

***Cognitive
Behavior
Management
#28***

Traumatic Incident Reduction

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Acknowledgement of source materials would need to include the work of Steve B. Reed - 'What is TIR?'; Robert H. Moore - 'Traumatic incident Reduction: Primary resolution of the Post Traumatic Stress Disorder '; Gerald French- 'Rational for Training Veterans Vocational consultants in Traumatic Incident Reduction (TIR)'; and Peter Shefler a client who has benefitted from the technique. All of these sources, and I am sure many more, were found on the internet in 2001.

Technique #28

Traumatic Incident Reduction

Clinical Prompt

Assessment Criteria

- Client has identified a specific traumatic event period.
- Client is seeking desensitization.
- Client understands that the traumatic event prevented completion of something and relief evolves from successful completion, insight, and growth.
- Client understands the procedure and is motivated to try.
- Sufficient time is reserved (.5 to 3 hours).
- Client understands that once the 'end point' (desensitization) occurs, the sessions is over, and it ends without discussion.
- Client feels safe and has practiced a self-soothing method [See Relaxation Techniques] that can be used as needed.
- Client specifies to the facilitator a way to know that s/he needs to take a break and use the self-soothing method.
- Client feels safe and able to withstand 3 hours of talking about the event.
- Client can call upon a supporter following the session.

Procedures Overview

- Establish safety, trust, and alliance.
- Explain purpose and procedures.
- Facilitator must retain completely neutral stance, focusing the client on the observation of the experience and the dimensions included in those observations, but not commenting on the observations, the feelings the observations might arouse, or the experience itself.

Exact Procedures (abbreviated) (See Descilo, in press or Moore, 1996 for Details)

- *Facilitator*: "Tell me what you are interested in focusing on now."
- *Client*: [specifies a particular event that is identifiable with a few terms and a period of time]
- *Facilitator*: "Thank you. Please tell me when it started and ended approximately (dates)."
- *Client*: [specifies this information]
- *Facilitator*: "Thank you. Now go to the beginning of the event and think it through (all of the major aspects) in your mind - either shutting your eyes or not. Let me know when you have done this."
- *Client*: [usually shuts eyes for a few minutes at most and then opens and looks directly at the therapist to signal that s/he is finished the silent review]
- *Facilitator*: "Thank you. Now, please go to the beginning of the event and tell me about it in as much detail as you wish."
- *Client*: [S/he tells the facilitator about the incident. At first the client awaits responses from the facilitator, like any other two-way conversation. Eventually s/he senses that s/he is the one who must do the talking and not rely on signals from the facilitator about what to discuss more or less.]

Clinical Prompt [two pages]

- *Facilitator:*
 - a. Notices the degree of client distress
 - b. Understands that it gets worse before it gets better
 - c. Expects the story will be told at least five times and often more
 - d. Looks for end points (how the client appears at the end of his/her story description) that indicate desensitization:
 - (1) no anxiety,
 - (2) laughter,
 - (3) insight,
 - (4) acceptance,
 - (5) at peace.

Unless an end point is reached the clinician follows procedure D#6 above and continues with the same procedures until an end point is reached.

Alternate Procedures

1. Clients frequently (30-40% of the time) recognize that there is another, often earlier, event that is linked to the current traumatic incident.
2. Facilitator must make a judgement about shifting attention to this alternative event.
3. Usually s/he takes a cue from the client and says: "You seem to be more interested in that event than the one you are focusing on. Continue to describe this event until the end of it and we will have the option of shifting to that event at that time."
4. If so, the facilitator follows the same procedure as described above.

Ending the Session

1. Client is alerted that when an end point is reached the session is terminated without discussion.
2. At that point the facilitator says: "Good. Let's call it a day today and set up your next appointment to talk about it. Keep a journal of your thoughts between sessions because your thoughts are far more important than mine about what happened here."
3. The next session is merely to ensure that the client has not identified other areas of concern and to assess the effectiveness of the procedure.

Technique #32

Traumatic Incident Reduction

Introduction

The PTSD experience is characterized by the fact that the survivor is living in the past instead of the present.

Symptoms

Symptoms associated with Post Traumatic Stress Disorder (PTSD) include:

- 1) re-experiencing the event in varying sensory forms (flashbacks),
- 2) avoiding reminders associated with the trauma, and,
- 3) chronic hyper-arousal in the Autonomic Nervous System (ANS).

PTSD is present when these symptoms last more than one month and are combined with loss of function in areas such as school, work or social relationships.

Many believe that the core is the last symptom - increased ANS arousal. People who suffer from PTSD are plagued with frightening body symptoms which are characteristic of hyper-arousal: accelerated heart beat, cold sweating, rapid breathing, heart palpitations, hyper-vigilance, and hyper-startle response (jumpiness). These symptoms lead to sleep disturbances, loss of appetite, sexual dysfunction and difficulties in concentrating, which are further hallmarks of PTSD. Hyper-arousal both

instigates flashbacks and is also increased by them, and hyper-arousal is the underlying cause of the symptom of avoidance, as traumatic reminders increase ANS arousal.

The consequences of trauma and PTSD vary greatly depending on the age of the client, the nature of the trauma, the response to the trauma and the support to the person in the aftermath. In general, PTSD clients suffer reduced quality of life due to the intrusive symptoms which restrict their ability to function.

Child victims of trauma are a special area for study. Psychological and motor development can be arrested in child victims of trauma, leading to increasingly negative impact on their lives if they continue to mature without intervention to restore lost or undeveloped resources and skills.

The victim of PTSD will feel unable to contain the traumatic experience(s), will have become afraid of his/her body, and will have lost the sense of what was then and what is now. It is these three areas - containment, positive body awareness, dual time awareness - that must first be strengthened, before addressing the memory of a traumatic event can be done productively.

Containment of out-of-control emotions and thinking processes will help restore a feeling of control over the psychological self. Positive body-awareness will help restore a sense of the body and its sensations as friend, not foe. Dual time awareness will help to separate that the trauma occurred in the past even though it feels as if it is occurring now.

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. Lodged like a startle response beyond conscious control, the reaction frequently catapults the

person into a painful dramatization of an earlier trauma and routinely either distorts or eclipses their perception of present reality.

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, an experience must ordinarily stimulate certain components of an individual's preexisting irrational beliefs. 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 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". 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. 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.

The key cognitions contained in the memory of any traumatic incident that later cause trouble when they are re-stimulated 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, potentially 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.

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, 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 reexperience the painful emotional 'charge' its re-stimulation 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.

When accessed with the specific cognitive imagery procedure of Traumatic Incident Reduction, 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 traumatic incident becomes innocuous and thereafter remains permanently incapable of re-stimulation and intrusion into present time.

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.

The simple fact is that in order to deal effectively with past trauma, we must guide the client through to its resolution in metaperceptive 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.

Symptom effectiveness

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 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 incidents, 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

Time for Mastery

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. The clinician 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.

Instructions

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 drugs, scheduled for viewing. It is not unusual for a TIR *narrative* procedure to resolve an obvious primary traumatic incident. 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. In chronic cases, including some phobias and panic disorders in which flashbacks are absent, clients often have no clue 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.

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 present time emotional and somatic symptom (theme) back through its chain(s) of secondary incidents, one at a time, until the originally hidden primaries come into awareness and can be dealt with routinely.

The lexicon of TIR reflects its purpose and procedure. The client is called a 'viewer' because his/her primary function is to confront,

via the viewing process, past trauma. You, in conducting the session, are called a 'facilitator' because your purpose is simply to facilitate the viewer's process of viewing.

TIR, like other cognitive imagery processes, holds errant cognition to be at the root cause of emotional disturbance. Unlike the mainstream cognitive approaches, TIR carries the revision process back to the specific experience(s) that originally produced and enforced such cognition. TIR guides clients in the discovery and revision of their own original disturbance-causing cognitions.

What is particularly remarkable about the cognitive restructuring that takes place in TIR is that it takes place so obviously and spontaneously during the course of a given session. Equally remarkable is the fact that it takes place and truly must take place without didactic or corrective facilitator input. The facilitator's role in TIR is mainly to so conduct the session and guide the viewer in 'repeated review' of the selected trauma (in strict accord with the established protocol) that the viewer will be able rationally to restructure his own 'misconceptions' about it.

Bear in mind that at this level of intervention the viewer is truly the only one who can decipher (by patient and careful re-examination of the cognitive images stored in memory) what actually happened or appeared to happen in the incident, what its significance was, what s/he was thinking at the time, why it was so extraordinarily painful, how s/he coped with that pain, and what trauma-related conclusions and/or decisions were made at the time. So, as the viewer examines this highly sensitive and very painful material repeatedly in imagery in order to discharge the emotional impact holding the cognitive distortions in place, the facilitator *says not a word*.

The facilitator may, however, offer suggestions as to how to view if the client is having difficulty with the painful material. These suggestions are connected to dissociation - e.g., placing the child

in a position which is safely disconnected from the situation being viewed. The placement in second or third positions or the imaginary insertion of a plexiglass partition between the viewer and the sight may help to make the viewing more comfortable.

Although in TIR's handling of PTSD the operant trauma related distortions virtually self correct once the inordinate emotional distress of the traumatic experience is relieved, viewers frequently want to follow a completed TIR session with some discussion or review of some of the ways in which certain of their newly surrendered trauma-related beliefs and attitudes had affected them since the occurrence of their original trauma. A fully resolved traumatic experience is neither completely nor mostly forgotten. It is, by definition, simply benign and incapable of intrusive re-stimulation.

TIR offers the following advantages as a tool for those working in the arena:

- TIR is itself neither counseling nor a 'therapy' in the conventional sense.
- Its application does not require any great degree of intuitiveness, nor prior training as a counselor, on the part of anyone using it.
- The technique itself is simple and can be quickly taught.

TIR is systematic, trans-cultural and non-ideological, and rapidly effective in producing stable relief from many of the most painful and seemingly intractable symptoms of PTSD.

Process

TIR involves a very specific but fairly simple procedure that helps people resolve painful incidents.

- The first step is to have the subject identify a traumatic incident.
- Next, the subject identifies when it happened, how long it lasted and where s/he was at the time.
- Then s/he will be asked to imagine going to the start of that incident. The starting point is that moment just before the upsetting event began. Once at the starting point the subject will close his/her eyes, report what s/he is aware of and then imagine moving through the incident until it is over. At the end of the incident the subject will open his/her eyes and report what happened as s/he moved through it.

The only variation on this process may be the metaperception process of dissociation. The subject will be asked to repeat the process of going back to the beginning of the incident, moving through it in his/her mind to the end and reporting what happened. The subject will repeat this process of reviewing the incident multiple times (often 5 to 25). With each subsequent reviewing:

- s/he will notice or remember different things,
- s/he may release pent-up emotions,
- the feelings and sensations will start to change,
- the incident will become less disturbing,
- s/he will gain a deeper insight into the experience, and
- ultimately s/he may revise the meaning associated with the event.

This method of reviewing the trauma facilitates the mind to

desensitize the pain, reprocess the event and enables the subject to move toward recovery. By the end of the process s/he should be able to talk about the incident and either feel completely comfortable or much improved.

In thematic TIR, incidents related to the theme are identified and resolved one by one until the subject works his/her way back to the root or core incident. Once the core incident and anything else that triggers the pain are addressed, the theme no longer has power over the subject's life. TIR is a proven method for bringing relief and healing with most clients who fit the criteria for PTSD. An exception is that TIR does not work well with people who are currently abusing drugs or alcohol. Virtually every time a failure has occurred, it has turned out that the viewer was drinking heavily or abusing other substances between sessions.

End Points

When the client finds and discharges the root incident, a very specific and often quite dramatic series of phenomena appear, showing that the viewer has achieved a thorough discharge. Then we say the viewer has reached an 'end point'. These phenomena usually appear in the following order:

1. *Good indicators*: The client appears happy, relieved, or serene. S/he is not sitting in the middle of something heavy. Sometimes s/he will laugh or say something cheerful. In the absence of good indicators, no end point has occurred.
2. *Realization*: Then the client will usually voice some kind of realization or insight, a reflection of the fact that s/he is becoming more aware.
3. *Extroversion*: Finally, the client will open his/her eyes or

otherwise indicate that his/her attention is now back in present time. S/he will usually look at the facilitator or at the room, or make some comment about something in the here and now.

4. Intention expressed: Often, the viewer will explicitly tell the facilitator what intention was present in the incident. If s/he doesn't, the clinician has the option of asking of any decisions the client may have made at the time of the incident.

When you see an end point, the most important thing to do is to stop. If you continue past the point when the root incident has been discharged and continue to ask the viewer to look for incidents, s/he will start to wander around more or less randomly in the Net, and will often end up triggering a lot of things that you will not be able to resolve with TIR. [See Prompt for specific detailed process.]