What Researchers are Saying About the Subject of Traumatic Incident Reduction and Related Techniques:

"We are very impressed with the power and simplicity of TIR in helping trauma sufferers work through their frightening experiences and find great relief."
— Charles R. Figley, Ph.D., editor of TRAUMATOLOGY

"Being able to watch someone go from confusion to certainty, from sadness to happiness in a single session is a wonderful privilege. It is invigorating. I get the same satisfaction and joy from teaching Metapsychology techniques to others."
— Lori Beth Bisbey, Ph.D., Chartered Counselling Psychologist

"TIR does not require years of collegiate study to pre-qualify the provision of assistance to others. The efficacy of TIR is not contingent on the unique talents of a particular facilitator. The procedure is standardized and does not require continuous adjustments."
— Wendy Coughlin, Ph.D.

"In many cases, TIR results in the complete and permanent elimination of PTSD symptomatology. [My] dissertation suggests the use of TIR as an effective technique in the treatment of child and adolescent Post Traumatic Stress Disorder with the identified population."
— Francine Odio, Ph.D.

"…in TIR you do no interpretation for the client. You do not say to your client: 'That's probably related to something that happened in your childhood.' You would not presume to know what happened; you would not in fact interpret those things for the person."
— Joyce Carbonell, Ph.D., Florida State University

"The comments given by female inmates [in this study] suggest that they were highly appreciative of the client-respectful nature of TIR. For many of them, this was their first experience with a treatment provider who was both effective and respectful."
— Pamela Vest Valentine, Ph.D.

Traumatic Incident Reduction:
Research and Results

Edited by Victor R. Volkman
Public Information Chair, TIR Association

Traumatic Incident Reduction: Research and Results

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Series Editor: Robert Rich, Ph.D.

"To be what we are,
and to become what we are capable of becoming,
is the only end in life"

—Robert Louis Stevenson (June 1880)

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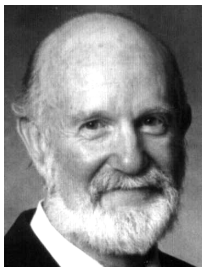

Loving Healing Press is pleased to announce Robert Rich, Ph.D. as Series Editor for the *Explorations in Metapsychology Series*. This exciting new series plans to bring you the best of Metapsychology in practical application, theory, and self-help formats.

Robert Rich, M.Sc., Ph.D., M.A.P.S., A.A.S.H. is a highly experienced counseling psychologist. His web site www.anxietyanddepression-help.com is a storehouse of helpful information for people suffering from almost any way we can make ourselves and each other unhappy.

Bob is also a multiple award-winning writer of both fiction and non-fiction, and a professional editor. His writing is displayed at www.bobswriting.com. You are advised not to visit him there unless you have the time to get lost for a while.

Two of his books are tools for psychological self-help: *Anger and Anxiety: Be in charge of your emotions and control phobias* and *Personally Speaking: Single session email therapy*. However, his philosophy and psychological knowledge come through in all his writing, which is perhaps why three of his books have won international awards, and he has won many minor prizes. Dr. Rich currently resides in Wombat Hollow in Australia.

About the Cover

The cover image depicts a view of 10,000 galaxies, the deepest visible-light image of the cosmos ever captured. This image required a total exposure time of 11.3 days over the course of three months by the Hubble Space Telescope. The width of the image represents billions of light years.

The center 'psi' logo was engineered by Joseph M. Ciarrocchi and rendered using Imageware 12. The sunburst illumination effect was added later with JASC PaintShop Pro 7. Creative director for the cover was Victor R. Volkman.

Dedication:

This book is dedicated to the memory of

Stephen Bisbey (1952-2004)

counsellor, trainer, author, and beloved friend of the many people he worked with and helped.

Table of Contents

Introduction: A Brief History of TIR Research and Results

The purpose of *Traumatic Incident Reduction: Research & Results* is to summarize the major outcomes of the first decade of research on this subject (approximately 1994 to 2004). TIR as a formal subject came on the scene in 1988 with the publication of *Beyond Psychology: An Introduction to Metapsychology (1st Ed.)* by Frank A. Gerbode, M.D. This book codified a straightforward step-by-step technique for handling the effects of multiple past traumas connected by similarity of incident or theme. Of course, TIR did not spring into existence by itself and is the product of diverse influences and the input of many authors. As Robert H. Moore, Ph.D. points out in his essay "Psychological Foundations of TIR", there are clear antecedents and concepts borrowed from imaginal flooding, desensitization, repetitive review, Rogerian techniques, and Pavlov, just to name a few.

Following the introduction of TIR and workshop-level training in the late 1980s, there came a flood of anecdotal evidence of the efficacy of TIR. Among the most dramatic of the early successes involved Post-Traumatic Stress Disorder (PTSD) in Vietnam combat veterans (see *Beyond Trauma: Conversations on Traumatic Incident Reduction, 2nd Ed,* 2005). Please note that TIR can be applied to the vast majority of traumatic stress cases and is not limited to the particular diagnosis of PTSD. However, a mountain of anecdotes does not a scientific research project make.

In the early 1990s, two researchers began independent studies of TIR as part of their doctoral dissertation work. In the UK, Lori Beth Bisbey began a groundbreaking study of traumatic stress in crime victims and how TIR alleviated their symptoms. This study showed for the first time the advantage of TIR over Direct Therapeutic Exposure techniques. Shortly thereafter, Wendy Coughlin employed TIR facilitators around the United States in a study of how anxiety and panic attack symptoms might be relieved by TIR. Both dissertations were published in 1995 and brief summaries appear in this book.

During this same period (1994), Charles R. Figley and Joyce Carbonell of Florida State University developed the "Active Ingredient" study. The purpose of this research was to analyze four brief treatments for traumatic stress [1] (TIR, VK/D, EMDR, TFT) and hopefully discover or distill the common element which made them effective. Two summaries of this research appear in this book.

Pamela V. Valentine built on the results of Bisbey and Coughlin with her outcome study on a controlled study of incarcerated females in Florida prisons. This study was published as a dissertation in 1997 and is also summarized in this book. In this study, the experimental condition showed a statistically significant decrease in symptoms of posttraumatic stress disorder (and its

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[1] Traumatic Incident Reduction (TIR), Visual Kinesthetic/Disassociation (VK/D), Eye Movement Desensitization and Reprocessing (EMDR), and Thought Field Therapy (TFT).

related subscales) and of depression and anxiety, while those in the control condition remained approximately the same. Subjects assigned to the experimental condition improved on the measure of self-efficacy at a statistically significant level, while subjects assigned to the control condition did not.

1998-99 saw the publication of the first two textbooks devoted solely to teaching the principles and methods of TIR. In the USA, Gerald French and Chrys Harris published *Traumatic Incident Reduction* as part of the Innovations in Psychology series (CRC Press, Series Editor: Charles R. Figley). In the UK, the team of Stephen and Lori Beth Bisbey published *Brief Therapy for Post-Traumatic Stress Disorder: Traumatic Incident Reduction and Related Techniques* as part of the Brief Therapy and Counselling Series (Wiley, Series Editor: Windy Dryden). As I write this introduction, preparations are underway for the release of a greatly revised second edition of French and Harris' book in late 2005.

Although not a research project, I have included the work of Teresa Descilo, MSW because it is the first published outcome results of TIR with middle-school aged children. Beginning in 2001, this project has shown significant results in reducing post-traumatic and depression symptoms in this vulnerable population of at-risk students.

It is my most fervent hope that in presenting summaries of TIR research data that it will inspire others to back and look at the original studies and consider taking TIR research to the next level of scrutiny and validation. If you would like to learn more about the philosophical roots of TIR or read selected case histories, I highly recommend you peruse *Beyond Trauma: Conversations on Traumatic Incident Reduction, 2nd Ed.* (2005) after reading this book.

Victor R. Volkman (victor@tir.org)
Public Information Chair, TIR Association
April 15th, 2005

TIR: Primary Resolution of the Post-Traumatic Stress Disorder

By Robert H. Moore, Ph.D.

About the Author

Dr. Moore is a licensed marriage and family therapist, school psychologist and mental health counselor with graduate degrees in counseling psychology from Lehigh (1965) and Walden (1977) Universities. He is a Fellow and Diplomate of the American Board of Medical Psychotherapists; a Diplomate of the International Academy of Behavioral Medicine, Counseling and Psychotherapy.

With over thirty years of practice, seventeen as Director of the Institute for Rational Living in Florida, he has co-edited or contributed to six popular books by Albert Ellis; authored chapters on various applications of Cognitive Behavior Therapy and Traumatic Incident Reduction for professional texts by Windy Dryden, Larry Hill and Janet Wolfe; hosted his own nationally syndicated daily talk radio program; and produced over three hundred psychologically-topical news and public service segments for radio and television. He most recently operated a Domestic Violence Intervention Program in Clearwater under contract to Florida's Department of Corrections.

Problem Profile

In the early 1990's, significant media attention was given to the Post-Traumatic Stress Disorders (PTSD) of Vietnam veterans, whose post-war "nervous" problems (i.e., sleep disturbances, hypervigilance, paranoia, panic attacks explosive rages, and intrusive thoughts) were known to veterans of earlier campaigns as "battle fatigue," "shell shock," and "war neurosis" (Kelly, 1985). As any number of mugging, rape, and accident victims have demonstrated, however, one need not have been a casualty of war to experience the problem (APA, 1987). PTSD appears in children as well as adults (Eth & Pynoos, 1985) and has been attributed to abuse, abortions, burns, broken bones, surgery, rape, overwhelming loss, animal attacks, drug overdoses, near drowning, bullying, intimidation, and similar traumata. It manifests as a wide range of anxieties, insecurities, phobias, panic disorders, anger and rage reactions, guilt complexes, mood and personality anomalies, depressive reactions, self-esteem problems, somatic complaints, and compulsions.

The PTSD reaction is most easily distinguished from emotional problems of other sorts by its signature flashback: the involuntary and often agonizing recall of a past traumatic incident. It

can be triggered by an almost limitless variety of present cognitive and perceptual cues (Kilpatrick, 1985; Foa, 1989). Lodged like a startle response beyond conscious control, the reaction frequently catapults its victims into a painful dramatization of an earlier trauma and routinely either distorts or eclipses their perception of present reality. Although we can't confirm that any of the countless animal species with which researchers have replicated Pavlov's (1927) conditioned response ever actually flashed back to their acquisition experiences, the mechanism of classical conditioning is apparent in every case of PTSD. As salivation is to Pavlov's dog, so PTSD is to its victims.

Like emotional problems of other sorts, however, PTSD is not accounted for solely in terms of antecedent trauma and classical conditioning. In order to provoke a significant stress reaction, as Ellis (1962) and others observe, an experience must ordinarily stimulate certain components of an individual's pre-existing irrational beliefs. Veronen and Kilpatrick (1983) confirm that the rule holds for trauma as well as for more routine experience. Errant beliefs—related to the tolerance of discomfort and distress; performance, approval, and self-worth; and how others should behave—

> "…may be activated by traumatic events and lead to greater likelihood of developing and maintaining PTSD symptomatology and other emotional reactions. Individuals who pre-morbidly hold such beliefs in a dogmatic and rigid fashion are at greater risk of developing PTSD and experiencing more difficulty coping with the resulting PTSD symptomatology"
> (Warren & Zgourides, 1991, p. 151).

Also activated and often shattered by trauma are assumptions regarding personal invulnerability; a world that is meaningful, comprehensible, predictable and just; and the trustworthiness of others (Janoff-Bulman, 1985; Roth & Newman, 1991). Such pre-existing beliefs and assumptions, plus the various conclusions, decisions and attitudes specific to a particular traumatic incident (especially when held as imperatives) constitute the operant cognitive components of PTSD.

Primary and Secondary Trauma

What makes PTSD a particularly persistent and pernicious variety of disturbance is the occurrence, at the time of its acquisition trauma, of significant physical and/or emotional pain. Such pain, in association with the other perceptual stimuli, thoughts, and feelings one experiences at the time, constitutes the "primary" traumatic incident. The composite memory of the primary incident, therefore, contains not only the dominant audio/visual impressions of that moment, but also one's mind-set (motives, purposes, intentions) and visceral (emotional and somatic) reactions. Thus, whenever one subsequently encounters a "restimulator"—any present-time sensory, perceptual, cognitive, or emotive stimulus similar to one of those contained in the

memory of an earlier trauma—one is likely to be consciously or unconsciously "reminded" of and, therefore, to re-activate its associated pain or upset. It is this subsequent painful reminder, the involuntary "restimulation" of the primary trauma, that constitutes the painful secondary experience we recognize as PTSD (Foa, 1989).

In the Pavlovian model, the occurrence of the restimulator (trigger stimulus) equates to the ringing of the bell; the stress reaction itself equates to salivation. The mechanism is almost indefinitely extendible by association. Once the dog has been conditioned to salivate to the ringing of the bell, for example, the bell may be paired with a new perceptual stimulus—say, the flashing of a light—so that the dog will then salivate to the light as well as to the bell. If one next flashes the light and pulls the dog's tail, the dog will learn to salivate when his tail is pulled (Hilgard, 1962). By sequencing stimuli so as to create a "conditioned response chain" in this manner, we expand the domain of stimuli that will elicit the salivation response.

This process may be illustrated by the following common example: A veteran originally injured in an artillery attack (the primary trauma) will often tend to be restimulated, even years later, by such things as smoke and loud noises. So it's no surprise when he panics, post-war, in response to fireworks. However, should he happen to be triggered into a full-blown panic reaction by a fireworks display while eating fried chicken one day at a picnic in the park, he is likely thereafter, as strange as it seems, to get panicky around fried chicken (whether he flashes back to the park at the time or not). In such a circumstance, fried chicken gets added to the domain of toxic secondary restimulators of his war experience, and the "picnic in the park" incident acquires secondary trauma status and is itself subject to later restimulation. If, for instance, fried chicken subsequently gets (or previously had gotten) associated with his mother-in-law (who prepares it for his every visit), his contact with her also becomes subject to PTSD toxicity by association. The dynamic effect of such repeated reactions over a period of time is a gradual increase in the client's toxic secondary reactions. This, in turn, produces a corresponding reduction of his day-to-day rationality and an inability both to comprehend and to break out of his increasingly volatile reactive pattern (see Hayman et al, 1987).

The more reactions one experiences, the more new toxic secondary stimuli develop. The more new toxic stimuli there are, the more reactions one has, which suggests that those experiencing PTSD would eventually come to spend most of their time with their attention riveted painfully on past trauma. In point of fact, that does happen. The longer and more complex the chains or sequences of secondary incidents become over time, however, the less likely one is to flash all the way back to the primary trauma. This is why so many PTSD clients who appear to succeed in getting their attention off their primary traumata nevertheless withdraw from many of the life activities they previously enjoyed. Because they flash back to "the big one" a lot less, their PTSD cases are presumed to have abated. In reality such clients are in worse shape overall because a lot of little things in their traumatic incident networks (all the secondary restimulators

or "cues" they picked up in the years following their primary traumata) bother them much more than they did in the past (Gerbode, 1995).

PTSD and the Cognitive Therapies

Gerbode points out that some of the key cognitions contained in the memory of any traumatic incident that later cause trouble when they are restimulated are those specific conclusions, decisions, and intentions the individual generated during the incident itself in order to cope emotionally with the painful urgency of the moment. In such a circumstance, not only would certain pre-existing beliefs govern one's reaction to a traumatic event, but also the traumatic event itself would give rise to the formulation of new, potential errant cognitions. Viewed in this light, PTSD is very much a cognitive-emotive disorder and not nearly as Pavlovian as it at first appears to be. Accordingly, an effective cognitive-emotive approach is called for in its remediation, one in which the errant cognitions generated under the duress of the trauma are located and corrected.

Most cognitive therapists have traditionally favored challenging a client's current disturbance-causing belief system over directly confronting the earlier experience(s) responsible for its acquisition (Ellis, 1962, 1989). A therapist's decision to focus an intervention mainly on a client's responses to day-to-day stressors is most understandable when the client does not report flashing back at the time of the upsets. Most non-PTSD clients, after all, have no special awareness of their early acquisition experiences and, therefore, have little or nothing to say about them. Their attention is fixed on a steady stream of disturbance-provoking current events for which both we and they realize they do need more rational coping skills. In the clear-cut PTSD case in which flashback is evident, the client not only puts the acquisition experience (the primary trauma) in focus right at the start but also often seems virtually obsessed by it. Flashback content, which is often concurrent with the client's upset over something in present time, is so painfully "charged" that he or she is either barely able to shift attention from it or else must regularly struggle to resist attending to it (Solomon, 1991). In such a circumstance, the therapist who focuses intervention exclusively on the client's dramatic over-reactions to current (secondary) events (on the restimulator, rather than on what is being restimulated) bypasses the opportunity to address directly and resolve the core of the client's PTSD case. Such attention mainly to the present-time "cueing effect," according to Goodman and Maultsby (1974, p. 62), "explains many failures or partial successes in psychotherapy, despite the best intentions of patient and therapist."

Given the extreme volatility of the memory of a trauma, though, it's really no wonder that many therapists and their PTSD clients (tacitly) agree not to confront such incidents head on. To understand why this is so often the case, consider the following:

- It is nearly impossible to get PTSD clients to perceive or appraise objectively a traumatic experience they are in the midst of dramatizing;
- It is usually difficult, even when they are not dramatizing, to sell PTSD clients on the idea of re-evaluating a traumatic event that has given them nightmares for the last fifteen or twenty years;
- Cognitive restructuring, thought stopping, and stimulus blunting techniques give PTSD clients little or no control over their tendency to flashback spontaneously and go into restimulation; and
- Helping PTSD clients minimize the disruptive impact of their intrusive thoughts and teaching them not to down themselves over the persistence of their symptoms is better than nothing.

It becomes understandable, then, that many therapists choose to assist clients in their ongoing struggles to distance themselves from the memories of their traumata in an attempt simply to limit the frequency and intensity of their post-traumatic episodes.

Therapists may actually bring superb therapeutic skills to bear on clients' over-reactions to a variety of contemporary stimulus-events (e.g., rage over a spill, anxiety at a meeting), but unless they help PTSD clients to resolve the prior trauma (e.g., auto accident, childhood abuse, war experience) that actively supports their current disturbance and to revise the errant cognition associated with that primary experience, they have elected not to address the PTSD at all. The result of such a purely secondary intervention is that clients' unresolved primary traumas continue intermittently to intrude into consciousness, and clients are left to struggle alone to secure a sense of rationality against the influence of these traumas.

Primary Approaches

Because a traumatic incident is, by definition, exceedingly unpleasant, there is an understandable tendency, at the moment one is occurring, to resist and protest it as best one can. It is at just such moments of extreme physical and/or emotional pain, according to Gerbode (1995), that one's thinking (evaluative cognition) is least likely to be well-reasoned and objective and most likely to be irrational and distorted. There is, moreover, a subsequent tendency to suppress and/or repress the memory of such an incident so as not to have to re-experience the painful emotional "charge" its restimulation carries with it. Unfortunately, suppression/repression of the memory of a traumatic incident effectively locks its distorted ideation and painful emotion away together (along with the incident's sensory and perceptual data) in long-term storage. Thus, the stage for PTSD is set. Fortunately however, when accessed with the specific cognitive imagery procedure of TIR, a primary traumatic incident can be stripped of its emotional charge permitting its embedded cognitive components to be revealed and restructured. With its emotional impact depleted and its irrational ideation revised, the memory of a trau-

matic incident becomes innocuous and thereafter remains permanently incapable of restimulation and intrusion into present time (Gerbode 1989).

As Manton and Talbot (1990) observe:

> "Traumatic events...can bring into consciousness unresolved [prior] situations (with similar themes) such as incest, child abuse, or the death of an important person in the victim's life" (p.508).

When clients have more than one trauma in their history, the only completely effective procedure is one that traces each symptom of the composite post-traumatic reaction back through sequence(s) of related earlier incidents to each of the contributing primaries. Interestingly, a very similar observation was made by one of our earliest colleagues, (Freud, 1984) who wrote:

> "What left the symptom behind was not always a single experience. On the contrary, the result was usually brought about by the convergence of several traumas, and often by the repetition of a great number of similar ones. Thus it was necessary to reproduce the whole chain of pathogenic memories in chronologic order, or rather in reversed order, the latest ones first and the earliest ones last" (p. 37).

The simple fact is that in order to deal effectively with past trauma, we must guide the client through to its resolution in imagery. The imagery process itself, however, is just the means by which we help PTSD clients get through their residual primary pain. It is by revising the errant cognition associated with that pain that they are freed from the grip of their PTSD.

Traumatic Incident Reduction

The most thorough and reliable approach to the resolution of both long-standing and recent disaster PTSD currently in use is Traumatic Incident Reduction (TIR), a guided cognitive imagery procedure developed by Gerbode (1995). A high-precision refinement of earlier cognitive desensitization procedures, TIR effectively resolves the outstanding trauma of the majority of the PTSD clients with whom it is used when carried out according to its strict guidelines.

TIR appears to be more efficient and more effective than other cognitive-imagery or desensitization procedures, as such procedures frequently focus mainly (and most often incompletely) on secondary episodes. By tracing each traumatic reaction to its original or primary trauma(ta) and by taking each primary trauma to its full resolution or procedural "end point" at one sitting (a crucial requirement), the TIR process leaves clients observably relieved, often smiling, and no longer committed to their previously errant cognitions. At that point, the traumatic in-

cidents, their associated irrational ideation, and consequent PTSD have been fully handled, and clients are able to re-engage life comfortably in ways they might not have been able to do since their original traumata.

Done one-on-one, the core TIR procedure may be completed in as little as twenty minutes or it may require two or three hours (average: 1.5 hrs) of "viewing" per incident. No procedure that is confined to the fifty-minute hour can be considered flexible enough to handle the average primary traumatic incident. The therapist needs to be willing to take the time necessary to guide the client back through the relevant trauma, carefully following TIR procedural guidelines, to permit the client to work through the painful memories of the experience in order to restructure its cognitive content as needed for full resolution.

Ideally, PTSD clients correctly identify their active primary incidents during intake. Clients who have regular flashbacks generally do this with ease. Such clients may be briefed on TIR the same day and, if not on psychoactive drugs, scheduled for viewing the next day. Their PTSD problems can often be alleviated within the week. It is not unusual for a TIR narrative procedure to resolve an "unoccluded" (obvious) primary traumatic incident in as little as two or three hours. Case resolution then would depend mainly on how many primary and secondary traumata needed to be addressed to restore full functioning.

More commonly, however, PTSD clients do not correctly identify all their active primary incidents at intake. A war veteran, for instance, may at first report with conviction that it all dates back to Vietnam; he's only had the problem since then, and that is the content of his flashbacks. Once he gets into it, however, he is sometimes surprised to discover that his wartime experience was actually secondary to some previously occluded or less memorable earlier trauma.

In chronic cases, including some phobias and panic disorders in which flashbacks are absent, clients often have no clue at intake as to where or when their reaction patterns were actually acquired. Although technically not classified as PTSD, many such clients have had a significant number of stressful experiences over the years. Yet they cannot, at first, identify any one incident as having been much more significant than any other. They are often thoroughly frustrated and discouraged, as well as genuinely baffled, about the persistence of their symptoms. Those among them who lead otherwise comfortable lives and seem not to think much less rationally, day-to-day, than the majority of the population frequently come to the usually erroneous conclusion that their problems must be genetic in origin ("run in the family"). (Needless to say, such cases are not resolved within the week.) They are not generally a problem for TIR, however, as they may be handled to resolution very adequately by the thematic approach, a variation of the narrative procedure. Thematic TIR does not require clients to be aware of or to identify correctly the relevant historic components of their cases right at the start of their intervention. Instead, the thematic procedure simply traces each manifest (present