Contents

I have changed. I got back to my self and to be the person that I was before the incident. I got to see and deal with things that happened to me and sort my feelings out so I can deal with it. I learned a lot about myself and other people. Also I learned to not be responsible for things that others do to us, but for ones that we do to others. I also feel strongly that if I need it, help is out there, it is my responsibility to find it and live life the way I want to.
-- Domestic Violence survivor after TIR (VSC Miami)

Foreword by the Editor

Who Should Read this Book

This book defies some of the conventional pigeonholes for trauma and therapy books because it is targeted towards two distinct audiences: people with a history of trauma who are looking for resolution of their past, and mental health professionals who are interested in a powerful and proven technique to resolve the effects of past traumas. It is also my fervent hope that TIR practitioners will recommend this book to their clients as a means of educating them in the process of discovery they are about to embark upon.

How to Read This Book

The structure of the book is encyclopedic in that each chapter is self-contained and requires no prior experience. Even so, I would recommend completing Chapter 1 (Trauma and TIR) first for a basic grounding in the material. Then you may wish to jump to one of the application chapters (2-5, 7, 8, 10, and 11) which show specifically how Traumatic Incident Reduction (TIR) has been successfully applied to various experiences (veterans, crime victims, terrorism, etc.). Mental health practitioners with backgrounds in other techniques, such as EMDR, might want to read about Traumatology (Chapter 6) or Integrating Therapies (Chapter 9) early on.

The Nature of Conversations

Since this book consists primarily of conversations with people of many different backgrounds and experiences, the viewpoints each person expresses are their own and don't necessarily represent the viewpoint of any other individual or group. You may read opinions of various treatment methods with which the developers of those methods might disagree. The intent of the book is to share this broad range of viewpoints and you are encouraged to draw your own conclusions.

The Terminology of Trauma

Traumatic stress, like any other area of scholarly study, has developed its own language to describe symptoms and treatments. I have taken care to make the book as accessible to lay

people as it is to professionals. Please use the index at the back of the book to find definitions of unfamiliar terms. Generally, a term is defined in the text the first time it is used.

Certified Trauma Specialist (CTS)

You may notice that quite a number of the contributors to this book have the CTS designation after their names. The Association for Traumatic Stress Specialists was formed in the 1980's to provide organization, continuing education and recognition to people working to alleviate the effects of traumatic stress. ATSS offers three kinds of certification depending on the education and experience of the applicant. The CTS designation was created for counselors, clinicians, and treatment specialists who provide individual, group, and/or family counseling and/or intervention. Among other criteria, CTS requires 240 hours of trauma treatment training and 2,000 hours of trauma counseling and intervention.

We highly recommend ATSS for their excellent annual conferences and their fine certification program. Visit them at: www.atss-hq.com.

About the Book

It has been my very great pleasure to collect and edit stories of how Traumatic Incident Reduction (TIR) has made a difference in people's lives. In the 20 years since Frank A. Gerbode began developing the technique known as TIR, it has spread as far as Australia and Russia and from Alaska to Brazil. TIR has been successfully applied by not only psychologists and social workers but also by ministers and even lay trauma survivors, such as Vietnam veterans. Furthermore, it has proven its usefulness in the full spectrum of human woes: from birth to bereavement, war veterans to widows, children to car crash victims. TIR is used every day in a variety of locales beyond the therapist's couch including domestic violence centers, jails, and even the frontlines of disasters.

I believe the multiplicity of voices and experiences that you find in this book makes the case for the broad workability of TIR. At the time of this writing, this is the first book to embrace the experiences of dozens of practitioners and clients in varied milieu and weave them into an argument for efficacy. If this book had been merely the work or experience of a single author, its voice would have been considerably weaker.

TIR allows practitioners to address trauma more deeply while simultaneously resolving trauma quickly. This allows practitioners to be more effective and able to handle more clients. Anecdotally speaking, compassion fatigue is virtually unknown among TIR practitioners. The following quote from Alex Frater, Ph.D will testify the power of this:

"In the early 90's, my practice involved 70 hours/week of face-to-face therapy in which the number of my clients/patients with trauma related matters was growing alarmingly. Through increasing medical referrals, my practice was progressively becoming unmanageable, and I began to seek more efficient ways of dealing with trauma. By chance, I came across an article written by Dr. Robert Moore of Florida, extolling the virtues of a new approach to resolving trauma known as Traumatic Incident Reduction (TIR). I went to Menlo Park in 1994 to train at Moore's recommendation with Gerald French and Frank A. Gerbode, MD.

The results I have obtained since returning to Australia with this innovative therapy are nothing short of miraculous. TIR has done nothing to reduce my workload, but it has increased my efficiency enormously. My trauma-related patients now number something like 45/week, up from the 20 or so that I was seeing at the time I went to California, and at the same time TIR has, in fact, enabled me to produce better, faster, and much more thorough results in dealing with trauma and related matters than have any other techniques at my disposal. Quite fantastic, really. More than worth every bit of time and expense of traveling to America for the training."

Alex D. Frater, CTS
Campbelltown, Australia

If TIR existed whole and independent of everything else, it would still be the marvelous tool that you'll learn about in this book. In fact, TIR is part of Applied Metapsychology, a larger area of study developed simultaneously by Dr. Gerbode. Along the way, I'll be introducing a few other of the key procedures available in Metapsychology (most often, that of Unblocking). The philosophy of Metapsychology is developed further in the final chapter of this book as well as Dr. Gerbode's own book *Beyond Psychology: Introduction to Metapsychology*.

One of the challenges of editing lies in the classification and categorization of the stories presented herein. Keep in mind that these divisions are arbitrary, and though a practitioner may be highlighted in a particular area of trauma, it doesn't imply that such a practitioner is limited to that area, in general practice or specifically with using TIR. For example, John Nielsen has had great success in working with jail inmates, but their traumas are not unique to prisoners. In one case, the root trauma of an inmate related back to experiences as a civilian in the Bosnian conflicts.

It's also important for you to understand what this book is not about. Specifically, it's not a "how to" manual or instructional guide of any sort. Although you can learn the complete theory from the textbooks of Frank A. Gerbode, M.D., Gerald French, and Bisbey and Bisbey, the only way to fully achieve the potential results of TIR is to attend a TIR Workshop (see Appendix B).

At this point, you may be wondering why I personally decided to write this book given that a perfectly fine technical and training environment already exists. In the past 20 years the good word about TIR has not spread outside certain small circles of Traumatology and into widespread public knowledge. Prior to 2003, my primary efforts to promulgate TIR consisted of creating the Traumatic Incident Reduction Association (www.TIR.org) website in 1996 and supporting my wife's practice.

In early 2003, I heard a call-in program on National Public Radio about Vietnam veterans and their families suffering the effects of post-traumatic stress disorder (PTSD). They discussed the full gamut of flashbacks, panic attacks, unaccountable rage, depression, substance abuse, and other aspects of PTSD. The expert's consensus was basically "Well, you just try to be patient and understand what they're going through and maybe over time they'll get better."

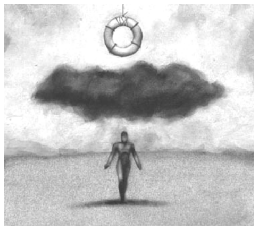
This sort of scarred-for-life mentality is promulgated on the six o'clock news after each and every disaster. As such, the public at large is left with the impression that really nothing can be done about the effects of trauma. I believe what's missing, the presence of which would make a difference, is a book presenting the possibility for healing that TIR offers.

The Conversation Continues

I'm still actively seeking stories from clients who have been healed through their use of TIR and how it's made a difference in their lives. Please contact me via email to info@LovingHealing.com and be sure to put "TIR" in the subject line.

Victor R. Volkman, Editor
Loving Healing Press
Ann Arbor, Michigan
November 17th, 2003

1 Trauma and TIR

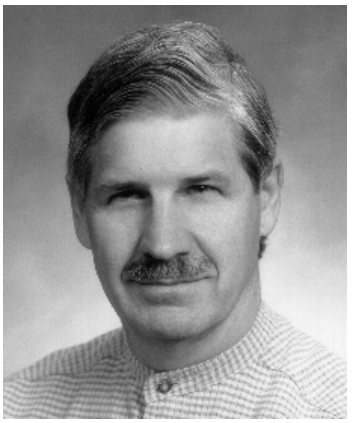


Critical Issues in Trauma Resolution

by Frank A. Gerbode, M.D.

Originally presented as lecture notes from the seminar of the same name

About Frank A. Gerbode, M.D.



Dr. Gerbode is an Honors graduate of Stanford University who later pursued graduate studies in philosophy at Cambridge University in England. He received his medical degree from Yale University, and completed a psychiatric residency at Stanford University Medical Center in the early 1970s. Gerbode is the author of numerous papers and articles, which have been published in the *Journal of Neurochemistry*, the *International Journal of Neuropharmacology*, the *Journal of Rational Emotive and Cognitive Behavioral Therapy* and elsewhere. He teaches and lectures internationally, and is the author of *Beyond Psychology: An Introduction to Metapsychology*, now in its 3rd edition.

Traumatic Incident Reduction: A Simple Trauma Resolution Technique

Most common approaches to post-traumatic stress reduction fall into two categories: coping techniques and cathartic techniques. Some therapists give their clients specific *in vivo* (literally “in life") methods for counteracting or coping with the symptoms of PTSD--tools to permit their clients to learn to adapt to, to learn to live with, their PTSD condition. Others encourage their clients to release their feelings, to have a catharsis. The idea is that past traumas generate a certain amount of negative energy or “emotional charge”, and the

therapist's task is to work with the client to release this charge so that it does not manifest itself as aberrant behavior, negative feelings and attitudes, or psychosomatic conditions.

Coping methods and cathartic techniques may help a person to feel better temporarily, but they don't *resolve* trauma so that it can no longer exert a negative effect on the client. Clients feel better temporarily after coping or having a catharsis, but the basic charge remains in place, and shortly thereafter they need more therapy.

The Need for Anamnesis (recovery of repressed memories)

Traumatic Incident Reduction (TIR) operates on the principle that a permanent resolution of a case requires anamnesis (recovery of repressed memories), rather than mere catharsis or coping. To understand why clients have to achieve an anamnesis in order to resolve past trauma, we must take a person-centered viewpoint, i.e., the client's viewpoint and, from that viewpoint, explain what makes trauma traumatic.

Time and Intention

Let us start by taking a person-centered look at the subject of time (see p. 3). Objectively, we view time as a "never-ending stream", an undifferentiated continuum in which events are embedded. But subjectively, we actually *experience* time differently. Subjectively, time is broken up into "chunks" which we shall call "periods" of time. "A time", for me, is a period during which something was happening or, more specifically, during which I was doing something, engaging in some activity. Some periods of time are in the past; some are in the present. Those periods defined by completed activities are in the past; those defined by ongoing (and therefore incomplete) activities are in the present.

The Contents of Present Time

For that reason, we don't experience present time as a dimensionless point. It has breadth corresponding to the width of the activities in which we are currently engaged. For example, I am still in the period of time when I was a father, when I was attending this conference, when I was delivering this workshop, when I was uttering this sentence, when I was saying this word. These are all activities in which I am engaged, and each defines a period of time with a definite width. In fact, I am inhabiting a host of periods of time simultaneously.

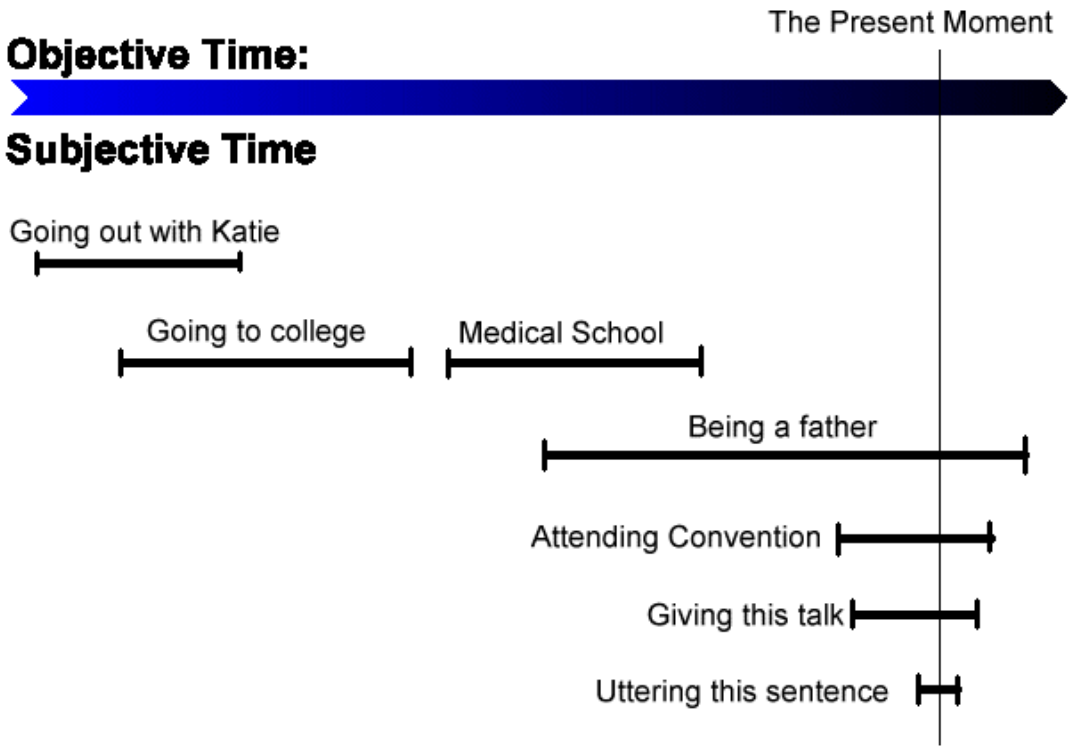


Figure 1: Objective vs. subjective time

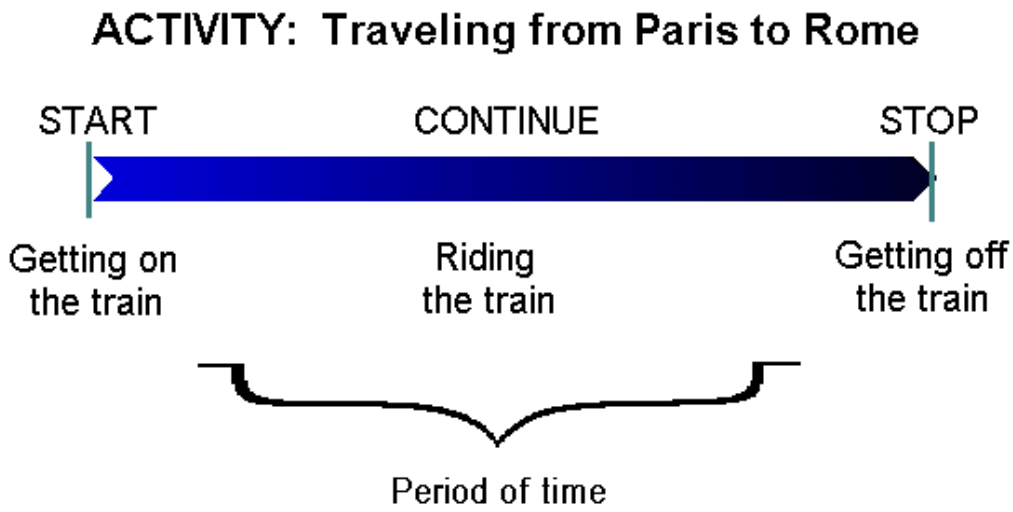


Figure 2: Intention and time

Activity Cycles

A period of time has a simple but definite anatomy, determined by the activity in which you are engaged, which we call an "activity cycle" or just a "cycle" (See Fig. 2). The period of time (and the cycle) starts when the activity starts, continues as long as the activity continues, and ends when the activity ends. The activity in question may be related or unrelated to trauma. It could be trying to get away from a sniper, or it could be vacationing. For instance, the period of time "when I was going from Paris to Rome" starts when I begin the process of getting from Paris to Rome, continues while I get the train tickets, get on the train, and eat in the dining car, and ends when I arrive in Paris. If an activity has started but not ended for me, that period of time is still ongoing and is part of my present time.

The Ruling Intention

Moreover, each of the activities in which I engage is ruled by a governing intention. In the example I just gave, the intention was to get from Paris to Rome but, in the case of a combat veteran, it could be an intention "to get revenge". In effect, therefore, an activity cycle starts when I formulate an intention, continues so long as that intention continues to exist, and only ends when the intention is ended. Therefore, there is an intimate relation between time and intention.

Each of the activities in Fig. 1 is coextensive with the existence of a corresponding intention. Each continues until the intention is fulfilled or unmade. Present time consists of periods of time that are determined by my current intentions.

Ending an Intention

In fact, there are only two ways to end an intention and thus to send a period of time into the past:

Fulfill it: An intention ends more or less automatically when it is fulfilled; because you don't keep intending to do things that you know you have already finished doing.

Discontinue it: Even if an intention is not fulfilled, you can deliberately and consciously decide to *unmake* the intention. Unmaking it, however, requires that you be *aware* of it and of your reasons for making it. You cannot unmake an intention of which you are unaware.

In other words, you can't stop doing something you don't know you are doing.

The Effects of Repression

Repressing an incomplete cycle makes it destructive and, at the same time, much more difficult to complete. As mentioned above, to complete a cycle, I must be aware of the intention that rules it. But if, because of the trauma it contains, I have repressed the incident in which I created the intention, I am not aware that I *have* that intention or why I have it, so I cannot unmake it! That period of time continues up into the present, and some energy remains tied up in it. In fact, it makes sense to define charge as "repressed, unfulfilled intention". Getting rid of charge, then, consists of un-repressing intentions and then unmaking them.

Now it becomes obvious why we need anamnesis in order to resolve the effects of past traumas. To reduce the charge contained in past traumas, the client must come fully into contact with them, so that he can find the unfulfilled intentions that he has repressed and why he formulates them, and unmake them.

To Repress or Not to Repress?

Whenever something painful and difficult to confront shows up in life, one has a choice.

1. Allowing oneself to experience it fully.

   a. Thus being fully aware of one's intentions in the incident, and why one formed those intentions.
   b. Thus having a choice whether or not to unmake the intentions.
   c. At which point, the incident is discharged, by the above definition of "charge", and becomes a *past* incident.

   or

2. Repressing it, wholly or partially.

   a. Thus not being aware of the intentions one made in the incident, or why one made them.
   b. Thus not being able to unmake those intentions.
   c. So that the incident remains charged and continues on as part of present time.

Paradoxically, by trying to get rid of the incident by repression, one causes it to remain present indefinitely.

Effects of Charge

Charge represents a drain on a person's energy or vitality, because energy remains tied up in the incomplete cycle connected with the intention in the trauma, and more is tied up in the effort to repress the incident. Hence a person with unresolved past traumas tends to be rather listless or goalless in life. A second effect of past traumas compounds the difficulty: similar conditions in the environment can trigger or "restimulate" past, repressed traumas, just as the sound of a bell could cause Pavlov's dog to salivate. When one is reminded of a past trauma, one has, again, the choice given above: one can either allow oneself to become fully aware of what happened in the original incident or one can repress the incident of being *reminded*. Repression causes the "reminder" incident to become a secondary trauma in itself. Later, similar occurrences can then restimulate the secondary traumatic incident as well as the original one.

Paradoxically, by trying to get rid of the incident by repression, one causes it to remain present indefinitely.

A Sequence of Traumatic Incidents

For example (See Fig. 3), consider a Vietnam combat veteran who has a past traumatic incident of being in a combat situation in which a close friend was killed. Contained in this incident are, say, the sound of a helicopter, a loud noise, the taste of chewing gum (assuming he was chewing gum at the time), and, perhaps, children (if he was in a Vietnamese village). Also, a tree line. Since this incident is extremely traumatic, the soldier represses it, at least partially. He "doesn't want to think about it." Later, some years after leaving Vietnam, he goes to a barbeque in the park. There, he is, say, chewing gum and sees some children. He also sees a tree line. He starts to be reminded of the original incident and feels the rage contained in it. This becomes uncomfortable, so he represses the incident in the park, wholly or partly. Contained in it were also a barbeque smell and a dog barking.

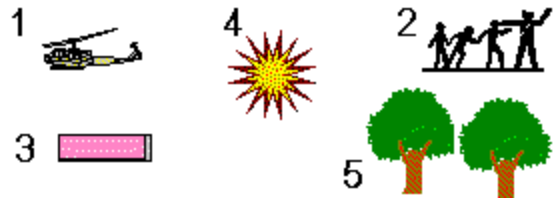
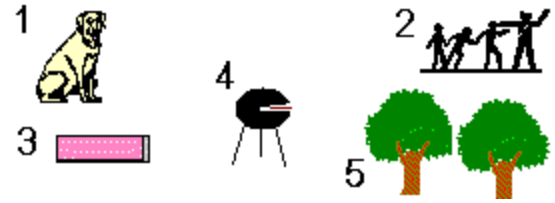
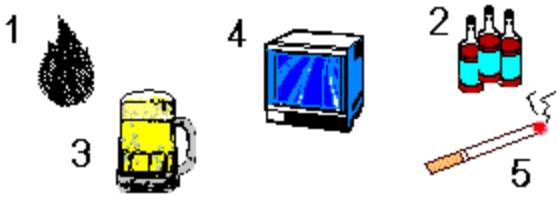
External Restimulators	Icons of Stimuli	Theme (Response)
1. Helicopter Sound 2. Children 3. Taste of Chewing Gum 4. Loud Noise 5. Tree Line		 Blinding rage
1. Sound of Barking Dog 2. Children 3. Taste of Chewing Gum 4. Barbeque Scent 5. Tree Line		 Blinding rage
1. Sound of Barking Dog 2. Children 3. Traffic Sight/Sound 4. Wife 5. Scent of Cigarette Smoke		 Blinding rage
1. Sensation of Intoxication 2. Children 3. Taste of Beer 4. Loud Noise 5. Scent of Cigarette Smoke		 Blinding rage
1. Sensation of Intoxication 2. Bottles 3. Taste of Beer 4. Television 5. Scent of Cigarette Smoke		 Blinding rage

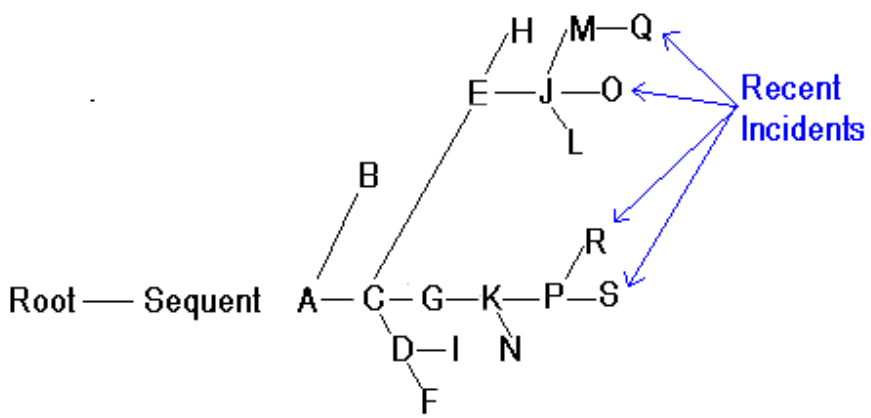
Figure 3. A sequence of traumatic incidents

In a later incident, he is talking with his wife and chewing gum, and they are barbequing on the back porch with the kids, the dog barks, and the veteran suddenly experiences a feeling of rage, because the earlier incident, the one in the park, is restimulated by the common elements: the dog barking, the barbeque smell, and the chewing gum. This is uncomfortable, so he represses this one also, and it becomes another secondary trauma. This incident also contains some additional elements: the sound of traffic, and the person's wife.

Later, he is drinking beer on the back porch with his baby and his wife and smoking a cigarette, and he is trying to talk to his wife but there is also traffic noise. Again, he flies into a rage because of the reminders, although, because the past trauma is repressed, he will attribute the rage to something else, e.g., to the fact that his wife forgot the salt shaker for the *third* time. This incident contains a sensation of being intoxicated, the taste of beer, the smell of cigarette smoke, and his baby. It, too, is repressed.

Later still, he is smoking, drinking beer, and watching TV. The sensation of intoxication and of smoking reminds him of the earlier incident and he feels rage. Now whenever he gets drunk or watches television, he is prone to fly into a rage. Random dream elements restimulate the same sequence of traumas, resulting in recurrent nightmares. Finally, he goes to a therapist and is found to be a full-blown PTSD case.

This is a sequence of traumatic incidents, starting with a "root" incident and encompassing, probably, a large number of subsequent incidents in which the root incident or one of its sequents got restimulated. The only thing in common to all these incidents is the feeling of rage that he experiences each time. He attributes this rage to something in present time, but it actually stems from the original rage he felt in the root incident.



Tree structure of a sequence of traumatic incidents

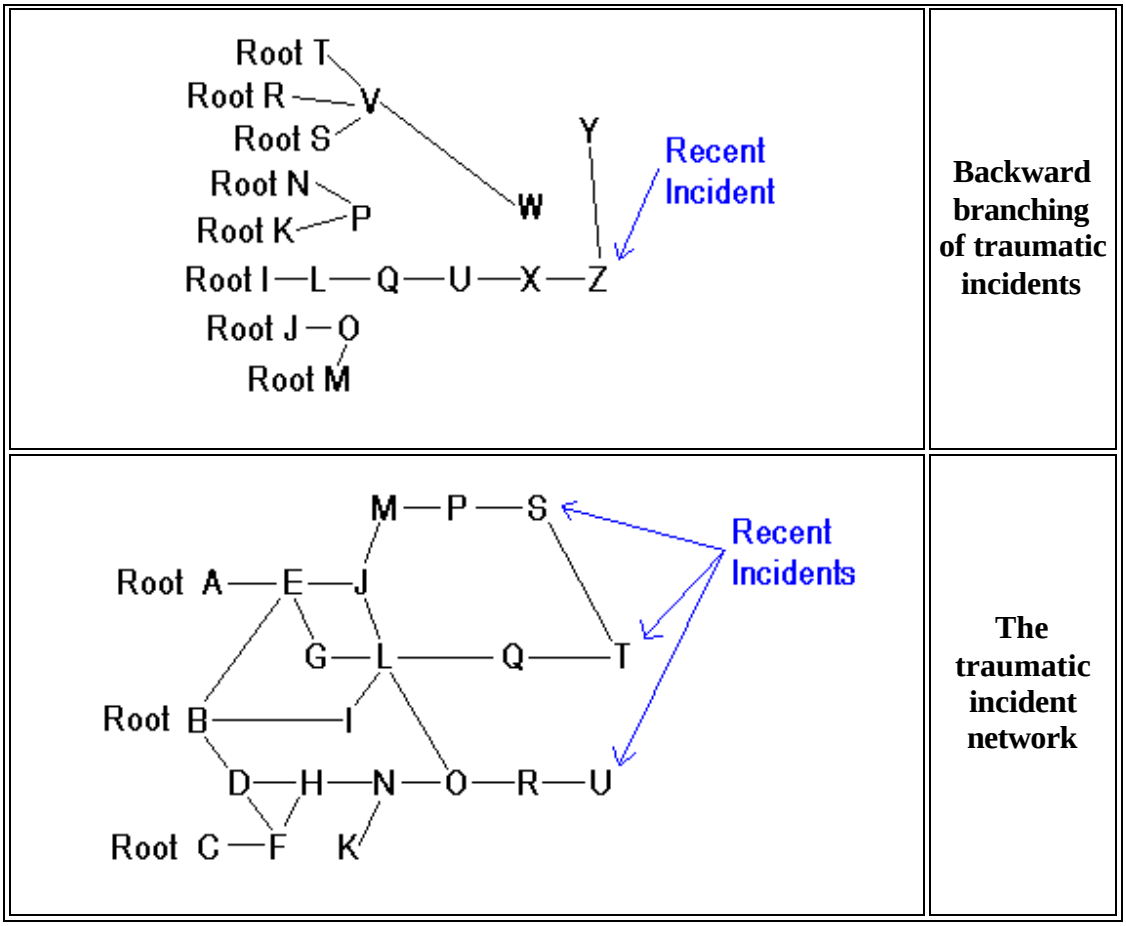


Figure 4. The traumatic incident network

The Traumatic Incident Network

Although we have only shown a few incidents, in real life a sequence may contain hundreds or even thousands of incidents. Furthermore, the average person usually has a fairly large number of these sequences, with different themes in common. These sequences overlap each other to form a network of traumatic incidents which we call the traumatic incident network or "Net" (See Fig. 4). The object of TIR is to reduce the amount of charge the Net contains so that the person is not subject to the restimulating effects described above, and also so that he can reclaim the intention units that are tied up in the Net.

What we have shown, here, is not just the situation of a Vietnam combat vet or a rape survivor. It is the human condition. Every one of us has had at least some past traumas that cause us to be dysfunctional in certain areas of life -- the ones that contain restimulators.

The Solution to the Net

Stating the solution is easy, but accomplishing it is somewhat trickier. Traumas contain very intense, repressed, unfulfilled intentions, such as the intention to get revenge, to escape -- and, of course, the intention to repress the incident. The client needs to find the root incident for each sequence and bring it to full awareness. Traumatic Incident Reduction accomplishes this result. When that occurs, the person becomes aware of the intentions in them and, since these intentions are generally no longer relevant to the here and now, she unmakes them. At that point, the cycles contained in the incidents are completed; they become part of the past, and they can no longer be restimulated.

Undoing Amnesia

What is required, then, to obtain the necessary anamnesis? An incident has four dimensions, not just three. In order to be aware of an incident, it is necessary to start at the beginning and go through to the end, like viewing a motion picture, not like looking at a snapshot. Hence, we call the procedure "viewing", the client a "viewer", and we call the one who helps the client to do the viewing the "facilitator". [For more explanation of these terms, please see the FAQ on p. 251]

You can't just glance at a part of an incident and expect thereby to have fully completed the process of anamnesis, because you will miss other parts of it -- probably the most important ones, the ones that are most difficult to confront. In order to achieve a full anamnesis, you must be allowed to go through the entire incident without interruptions, without reassurances -- in short without *any* distractions. Furthermore, it does not suffice to go through the incident only once. If you want to become fully familiar with a movie, you must see it a number of times, and each time you will notice new things about it. The same thing happens during Traumatic Incident Reduction, except that the client is viewing a past traumatic incident instead of a movie, and that's somewhat harder to do.

Basic vs. Thematic TIR

If, as is often the case with combat vets and rape victims -- survivors of single or discreet incidents -- the viewer already knows which trauma needs to be looked at, you can use a relatively simple form of TIR called "Basic TIR". You simply have the viewer go through the single, known incident enough times to resolve it. But in most cases, the viewer starts out being entirely unaware of what the root trauma underlying his difficulties is. So how can he find it? For that, we use a technique called "Thematic TIR", in which we can trace back an unwanted feeling, emotion, sensation, attitude, or pain to the root trauma from which it originates.

End Points