The author conducted a one-hour treatment session using Callahan’s causal diagnosis. Darby’s results showed a significant difference between pre-treatment and post-treatment on both measures, concluding that TFT was effective for this population.

The results of this study are strong and deserve our attention. However, there is methodological concern in that the researcher performed both the treatment and the evaluation, which may have placed demand characteristics on the participants. Other limitations included no random assignment or control group.

An entire issue of The Journal of Clinical Psychology (Beutler, 2001) was devoted to TFT. This issue contained three studies which were not peer-reviewed; however, each study was accompanied by an analysis, written by another author, which was an attempt to evaluate the findings.

The first was an uncontrolled study conducted at a health maintenance organization (HMO) with 714 participants on a variety of presenting complaints, including adjustment disorder, anxiety, depression, trichotillomania, work stress, etc. (The Journal of Clinical Psychology, Sakai, Paperny, Matthews, Tanida, Boyd & Simons, 2001). Seven participating therapists, who completed 1,594 sessions, were attempting to explore the possible application of TFT for various conditions. Each participant was treated with an algorithm appropriate to their problem or symptom. The measure used to evaluate results was the SUD scale (Wolpe,
1969). They reported, “Paired t-tests of pre- and post-treatment SUD were statistically significant in 31 categories reviewed” (p. 1215).

This study had some methodological flaws. Because it was an attempt to evaluate the effectiveness of TFT in a treatment environment, the authors did not attempt to provide controls. However, the variety of pathologies treated, the number of participants and the positive results in this setting are provocative and, as the researchers suggest, provide a rationale for controlled research on this method.

In the same issue of *The Journal of Clinical Psychology*, Jeffrey Lohr (2001) criticizes this study in view of the fact that prior TFT research has been weak. His contention is that since TFT has not been previously validated in the literature, research in a practice setting is not appropriate. He says, “Effectiveness research is a valuable research tool, but only when there is prior efficacy research to support its effectiveness in more restrictive, controlled experiments” (p. 1230). He also questions the existence of acupuncture meridians and concludes that “TFT theory is without an empirical basis for the bioenergetic model from which it derives” (p. 1231).

The second article in *The Journal of Clinical Psychology* (Johnson, Shala, Sejdijaj, Odell & Jabashevi, 2001), reported on a study in which clinicians treated 105 Albanian residents in war-torn Kosovo in 2000. They completed five separate trips and treated 105 patients with TFT using causal diagnosis. The participants reported 249 separate traumas. They used subjective distress to measure outcome. They reported:

For 103 of the 105 patients and for 247 of 249 separate traumas, treatment was successful. In addition to the self report of complete relief, their spontaneous expressions provided confirming clues. People gave that look of astonishment,
hugged, put their palms to their temples, and looked up to the heavens in gratitude - looked up from the very yards outside the home, where family members had fallen to a firing squad. (p. 1239)

Follow-up data averaging 5 months showed results remained consistent. This was intended as a humanitarian field study with no provision for controls or other important research criteria; however, as a case study the results for treatment with TFT for trauma are impressive.

While Rita Rosner, in *The Journal of Clinical Psychology*, (2001) lauds the humanitarian effort of this study as being commendable, she criticized it as research because it was delinquent in several important areas. She asserted only superficial information was used to describe the sample, the diagnostic criteria of PTSD were absent, the measuring system was crude and there was not enough information about the methodology of TFT treatment; that natural remission was not controlled for and a comparison with other methods, which have been validated for the treatment of PTSD, should have been included. Rosner concludes by saying, "This study provides very limited evidence for the effectiveness of TFT" (p. 1241).

Pignotti and Steinberg reported on 39 case studies in *The Journal of Clinical Psychology*, (2001). The presenting complaints were varied and included conventional psychological problems such as phobias, anxiety, depression, but also conditions out of the range of treatment in mental health practices such as physical pain. In addition to the SUD scale (Wolpe, 1958), Pignotti and Steinberg used heart rate variability (HRV) as a pre-treatment and post-treatment measure of outcome results.
The authors contend that HRV measures homeostasis in the autonomic nervous system which is linked to emotions. Heart rate variability “gives us a window in which to view such activity, thus providing an objective measure of an individual’s emotional state” (p. 1195). Pignotti and Steinberg report, “Changes in HRV, after a brief treatment for an emotional problem are substantial and changes to this extent have not been linked to any other modality” (p. 1203). Follow-up, which was done on only four of the participants, reported that treatment held. While these case studies are interesting, the use of the HRV as a measuring device for emotional conditions is still controversial (Hartung & Galvin, 2003).

Herbert and Gaudiano in *The Journal of Clinical Psychology* (2001) criticized this study on the basis that there were serious methodological flaws. For example, there was no accounting for statistical regression, placebo effect, non-standardized measure and procedures, experimenter demand characteristics and the consequence of the passage of time. They concluded: “This collection of case studies will not convince any thoughtful scholar or clinician that the observed changes have anything at all to do with TFT” (p. 1209).

This author has attempted to give the reader an opportunity to peruse as much as the literature as is available. However as Hartung and Galvin (2003) remind us, “Lack of empirical evidence is not unusual in the field of psychology” (p. 53). Even though case studies and clinical experience suggest that these concepts are useful in healing psychological problems, we may have to wait until there are more sophisticated tools to measure these energies and more scientific substantiation to determine how they operate.

**Summary**

This chapter covered the communication apprehension literature and how public speaking anxiety is conceptualized; the possible causative factors for public speaking
anxiety; current treatments in the communication literature; treatment models in psychology and psychotherapy; Thought Field Therapy theory and methodology including: energy, subtle energy and energy fields; evidence that energy can be used for healing; acupuncture and the meridians; research describing the existence of the meridian system and how it can be used for healing; applied kinesiology and manual muscle testing; thought fields; perturbations, attuning to the thought fields; causal diagnosis; algorithms; psychological reversals and neurological disorganization; nine gamut treatment; floor to ceiling eye roll; energy toxins; voice technology; subjective units of disturbance; treatment session components and Thought Field Therapy training. The chapter concluded with Thought Field Therapy research including: surveys; case reports; and experimental designs.
Chapter III—Methodology

Introduction

This chapter includes the research methodology used in this study; research design; participants; initial interview; research team; research environment; Thought Field Therapy (TFT) treatment procedures; measurement tools and reliabilities; measurement periods; 5 month follow-up; statistical analysis used; treatment fidelity; and a summary.

Research Design

This study researched the effects of one 60-minute Thought Field Therapy (TFT) session on public speaking anxiety. There were 48 participants. Within that group, 38 were women and 10 were men, varying in age from 27 to 59. Participants were randomly assigned to a treatment group or a delayed treatment group. There were 28 participants in the treatment group (5 males and 23 females) and 20 participants in the delayed treatment group (5 males and 15 females). They were assigned to one of 11 therapists.

An initial interview was required. Within 2 months of this meeting, the participants met at the research center. Each participant gave a 3-minute speech to an audience consisting of other study participants and people recruited to be an audience. They were given 3 minutes to compose a speech which was videotaped. Speech topics were selected from a list of possibilities that were available. After their speech, participants met with an independent assessor to complete the Speaker Anxiety Scale (SA Scale), (Clevenger & Halvorson, 1992) (see Appendix B), a measure of state communication apprehension (CA) and the subjective units of disturbance (SUD) scale, (Wolpe, 1958).
Half of the participants were randomly selected to be treated at that time (treatment group). After treatment, the participants gave another speech and met with the independent assessor to repeat the previous tests.

The other half of the participants (the delayed treatment group) returned in one month. At that time, the participants observed one or two speeches, gave another speech, and met with the independent assessor to complete the SA Scale and to rate their SUD score. They met with a research therapist and were treated. After treatment, the delayed treatment participants gave another 3-minute speech with the same parameters as the treatment group. Later, each delayed treatment participant met with the independent assessor, completed the SA Scale, The Speilberger State-Trait Anxiety Inventory (STAI) (1983) (see Appendix C) and were asked to rate their SUD score when they thought about making a speech.

After 5 months, the principal investigator met with 31 (64%) of the participants to discuss the long-term effect of the treatment.

Participants

Participants were recruited from the general population of the Colorado Springs community. Notices asking for volunteers to participate were placed in community organizations, therapist’s offices and at local colleges (see Appendix D). The principal investigator also recruited participants from audiences at organizations where she spoke. An initial telephone interview was conducted to determine if the participant met the criteria for public speaking anxiety and if they were able to commit the time necessary to complete the research.

This researcher then met with each participant individually. At this time, participants were pre-screened for psychological and medical problems, which would preclude them from
being in the study. At least one person was discouraged from participating in the study because he had no address, therefore, he could not be contacted. They were asked to rate the severity of their anxiety based on the SUD scale developed by Joseph Wolpe (1958). This is an 11 point scale with 0 representing no anxiety and 10 representing the most severe anxiety. They were asked to recall their anxiety regarding public speaking and report the number based on this scale. Those reporting a distress of six met the criteria for inclusion.

Fifty-five people were interviewed. Out of that group, 48 people participated, 6 did not follow through with their appointment and one did not have an address. Thirty-eight were women and 10 were men, ranging in age from 27 to 59 years. Six did not follow through with their appointments, and one did not have a mailing address. Their education varied from people who attended some high school to people who had doctoral degrees. Seventy-seven percent attained a B.A. or higher degree. The participants were Caucasian with the exception of one African American and one Hispanic.

The principal investigator designed and conducted this research project to comply with the American Psychological Association’s Principle 8, Research with Human Participants, (2002) (see Appendix E).

_The Initial Interview_

The interview consisted of the following: introduction, credentials and responsibilities of the principal investigator; purpose of the study; description of the study; volunteer requirements; discussion of public speaking anxiety in general and the participant’s anxiety in particular and the completion by the participant of a written questionnaire, an informed consent, and a permission to videotape during public speaking and treatment (see Appendix F.
for initial interview form, Appendix G for responsibilities of the participants, Appendix H for the informed consent, and Appendix I for the permission to videotape or audiotape).

The Research Team

The research team was composed of the principal investigator and 13 additional members: the statistician, the independent assessor and 11 research therapists. All treatment therapists were proficient in the second level of TFT. They participated in an additional training organized by the principal investigator so that each participant would have consistent treatment. With the exception of the independent assessor and the statistician, all members of the team generously donated their time to complete this project.

This author and principal investigator is a PhD, candidate in Psychology at the Union Institute in Cincinnati, Ohio. After receiving a Master of Arts (MA) in Counseling Psychology at the University of Northern Colorado in Greeley in 1989, she became a Licensed Professional Counselor in the State of Colorado. Initially trained in TFT by psychologist Fred Gallo in 1995, she sought advanced training at the diagnostic level with psychologist Roger Callahan, the developer of TFT, in 1996. During the following 6 months, she was supervised by Callahan in these techniques. She took advanced toxin training with him in 1997.

Sherry Marshall was the statistician for the study. She holds a MA in sociology with an applied emphasis in research methods from the University of Colorado in Colorado Springs. She has 13 years experience with the Statisctical Package for Social Science (SPSS). She has taught research methods at the University of Colorado in Colorado Springs for the past 6 years and statistics at Colorado Technical University for 3 years.
The research therapists were a devoted and talented group of people. They gave generously of their time to insure the participants were treated with the utmost professionalism. There were eight women and three men, whose degrees varied from masters level counselors and social workers to doctoral level psychologists. A brief discussion of who they were and what their accomplishments were, are as follows:

Robert Armstead holds a PhD in educational psychology which he received from the University of Washington in Seattle in 1973 and a PhD in clinical psychology which was awarded in 1976 from the California School of Professional Psychology. He is licensed as a Clinical Psychologist in Colorado and Arizona. He has had extensive experience in a supervisory and training capacity with many organizations throughout his career. Robert was trained in TFT in 1996.

Sharon Blake received an MA in counseling from Colorado State University in Fort Collins in 1968. She is a Licensed Professional Counselor and has had over 20 years of experience, both as a counselor and as a supervisor. She was trained in TFT in 1997.

Ellie Coriell received an MA in Guidance and Counseling from Wheaton College in Illinois, where she graduated summa cum laude in 1981. She is a Licensed Professional Counselor and a Certified Addictions Counselor, level III. Ellie has held many supervisory positions throughout her career. She has an extensive background in addiction issues and was awarded the Practitioner of the Year for the Tennessee Alcohol and Drug Division in 1988. She was trained in TFT in 1995 and 1996.

Mary Delaney was awarded a PsyD in Clinical Psychology from University of Denver in 1996. Mary was trained in TFT in 1997 and 1998. In addition to a private practice,
Mary is a supervisor of a social learning program for the chronically mentally ill at The Colorado Mental Health Institute in Pueblo.

Connie Fairchild has an MA in counseling from the University of Colorado in Colorado Springs. She is a Licensed Professional Counselor. Connie has been employed in various capacities at Pikes Peak Mental Health Center since 1994. She has worked with individuals and groups in a supervisory capacity. She has used TFT since 1996.

Sandra Felt was awarded an MSW from Syracuse University in 1967. She is a Licensed Clinical Social Worker who has comprehensive background in child, family and abuse issues. She has held many supervisory positions throughout her career and has published extensively in her field. Sandra has been in private practice since 1982, and was trained in TFT in 1995 and 1996.

Polly Fiedler holds an MA in counseling from the University of Colorado in Boulder. She is a Licensed Professional Counselor and a Certified Addictions Counselor, level III. She has been practicing in Colorado for 19 years, and was trained in TFT in 1997.

Edward Fields received a PhD in medical psychology from The Union Institute in 1985. He is a Licensed Clinical Psychologist in Colorado and Arizona. He was trained in TFT in 1996. He is presently working on an Indian Reservation in Arizona.

Michael Galvin was awarded a PhD in Clinical Psychology from the University of Florida in 1975. Michael is a Licensed Clinical Psychologist. During his career, Michael has held many supervisory and training positions, and has co-authored the book Energy Psychology and EMDR (Hartung & Galvin, 2002). He was trained in TFT in 1995.

Connie Russo received an MSW from the University of Denver in 1987. She is a Licensed Clinical Social Worker. She received training in TFT in 1995.
Lillian Sideris received her MA in Counseling Psychology from the University of Northern Colorado in Greeley in 1989. She is a Licensed Professional Counselor. Lillian has held many supervisory positions, including being the Clinical Coordinator of the Southern Colorado Critical Response team since 1999. She was trained in TFT in 1995.

**Research Environment**

The research environment was carefully selected to replicate common testing and therapy offices. The participants were interviewed and selected in the principal investigator’s therapy office. All of pre-testing and post-testing, speeches and treatment were done in a Victorian house, which had been converted into therapy offices. The house had a large waiting room and generous porch, so that participants had room and privacy to create their speeches. Because this research was done on 4 weekends, the therapists in the building graciously allowed us the use of their facilities.

**TFT Treatment Procedures**

Treatment consisted of one 60-minute session. The research therapists were all licensed and had completed TFT, level II training. They used a TFT research treatment manual provided by the principal investigator (see Appendix A). During the treatment phase, the participants were asked to focus on their present anxiety regarding speaking in public, or envision a time in the past when they were anxious in a speaking situation. They then rated their SUD score.

They were questioned about their reaction to past traumatic events, their fears anxieties and phobias, the embarrassment that may surface as a result of speaking, perspiring and other physical symptoms, claustrophobia, and the effect of having all eyes on them. Any,
or all of these, might be the focus of treatment using appropriate algorithms which are delineated below.

The research therapists could use any of the psychological reversals during the session, but began treatment with the massive PR treatment for psychological reversal. A massive PR is treated by having the client stimulate a point on the left side where the lymphatic drain is located while stating a positive affirmation such as, “even if I have this problem (or anxiety, anger, etc.) I completely and profoundly accept myself.” A specific reversal is treated by tapping continuously on the little finger side of your hand while making the following statement three times: “I accept myself even if I still have some of this problem (or anxiety, anger, urge, etc), (see Appendix A for illustrations of these points). In the last few years, Callahan has deleted the affirmations believing the physical technique alone, rather than the words used, engender the shift, however, we used the statements in this study.

After treating for PR, treatment therapists used the appropriate algorithms:

Trauma algorithm: (PR, cb, e, a, cb, 9g, eb, e, a, cb, er)

Fear, phobia and anxiety algorithm: (PR, e, a, cb, 9g, e, a, c, er)

Embarrassment algorithm: (PR, un, cb, 9g, un, cb, er)

Perspiring and other physical symptoms: (PR, e, a, cb, 9g, e, a, cb, er)

Claustrophobia algorithm: (PR, a, e, cb, 9g, a, e, cb, er)

All eyes upon me: (PR, a, e, cb, 9g, a, e, cb, er)

Complex problems: (PR, eb, e, a, cb, 1f, cb, if, cb, 9g, eb, e, a, cb, 1f, cb, if, cb, er)

On if you may say 3x’s: “I forgive ____/she/they did the best they could, or I reach out with forgiveness and love.”

On if you may say 3x’s: “I forgive myself, I did the best I could.”
Rapid stress reduction protocol: (pr, er, 9g, er)

Anger algorithm: (PR, if, cb, 9g, lf, cb, er).

On if you may say 3Xs: “I forgive ____he/she/they did the best they could or
I reach out with forgiveness and love.”

Guilt Protocol: (PR, if, cb, 9g, if, cb, er).

On if you may say 3Xs: “I forgive myself, I did the best I could.”

Rage algorithm: (PR, oe, cb, 9g, oe, cb, er).

On oe you may say 3Xs: I forgive ____he/she/they did the best they could, or I forgive
for my own healing or I reach out with forgiveness and love.”

Abbreviations:

cb: inside corner of eye brow at eyebrow

a: under arm

e: under eye

oe: outside eye

a: arm

cb: collarbone

lf: little finger

if: index finger

er eye roll: (slowly roll the eyes from floor to ceiling while tapping the gamut spot)

9g (nine gamut): The 9g treatment is accomplished by tapping the gamut spot, which is on
the back side of the hand between the ring finger and the little finger (the third acupoints on
the tri-heater meridian), while at the same time opening and closing the eyes, looking down
to the right, down to the left, circling the eyes in both directions, humming, then counting and humming.

At that point they asked each participant to rate their SUD score. If the SUD did not decrease at least three points, they were treated again for PR or for neurological disorganization. These treatments are as follows:

Neurological disorganization: for collarbone breathing (CBB) use two collarbone points (See Appendix A for illustration).

There are five breathing positions in this exercise, to be followed in this order:

1. Breathe normally.
2. Take in a deep breathe, and hold it.
3. Let out about half of that breathe, and hold it.
4. Let out the remainder of that breathe, and hold it.
5. Take in a half breathe, and then release it.

The Touching Steps

These touching steps should be performed while moving through the breathing techniques above, start with either hand.

1. Using two fingertips touch one of the collarbone points. As you do, tap the gamut spot of that same hand with two fingertips of the opposite hand. Simultaneously, proceed through the five breathing techniques. Tap rapidly about five good taps for each of the five breathing steps.

2. Move the same two fingertips from the original collarbone point to the other collarbone point. Then repeat the tapping and breathing maneuvers in step 1.
3. Bend the same two "touching" fingers at the knuckle (as though you were making a fist with them), and place these knuckles so they are touching the first collarbone point. At the same time, tap the gamut spot of that hand and proceed through the five breathing techniques described in step 1.

4. Move the same knuckles to the other collarbone point and tap the gamut spot of that hand while going through the five breathing steps.

Repeat this procedure with the other hand and continue the treatment using steps 1, 2, 3 and 4 (Callahan with Trubo, pp. 87–88).

The cook's hook-up was also employed. This is another treatment for neurological disorganization. The protocol is as follows:

1. While seated place left foot over right foot.
2. Place right hand over left hand with palms facing outward.
3. Clasp palms together.
4. Draw hands under arms to chest.
5. Breathe deeply. On the "in" breath place tongue at the roof of the mouth. On the "out" breathe place tongue at the bottom of the mouth.

Treatment continued until the SUD level was zero, or 60 minutes had elapsed. If the SUD score reached zero, the therapist employed the installation protocol. In this protocol, participants were asked to tap the gamut spot on the back of the hand between the ring and pinkie finger (see Appendix A for the treatment locations and techniques) and to visualize a successful public speaking experience. Participants were given the algorithms to take home so they could self-treat at a later time, if necessary. All of the treatment sessions were videotaped for treatment fidelity.
Measurement Instruments

Measurement Instruments used were the subjective units of disturbance (SUD), Wolpe (1958), the Speaker Anxiety Scale (SA Scale) (Clevenger & Halvorson, 1992) (see Appendix B) and the State-Trait Anxiety Inventory (STAI), (Speilberger, 1983), (see Appendix C).

Wolpe's (1958) SUD was used as a measurement, both during the therapy and by the independent assessor to report anxiety after speeches and after treatment was given. Thyer, Papsdorf, Davis, & Vallecorsa, (1984), compared the subjective report of anxiety with two physiological indices (peripheral vasoconstriction and heart rate) and found a significant correlation. They conclude that these results support the use of the SUD scale as a clinical assessment tool.

In the communication literature McCroskey (1984a) maintains that the self-report is the most valid assessment of anxiety because it is “directed toward the cognitions of the individual” (p. 86).

Another measurement tool used in this research was SA Scale. It was derived from the Personal Report of Communication Apprehension-24 (PRCA), (McCroskey, 1982) which was comprised of 32 questions that evaluated the speaker’s anxiety regarding a speaking event. The structure of this test was designed by (Clevenger & Bledsoe, 1990) and normed from the data collected from over 1700 students in four colleges in the United States. It was redesigned by Clevenger and his associates at Florida State University to measure state anxiety.

The SA Scale is 10-item instrument which evaluates anxiety before, during and after a speech is delivered. The questions are answered in a 5-point Likert scale. In addition to
measuring overall state-anxiety, other factors are also measured: Pre-speech Tension, Positive Anticipation, Poise, Shyness, Confusion, Physiological Activation and Environmental Threat.

Halvorson (1993) reports reliability of the SA Scale at .920. Clevenger, Halvorson and Bledsoe, (1991) state that they have “found evidence of ‘predictive validity’ of the SA Scale,” (p. 53) measured after skill training reduced anxiety.

In addition the State-Trait Anxiety Inventory, Form Y (STAI) (Speilberger, 1983) (see Appendix C), a measure of both state and trait anxiety, was administered to both groups pretreatment and to the delayed treatment group post-treatment. This instrument is one of the most commonly used measures of state anxiety in the communication literature. More than 5,000 high school and college students and working adults were tested to provide information about reliability and validity. The median reliability coefficient for high school and college students was .765 and .695 respectively. Speilberger reports “Correlations of the STAI scales and other measures of personality provide evidence of the convergent and divergent validity of the STAI” (p.32). Reviewers in Buros’ *Eighth Mental Measurement Yearbook* (1978) report: “The revised STAI is one of the best standardized anxiety measures, if not the best” (p. 683).

*Measurement Periods*

The participants of the treatment group met with the independent assessor to evaluate their level of distress after they gave their first speech (T1) and again after they had been treated and had given their second speech (T2). The participants in the delayed treatment group also met with the independent assessor after they gave their first speech (T1) and then
4 weeks later when they gave their second speech (T2). They subsequently were treated, gave an additional speech, and met with the independent assessor one more time (T3).

*Five-Month Follow Up*

At the end of 5 months, 31 (64%) participants met with the researcher to evaluate their anxiety levels and their experience with speaking in public (see Appendix K for TFT Research Project Exit Interview).

*Statistical Analysis*

The SUD scores were analyzed using General Linear Model (GLM) repeated measures test. For the SA Scales, the GLM was also used to analyze the results on the nine dependent measures. The first analysis for the SA Scales answered the question: “Was TFT effective relative to the treatment group?” A second analysis was conducted to assess the question: “Was the effectiveness of the TFT treatment replicated when the delayed treatment group finally received TFT treatment?” The State-Trait Anxiety Index (STAI) measures were also analyzed using the GLM on the delayed treatment group, since this measure was given post-treatment only to this group and not to the treatment group. A third analysis was also conducted on all participants on the pre measures taken immediately prior to treatment and the post measures conducted after treatment.

*Treatment Fidelity*

The TFT Research for Public Anxiety manual was based on direct training and supervision received by Roger Callahan. Treatment fidelity was maintained by a series of research team meetings held before the start of research in which refresher training in the TFT protocols was provided and/or reviewed. The treatment therapists used these manuals
for every session with all participants and sent a TFT protocol home with the participants
(see below). Each session was videotaped, as were all of the speeches.

Thought Field Therapy Applications sent home with participants (as shown in Appendix J):

Abbreviations:

PR Psychological Reversal
e under eye
eb eyebrow
eo outer eye
a armpit
cb collarbone
lf little finger
if index finger
9g Nine Gamut (see 9g below)
ear eye roll (slowly roll eyes
from floor to ceiling while
tapping gamut spot)
sq total sequence is repeated

PR Treatment: Rub sore spot on left side of chest (i.e., neurolymphatic reflex) while making the following statement three times, specifying the type of psychological reversal present: “I deeply and profoundly accept myself even though I have this... (anxiety, anger, etc.).”

Note: If your distress level has lowered some but seems stuck, tap continuously on the little finger side of your hand while making the following statement three times: “I accept myself even if I still have some of this... (anxiety, anger, urge, etc.).”

Note: If there seems to be no movement at all, drink some water, thump on your thymus and breathe deeply. Then begin the algorithm again.

9g or Nine Gamut Treatments: While continuously tapping the gamut spot between the ring and little finger do the following: eyes closed, eyes open, eyes down right, eyes down left, whirl eyes right, whirl eyes left, hum, a tune, count to 3, hum again.

Before each treatment and several times during treatment (when you see this symbol, rate the level of intensity of your distress/anxiety of your problem. Use a scale of 0 (no distress) to 10 (intense distress), (see Appendix J for locations of treatment points).
Algorithms:

Rapid stress reduction
PR→er→9g→er

Anger
If→c→9g→sq→er
At If point say 3 x’s “I forgive x, I know he/she can’t help it”

Frustration/Impatience
PR→eb→e→a→c→If→c→9g→sq→er

Guilt
if→c→9g→sq→er
(At if point say 3x’s « I forgive myself, I know I can’t help it.)

Rage
PR→oe→c→9g→sq→er
(At oe point say 3x’s « I forgive x, I know (he/she or I) can’t help it” or I reach out with forgiveness and love.”)

General anxiety and addictive urge
PR→e→a→c→a→e→c→9g→sq→er

Phobia
PR→e→a→c→9g→sq→er

Trauma
PR→e→a→if→c→9g→sq→er

Extended traumas
PR→eb→e→a→c→If→c→if→c→9g→sq→er

Summary

This chapter explained the research methodology used in this study. It also described:

the research design; participants; initial interview; research team; research environment;

Thought Field Therapy (TFT) treatment and procedures; measurement instruments and

reliabilities; measurement periods; 5-month follow up; statistical analyses used; and

treatment fidelity.
Chapter IV—Results

Introduction

This chapter presents the results of the statistical analysis of the data. Measures collected pre- and post-treatment by the independent assessor will be discussed. This analysis also includes the statement regarding the equivalence of groups, treatment fidelity, treatment effect size and the results of the non-psychometric 5-month follow-up and the summary.

Results of the Statistical Analysis of the Data

Thought Field Therapy (TFT) effectiveness was demonstrated statistically on all process and outcome measures after one 60-minute treatment session regardless of demographic variables.

Ho 1: There will be no statistically significant reduction of anxiety regarding public speaking, as measured by the subjective units of disturbance (SUD) score on the part of participants, as a result of TFT treatment. Analysis of the data yielded statistical and clinical significance. Thus, the null hypothesis was rejected.

Ho 2: There will be no statistically significant reduction of anxiety regarding public speaking as measured by the Speaker Anxiety Scale (SA Scale) scale on the part of participants as a result of TFT treatment. Analysis of the data yielded statistical and clinical significance. Thus, the null hypothesis was rejected.

The SUD scores were analyzed using General Linear Model (GLM) repeated measures test. Since the GLM showed no significant difference between the two groups, the results were analyzed using combined scores.
The State-Trait Anxiety Index (STAI) measures were analyzed using the GLM on the delayed treatment group, since this measure was given post-treatment only to this group and not to the treatment group.

For the SA Scales, the GLM was also used to analyze the results on the nine dependent measures. The first analysis for the SA scales answered the question, “Was TFT effective relative to the treatment group?” A second analysis was conducted to assess the question, “Was the effectiveness of the TFT treatment replicated when the delayed treatment grouped finally received TFT treatment?” This would diminish the probability that anxiety would decrease only because a participant had already given one speech.

In addition, the baseline effects on all SA subscales for the two pre treatment measures of the delayed treatment group showed no significant difference between these two pre-measures. Furthermore, there were no significant main effects of group indicating that on these measures, there was no statistical difference between the treatment and the delayed treatment groups. Thus, a third analysis was conducted on all participants on the pre measures taken immediately prior to treatment and the post measures conducted after treatment.

The alpha level of .05 was used for all GLM repeated measures test.

**SUD Measures**

The null hypothesis which states the average SUD scores would decrease after treatment was rejected as illustrated in Figure 1. The GLM repeated measures analysis showed a very strong main effect for treatment with the mean pre-test scores significantly decreasing post-treatment ($F = 201.541, df = 1, 46; p \leq .000$). The overall treatment effect size between average pre-test and post-test SUD scores is $d = 2.10$, and the within-subject
effect size as measured by partial $\eta^2$ was .82. These results suggest that treatment does significantly decrease one’s level of anxiety.
Figure 1. Average pre and post SUD scores, treatment and delayed treatment groups combined.
Figure 2. Average SUD scores by treatment groups.

In further analyzing the SUD measure, the GLM repeated measures indicated there was no significant difference for the main effect of group ($F = 0.232$, $df = 1, 46; p = 0.633$) or for the interaction of treatment by group ($F = 1.041$, $df = 1, 46; p = 0.313$) as represented with Figure 2.
Figure 3. Average State-Trait Anxiety Inventory (STAI) scores for treatment and delayed treatment groups combined.

This figure shows the average scores of all participants for the State-Trait Anxiety Inventory (STAI) measure. Figure 3 shows the average scores of all participants for the STAI measure. There were no significant differences between the treatment group and the delayed pre-treatment on either the State ($t(45) = 1.55, p = .128$) or the Trait measure of anxiety ($t(45) = .77, p = 0.443$).
The hypothesis that the STAI measure would decrease post-treatment was supported by the delayed treatment group data. When anxiety was measured across time (see Figure 4), the GLM results indicated a significant time effect with Wilks's $\Lambda = .35 \ (F = 2.17) = 16.01$; $p \leq .000$, multivariate $\eta^2 = .65$ with pre-treatment 1 and pre-treatment 2 being significantly different than post-treatment ($F = 16.53, \ df = 2, 36; \ p \leq .000$). (This test was administered only to the delayed treatment group). These results suggest that anxiety levels decrease post-treatment.
Speaker Anxiety Scales (SA Scales)

The Hypothesis that anxiety levels will decrease post-treatment as measured by the SA Scales was supported for the treatment group, the delayed treatment group and when both groups were combined on both Positive and Negative Factors. There was no significant difference between the two groups of participants pre-treatment on the Sum of Negative factors ($t(42) = .66, p = .512$), the Sum of Positive factors ($t(45) = -.41, p = .687$), or the Overall State Anxiety ($t(41) = .42, p = .676$).
Figure 5. SA sub-scales across time by treatment group.

In analyzing the data for the treatment group, we found that the overall state anxiety decreased, with negative factors decreasing and positive factors increasing, as shown in Figures 5 through 7.

The results indicate that anxiety levels significantly decreased post-treatment for the Sum of Negative sub-scales \( (F = 44.202, df = 1, 23; p \leq .000) \), the Sum of Positive sub-scales \( (F = 25.686, df = 1, 23; p \leq .000) \), and the Overall State Anxiety \( (F = 44.773, df = 1, 23; p \leq .000) \). (See Figure 5). The within-subjects effect size as measured by partial \( \eta^2 \) was for the Sum of Negative factors \( \eta^2 = .66 \), for Sum of Positive factors \( \eta^2 = .53 \), and for the Overall State Anxiety was \( \eta^2 = .66 \).
Figure 6. SA negative sub-scales by treatment group.

This figure shows the mean scores for the SA Negative sub-scales across time for the treatment group. Once again, there were significant differences between the mean scores pre- and post-treatment. These results indicate that negative responses tend to decrease after treatment has been administered. $F$ values range from 6 to 44 ($df = 1, 23$) with all negative factors significant at the $p \leq .000$ level except for “Shyness” ($p \leq .02$). See Table 1 for additional statistical information for each negative factor.
Figure 7. SA positive sub-scales by treatment group.

The SA Positive sub-scales, illustrates an increase in positive responses post-treatment. All factors showed significant differences between the mean scores pre- and post-treatment. These results indicate that positive responses tend to increase once treatment has been administered. $F$ values range from 5 to 22 ($df = 1, 23$) with all positive factors significant at the $p \leq .000$ level except for “Wants More” ($p \leq .03$). See Table 1 for additional statistical information for each positive factor.
Table 1

*Treatment Group: Means, Standard Deviations and Effect Sizes for the SA Factors Across Time*

<table>
<thead>
<tr>
<th>Negative factors</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-speech tension *</td>
<td>3.08 (.88)</td>
<td>1.60 (1.16)</td>
<td>1.13</td>
</tr>
<tr>
<td></td>
<td>n = 28</td>
<td>n = 28</td>
<td></td>
</tr>
<tr>
<td>Shyness **</td>
<td>1.94 (.80)</td>
<td>1.36 (.91)</td>
<td>.54</td>
</tr>
<tr>
<td></td>
<td>n = 28</td>
<td>n = 28</td>
<td></td>
</tr>
<tr>
<td>Confusion *</td>
<td>2.35 (.92)</td>
<td>1.44 (.84)</td>
<td>.86</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td></td>
</tr>
<tr>
<td>Physiological activation +</td>
<td>2.20 (.83)</td>
<td>1.19 (.80)</td>
<td>1.15</td>
</tr>
<tr>
<td></td>
<td>n = 26</td>
<td>n = 26</td>
<td></td>
</tr>
<tr>
<td>Post-speech activation +</td>
<td>2.69 (.82)</td>
<td>1.36 (.96)</td>
<td>1.20</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td></td>
</tr>
<tr>
<td>Environmental threat *</td>
<td>2.19 (.89)</td>
<td>1.05 (.91)</td>
<td>.99</td>
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<tr>
<td></td>
<td>n = 28</td>
<td>n = 28</td>
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</tr>
<tr>
<td>Sum of negative *</td>
<td>2.40 (.64)</td>
<td>1.33 (.74)</td>
<td>1.56</td>
</tr>
<tr>
<td></td>
<td>n = 26</td>
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</table>

<table>
<thead>
<tr>
<th>Positive factors</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive anticipation *</td>
<td>1.48 (.85)</td>
<td>2.46 (1.13)</td>
<td>.92</td>
</tr>
<tr>
<td></td>
<td>n = 28</td>
<td>n = 28</td>
<td></td>
</tr>
<tr>
<td>Poise *</td>
<td>.96 (.66)</td>
<td>2.09 (1.02)</td>
<td>1.01</td>
</tr>
<tr>
<td></td>
<td>n = 26</td>
<td>n = 26</td>
<td></td>
</tr>
<tr>
<td>Wants more ***</td>
<td>2.09 (1.01)</td>
<td>2.50 (1.17)</td>
<td>.47</td>
</tr>
<tr>
<td></td>
<td>n = 28</td>
<td>n = 28</td>
<td></td>
</tr>
<tr>
<td>Sum of positive *</td>
<td>1.40 (.66)</td>
<td>2.31 (.96)</td>
<td>1.12</td>
</tr>
<tr>
<td></td>
<td>n = 26</td>
<td>n = 27</td>
<td></td>
</tr>
<tr>
<td>Overall state anxiety *</td>
<td>3.03 (.63)</td>
<td>1.96 (.77)</td>
<td>1.52</td>
</tr>
<tr>
<td></td>
<td>n = 24</td>
<td>n = 24</td>
<td></td>
</tr>
</tbody>
</table>

Note 1: Paired t-tests indicate significant differences between Pre and Post Treatment at the *p ≤ .000, **p ≤ .01, or ***p ≤ .02 levels of significance.

Note 2: Standard Deviations are shown in parentheses.

Note 3: For **Negative Factors**, a decrease in mean indicates a decrease in Anxiety. For **Positive Factors**, an increase in mean indicates a decrease in anxiety. For **Overall State Anxiety**, a decrease in mean indicates a decrease in Anxiety.

Note 4: Cohen’s d is computed by taking the mean paired difference between Pre and Post divided by the standard deviations paired difference.
SA Scales: Delayed Treatment Group

In analyzing the data for the delayed treatment group, we found that over time, the Sum of the Negative factors significantly decreased post-treatment, the Sum of the Positive factors significantly increased post-treatment, and the Overall State Anxiety significantly decreased post treatment. GLM repeated measures conducted on all sub-scales showed no main effect for time between pre-test 1 and pre-test 2 (Multivariate $F = 1.060$, $df = 1, 16; p = 0.473$), but that there were significant differences between both pre-1 and post-treatment and pre-2 and post-treatment measures (see Figures 9 and 10).
Figure 8. SA negative sub-scales across time by delayed treatment groups.

The results shown in Figure 8 indicate that post-treatment, the Sum of Negative responses decreased with a significant time effect with Wilks's $\Lambda = .10$ ($F = (2,14) = 62; p < .000$, multivariate $\eta^2 = .90$), the Sum of Positive responses increased in positive responses post-treatment with a significant time effect with Wilks's $\Lambda = .12$ ($F = (2,17) = 62.40; p \leq .000$, multivariate $\eta^2 = .88$). For the Overall State Anxiety, results indicated a significant time effect with Wilks's $\Lambda = .08$ ($F = (2,14) = 80.79; p \leq .000$, multivariate $\eta^2 = .92$). These results indicate that anxiety levels decreased after receiving treatment.
Figure 9. SA negative sub-scales across time by delayed treatment group.

Figures 9 and 10 shows the individual negative and positive sub-scales for the delayed treatment group across the three time frames. The GLM repeated measures showed significant decreases for the negative factors and significant increases for the positive factors with pre-treatment 1 and pre-treatment 2 being significantly different than post-treatment measures. $F$ values ranged from 14 to 95 ($p \leq .000$ for all sub-scales). Each sub-scale is significantly different with anxiety levels decreasing from pre- to post-treatment. See Table 2 for additional statistical information for each negative and positive factor.
Figure 10. SA positive sub-scales across time by delayed treatment group.
<table>
<thead>
<tr>
<th>Negative factors</th>
<th>Pre-treatment-1</th>
<th>Pre-treatment-2</th>
<th>Post-treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-speech tension</td>
<td>3.25 (.70)</td>
<td>2.77 (1.00)</td>
<td>1.05 (1.06)</td>
</tr>
<tr>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
</tr>
<tr>
<td>Shyness</td>
<td>1.85 (1.11)</td>
<td>1.96 (1.02)</td>
<td>1.10 (1.09)</td>
</tr>
<tr>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td>Confusion</td>
<td>2.34 (.89)</td>
<td>2.43 (.98)</td>
<td>1.38 (1.06)</td>
</tr>
<tr>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
</tr>
<tr>
<td>Physiological activation</td>
<td>2.04 (.81)</td>
<td>1.94 (.91)</td>
<td>1.06 (.94)</td>
</tr>
<tr>
<td>n = 18</td>
<td>n = 18</td>
<td>n = 18</td>
<td>n = 18</td>
</tr>
<tr>
<td>Post-speech activation</td>
<td>2.65 (.93)</td>
<td>2.46 (.99)</td>
<td>1.13 (.97)</td>
</tr>
<tr>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
</tr>
<tr>
<td>Environmental threat</td>
<td>1.80 (.91)</td>
<td>1.95 (.94)</td>
<td>1.02 (1.14)</td>
</tr>
<tr>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td>Sum of negative</td>
<td>2.31 (.63)</td>
<td>2.13 (.57)</td>
<td>1.02 (.73)</td>
</tr>
<tr>
<td>n = 16</td>
<td>n = 16</td>
<td>n = 16</td>
<td>n = 16</td>
</tr>
<tr>
<td>Positive factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive anticipation</td>
<td>1.47 (1.19)</td>
<td>1.47 (1.01)</td>
<td>2.75 (1.10)</td>
</tr>
<tr>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td>Poise</td>
<td>1.18 (.89)</td>
<td>1.34 (.83)</td>
<td>2.70 (.91)</td>
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<tr>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
</tr>
<tr>
<td>Wants more</td>
<td>1.90 (1.07)</td>
<td>1.80 (.97)</td>
<td>2.93 (.98)</td>
</tr>
<tr>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td>Sum of positive</td>
<td>1.39 (.84)</td>
<td>1.47 (.76)</td>
<td>2.74 (.82)</td>
</tr>
<tr>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 19</td>
</tr>
<tr>
<td>Overall state anxiety</td>
<td>2.97 (.67)</td>
<td>2.81 (.56)</td>
<td>1.66 (.74)</td>
</tr>
<tr>
<td>n = 16</td>
<td>n = 16</td>
<td>n = 16</td>
<td>n = 16</td>
</tr>
</tbody>
</table>

Note: GLM repeated measures analysis indicates a significant difference between Pre 1 and Post Treatment as well as between Pre 2 and Post Treatment at the $p \leq .000$ level of significance for all SA Factors. There is no significant difference between Pre 1 and Pre 2 on any SA factor.

Note: Standard Deviations are shown in parentheses.

Note: For **Negative Factors**, a decrease in mean indicates a decrease in Anxiety. For **Positive Factors**, an increase in mean indicates a decrease in anxiety. For **Overall State Anxiety**, a decrease in mean indicates a decrease in Anxiety.
Figure 11. SA sub-scales pre- and post-treatment for the combined groups.

The third analysis of the SA Scales indicated that there was no significant difference for the main effect of groups \( (F = 1.422, df = 1, 46; p = 0.220) \), and thus, the treatment group and the delayed treatment group were combined. The null hypothesis that anxiety levels will not decrease post-treatment as measured by the SA Scales was rejected on the Sum of Positive, the Sum of Negative and the Overall State anxiety, as shown in Figure 11. These results indicate that there were significant decreases between pre-treatment and post-treatment measures within the Sum of Negative factors \( (F = 107.09, df = 1, 40; p \leq .000) \), the Sum of Positive factors \( (F = 86.99, df = 1, 40; p \leq .000) \) and the Overall State Anxiety \( (F = 125.84, df = 1, 40; p \leq .000) \). The within-subjects effect size as measured by partial \( \eta^2 \) was for the Sum of Negative factors \( \eta^2 = .73 \), for Sum of Positive factors \( \eta^2 = .69 \), and for the Overall State Anxiety was \( \eta^2 = .76 \).
Figures 12. SA negative sub-scales by pre- and post-treatment for the combined groups.

As shown in the following figures, a more detailed analysis of the negative and positive sub-scales reveal that state anxiety significantly decreased, with negative factors decreasing and positive factors increasing. Figure 12 shows the mean scores for the SA Negative sub-scales across time. Once again, a GLM repeated measures showed significant decreases between the mean scores pre- and post-treatment with $F$ values ranging from 22 to 125 ($p \leq 0.000$ for all sub-scales). See Table 3 for additional statistical information for each negative factor. These results indicate that negative responses tend to decrease after treatment has been administered.
Figure 13. SA positive sub-scales pre- and post-treatment for the combined groups.

Figure 13 shows the mean scores for the SA Positive sub-scales across time and illustrates an increase in positive responses post-treatment. The GLM repeated measures showed significant increases between the mean scores pre- and post-treatment with $F$ values ranging from 31 to 64 ($p \leq .000$ for all sub-scales). See Table 3 for additional statistical information for each positive factor. These results indicate that positive responses tend to increase once treatment has been administered.
Table 3

*Combined Groups Means, Standard Deviations, and Effect Sizes for the SA Factors*

**Across Time**

<table>
<thead>
<tr>
<th>Negative factors</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-speech tension</td>
<td>2.96 (.93)</td>
<td>1.38 (1.14)</td>
<td>1.35</td>
</tr>
<tr>
<td>n = 47</td>
<td>n = 47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shyness</td>
<td>1.95 (.88)</td>
<td>1.25 (.99)</td>
<td>.71</td>
</tr>
<tr>
<td>n = 48</td>
<td>n = 48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confusion</td>
<td>2.39 (.94)</td>
<td>1.42 (.92)</td>
<td>.96</td>
</tr>
<tr>
<td>n = 46</td>
<td>n = 46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiological activation</td>
<td>2.07 (.86)</td>
<td>1.11 (.85)</td>
<td>1.26</td>
</tr>
<tr>
<td>n = 46</td>
<td>n = 46</td>
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<td></td>
</tr>
<tr>
<td>Post-speech activation</td>
<td>2.60 (.89)</td>
<td>1.27 (.96)</td>
<td>1.25</td>
</tr>
<tr>
<td>n = 46</td>
<td>n = 46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental threat</td>
<td>2.09 (.91)</td>
<td>1.04 (1.00)</td>
<td>1.06</td>
</tr>
<tr>
<td>n = 48</td>
<td>n = 48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum of negative</td>
<td>2.28 (.62)</td>
<td>1.18 (.75)</td>
<td>1.58</td>
</tr>
<tr>
<td>n = 44</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive factors</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive anticipation</td>
<td>1.47 (.91)</td>
<td>2.58 (1.12)</td>
<td>1.07</td>
</tr>
<tr>
<td>n = 48</td>
<td>n = 48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poise</td>
<td>1.12 (.756)</td>
<td>2.34 (1.01)</td>
<td>1.28</td>
</tr>
<tr>
<td>n = 45</td>
<td>n = 45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wants more</td>
<td>1.97 (.99)</td>
<td>2.68 (1.10)</td>
<td>.77</td>
</tr>
<tr>
<td>n = 48</td>
<td>n = 48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum of positive</td>
<td>1.43 (.70)</td>
<td>2.49 (.92)</td>
<td>1.44</td>
</tr>
<tr>
<td>n = 45</td>
<td>n = 45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall state anxiety</td>
<td>2.92 (.61)</td>
<td>1.81 (.77)</td>
<td>1.75</td>
</tr>
<tr>
<td>n = 42</td>
<td>n = 42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note 1: Paired t-tests indicate significant differences between Pre and Post Treatment at the $p \leq .000$ levels of significance for all SA factors.

Note 2: Standard Deviations are shown in parentheses.

Note 3: For **Negative Factors**, a decrease in mean indicates a decrease in Anxiety. For **Positive Factors**, an increase in mean indicates a decrease in anxiety. For **Overall State Anxiety**, a decrease in mean indicates a decrease in Anxiety.

Note 4: Cohen’s $d$ is computed by taking the mean paired difference between Pre and Post divided by the standard deviations paired difference.
Five Month Follow-Up

Of the 31 (64%) respondents who participated in the follow-up, 3 reported no improvement from the treatment. Twenty-five reported less apprehension in public speaking situations. These responses were on a scale from some decrease in anxiety to no anxiety at all (see Chapter V for more details).

Summary

This section presented a summary of the study, including a statistical and clinical analysis of the data; process and outcome measures; statements regarding equivalence of groups, treatment effect sizes, and a report of the information from the 5-month follow-up.
Chapter V—Discussions and Conclusions

Introduction

This chapter is organized into seven sections: a brief overview of the study; the summary of the findings; methodological issues; the social change applications of the study; the limitations of the study; recommendations for further research; and the summary.

Overview of the Study

This study was developed to evaluate the efficacy and efficiency of Thought Field Therapy (TFT) as a treatment modality for public speaking anxiety. On the day of the study, participants were randomly assigned to a treatment group and a delayed treatment group.

Participants in the treatment group gave a speech to a live audience, met with an independent assessor to evaluate their level of distress, had 60 minutes of TFT treatment, gave another speech and met again with this assessor to re-evaluate their anxiety level.

Participants in the delayed treatment group gave a speech to this same audience, met with the independent assessor to evaluate their level of distress and were asked to come back 2 weeks later. At the 2-week follow-up, they gave another speech to a live audience, met with the independent assessor to evaluate their level of distress, had 60 minutes of TFT treatment, gave another speech and met with the independent assessor to evaluate their level of distress.

Five months later, 31 of the participants (64%) met with the principal investigator to discuss the effects of the treatment. All of the speeches, as well as the treatments, were videotaped for fidelity purposes.
Summary of the Findings

All of the null hypotheses were rejected. A 60-minute treatment session with TFT was found to be effective and efficient at removing or substantially decreasing anxiety about public speaking as measured by the subjective units of disturbance (SUD) score, the Speaker Anxiety Scale (SA Scale) and the Speilberger State-Trait Inventory of Anxiety (STAI) on the delayed treatment group. It was also found to be effective at increasing positive responses regarding public speaking as measured by the Positive sub-scales of the SA Scales.

There was no significant difference between the treatment group and the delayed treatment group at pre-treatment on any measures. (Participants randomly assigned to the delayed treatment group showed no significant improvement in the 14 days prior to their treatment.) This demonstrated that neither the passage of time, nor the initial speech they gave at the pre-test reduced the anxiety for the delayed treatment group.

When post-treatment between subjects measures of the 9 outcome variables were examined, it was found that there was no significant difference between 8 of the 9 outcome measures. The exception was “poise,” where there was a significant difference between the means of the treatment group and the delayed treatment group favoring the latter ($p \leq .05$). This may have been caused by desensitization, a conventional treatment for public speaking anxiety because the delayed treatment group gave an additional speech.

The analysis of within-subjects measures revealed there was a significant difference between pre-treatment and the post-treatment on all outcome measures. This suggests that TFT was effective in decreasing public speaking anxiety.

In addition to the above assessment, another analysis suggests the strength of the findings. Despite the brevity of the treatment, the treatment effect sizes in this study range
from .71 to 1.58. The mean effect size on overall anxiety was 1.75. This compares favorably with other well controlled studies on psychotherapy as reported by Lipsey and Wilson (1993).

These findings are remarkable in that previous attempts to remediate the public speaking anxiety take much longer to produce change. Informal settings, such as Dale Carnegie seminars are offered in a 12-week course.

Toastmasters is a self-selected informal group where individuals meet to practice public speaking. It provides ongoing desensitization and support. Most classes at the university level are taught in 16-week increments. Treatment includes: Rational Emotive Therapy, (Ellis, 1957; Fremouw, 1984; Watson & Dodd, 1984), systematic desensitization, cognitive modification and skills training (Allen, Hunter & Donohue, 1989), visualization (Ayers & Hopf, 1985), or combinations of these techniques.

Mc Croskey, Beatty and Heisel (2000) and Kelly and Keaton (2000) opine that conventional treatments, such as those just enumerated, are marginally successful in decreasing communication apprehension (CA) because CA is physiologically mediated. If their hypothesis is valid then it seems plausible that an intervention focused on the body’s energetic system could be effective in reducing the trait-like qualities responsible for this condition.

**Methodological Issues**

Since the results of this study were strong, it is important to consider some potentially confounding issues: the effects of desensitization; the consequence of the audience, especially on anticipatory anxiety; the variable of therapist skill and the possible inclusion in the treatment of other therapeutic tools; the demand characteristics placed on the participants;
the placebo effect which may have been caused by any treatment; and the efficacy of SUD
scores as a measurement tool.

Because desensitization is a conventional treatment for public speaking anxiety, the
fact that the treatment participants gave at least two speeches, and the delayed treatment
group gave three speeches, this could have been a factor in the reduction of their anxiety.
However, since there was no difference between pre-treatment time 1 and pre-treatment time
2 for the delayed treatment group, desensitization is not suspected as the operational factor. If
the effect had been due to desensitization, there should have been a significant difference
between the first and the second speech. Since there was not, this suggests that the TFT
treatment was the critical element in the reduction of the participant’s public speaking
anxiety.

Another matter to consider is the effect of the audience. If they made positive
comments after the participant’s first speech or gave positive nonverbal signals (e.g., smiled
and nodded) during that speech, those factors could have contributed to a reduction of the
SUD on the second (or third) speech. However, although the audience was not intimidating,
they were cautioned not to respond in any way during the participant’s presentations.

This same un-intimidating audience may have had an effect on anticipatory anxiety.
The participants expected the speaking experience to be stressful, so as a result, the first
speech and subsequent SUDS were high because of the anticipation of this stress. However,
they found the audience “easy” and subsequently had less anticipatory anxiety for their
second speech, as measured by the SUDS, the SA and the STAI (third speech for the delay
group).
The answer to this issue is the same as it was for desensitization. There was no significant difference between pre-treatment time 1 and pre-treatment time 2 for the delayed treatment group. If the results were due to the effect of the lowering of anticipatory anxiety, there should have been a significant difference between the first and the second speech for the delayed treatment group. Since there was not, this variable was negligible.

Another issue one might consider in evaluating the positive results is the effect of the treatment therapist. Were they particularly strong practitioners? Is there the possibility they introduced other therapeutic techniques during the TFT treatment, such as statements that contributed to reduced anxiety (e.g., the therapists increased hope, normalized the feelings of anxiety during public speaking, helped externalize the problem, helped reframe the problem, etc.)? However, although the 11 treatment therapists were accomplished and had wide and varied backgrounds as to professional training, they had similar TFT training. They were also working with the standard TFT treatment protocols, and their sessions were videotaped. Because of these safeguards, these concerns are probably minimal.

Because participants have a tendency to be accommodating, there may be concern that the outcome data was affected by this phenomenon. For this reason, an independent assessor, with whom the participants had a passing relationship, collected the pre- and post-test measurements, thus minimizing the demand characteristics placed on them.

Another factor to consider is the placebo effect which could be engendered by meeting with a therapist. However, Lipsey and Wilson (1993), who did a comparison of meta-analytic studies using placebo controls with no placebo controls, conclude that the average placebo effect size was .19. This suggests that while placebo effect might account for
part of the effect size, it is not likely that they could fully account for the result in this study where the overall effect size for the reduction of anxiety was 1.75.

Regarding the use of the SUD, Wilson, Tinker and Becker (1995) reported that the efficacy of using SUD scores as a modality for accurately assessing anxiety has been under scrutiny by researchers. One concern is that the SUD score was not found to be a valid measurement device. This was addressed in an article by Thyer, Papsdorf, Davis and Vallecorisa (1984), who compared the subjective report of anxiety with two physiological indices (peripheral vasoconstriction and heart rate) and found a significant correlation. They conclude that these results support the use of the SUD scale as a clinical assessment tool.

As a measurement issue, the SUD results were stronger than the SA results ($F = 201.541$ versus 17.554, respectively). SUD may be particularly sensitive to small changes in anxiety, thus giving exceptionally strong results. We then need to consider the possibility that the SUD measure itself may contribute to the strong statistical significance. However, if we remove the results of the SUD and just consider the SA results an $F$ value of 17.554 is still a strong outcome.

*Social Change Applications for the Study*

Apprehension with regard to speaking in public is widespread (Wallechinsky, 1977; McCroskey, 1972) and affects success at school (Frymier, 1993; McCroskey, 1989; Comadena, 1988; Payne, 1989), lack of desire to share ideas with others (Henrikson, 1943), personal relationships (Ayers, 1989; McCroskey & Sheanan, 1978), self-esteem (Paulson, 1951) and success in a work environment (Daley & Stafford, 1984). Obviously finding a cure for this anxiety would have widespread implications. Investigating the efficacy of TFT also has a great deal of social relevance. If this method is as rapid, as effective, as long lasting and
as painless as practitioners and case reports suggest, it is a breakthrough with profound implications for healing many psychological problems.

In evaluating clinical significance as opposed to statistical significance, Lefort (1993) proposed that “for a change to be clinically significant it must make a qualitative difference in people’s lives” (p. 61).

Some comments made in the 5-month follow-up speak to an acknowledgement of that improvement. These remarks include:

“I felt a huge shift”; I can say what I’m thinking…usually when I’m in a small group I have to know the people before talking”; “I have more confidence, I’m not worried about people looking at me”; “When I thought about that auditorium I thought…well why not…it might be fun”; “People have noticed the difference, I speak longer at Bible study”; “I am more comfortable in group meetings…if something comes up I would suppress it…now I don’t have the anxiety”; “I like that I can do this by myself…I don’t have to go to a therapist to get better”; “At my childbirth class I could speak without anxiety. Previously I had anxiety even if I did not speak…anticipating that I wanted to speak I would perspire, feel flushed and my body would start to shake”; “I have to give a presentation (to a professional group)...I’m not dreading it...previously I would have dreaded it”; “I had three or four situations where I thought, here I am again...this is tough, I have a lot to lose if I don’t perform competently...I did fine”; “I have more confidence in my ability...all eyes are on me...my focus has changed to...I have information that they want.”

Still another reported that after she spoke “off the cuff,” a friend said laughingly, knowing of her previous discomfort, “You’re like the mouse that roared.”
Limitations of the Study

The first limitation of this study was sample size. There were 48 participants; 10 were men and 38 were women.

A second limitation was the ability to generalize. The sample was drawn from participants who self-selected in response to announcements for research volunteers. A majority of the participants were Caucasian and had completed college or had advanced degrees. One participant was an African American and one was Hispanic. These factors make it difficult to assume these results would hold true for a larger population.

A third limitation was measurement inconsistency. Only the delayed treatment group was measured for both state and trait anxiety. Since there was a decrease in anxiety measures from pre-test to post-test in the trait anxiety measurement, it would have been desirable to measure the treatment group with both measures as well.

A fourth limitation was that the follow-up was done in an interview format without the previous standardized test measures. Repeating these tests could have provided more information regarding the effectiveness of TFT in the long term. A related limitation in this follow-up was that the principal investigator conducted the interview which may have placed demand characteristics on the participants.

The fifth limitation, which may or may not be construed as such, was that during the period between the last treatment and the follow-up interview participants were encouraged to continue using the protocols whenever needed. On the other hand, while this may affect the follow-up results, it also underscores the ease, availability and the efficacy of the treatment.
Further Recommendations for Future Research

The robustness of our statistical findings, as well as the anecdotal remarks from the exit interview lead one to acknowledge the value of continued research on communication apprehension, using TFT as a treatment modality. There was a statistically significant improvement on the delayed treatment group with the Spielberger State-Trait Anxiety Inventory. Using both the Personal Report of Public Speaking Anxiety (PRCA), which is a measure of trait anxiety, the SA and the Spielberger State-Trait Anxiety Inventory on a larger, more diverse sample, might produce additional information.

There has not been a great deal of research on TFT which contains the elements of random assignment to treatment and control groups, a consideration of confounding variables, standardized test measures, independent and blind assessor, statistical analysis and treatment fidelity with a large diverse sample. Future research should account for these elements. It should also provide for a longer treatment period. While this study was successful at remediating symptoms with one intervention, not all participants in this study benefited and it would be interesting to investigate if extended treatment would amplify benefits.

However, the success of this study does not prove or disprove the theoretical issues. It does demonstrate that the method works and it appears to work faster then other conventional techniques. None the less there are individuals in the Energy Psychology community like Craig (1995, 2004) and Pignotti who question the need for the specific sequences that TFT employs. Even though Pignotti (2004) reported on data collected- questioning Callahan’s VT and specific sequenced algorithms, she did not question meridian based treatments. She found that random tapping of the key meridian points was as effective in eliminating patient
symptoms as was the use of specific sequences prescribed by Callahan. While not concluding that TFT algorithms are ineffective she did question whether they were any more powerful than random tapping sequences.

Future research comparing other meridian based treatment techniques with TFT would help clarify whether the specific protocols used in this study are necessary or whether some other form of stimulating meridian points would be equally successful.

It would also be intriguing to compare TFT to other treatment modalities for public speaking anxiety such as desensitization, visualization, skills training, Eye Movement Desensitization and Reprocessing (EMDR) or a combination of these.

This researcher hopes the results of this study will make a contribution to the body of knowledge that is part of the scientific community and others will be inspired to design studies which will expand upon the scope of this work.

Summary

This chapter included a brief overview of the study; a summary of the findings; the methodological issues; the social change applications which apply; the limitations of the research; and recommendations for further research.
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Appendix A

TFT Research Treatment for Public Speaking Anxiety
TFT TREATMENT FOR PUBLIC SPEAKING ANXIETY

Participant #: Date: Clinician

_____Rapport built

_____Participant Preparation

The theorists that developed Thought Field Therapy believe that the body is composed of energy fields. They also believe that thoughts have their own field and that all negative emotions are caused by a disturbance in these fields. It is their opinion that tapping firmly on acupuncture points balances the energy field so that the disturbing emotions are eliminated or no longer present to the same degree.

We will have you think of upsetting feelings, or events categorize them on a scale of 0 to 10 and ask you to tap on different parts of your face and body while you repeat certain phrases and say or hum different things. It may appear odd, or even comical, but we ask that you try to follow the directions that are given. Do you have any questions?

_____Answered questions

_____Participant History Was Taken

Explore the genesis of the fear:

Was there a time when the participant felt publicly humiliated while or after presenting a speech?

-----------------------------------------------

-----------------------------------------------

Were there other previous events that might have contributed to the fear?

-----------------------------------------------

-----------------------------------------------

_____Which is the most intense as you think about it now?

-----------------------------------------------

Identify any physical sensations or other manifestations that accompany the
PAST TRAUMATIC EVENTS:
This includes things that have happened in the past. When you tune into or think about these past events, you feel discomfort. They include things like:
- Previous speaking engagements where you froze, forgot your lines or otherwise bombed."
- Job loss or retribution, or punishment due to not performing well in a speaking situation. (Past severe anxiety prior to or during a speaking event.)
- Peer rejection or criticism after a past performance.

FEARS, PHOBIA AND ANXIETY:
This includes the emotion of fear or anxiety when you merely think about performing or speaking in public. This also includes the avoidance and/or reluctance you feel to engage in any speaking capacity. It can include things like:
- Speaking before a group
- Meetings with superiors
- Leading your peers or a group discussion or event
- Giving presentations
- Cold calls and sales
- Fear of rejection
- Fear of making the wrong decision
- Over-stressed work environment
- Performance anxiety
- Shyness

EMBARRASSMENT:
This includes both the physical as well as emotional components of being embarrassed.
*Note: If you have worry associated with blushing, you need to address the worry portion of the problem in the Fears Section.

PERSPIRING AND OTHER PHYSICAL SYMPTOMS: This includes the actual physical symptoms and the associated worry and anxiety about them, including the fear about future physical symptoms occurring.
- Sweating or perspiring
- Shaking or nervousness
- Clammy hands
- dry mouth
- Mild stuttering or voice problems

CLAUSTROPHOBIA:
This area includes any type of feeling or concern about being restricted, trapped or stuck. It also includes the worry about such things occurring.
- Feeling discomfort sitting in the middle of a row or group
- Feeling trapped when in front of a group or leading a meeting
- Not wanting to have the door closed in any room or small area
- Avoiding elevators
- Stress about being trapped in a certain position emotionally

ALL EYES UPON ME:
This area includes any problem or fear associated with people looking at you or watching you.
- Everyone is watching me
- Self consciousness

COMPLEX PROBLEMS: This includes any problems that may not be included in the specific areas mentioned above. You can also try this treatment area if you find that the above problem areas only partially addressed your individual problem.
Treatment Initiated:

Identify the first target. Treat the area with the highest SUD level first and then treat the others.

Identify an image and/or sensation that goes with the target and continue to do this with each area treated.

Treatment for Reversals

Treat for reversals and continue to do this if there is no decrease in SUD:

Statements to use while rubbing the NEUROLYMPHATIC DRAIN SPOT on the left side of the chest, or the SIDE OF THE HAND.

I deeply and profoundly accept myself WITH ALL MY LIMITATIONS. I deeply and profoundly accept myself EVEN IF I HAVE THIS (FEAR, PANIC, ETC..) Be precise in your wording about this limiting condition. I deeply and profoundly accept myself even if I STILL HAVE SOME OF THIS PROBLEM.

Statements to use while tapping UNDER THE NOSE

I deeply and profoundly accept myself even if I NEVER GET OVER THIS PROBLEM. I accept myself even if I NEVER GET COMPLETELY OVER........

Statements to use while tapping on the CHIN

I deeply and profoundly accept myself even though I don’t DESERVE .......... I deeply and profoundly accept myself even if it’s not SAFE........... I deeply and profoundly accept myself even if it’s not LOYAL...............

Neurological Disorganization

If there is no decrease in SUD during treatment you may use the Cooks Hook-Up or Collarbone Breathing exercise. (See next page.)
COLLARBONE BREATHING EXERCISE (CB2)

While tapping on the gamut spot on the hand:
- Do five breathing positions
  breathe normal, breath all the way in, half way out, all the way out, and half way back in. (FIVE TAPS EACH BREATH POSITION)

WHILE BREATHING HOLD FOUR FINGER POSITIONS
- Do 2 finger positions on each collarbone
- Left Hand:
  1. Tips of 2 fingers of left hand on left CB
  2. Tips of 2 fingers of left hand on right CB
  3. Knuckles of left hand on right CB
  4. Knuckles of left hand on left CB
- Right hand
  5. Tips of 2 fingers of right hand on right CB
  6. Tips of 2 fingers of right hand on left CB
  7. Knuckles of right hand on left CB
  8. Knuckles of right hand on right CB.

COOK'S HOOK-UP

Place left foot over right foot.
Place right hand over left hand with palms facing inward.
Clasp palms together.
Draw hands under arms to chest.
Breathe deeply. On the “in” breath place tongue at the roof of the mouth.
On the “out” breath place tongue at the bottom of the mouth
AREAS TREATED:

_____ PAST TRAUMATIC EVENTS: (pr, eb, e, a, cb, 9g, eb, e, a, cb, er)

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______

_____ FEARS, PHOBIA AND ANXIETY: (pr, e, a, cb, 9g, e, a, c, er)

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______

_____ EMBARRASSMENT: (pr, un, cb, 9g, un, cb, er)

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______

_____ PERSPIRING AND OTHER PHYSICAL SYMPTOMS: (pr, e, a, cb, 9g, e, a, cb, er)

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______

_____ CLAUSTROPHOBIA: (pr, a, e, cb, 9g, a, e, cb, er)

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______

_____ ALL EYES UPON ME; (pr, a, e, cb, 9g, a, e, cb, er)

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______

_____ COMPLEX PROBLEMS: (pr, eb, e, a, cb, if, cb, if, cb, 9g, eb, e, a, cb, if, cb, if, cb, er)

If you may say 3x’s “I forgive ____/she/they did the best they could, or I reach out with forgiveness and love.”
On if you may say 3x’s “I forgive myself, I did the best I could.”

Pre-treatment SUD _______  Post-treatment SUD _______
General SUD _______
YOU MAY USE ANY OF THESE OTHER ALGORITHMS

____ RAPID STRESS REDUCTION PROTOCOL, (pr, er, 9g, er).
Pre-treatment SUD      Post-treatment SUD
General SUD

____ ANGER PROTOCOL, (pr, if, cb, 9g, lf, cb, er).
  On if you may say 3Xs “I forgive ____ he/she/they did the best they could or I reach out with forgiveness and love.”
Pre-treatment SUD      Post-treatment SUD
General SUD

____ GUILT PROTOCOL (pr, if, cb, 9g, if, cb, er).
  On if you may say 3Xs “I forgive myself, I did the best I could.”
Pre-treatment SUD      Post-treatment SUD
General SUD

____ RAGE PROTOCOL (pr, oe, cb, 9g, oe, cb, er).
  On oe you may say 3Xs I forgive ____ he/she/they did the best they could, or I forgive for my own healing or I reach out with forgiveness and love.”
Pre-treatment SUD      Post-treatment SUD
General SUD

INSTALLATION
____ When SUD is zero do the Installation Protocol. While the participant taps on the gamut spot have them visualize the steps that they will take to complete a successful public speaking experience:
  initial apprehension that they may feel when asked to give a speech
  preparation phase
  the morning of the speech
  walking into the room
  being introduced
  walking up to the front of the room
  giving the speech
  answering questions
Have them also visualize:
  forgetting lines
  feeling uncomfortable sensations
  having the audience be unresponsive
  having a superior evaluate them
  any other trigger that might make this experience more anxiety provoking.
Desensitize the areas where the anxiety resurfaces. Go through this exercise until SUD equals zero for all situations/aspects.

Therapist Signature

Length of Treatment in Minutes      Date

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1. Collar Bone
2. Eye
3. Arm
4. Collar Bone
5. Nine Gamut
6. Collar Bone
7. Eye
8. Arm
9. Collar Bone

Collar Bone Breathing

1. Full Breath In - Hold
2. Half Breath Out - Hold
3. Rest of Breath Out - Hold
4. Half Breath In - Hold
5. Breathe Normally

The Nine Gamut Treatment
(Done while tapping the Gamut Spot)
1. Eyes open
2. Eyes closed
3. Eyes open and down to the right
4. Eyes down to the left
5. Eyes in a circle
6. Eyes in a circle - Opposite direction
7. Hum a tune
8. Count to five
9. Hum a tune
Appendix B

Speaker Anxiety Scale (SA Scale)
SA Scale

Directions: This questionnaire concerns your reactions before, during and after the speech or presentation you just made. Please circle the number to indicate whether you: (1) Strongly Agree, (2) Agree, (3) are Undecided, (4) Disagree, or (5) Strongly Disagree.

1. Before getting up to speak, my body felt strained and tense. 1 2 3 4 5
2. I was nervous just before getting up to speak. 1 2 3 4 5
3. The thought of giving this speech made me feel tense. 1 2 3 4 5
4. I felt good about the prospect of making this speech. 1 2 3 4 5
5. I looked forward to expressing my ideas. 1 2 3 4 5
6. I faced the prospect of making this speech with confidence. 1 2 3 4 5
7. After I began speaking, I soon forgot my fears and enjoyed the experience. 1 2 3 4 5
8. I felt relaxed and comfortable while speaking. 1 2 3 4 5
9. During the speech, I wanted to talk less because I felt shy. 1 2 3 4 5
10. I was reluctant to express myself to the group. 1 2 3 4 5
11. I dislike using my voice and body expressively. 1 2 3 4 5
12. The speaking experience felt very natural to me. 1 2 3 4 5
13. I was sometimes at a loss for words. 1 2 3 4 5
14. My thoughts became jumbled and confused at times. 1 2 3 4 5
15. At times during the speech I got things mixed up. 1 2 3 4 5
16. Sometimes I could not think clearly. 1 2 3 4 5
17. I felt poised during the speech. 1 2 3 4 5
18. My mouth felt dry during the speech. 1 2 3 4 5
19. During the speech, I could feel my heart beating rapidly. 1 2 3 4 5
20. I had trouble coordinating my movements. 1 2 3 4 5
21. My palms were sweating during the speech. 1 2 3 4 5
22. I found it hard to look the audience in the eye. 1 2 3 4 5
23. After the speech, my body remained tense and strained for awhile. 1 2 3 4 5
24. After the speech I felt exhausted. 1 2 3 4 5
25. I would have enjoyed answering more questions about the subject from the audience. 1 2 3 4 5
26. I would enjoy the chance to present these ideas again. 1 2 3 4 5
27. I felt short of breath after the speech. 1 2 3 4 5
28. After the speech, I could feel my heart pounding. 1 2 3 4 5
29. Parts of my body trembled after the speech. 1 2 3 4 5
30. The surroundings made me feel intimidated. 1 2 3 4 5
31. Speaking in this situation made me feel uncomfortable. 1 2 3 4 5
32. I found the speaking conditions somehow threatening. 1 2 3 4 5
Appendix C

The State-Trait Anxiety Inventory (STAI)

(Spielberger, 1983)
SELF-EVALUATION QUESTIONNAIRE  STAI Form Y-1

Please provide the following information:

Name.................................................. Date...................................... S

Age_____________________ Gender (Circle) M F T

DIRECTIONS:

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

1. I feel calm................................................................. 1 2 3 4

2. I feel secure ............................................................. 1 2 3 4

3. I am tense ................................................................... 1 2 3 4

4. I feel strained ............................................................ 1 2 3 4

5. I feel at ease .................................................................. 1 2 3 4

6. I feel upset .................................................................... 1 2 3 4

7. I am presently worrying over possible misfortunes ......... 1 2 3 4

8. I feel satisfied ............................................................. 1 2 3 4

9. I feel frightened .......................................................... 1 2 3 4

10. I feel comfortable ....................................................... 1 2 3 4

11. I feel self-confident .................................................... 1 2 3 4

12. I feel nervous ............................................................ 1 2 3 4

13. I am jittery .................................................................... 1 2 3 4

14. I feel indecisive .......................................................... 1 2 3 4

15. I am relaxed ............................................................... 1 2 3 4

16. I feel content ............................................................. 1 2 3 4

17. I am worried ............................................................. 1 2 3 4

18. I feel confused .......................................................... 1 2 3 4

19. I feel steady ............................................................... 1 2 3 4

20. I feel pleasant ........................................................... 1 2 3 4

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Appendix D

Notices Asking for Volunteers to Participate
NEEDED

RESEARCH PARTICIPANTS

WITH

PUBLIC SPEAKING ANXIETY

Thought Field Therapy (TFT), a new experimental treatment for decreasing anxiety and phobias is being studied by a group of licensed psychotherapists in Colorado Springs.

Participants will receive a qualifying interview and one free hour of TFT treatment

Deadline March 15, 1998

Call the TFT Research Project for more information 578-9997
Appendix E

American Psychological Association

Ethical Principles of Psychologists and Code of Conduct
2002

Ethical Standard 8
8. Research and Publication

8.01 Institutional Approval
When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research
(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants’ rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research
Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants
(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.
(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research
Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants’ employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation
(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research
(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study’s significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing
(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.
(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research
(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal’s life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results
(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism
Psychologists do not present portions of another’s work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit
(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their
relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student’s doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data
Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification
(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers
Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.
Appendix F

Initial Interview Form
The purpose of this questionnaire is to obtain information about you for this research project. Completing these questions as fully and as accurately as you can is greatly appreciated. Case records are strictly confidential. NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR SIGNED PERMISSION.

Date ___________________ Participant Number ______________

I. GENERAL INFORMATION

Name_________________________________________ Birthdate: ________________

Address ______________________________________________

____________________________________________________________________

Phone Numbers: (Days)____________________ (Evenings)____________________

Gender: M_____ F_____ Age_____ Occupation:____________________

Race: Caucasian_____ Hispanic_____ Black_____ Other_______________

Education: Highest grade completed____________________

Marital Status: (circle one) Single Cohabitation Married

Separated Divorced Widowed

Date: __________ Date: __________ Date: __________

Partner’s Name/Occupation (optional) ______________________________

Children’s Names/Ages: ____________________________________________

____________________________________________________________________
2. PERSONAL AND SOCIAL HISTORY

(a) Previous Occupations: ____________________________________________________________

(b) Extended Unemployment? Yes___ No___
    Reasons: _________________________________________________________________________

(c) Annual Family Income:  
   0-10,000___ 30-35,000___  
   10-15,000___ 35-40,000___  
   15-20,000___ 40-45,000___  
   20-25,000___ 45-50,000___  
   25-30,000___

(d) Financially Stable? Yes___ No___

(e) Health Insurance? Yes___ No___ Company______

(f) Mother: Name________ Age____ Father: Name________ Age____

    Occupation: ________________________________________________________________

    Deceased? Yes___ No___ Date____ Deceased? Yes___ No___ Date____

(g) Siblings: Brothers (How Many)____ Ages:______________________________

    Sisters (How Many)____ Ages:__________________________

3. PHYSICAL

Height____ Weight____ Current Medication__________________________________________

Are you pregnant? Yes___ No____ Due Date______________________________

Do you have any current physical health problems? Please specify:______________________

______________________________________________________________________________

Do you have any physical handicaps? Yes___ No____

Do you have any disability? Yes___ No____
Check any of the following that often apply to you:

- Headaches
- Dizziness
- Palpitations
- Muscle Spasms
- Tension
- Sexual Disturbance
- Unable To Relax
- Constipation
- Tingling
- Numbness
- Diarrhea
- Sighing
- Stomach Trouble
- Tics
- Fatigue
- Twitches
- Back Pain
- Tremors
- Painting Spells
- Hear Things
- Watery Eyes
- Flushes
- Lump in Throat
- Skin Problems
- Dry Mouth
- Burning or Itchy Skin
- Chest Pains
- Rapid Heart Beat
- Don’t Like Being Touched
- Blackouts
- Excessive Sweating
- Visual Disturbances
- Hearing Problems
- Loss of Memory

Please list any medicines you are currently taking, or have taken during the past six months (including aspirin, birth control pills, or medicines that were prescribed or taken over the counter).

Check any of the following that have applied to you in the past month:

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquilizers</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sedatives</td>
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<tr>
<td>Aspirin</td>
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<td>Cocaine</td>
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<td>Painkillers</td>
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<td>Alcohol</td>
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<td>Coffee</td>
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<td>Cigarettes</td>
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<td>Narcotics</td>
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<td>Stimulants</td>
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<td>Hallucinogens</td>
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<tr>
<td>(LSD, etc.)</td>
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### Symptoms:

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<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
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<tbody>
<tr>
<td>Allergies</td>
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<td>Ulcers</td>
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<td>Heartburn</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Nausea</td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Insomnia</td>
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<tr>
<td>Early Morning Awaking</td>
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<td>Fitful Sleep</td>
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<td>Overeat</td>
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<tr>
<td>Poor Appetite</td>
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**4. BEHAVIOR AND FEELINGS**

Check any that have been a serious experience for you:

- Learning Problems
- School Problems
- Physical Problems
- Emotional Problems
- Behavior Problems
- Family Problems
- Friend Problems
- Eating Disorders
- Physical Abuse
- Emotional Abuse
- Drug Abuse
- Alcohol Abuse
- Sexual Abuse
- Rape
- Legal Trouble
- Loneliness
- Unhappy Childhood
- Anger
- Sadness
- Rage
- Sexual Issues

Check any of the following behaviors that have applied to you in the past month:

- Insomnia
- Concentration Difficulties
- Vomiting
- Suicide Attempts
- Alcohol Abuse
- Can't Keep Job
- Impulsive Reactions
- Crying
- Withdrawal
- Work Too Hard
- Smoke
- Loss of Control
- Lazy
- Procrastination
- Sleep Disturbance
- Outburst of Temper
- Drug Abuse
- Odd Behavior
- Compulsions
- Take Too Many Risks
- Phobic Avoidance
Check any of the following feelings that often apply to you:

- Angry  
- Annoyed  
- Sad  
- Depressed  
- Anxious  
- Fearful  
- Panicky  
- Energetic  
- Envy  
- Guilty  
- Happy  
- Conflicted  
- Regretful  
- Hopeless  
- Hopeful  
- Helpless  
- Relaxed  
- Jealous  
- Unhappy  
- Bored  
- Restless  
- Lonely  
- Contented  
- Excited  
- Optimistic  
- Tense  
- Others: ________

(A) Have you ever been hospitalized for psychological problems?  
Yes ___ No ___ If yes, when and where? ________________________________

(B) Have you ever attempted Suicide?  Yes ___ No ___  
Number of Times ________.

(C) List your main fears:  
1.  
2.  
3.  

5. PUBLIC SPEAKING HISTORY

Have you experienced any public speaking experiences in which you felt inadequate? If so please describe.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Was there an atmosphere in your home that discouraged communication? Yes___  No___.

On a scale of 0 to 10 (with 10 being the most intense) how uncomfortable are you speaking in groups of ten or more people? ______  Five to ten people? ______

On the same scale how uncomfortable to you feel when being videotaped?_____

Check any that apply to you:

When I get up to speak I am afraid that I will forget what I have to say._____
When I begin to feel anxious, I know that I will mess up._____
I have to be a good performer to be a good public speaker._____
I'm especially anxious when I feel like the audience is judging me, and I am not meeting their expectations._____
Good public speakers have a special talent that I don't have._____
I am not comfortable speaking unless I have a lecture._____
When speaking in public, I get nervous when I see that people are not responding to me._____

I'm not sure that I want to get over this public speaking anxiety._____
I will not feel like myself if I don't have this public speaking anxiety._____
My career has been handicapped by having this public speaking anxiety._____
I will never get over this public speaking anxiety._____
I'm embarrassed that I have this public speaking anxiety._____
It could be dangerous for me to get over this public speaking anxiety._____
It could be bad for someone else for me to get over this public speaking anxiety._____
I don't deserve to get over this public speaking anxiety._____
This public speaking anxiety is bigger than I am._____
There are some good things about having this public speaking anxiety._____
I've had this public speaking anxiety so long I could never completely solve it._____
If I solve this public speaking anxiety, I could lose a lot._____
If I solve this public speaking anxiety it will mainly be for someone else._____

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Check any that apply to you:

- This includes things that have happened in the past. When you tune into or think about these past events, you feel discomfort. They include things like:
  
  Previous speaking engagements where you froze, forgot your lines or otherwise "bombed."
  
  Job loss or retribution, or punishment due to not performing well in a speaking situation. (Past)
  
  Severe anxiety prior to or during a speaking event.
  
  Peer rejection or criticism after a past performance.

- This includes the emotion of fear or anxiety when you merely think about performing or speaking in public. This also includes the avoidance and/or reluctance you feel to engage in any speaking capacity. It can include things like:
  
  Speaking before a group
  
  Meetings with superiors
  
  Leading your peers or a group discussion or event
  
  Giving presentations
  
  Cold calls and sales
  
  Fear of rejection
  
  Fear of making the wrong decision
  
  Over-stressed work environment
  
  Performance anxiety
  
  Shyness

- This includes both the physical as well as emotional components of being embarrassed and the associated worry and anxiety about them, including the fear about future physical symptoms occurring.
  
  Sweating or perspiring
  
  Shaking or nervousness
  
  Clammy hands
  
  Dry mouth
  
  Mild stuttering or voice problems

- This area includes any type of feeling or concern about being restricted, trapped or stuck. It also includes the worry about such things occurring.
  
  Feeling discomfort sitting in the middle of a row or group
  
  Feeling trapped when in front of a group or leading a meeting
  
  Not wanting to have the door closed in any room or small area
  
  Avoiding elevators
  
  Stress about being trapped in a certain position emotionally

- This area includes any problem or fear associated with people looking at you or watching you.
  
  Everyone is watching me
  
  Self-consciousness
IN CASE OF EMERGENCY CONTACT:

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<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Telephone No.</th>
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THANK YOU FOR YOUR COOPERATION IN FILLING OUT THIS RESEARCH QUESTIONNAIRE.

Beverly Schoninger, M.A., L.P.C., P.C.  Research Participant
Experimenter

___________________________________________
Date
Appendix G

Responsibilities of the Participants
RESPONSIBILITIES OF PARTICIPANTS AND THE EXPERIMENTER

1. Initial Interview

2. On the day of scheduled treatment:
   a) Please arrive promptly at the appointed time. You will be advised of this time at a later date.
   b) You will meet with the independent assessor and complete a self-report about your discomfort in public speaking situations. (20 minutes)
   c) You will give a 1 1/2 minute speech on a very simple subject that you will select from a list of possible choices. (This speech will be videotaped and there will be a small audience present.)
   d) You will be asked to complete a self-report about your anxiety level.
   e) If you are in the “delayed treatment group” (group B or D) you will be required to watch one speech, and then complete the self-report. (Group B or D) may leave after this self-report is completed.
   f) You will participate in one hour of individual treatment.
   g) You will give another 1 1/2 minute speech which will be videotaped.
   h) You will complete a self report to measure your comfort/discomfort level in the second public speaking situation.

3. If you are in the “delayed treatment group” (B or D) you will be responsible for returning one Saturday in the following month. This commitment is extremely important. If you do not feel that you can return for a second appointment, please do not sign up for the study.

4. Your participation in this study is confidential. Data collected will be viewed by the research team, and will be considered for that purpose only. If you know someone in the treatment group, please respect their privacy. If you would like any information about your treatment, or about the results of the study, please do not hesitate to consult us.

5. You will be required to meet with the independent assessor to respond to these questions in two or three months.

   Your commitment to this scientific inquiry is deeply appreciated.
Appendix H

The Informed Consent
INFORMED CONSENT FOR THOUGHT FIELD THERAPY TREATMENT

I have been advised and understand that Thought Field Therapy (TFT) is a new, and as yet experimental treatment approach. I have been informed that the initial studies completed on TFT have produced promising results; however, I am aware that my symptoms may not change as a result of this treatment.

All information is confidential and will be seen only by the immediate research staff of this project. These questionnaires, interviews, and videotapes will be used in the compilation of a dissertation research project and other publications, and all of the reporting regarding your participation and scores will be strictly anonymous.

Before commencing TFT treatment, I have thoroughly considered all of the above, and by my signature below hereby consent to participate in this study.

My signature on the Acknowledgment and Informed Consent form is free from pressure or influence from any person or entity.

Dated:__________

Participant’s Signature

Please write down the following address. If you should have any complaints or questions about the way this research project was conducted, you may contact someone at the address listed below:

The Union Institute
Office of the Graduate Dean
440 East McMillan Street
Cincinnati, Ohio 45206-1947
Appendix I

Permission to Videotape and Audiotape
PERMISSION TO USE VIDEOTAPE AND/OR AUDIOTAPE

Agreement entered into this ____ day of ___________ .19 ____ between Beverly Schoninger, M.A., L.P.C., P.C. and __________________________.

It is understood that Beverly Schoninger wishes to use the tape for the purpose of professional education, treatment and research, and I endorse and support the use of such tapes for those purposes only.

It is therefore agreed by both parties as follows:

1. The tape will be used solely in the interest of advancement of mental health programs and only for the purpose of professional education, treatment or research activities connected with such programs, and will not be used for any other purpose.

2. Beverly Schoninger agrees not to use or permit the use of the full name of __________________________ in connection with any direct or indirect use of exhibition of such tape.

3. I agree that Beverly Schoninger is to be the sole owner of all rights in and to the tape for all purposes herein set forth.

4. There shall be no financial compensation for the use of such tape.

__________________________
Beverly Schoninger, M.A., L.P.C., P.C.  Participant

__________________________
Date  Date
Appendix J

TFT Algorithms Sent Home with Participants After the Research was Completed
Thought Field Therapy Applications

Abbreviations
PR Psychological Reversal
e under eye
eb eyebrow
oe outer eye
a armpit
cb collarbone
lf little finger
if index finger
9G Nine Gamut (see 9G below)
er eye roll (slowly roll eyes from floor to ceiling while tapping gamut spot)
sq total sequence is repeated

PR Treatment: Rub sore spot on left side of chest (ie neurolymphatic reflex) while making the following statement three times, specifying the type of psychological reversal present: “I deeply and profoundly accept myself even though I have this ...(anxiety, anger, etc.).”

Note: If your distress level has lowered some but seems stuck, tap continuously on the little finger side of your hand while making the following statement three times: “I accept myself even if I still have some of this ...(anxiety, anger, urge, etc.).”

Note: If there seems to be no movement at all, drink some water, thump on your thymus and breathe deeply. Then begin the algorithm again.

9G or Nine Gamut Treatments: While continuously tapping the gamut spot between the ring and little finger do the following: eyes closed, eyes open, eyes down right, eyes down left, whirl eyes right, whirl eyes left, hum, a tune, count to 3, hum again.

Before each treatment and several times during treatment (when you see this symbol , rate the level of intensity of your distress/ anxiety of your problem. Use a scale of 0 (no distress) to 10 (intense distress).
Algorithms

Rapid Stress Reduction
PR → er → 9G → er

Anger
If, c → 9G → Sq → er
[At "If" point, say 3 times, "I forgive x, I know ...(s/he, or I)... can't help it."]

Frustration/Impatience
PR → eb, e, a, c, If, c → 9G → Sq → er

Guilt
If, c → 9G → Sq → er
[At "If" point, say 3 times, "I forgive myself, I know I can't help it."]

Rage
PR → oe, c → 9G → Sq → er
At "oe" point, say 3 times, "I forgive x, I know (s/he, or I) can't help it." OR "I reach out with forgiveness & love."

General Anxiety (& Addictive Urge)
PR → e, a, c, a, e, c → 9G → Sq → er

Phobia
PR → e, a, c → 9G → Sq → er

Trauma
eb, e, a, c, If, c → 9G → Sq → er

Extended Trauma
PR → eb, e, a, c, If, c, if, c → 9G → Sq → er

*Dr. Roger Callahan's
Thought Field Therapy Applications
Appendix K

Exit Interview
TFT RESEARCH PROJECT
Exit Interview

1. What changes, if any, have occurred in your life since the last time we met?

2. What changes have you noticed with regard to the issues that brought you into the research?

3. Tell me about any experiences that you have had speaking in large or small groups?

4. Has this experience had any impact in the way that you think about therapy?

5. Tell me about any instances in which you used or might have used the protocols that were given to you?

6. When you think about giving a speech on a scale of 0-10 if 10 is the worst and 0 is the least anxious, what is your anxiety level?

7. Is there anything else that you would like to add?