Awareness descriptions of three PTSD diagnosed patients’ inner experiences before, during and after Thought Field Therapy.

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Master thesis

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2 May 2016
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http://www.duo.uio.no/

Print: CopyCat Nydalen, Oslo
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1 INTRODUCTION

1.1 Social and cultural context

Of the many incentives for investigating psychotherapy, two important issues bear significance to this study.

One issue is the adverse childhood experience (ACE) study, (Felitti et al., 1998), which confirms that negative experiences in childhood influence health risk behaviours and mental and physical health throughout life and cause premature death, and shows that the influences of childhood experience do not disappear over time. The original study was conducted with two waves of data collection. Over 17,000 adult health clinic patients completed surveys regarding their childhood experiences and current health status and behaviors. This first wave study (Felitti et al., 1998) was based on information from more than 9,500 adult patients of a health clinic, who were asked about seven categories of adverse childhood experience, and their answers were then compared to their health records. Three categories pertained to abuse: sexual, recurrent physical and recurrent emotional abuse; and four categories pertained to being brought up in a dysfunctional household where: alcohol or drug abuse was present, a family member was in prison, a family member was mentally ill or suicidal, or there was violence against the mother. A final category later included pertained to the loss of a parent, by death, divorce or other causes. The number of categories was compared to adult health status, risk behaviour and disease. A graded relationship was established between the number of categories of childhood exposure (Felitti et al., 1998 p.245) and health risk behaviour and disease. A strong dose response relationship was found between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults (p.251), including diseases such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Poor self-rated health also showed a graded relationship to the range of childhood exposures. The study has generated a multitude of research, and there still is ongoing assessment of the study participants’ medical status via periodic updates of morbidity and mortality data (CDC, n.d.). A number of other studies have supported these findings (Solis et al., 2015), confirming how health is influenced by previous negative experiences.
Negative history of experiences are underestimated and under-reported, even during treatment. In a sample of 18-year-olds who had undergone treatment in Norway, 60% self-reported previous experiences of physical and sexual abuse and neglect, while only 0.4% of such cases had been registered in treatment journals of physical and sexual abuse (Reigstad, Jørgensen, & Wichstrøm, 2006). The study does not focus on the causes of this discrepancy, but the investigators hypothesise that there is reluctance on the part of clinicians to ask about, and patients to report, these issues. Possible explanations for this includes the practical consequences of having to involve child protection services, and clinicians’ fears about the reaction from parents, who have a right to view their children’s medical records. These figures give reason to believe that the non-reported traumas had not been treated, and reason to speculate that they had not been inquired about. An explicit question about sexual abuse posed to a sample of female emergency patients in a psychiatric emergency ward revealed a substantially higher number of cases of abuse (70%) compared with those who were asked routine questions (6%) (Briere & Zaidi, 1989).

Bodily manifestations of trauma and mental and physical disorders are repeatedly traced back to previous negative experiences in Anna Luise Kirkengen’s book “The lived experience of violation: How abused children become unhealthy adults” (Anna Luise Kirkengen, 2010).

If treatment could resolve the emotional and physiological impact of negative experience before these lead to psychiatric and somatic disorder, the consequences for the victims could be considerable. There is therefore a need to treat and counteract the influence of negative experiences, and to suggest a research and therapy focus that seeks to accomplish this task. This study examines patient descriptions of Thought Field Therapy when used for trauma treatment.

The issue of resources is another strong incentive for doing research on psychotherapy phenomena. In the period 2000-2011, mental disorder-related sick leave increased by 20% in Norway. The largest rise took place in the group with milder mental ailments, which showed an increase of 145% (Brage, Nossen, Kann, & Thune, 2012). Mental ailments cause nearly 20% of the total number of days of sick leave in Norway, with anxiety and depression the most common diagnoses (Ministry of Health and Care Services, 2013). The above-mentioned ACE study correlated self-defined current depression to the eight categories of adverse experiences, and found that a person who had experienced four or more of the categories of adversities were 4.6 times more likely to run the risk of developing
depression than a person with an ACE score of 0. It was also found a historical increase in attempted suicide of a factor of 12.2 between these two groups (Felitti et al., 1998). The figures from the ACE study are not replicated in the Norwegian population, but they represent a useful focus on trauma and depression.

This focus has been emphasised in a study correlating lifetime trauma exposure and PTSD and severe mental illness (Cusack, Grubaugh, Knapp, & Frueh, 2006). This study found that 87% of patients with severe mental illness (SMI) had traumatic experiences in life, and that 19-30% had post-traumatic stress disorder (PTSD).

Other large studies confirm the relationship between negative childhood experiences and a wide range of mental illness, including severe diagnoses (Afifi et al., 2014; Varese et al., 2012; Subica, Claypoole, & Wylie, 2012).

Figures from the Norwegian Directorate of Health show that in 2014 Norway’s total annual costs related to the effects of mental illness amounted to approximately NOK 185 billion. This figure includes disability, treatment and social expenses; loss of life quality; and lost years, totalling over 20 billion euros (Norwegian Directorate of Health, 2015). Even if these figures do not reflect an increase in the population’s total suffering, they may reflect a rise in people’s expectations that emotional pain be treated, and draw on society’s economic, therapeutic and educational resources.

During the course of the project, and especially in 2015, the global refugee problem has spread to the West at a speed that could overwhelm the capacities of nations to cover treatment needs. Migrants from long-suffering regions are fleeing from uncertain and unsafe living conditions, and bring with them traumas relating to both unsafe conditions during childhood and traumas directly resulting in the migration (Opaas and Varvin 2015).

The rising mental health costs indicate a need for short, comprehensive treatments to address and counteract negative experience and traumas.

The focus of this study is Thought Field Therapy (TFT), which is often characterised as a short-term treatment, and here also as a psycho-sensory therapy. Short-term treatments may also include other therapies with cognitive, emotional or body approaches, but none of these bear relevance for this study and will not be mentioned.

Internist Dr Ronald Ruden introduced the term “psycho-sensory therapy”, which relates to the sensory intervention involved in these modalities (Ruden, 2005). He classified treatment for emotional disorders into three main categories: psychological (mind to brain), – involving
talking, exploring and content specific thinking; pharmacological treatment (drugs) – altering brain functions with chemicals; and psycho-sensory – applying sensory input, such as touch, hearing or eye movements to alter behaviour, mood and thought. Eye Movement Desensitisation and Reprocessing (EMDR), Thought Field Therapy (TFT) and its derivative Emotional Freedom Techniques (EFT) may be said to belong to the third category. Peter Levine’s Somatic Experience (Payne, Levine, & Crane-Godreau, 2015) and Pat Ogden’s Sensorimotor Therapy (Ogden & Minton, 2000) also work directly on bodily sensations, and may be seen as psycho-sensory therapies.

Due to its similarities to TFT, EMDR needs further explanation. EMDR was developed by Francine Shapiro in the 1990s. She originally utilised sensory input from eye movements to desensitise traumatic memories, and included a protocol that facilitates cognitive processing (Shapiro & Laliotis, 2011). The method was further developed to include sound and touch as sensory mediators (Zabukovec, Lazrove, Shapiro, & Gold, 2000). The use of sound, touch and eye movements as sensory sources were already part of the TFT procedure as early as the beginning of the 1980s (Callahan, 1995).

Initially, EMDR was beside Thought Field Therapy met with a great deal of resistance and criticism (Rosen & Davison, 2001), before slowly gathering academic recognition (Shapiro & Laliotis, 2011). Currently, it challenges the position of cognitive behavioural therapy (CBT) as best choice for treating PTSD, and is now practised in hospitals alongside behavioural modalities. EMDR therapy is well researched; TFT, the focus of this study, is not.

1.2 TFT

Thought Field Therapy (TFT) is an easily learned therapeutic method intended to reduce painful emotions by stimulating specific acupuncture points in combination with the use of awareness exposure of the painful emotions. The acupuncture points are located on the client’s face, hands and upper body. These are rhythmically tapped on while the patient focuses on the traumatic memory. Sequences combining breathing and tapping, and sequences including eye movements and vocal activity with sound and counting are also employed. The procedures may be performed by the therapist or the client himself (Callahan, 1995), and the principles for the tapping and the sequence of the points can be learnt in minutes (see 6.2 TFT method).
The duration of TFT therapy varies, but typically lasts between one and five sessions, all depending on the patient’s issues and the extent of trauma experienced, therapist skills and patient receptivity to treatment.

TFT was developed after cognitive psychologist Roger Callahan discovered in 1979 that he could completely eliminate his client’s fear of water by tapping on an acupuncture point on her face (Callahan, 1997). He built upon the work of chiropractor George Goodheart, who combined results from subtle muscle testing with Chinese medicine, and psychiatrist John Diamond, who discovered that combining emotional affirmations with the stimulation of acupuncture meridians would influence both muscles and emotions (Mollon, 2007). In the early 1980s, Callahan developed the method into what is now TFT. Several other techniques based on TFT have subsequently been developed; these were, controversially, named energy therapies (Mollon, 2005). The most recognised and more widely researched of these therapies is Emotional Freedom Technique (EFT) (Church, 2013), which differs slightly to TFT. Whereas TFT applies two sequences of points determined by the patient’s emotional problem, EFT uses all TFT points in a predetermined order, and adds a sentence for affirmation. Consequently the similarity between the two consequently renders research on EFT highly relevant for TFT, and hence for this study.

**Expansion**

The use of and research into TFT and EFT methods are growing internationally, and include reports and studies from Africa (Dunnewold, 2014), South-America (report) (Andrade & Feinstein, 2003), Asia and Middle East (ACEP, 2015) as well as in the west.

In Norway, where this project is taking place, TFT is taught both to licensed professionals and people having no formal education (Dyregrov, 2015). Between 1997 and 2015, more than 1,400 people were educated by the psychologist Mats Uldal, who introduced the method in Norway, (M. Uldal, personal communication, 19 April, 2015). Because the main technique is so easy to learn, the total number of people who have practised it and taught it further could be higher.

**Acceptance**

TFT has been controversial (Lohr, Olatunji, & Devilly, 2008), slowly researched, and acceptance has also been slow. In 2015 it was finally listed as an evidence-based practice in NREPP, the national registry of evidence-based practices for the US government agency
Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.). It is there listed as effective for trauma and stressor-related disorders, for self-regulation, and for personal resilience/self-concept; and under their promising outcomes category for four other symptom areas: depression and depressive symptoms; phobia, panic and general anxiety; general functioning and well-being; and for unspecified and other mental health disorders and symptoms.

**Scarcity of theories**

Roger Callahan loosely speculated about quantum physics and the cause of negative emotions existing in a thought field in the form of perturbations. By addressing the thought field and collapsing the perturbation through TFT, the upset would disappear (Callahan, 1997). The existence of thought fields and perturbations were not supported by any discipline. There is still an absence of a viable theory explaining the mechanisms behind its effect, and this has slowed research progress. Other theories have been proposed (Andrade & Feinstein, 2003; Lane, 2009; Ruden, 2005, 2007; Oschman, 2006), but none of these are found to be supported by experimental studies.

Theories on mechanism are beyond the scope of this study, but further research on this topic is expected.

**Research**

While not exactly extensive, the body of research on TFT and EFT is growing, and most of the studies relate to the topic of effect. The development in research might be characterised by the method’s ease of use; in spite of slow research support, it has expanded to many countries and is used both by therapists and others.

The relatively early studies include mainly anecdotal reports - often over one or two sessions, non-peer reviewed, non-controlled and with heterogenic samples. A non-peer reviewed TFT study by Caroline Sakai et al. examined the effect of TFT on many mental ailments among 714 patients. They found a significant in-session reduction in the 31 problem areas; however, a heterogenic sample, no randomisation, no follow-up, and lack of control and sampling information weaken the results (Sakai et al., 2001). The mere size of these studies intimated a more rigorous methodology, which came around a decade later.

One of the later studies was a randomised, wait-list-controlled study with a two-year follow-up that examined the effect of TFT on Post-Traumatic Stress Disorder symptoms in a sample
of Rwandan genocide survivors (Connolly & Sakai, 2011). Therapy was provided by local people who had completed a two-day TFT training course. The newly trained therapists treated 171 genocide survivors with a single session, and were supervised by TFT trainers when required. Participants were allocated alternately to a treatment or waiting list (control) group. Symptoms were assessed according to PTSD and trauma scales, which were translated into the local language. An inconsistency test excluded participants from the final assessment, and reasons for post-test drop-outs were recorded. The results suggested that brief TFT – albeit provided by local people with only limited training – reduced the symptoms of PTSD. Eighty-eight participants were assessed after two years, and these were found to have sustained benefits from the treatment.

These results bear relevance to the project at hand, as the collaborating psychologist here had only brief treatment experience in the TFT method before the study (see 2.4.4 The therapist).

Another subsequent study was conducted in Norway; two sessions of TFT (85 minutes in total) were investigated for effect in an RCT study of 45 patients with anxiety disorders (Irgens, Nysæter, Dammen, & Hoffart, 2012). This study suggested an enduring anxiety-reducing effect, with sustained results after 1-2 weeks’, 3 months’ and 12 months’ follow-up.

The relevance for this project is that two of its participants who had been diagnosed with PTSD had suffered from severe anxiety symptoms in their daily life.

(Gilomen & Lee, 2015) performed a meta-analysis of 18 EFT studies, and these have relevance for TFT due to the procedural similarities between the two therapies. The investigators found that EFT produced an effect, but concluded that due to the methodological shortcomings of the studies, it could not be determined whether acupoint stimulation or other treatment elements caused this effect. Of the 18 analysed studies, 12 were one- or two-session studies.

Case studies were also found; a study describing cases (Bray, 2006), a single case study with EFT and CBT on PTSD (Sheldon, 2014), and interviews conducted with TFT case workers (Mason, 2012). Bray’s study is a proponent’s description; Mason’s paper is a set of clinician’s reports, and may as such have interest for clinicians. Sheldon’s study is detailed and thorough, but other modalities were also utilised during the therapy course. Her study takes a rigorously objective perspective on the patient’s process, applying and describing assessment tools, and describing diagnoses, treatments and duration of interventions. None of
these studies directly relate to this project, which emphasises traumatised patient experiences and in-session details. In the above-mentioned reports, this focus is less apparent.

The research mentioned above shows that TFT is often used for treating post-traumatic reactions. The diagnosis chosen as a prerequisite for the study and most associated with adverse experience is post-traumatic stress disorder (PTSD).

Traumatic experience is also present in people with many other mental ailments and conditions (Afifi et al., 2014; Varese et al., 2012) or with no diagnosis at all, and it would have been possible to investigate such a sample. That choice would entail time-consuming work of confirming the relationship between symptomatic expression and former traumatic experience. This task had already been completed, as specialists in the collaborating out-patient clinic had diagnosed the patients.

In order to avoid ambiguity, the author has chosen to focus on patients who have been assigned a clear diagnosis.

1.3 PTSD

This study focuses on five domains of patients’ experience: physical body, feelings, thoughts, relations and initiative/behaviour. The diagnosis of PTSD influences all these areas.

In the diagnostic manual of DSM-IV (American Psychiatric Association Task Force on DSM-IV, 2000), post-traumatic stress disorder is described by criteria for the trauma and criteria for three symptom clusters presented by the patient after having been exposed to a traumatic event.

A. Criteria for the trauma: it should carry the threat of death, injury or violation of physical integrity of self or others, and cause strong emotions of fear, helplessness or horror at the time.

The symptom clusters are:

B. Intrusion symptoms, such as:
   re-experiencing the trauma during sleep with nightmares or dreams, with distress; or awake with memory, with perceptions, images, thoughts, all with distress; reliving
flashbacks, with illusions, hallucinations or dissociative episodes, all with distress; experiencing reminders, with distress; physiological reactivity when reminded of the event (one or more of these symptoms are required).

C. Avoidance of reminders of the trauma: people, places, activities, thoughts, feelings, talk; and numbing symptoms: an inability to remember parts of the trauma, feelings of detachment from other people or activities, fewer positive feelings, less sense of having a future (three of these symptoms are required).

D. Increased arousal, with hypervigilance and increased startle response; anger or irritability; concentration problems; sleep problems (two of these symptoms are required).

There are also criteria regarding duration (> 1 month) and regarding negative effects on the patient’s relations to the environment, in social, occupational or other areas. Children’s symptoms may differ.

In the newer DSM-5 manual (American Psychiatric Association, 2013), which is a 2013 revision of DSM-IV, the criterion C was replaced by two criteria: C for avoidance and D for negative alterations in cognition and mood. The negative alterations consist of blaming oneself or others, and of being in a negative emotional state (a new feature is that one avoidance symptom is required). The arousal criterion, now labelled E in DSM-5 included reckless or destructive behaviour. DSM 5 also mentions marked physiological reactions to reminders of the traumatic event(s). In criterion A the requirement of fear, helplessness, and horror was excluded.

If we reorganise the manual’s descriptions of PTSD symptoms into the five domains of experiences researched in this study (thoughts, feelings, bodily sensations, relationships and initiative/behaviour), we see that the areas influenced by this diagnosis correspond to this study’s five domains of interest:

- cognitive responses: reliving; intrusive memories and flashbacks, perception and images; illusions and hallucinations; concentration difficulties; inability to recall parts of the trauma;
- emotional responses: the intrusive memories and flashbacks are coupled with distress and negative feelings, manifested by numbness and inability to feel pleasure and loving feelings, or hypervigilance, outbursts of anger, irritability, fear or panic. DSM-5 also includes blame and negative alterations of mood;
- bodily responses to reminders of the event,
- relational responses; detachment from and avoidance of others,
- in the field of initiative/behaviour there is avoidance of earlier activities and those reminiscent of the trauma. DSM-5 also includes reckless and destructive behaviour.

In Norway, the prevalence of PTSD is estimated at 2-3 % of the population at any given time (Amstadter, Aggen, Knudsen, Reichborn-Kjennerud, & Kendler, 2013). In one US study, the figures were estimated at around 8 % of the population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), falling to 6.6 % in a subsequent study (Pagura et al., 2010).

The treatments most widely used for PTSD have addressed PTSD from a cognitive point of view, with the different forms of Cognitive Behavioral Therapy, (CBT). CBT is the most thoroughly researched psychotherapy of today (Butler, Chapman, Forman, & Beck, 2006). CBT’s approach is based on insight and learning skills. Untrue perceptions and incorrect beliefs and behaviour are identified and modified, and emotions and behaviour change after a restructuring of the way the patient thinks. Sometimes CBT is coupled with different forms of exposure to trauma memories, and from the millennium shift, it has evolved into many modalities, such as for example Trauma Focused CBT (Cohen, Mannarino, Kliethermes, & Murray, 2012).

No studies have been found on cognitively focused therapies investigating patients’ subjective therapy experiences on a detailed level, as is this study’s focus.

1.4. Research questions, reflexivity and scope

This study investigates three people’s descriptions of their unique experiences of the treatment. The project may thus be perceived as a small pilot study or case study, and is descriptive in its approach.

Research question:
How do PTSD patients describe their inner experiences before, during and after Thought Field Therapy?

Investigating descriptions of an inner process of treatment from a phenomenological perspective implies investigating perceived change, as a process is by definition a row of
changes: “a series of actions that produce something or that lead to a particular result”, or “a series of changes that happen naturally” (Process [Simple Def.], n.d.).

Change in this project is defined as the difference between two unique moments in a human being’s experience.

Change is an extensive topic to investigate in treatment contexts. The concept of treatment change can be discussed at great length. Does it imply feeling less pain? Is it constituted by personal development, acquiring different thoughts, another behaviour? Is it acceptance of a situation or less need for medication, or effects of medication? Is it catharsis, adherence to society’s norms or the removal of emotions? Regardless of definition; change or difference is what the patient and therapist often view as the purpose of treatment; for example, change in the patient’s severity of symptoms, in life quality, in approach to his own suffering or to relationships.

The patient’s attitude to change may differ greatly from that of the therapist.

This study has made no attempt to register all changes during or after treatment sessions. Nor have attempts been made to identify impartial measures of change, or change from the therapist’s viewpoint. What is included in the data acquisition is the participant’s own experience in the process of treatment and perceived inner change. It is thus necessary to investigate the two fields of her experience, each with their own time perspective.

The first field investigated is the treatment session, where the participant describes the chronology of her experience of inner phenomena as contemporaneously as possible - the ‘now’. This is obviously unachievable, as any description will be provided after the experience. In order to approach the moment of experience as closely as possible, the treatment was video-recorded and an interview with the participant was conducted as she watched the recorded session. In order to narrow the time frame even closer towards the now, the information acquired during the treatment session and interviews constituted awareness data, meaning subjective registrations of the flow of phenomena emerging moment-by moment from body, feelings and mind, separated from the participants’ opinions, explanations and comments - their thought content. This is elaborated on in section 2.4 Design.

The second field investigated is the patient’s inner experiences of his daily life in the immediate periods before and after treatment. Pre- and a post-treatment interviews depict how the domains body, thought, feelings, relationships and initiative manifest in the
participant’s awareness before and after treatment. Here no attempt is made to identify the participant’s experience of the now, rather her understanding of her inner life “at this point in time”, or “nowadays”, i.e. her more general, overall impressions from a slightly wider time frame. When comparing these two points in time, differences are perceived, and these are understood as change.

The author has worked for a number of years on treatment in an experiential-phenomenological framework, gestalt-psychotherapy (Yontef & Jacobs, 2011), and on the psycho-sensory approaches TFT and EFT. Experiential-phenomenological treatment is profoundly analytical vis-à-vis inconspicuous phenomena of the treatment process. In this approach, moment-by-moment awareness is in this approach the most important tool in the therapist’s continuous analysis of his interventions and their in-session consequences for the patient. This entire study is permeated by the author’s mindset of applied phenomenology, and this analytical basis is retained, as the participant’s process is focused upon. Attempts are made to identify and understand patients’ bodily and emotional reactions that instantly follow the therapist’s interventions, hence the processual perspective in the tables (see 7.1.1 – 7.3.3 Tables).

1.5 Use of Terminology

Phenomenology

Phenomenology as a branch of philosophy is attributed to Edmund Husserl and Maurice Merleau-Ponty in the first half of the last century. Husserl argued that it was necessary to examine the bedrock of experience, because it was there, in our emotions, actions and perceptions of things and relationships, that an ultimately true understanding could be derived. Phenomenology strives to describe the essence of everyday experience. For Husserl, the attempt to engage with the process of identifying the essence placed a great demand on the inquirer, because it could only be achieved by the
individual rigorously examining their own personal experience of the world.

McLeod, J. (2001, p.37)

The ideas of Merleau-Ponty, in particular, have influenced this study. He emphasized the body’s importance, as his view was that humans experience the world as embodied creatures. According to Merleau-Ponty the “I” is consciousness through the body, existence is only through the body and learning and perception are physical experience (Merleau-Ponty, 2012, p. 45).

The now

Equally important is the emphasis on the now. Focus is on staying with what is, in the present, not on trying to control feelings or encourage change. That would require shifting one’s focus to the next moment arriving, and the awareness, the sense of I, thus leaves the present. Phenomena are experienced uniquely by the awareness of the patient in the now, as they arrive from the body, thoughts or feelings (Perls, Hefferline, & Goodman, 1994).

Experiential-phenomenological therapy

In the experiential approach a person has access to existence through the directly felt process of ongoing experiencing (Gendlin, 1973). Today this approach makes it possible to identify subconscious issues through experiencing, and find new experiences such as role play, the use of props and awareness on actions, positions, movement and activities to enhance empowerment and emotional growth. Experiential therapy is a category, and may include equine therapy, expressive arts therapy, music therapy, psychodrama and gestalt therapy.

The author’s approach to treatment is gestalt therapy, which may be called experiential – phenomenological, combining the phenomenological stance of being aware of one’s experienced existence in the now, together with experiential activity.

Awareness

This is the vantage point from which patients answer the therapist’s key question “How are you?”; they answer out of the awareness of their existence at the moment. The study’s use of the concept is elaborated in section 2.4.1

Psychosis
is defined as “a fundamental derangement of the mind (as in schizophrenia) characterized by defective or lost contact with reality especially evidenced by delusions, hallucinations, and disorganised speech and behaviour (Psychosis [Simple Def.], n.d.).

Domains

The areas investigated are in the study called domains. From these areas phenomena emerge into awareness. The five domains are body, emotion, thoughts, relationships and initiative/self-agency, and they all describe inner areas. The domain of relationship describes the inner drive toward being with others, its degree and quality, but is often described with its outward expression, such as the nature of a friendship. Initiative/self-agency describes the drive towards action and the ability to cover needs, and is often described by actions.

Feelings and emotions

Feeling and emotion are used interchangeably about inner state, and covers moods, feelings, emotions, affects; and also states such as curiosity, indifference or calmness. Bodily senses are here distinguished from feeling and emotion. This is not always achieved, due to the word “feelings” popularly being used about bodily senses as well.

Change

In the sessions and interviews, it is understood as difference on an inner level, at one point in time perceived as different from an earlier moment.
2 METHODS

Originally, six PTSD patients were randomised to TFT or CBT (cognitive behaviour therapy) in order to look for possible differences in the qualitative experiences of these two modalities. The size of that task proved too great for a master thesis, so the subject for this study is the TFT patients’ individual process only. The participants of the study had no contact with each other, and they were selected the same way and apart from each other.

2.1 Collaborators

The project was conducted in collaboration with an outpatient clinic in a little town in Norway. Because of its small size, there is a risk that patients might be identified, thus names of places and collaborators are not included.

The interviewer and study initiator is a medical nurse, a trained gestalt psychotherapist and a TFT therapist with private practice experience.

The Research Department of the central county hospital assumed research responsibility for the project, and was represented by the head of the department and a researcher.

The treatment staff at the clinic identified patients for the project and functioned as a reference group, and a secretary took on the role of project assistant. She collected consent forms from the participants, and scheduled sessions. Finally, the therapist was an experienced psychologist and member of the clinic staff.

2.2 Selection and criteria

The purpose of the study was to investigate the experience of TFT treatment in people who suffer negative aftereffects due to harmful experiences. To ensure this, one of the inclusion criteria was that the patients had a confirmed PTSD diagnosis.
Collaboration with the outpatient clinic was chosen because of access to participants and to utilise the clinic’s premises for interviews, treatments and filming.

There were many reasons for this choice of collaborator: it was ethically important that patients living with this diagnosis of fear should remain in safe surroundings during the interviews. Moreover, they should easily be able to return to their regular treatment after the study and be able to terminate the experimental treatment in case of unforeseen difficulties arising in connection with the project. It was important for practical and economic reasons that the psychologist administering the treatments be an employee of the clinic and therefore allowed use of its premises. To use the clinic’s project assistant and reference group was convenient for a student, and saved time and financial resources.

The task of recruiting suitable candidates was undertaken by the treatment staff at the outpatient clinic. They identified patients with a PTSD diagnosis from new patients or among their own patients who were in ongoing therapy.

Another criterion was that the participants had to be capable of being consciously aware of their unique experiences, with the communication skills to convey the details of these experiences. Exclusion criteria included impaired cognitive function or linguistic abilities, and severe concentration difficulties. Psychosis was also established as an exclusion criterion because of the problems associated with communication. Studies about the psycho-sensory treatment of EMDR have been conducted using a samples of patients with psychosis and PTSD (van Den Berg et al., 2015). However, TFT studies with similar samples have not been found.

Additional exclusion criteria comprised suicidal inclination and an age of less than 18 years. Also excluded were patients diagnosed with physical diseases involving pain. TFT therapists state that the focus in patients’ awareness during TFT first concentrate around physical pain, and thus TFT may target physical diseases before targeting emotional states (M. Uldal, A.T. Eia, personal communication 19 April 2015). The therapists argue the possibility that TFT’s treatment mechanism prioritise vital physiological functions ahead of emotional areas. To avoid this possible issue, patients with diagnosed somatic conditions involving pain were excluded. Two EFT studies investigating pain (Bougea et al., 2013; Brattberg, 2008), suggest EFT effect upon pain, but do not address this question.
In practical trauma therapy, focus on the body often dominates sessions, with numerous symptoms relating to vision, smell or hearing; bodily pain; numbness or function losses - symptoms which in early psychoanalysis were called “hysterical” (Herman, 1992, pp. 10-16).

Pat Ogden, who created Sensorimotor Therapy, points out that autonomous and somatic components of trauma-related disorders have been relatively neglected:

Traumatised individuals do not just suffer memories of tragic and horrifying experiences - they demonstrate a number of complicated and debilitating signs, symptoms, and difficulties consisting primarily of bodily responses to dysregulated affects. These bodily responses often have no clear subjective connection to their fragments of narrative memory (Ogden, Pain, & Fisher, 2006).

The existence of a relationship between physical and emotional pain has been described. Anna Luise Kirkengen cites multiple examples of painful life experiences manifesting in the victims’ continuous bodily pain (Anna Luise Kirkengen, 2010).

It is difficult to distinguish between patients with pain mainly caused by physical disease or injury (e.g. a broken leg) and patients who experience bodily pain with a strong component of emotional suffering. However, criteria requiring an absence of physical pain would exclude many PTSD-diagnosed participants from the study. It was decided to include patients who had been medically examined for their pain, including back pain, stomach aches and headaches, but for which no diagnosis had been reached. The rationale for doing so is that the diagnostic criteria of DSM 5 also mentions marked physiological reactions to reminders of the traumatic events. One patient in the study had suffered physical pain over several years. These symptoms of pain had been thoroughly medically examined, but no diagnosis had been made. Her pain thus did not meet the exclusion criteria for the study.

Patients with multiple traumas or additional diagnosis apart from psychosis were not excluded provided their additional diagnosis did not impede communication.

The criteria for diagnosing PTSD included assessment by a psychiatric specialist and a positive score on the symptom measuring scale IES-R (set to 33 by the clinic). In dubious cases, the specialist’s assessment was assigned more weight than the diagnostic tool. IES-R is an abbreviation for Impact of Event Scale (revised), which is a 22-item self-report form measuring the level of symptomatic response to specific traumatic stressors, as experienced in the past week. This is one of the most widely used tools for measuring trauma impact. It is
quick and simple to use. The patients completed the form themselves and submitted them to the project assistant.

The three participants had previously undergone lengthy periods of therapy, and it was important to confirm that their traumatic experiences still affected them. All participants completed the IES-R form prior to the study. One of the participants was diagnosed by a specialist shortly before the study commenced. The second participant had been diagnosed during a stay in a central institution of psychiatry three months previously. In the interim, she attended psychomotor physiotherapy, but had made no progress. This participant had dissociative episodes, and her PTSD diagnosis was affirmed. The third participant was the one who had the highest degree of physical and emotional symptoms in her daily life. She had been diagnosed 15 months earlier and had subsequently received regular treatment, but her symptoms remained unchanged. All three participants scored highly on the IES-R.

Patients in ongoing therapy and newly registered patients were asked by the medical centre staff whether they would participate. The investigator only met patients who had consented to join the study following a meeting with the project assistant, who gave them information and consent forms, and scheduled sessions. Data was not collected on the number of patients asked to join the study, or on those who did not consent.

One participant dropped out of the study. She regularly failed to show up to scheduled sessions with her therapist. At her request, the investigator met with her and her therapist to give her information about the study, and to allay any concerns she may have had before deciding. She decided to join the study, but dropped out after the first session and interview, and subsequently did not answer phone calls or text messages. Being filmed was one of the issues she reacted to in the pre-study conversation.

The study sample turned out to be single-gender, as only women agreed to participate. As is the case for many single-gender studies, this may weaken the results. Men might have had different experiences and perceptions of experienced phenomena, or expressed these experiences differently.

All three participants had experienced childhood traumas. The severity of each trauma was not assessed.
### Table 1 Participants included in the study

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age/ gender</th>
<th>Last specialist diagnosis</th>
<th>IES-R</th>
<th>First time in therapy</th>
<th>Duration of support or therapy</th>
<th>Traumas</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>W 38</td>
<td>15 months before study</td>
<td>63</td>
<td>11 y ago</td>
<td>11 y</td>
<td>Childhood over time, Stillborn baby five years before study</td>
</tr>
<tr>
<td>B</td>
<td>W 54</td>
<td>Prior to study</td>
<td>75</td>
<td>approx. 22 y ago</td>
<td>approx. 14 y</td>
<td>Childhood over time</td>
</tr>
<tr>
<td>C</td>
<td>W 57</td>
<td>Three months before study</td>
<td>57</td>
<td>approx. 20 y ago</td>
<td>approx. 20 y</td>
<td>Childhood over time</td>
</tr>
<tr>
<td>Mean</td>
<td>49.7</td>
<td>65</td>
<td>17.7</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The term “prior to study” means a week or two before the first interview. Mean figures are calculated.

The participants’ histories are included in chapter 4 FINDINGS.

### 2.3 Ethics

The project was evaluated and accepted by REK, the regional ethical research committee, with no additional demands for changes. The participants received REK’s information and consent forms to sign.

Because the study was carried out in a small town, confidentiality measures were discussed with the participants. Recordings and written materials were securely stored in the hospital systems, and in accordance with the regulations of the Norwegian Data Protection Authorities. Names of places and people are substituted by neutral terms or numbers in the study in order to ensure anonymity.
As the study proceeded, it became clear that the interviews themselves proved therapeutic for the participants. On several occasions during the interviews, the participants, speaking freely about their inner experience, were close to initiating their therapeutic process. This was undesirable, primarily for ethical reasons. Initiating a painful process without achieving resolution might leave the patient feeling abandoned and vulnerable. Secondly, therapy processes in the interview room would complicate data acquisition and impact on the findings. On two occasions, the interviewer’s therapeutic background and experience prevented trauma exposure during interviews.

On the first occasion, participant B in her pre-treatment interview about a crucial moment in art therapy, spoke about a possible repressed trauma. The other was at the beginning of participant C’s post-treatment interview, when she talked about her abuser, and was close to dissociating. On these occasions, their emotional processes were redirected, and the interview continued. These examples show the stress an interview may cause to people with severe diagnoses. Without the safety of a trusted therapist or an institution, an interviewee may leave the interview in a distressed emotional or retraumatised state. Comprehensive knowledge and skill about how to direct processes of emotional change are important. Awareness of this possibility is recommended when planning interviews with severely traumatised patients.

2.4 Design

The first aim of the study was to explore the nature of the participants’ experience, and therefore a qualitative design was chosen.

- An interview was held to map the participant’s state of mind before treatment.
- The first treatment session was video-recorded.
- Together, the participant and interviewer watched the recording in short clips, interspersed with conversation about the last-viewed clip.
- The recorded session and the in-treatment interview were chronologically merged.
- After the final treatment, the pre-treatment information was revisited in an interview.
- Each participant’s pre- and post-treatment interviews were compared, and differences and similarities were registered.

The merged in-treatment interview and the post-treatment interview constitute the two parts of the data set addressing the research question:
How do PTSD patients describe their inner experiences before, during and after Thought Field Therapy?

2.4.1 Awareness in the study

The analysis started by designing the study.

In order to gain an impression on a micro-processual level about how clients perceive their experiences of Thought Field Therapy, it was expedient to distinguish between ‘awareness’ and ‘opinion’. Awareness is used as an analytical aid to get closer to the experienced moment. This concept needs some explanation.

Fritz Perls introduced awareness, the main tool of his gestalt therapy, as the concept of “concentration therapy”, “not an intellectual procedure”, but intended to “waken the organism to a fuller life” (Perls, 1992, p. 220). More recently, the concept of awareness has been revitalised in the form of mindfulness, which is an awareness exercise in itself. Kabat-Zinn’s operational working definition of mindfulness is “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145). His emphasis on the present moment is useful for this study, as the patient’s moment-by-moment experience is focused upon here.

Babette Rothschild’s definition of body awareness is also valuable with regard to the project: “Body awareness implies the precise, subjective consciousness of body sensations arising from stimuli that originate both outside of and inside the body” (Rothschild, 2000, p. 101).

In this study’s treatment sessions, not only body awareness, but also awareness from feelings and thoughts is registered.

Rothschild and Perls both include in their definition of awareness a perception of the outer world. However, the outer world is of less relevance to the study; the inner world is what is examined, and only this part of awareness is focused on here.

Awareness in this study is understood as a synergy of the three definitions above, the immediate information perceived in the present, when the person is attentive to phenomena in the bodily senses, feelings and mind.
The act of being aware is clearly separate from the thinking process, which here may be viewed as a continuously ongoing analysis involving past, future, and other people and places. The processing functions of the conscious thinking mind – understanding, planning, assessments – do not exclusively deal with the phenomena emerging here and now from emotions and the body, as is the case with awareness.

A metaphor might clear up the abstraction: thinking may be thought of as a horizontal picture, an overview perspective from a distance, mixing the now, the future, others and ourselves. From a distance, size and depth are unclear, and the details less distinct from each other. Awareness can be thought of as a vertical line, like a rising fountain of phenomena where only the top is clearly visible, but quickly disappears as the next phenomenon emerges.

Subjective moment-to-moment phenomena in the now from feelings and bodily senses reach awareness one by one and provide the data with three features:

- the time they occurred
- their strength
- their quality

In practical therapy use, awareness perceives phenomena in the present, and therefore makes it possible to chronologically point inner experiences towards therapeutic interventions, thereby clarifying points of importance or change.

In this study, awareness data from the participants’ body, from their emotions and from their thoughts have been registered. One moment may contain, for example,: “Now, when (time) he talked about my mother, I got a slight (strength) feeling in my stomach, like nausea (quality).”

Personal experience might be deemed more reliable when related to personally registered awareness phenomena instead of to the thinking process in which opinions may vary and are influenced from various sources. Therefore, a decision was made to register the participant’s description of the content of awareness, and the continuous change in the moment-to-moment flow of internal phenomena experienced.

However, during the in-treatment interviews, each participant showed eagerness to talk about their first impressions, which may be seen as an evaluation of the whole experience, not a moment-to-moment description, as is the case for the rest of the data from the treatment.
session.

The first impressions of each participant were thus registered before viewing the video of the session. Some of the data derives from their first impressions, and these are marked in the text.

In the three post-treatment interviews, more of the participant’s evaluations, opinions and thoughts appear, as two other domains of interest – relationships and initiative – are added.

2.4.2 Choosing the first session

It was decided to film the first session on the basis of one-session studies (Connolly, Roe-Sepowitz, Sakai, & Edwards, 2013; Connolly & Sakai, 2011; Connolly, Sakai, & Oas, 2010; Gilomen & Lee, 2015). These studies show that the number of participants who scored positive for PTSD decreased after the first session, support the claims of TFT efficacy as a one-session therapy.

The author’s project took these claims into consideration. If the project participants’ experienced completion of therapy after only one session, investigation of the first session would be expedient to the understanding of experiences during therapy. Data would then be collected from a diagnosed PTSD patient. If the first session exhausted all traumatic content, the patient would no longer have PTSD. The study intended to investigate therapy experiences on patients who had a load of traumatic memory, namely PTSD-patients, and the first session was therefore chosen for investigation.

2.4.3 Choosing pre- and post-treatment interviews

The purpose of the pre- and post-treatment interviews was to provide an overview of the participants’ inner experience in their daily lives before and after a treatment course and thus gain a better understanding of their total therapy process.

A short treatment course of two additional sessions was therefore added to the plan, so that the participants would undergo a short therapy course of three 45-minute treatment sessions in total. The participants’ perceived inner experiences in daily life before and after treatment were described in a pre-treatment and a post-treatment interview.
A processual view implies a view upon alterations, in this study how phenomena emerge and disappear. This view would also reveal whether participants experienced alterations in their inner daily life beyond the three sessions, such as subjectively felt consequences in symptoms, behaviour or self-agency, as opposed to an emotional experience limited to the treatment session alone.

In larger samples, differences between pre- and post-treatment state might indicate effects of treatment. This small sample study does not focus on treatment effect but rather on the subjective experience of the process, where shifts in phenomena related to different points in time are described. The degree of subjectively perceived differences might inspire interest in carrying out a larger and more thorough study of effect.

The post-treatment interview was originally planned to take place one week after the last session, but this was shortened to correspond to the time limit of the study. Individual preferences and summer holidays set the final intervals for the participants to five, six and seven days, respectively.

Conducting a post-treatment interview less than one week after the third session meant that a very short time span was used. Because memory fades with time, it was assumed that a short time span would facilitate the perception of difference from pre-treatment state.

More research is required to determine whether the findings are replicable, and if so, if they are sustained over time.

The choice of a number of three sessions reflects the time limitations of a master’s thesis. TFT examines the most palpable feelings or sensations, and consequently not much time is required for the assessment of a trauma diagnosis, or for other evaluations. The low number of sessions also reflects the author’s work as a private therapist, where therapy consequences in the form of perceived life changes and inner development are commensurate with the client’s investments of time and money.

2.4.4 The therapist

The role of the investigator was to collect the interview data. Separating the roles of collecting interview data and performing the therapy was important, and to find a psychologist who was trained in TFT became vital to the study’s design.
This psychologist worked in the nearby out-patient clinic, and had undergone TFT training many years previously, but had not used it with patients. He therefore had little experience with psycho-sensory approaches, but had extensive experience as a psychoanalytic and cognitive therapist.

The use of the sensory points in TFT is easily learnt, and after a few hours of training with the interviewer and a volunteer, the psychologist had refreshed his knowledge of the method. The therapist’s treatment was transparent in the video-recordings and followed the TFT protocol as described in the appendix.

### 2.5 Data acquisition

Each participant had three individual weekly sessions and took part in three interviews. The treatments took place in the psychologist’s office, and the interviews were held in other rooms at the clinic’s premises.

The collected data include the three interviews and transcriptions from the recorded video.

#### 2.5.1 Recorded session

The first therapy session was video recorded.

The sessions were conducted thus:

- The therapist ensured that the participant was in contact with her traumatic memory, asking her to describe her feelings, her bodily sensations or thought content (e.g. an image)
- assessed by subjective units of distress, SUD
- followed by a short period of tapping on acupuncture points;
- the participant was again asked to describe what she was feeling, sensing or thinking; she then introduced the new feelings, new aspects or additional traumatic memories at this moment;
- tapping continued while this new matter was in her awareness and the sequence repeated.
Reflections on filming

The tripod-mounted camera was operated by the psychologist. Being filmed may have been a barrier to the willingness of the participants to join the study. The one drop-out in the study had expressed reluctance about this.

The interview was conducted as soon as possible after treatment; for practical reasons, this took place the next day. Some of the information would then come from what she expressed on film, while the rest would emerge from the follow-up interview. Memory of inner process is brief, so the recording was used as a memory aid.

There is a possibility that when watching the film, the participants may have produced or remembered inner phenomena that had not occurred during the session, had forgotten something or had confused their experiences. Attempts were made to eliminate these possibilities as far as possible by

- holding the interview as soon as possible after the session
- inquiring only about the phenomena, and not asking for opinions or explanation
- correlating the two sources of information - what is seen on the film with what is said in the interview. Incongruence between the two was not discovered in transcription.

These factors do not guarantee an absence of flaws, but are believed to minimise them.

Reflections on touch

In theory, the TFT touch intervention may influence the results – either positively or negatively. It may evoke a special, close emotional experience of contact, or it may create fear and the re-experience of trauma, especially in survivors of abuse.

All participants had experienced childhood traumas. When asked about their reactions to being touched, one participant said that she was only concerned with how comfortable the therapist felt; one had been anticipating that it would be worse, was aware of it only at the beginning, and was glad she had met the therapist before. The third participant said that it was unproblematic. While not absolutely conclusive, these answers do not indicate that touch, per se, had particular significance for the results. The reaction to touch was only described when inquired about by the interviewer.
The psychologist’s professional matter-of-fact introduction to the use of touch might have influenced the participants, along with the fact that the study’s use of touch was explained in the pre-study presentation.

The tapping touch is short and intermittent, and covers a small body surface area, making it qualitatively very different from other types of therapeutic touch, such as massage or Rosen therapy where the therapist maintains touch to larger areas over time.

Patients’ representations of touch as part of abuse or other trauma experiences are worth considering in any intervention utilising this tool. But when working with survivors of abuse, it must be remembered that good may sometimes paradoxically mean bad (abuse) and bad mean good (safe). Often, abuse is associated with friendliness and reward. Consequently, other positive attributes therapists convey, such as trust, interest and support, might for childhood abuse survivors be the very signs of danger and pending abuse. In this project, the therapist and interviewer relied on the participants’ consent and ability to let us know if they found touch distressing.

### 2.5.2 Interviews and the domains of interest

Each participant completed three interviews: a pre-treatment interview, an in-treatment interview and a post-treatment interview.

Pre- and post-treatment interviews:

The pre-treatment interview was held within one week before the first session, and aimed to show how the participant subjectively perceived her inner experience in daily life in the five domains of interest:

- her thoughts,
- her feelings,
- her body,
- her relationships with others, and
- her initiative, meaning her drive or energy level, her desire to work, her activity level and her ability to start and finish tasks.

The first three domains describe her inner experience.

The domain of relationships to others describes how she sees herself in relation to her surroundings, and with people close and distant.
The fifth domain, drive/initiative, reflects access to self-agency, and is an indication of the degree of vitality, where the individual is interested in living more fully, having new experiences and being active. Comments about behaviour are also included in this category.

All three interviews were semi-structured. The questions in the pre-treatment interviews were open and wide-ranging, and sought to elicit general statements about their well-being (Kvale, Brinkmann, Anderssen, & Rygge, 2009, p. 151). For example:

“Can you tell me about how your feelings are? Do they change often, or not? Are you often happy? Angry? Afraid?”

“Tell me about your thoughts. Do they stop you from being active? Are they good? Do you try to change them?”

“How is your body? Tell me about your breathing, digestion, sensations, illnesses/diseases?”

“Do you take the initiative to do new things?”

“How is your relationship with your family?”

Each participant gave individual answers to these questions, and follow-up questions were posed to explore their answers more fully.

In the post-treatment interview, these answers were revisited and the participant asked to assess any differences to or similarities with her present experience.

In this way, participants were able to describe differences in their inner selves from pre-therapy to post-therapy, and conveyed these to the interviewer.

**In-treatment interview**

The in-treatment interview was held the day after the filmed therapy session. The interviewer and the participant watched the recorded session in short sections. After each section she was asked how she remembered experiencing her awareness of body, feelings and thinking phenomena as she felt them at that particular moment in the recording.

In this interview only three of the five domains of interest were discussed. The domains of initiative and relationships were not investigated, as these topics were not related to the immediate present, which was the focus of the session.
**Dialect**

The Norwegian word “nei”, directly meaning “no” in English, is a dialectic expression in the geographic area where the study took place. It often comes at the beginning of sentences, and may be translated into English as “well”. Negative sentences or statements are often used to pose questions in the dialect spoken there. These questions may seem leading, but are not perceived as such by the local people. For the sake of the study, they were avoided when possible, and are used only when the question has already been answered to a certain extent by the participant.

**Translation**

The interviews were transcribed into English directly from the recorded Norwegian. The translation is as literal as possible, and attempts have been made to keep Norwegian expressions and linguistic metaphors. Any translation complexity is marked with a forward slash followed by the Norwegian phrase.

**Reflections on confluent speech**

The confluence concept has been borrowed from experiential phenomenological therapy – in this case Gestalt therapy – where in early writings it signified no resistance or differentiation, no formation of boundaries between two organisms. Today, confluence (“with flow”) is the contact mechanism of agreement, flowing together, not having clear differences or conflict (Korb, Gorrell, & Van De Riet, 2002, p. 39). Ultimate confluence is most clearly exemplified by the contact between a mother and her newborn, where contact sometimes feels so close that the boundary between the two is unclear.

The investigator has chosen a confluent way of speaking while eliciting information in the interviews, trying to some extent to use the techniques of Carl Rogers (C. R. Rogers, 1959, p. 223) in confirming the participants’ statements, thus creating feelings of confidence and trust in the interview setting.

When the interviewer shows understanding in a confluent way, there is a risk of influencing the information offered by the participant. However, if there is less confidence in the interview setting, the level of tension and fear rises, and less information will be shared. When fearful, the participant becomes cautious about opening up, as the natural impulse is to defend herself by witholding vulnerable information. When the level of trust is high, participants are able to disagree with the interviewer’s possibly leading questions, offer
additional information, interrupt the interviewer with a new thought and add supplementary points.

PTSD patients may often have had their relational trust compromised. The three participants had all been subjected to childhood abuse, which made trust and confluence even more important in the interview setting.

Therefore, the emotional level of trust in the interview is considered a more important factor in getting clear information than technically avoiding any question that might be judged as leading.

**Expectation and Subjective Units of Distress**

Expectation is a strong force in both therapeutic and educational empowerment, and might contribute to the results. The very act of participating in a study will generate expectations, as will a visit to the doctor, or going to school.

The study has not aimed to assess the degree of expectation towards this method, and the findings must be interpreted with this in mind.

Subjective Units of Distress (SUD) is a scale of self-assessment developed by Joseph Wolpe in the 1960s (Wolpe, 1969, p. 122) to show desensitisation over time (S. Rogers et al., 1999). The patient is asked how strong his feeling or bodily sensation is, and spontaneously expresses a figure from 0 to 10, or 0 to 100. In many modalities, including TFT and EMDR, it is repeatedly used throughout a session, and the patient’s spontaneous answers indicate the degree of desensitisation. Asking for a figure might lead the patient to be compliant, and please the therapist, though it might be less easy to please the therapist repeatedly over time, as new figures are offered.

**Interview details**

The full interviews are not included in the project, but background material is available on request.

I: the interviewer

P: the participant

Times when both talk at the same time are indicated using hyphens.

Short pauses are indicated by ellipses.
Unspoken communication or missing words are marked with parentheses. The five domains of interest for the study were colour-coded in the interviews:

**Body Thoughts Feelings Relationships Initiative**

The coding was extended to the condensation of the interviews, firstly to excerpts and then to tables for each interview.

Impressions of therapy are included in the post-treatment tables for each participant. These impressions relate to thought content, as opposed to awareness content of moment-by-moment phenomena.

In some of the interviews and tables, verbal material is excluded and withheld for privacy reasons. These areas are marked with a series of ellipses.

Time indications in tables and excerpts refer to the corresponding interview.

### 2.6 Data handling

The data for each participant were gathered from two sources: the recording and the three interviews. The in-treatment interview was merged with the recording to observe the treatments, and the pre- and post-treatment interviews were merged together to observe differences.

### 2.6.1 Handling the data from the in-treatment session

**Merging recording and interview**

In order to better understand the therapy interventions preceding the participants’ immediate reactions, the recorded therapy session was chronologically merged with the interview and separated into sections, and called an in-treatment interview. Each section included a description of a small segment of the recording, followed by the interview portion, where the client reported on what she had been aware of during that part of the recording. The in-treatment interview thus formed a chronological view of the therapy process, moving in detail between therapeutic interventions and the participant’s subsequent awareness of her three inner domains.
**Condensing into excerpts**

To gain a clearer understanding of the inner phenomena, surplus interview material was eliminated, and what remained constituted the excerpts.

The psychologist’s interventions and the participants’ awareness reactions were retained. Explanations, technical comments and the participants’ narratives, which constituted most of the contents of their thoughts were excluded. Expressions that showed awareness of thinking activity were included, such as “My thoughts are cotton”, or “here I am just thinking”.

**Separating the in-treatment excerpts into sections**

Each excerpt was separated into sequences around the tapping, which comprised:

- Firstly, the part in the recording where the psychologist converses with the participant about the painful topic, and helps her become aware in the now of the emerging inner phenomena of her painful feelings, thoughts and body. This is followed by

- A sensory part, where he taps on specific acupuncture points and the participant becomes aware of the most prominent feeling or sensation. The time of beginning and ending of tapping is noted.

- Lastly, the participant’s comments from the recording and from the interview, about her awareness of inner phenomena are included in this part.

The excerpt of participant A was made up of 7 sequences; participant B, 10 sequences; and participant C, 7 sequences.

**Condensing into tables**

Mainly in order to gain an overview of the material to analyse, tables condensed from the excerpts were made for each participant, showing their expressed reactions in thoughts, feelings and body throughout the in-treatment session. The in-treatment tables are included in the project, and provide a chronological overview of the process and time span. Here the intervention sentences were abridged to fit into a table.

The in-treatment tables show from moment to moment:

- the awareness of phenomena emerging from body, thoughts or feelings,

- the length of time in the sensory phase, and
the descriptions of changed phenomena after the sensory phase.

(See 7.1.1 - 7.1.3 Treatment tables)

2.6.2 Handling the data from pre- and post-treatment interviews

Condensing into excerpts
The pre- and post-treatment interviews were also condensed into excerpts.
In these interviews, there were five domains of interest: body, feelings, thoughts, relationships and initiative.

Here the time perspectives differed. When the participants in the pre- and post-treatment interviews were asked “How would you describe your feelings?” (or relationships, body, and so forth) the questions were very open, and referred to more than that actual moment; for example, how they had felt in recent days or weeks, in short, thought content. The awareness could not be as rigidly linked to a present moment as was the case in the in-treatment interview.

In the condensations, the material was abridged, and only remarks about the five domains of interest were retained.

Condensing into tables
Each participant’s pre- and post-treatment excerpts were compared with each other, then compiled in a table according to perceived differences and similarities after treatment. The full tables are included in the appendices (7.2.1 – 7.3.3 Tables).

2.7 Analysis

The analytical process of this project started in the interview guide, with the choice of including moment-by-moment awareness, but excluding thought content to get as close as possible to the participant’s momentary experience in the treatment session.
The awareness perspective included descriptions of experience data and excluded data mainly consisting of evaluation and explanations. The three analytical features of awareness – quality, strength and time – provided quite detailed data collection from the sessions.

Throughout the project, the awareness data aided and simplified a thematic analysis, which is the analytical method chosen here.

The study’s intention was to register descriptions of phenomena. A phenomenon is in itself a change, a novelty related to the point in time before its occurrence. Thus, the time perspective attaches phenomenon to process and change.

Change/no change thus was a core dimension of the project. Change in this project is considered as the difference between two unique moments in a human being’s experience. From a phenomenological point of view, it is not assumed here that the changes experienced would occur anywhere else other than in these participants, or apply to the time after these moments.

Leslie Greenberg states that in order to explain how psychotherapy produces change, a focus on the important in-session change episodes and their outcome is necessary (Greenberg & Kazdin, 1986). He also introduces the term Change Process Research as a methodological tool to register change:

    Rather than assuming that any given process has equal significance or a similar meaning at any point in therapy, it is important to segment therapy into different therapeutic episodes or events in order to understand process in the context of clinically meaningful units. One of the most important criteria for selecting episodes for study is whether or not they represent the process of change (Greenberg & Kazdin, 1986).

This study has chosen to examine treatment sequentially because TFT is already sequentially divided between exposing the patient to traumatic memory in her awareness and the sensory intervention.

Greenberg’s process research has been developed into different methodological designs, which all closely focus on the in-session communication between therapist and patient (Elliott, 2010). Elliott here mentions four branches of Change Process Research (CPR), where one is the Microanalytic Sequential Process Design, which bears relevance for the project at hand. This design analyses very short sequences of successive client and therapist responses
in order to observe the influence of therapeutic interventions on the patient’s process, and how the patient by her actions also influences the therapist’s activities.

This study follows Microanalytic Sequential Process Design in sequentially collecting detailed in-session data. It does not examine the relational process of the therapeutic setting, but rather the descriptions of internal processes as conveyed by the participants. This choice is based on the fact that TFT focuses on only one side of the relationship, namely the patient. Investigations focus on only one part of her experience, specifically her awareness and descriptions of internal phenomena during the sessions.

TFT’s focus on internal processes does not mean that relational factors are unimportant for therapy. All encounters in treatment are relational. As in all other treatments, areas such as trust, difficult therapeutic moments, contracts and expectations must be addressed and dealt with in TFT, but during the sensory phases in the process there is no time for, or focus on, the relational aspect. This may demand more of a therapist, who must deliberately pay attention to the necessary relational issues.

Before beginning the thematic analysis, this project’s in-session data were divided into sequences around the sensory phases of the session, and the patient’s awareness before, during and after each sensory intervention. Time spent on the sensory intervention was documented (see 7.1 Treatment tables).

The data were consequently chronologically organised when the search for themes in the data set began.

**Thematic analysis**

Thematic analysis was chosen as the analytical method because of its flexibility. The detailed data from the session and post-treatment interviews were organised by category and theme according to Braun and Clarke’s six phases of thematic analysis (Braun & Clarke, 2006) (Braun & Clarke, 2006).

1. **Becoming familiar with the data:**
   
   First, the data were transcribed, translated, read and re-read repeatedly.

2. **Generating initial codes:**

   Notes were made in the initial colour coding for the domains of interest and borders for marking change.
In the condensation of data into excerpts and tables, the time dimension of gathered information became clearer. The material was condensed into two parts with two different time concepts:

- the merged in-session recording/treatment interviews portray, in close detail, awareness of internal phenomena in thoughts, feelings and body, close to the moment in which they were experienced,
- the pre-/post-treatment interviews for each participant show the participants’ expressions of daily life change in the same inner domains over a longer time span covering several weeks.

The two different time frames in the two parts were determining factors in maintaining them as separate parts during condensation and analysis.

The two categories therefore included the experiences in the in-treatment interview and the experiences from the post-treatment interview.

3. Searching for themes:

   Category one: experiences in treatment
   - Theme one: desensitisation
   - Theme two: moving bodily focus and sensations
   - Theme three: losing thought focus
   - Theme four: desensitisation limited to the content of awareness
   - Theme five: mood at the end of the session

   Category two: post-treatment discoveries
   - Theme six: comparing pre- and post-treatment state
   - Theme seven: functions pre-treatment correspond to post-treatment initiative
   - Theme eight: new feelings
   - Theme nine: trauma memory not desensitised

4. Reviewing themes:

The themes for each category were repeatedly compared with the interviews, the excerpts and the tables.
5. Defining and naming themes: As described in Findings, each theme encompassed several elements, and were compared with the information from excerpts and tables and the research question.

6. Producing the report: Selected extracts of examples and tables were presented and controlled for relevance to the themes, along with narrated findings.
3 FINDINGS

In both categories, the in-treatment interview and the post-treatment interview, the participants expressed experienced differences from the pre-treatment interview.

In the section 3.1. “Category one: experiences in treatment”, the various kinds of change that surfaced during the treatment session are presented. The section is illustrated with examples from each participant.

The three domains of interest for the session are colour coded: **Body Thoughts Feelings**

Only the clearest changes are presented. For a complete overview of each participant’s change in the course of the session, see 7.1.1 – 7.1.3 Treatment tables.

In chapter 2 “Category two: post-treatment discoveries”, an overview of each participant’s post-treatment change compared to pre-treatment state is presented. Participants’ quotes exemplify the relationship between them.

In this category there are five domains of interest, and these are colour coded:

**Body Thoughts Feelings Relations Initiative**

Other post-treatment findings are presented in sections 3.2.2 and 3.2.3.

The stories of the participants are presented here to facilitate comparison with the findings. To gain a better overview of the changes, comparing each participant’s pre- and post-treatment tables is recommended.

**Participants’ stories**

**Participant A**

was in her late thirties. She had a husband and children, and had attended a family therapy centre for her problems. Her history was of sexual abuse as a child, a religious upbringing and her last trauma was that of giving birth to her stillborn baby five years previously. Her history included eleven years of treatment and support. During the two years before the
study, she had sessions with a psychologist and a psychomotor physiotherapist, and had previously undergone a variety of treatments. She had not worked for the past three years. Her everyday life was dominated by dissociation for three or four hours at a time. She struggled with overwhelming bodily pain, flashbacks, anxiety, dissociation, sleep, and having to be a mother of three.

She slept her days away, and her body pain on her right side had extended to her face; she even had a tooth extracted in an attempt to lessen the pain.

**Participant B**

was in her fifties. Her story was of childhood abuse and the feeling of having been excluded as a member of her birth family. Her life had been full of anxiety; she had constantly been alert and fearful of other people’s reactions to her. Twenty years previously, she was in psychoanalysis for a few years with the psychologist who performed the treatment in the study. In total, she had been in treatment for 14 years with a number of different psychologists. Four years previously, she had a three-month stay in an institution specialising in psychotherapeutic approaches. She had an important and alarming experience in art therapy, indicating repression of traumatic parts of her life. Her symptoms and fears worsened after this experience, and she experienced constant anxiety. The two years before study start she attended psychomotor physiotherapy.

**Participant C**

was also in her fifties. She was severely abused by her father from the age of three until she was eighteen. As a child, she was also abused on two other occasions by someone other than her father.

In adulthood her memory of this was repressed, until she started therapy for her eating disorder at around the age of forty. She had attempted suicide on a number of occasions, and had been admitted to a central psychiatric institution several times. At around 40 years of age, she started working as a support person and subsequently underwent vocational rehabilitation. She stopped working three or four years before this study began. In the five years prior to the study she had attended psychomotor physiotherapy. At the time of study
start, she had regular supportive talks with local community psychiatry professionals, and attended a day centre twice a week. In her everyday life she often dissociated for three or four hours, and afterwards she could not remember what she had been doing during the lost time. She had made her own safety routines such as never looking at herself in mirrors, always looking for a way out, never attending parties and many other precautions.

Throughout her life she had had an interest for physical exercise, which she did several times a week. She lived alone and had children and grandchildren she sometimes visited.

3.1 Category one: experiences in treatment

In the in-treatment interview all three participants reported a high degree of phenomena related to desensitisation, and described in-session change in their internal sensations.

Interventions
The sessions started with broaching sensitive topics related to the participant’s traumas, where the therapist inquired about awareness of pain in the three domains of thoughts, feelings and body: how strong this awareness was and where it was felt. Then he tapped at the sensory points (6.1.2 TFT method), before again asking about awareness. “What do you feel now? Does it hurt as much, more or less? Are you more aware of your body or your feelings?” and related questions.

Then he started a new sensory sequence.

Time in sensory phase
During their first session, one of the participants was in the sensory phase for nine minutes in total, one for seven and one for eight minutes (See 7.1.1-7.1.3 Treatment tables).

Consistency in desensitisation
A strength reduction in the experience of painful awareness content was reported in 22 of a total of 25 sequences of sensory intervention (See 7.1.1-7.1.3 Treatment tables).

Themes
Five themes were identified in the treatment experiences. They are each presented here with tables of therapy sequences describing the findings. In the tables I: is the interviewer, P: is the participant. Direct quotes are in italics.
3.1.1 Desensitisation, exemplified by participant A

All three participants reported that during the sensory stimulation their feelings became less painful.

The table below renders one entire sensory sequence visual of participant A. The table is organised to include the time of the sensory stimulation and the change in the three inner domains.

Table 2 Sequence of sensory intervention, participant A

<table>
<thead>
<tr>
<th>Sequence 4</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness</td>
<td>Asked about her baby. Imagining catastrophe.</td>
<td>Paralyzed.</td>
<td>Same pains as she had when her baby died. Quivering. SUD 6.</td>
</tr>
<tr>
<td>before tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>25 sec, pause 20 sec, 30 sec, pause 15 sec, 65 sec</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Her thought content became distant, and she became unfocused. She received some answers to the connection between her pain and her early history.</td>
<td>Feelings improved. A constant inner feeling of unrest is much calmer. She laughs.</td>
<td>Her body is very much better, less pressure in chest. Nausea is lessened.</td>
</tr>
</tbody>
</table>

On a subjective unit of distress scale ranging from 0 to 10, in this sequence she expressed subjective distress at six before the sensory intervention, but she did not provide a SUD value afterwards.

Therapists’ requests for the patient to assess her SUD may sometimes interfere with her inner process. Here she was only asked about what had changed.

After each sequence, a new topic was introduced in conversation, activating new painful feelings and bodily sensations; the sequence was repeated throughout the session, until at the end there was no painful material present. For this participant, a total of seven sequences
were required. After the last sensory intervention she was clearer in the head, she had no nervousness, was totally calm in her body, and there were no bodily aches.

Note that change in this sequence occurred in all domains, which was not the case in every sequence investigated.
For a chronological overview of all sensory sequences for each participant, see treatment tables.

### 3.1.2 Moving bodily focus and sensations during sensory intervention, exemplified by participant C

All participants described painful bodily sensations developing and emerging during conversations and receding during the sensory intervention.

Participant C described unusual phenomena: during the tapping, her felt focus of bodily discomfort moved within her body, sometimes increasing, changing into a different sensation, then subsiding and ultimately disappearing.
In the sequence below, participant C experienced pain in her chest. She has been telling the therapist about her worst flashback.

*Table 3 Sequence 1 of sensory intervention, participant C.*

<table>
<thead>
<tr>
<th>Sequence 1</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Flashback content of her pregnancy after being raped by her father</td>
<td>Discomfort in chest and body. SUD 7-8</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>22 sec</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>(She is not asked about her thoughts here, as he soon starts tapping again.)</td>
<td>Her anxiety “rose a bit.”</td>
<td>What had been stuck in her chest, “went to her stomach and a bit out”.</td>
</tr>
</tbody>
</table>

When she says it “rises a bit and a bit out”, she makes an expanding gesture with her hands.
During her therapy she has many bodily sensations, transforming and changing through the course of the session, shown by the sequence below:

**Table 4 Sequence 2 of sensory intervention, participant C.**

<table>
<thead>
<tr>
<th>Sequence 2</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>An absurd situation. She is in the hospital after a miscarriage of the abuser’s child. In front of the doctor the abuser asks her who she has been with.</td>
<td>Sensation in stomach. Frozen inside, but warm. Prickling sensation in the whole body, especially in hands</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>2 min 25 sec, minus a few seconds when she says it is good to be able to feel</td>
<td></td>
<td>Diminishes during tapping. Better breathing. She gets a limp feeling, hardly able to keep her head up.</td>
</tr>
<tr>
<td>After tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the interview, she describes her feeling during the tapping.

*P: It was on the inside it was cold, on the outside it was warm, and then it pricked.*

*I: And it pricked. And that feeling, did that go away now that he started tapping?*

*P: Yes, it gets smaller and smaller as he is tapping now.*

For many years being on medication she did not have any feelings at all. In therapy, most of her reactions to the sensory intervention were bodily phenomena.

The other participants did not describe experiences of phenomena such as those described in the table above. They experienced that the bodily pains they had focused on in awareness reduced during the sensory intervention (See 7.1.1 – 7.1.3 Treatment tables).

### 3.1.3 Losing thought focus, exemplified by participant B

During the sensory phases, participant B described repeatedly losing her train of thought about the painful situations during the session.
She experienced in five of her ten sensory sequences that she could not retrieve her thoughts after the sensory intervention.

Table 5 Sequence of sensory intervention, participant B.

<table>
<thead>
<tr>
<th>Sequence 1</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Her constant fear of not being good enough, not for her mother, not for her partner</td>
<td>Cries</td>
<td>Feeling in stomach and throat is SUD 8-9</td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Drawing away, cannot keep focus.</td>
<td>The strong feeling goes away, when tapping.</td>
<td></td>
</tr>
</tbody>
</table>

Irretrievable thought content

Participant A was very confused about the sudden losses of concentration/thought. During the sensory phase, she experienced the focus of awareness changing involuntarily, sometimes to another aspect of her painful memory, sometimes alternating to the bodily sensations, and sometimes jumping to another incident.

She had been instructed to think about her dead baby, but when the sensory intervention started, it was impossible for her to hold that in her consciousness, and her thoughts involuntarily turned to how she had protected herself in that situation: by thinking only of herself. This participant describes herself as always trying to do the right thing and follow instructions.

In the conversation below, she is watching the recording with the interviewer:

P: I tried to get back on track, get back, and retrieve the picture I had in my head, and...

She says she does think about the situation, but she cannot really imagine how it was. She became very confused about that.
I: He continues tapping. Do you remember what you were aware of?
P: I became very confused, because ... It was like - I could not manage to be in that situation any more, or how to put it ...

In the following conversation with the psychologist, he tries to get her to think about her worst experience, her dead baby. Her answer is that

- my thoughts were only spinning around myself.

... P: Yes, he actually asked what my focus was there and then when it happened, and I cannot remember anything else than how I experienced it myself. I do not remember what was happening around me.

She is trying to think about the moment she got the message.

P: During his tapping, no matter how hard I tried to think about that situation, other things kept popping up, other ... and then I tried to somehow push those away and not think about it.

3.1.4 Desensitisation limited to content of awareness

The participants did not report a general desensitisation of all painful emotional and bodily feelings at once; the desensitisation was limited to the awareness content of feelings, thoughts and/or/ bodily discomfort.

In the periods of talking between sensory phases, related or new painful memory content was introduced. The participants reported increased painful sensations and feelings during the conversation, and desensitisation during the tapping.

Participant C says:

I would say there is a change. At least those things that have been in my thoughts during the treatment now, they have become weaker... when he has been tapping, what I have held on to and what we have worked with.

During the sessions and in the interviews, the participants reported that their feelings were subsiding during the sensory phases and coming to the fore during the conversations, where new traumatic memory was brought up. Referring to her first impression after the first session, Participant A describes her experience clearly.

I was not able to explain what was wrong and what I was thinking about. But he asked me to be aware of ... the pains I have in my body and the feeling of being suffocated, and ... And then I felt very clearly that when he tapped at the different spots, it was as if the bodily symptoms became milder, in a way. The dizziness and nausea I had in my
stomach became lighter, and then he stopped tapping, and then we started to talk about this again, and then it increased again. And then he tapped more, and I felt it got better, and it got better for a little while, and then we started to talk about things related to what I felt today, and then I felt it got a little worse again, and then he tapped again, yes, we kept on like that for a while. And I felt that in the end I was so calm in my body, in my stomach, and I did not feel sick any more, but I still feel a little in my throat.

3.1.5  Mood at the end of the session

In the recording each of the three participants smile and laugh a little at the end of the session:

Participant A

At the end of the sessions she smiles and laughs a little. The interviewer asks about her expression preceding her smiles.

I: You say you feel relaxed and clear in your head. What happened to make you feel relaxed and clear?
P: I am not sure at all.
I: shall we watch again? (We do. The recording shows he asks her to do the eye roll. See 6.1.2 TFT method)
P: I do not quite remember that. But I remember I felt all calm in my body...no nervousness...and no aches.
I: Ok! (we both laugh).

Participant B

In the in-treatment interview we watch her in the recording inhale deeply towards the end the session, and the interviewer asks about that.

I: It was good to take a deep breath? You managed?
P: Yes. I managed. It was like something was released, or something had stopped.

In the recording we watch her stamp her feet on the floor with a big smile. She feels she cannot quite recall her thoughts (the situation of floating into the partner, pleasing), and explains this by saying she is probably getting tired. The psychologist asks if it is warm in the
room, her cheeks and chest are red, her face is vivid and smiling, and she is touching her chest. In the interview she just says

P: (laughs a little) I think I sat a little like that, I think. I felt I sweated.

Participant C

By the end of the session she had a tune in her head.

P: I think that was so weird (tune). I: What did you say now?
P: - That the tune just took over my thoughts. It was “Love”, with Sissel.

In the recording they are talking about the tune, she smiles and laughs several times, saying it was good. She talks more vividly, answers quickly, laughs heartily and seems happy. In the interview shortly afterwards she says:

I felt that my head was very..it was not.. it was very exhausted. It was empty. Empty and tired. It got even worse when I got home.

### 3.2 Category two: post-treatment discoveries

This category presents an overview of each of the participants’ inner state after treatment, and differences from pre-treatment state.

The participants report how they currently perceive their inner state, everyday phenomena regarding thoughts, feelings and body. As in the pre-treatment interview, they are also asked about their social and family relationships, and their level of initiative or self-agency.

The initiative domain is an area of special interest. Here are listed differences in behaviour and new desires and intentions, as well as increased activity.

Four themes were identified in the post-treatment data.
3.2.1 Comparing pre- and post-treatment state.

These are examples of how the patient describes her state in one of the five domains of interest before treatment, the focus during treatment and how she describes her life after treatment.

A full overview of each participant’s description of her pre-treatment state is provided in pre-treatment tables (7.2.1-7.2.3).

Participant A describes her bodily sensations **before treatment**. Direct quotes are in italics, and the sentences are organised thematically:

- *My bodily reactions constrain and trash my whole life.*
- *I have panic anxiety, where I get heart palpitations, shivering, cold sweats, I feel my legs will not carry me, I almost just want to faint.*
- *I had problems breathing, I still have. Periodically I hurt when I breathe. But then I also have a tendency to stop, and not breathe. I do not have asthma or any particular disease.*
- *I have a lot of pain. After losing my boy, after some time I started to hurt immensely in my neck, and head, and jaw. I ache all the time. I have numerous aches, especially on my right side. It is my throat, all the way around the right side of my face, it is my jaw, my ear, right side of my head, my neck, my back and then I have started getting aches down my leg and my hip. The aches move and I get aches in other areas. I hurt across my chest, at one time I thought I was having a heart attack.*

Her everyday life was severely curtailed by her symptoms. She dissociated for three or four hours at a time. She struggled with overwhelming bodily pain, flashbacks, anxiety, worries, catastrophic thinking and nightmares, dissociation, sleep, and having to be a mother of three.

**During treatment**, participant A only concentrated on her most recent loss, her stillborn baby. She did not work in therapy with her childhood abuse story. During the session, she described a great deal of phenomena in the three domains: body, feelings and thoughts.
After treatment:
The overview below shows that she described considerable differences in daily life from her pre-treatment condition in all domains, particularly in the domain of initiative. The five domains investigated in the study are coded in the following colours:

**Body**  **Feelings**  **Thoughts**  **Initiative**  **Relationships**

Table 6 Participant A, overview of expressed differences from pre-treatment interview.

Pain right side; jaw, throat, neck, arm, legs are better. Less bodily pain, but it still is there.
Breathing pains are better.
Headaches are better.
No pain killers for five days. Used to take more.
After she got angry (new) with husband, relief in her body.
Calm in body after sessions, still lasting now.
Previous therapy made her think, ponder heavily
Panic anxiety when outside and often at home as well, with heart racing, shivers, cold sweats,
legs unable to carry her; she thinks she had one last week.
Continuous anxiety is now different, better, less. Connects it to a session. Drove home calm.

More confident in herself.
She felt “lighter” after treatment /then later having down periods.
Has before tried to avoid feelings, not to relate to them. Now she may have a lump in her throat, as if tears are welling. New. Extremely scary.
Has been silent and withdrawn; in disagreements with husband. Now angry, irritated. It is a new thing to be angry. Recognised anger when aware of her own brisk movements.
Relieved after yelling at husband.
Never knowing what could give joy. Now finding enjoyment in making sandbox, fixing things, a new feeling.
Feeling less of being surveyed during day-time.

Less time analysing.
Twisting things into a negative direction; this has become better. Not twisting so much, not so bad.
Less pondering after taking kid to day-care. Analyse, but not that long.
Not having catastrophic dreams, but that used to happen periodically.
Catastrophe thoughts lasting shorter.
She is now getting to know what is nice for her.
Worries less, she connects it to one special session; calm after session, less worried now.

Sleeps less during daytime. Does not experience the extreme tiredness like before.
Started to exercise, with other people.
Yelled at husband. All new.
Making sandbox for her boy. Painting garden furniture.
Has the desire to do things.
Being alone one night. New, but she was anxious. She is better at being alone during daytime.
Wants to put herself to the test, challenge herself.
Wants to be in shape.
Wants to function among people.
Has been going to shop, also with child. Earlier with strong anxiety. Now less anxiety, more able to shop.
More energy. Goes for walks. Does several things in one day.

P: I was at the shop yesterday, then I had my youngest boy with me, which is something that initially stresses me very much, for then I have to take care of him, in addition to finding out what I have to buy, in addition to maybe having to relate to other people, and the buzz around me, it usually gets too much. But yesterday it went quite well. I was quite quick, I just purchased a few things.

Talked with husband after being angry. New. They have never done that, really talked.
New awareness: She became aware that her parents walked right over her.
Has become closer to a friend, whom she talked to on the phone while being home alone.

After each session, she experienced calmness in her body. The anxiousness and bodily symptoms slowly returned between sessions, but her calmness continued for the five days after her last session.

She still dissociated:

I dissociate so that I do not feel how I am.

Participant B

had a life of deep anxiety.

Before treatment:

In her pre-treatment interview she says:

I am very alert in situations, when I come into a room, I am quickly aware of the atmosphere. I am extremely “out there”, so I have very little presence inside of me. I have been afraid all my life. When my dad did not come home, I was always on my toes, I had to look for the lights, for the cars.
Participant B describes her painful thinking pre-treatment:

-I have a guilty conscience about people at work, all the time, it is as if it lies inside me. That I do not do it well enough, that I am not, not good enough. It lies there...
- The sorrow that lies there, you know, under everything, it was triggered at (name of institution) four years ago. And of course, when I talk with you about it, and start talking about that loneliness, then it gets terrible (tears up). There is more sorrow now, for I have understood how terrible it has been, (crying) how lonely it has been.
- No, I do not feel so much joy. I have somehow not been able to be allowed to lean back and be me. I have not found out what is good for me, what is my joy? - and there lies a sorrow (cries).
- I am very short-tempered. When I was a little, I had extreme anger when I got angry. But I pushed it down.
- I am afraid all the time. I get afraid that I shall not be present for my partner, a little afraid for the future, for my economy, I am also afraid of being alone, afraid to walk in the fields alone. I am afraid of being harmed, I am scared to death of being killed, or that someone shall hurt me. All the time I have a fear inside me. My biggest fear in all my life has been losing close relationships, fear of not being good enough for my child and for my partner.
- I am not so indifferent. I am quite dedicated, really, in a lot of things.
- I have made myself a bit numb about the people I miss.

She also describes in the pre-treatment interview the way she used her thinking as a protection mechanism:

P: I think very much ahead, there ahead, then, because it gets too.. There is a kind of solution up there ahead... I visualise the future. Maybe a year ahead, or two, maybe three. I hope sleep comes in a year or two, maybe I will find a way back to myself a little, or become a little calmer in everyday life, or get help from someone.
I: Do you think a lot about what happened to you in your childhood?
P: Yes, I actually do. For I think it characterises me so much today. I do think a lot about my childhood. I do think many of the thoughts over again... I protect myself against it.
I: You protect yourself against.. the old part of your life..?
P: Yes, when I was little, that extreme loneliness, yes.
I: And you protect yourself by....
P: Thinking ahead.

In her daily life, she pushes herself to attend to normal activities. She is constantly in an alarmed state scanning her surroundings and people around her, and has the feeling of a continuous “motor” of anxiety and fearfulness, involving mostly feelings and thoughts.
During treatment, the phenomena from thoughts were most apparent for her. Despite trying, she was unable to retrieve painful thought content in five of ten treatment sequences after sensory intervention.

After treatment:

At the beginning of the post-treatment interview, she thought there were few differences in her inner experience in her daily life from before treatment. When she was presented with her description of her pre-treatment state, she recognised differences in many areas. Most of the changes she describes relate to her way of thinking.

Table 7 Participant B, overview of expressed differences from pre-treatment interview.

<table>
<thead>
<tr>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less pain in neck</td>
</tr>
<tr>
<td>Less breathing problems</td>
</tr>
<tr>
<td>Left shoulder hurts less</td>
</tr>
<tr>
<td>No problems any longer stretching arms out</td>
</tr>
<tr>
<td>Calmer.</td>
</tr>
<tr>
<td>Permits herself to have the feeling of disgust. “If I feel like that, it is all right.”</td>
</tr>
<tr>
<td>Not so extremely afraid. No need to have closeness all the time, or confirmation.</td>
</tr>
<tr>
<td>Reduced use of tranquilisers for the past two weeks, from one or two a week to a half now.</td>
</tr>
<tr>
<td>Less anxiousness; it comes and goes, which is new. But it was not there yesterday morning, which has almost never happened.</td>
</tr>
<tr>
<td>Less afraid to walk in the mountains, less afraid of being alone.</td>
</tr>
<tr>
<td>More irritable, maybe more touchy.</td>
</tr>
<tr>
<td>More angry about her deceased mother, and her partner, more aware of it, and allows it more.</td>
</tr>
<tr>
<td>Less confluence, less of her attention is on other people. She feels more present in herself.</td>
</tr>
</tbody>
</table>

Pre-treatment:

Well, I cannot find calm. I mean, yesterday I was extremely restless, extremely, so that I thought my God, I cannot handle this, I cannot endure this restlessness. And I never experienced that until I came to the institution. This extreme... it is like a motor inside you, you know. Where you think, my God, if my body cannot relax...

Post-treatment:

Yes, after the first time I noticed that it was a bit calmer in the evening, and the anxiety diminished a bit, actually, yes. That has returned. I do have some restlessness, I have. It
She is beginning to believe that she can take it easy now. No need to master everything. Thinking less ahead, more in the now, more at one with herself. She used to deliberately think ahead to avoid painful thoughts. Putting herself in focus. She has been afraid of a person, but now she thinks it is not good for her to be with someone who is not kind to her. A new thought. Setting down boundaries. Thinking that is theirs, and this is mine. When she gets scared, she thinks it is possible to wait for a while. New. She had forgotten her sleeping pills, then had a new thought: Never mind, I just have to stay awake, then (she slept). Her anxiousness is existential. New view.

Sleeping better. Falling asleep after waking up. Has reduced use of sleeping pills. Used to take every night, has not had a night without medication in approximately four years. Writes down her feelings of both anger and joy. Plans to stay in a somewhat isolated house for a week. New. Was afraid to be alone. More aware of tiredness. Allows herself to feel tired, and to have “one of those days”. “Lower shoulders”, more relaxed, slower pace. Able to feel she is always worn out.

Close relationships feel worse. More guilt for her child. Less shame. There are other things about the child that might be good. More angry towards partner. Partner is perceived as more annoyed. More afraid of partner. Conflict with family relation.

Some of her restlessness returned between sessions, as well as after treatments.

Participant C

Before the study starts, she leads a quiet life with the same physical exercises she has been doing all of her life. Exercise has been her safe haven. She socialises with her children and grandchildren, and has developed rules for herself, such as always to look for a way out, never go to parties, never to try on clothes when in stores, and many others. Her problem is the dissociation, which takes place when she unexpectedly encounters something that triggers her memory about earlier traumas, and which lasts for four or five hours.
When the psychologist asked her during treatment to focus on traumatic memories, it was easy for her to recollect the painful experience, and she started the treatment with her most traumatic memory.

During the sensory intervention, she experienced a variety of new and unusual sensory phenomena in the body, which gradually faded and disappeared (see 7.1.3 Participant C Treatment table).

In the post-treatment interview, it becomes clear that the body is not the domain in which she experiences the most differences, it is in her feelings she experiences the biggest difference. She also dissociates less after treatment, for shorter periods, and it is easier for her to stop the process when she is about to dissociate.

Of the three participants, she experienced the least differences from the pre-treatment interview.

Table 8 Participant C, overview of expressed differences from pre-treatment interview.

<table>
<thead>
<tr>
<th>She feels heavy and exhausted five days after last session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now she is passive about her body. Before treatment, actively tried to repress she had one.</td>
</tr>
<tr>
<td>Had anxiety attack, but less severe. No panic attack.</td>
</tr>
<tr>
<td>It takes time for her to feel that she is sad. Her feelings used to feel flat.</td>
</tr>
<tr>
<td>Calmer on mountain hikes than before. Is calmer than what she used to be.</td>
</tr>
<tr>
<td>But more jumpy.</td>
</tr>
<tr>
<td>Joy over having done something well. That is new.</td>
</tr>
<tr>
<td>Does get tense, but can snap out of it.</td>
</tr>
<tr>
<td>Feels that something in her past life is now in a box. Used to carry it on her back. Has put it away.</td>
</tr>
</tbody>
</table>

Some of her hurtful thoughts have changed.
A bad memory triggered by a movie got better.
Those things that have been in her thoughts during tapping are now weaker.
Less dissociating. Not as often and not for so long. She is better at stopping the dissociation, if it is not too sudden.

Still drained after therapy.

No change in relationships.
In between sessions she is totally worn out. The exhaustion gradually subsides, but is present until next session. Post treatment she is still exhausted.

P: Well, it is tough to think about things when he is tapping, and tough afterwards, for I get so both physically and mentally very drained.

3.2.2 Functions pre-treatment correspond to post-treatment initiative

It appeared that for each of the participants the degree of impaired daily life function before treatment corresponded to the amount of post-treatment increase in initiative. It also appeared that the degree of daily suffering or painful symptoms before treatment corresponded to the amount of post-treatment release of those painful symptoms.

Participant A, whose daily life was most curtailed by her trauma history in all domains of interest, described the highest level of change in all the domains of interest, both during the treatment session and after sessions (See 7.2.1 Participant A pre-treatment table, 7.3.1 Participant A post-treatment table).

Participant B’s daily life was not as curtailed as that of participant A. She had severe anxiety, and spent a great deal of time on thinking activities, trying to control the future and imagining other people’s moods and opinions. In spite of her anxiety, she did pursue activities in her life. Post treatment she described changes in all domains, particularly in her thoughts, both during the treatment session and post treatment (See 7.2.2 Participant B pre-treatment table and 7.3.2 Participant B post-treatment table).

Participant C had led a very dramatic life, but now she lived calmly with a rigid structure of activities, including physical exercise. She described several unusual phenomena in her body during treatment, but fewer changes after treatment, except for extreme bodily exhaustion (See 7.2.3 Participant C pre-treatment table and 7.3.3 Participant C Post-treatment table).
3.2.3 New feelings

Two participants described the emergence of feelings that had not previously been present or that they had not been aware of before therapy.

Participant A became angry at home, which was a new feeling for her; she also got sad, which was also a new feeling.

I: And now, do you feel sadness at times?
P: It is those, maybe those two feelings that I felt during this weekend, and maybe after one of those treatments I felt I got that lump in my throat and it started to build up-
I: - what do you call that?
P: It is probably sadness.
P: After I got angry with my husband and we had talked, I felt so relieved in my body.
P: Yes, now I have actually been angry, or irritated. I felt irritated.
I: Is that something new?
P: Yes, it is something new.

She also became aware that her parents were invading her privacy, meddling in her life.

P: - a very strong feeling that something was not completely right, for my part. And I realise, they walk right over me.

And she suddenly noticed there was joy.

I: You manage to do things, and you say that some of these things actually give you pleasure.
P: Yes.
I: And the last time you said you did not really know what or how, but you remembered there were things giving you pleasure, but you did not really know if they could bring you pleasure now, for you did not know what was joyful.
P: Yes.
I: Is that different?
P: Yes, what is new to me, is that I feel that it is nice, to make a playground, it is nice to sand a bench and paint it, and... and I hold on to that feeling, for that is the one I am looking for.

Participant B describes her new feeling, which she finds difficult to name.

P: I allow myself more to think like...: feel now, just feel how you really are. And it is a bit new to me that I let my shoulders down and I am just inside of myself, you know. And then I feel that I am actually worn out. I could have stayed in bed for a long time. ...But if I really listen to myself, then... I shall do that, listen to what the body says.
P: It is a bit of putting myself in focus.
P: .. and then it is sort of like I think, I have to protect myself, and protect what is inside my space... Like I..try not to spread myself so much. For I have tried to satisfy others. I have spent a whole life doing that.

P: Yes, .. I do not spread myself so much, I do not interfere in..., well, floating into others, in many ways, like I have always done.

P: So maybe it is a little about protecting myself, maybe a little, the placing of boundaries. You know, I have never liked to see others suffer, and automatically, it has been my fault. I have been sensitive to everything, where others feel pain, in a way. Maybe that has receded a bit, too. Maybe I am a bit more inside of myself.

P: Maybe I can compose myself more, and be a little more in the now. Since I am a bit calmer, it is maybe a little easier for me to stay in the here and now. Maybe. It is a bit about putting myself in focus.

She is now focusing on herself, protecting herself a little more and is more aware of her own boundaries, thinking “that is theirs” and “this is mine”.

### 3.2.4. Trauma memory not desensitised

At the beginning of treatment, participant B is asked about her traumatic history. Her first association is the moment during an art therapy session, when she was assigned to draw her father. She says in her pre-treatment interview:

> At the institution I was supposed to draw my dad, and it was all black, I could not have made it more black than... than... it was so black that it was...I used black and black and black and black and black, so that...yes... I think yes...now I switch off. It gets too much for me, actually, not too much, but when I start talking about it, I get such cotton in my head (tears).

This moment was the first image in her awareness in the treatment session, but sensory intervention was not initiated at this moment. This image was not treated during the sessions.

The sensory interventions began by the time the next image emerged– her fear of not being good enough for her mother, nor her partner– and painful subject matter was treated.
4 DISCUSSION

Research question

The purpose of the research question was to gain a better understanding of the patients’ awareness of their inner experience of phenomena during a TFT therapy course:

How do PTSD patients describe their inner experiences before, during and after Thought Field Therapy?

Findings and relevance

Two main topics in the findings pertain to the research questions: the participants’ descriptions of in-session desensitisation and their descriptions of post-treatment change.

In-session finding, desensitisation

The three participants described desensitisation of painful feelings and bodily discomfort during sessions in addition to losing focus on traumatic thought content, which sometimes could not be wilfully retrieved.

The desensitisation process was described as being limited to the sensory phases, and the tapping during each session lasted for less than ten minutes. The change in awareness phenomena during this phase was described as taking place in all investigated domains: desensitisation of emotions, transformation and relief of bodily pain, and an inability to focus on desensitised awareness content. Each participant presented a unique process and a different degree of change in each domain.

They also stated that the process of desensitisation was limited to their awareness content during the sensory intervention.

During conversations between sensory phases, subjective distress increased with exposure to new aspects of the traumatic memory or when new traumatic memories were introduced.

For one of the participants, her awareness content seemed not to be consciously controlled. During the tapping, she struggled intensely to focus on a specific trauma, but was unable to do so, despite her great efforts. Other thoughts emerged in awareness and prevented her from
concentrating. The contents of those thoughts were not identified, and it is not known whether they were traumatic or not.

No explanation has been found for the desensitisation process described by the participants in this study, but resemblance to TFT’s sensory phase has been found in EMDR’s reprocessing phases 3-7, as described in Shapiro’s 2011 article in which she refers to a specific case (Shapiro & Laliotis, 2011). Exposure to traumatic memories and present awareness of body, feeling and thoughts and the therapist’s efforts to access the earliest memories of present painful awareness (see 6.1.2 TFT method) are similarly practised in the two modalities. The sensory phases in which desensitisation occurs were brief in this author’s study, and are also described in EMDR (Shapiro & Laliotis, 2011). The same sensory sources of touch, vision and sound are now used in EMDR and TFT modalities. Comparable to this study, the Shapiro article (Shapiro & Laliotis, 2011) also reports additional memories spontaneously emerging (see 3.1.3 Losing thought focus). There is still no consensus about the neurophysiological basis of EMDR (Greenwald & Shapiro, 2010; Solomon, Solomon, & Heide, 2009), or TFT, but the similarity between the two approaches might warrant future investigation into the sensory aspects of desensitisation.

Post-treatment findings

Correlation pre-and post-treatment

In post-treatment interviews, there appeared to be a positive relationship between each participant’s degree of impaired daily life function pre-treatment and her degree of post-treatment initiative. There also appeared to be a positive relationship between the degree of daily life suffering or painful symptoms pre-treatment and the degree of post-treatment pain reduction in those areas. The sample is too small to establish a connection, but the finding calls for larger studies of pre- and post-treatment comparison. If correlation is found between a high degree of pre-treatment impairment and a high degree of regained self-agency, it may have consequences for PTSD treatment.

With the use of awareness descriptions and follow-up assessments in 12 months, larger studies could explore this possibility and confirm or refute this connection.
Not all traumas treated

Another post-treatment finding is that in this study TFT was not a one-session therapy. The choice to examine the first session was made to address the possibility of exhausting all traumatic subject matter in one session, as described in some studies (Dunnewold 2014) (see Selection and criteria). For the three TFT participants in the study, elimination of traumatic subject matter in the first sessions did not occur, and even after three sessions, some traumatic content remained.

One of the participants indicated that important childhood traumas were not treated during the sessions. These trauma memories might have been subconsciously blocked from desensitisation (see 3.2.4 Trauma memory not desensitised). A more detailed trauma history might have resulted in these important issues being treated.

Mapping a more detailed trauma history is also a suggestion for TFT practitioners. TFT has been promoted as a self-help process, and is supported by studies (Connolly & Sakai, 2011; Feinstein, 2012). Based on the findings of this project in working with severely traumatised people, the absence of a systematic focus on patient history has surfaced. Traumatic content undiscovered in a less comprehensive process can be treated and revisited after interventions.

Consequently this study lays the ground work for a more extended study to map a systematic trauma history for each participant, and to continue treatments until the participants themselves no longer experience traumatic subject matter.

Body pain

One study participant experienced daily pains on the right side of her body. After years of gradually worsening pain, numerous examinations with negative results and treatments without improvement, she concluded that they were related to her traumas. Her pains were influenced by the tapping procedure many times through the sessions along with the desensitisation of painful emotions, even when she did not convey the nature of her painful thoughts before tapping (in 7.1.1 Participant A treatment table, sequence 2). At one time during therapy, she expressed a new point of view in which she had found a connection between her pains and her early history (see 7.1.1 Participant A treatment table Sequence 4). The other participants experienced bodily pains that emerged in the exposure phases and receded as the traumatic memory content was treated (see 3.1.3 Losing thought
focus...Participant B, and 7.1.3 Participant C treatment table).
The connection between life burdens and body pain is well established (Anna Luise Kirkengen, 2010; Anna Luise Kirkengen & Ulvestad, 2007). The project participants’ experiences in desensitisation represent a comment in the evolving discussion and knowledge of mind-body context and treatment of psychogenic pain (Schechter, 2014).

In this study it was described that the participants reacted with bodily pains or discomfort in the conversation about trauma, and that the therapist was able to reach and desensitise the participant’s emotions as well as bodily sensations by applying the sensory intervention only; this phase was conducted in silence.

There are four groups which might be seen to benefit on therapies with less need for narrating trauma, such as the psycho-sensory therapies. Severely traumatised patients, to whom just thinking about their trauma experience might be an almost unsurmountable challenge; military personnel and others whose confidentiality issues prevent them from seeking help; patients with communicative problems, for example refugees where a translator and cultural obstacles related to feelings may block the therapy process; and children, who might not have developed adult concepts of inner experience and process. Not having to talk about the hurtful memory may ease the path through therapy for these groups.

There is found little research on children undergoing TFT or EFT. There is a randomised controlled EFT study on 16 abused adolescents aged 12-17 (Church, Piña, Reategui, & Brooks, 2012), and a TFT study on 50 Rwandan genocide survivors aged 13-18 (Connolly et al., 2010). Studies on younger children’s experiences with this modality have not been found, but would be much needed, to shed some light on therapeutic possibilities for this group.

**Data source and analytical tool**
The registration of inner awareness in the ‘now’ was the source of data for the study. The inner phenomena were categorised separately; raw sensory data of experienced phenomena emerging into awareness from the body and feelings were separated from the process following the experiences: thinking, analysis, comparison and assessment.

In qualitative treatment studies, analysis can be challenging due to the size of the data set. Limiting the analysis to include only awareness content in the now may sometimes offer a solution to this task, and this approach is proposed for other studies investigating subjective patient experience. This form of data acquisition was chosen to narrow the focus onto the
relevant information from the three participants. That choice consequently excludes much material, such as opinions about each phenomenon and descriptions of how it could be related to other aspects of their experience or lives — information that would better inform the reader’s understanding. Nonetheless, by using this source of data, other aspects became apparent. Registering phenomena close to the moment they occurred formed the study’s chronological view, and made it possible to make temporal connections between therapeutic interventions and participants’ reactions.

This model also has its flaws, one being the inherent impossibility of describing the ‘now’. Even as it is being described, the ‘now’ is already the past, and a new ‘now’ has taken its place. One potential consequence of this is that participants might have forgotten parts of their in-session process, when interviewed even after just one day. In order to acquire more accurate descriptions, it would be expedient to also describe the internal phenomena while in the therapy session, and record the whole process. This is possible to achieve, and is the author’s preferred choice for a next qualitative study. Questions and discussions during therapy might slow and interrupt the process, but could yield new insights. It was important for the project’s credibility to separate the roles of therapist and interviewer, so the above-mentioned model was not chosen.

Limitations and suggestions

Sample size

A small sample size is both an advantage and a disadvantage in this qualitative study. The findings from three persons are not transferable. The advantage of the small size of the study is that it facilitates a detailed and chronological overview of phenomena in the process. Larger TFT studies focusing on details of inner phenomena would be welcomed, but more extensive qualitative studies with a design this detailed would require substantial resources of time and labour. Nonetheless, it would be interesting to see more qualitative studies focusing on subjective participant phenomena in psycho-sensory therapy.
Short post-treatment follow up

This study registers perceived post-treatment change after barely one week. Such a short interval only indicates change immediately after the therapy session. Indications of sustained change would require further study, including follow-up interviews after six months, one year, or both. Once again, it is necessary to emphasise that these findings are not conclusive or generalisable. To the author’s knowledge, no other study of psycho-sensory modalities has been found to investigate detailed subjective experience. Accordingly, the results of this study raise more questions than they answer. In terms of relevance for future research, the questions are what might be taken into consideration when designing other studies.

Alternative explanations

Apart from the sensory intervention, many other factors could have contributed to the experiences described. Explanations of the participants’ perceived in-session experiences might include exposure, relaxation or distraction, for example. It could be argued that exposure and distraction caused by touch led to the relaxation, because the process included exposure, and relaxation and a calming of feelings were observed. Exposure to trauma memories are documented to be effective trauma treatment (Foa, Keane, Friedman, & Cohen, 2009).

Prolonged Exposure (PE) is particularly well documented (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Prolonged Exposure is a manualised treatment package consisting of 9-12 90-minute sessions of exposure to trauma memories (Powers et al., 2010). The chronological data in this study indicate that relaxation occurred after or towards the end of each sensory intervention. All three participants had previously been exposed to their traumatic history on several occasions. The phases of exposure were here short (seconds or minutes), and not likely to bring about relaxation over days, as described see 3.2.1 Comparing pre- and post-treatment state, at the end of Participant A).

The distraction aspect of the sensory intervention might be an important factor in the desensitisation process, and could be a topic for further research. However, distraction does not explain the involuntary emergence of new material during sensory phases, and the inability to retrieve thought content.
One alternative explanation for the post-treatment change in initiative could be the time of the year. The interviews and sessions were held during the outbreak of spring, which is synonymous with more activity and positive feelings after winter. But the participants reported that their change in post-treatment activities were new, and had not occurred in the spring of previous years.

Positive personal experiences in each participant’s life might also contribute to increased initiative. The participant with the highest degree of post-treatment initiative had bonded more with her husband between sessions. This could be interpreted either as being a result of treatment, or as a cause of the internal change.

Data from the small sample size consequently requires cautious interpretation.

**Selection**

Selection issues must be considered. There is no list of patients who declined the invitation to join the study; nor were reasons for these decisions provided. Due to the phenomenological nature of the study, this point is considered to be less relevant compared with the more important lack of knowledge about the patient who left the study after the first session. One might speculate that she had a negative experience, which is highly relevant to the understanding of experiences after a therapeutic modality. Or she might have had an unforeseen positive experience, or dropped out for reasons completely unrelated to this project.

Two participants knew the therapist before the study (see 2.2 Selection and criteria). This might have influenced in-session relational issues in that the participants might have given false positive answers to the therapist when after each sensory intervention he asked how they were, believing that he wanted them to feel better each time they were asked.

This possibility cannot be discounted. On the other hand there is congruence between the findings on desensitisation and change for all three participants (see 3.1 Category one:…, Consistency…), and the findings from the recording are also congruent with the findings from the interviews (see 3.1.5 Mood at the end of the session).

Information from two sources to identify categories and themes in findings is referred to as triangulation (Golafshani, 2003). Here two sources systematically compare the recordings and the participants’ accounts, but employed like this, in the initial parts of the process of
acquiring data, it cannot be characterised as triangulation, though it is also used to establish congruence between what is said in the interviews and what is observed in the recordings (see 3.1.5 Mood at the end of the session).

Nonetheless, the small size of the study requires cautious interpretation of these findings.

In order to ensure qualitative rigor of the study, it was a precondition that the selected participants had suffered severe traumatic experiences and had been diagnosed with PTSD. The principal reason for conducting the study was to investigate topics around negative experience, which may be a feature of many diagnoses (Bellis, Lowey, Leckenby, Hughes, & Harrison, 2014; Felitti et al., 1998; Afifi et al., 2014; Varese et al., 2012; Subica et al., 2012), and PTSD is the diagnosis clearest associated with negative experience. Throughout the study, the therapy did focus on traumatic experiences described as related to bodily, emotional and cognitive levels, and, in this respect, the study has achieved its purpose.

It should be noted that this qualitative study did not set out to identify objective therapy outcomes. For this reason, the participants’ diagnoses were not assessed after treatment. The findings are subjective impressions of internally perceived changes in the therapy experience and in the participants’ lives. The subjectively perceived pre-treatment impressions, therefore, form the basis for the post-treatment findings.

Bias

Nahid Golafshani characterises the researcher as the tool for qualitative research: “Thus, it seems when quantitative researchers speak of research validity and reliability, they are usually referring to a research that is credible, while the credibility of a qualitative research depends on the ability and effort of the researcher” (Golafshani, 2003).

There are some credibility issues in this study pertaining to the researcher, one of which concerns pre-understanding. The author’s interpretation of findings may have been coloured by her background of having worked with TFT. The author has previously observed brief desensitisation periods, as well as the emergence of new aspects during therapy, and this is supported by the data here. The author has also previously observed an emerging line of emotionally connected traumatic subject matter, but not in this study. In the past, the author has also observed instances in which TFT was unsuccessful, or when it was too time-consuming and other approaches were more productive. This was not the case here, possibly
due to the study’s small size. On no occasion has the author observed harm to patients or negative side effects, and no study relating to this issue has been found; this may be warranted. New to the author is the high degree of post-therapy initiative reported by some patients and the unexpected finding that potential important traumas had not been treated; nor had correspondence between pre-treatment impairment and post-treatment improvement previously been observed by the author.

Prior knowledge of the field has been the driving force behind the project, but also a source of bias, which could weaken the study’s credibility pertaining to the researcher’s awareness of preconceptions and her ability to counter them. In interviews, she might have played a role in influencing the participants to produce results that support the efficacy of this particular form of treatment and subconsciously communicated the expected results to the participants. Being so familiar with the therapy, she might have misinterpreted statements and failed to detect data in conflict with her bias. She might also have subconsciously altered the wording of questions so that the interviews were slightly different for each participant. In this respect, the credibility of the study might have been strengthened if someone less partial had conducted the interviews. However, because the study is the author’s master thesis, it was a necessary precondition that she conduct the interviews herself. Given the sheer volume of details, some degree of unintentional bias may occur, and a cautious interpretation of results is again recommended.

Questions arising

A substantial body of qualitative research will form the basis of a stronger theory development for this modality, and larger qualitative studies may elucidate this process. Two findings of this project are of special interest for further research: the rapid desensitisation process, and the regained initiative shortly after therapy with regard to everyday needs.

Topics related to this question include the physiology behind the sensory interventions; structures involved in the process (acupuncture meridians, nerves, connective tissue, energetic fields); the speed of desensitisation; and the involuntary emergence of awareness focus. Answers to these questions might involve efforts of many academic fields, including physiology, psychology, neuroscience and even physics. Other issues include investigating the process by which trauma is stored, how and why. The different sensory interventions – eye movements, touch and sound – should be researched to see if they reach different aspects
of the trauma. Inability to retrieve thoughts after desensitisation is a topic of interest, involving the question of whether desensitised traumatic thoughts are retrievable or not.

Themes concerning the findings of regained initiative include the role of self-agency after trauma, and the role of self-agency or initiative in maintaining health. A quantitative study investigating the study’s tentative finding of correlations between impairment of certain areas of functions and improvements of these areas after psycho-sensory therapy would be of interest.

In order to determine when the use of sensory approaches are not appropriate, further qualitative studies examining cases of negative therapy experiences are warranted, and may result in better therapy.

**Closing remarks**

As mentioned in the introduction, two incentives for investigating psychotherapy were to find ways of preventing or minimising suffering after negative experience, and to find the appropriate tools to satisfy society’s increasing needs for treatment within limited resources.

The three participants in the study have described how their suffering lessened through the three sessions, and how they regained initiative and activities, which are core individual requirements for health, work and relational skills as members of society.

To therapists who work with patients who are disempowered by their negative experiences, these descriptions may bring further understanding of these stored experiences inner connections to emotions, body and thoughts.
5 REFERENCES


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6 APPENDIX

6.1.1 Interview guide

Now you have met me. I am.. , and I will be interviewing you, to summarise what we have found, and write it. The information about you will be anonymised, so that it cannot lead specifically to you. What we will do in this investigation, is to attempt to find out as much as possible about how you are and feel before, during and after this therapy.

First interview, before sessions, and third interview, after the third session:

Your thoughts – can you tell me a little about them?

Are you thinking much about what has happened, or not?

Are you thinking the same thoughts over and over many times, or not?

How about when you are about to sleep?

Do your thoughts stop you? – in work, rest, socially or in other areas?

Do you try to do something with your thoughts, try to think about…not think about?

How painful or bad / good are your thoughts, measured from 0 to 10, where 10 is the worst?

Feelings– can you tell me a little about how you feel? (preferably on the SUD – scale) Do you have feelings like joy, anger, fear, disgust, sadness, indifference?

Do they change, or do you have mostly one feeling?

Do you try to do something to your feelings, or do you leave them be?

Body – how is your body?

Be aware from head to foot, breathing, digestion, tiredness /excitement.

Do you have any disease or ailments?

How is your body affected with what has happened?
Relationships – how are your relationships with the ones around you / near you?

Family?

Children?

Friends?

Neighbours, random, e.g. shop, bus?

Work, school?

How are you with previous relationships?

Initiative – how much power do you have?

Are you getting up in the morning?

Do you eat?

Work?

Rest?

How many activities are you initiating/starting during a day/week?

Do you do something nice during a day / week?

Is there anything you would like to add that is not mentioned here?

After third interview: Have you had other therapies before?

What is the difference/similarities to this?

Second interview, after first session, conversation about the video recording.

How was this? Describe in your own words.

Touch: we will talk a little about touch. How is it for you to be touched? Are you familiar with touch? What do you think about it?

What did you experience – in your thoughts, your body, your feelings at this.. and this… and this point of the treatment? (this question is repeated several times through the interview).
Is anything changed? if so, → what?

Have you undergone other kinds of therapy before this? Was it like this? What was the main difference? How was the difference inside you – in your thoughts, body, feelings?

[Strong feelings are expressed to the therapist as crying, tears, increased frequency of breathing, increased heart rate, troubled facial expression, quick movements, bent or restless body posture. Less strong feelings give less strong expressions. If the interviewer does not see correspondence between SUD-reduction and the clients expressions, control questions are asked, such as “I see...(bodily expressions) and hear you say (it is better/ not better). Are you sure? Can you say something about the connection between what I see, and what you say?”]

“Is there anything that has not been mentioned here, that you would like to add?
6.1.2 TFT method

Chart of Tapping Points

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Treatment Points

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www.RogerCallahan.com
Classic TFT – as applied in the study.

The patient thinks about an experienced traumatic incident or relationship. Spend some time to make the client get into awareness of the feelings attached to the visual memory; make the client aware of the hurt felt in this present moment.

Assess the degree of discomfort.

On a SUD-scale (Subjective Units of Distress) from 0 to 10, 10 stands for the most discomfort, 0 for absence of discomfort.

T.: Apply the trauma algorithm (T) 1-2 times. Tap suitably firmly, with three or four fingers, 5-10 times, to cover a larger area. The trauma algorithm follows this sequence of points:

- Eye brow point between the eyebrows, right over the nose
- Under the eye – 3 cm under the eye on the front of the cheekbone right or left
- Under the arm – 15-20 cm below the armpit
- Collarbone at an oblique angle from the throat pit 5 cm down and 5 cm to the side

Assess the degree of discomfort, so you can see if there is a reduction, and how much, and choose PR or 9G (nine gamut). PR is an abbreviation for psychological reversal, and is based on a theory that the flow of energy is reversed and blocked.

PR.: If the reduction in assessed discomfort is minor, i.e. less than 2 on the SUD-scale, specific points are used to enhance the effect of the algorithms.

- PR 1 tap 15 times at the karate point at the edge of the hand and/or
- PR 2 rub 4-5 times with a flat hand below the middle of the collar bone on the left side and/or
- PR 3 tap 15 times above and below the mouth.

Then return to the trauma algorithm.

9G: If the reduction in assessed discomfort is 2 or more, perform 9G the algorithm of feelings. It consists of this sequence:
Tap with three fingers on the gamut-point, which is situated on the back of the hand, in the elongated pit between the two distal fingers, 1-2 cm from the knuckles, while:

The patient closes his eyes a few seconds, and opens them again, then
He looks down to the left, and then down to the right,
He rolls his eyes in a full circle first in a clockwise directions starting at the downwards position and then in an anticlockwise direction
He hums a little, counts a little, and hums a little.
The collar bone point is tapped 5-10 times.

Assess the degree of discomfort. Continue until the discomfort is on 1-2 on the SUD–scale.

Eye roll: By discomfort 1-2 the eye roll is performed:

The gamut-point is tapped at, while the patient slowly moves his eyes from the floor to the ceiling a couple of times.

Experienced therapists alternate freely between the three sequences T, PR and 9G.

Collar bone breathing: If the discomfort reduction still progresses slowly, collar bone breathing is performed:

The gamut point is tapped on while the patient’s right hand with fingers bent inwards, is laid flat on his collar bone. He draws his breath halfway and holds his breath there; he draws his breath all the way in, and holds it there; he breathes halfway out and holds it there; and he breathes all the way out.

The gamut point is still tapped upon, while his fingers stretch out together, and the hand lies flat on the collar bone, while he repeats the breathing sequence as detailed above.

If a reduction in SUD proves difficult to achieve, the focus is turned to the questioning.
The therapist tries to access the earliest episode/relationship where the painful feeling emerged, and access the aspect of the episode/relationship that produces the strongest feeling, e.g. by the question: “What is the worst about…?”

On the Callahan website, http://www.rogercallahan.com/freestuff.php, the points slightly differ. The method has developed and changed over time, and has even evolved into derivatives such as EFT.

This overview is conveyed by late study mentor Gunnar Sørbotten, student with Roger Callahan.
7 TABLES

In the tables presented, the participants’ statements are kept intact or are abbreviated. The participants do not necessarily always express themselves in correct Norwegian, but their language in the tables and citations is maintained as close to the original expression as possible, sometimes in English that is as inventive and colloquial as the original Norwegian.

7.1 Treatment tables

The tables form a complete and chronological overview of each participant’s description of her internal experiences throughout the session.

SUD means subjective units of distress, a scale here from 0 up to 10.

7.1.1 Participant A treatment table

<table>
<thead>
<tr>
<th>Sequence 1</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>The moment she got the message that her baby was dead. Staying with the hurtful thought. SUD is six or seven.</td>
<td>Discomfort about the memory</td>
<td>It is a pressure on her chest, and she gets dizzy and gets nausea.</td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec, pause 30 sec., 30 sec.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
After tapping | She lost focus, tried to find it. SUD is six. She cannot find how the situation was. It is distant. Did not manage to be in that situation. | Confused. |
---|---|---|

**Sequence 2**

<table>
<thead>
<tr>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>The worst about the hurtful episode. Her thoughts are spinning around herself in the hurtful situation</td>
<td>Nausea, dizziness, pressure upper chest</td>
</tr>
<tr>
<td>Tapping time</td>
<td>25 sec.</td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td></td>
<td>Got better when he kept on with that tapping</td>
</tr>
</tbody>
</table>

**Sequence 3**

<table>
<thead>
<tr>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>How it was for her to get that message</td>
<td>Nervousness</td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>She lost her focus, totally. She tried hard to concentrate about that death message but was not able to. Other things kept popping up. She tried to push that away from thinking. She was puzzled about that. The picture of the situation was changed.</td>
<td>Relaxed gradually</td>
</tr>
</tbody>
</table>

**Sequence 4**
<table>
<thead>
<tr>
<th>Sequence 5</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>She is stupid, not worth anything, not coping, being anxious of catastrophe, not able to relate to others.</td>
<td>Feels she wants to pull back. Ties up. Bodily pains around five.</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Maybe she lost her focus, she does not manage to think the very same thought. Her head is chaotic.</td>
<td>It gets better</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 6</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Catastrophic thoughts about herself dying.</td>
<td>Feels it, problems breathing. SUD 7</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>55 sec., few sec. pause, 30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>She is not able to think about it.</td>
<td>She laughs.</td>
<td>Better, calmer, managed to breathe. Pressure in chest got better.</td>
</tr>
</tbody>
</table>
### 7.1.2 Participant B treatment table

In conversation she first brought up a moment in art therapy where she could not draw her family, only black all over the pane. There is not done any sensory intervention when this was brought up.

The next topic she presents, is addressed:

<table>
<thead>
<tr>
<th>Sequence 1</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Her constant fear of not being good enough, not for her mother, not for her partner</td>
<td>Cries</td>
<td>Feeling in stomach and throat is SUD 8-9</td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Drawing away, cannot keep focus.</td>
<td>The strong feeling gets away, when tapping.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 2</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Uncertainty of being seen by partner. She has the need always to be sure he sees her.</td>
<td>More anxiety. The feeling is deep.</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sequence 3</td>
<td>Thought</td>
<td>Feeling</td>
<td>Body</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>In awareness before tapping</td>
<td>Fear of doing something wrong in relationship.</td>
<td>Discomfort throat, chest, upper stomach.</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>50 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Not able to recollect last night’s anxiety.</td>
<td>Sobbing fades.</td>
<td>The feeling diminishes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 4</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>She fears that she is making her partner leave.</td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Not able to bring it to mind.</td>
<td>Calmer.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 5</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>The fear of being left because of her mistakes. It applies both to her childhood and to her relationship with her partner. Thinking about how her mother treated her unfairly.</td>
<td>Crying.</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>45 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>It fades away</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 6</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

85
<table>
<thead>
<tr>
<th>Sequence 7</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Never knew if she was good enough, what to do to get love.</td>
<td>Cries</td>
<td>Feelings in stomach and throat.</td>
</tr>
<tr>
<td>Tapping time</td>
<td>23 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>To recognise how it has been. Like “that is how it was”.</td>
<td>Disappears, she cannot feel it.</td>
<td>Her body loosened a bit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 8</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Thinks about escalating fear, especially in the relationship.</td>
<td>Cannot feel it, cannot find it.</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>17 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>I remember the feelings, but they were not there.</td>
<td>They laugh.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 9</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Nobody loved her</td>
<td>Cries</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>After 55 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>Focus may have faded</td>
<td>Sobbing has stopped for a while. She starts crying again.</td>
<td>Tension in upper stomach</td>
</tr>
<tr>
<td>Tapping time</td>
<td>After 2 min 12 sec. total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>She distances herself</td>
<td>It faded a bit. Anxiety disappeared. Something is less intense.</td>
<td>She relaxes a bit more.</td>
</tr>
</tbody>
</table>
In awareness before tapping: She finds no discomfort first, but tries to scan her memory. After 30 sec. a picture of a relative emerges in awareness.

Shame, like she felt towards her mother.

Tapping time: 1 min 30 sec.

After tapping: The feeling is gone.

<table>
<thead>
<tr>
<th>Sequence 10</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Not being able to be oneself, floating into others.</td>
<td>She has no name for this feeling</td>
<td></td>
</tr>
</tbody>
</table>

Tapping time: 1 min 25 sec.

After tapping: The feeling disappears, she feels flattened. She gets a little numb. Subsided overall. Good to draw her breath. Something released or has stopped.

**7.1.3 Participant C treatment table**

<table>
<thead>
<tr>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before therapy in awareness</td>
<td>Watching herself in the film she thinks she looks terrified. Has a wish to diminish dissociation time.</td>
<td>Tense, uncertain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 1</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Flashback content of being abused by her father</td>
<td></td>
<td>Discomfort in chest and body. SUD 7-8</td>
</tr>
<tr>
<td>Tapping time</td>
<td>22 sec.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
After tapping | Her anxiety rose a little, and a bit “out”. | What had been stuck in chest, went to her stomach and “out”.

<table>
<thead>
<tr>
<th>Sequence 2</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>An absurd situation. She is in the hospital after a miscarriage of the abuser’s child. In front of the doctor the abuser asks her who she has been with.</td>
<td>Sensation in stomach. Frozen inside, but warm. Prickling sensation in the whole body, especially in hands</td>
<td>Diminishes during tapping. Better breathing. Limp feeling, hardly able to keep her head up.</td>
</tr>
<tr>
<td>Tapping time</td>
<td>2 min 25 sec., minus a few seconds when she says it is good to feel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 3</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>The situation distances a little, gets weaker even if she thinks about it.</td>
<td>Discomfort weakened. SUD 7-8</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>30 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 4</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>She has the same hurtful situation in awareness.</td>
<td>SUD 4-5</td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>2 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
After tapping  | Upsetting images no longer present in awareness. | She is smiling and laughing | Discomfort in stomach has receded to SUD 1. Now more calm. Nothing happens in her body, she says.

<table>
<thead>
<tr>
<th>Sequence 5</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>She thinks about a doctor who resembled an earlier rape threat. She can now feel and talk about her body, not sealing off.</td>
<td>Feels good to be able to feel.</td>
<td>Shaky. Freezing inside, but feeling warm. Tingling feeling.</td>
</tr>
<tr>
<td>Tapping time</td>
<td>55 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After tapping  | The freezing feeling is gone, but she feels a little tingling in fingertips and legs. |

<table>
<thead>
<tr>
<th>Sequence 6</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>A prickling feeling in legs and fingertips.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>35 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence 7</th>
<th>Thought</th>
<th>Feeling</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>In awareness before tapping</td>
<td>Melody in her head, “Love”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tapping time</td>
<td>60 sec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After tapping</td>
<td>She got a bit empty. Laughs a lot, heartily.</td>
<td>The freezing is all gone.</td>
<td></td>
</tr>
</tbody>
</table>
### 7.2 Pre-treatment tables

#### 7.2.1 Participant A pre-treatment table

<table>
<thead>
<tr>
<th>Body</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My bodily reactions constrain and trash my whole life.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I have panic anxiety: where I get heart palpitations, shivering, cold sweats, I feel my legs will not carry me, I almost just want to faint.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A lot of pain. After losing my boy, after some time, I started to hurt immensely in my neck, and head, and jaw. I am aching all the time.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I had problems breathing, I still have. Periodically I hurt when I breathe. But then I also have a tendency to stop, and not breathe.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I have numerous aches, especially on my right side. The throat, all the way around the right side of my face, it is the jaw, the ear, right side of the head, the neck, the back and then I have started getting aches down my leg and my hip.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>The aches are moving and I get aches in additional areas. I hurt over my chest, at one time I thought I had a heart failure.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I do not have asthma or any special disease.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I: When you were four, the things you experienced then, are they related to how your body is today?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>P. Yes, I am perfectly certain about that.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I: And this with your right side, is that connected to your experiences?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>P: Yes, I am very unsure, it came after I lost my boy. He was stillborn. And after that, after some time, I started to hurt immensely in my neck, and head, and jaw.</strong></td>
<td></td>
</tr>
<tr>
<td>Feeling</td>
<td>My feelings, they are also just chaos.</td>
</tr>
<tr>
<td><strong>My bodily reactions trash everything, from shopping in stores, going out of the house, actually being alone in the house gives me some anxiety and a sense of insecurity, I feel under surveillance, very afraid, out of house I get afraid of that, because the world is too big.</strong></td>
<td></td>
</tr>
</tbody>
</table>
When I lost my boy, I lost control over feelings, everything.

I just get anxious when I feel that I have pain I cannot name.

My problem is that I sometimes do not feel anything. I have understood that feeling nothing is bad really, to me it has maybe in one way been all right, because I have not had to feel anything toward the sad things I have been through, but I do not manage to feel any joy either.

I do not have any anger.

I: Things like disgust? P: What does that mean?
I: (makes grimace of aversion) There are people who get disgust against things and people “I do not like this and that, or this one and that one”. P: No.

I do not know if I have sadness. Maybe it is sadness that I feel. I know what I liked before, and such things, but I do not manage to feel any joy about it.

I: You do not feel that much? You notice indifference?
P: Yes. And I am very uncertain about my feelings. I search very much for the good feelings that made me do something. Because it has flattened out.

I know I am very worried, and afraid that people shall die away from me, or that I shall die myself and… afraid to lose.

**Thought**

I: Do you think much about what has happened to you that led to this diagnosis, or do you not?
P: I try not to . I: What do you do, in order not to?
P: I have an unfortunate tendency to dissociate, to just remove myself away.

P: Some thoughts come over again.

P: When I am going to sleep, ..I am pondering terribly much. And then it ends up with nasty dreams, and maybe not being able to sleep at all. I am not really able to distinguish between dream and reality, always, and then I get stressed.

I: Do your thoughts prevent you from things, work, rest, social relationships, or other things? P: yes, many, many things. For I try to..
I do not manage quite to understand my feelings. When things happen around me, I get very, very confused. I fall out.

Losing friends, I thought it was a burden for them to have to relate to me. I analysed very much, what is it that they want to hear, …I got very exhausted by it. So I withdrew myself a lot from others.

I think the thoughts are just chaos. It is very chaotic in my head.

So I think that a lot comes from thoughts.

**Initiative**

If I read till I fall asleep, the book just falls down, then it i fine.

I have extremely many limitations in my everyday life.

Food and eating, it is about right, I guess. I have gained some weight lately. Eating is no concern.

**Connect to experience**

I am in a period where I want to sleep very much. I get a totally extreme drowsiness. I sleep probably seven or eight hours during the night, bring my kid to day care, go home, and have now had a period where I have been sleeping almost three hours after leaving him in day care, he goes to bed at seven – half past seven, fallen asleep with him in the night, I may have slept beside him for a while, and then I go to bed, in the night.

I have actually had periods of tiredness for many years, that I... But I experienced some things from I was four years old, that may influence.

I do not think I rest always. :..I wake up being a little stressed

I have to pick my three-year old up from day care, it is a huge job. It is quite unpredictable what is going to happen when I get in there, who I must relate to and how many.

I: Do you take the initiative to do something ..fun?
P: That is very rare, and it is about that I am uncertain about what is fun... .

I do not have the energy to do much. - dinner, kids and school homework, it is on the auto-pilot

I like very much to be out in nature, so I try to get me out there every week, even if I feel that I do not have the energy for it. When I do, I can breathe.
Tried supported work, but totally drained.

**Relationships**

I have lost many relationships. A branch of relatives distanced themselves for religious reasons. At twenty-two I lost many who I had been very close to. I have no contact with them now.

I had many friends, loads of them before. So then after I lost my boy (his name), it has been reduced very much. Some people just acted as if they did not recognise us. I have thought that it has been extremely difficult. Losing friends led very much to me drawing back, becoming very insecure about how to relate to other people.

People, I struggle relating to people.

I am very fine with my husband and my kids, three children, Two teenagers, and this three-year old.

My mom and dad, my two brothers and my in-laws. I am close to them.

But you and your husband are good together? Yes.

I do have friends. Women and men. Also in common with my husband, couples. Three female friends.

Neighbours, to casually meet people and neighbours, take the bus or go to the shops, or… Yes, I struggle with that. I cannot go to parents meetings, cannot attend joint voluntary work, I cannot be at occasions where there are many people.

**7.2.2 Participant B pre-treatment table**

<table>
<thead>
<tr>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hurt a lot in my right hip.</td>
</tr>
</tbody>
</table>

**Connects to experience**

<table>
<thead>
<tr>
<th>I have started getting so much pain in my stomach last six months. And five years ago, when my mother died, had trouble with a relative.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have gall bladder problems.</td>
</tr>
<tr>
<td>I have very much tension in my chest muscles and in the upper stomach.</td>
</tr>
<tr>
<td>I have loud tinnitus. That bothers me.</td>
</tr>
</tbody>
</table>
I have got chronic sinusitis.

I have headaches in the evening for the last there or four years.

My neck hurts a lot.

I have been afraid all of my life so I feel my breathing is locked. I have become marked in my body by having been exhausted of having had to fight.

I have started to hurt a lot in my left shoulder here, I am not able to stretch my arms out. So I feel that I do this, (crossing arms over chest) it is somehow safe, in many ways, I somehow protect myself.

So in the last year I have physically become much worse.

no disease or ailment that I take medication for, other than sleeping problems

**Feeling**

<table>
<thead>
<tr>
<th>Feeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been afraid all of my life. When my dad did not come home, I was all the time on my toes, I had to look for the lights, for the cars.</td>
</tr>
<tr>
<td>I am very alert on situations, when I come into a room, I can quickly scan the ambience. I am extremely “out there”, so I have been very little presence inside of me.</td>
</tr>
<tr>
<td>In the institution I should draw my dad, and it was all black, I could not have made it more black than.. than… it was so black that it was..I used black and black and black and black and black, so that ..yes.. I think yes…now I fall out. It gets too much for me, actually, not too much, but when I start talking about it, I get such cotton in my head. (tears)</td>
</tr>
<tr>
<td>P: Yes, what has been, if I am to talk about the childhood, it is.. it is….something I really cannot take in, so that I, it is difficult, it is like it becomes cotton if I just start talking much about it, you know</td>
</tr>
<tr>
<td>Yesterday I was extremely restless, extremely, so that I thought my God, this I cannot handle, I cannot endure this restlessness. And that I never experienced before I was at the institution. I am restless. I go for a walk, or reading, or on the pc, it is difficult for me to sit down and just be.</td>
</tr>
</tbody>
</table>
I have a guilty conscience for them at work, the patients, all the time. It is just like it lies inside me. That I do not do it well enough, that I am not, not good enough. It lies there.

The sorrow that lies there, you know, under everything, it was activated at (name of institution) four years ago. And of course, when I talk with you about it, and start talking about that loneliness, then it gets terrible. (tears up) There is more sorrow now, for I have understood how terrible it has been, (crying) how lonely it has been, (childhood).

I can feel joy towards the future, when I get better. I can feel joy if my partner is good to me, and listen to me. No, I do not feel so much joy. I have somehow not been able to being allowed to lean back and be me. Found out, what is good for me, what is my joy? and there lies a sorrow (cries)

P: I am very short-tempered. When I was a little, I had an extreme anger when I got angry. But I push it down.

P: I am afraid all the time. I: an underlying feeling?
P: Yes. I get afraid that I shall not be present for my partner, a little afraid for the future, for economy, I am also afraid of being alone, afraid to walk in the fields alone. I am afraid to be harmed, I may be scared to death of being killed, or that someone shall hurt me. I all the time have a fear inside me.

I may get such a condescending attitude, a bit of disgust, I may feel a little better than others.

I am not so indifferent. I am quite dedicated, really, in a lot of things.

My biggest fear in all my life has been losing close relationships, fear of not being good enough. For son and partner.

I have made myself a bit numb about the people I miss.

I have become aware that I am actually shy.

**Thought**

P: I think very much forward, there ahead, then, because it gets too.. It is a kind of solution there ahead... I visualise the future. maybe a year, or two, maybe three. I hope sleep comes in a year of two, maybe I will find the way back to myself a little, or get a little calmer in everyday life, or get help from someone.
I: Do you think much of what has happened to you, in your life as a child? P: Yes, I actually do that. For I think it characterises me so much today. I do think much about my childhood.

I do think many of the thoughts over again…

P: I protect myself against it.
I: You protect yourself against.. the old part of your life..
P: Yes, when I was little, that extreme loneliness, yes.
I: And you protect yourself by….P: Thinking ahead.

I have begun to understand more that the others have feelings, too.

I have never been good enough for myself, either.

### Initiative

I do not sleep, and I get sluggish at work, when I sleep that badly. P: I sleep six or seven hours a night, on a sleeping pill I: And if you do not take a sleeping pill? P: then I do not know if I will sleep at all. I have done that all the time since the institution.

I know I have always fixed things. in the middle of all that being so lonely, I have always had to cope (tears), too.

And then I am often fatigued. One day I may feel not so bad, you know, and then suddenly I am so exhausted I have always been exhausted.

P: I have had difficulties resting, after coming out from the institution. It is hard for me to find calm. It is difficult to sit down.I: How many hours do you work a day? P: I am doing something all the time. a sense of duty. I do not find calm anywhere, you know, so..

Yes, I do get up in the morning. I actually like the mornings.

I am a bit rigid, I like to eat healthy. I get worn-out and tired if I do not eat, so I eat every three or four hours. In the institution I really felt a wish for food.

I do enjoy to go and sit and drink coffee. I may invite people for coffee. I do nice things for myself one or two times a week.

### Relationships


I have been ashamed of a relative,............. He calls me, he does. I have a relatively close relationship to him.

My partner, co-habitant for eight years, I can never quite trust that I am good enough. He has also been very stable in my life, and grown up and sensible.

I have lost some friends, I have only one very good friend that I trust.

I have a few out there, childhood friends in my home city, there I have two, and I have maybe two-three of my childhood friends. A little contact. I am more vulnerable now, in relation to this about friends.

Neighbours, and casuals- P: -there I am good- I: -shops and buses- P: -no, there I am good, I am good talking to people, and good -I: -Collegues and- P: Yes, it is mostly all right.

I am in conflict with a relative. Missing some relatives, sore about it.

### 7.2.3 Participant C pre-treatment table

<table>
<thead>
<tr>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>I work to accept my body. It is closed off. My feet are quite all right. I have worked a lot with them, to massage them to get me to be present, to accept my body. I have worked with the hands, they are mine, and so I have worked with my upper arms.</td>
</tr>
<tr>
<td>I sometime hurt a little in a leg, in a hip and a little in my back.</td>
</tr>
<tr>
<td>I have lots of headaches</td>
</tr>
<tr>
<td>When I get anxiety it gets hard to breathe, hard to swallow., my neck and throat.</td>
</tr>
<tr>
<td>Stomach is ok, no diseases or ailments.</td>
</tr>
<tr>
<td>constantly drained</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connect to experience</td>
</tr>
<tr>
<td>My body is influenced so that I do not like physical contact. I hug children and grandchildren and sons-in-laws.</td>
</tr>
</tbody>
</table>
I do work with my feelings, with the psychomotor physiotherapist.

I blocked everything. Until about forty and I got eating disorders. For then they started medicating me. And I got flat. Until a year ago I have not had a past.

I moved to another city where I got out-patient aftercare and stopped medication. A year ago, maybe. I have a little more feelings than I had before. A while ago I got tears in my eyes, I did not get that.

Now I have more feelings than I had last year.

I have joy, but mostly when I am with my grandchildren.

I am never angry. But if things had happened towards my kids, or grandchildren I think I had gotten angry, I had exploded. I had done something which had not been good.

I do have fears. I always lock my doors at home. .. I need to be in control of who is coming, and..

Social gatherings, many people, I have fear for that.
I need to control that I do not.. It.. in the middle of a crowd I think I get panic /angst.

I am of course scared when I see old men, drunk men.
I am very jumpy when I hear high voices and discussions.

I probably am a little sad sometimes. This year I have developed into being able to feel that things are sad, but it is a bit new, still.

I: Disgust, do you have such feelings? P: I am a bit uncertain if it is…I have a strong urge to defend people who are badly treated.

My feelings are very much varied. Up and down, caused by little things.

But then I have not come so far as to being indifferent.

**Thought**

I do not think the same thoughts over and over
But it quickly comes if I listen to the radio, or see something on TV that may remind me of things that have happened to me

If the worst thoughts come, and I am by myself, then I dissociate. I lose from one till three or four hours, where I am not present at all.
I: So that means that, you say that sometimes you can feel you are about to dissociate, is that what you say?-P: Yes. I: - and then you can be aware that it is happening, and then you can reverse it by doing something? P: Yes. “This I cannot think about,” then I must do something else. If I am sitting in the chair and it comes suddenly.

If ten is the worst, my thoughts are seven, maybe. (Subjective units of distress, 10 is the worst)

I: So the feeling of not being able to talk so much about it, makes you think more about it? P: Yes.

I: Mm. Do your thoughts prevent you from working, or to socializing, do your thoughts stop you from participating in things? P: Yes, sometimes they do. Not always. It stops me a bit from going to celebrations, parties.

**Initiative**

I avoid mirrors.

I do not go into a store, clothing, for instance, to try on. I buy without trying.

In the supermarket I only thought about that I had to be observant about where things were, and how to get out of there. In food stores. Cannot stay in there, not even with a friend.

My bed is only for sleeping. I do not like bedrooms.

Now I sleep maybe three hours, but then I manage to fall asleep again, and maybe sleep two hour, three hours more. I take sleeping pills and an antidepressant (name). For a sleep onset.

I do not work, have a wish I might find work here.

Doing something nice..?…it is actually nice to go Tuesdays to the day center. I am at the day center twice a week

And then I shall join for an excursion next week, competitions and gatherings, a convention in France, travel to an event with a friend…

Well, I eat, but it is not like I have to eat because I am hungry, I eat just because the body needs it. I do not feel I want food. But I stick to normally healthy food.
I have gymnastics for senior women, and then I coach youths in gymnastics.

I have to get out of my bed when I wake up. My bed is only for sleeping. I do not like bedrooms.

At home I sit in a chair. And do handiwork. I knit and crochet, and.. Must have a work in my hands watching TV, or.. I do sow a little, but that is at the day centre.

**Relationships**

Good relationships to family, two girls living nearby and two sons-in-laws I am good with, and grandchildren I get happy being with, picking them up from kindergarten sometimes.

I have one close friend.

People I meet randomly, like in the store, or acquaintances,. I am ok I am open, I might say” it could have been better, but I know there are those who are worse off”. 
## 7.3 Post-treatment tables

### 7.3.1 Participant A table post-treatment

Six days after sessions.

<table>
<thead>
<tr>
<th>General Impressions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that it is just like something has loosened its grip</td>
<td></td>
</tr>
<tr>
<td>It reminds a bit about mindfulness, presence staying in the now, increased awareness about herself in the now, but still different.</td>
<td></td>
</tr>
<tr>
<td>After other treatments I have been thinking, pondering, and digging. Now I am light in my body.</td>
<td></td>
</tr>
<tr>
<td>I have tried so many things, I thought there is probably nothing that can help me. Now, after having felt in my body what I have felt, I believe it can help me.</td>
<td></td>
</tr>
<tr>
<td>What is different, must be that I so quickly noticed a difference. In my body.</td>
<td></td>
</tr>
<tr>
<td>He asked me to be aware of the feeling I had in my body, that is the pains I have in my body and the feeling of being suffocated, and..And then I felt very clearly that when he tapped at the different spots, it was just like the bodily symptoms became milder, in a way.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body</th>
<th>Similar to pre-treatment interview</th>
<th>Different from pre-treatment interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less body pain, but it still is there.</td>
<td>Pain right side; jaw, throat, neck, arm, legs are better. Less body pain, but it still is there.</td>
<td></td>
</tr>
<tr>
<td>Sometimes her legs will not bear her.</td>
<td>Breathing pains are better.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Headaches are better.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No pain killers for five days. Used to take more.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After she got angry with husband (very new), been relieved in her body.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calm in body after sessions, lasting now. Earlier therapy has made her think, ponder, heavy.</td>
<td></td>
</tr>
<tr>
<td>Panic anxiety when outside, with heart racing, shiver, cold sweats, legs</td>
<td>Had once.</td>
<td></td>
</tr>
<tr>
<td>Feeling</td>
<td>Thought</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Still a little anxiety.</td>
<td>Dissociating. So that I do not feel how I am.</td>
<td></td>
</tr>
<tr>
<td>Continuous anxiety is totally different, better, less. Connects it to</td>
<td>Still dissociating</td>
<td></td>
</tr>
<tr>
<td>a session. Drove home all calm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling more confident in herself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She was lighter after treatment</td>
<td>Feeling surveyed, tense and unsafe, still does.</td>
<td></td>
</tr>
<tr>
<td>Later she had periods of down. She is either way up, or way down there</td>
<td>Feeling less of being surveyed during daytime.</td>
<td></td>
</tr>
<tr>
<td>getting paralyzed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earlier she has tried to leave feelings, not to relate to them. Now</td>
<td></td>
<td></td>
</tr>
<tr>
<td>she may have a lump in her throat, as if tears press. New.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely scary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has been silent and withdrawn in disagreements with husband. Now</td>
<td></td>
<td></td>
</tr>
<tr>
<td>been angry, irritated. New. Was aware of her own brisk movements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relieved after yelling at husband.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling surveyed, tense and unsafe, still does.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never knowing what could give joy. Now finding enjoyment in making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sand-box, fixing things. New.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A little worried</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less worried</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pondering all the time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less pondering after taking kid to daycare. Analyse, but not that long.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing friends after losing baby; thought it was a burden for them to be with her. Now she thinks it was she who had a tough time. She means the change happened before the study.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having catastrophic dreams now, but that has earlier occurred periodically.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has catastrophe thoughts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophe thoughts lasting shorter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting to know what is nice for her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less worries, she connects it to one special session; calm after session, less worried now.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Initiative

<table>
<thead>
<tr>
<th>No difference in falling asleep.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeps less during daytime. Does not have the extreme tiredness like before.</td>
</tr>
<tr>
<td>Started to exercise, with other people.</td>
</tr>
<tr>
<td>Yelled at husband. All new.</td>
</tr>
<tr>
<td>Making sandbox to her boy. Painting garden furniture.</td>
</tr>
<tr>
<td>Has the wish to do things.</td>
</tr>
<tr>
<td>Being alone one night. New. Was anxious. She is better at being alone at daytime.</td>
</tr>
<tr>
<td>Wants to put herself to the test, challenge herself. Wants to be in shape. Wants to function among people.</td>
</tr>
<tr>
<td>Has been going to shop, also with child. Better.</td>
</tr>
<tr>
<td>More energy. Goes for walks. Does several things in one day.</td>
</tr>
</tbody>
</table>
Relationships

Talked with husband after being angry. New. They have never done that, really talked, for 18 years.

New awareness. She became aware that her parents walked right over her. Worked in a session about that, which included physical symptoms.

Struggle relating to others, feels she is not good enough.

Has become closer to a friend, whom she talked to on the phone while being home alone.

7.3.2 Participant B Table Post-treatment
Seven days since the last session.

<table>
<thead>
<tr>
<th>General impressions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>She does not know if she has noticed any particular difference.</td>
<td></td>
</tr>
<tr>
<td>It was exhausting, quite a bit draining, been worn out afterwards.</td>
<td></td>
</tr>
<tr>
<td>After first time it was calmer in the evening, the anxiety diminished. Has come back.</td>
<td></td>
</tr>
<tr>
<td>Too early to say if something happened.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Similar to pre-treatment interview</th>
<th>Different from pre-treatment interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip comes and goes.</td>
<td>Less pain in neck.</td>
</tr>
<tr>
<td>Stomach is passable</td>
<td>Less breathing problems.</td>
</tr>
<tr>
<td>Tinnitus is no change</td>
<td>Left shoulder hurts less.</td>
</tr>
<tr>
<td>Headaches come and go, no change</td>
<td>No problems any longer stretching arms out.</td>
</tr>
<tr>
<td></td>
<td>Head resting on spine instead of leaning forward.</td>
</tr>
<tr>
<td>Feeling</td>
<td>Repetitive sinusitis, no change.</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Some restlessness.</td>
<td>Calmer.</td>
</tr>
<tr>
<td>Permits herself to have the feeling of disgust. If I feel like that, it is all right.</td>
<td></td>
</tr>
<tr>
<td>Uncertain towards partner. Says later she is more afraid.</td>
<td>Not so extremely afraid. No need to have closeness all the time or confirmation.</td>
</tr>
<tr>
<td>Reduced tranquilisers for the last two weeks, from one or two a week to now a half.</td>
<td></td>
</tr>
<tr>
<td>Anxiousness still.</td>
<td>Less anxiousness, comes and goes. New. But it was not there yesterday morning.</td>
</tr>
<tr>
<td>Less afraid to walk in the mountains, less afraid to be alone.</td>
<td></td>
</tr>
<tr>
<td>More irritable, maybe more touchy.</td>
<td></td>
</tr>
<tr>
<td>More angry about her mother, and partner, more aware of it, and allows it more.</td>
<td></td>
</tr>
<tr>
<td>Less confluence, less spreading out.</td>
<td></td>
</tr>
<tr>
<td>There has earlier been no indifference, always high efforts at care-taker work. That has receded. More inside of herself, less confluent.</td>
<td></td>
</tr>
<tr>
<td>More guilt for her child, less ashamed about her child.</td>
<td></td>
</tr>
<tr>
<td>Thought</td>
<td>She has been thinking more that she can take it easy. No need to master everything.</td>
</tr>
<tr>
<td></td>
<td>Thinking less ahead, maybe more in the now, collecting herself more. She used to deliberately think ahead, getting away from painful thoughts.</td>
</tr>
<tr>
<td>Initiative</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Putting herself in focus, protecting herself.</td>
<td>She has been scared of someone, but now she thinks it is not good for her to be with someone who is not kind to her. A new thought.</td>
</tr>
<tr>
<td>Setting down boundaries. Thinking that is theirs, and this is mine.</td>
<td>When she gets scared, she thinks it is possible to wait for a while. New.</td>
</tr>
<tr>
<td>She had forgotten her sleeping pills. New thought: Never mind, I have to just stay awake, then. She slept.</td>
<td>Her anxiousness is existential. New view.</td>
</tr>
<tr>
<td>Her anxiousness is existential. New view.</td>
<td></td>
</tr>
<tr>
<td>Sleeping better. Falling asleep again after waking up. Has reduced sleeping pills. Used to take every night. Last four days only half a pill.</td>
<td></td>
</tr>
<tr>
<td>Writes down her feelings of anger and of joy.</td>
<td></td>
</tr>
<tr>
<td>Plans to stay in a somewhat desolate house for a week. Used to be afraid to be alone for short periods.</td>
<td></td>
</tr>
<tr>
<td>Goes mountain hiking.</td>
<td></td>
</tr>
<tr>
<td>More aware of tiredness. Possibility to follow it. Allows herself to have one of those days. Lower shoulders. Able to feel she is always worn out.</td>
<td></td>
</tr>
<tr>
<td>She is on sick leave. Is about to stop working and get disability pension.</td>
<td></td>
</tr>
<tr>
<td>Eating habits are the same.</td>
<td></td>
</tr>
<tr>
<td>Close relationships feel worse.</td>
<td></td>
</tr>
</tbody>
</table>
More guilt for her child….. Less shame. There are other things that might be good.

<table>
<thead>
<tr>
<th>No change with friends.</th>
<th>More angry towards partner.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partner is perceived as more annoyed.</td>
</tr>
<tr>
<td></td>
<td>More afraid towards partner.</td>
</tr>
<tr>
<td></td>
<td>Conflicts with family relation.</td>
</tr>
</tbody>
</table>
### 7.3.3 Participant C Table Post-treatment

Five days since last session

<table>
<thead>
<tr>
<th>General Impression</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Something is happening, for she is still drained five days after last session. It is all right to be drained; she knows the reason.</td>
<td></td>
</tr>
<tr>
<td>It has been tough to think about things when he is tapping. Physically and mentally draining.</td>
<td></td>
</tr>
<tr>
<td>It does not resemble any other treatment.</td>
<td></td>
</tr>
<tr>
<td>It is scary, but at least something happened. A huge difference in one treatment. She was at eight or nine on a scale, and down to one.</td>
<td></td>
</tr>
<tr>
<td>Good to be with someone she has met before.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Similar to pre-treatment interview</strong></th>
<th><strong>Different from pre-treatment interview</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body</strong></td>
<td></td>
</tr>
<tr>
<td>Pains in hips and back</td>
<td>Heavy and exhausted</td>
</tr>
<tr>
<td>Headaches no change</td>
<td></td>
</tr>
<tr>
<td>Neck pain comes and goes</td>
<td></td>
</tr>
<tr>
<td>Does not like physical contact. Does not know if that has changed, has not tried.</td>
<td></td>
</tr>
<tr>
<td><strong>Feeling</strong></td>
<td></td>
</tr>
<tr>
<td>Now she is passive towards her body. Has before treatment actively tried to repress she has one.</td>
<td></td>
</tr>
<tr>
<td>Has had anxiety attack.</td>
<td>Has had anxiety attack, but less fierce. No panic attack.</td>
</tr>
<tr>
<td>It takes time for her to feel that she gets sad. Her feelings have earlier felt all flat.</td>
<td></td>
</tr>
<tr>
<td>Calmer on the mountain hike than before. Is calmer than what she used to be.</td>
<td></td>
</tr>
<tr>
<td>Still no feeling of disgust.</td>
<td></td>
</tr>
<tr>
<td>Still never angry.</td>
<td></td>
</tr>
<tr>
<td>Not more afraid --</td>
<td>--But more jumpy</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Does have joy for children and grandchildren, like before.</td>
<td>Joy over having done something well. That is new.</td>
</tr>
<tr>
<td>Feelings go up and down, changing with situations. Like before.</td>
<td>Does get tense, but can go out of it.</td>
</tr>
<tr>
<td>Something in her past life is now placed in a box. Used to carry it on her back. Has put it away.</td>
<td></td>
</tr>
</tbody>
</table>

**Thought**

<table>
<thead>
<tr>
<th>Some of her hurtful thoughts have not changed.</th>
<th>Some of her hurtful thoughts have changed. A reminder of a bad memory got better.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those things that have been in her thoughts during tapping, are weaker.</td>
<td></td>
</tr>
<tr>
<td>Less dissociating. Not as often and not for so long. She is better at grabbing hold of the dissociation, stopping it, if it is not so sudden.</td>
<td></td>
</tr>
</tbody>
</table>

**Initiative**

<table>
<thead>
<tr>
<th>Does not know about change in going to new shops. Has not tried.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never looked at herself in a mirror. Still does not, but-</td>
</tr>
<tr>
<td>Never tried clothes in shops. -tried jeans in a shop. All new. Joy.</td>
</tr>
<tr>
<td>No change as to sleep and sleeping medication.</td>
</tr>
<tr>
<td>No change as to eating.</td>
</tr>
<tr>
<td>Still drained after therapy.</td>
</tr>
</tbody>
</table>

**Relationships**

| No difference towards children and grandchildren, has good relationships. |
| No difference towards acquaintances, no challenges. |  |