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Thought Field Therapy and Pain

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Chronic pain is such a prevalent problem that a sub-specialty for anesthesiologists, Pain Management, is a relatively new development in medicine. Multi-disciplinary professionals have worked on the deleterious effects of pain; it is now being reconsidered as a disease in and of itself. (Basebaum, A.,1998; Cousins, M.J., 1999; Leibeskind, J.C., 1991).

I have used numerous psychological techniques in working with chronic pain patients, a large part of my patient population. Thought Field Therapy (TFTdx) is one of a number of procedures that I have used to help people with the psychological difficulties posed by chronic pain. TFTdx has decreased patients' frustration about their pain, their sense of helplessness, and depression in reaction to or part of the chronic pain syndrome. When communicating these results to a fellow TFTdx clinician, he suggested that I treat the pain directly. My first reaction was to think that this is not possible since pain is largely organically based. However, since I have been pleasantly surprised in the effectiveness of TFTdx for other problems, I decided to try to use it to reduce pain.

My first treatment was with a fifty-five year old obese woman who suffered from bilateral carpal tunnel syndrome. Braces were always on both wrists. Physical therapy only provided slight and temporary relief. The TFTdx treatment went smoothly. To the surprise of all, her pain went from a 6 down to a 0.

During the next two years, I continued to use TFTdx to try to reduce patients' pain. The vast majority of patients received temporary relief with one TFTdx treatment session. The results were sufficiently impressive that I thought a study should be conducted on the effectiveness of TFTdx in relieving muscular, skeletal, nerve, and spinal pain.

Subjects (Patients): The next twelve patients from my practice suffering from pain became the subjects of this study. There were seven females and five males. The age range was twenty-eight to sixty-six years of age. Seven were injured in an automobile accident. Collectively, they had received treatment from family physicians, physiatrists, anesthesiologist-pain management physician, neurologists, neurosurgeons, and chiropractic doctors. Most have received physical therapy and almost all have received pain related medication at some point in time. Two had prior surgery in the lumbar region, one had prior surgery in the cervical area, and one patient had surgery in both areas. Diagnoses included herniated, bulging and ruptured discs, stenosis, carpal tunnel syndrome, radiculopathy, pinched nerves, and muscular strain/sprain syndromes.

Procedure: Once starting the study, the next twelve pain patients who came in with a disturbing level of pain were offered the opportunity to have TFTdx treatment to attempt to reduce pain. The procedure was explained to them, especially since the therapy would not have face validity as being the treatment to likely reduce pain. All twelve subjects gave their informed consent. Ratings of pain levels were done before and after the patient received TFTdx. To determine the duration of the pain relief, all those who experienced relief were instructed to record when their pain increased to a disturbing level. A rating of

their overall pain levels was obtained at the patient's next session, which generally was one or two weeks after the TFTdx treatment was administered.

Results: Table 1 lists all 12 subjects' pain levels before and after the TFTdx. Pain level were rated from 0 – 10. The last column in table 1 represents the degree (or percent) of pain relief from TFTdx. Percent of pain relief was calculated by a fraction. The numerator was the pain rating before TFTdx subtracted by the pain rating after having TFTdx. The numerator was then divided by the patient's pain rating before receiving TFTdx. For example, subject #3's pain relief was 8-1 = 7. Thus, the fraction was 7/8 = 87.5% pain relief. Note that nine had complete relief reporting no pain after TFTdx. Two did not experience any improvement at all, and one almost had complete pain relief from TFTdx. In grouping the data, the average pain reduction was 82% (SD=39%).

TABLE 1
PAIN LEVELS BEFORE AND AFTER TFTdx TREATMENT

Patient	Pain Level Before TFTdx	Pain Level After TFTdx	% of Pain Relief
1	7	0	100
2	6.5	0	100
3	8	1	88
4	6	0	100
5	6	6	0
6	5	0	100
7	9.5	0	100
8	8	0	100
9	8.5	0	100
10	8	0	100
11	8	0	100
12	8	8	0

Patients who had pain relief were asked to note when the pain increased by at least a moderate degree. Although not a perfect measure, data regarding the duration of pain relief was obtained. TFTdx engendered pain relief that lasted from 4 – 96 hours for the ten patients who experienced pain relief from TFTdx. The average duration of the pain relief was 33.2 hours (SD = 37.3 hours).

Patients were seen for their normal therapy sessions approximately one to two weeks later. Pain levels on the same 0-10 scale were obtained. Ten of these patients were seen six to eight days later and two were seen fourteen days later. Of the ten patients that I saw six to eight days later, two had not experienced any pain relief immediately after the TFTdx. They also did not experience any lower pain levels when seen in the follow-up session. They are included in the following data. The degree (or percent) of pain relief the patients were experiencing six to eight days later was calculated as was done in the last column in Table 1. A fraction was made where the numerator was: the patient's pain level before TFTdx, subtracted by the pain level at their next visit with me. This numerator was then divided by the initial pain level before receiving the TFTdx. For instance, one patient's pain level before TFTdx was 8. One week later the pain level was reported to be at 6. Thus, the percent of pain reduction experienced one week later could be calculated: 8-6 /8 = 25% lower pain level. Even including the two unresponsive patients, follow-up pain levels were

30% less (SD = 29%). The large standard deviation reflects the varying amounts of pain alleviation experienced one week later by these patients.

Two patients were not seen until two weeks later. Both had experienced substantial pain reduction immediately following TFTdx. These two patients were reporting pain levels that were 49% less (SD = 16%) two weeks after having received TFTdx.

Discussion: TFTdx reduced muscular-skeletal, nerve, and spinal pain in ten of twelve patients treated in an outpatient psychology private practice. A comparison of pre and post pain rating showed an 82% reduction in patients' pain ratings immediately after the procedure was administered. Ten of the twelve patients had complete pain reductions immediately after the procedure, experiencing pain relief of 88% or greater. The other two patients had no pain reduction.

It was impressive to patients and myself that ten experienced pain relief, especially since the procedure of TFTdx does not appear to logically have pain reduction properties. It is not consistent with other conventional medical and chiropractic treatment methods. There is nothing like the application of electric stimulation, ultrasound, exercises, and spinal adjustments. Furthermore, the TFTdx treatment generally does not elicit expectations of pain relief and yet it occurred in ten of the twelve patients treated. Two patients did not experience pain relief. For these two patients, massive and/or polarity reversals could not be corrected1. Four others had similar energy reversals that were helped by oral neutralization to ultimately be effective. I was not aware of the toxin neutralization technique when treating this patient population.

To be able to relieve pain is important, but the duration of the analgesic effect is also paramount to the patient. For those who had pain relief, instructions were given for them to notice when the pain significantly increased. TFTdx resulted in relatively long pain reductions for some (20-96 hours) and lost its effect within six hours for others. The average duration of pain relief for the ten patients who experienced pain reduction from

TFTdx equals 33.2 hours (SD = 35.41 hours). TFTdx obviously provided longer relief than what patients experienced from pain medications.

Even with including the two patients who did not experience relief after TFTdx and who continued not to have any lower pain levels, the ten patients who saw me 6-8 days later reported a pain reduction of 30% (SD = 29%). Only two of the twelve patients were seen at follow-up two weeks later. Their pain levels were decreased an average of 49% (SD = 16%).

Although most patients complained of pain at multiple sites, all reported having lower back pain. Any method that would help lower back pain would be helpful given this disorder occurs in four of five people during their lifetime, is a most frequent cause of disability for workers aged nineteen to forty-five, and is the second most common cause of missed work days. A number of these patients not only had muscular-skeletal injuries, but had spinal injuries (herniation, herniated and bulging disc). Information from their medical reports is illustrative. For instance, a sixty-five year old woman had a seven year history of active

treatment for her pain. Herniations were noted at the L5-S1, L3-4, and L4-5 levels. Two different pain management-anesthesiologists collectively had previously administered injections in her cervical and lumbar region about ten different times. She was patient #6 and experienced a reduction of pain of 5-0 that lasted for four hours. A forty-four year old man had been in two car accidents since 1995. Radiology studies indicated "scattered degenerative changes of the cervical spine are noted with more severe focal changes seen at C3-4 and C5-6. At C3-4, spurring is noted predominantly in the left lateral recess. AT C5-6, spurring is noted predominantly centrally and to the left. A tiny herniation to the right of midline is present as well at C6-7…At L3-4, a bulging annulus has combined with facet and ligamentous hypertrophy to cause a slight spinal stenosis". His neurosurgeon writes that he was "involved in a second motor vehicle accident in August of 1996, in which he had worsening of his symptomatology, as well as changes in the workup, consisting of a disc herniation at the C5-6 level. This was complicated by the development of cervical radiculopathy secondary to disc herniation at that level, for which the patient was managed with surgery". This patient had a pre-TFTdx pain level of 8 which turned into a 0 and he had pain relief last for six hours. A thirty-eight year old man received TFTdx after he had cervical and lumbar surgery. His orthopedic diagnosed him as "post-traumatic cervical sprain and strain with herniated nucleus pulposus at C3-4, C4-C5 and C6-C7, with right upper radicular symptoms…Posttraumatic lumbosacral sprain and strain with herniated nucleus pulposus at L5-S1 with left lower radicular symptoms". An MRI of his lumbar spine showed "broad disc herniation at L5-S1, which has combined with facet/ligamentous hypertrophy to cause a mild spinal stenosis". He had an initial pain rating of 8 which TFTdx brought to a 1 and this relief lasted four hours. These are three of the twelve patients in this study and indicate that serious spinal injuries were involved.

These were the more seriously injured patients. Less injured patients had reported pain relief of 96 hours following TFTdx.

The nature of the treated patients makes these findings that much more interesting. Seven of the patients were involved in a lawsuit against a "negligent party" whose actions caused their injuries. If a bias exists for these litigants, one would wonder what their likely response would be to TFTdx. It would likely be to not exaggerate that TFTdx works. How would their legal case about their injuries appear if this unusual procedure that does not appear to directly treat their injuries ends up reducing their pain? How serious would their injuries appear to be to others? Not very severe. On the other hand, it would be hypothesized that the bias would be to resist the pain reduction as that would make the injuries seem more serious and treatment resistant. More severe injuries generally lead to higher monetary settlements. However, my distinct impression was that these patients were accurate in their verbal reports and in their muscle testing. All were interested to see if a different procedure might help in their struggle against pain.

There was no control group utilized to assess for placebo effects. That would be unethical in a clinical private practice population. This study clearly was not a double blind experiment nor even a single blind study. However, this investigation was never intended to be that, but to be a systematic collection of data on the effects of the TFTdx treatment on reducing pain. Since numerous patients have responded to this treatment before, the study was attempting to collect data on patients in a clinical setting.

Future research is needed by clinicians in the areas that TFTdx have been helpful. Reports on the usefulness of TFTdx on one person have been the predominant type of article published in "The Thought Field". Greater acceptance of TFTdx into general health care will

be facilitated by research. Although this study does not adhere to strict research design requirements, a collection of similar studies may eventually interest researchers to examine TFTdx's usefulness for pain management in a systematic manner.

Comment by Dr Callahan

Dr Pasahow has carried out a very interesting and important study. My treatments for pain have been known to be effective for about 23 years. In addition to demonstrating the power of my pain treatments Dr P's data shows the power of Psychological Reversal to completely block otherwise effective treatments from working. Dr P wisely notes that he was unfamiliar with my toxin corrective treatments at this time and with the addition of these treatments it is likely that all of the patients might have been helped. In addition, the duration of the treatments can be extended with my toxin treatments (see the chapter Cure and Time from Stop the Nightmares of Trauma, for an explanation). For students of TFT it will be interesting to note that HRV results lend strong support Dr P's findings (see Callahan, R and Sakai et al in J Clinical Psychology, Oct, 2001). Also, see Dr McKoy's comment over a decade ago: "When I observe a number of suffering patients who did not respond to our usual treatment modalities, suddenly get better after TFT treatments are given, I don't need a double-blind controlled study to tell me the value of Callahan Techniques® TFT." James McKoy, MD Chief, Pain Clinic, Chief, Rheumatology Service,Assistant Chief, Neuroscience Department Kaiser Permanente.