In our Western culture, death is a taboo subject. Perhaps because of our technologically advanced state, we've lost sight of some of our basic humanity - this lack of sight includes fully preparing our families for the inevitability of death and our unwillingness to patiently listen to our loved ones and friends when they are burdened with the pain of loss. Consequently, we are less prepared to cope with death and do not have adequate support systems. On both counts, death of a loved one can result in symptoms, which are associated with traumatic stress. Chapter 9 offers an extensive overview of two approaches which have proven effective in relieving the symptoms associated with traumatic stress - Traumatic Incident Reduction and Eye Movement Desensitization and Reprocessing. While full training is highly recommended for competency in both approaches, the reader will gain an understanding of the value of these approaches in helping those who are suffering from traumatic stress symptoms following the loss of a loved one.

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Chapter 9:

Relieving the Traumatic Aspects of Death with Traumatic Incident Reduction and EMDR

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Published in C. Figley (Ed.) The Traumatology of Grieving: Conceptual, Theoretical, and Treatment Foundations. London: Taylor & Francis

Significance of the Stressor to the Child/Adult System

In Uganda, when someone loses a loved one, each person who knows the surviving family member spends time with him, letting him recount his experience and what he's feeling, J. Nambi (January, 1995). The visitor then recounts her experience with death. In their cultural wisdom, Ugandans understand that everyone is impacted by a death, that normalizing and social supports prevent posttraumatic stress, and that telling one's story over and over again brings relief. I would wager that their cultural practice prevents posttraumatic symptoms from developing from the loss of a loved one, no matter what the circumstances were surrounding the death.

James, 1994, in her book regarding children and attachment trauma offers the following definition: ". . .trauma occurs when an actual or perceived threat of danger overwhelms a person's usual coping ability". This definition can be expanded to: trauma occurs when an actual or perceived threat of danger *or loss* overwhelms a person's usual coping ability. While she was defining trauma for children, the definition seems to describe what we all experience. This definition serves to explain how death could produce posttraumatic stress.

In our Western culture, where we tend to view death as a option, B. Smith (personal communication, 1995), we are ill-prepared to deal with the reality of a death, no matter what the circumstance. Because of our general lack of acknowledgment and discussion about death within our families, when it occurs, our usual coping mechanisms tend to be overwhelmed.

For those of us who do not have the cultural practice of recounting our loss to many willing listeners, seeking a professional who will help us relieve and integrate our loss becomes the solution. To this end, two approaches, which are person-centered and have proven efficacy in relieving trauma (Figley, 1996) are offered here as part of our "cultural practice."

Interventions for Bereavement

It is evident from the literature that bereavement will create symptoms which would be classified as traumatic stress symptoms (Prigerson, H. G., Shear, M. K., Frank, E., Beery, L. C., Silberman, R. Pilgerson, J., & Reynolds, C. R. 1997; Figley, C.R., Bride, B., and Mazza, N., 1997 and Raphael, B. and Martinek, N., 1997). These include any of the descriptors in the DSM IV of posttraumatic stress disorder. For anyone who has experienced the death of a loved one, the feelings of distress at reminders of the loved one, sleeplessness, having no energy for normal activities, feeling detached from others, and lack of concentration are all familiar feelings. While these are also descriptive of normal grief reactions, any symptoms which become long-term or debilitating require intervention. Long-term or debilitating mourning is also referred to as morbid grief or complicated bereavement. Potocky, 1993, described morbid grief as "characterized by high distress and high symptom

levels that are present four months after a death and may persist for a year or longer."

Those who are prone to developing morbid grief, have one or more of the following characteristics:

> (1) a low level of social support during the crisis; (2) a moderate level of social support coupled with particularly traumatic circumstances of the death; (3) a highly ambivalent relationship with the spouse; and (4) the presence of a concurrent life crisis at the time of the death. In addition, coping with sudden loss should be seen as a special high-risk group. (Potocky, 1993)

Most of the interventions described in the literature reviewed were group interventions. Potocky's (1993), analysis of nine experimental studies of bereavement interventions were all therapeutic group interventions. Her article revealed ". . . that grief intervention is effective in preventing or reducing symptoms of morbid grief among spouses who are at high risk or in high distress."

Rando, 1995, defines complicated mourning as the state when normal grief steps, which require recognizing the loss, processing it, and essentially moving on with life, are compromised, distorted, or not completed, resulting in debilitating psychological, behavioral, social or physical symptoms.

In the book, Living With Grief After Sudden Loss, most of the interventions offered could be utilized in conjunction with TIR and EMDR. For example, Rando (1996) summarizes a number of steps that a caregiver attempts to achieve with someone following a traumatic death. The first step reads: "Bring into consciousness the traumatic experience; repeatedly reviewing, reconstructing, reexperiencing, and abreacting the experience until it is robbed of its potency." (p. 157) This is essentially a description of TIR. The family treatment approaches described by Figley could also incorporate either EMDR or TIR at various stages for family members who require them. Cable adapts the Critical Incident Stress Debriefing model to traumatic loss. A family or individual would benefit from receiving the seven steps described in her article. Once these steps were done, TIR or EMDR would be appropriate to obtain a deeper level of resolution.

Theoretical Perspective - Traumatic Incident Resolution (TIR)

Moore (1993), describes TIR as "…a guided cognitive imagery procedure …" which is "…a high-precision refinement of earlier cognitive desensitization procedures."

Coughlin (1995), writes that:

> TIR is a unique procedure in comparison to traditional cognitive and behavioral therapies. Unlike traditional therapies, TIR bypasses

clinician-centered directive and didactic ideas to the client in favor of working directly with the client's knowledge, perspective, and internal awareness. The clinician facilitates the processing of the client-identified issues (traumatic incidents and/or emotional or somatic symptoms) and does not interpret the material.

Gerbode's (1989) theory as to why TIR brings relief from traumatic events is explained by a definition of time as a series of subjective activities that are set into motion by an individual forming an intention to do something. If the individual completes the intended activity, that activity is finished and no longer is carried into the present by the person. However, if an activity isn't completed, it continues on into the present, holding a greater or lessor degree of the person's attention, whether or not the person is consciously aware that their attention is so occupied. In the case of trauma, the common experience of most of human kind is to repress the content of the event in whole or in part. The result of this repression is that the traumatic event is never given the opportunity to complete itself. To further compound the effects of the traumatic event, it is common for an individual to form a decision at the time of the event, similar to what is referred to as an "irrational belief" in Cognitive-Behavioral Therapy (Gerbode and Moore, 1994). This decision carries forward in time as an incomplete activity, which an individual may or may not be aware of. On both counts, a traumatic event continues into the present, giving all or many of the symptoms of the original event.

This theory finds support in Levine, 1997 who wrote:

My observations of scores of traumatized people has led me to conclude that post-traumatic symptoms are, fundamentally, incomplete physiological responses suspended in fear. Reactions to life-threatening situations remain symptomatic until they are completed. Post-traumatic stress is one example. These symptoms will not got away until the responses are discharged and completed. Energy held in immobility can be transformed… (p. 35)

Valentine, 1994, offers a different view of TIR theory. She reports that TIR has its roots in cognitive theory:

Since trauma is experienced forcefully and impairs the defense mechanisms (Everstine & Everstine, 1993), old constructs are shattered (Janoff-Bulman, 1992),and one begins operating from hastily made constructs formed during or immediately after the traumatic incident. Insight "is a luxury that the mind cannot afford when locked in a struggle for survival" (Everstine & Everstine, 1993, p.18). Cognitive distortions follow. TIR presents clients with the opportunity to correct those distortions. Clients retell their story, relive the event in a safe, controlled environment, reexamine the conclusions that were drawn from the experience(s), and come to a different understanding of the event (Valentine, 1994).

In her dissertation, Coughlin, 1994, describes how TIR "… builds on the psychoanalytic, behavioral, and cognitive theories and techniques that precede it in the field of psychotherapy."

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a controversial yet undeniably effective method for relieving trauma and stressful life issues. Part of the controversy regarding the approach lies in the fact that no one knows exactly why it works. Shapiro, 1995, offers the following explanations:

> When someone experiences a severe psychological trauma, it appears that an imbalance may occur in the nervous system, caused perhaps by changes in neurotransmitters, adrenaline, and so forth. Due to the imbalance, the system is unable to function and the information acquired at the time of the event, including images, sounds, affect, and the physical sensations, is maintained neurologically in its disturbing state. Therefore, the original material, which is held in this distressing, excitatory state-specific form, continues to be triggered by a variety of internal and external stimuli and is expressed in the form of nightmares, flashbacks, and intrusive thoughts-the so-called positive symptoms of PTSD.
>
> The hypothesis is that the eye movements (or alternative stimuli) used in EMDR trigger a physiological mechanism that activates the information-processing system. Various mechanisms by which this activation and facilitation of processing occurs have been proposed, including the following:
>
> 1. Activation and facilitation of information processing due to the clients dual focus of attention as he simultaneously attends to the present stimuli and the past trauma
> 2. A differential effect of neuronal bursts caused by the various stimuli, which may serve as the equivalent of a low-voltage current and directly affect synaptic potential (Barrionuevo, Schottler, & Lynch, 1980; Larson & Lynch, 1989)
> 3. Deconditioning caused by a relaxation response (Shapiro, 1989a, 1989b; Wilson et al., 1995). P 30

Another explanation for EMDR's effective can be found in Weil's book, Spontaneous Healing, 1995. Weil, in stressing the importance of walking, wrote the following:

> When you walk, the movement of your limbs is cross-patterned: the right leg and the left arm move forward at the same time, then the left leg and the right arm. This type of movement generates electrical activity in the brain that has a harmonizing influence on the whole central nervous system-a special benefit of walking that you do not necessarily get from

other kinds of exercise. Dr. Fulford, the old osteopath who first taught me the basic principles of healing, believed that cross-patterned movement was necessary for normal development and optimal functioning of the nervous system. When babies first start to crawl, this movement stimulates further brain development. I often heard Dr. Fulford instruct adult patients to crawl as a way of speeding recovery from injuries. 'Go back to that simple movement, and you will help the nervous system move beyond any blocks,' he would say. (p. 188-190)

Brief Description of the Intervention Approaches

TIR can be described best by comparing it to watching a movie. In this approach, the clinician directs the client to repeatedly review a traumatic or distressing event, asking him to rewind to the beginning of an incident, viewing the incident until the end, and then reporting what he saw, heard, felt, and thought while reviewing it. As in the case of watching a movie a second, third or fourth time, when a client repeatedly views an event, different aspects emerge. It seems that repetition of an technique is used to achieve a deeper level of resolution. This is possible because repetition of a concept or trauma reactivates the material connected to it. This reactivation creates what is described under the concept of state-dependent learning, wherein a person must be in a similar state to the time one learned or experienced something in order to be able to recall it (Goodwill, Well, Brewer, Hoine, and Stern, 1969). Repeating an emotionally uncomfortable concept or traumatic event serves to trigger the event or the material connected to the concept, which are stored in state-dependent form. By repeating material that is in a client's conscious awareness, the preconscious material will begin to surface, and as the repetition is continued, the client will become aware of what was previously unconscious material.

EMDR is described by Shapiro, 1995, as an eight phase process which follows:

Phase One: Client History and Treatment Planning

Phase Two: Preparation, which includes establishing a therapeutic alliance, ensuring that the client can successfully do a relaxation tape or exercise, explaining EMDR to the client, the procedures involved, and what's expected of the client.

Phase Three: The assessment phase entails determining the issue to address in a session, choosing an image which represents the issue, identifying the negative and positive cognitions, establishing the validity of the positive cognition, identifying the emotion connected with the negative cognition and the image and the level of disturbance, and finding where the disturbance is felt in the body.

Phase Four: The desensitization stage wherein the client processes the representing picture, emotion, and physical disturbance.

Phase Five: In the installation phase, the positive cognition is revised if the client decides to, and is installed and strengthened.

Phase Six: In the body scan, the client is asked to think of both the original picture and the positive cognition and to scan her entire body for any sensations. EM is done on any reported sensations.
Phase Seven: The closure phase is done when a client needs to be returned to a state of emotional equilibrium.
Phase Eight: At the beginning of the next session, the prior presenting issue is reevaluated to determine if any further work needs to be done.

Basic Assumptions of the Approaches

Both TIR and EMDR assume that everyone has the innate ability to fully resolve traumatic issues (Shapiro, 1995; Gerbode, 1989). Both approaches hold that a client will only be able to process a traumatic event in the presence of a safe environment. TIR training specifically directs a clinician as to how to create a safe environment by describing a set of rules which must be adhered to and a communication discipline which must be followed in order for a client to feel empowered enough to process painful material. The efficacy of both TIR and EMDR are possible only when a clinician creates an environment wherein a client feels completely safe to access traumatic material. It has been noted that "…trauma victims face two major obstacles in their efforts to express their trauma-related emotions; their own reluctances to revise fundamental world assumptions, and other peoples' resistance to hearing about traumatic events" (Harber and Pennebaker, 1992). As trauma is so common place, all clinicians should be prepared to listen without resistance and for as long as it takes, for resolution to occur.

Clinical Traumatology Rules (Gerbode, 1986; Moore, 1993, Descilo, 1996)

1. Ensure that the client is in optimum physical condition for the session. Processing painful material requires that a client be well rested and fed and not under the influence of drugs or alcohol.
2. Ensure that the session is being given in a suitable place and at a suitable time. A suitable place means that there will be no interruptions from other people, phones, or pagers. A suitable time means that both clinician and client have at least a two hour block set-aside to ensure an end point is reached.
3. Do not interpret for the client. This is one of the hardest points for someone trained in traditional therapy to practice. A client is the ultimate authority of his or her experiences. TIR and EMDR are empowering approaches as they allow clients to come to their own conclusions.
4. Do not evaluate for a client. This approach requires that the clinician does not tell a client if they are right or wrong. "Do not judge, criticize, disparage, or invalidate the client or client's perceptions, assumptions, conclusions, values, reactions, thoughts, feelings or actions" (Moore, 1993).

5. Control the session and take complete responsibility for it without dominating the client. This allows a client to concentrate on the difficult material that they are confronting.
6. Be sure to comprehend what the client is saying. We all know when we are not really understood. A client will feel alone and unsupported if he is not understood. Also, ask for clarification without feedback or active listening. Simply tell the client that you haven't understood and would like clarification.
7. Be interested in the client and in what the client is saying instead of being interesting to the client. A clinician's interest supports the client's willingness to view and report on the material being viewed.
8. Act in a predictable way so as not to surprise or distract the client.
9. Do not try to work with someone against that person's will or in the presence of any protest. Trauma resolution can only occur when a person is fully willing to participate in the process.
10. Carry each session to success for the client. Trauma resolution cannot occur in the context of a 50 minute hour. TIR and EMDR sessions must be given with an open end to allow a client to reach a point of resolution.
11. Maintain a firm and primary intention to help the client. While this may seem obvious, if a clinician's primary intentions are to make money or improve skills, a client will perceive this and be less willing to trust the clinician.

Clinical Traumatology Communication Skills (Descilo, 1996 and Gerbode and French, 1995)

The purpose of communication can be stated as: to have a desired idea, experience or feeling fully understood. The components of communication include a point to communicate from, a point to communicate to, something to communicate, an intention to give or receive the communication, attention on the recipient and originator of the communication, acknowledgment of the concept, and comprehension on the part of the recipient.

The ability to control one's attention and intention unlocks personal power and success in any endeavor. The success of any approach depends on the attention and intention of the clinician. Chopra, (1994), writes:

> Attention energizes, and intention transforms. Whatever you put your attention on will grow stronger in your life. Whatever you take your attention away from will wither, disintegrate, and disappear. Intention, on the other hand, triggers transformation of energy and information. Intention organizes its own fulfillment.

The following drills teach the underlying communication micro-skills that are vital to obtaining results with traumatized clients.

There are seven drills in total. Each drill addresses one of the components listed above. The first two drills will be run by the instructor. The five remaining drills require that students work in teams of two, reversing the roles of "student" and "trainer." These roles will be fully defined later in the text.

Focusing Drills

The first three drills teach the ability to focus. While this may sound like a simple task, think of all the times during this workshop that your attention wandered to another topic. Now think of a time in the last week when you had something to communicate to someone, who reacted to what you said, which in turn caused you to react, with the result that the original communication was never resolved. These are examples of losing focus. Unfortunately, we're not in total control of parts of our minds. Others' actions or inaction and words can cause a reaction on our part that we would not give in to, given a conscious choice. The purpose of the first three drills is to develop the awareness of how it feels to trigger and lose focus, and then gain mastery of one's attention Mastery of one's attention would manifest in the ability to not react, or at the very least, to not transmit a reaction to what has been said or done. Attaining the ability to control one's attention is no small accomplishment. The person who is able to keep his or her attention focused and not react to a situation is the person in control. In a therapeutic context, controlling one's attention safeguards against counter-transference issues. When a clinician is able to continuously direct his or her attention outward, no matter what content is being presented, personal material is less likely to be triggered. Have you ever had the experience of listening to the grisly details of a traumatic event and being completely interested and immersed in the story? Did you feel triggered by the experience?

Maintaining focus is the secret to not accumulating trauma at best or, at the very least, remaining functional in the wake of trauma. A traumatic event is able to complete itself if one is able to maintain focus throughout the event. It is only what we allow ourselves not to know, not to focus on, not to complete, that can harm us. In support of this view, Herman, 1992, reports that “A study of ten Vietnam veterans who did not develop post-traumatic stress disorder, in spite of heavy combat exposure, showed once again the characteristic triad of active, task-oriented coping strategies, strong sociability, and internal locus of control. These extraordinary men had consciously focused on preserving their calm, their judgment, their connection with others, their moral values, and their sense of meaning, even in the most chaotic battlefield conditions.”

Each of the following drills build on the skills of the preceding drill.

Focusing Drill 1

All of the drills are performed sitting face-to-face with a partner, knees almost touching. The purpose of the first drill is to become comfortable sitting

in front of another person with eyes closed, maintaining awareness of the other person, and controlling body movements. Each student sits with feet flat, hands on lap, with no fidgeting, laughing, or mental wandering. Ideally we could disengage from all thoughts in our minds and be totally aware of the person in front of us. However, gaining an ability to not engage in the thoughts which our minds present is a more likely goal.

Focusing Drill 2

The purpose of the next drill is to feel comfortable facing another person for any length of time, while remaining still, attentive, and not caught up in personal thoughts or physical discomfort. The idea is to maintain the ability to be an interested point to communicate to or from regardless of what mental or physical phenomena is occurring.

It is this part of communication that most people have difficulty with.

In doing trauma work, it is necessary for a clinician to feel comfort with discomfort. In fact, in any process which will result in a higher level of resolution or understanding, it is necessary that we don't resist unpleasant emotions or situations that may be evoked as the process is begun. It is impossible to reach a higher level of resolution or understanding in any area of life if one is unwilling to experience giving or receiving discomfort.

Mastering this drill also helps build true empathy. Only when we can put our own agendas aside and completely attend to another person are we capable of fully understanding the motives and feelings of another.

This drill is complete when one is able to sit comfortably for some time, facing and focusing on another.

Focusing Drill 3

For this drill, a new role is added - that of trainer. Each student will take turns being a trainer. The trainer is the one who is running the drill. The student is the one learning the drill. The trainer has the task of helping the student master the purpose of the drills which follow. There are certain guidelines for the trainer to follow. These are:

1. Begin a drill by telling your partner to "start." If the student reacts or needs correction for an error, give a time out signal, saying "time out" and tell the student what the mistake was. And then tell the student to "start."
2. Repeat whatever caused the reaction. Or, in later drills, have the student repeat a phrase that caused her to react.

Always begin training with simpler, less difficult material. The idea is to build skills, giving a gradient of successes.

Only correct one mistake at a time, concentrating first on the more obvious ones, and then working on more subtle errors.

Keep working at the drill until it is mastered. Be responsible for ensuring that time is spent on drilling, not talking about it.

The last of the focusing drills requires that a student maintain focus no matter what the trainer says or does. The purpose of the drill is for the student to gain a mastery over the mind and body's reaction to outside stimulus.

The trainer starts the drill by saying "start" or "begin." The trainer "baits" the student by doing or saying some simple thing, like sticking his tongue out at the student. If the student laughs, the trainers gives the time out signal, saying "Time out, you laughed. Begin." Once the student has completely composed himself, the trainer will again stick his tongue out. If the student again laughs, the trainer will again give the time out signal and message as above. The trainer will continue to stick his tongue out at the student until the action no longer provokes a laugh.

The material used to bait can be incidental, personal, nonsensical, or rude. The only thing the trainer cannot do is leave his chair.

The purpose of the drill is to gain mastery over one's reactions to outside stimulus. While this is being accomplished by finding control over situations which evoke laughter, the mechanism which allows us to control our reaction to humor is the same mechanism which allows us to control our reactions to unpleasant material. Once mastery is gained in directing attention while being baited, one will then be able to direct attention in other situations.

Attitude Adjustment Drill

This drill has the dual purposes of learning to clearly communicate a phrase or question and to do so without expressing any type of judgment or secondary meaning through body language or tone of voice. Herman, 1992, notes that “Chronically traumatized patients have an exquisite attunement to unconscious and nonverbal communication. Accustomed over a long time to reading their captors’ emotional and cognitive states, survivors bring this ability into the therapy relationship….The patient scrutinizes the clinician’s every word and gesture, in an attempt to protect herself from the hostile reactions she expects.” (p. 139)

An important component needed to create a safe therapeutic environment is refraining from communicating any evaluation or judgment in response to what a client says during a session. We are all familiar with the meaning of "body language" and know that if someone is saying words that their body language contradicts, it is wise to believe the body's communication and not the words.

We are not always aware that we are communicating through our facial expressions and tone of voice. This drill is done to become aware and eliminate any attitudes that may be expressed through physical mannerisms or tone of voice. While in most social communication, we can just "be ourselves" and not edit our body expressions and voice tone, there are many situations where having control of our output would be in order. As this entire discipline requires that a clinician never evaluates or judges a client, having the awareness and control over body language is vital. Another situation which would require awareness of body language and voice expression is during a

potential conflict. A raised eyebrow or a condescending tone of voice could certainly escalate a situation that was already precariously balanced.

This drill, as well as all of the others that follow, is done in the trainer/student dyad. The trainer, as outlined above, will tell the student "begin," at which point the student will read a phrase from the indicated prepared sheet, memorize it, look at the trainer, and say it as though it were the student's own phrase. In the beginning of the drill, the trainer allows the student to say a number of phrases without correction, just to become accustomed to executing the drill. Once the student has given a few phrases, the trainer will begin to point out any facial expressions or tones of voice that convey secondary meaning. The student will then repeat the phrase that evoked the expression until the student can do so, sounding natural, but without any physical or vocal additions.

When the student can deliver a phrase that consistently sounds natural, without any additional body language or vocal attitude, the drill is complete.

Acknowledgment Drill

The purpose of the next drill is to learn to acknowledge communication. An acknowledgment is an indication that a communication has been heard and understood. It is a method of ending and controlling communication. While acknowledgment does convey understanding, it does not mean one agrees with what was said.

Have you ever had the experience of explaining the same idea more than once to a person? The person probably did not acknowledge you the first time. Have you ever felt as though someone wasn't interested in what you had to say because the person cut off your communication before you were finished? The person probably acknowledged you prematurely which is what left that impression with you. Have you ever become exasperated with someone who you knew was willfully not acknowledging you? (Were you telling that person to perform a task that they didn't want to do?) Now think of someone with whom you enjoy communicating. What part does acknowledge play in their communication with you?

Acknowledgment also should not express judgment or evaluation. Using simple statements such as "fine," "thank you," "I hear what you're saying," "good," "OK," "I understand" are all that are needed to convey understanding.

This drill is done in the following manner: the trainer tells the student to "begin." The trainer then reads a line from a prepared list as her own. The student uses one of the above acknowledgments to let the trainer know he was understood. The trainer corrects the student for any of the following: if any attitude is conveyed by voice or mannerism, for using an inappropriate acknowledgment, for timing - either too soon or too late, or for any break in focus.

The drill is complete when the student can naturally acknowledge a communication without using body language.

Closure Drill

From the theory on trauma previously described, any intention not completed by the desired activity being done or by a conscious decision to end it, continues into the present. Any of us, at any given time, only has so much energy to intend activities. At best, the result of having incomplete intentions is feeling tired and less energetic to participate in new communication or activities. At worst, having too many incomplete intentions and activities is a cause of burnout and all of its implications. After Hurricane Andrew, a favorite T-shirt of mine read, "I survived Hurricane Andrew, but the recovery is killing me."

When working with clients, and especially with trauma clients, it is vital to complete a communication. (It is vital to complete communications in any area of life.) Specifically, if a question is asked or when a particular topic is chosen for resolution, it is vital to bring closure to that question or topic. The next two drills address the topic of bringing a question to a point of closure.

When any question is asked, there are four different responses possible. One is an answer to the question, which deserves an acknowledgment. The second is a comment, which is defined as a social response to a question that doesn't answer the question, but that requires a brief, polite, response. The third is an evasion, which is an attempt to misdirect another from the issue that was raised. Evasions are ignored. The fourth possible response to a question is what is described as a concern. A concern is a subject or situation that so holds a person's attention that the concern must be addressed before the person can answer the question asked. Examples of the above and how each would be completed are as follows:

1. An answer:
   - Mother: "Did you do your homework?"
   - Child: "Yes, Mom, I did."
   - Mother: "Great."
2. A comment:
   - Mother: "Did you do your homework?"
   - Child: "Your hair looks really nice."
   - Mother: "Well, thank you! Did you do your homework?"
3. An evasion:
   - Mother: "Did you do your homework?"
   - Child: "It's time for my favorite TV show!"
   - Mother: "You didn't answer my question: Did you do your homework?"
4. A concern:
   - Mother: "Did you do your homework?"
   - Child: "I have a terrible headache."
   - Mother: "I'm so sorry to hear that. When did it start?"
   - Child: "Around lunch time."
   - Mother: "Would you like a painkiller?"

Child: "I took one about 20 minutes ago."
Mother: "All right. Were you able to do your homework?"
Child: "No, not yet. I was waiting for the pill to kick in."
Mother: "OK. Let me know how you're doing later."

These are simple examples of each. Answers are not always so clear-cut. Sometimes they are buried in long explanations. Evasions are not always that obvious. Some people are quite expert at giving "almost answers" that are in fact evasions. Or they are very skilled at directing your attention to some other topic with the result that your original question is left incomplete. Politicians are usually expert at this. Concerns can take an entire session to resolve. However, it is always important to remember to return to the original question or topic and bring closure to the that communication.

This drill is broken down into two parts. In the first part, the purpose is to learn to distinguish between an answer, evasion, and comment.

The drill is done as follows: the trainer, as above, will start the training period with "start" or "begin." The student asks an insignificant, non-personal question, such as "Is the earth round, is the grass green, are birds blue?" Once the student has picked a question, it is not changed. The same question is asked over and over again as though it had never occurred before. The idea of the drill is to master the mechanics of bringing closure to a topic or question, not to have to think about new and interesting questions to ask. After the student has asked a question, the trainer has three choices - he can answer it, make a comment, or give an evasion. If the trainer answers the question, the student gives a simple acknowledgment. If the trainer offers a comment, the student gives it an appropriate acknowledgment and then says, "I'll repeat the question, is the earth round?' In sessions and in life one doesn't necessarily use a "repeat" statement. However, for purposes of the drill, this statement is used to indicate to the trainer that the student knows that the question wasn't answered. If the trainer answers with an evasion, the student only says, "I'll repeat the question, is the earth round?"

In this part of the drill, the trainer may bait the student in an attempt to make the student lose focus. If the student loses focus, doesn't acknowledge an answer, doesn't correctly handle a comment, doesn't ignore an evasion, or communicates with any mannerism or attitude in his voice, the trainer gives a "time out," tells the student what needs to be corrected, and repeats whatever was done that threw the student off.

When the student can consistently distinguish between an answer, evasion, and comment, the next part of the drill is done.

Closure Drill Part 2

The purpose of this part of the last drill is to teach a student how to recognize and effectively deal with a concern and then reach closure on the original topic. Effectively handling a concern entails comprehending it, acknowledging it, taking steps to resolve it for the client, and then returning the client to the procedure.

The instructions for this drill are the same as the last with the following changes: no baiting is done in this drill. Occasional concerns are voiced by the trainer that the student needs to effectively handle before returning the trainer to the original question.

An example of this drill is as follows:

Student: Is the earth round?
Trainer: I am feeling extremely tired.
Student: When did this feeling start?
Trainer: About five minutes ago.
Student: How many hours of sleep did you get last night?
Trainer: About seven.
Student: It's not unusual in doing this kind of work for tiredness to start like this. Let me know how it goes as we continue with the question we were on: Is the earth round?

The student must indicate in some way that he is repeating the question that wasn't answered before.

This drill is complete when a student can distinguish between an answer to a question, an evasion, comment, and concern and effectively bring closure to each.

End Points

While training in TIR includes specifically identifying an "end point," the assumption that end point occurs as a result of processing trauma is also manifest in EMDR. Gerbode (1989) defines an "end point" as "The point at which an activity has been successfully completed. This is the point at which the activity should be ended. It is manifested by a set of phenomena that indicate the successful termination of the activity." (p 513) An end point includes that a client extroverts from the subject being addressed to a greater or lessor extent, feels and looks better, and has some sort of insight regarding the area being addressed. It is vital to recognize and stop a procedure at an end point. Continuing past an end point can cause a client to engage in a number of undesired outcomes. These are: Continuing to create the material that had been resolved, which will result in a client experiencing self-doubt and uncertainty about his or her ability to unravel issues; becoming immersed in different, unidentified material that the client now misassociates with the subject originally addressed, or the client creating new and uncharged material related to the original subject.

Herman, 1992, in describing the following, also describes what is referred to as an end point:

> After many repetitions, the moment comes when the telling of the trauma story no longer arouses quite such an intense feeling. It has become part of the survivor's experience, but only one part of it. The story is a memory like other memories, and it begins to fade as other memories do.
>
> The major work of the second state is accomplished, however, when the patient reclaims her own history and feels renewed hope and energy for engagement with life. Time starts to move again. When the "action of

> telling a story" has come to its conclusions, the traumatic experience truly belongs in the past. (p195)

Levine, 1997, also supports the idea of an end point:

> If we allow ourselves to acknowledge these thoughts and sensations using the felt sense and let them have their natural flow, they will peak, then begin to diminish and resolve. As this process occurs, we may experience trembling, shaking, vibrations, waves of warmth, fullness of breath, slowed heart rate, warm sweating, relaxation of the muscles and an overall feeling of relief, comfort and safety. (p 129)

Another specific assumption in the theory of TIR is that traumatic events and issues need to be addressed from different "causal directions" (CD). A CD is defined as the direction of an activity as observed by an individual. There are four basic CDs. They are: something that has been caused by an outside source which we experience personally, those things which we cause another to experience, what we observe another or others cause for another or others, and what we directly cause ourselves to experience. For example, if a client resolved the traumatic event of a car accident wherein another was at fault, the next series of trauma to ask about and apply TIR to would be any time or times the client caused a car accident, followed by any incidents wherein the client observed a car accident, and finally any car accidents which the client caused and solely experienced.

While causal directions have been specific to the practice of TIR, they can and should be applied to the practice of EMDR.

The Emotional Scale (Gerbode, 1989)

A final assumption taught as part of TIR, but which is also evident in practice with EMDR is the role emotions play in processing and assessing client progress.

The word emotion is defined in the World Book Dictionary as "a strong feeling of any kind," which really doesn't say much. A far better definition is given by Goleman, (1995), who offers the following:

> All emotions are, in essence, impulses to act, the instant plans for handling life that evolution has instilled in us. The very root of the word *emotion* is *motere*, the Latin verb "to move" plus the prefix "e-" to connote "move away," suggesting that a tendency to act is implicit in every emotion. (p. 6)

Building upon this definition, the emotions seem to fit in a hierarchy, based on the degree of *conscious*, *self-determined* motion possible. Bower, 1992, observed that "…very depressed or anxious people are usually poor learners because their working memory is so preoccupied or 'filled' with ruminations associated with their emotions." While his example applies to the ability to learn, the concept also supports the idea that negative emotions make one less conscious of one's environment due to the preoccupation of attention that is normally accompanied by the emotion. I think we have all seen that

someone who is grief-stricken, is less able to control their attention and so motivate himself or engage in activity, whereas an enthusiastic person is far more able to direct their attention and to motivate himself easily and engage in any activity that interests him. It appears that where a particular emotion fits on the following scale correlate with consciousness, awareness of self and environment, ability to choose, and degree of control of one's life. Support of the view that different emotions effect our consciousness, awareness, and ability to learn can be found in Bower, 1992; Leichtman, Ceci, & Ornstein, 1992 and Nilsson and Archer, 1992.

Any one of the emotions named in the Scale of Emotions can either be acute or chronic. A chronic emotion colors and eventually structures the world that is seen and lived in. For example, a person who has been mugged can continue to manifest the emotion of fear beyond the duration of the event. Fear can manifest by an unwillingness to drive at night, needing a companion every time one leaves the house, or refusing to allow one's children to walk to the store.

We also experience acute emotions. Even someone who's chronically sad can receive news which would make them at least momentarily happy. A usually happy person can experience an event which can leave him temporarily angry.

The various emotions and their proposed order follows (Gerbode, 1989):

Elation
Enthusiasm
Complacency
Contentment
Ambivalence
Antagonism
Anger
Resentment
Hidden Hostility
Anxiety
Fear
Grief
Apathy

The Role of Emotions In Processing Traumatic Events

Emotions play an integral role in the process and outcome of resolving trauma. Understanding how each emotion manifests, where each emotion stands in relationship to the others, and accurately assessing the chronic emotional state of a client are observation skills that need development to successfully apply TIR and EMDR.

Affect is a major indicator that a primary trauma has been found. Most of us have been socially trained to balk at affect. When someone manifests unpleasant emotion, most people will try to change the subject, direct a person's attention elsewhere or minimize the upsetting event in an attempt to

make the distraught person “feel better.” If any of the preceding were done when a client was manifesting affect during a session, it would result with the client being stuck in the affect. Also, in any subsequent session, the client would be less likely to feel safe enough to connect with the affect again.

> As Breuer and Freud noted a century ago, ‘recollection without affect almost invariably produces no result.’ . . . As the patient explores her feelings, she may become either agitated or withdrawn. She is not simply describing what she felt in the past but is reliving those feelings in the present. The clinician must help the patient move back and forth in time, from her protected anchorage in the present to immersion in the past, so that she can simultaneously reexperience the feelings in all their intensity while holding on to the sense of safe connections that was destroyed in the traumatic moment, (Herman, 1992).

The importance of contacting and relieving emotion during trauma work is also supported by Harber and Pennebaker who wrote that: “…the problems of post-traumatic thought intrusion lie not so much with the memories themselves, as with the unassimilated emotions that drive these memories to the surface of consciousness,”

Ultimately, a client's chronic emotional state will improve as traumatic events are resolved. A client who has been locked in an emotional state of grief can be expected to cycle through the emotions above grief, until, ideally, he or she is closer to a "cheerful" outlook on life. In the case of single incident trauma, this change can happen over the course of one session. For a client who has suffered multiple traumas throughout their lifetime, this change of emotional outlook will take a number of sessions.

Whenever a client is manifesting change while reviewing a trauma, it is considered a positive indicator. Change can mean a change in affect or it could mean a change in content. The content of a traumatic event often changes as the client gets a clearer picture of the event. The material also changes as a client manifests different emotions experienced during the event. Different emotional states will seemed cued to different memories within the same traumatic event. In both EMDR and TIR, change means that you are on the right track and should continue with what you are doing. The change will eventually taper and the client will reach an end point.

During the process of resolving a trauma with TIR or EMDR, clients will often manifest acute emotional changes. It is not unusual for a client to begin a session with no emotion, and during the course of a session, cry, express anger, experience fear, cry again, feel hateful, and so on, until the trauma and all of it's content has been fully confronted. At this point, a client will usually express relief and in most cases manifests an emotional level closer to cheerful.

Issues of Assessment

In the case of the loss of a loved one, whether or not TIR or EMDR should be utilized would be determined by the following:

1. If a client presents herself for treatment because of a death, utilize either TIR or EMDR as indicated by other factors pertaining to the client's mental status. In other words, no other assessment is needed. The client, by presenting herself for treatment, has assessed that intervention is required.
2. If a client in a long-term therapeutic relationship still manifests undesired emotions, thoughts, or behaviors following any death that occurred during the client's life time, the clinician would ask the client if he had interest in addressing the loss with one of the above approaches.

Determining which approach to utilize will be covered in the following section.

Approach Methodology - Traumatic Incident Reduction

When a client is unable to remember a traumatic event and is presenting some unwanted feeling or condition, thematic TIR is utilized. Thematic TIR is similar to what is referred to as "affect bridging" in hypnosis. What this means is that whatever affect the client is presenting is traced back utilizing the TIR steps which follow. If a client is concerned about feeling anxious, the client will be asked for times when he felt anxious. These times may include having to take a test, calling a new girlfriend, meeting a new boss. In other words, the situations may be completely different, but the feeling he had was the same in each instance. Thematic TIR is a more complicated form of TIR who description lies outside the scope of this article.

Many clients know what their traumatic event was. When this is the case, Basic TIR is used. For example, all the times a person was in a car accident is an example of events which would be addressed with Basic TIR. Many times, an incident only occurred once, such as the time someone was mugged. While Basic TIR would be utilized in the case of a death, the feelings which result - sadness, fear of being alone, feeling abandoned - are examples of themes would be address with Thematic TIR.

The following are the steps for preparing a client for TIR and a description of the protocol.

1. Education: Give an explanation of trauma - that ". . .trauma occurs when an actual or perceived threat of danger or loss overwhelms a person's usual coping ability" (James, 1994). Also give the definition from Levine, 1997: "trauma occurs when an event creates an unresolved impact on an organism." Go over the rules concerning being well rested and fed, no alcohol for a 24 hour period before a session, no recreation drugs for weeks before a session and being on time for appointments. A client will need to concentrate on elusive material and needs to be in good physical and mental shape to do so.
2. Explain to the client how the technique works and what is expected of them. (How we all have a natural defense mechanism called "repression" which can kick in when we are traumatized. When something gets repressed one can't remember all or parts of the event. And because an event is repressed, it never

gets to end. That a trauma is never ending is seen by the fact that people continue to have symptoms as though the trauma were still occurring. Another point that prevents a trauma from ending is that most times a person will make a decision at the time of the incident. Any decision made at these times also continues on into the present, unknown to the person. TIR helps a person "unrepress" their traumas and find the forgotten decisions. When this is done, the trauma becomes a harmless memory and a person is no longer effected by it. Sometimes while doing TIR, unpleasant emotions stir-up. While it may feel terrible for awhile, it means stable relief is on the way. The end point is always worth the journey.) Ensure that the client understands the basic terms and procedure. Cover the following points:

1. No interpretation or evaluation.
2. Unfixed session lengths
3. Sleep, food, no drugs or alcohol
4. Go over the procedure explaining each part
5. Why repetition
6. Expect affect (really prepare them for this)
7. Answering with whatever comes up. Ensure the client knows not to edit the material that entered their mind.
8. Run a dummy sequence, such as "The time you ate breakfast."

3. Make up the Charged Areas List (Bisbey, 1995) as follows:

a. Cull the intake taken in the first session and make a list of all traumatic
incidents and emotionally charged persons and areas.

b. Show the list to the client. Get them to add anything to the list that may have been left off. If any items on the list are broad emotions such as fear or anger, have the client reword them to something more specific, such as fear of the dark.

c. Read the items on the list to the client, asking them to assign a number between 0 and 10 to the item as follows:

0 = not at all emotionally charged to 10 = completely emotionally charged

(this is referred to as a SUDS rating - subjective units of distress.)

d. Once this is done, show the client the list and ask, "Which item on this list most holds your attention?”

e. Take up whatever the client gives you, whether it is a 10 or not. Note that a client may not choose the issue that brought to the session. However, start with where the client is at. With some clients, it may be appropriate to ask them to choose something that is less than 10 if there are indicators that they need to build ego-strength.

4. If it is a traumatic incident, or some feeling, emotion, attitude, or pain , utilize TIR. (See following description.)

5. If it is a person, place, or subject, explore the subject with the client. Ask them what unwanted emotion or feeling is connected with the subject and then address that emotion or feeling with TIR.

6. At the beginning of each session, ask the client if they have had sufficient sleep and food. Ask if they have consumed any drugs or alcohol since the last session.
7. Address any CD that was not completed in the last session. Once this has been done, hold up the Charged Area List and ask which item most holds their attention.
8. Take the item the client chooses and run per above.
9. At the beginning of the session AFTER the session in which the client has run the traumatic event for which they were referred, ask for feelings, emotions, sensations, attitudes, or pains (FESAPs) connected with the traumatic event, add them to the Charged Items List, and ask the clients for the SUDS rating on each FESAP so added.
10. Repeat steps 7 -9 until the client appears to have changed dramatically or until they express no interest in any remaining items on the list.

Summary of TIR Steps (French and Gerbode, 1995)

For the first incident and any time a new incident is encountered:
A1. Locate the incident or Locate the time when ___________
A2. When was the incident? or When did it happen?
A3. How long does the incident last?
A4. Where did the incident happen?
A5. If not already closed: Close your eyes.
A6. Go to the start of the incident and tell me when you have done so.
A7. What are you aware of? or What are you aware of at the beginning?
A8. Go through to the end of the incident.
A9. Tell me what happened.
Second and subsequent times a client is asked to review the incident:
B1. Go back to the beginning of the incident. Tell me when you are there.
B2. Go through to the end of the incident.
B3. Tell me what happened.
B4. Is the incident getting lighter or heavier? (This question is asked when the clinician is unsure as to whether the traumatic event being addressed is resolving or not. When the affect demonstrated by the client and content of a traumatic event are unchanging after three or four repetitions, one would ask the client if the incident is getting lighter or heavier. If the client indicates that the incident feels heavier or isn't sure which, then do the Earlier Beginning/Earlier Incident procedure (below). If the client feels that the incident feels lighter, continue with steps B1 through B3.)
Earlier Beginning Procedure
EB. Is there an earlier beginning to the incident we are running? (An earlier beginning to a traumatic event could be a concrete event, such as "He slapped me in the face before he beat me" when one is addressing a beating. Or it could be a thought or emotion such as "When I woke up, I had the feeling it would be a rotten day" when the traumatic event was a car accident.)
If there is an earlier beginning, then do the second run-through procedure B1 - B4 above, but instead of: Go back to the beginning of the incident

Use: NB. Go back to the NEW beginning of the incident.

If no earlier beginning, do Earlier Incident Procedure (below).
Earlier Incident Procedure
EI. Is there an earlier similar incident?
If yes, use first run-through procedure A2 - A8 above.
If no earlier incident, just redo second run-through procedure B1 - B4 above.

End Point

End off when the client has had a realization, is extroverted and has brightened up.

Checking Other Causal Directions (CD)
After completing the first CD, check the other CDs as follows:
CD 2 Is there an incident when you caused another ________(example: an incident similar to the time when you had your car accident).
E2 Is there an earlier incident when you caused another _______?
CD 3 Locate an incident when another caused others ________.
E3 Is there an earlier incident when another caused others _______?
CD 4 Locate an incident when you caused yourself _______.
E4 Is there an earlier incident when you caused yourself _______?
Repeat above steps A2 through B4 on any flow as indicated.

Questionable End Points

At any point that an incident seems to have reached an end point, but all indicators are not present, ask either:
Flat? How does the incident seem to you now?
Dec? Did you make any decision at the time of the incident?

EMDR Protocol (Shapiro, 1995)

A. Set up your chairs in the necessary positions. If you will be using eye movement to process, you will need to set up your chair either to the right or left of your client so that when you move your arm back and forth, the client is not looking at your face.
B. Explain EMDR to your client. How much you explain will depend on your client. The following explanation is from the EMDR training materials (Shapiro, 1996):

When a trauma occurs it seems to get locked in the nervous system with the original picture, sounds, thoughts and feelings. (This material can combine factual material with fantasy and with images that stand for the actual event or feelings about it.) The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements help to process the unconscious material. It is important to remember that it is your own brain that will be doing the healing and that you are the one in control.

What we will be doing often is a simple check on what you are experiencing. I need to know from you exactly what is going on with as clear feedback as possible. Sometimes things will change and sometimes they won't. I'll ask you how you feel from 0 - 10 –sometimes it will change and sometimes it won't. I may ask if something else

comes up – sometimes it will and sometimes it won't. There are no "supposed to's" in this process. So just give as accurate feedback as you can as to what is happening, without judging whether it should be happening or not. Let whatever happens, happen. We'll do the eye movement for awhile, and then we'll talk about it.

C. Establish the stop signal. Some clients can't always articulate when they are abreacting or we may misinterpret their need to stop as part of the abreaction. Agree before beginning processing on some physical sign, like the time out signal, to indicate that the client needs to stop the processing.
D. Establishing a metaphor - for any time a client needs some encouragement to get through an abreaction. An example of a metaphor that is commonly use is to tell the client to imagine that they are on a train and that the material they are viewing is just scenery that is passing them by.
E. Establish if you will utilize eye movement or some other method to process such as a sound device or tapping on the client's knees. Work out a comfortable distance and speed or volume and speed if using a sound device. (To do eye movement with a client, hold your hand up as though you are giving someone the "peace" sign, but hold your fingers together. Extend your arm so that your elbow is almost straight and then bring your hand back so that it is almost touching your head. Be sure not to point your fingers at the client. The faster the eye movement, the faster the material processes, but you must establish what is comfortable for the client. Each client will require a certain number of eye movements before taking a break. However, start with at least 24 repetitions until you observe what your client needs. Also, when a client is processing more distressing materials, more eye movement will be necessary. When stopping your fingers, do so slowly, not suddenly, returning your fingers to the client's center of vision.
F. Safe space. Ask the client for some real or imagined place where they feel safe. Have the client picture it, remember what it feels like. Use the safe space if a client needs a break during a session or if a session doesn't reach a full end point.

1. Ask the client for the issue or memory they would like to address.
2. What picture represents that issue or memory?
3. When you look at that picture, what negative belief do you have about yourself now?
4. When you think of that picture, what positive belief would you like to have about yourself now?
5. Validity of Cognition (VoC) When you think of that picture, how true does (the positive belief) feel to you now on a scale of 1 - 7, where 1 feels completely false and 7 feels completely true? ________
6. When you look at the picture, what emotions or feelings do you get now?
7. How intense are those feelings/emotions on a scale of 0 through 10, with 0 being no disturbance and 10 being complete disturbance? __________
8. Where to you feel the disturbance in your body?

9. Look at the original picture, the feelings of _____, and the (negative belief). Hold these things together as best you can and follow my fingers.

   Utilize eye movement, tapping or sounds (EM) as previously established. Take a deep breath. What do you notice now?

   Go with that. EM. Deep breath. (Tell me what happened, what do you notice now?)

   (Continue until there is no change, negative or positive, for two sets. If the client abreacts, do longer EM sets.)

   After two sets of no change, ask the client to think of the original picture. Ask "How disturbing is that image now to you on a scale of 0 - 10?" If 2 or more, have the client focus on the disturbance and do EM as above.

   If the SUDS is at 0 or 1, continue.
10. Do the words _________ (positive belief) still fit or is there another positive statement that you feel would be more suitable?
11. Think about the original picture and ________ (positive belief). On a scale of 1 - 7, with 1 being completely false and 7 being completely true, how true does that belief seem now?
12. Have the client hold the statement and the original picture together. Do EM. Check for how true it feels again. Repeat doing EM until it no longer strengthens.
13. If the positive belief doesn't move above a 5, check to see if it is appropriate. If not, have the client change the belief and do EM. Or check if there is a blocking belief. Establish the blocking belief and do EM.
14. Body Scan: Close your eyes. Concentrate on the picture, the positive belief, and mentally scan your entire body. Tell me if and where you feel anything. Focus on that. EM. Repeat this step until there are no more body sensations.
15. Closure/debrief. Sometimes things will emerge between sessions. Please note them down so that we can take them up in our next session. (If this session didn't close on an end point, utilize a visualization or anchoring technique to bring the client back into the here and now and then let the client know that she can call you between sessions if needed.)

Instructions and Observations Regarding EMDR

Regarding abreaction: if a client begins to manifest affect, continue with the EM until they subside. For purposes of clinician arm-comfort, you may need to take a change in the affect as a point to lower your arm and have the client pause. Continue with the EM as soon as possible, as it is important to get the client through this period. It will end! While it may be necessary to encourage a client to continue through an abreaction, I keep comments at a minimum so as not to distract the client from getting through. I don't use a metaphor at this point to keep the client going.

Each client needs a different length of EM. Some clients will noticeably brighten up after 18 EM. Notice your client. Look at their facial expressions. Use your judgment.

After completing EMDR on a target area, ask the client for the other causal directions regarding the area. For example, if the client's presenting issue was fear of the dark, ask if they have ever caused another to be afraid of the dark, ask for the picture that represents that and continue with the procedure. When done with CD 2, check to see if the client also has CDs 3 and 4 on the same presenting issue (a time when another caused another to be afraid of the dark and a time the client caused himself to be afraid of the dark.)

While EMDR training tapes showed the clinician making encouraging comments during eye movement, the approach works well with the clinician silent during EM and only making an encouraging comment if the client is hesitant during an abreaction.

For overwhelming or repeated trauma, after addressing the trauma with EMDR or TIR, ask the client to think of the event and notice what unwanted emotions or feelings are present now. Address one emotion or theme at a time with EMDR (or TIR).

While I was trained in the first EMDR training to go through all of the steps with a client, Dr. Shapiro indicated in the second training I attended that if a client extroverts completely, she would end the session at that point. When I use EMDR, I recognize and stop the session when the client manifests an end point, as described previously.

One of the reasons the approach is so powerful has to do with asking for the basic beliefs connected with the incident. This speaks to a person's basic identity and is very effective in bringing about desired change when done correctly. It is also a point where one needs to be cautious. The basic beliefs must be ones that completely feel right to a client. While it is acceptable to help a client identify the exact wording of a negative or positive belief, the final statement must completely fit for a client. There have been reports of client distress between EMDR sessions. While this distress could be the result of more memory processing, it could also be caused by a positive or negative belief that wasn't completely correct for the client. If a client ever becomes very upset or apathetic between sessions, first check the negative and positive beliefs for correctness. If either or both beliefs were not correct for the client, find out what wording or belief is right and then continue with EMDR. If they are correct, continue processing what emerged during the week.

What Can Go Wrong in TIR

Given that TIR was appropriate for the client, the two most common reasons why a TIR session doesn't reach an end point are that there was an earlier similar incident or an end point was missed.

Sometimes a clinician will accept an earlier similar incident that isn't similar at all. At other times a client has a pressing problem which prevents him from being able to focus on a traumatic event. These situations will also prevent an end point from occurring.

If you suspect one of the above to have occurred, ask the client the following:

1. Is there an earlier similar incident? If so, proceed with the protocol.

2. Was there some point when you felt better about this event (or theme)? If so ask, when did that occur? Then ask, what happened at that point?

3. Is there some other situation that is holding your attention? Is so, get all of the information pertaining to the situation and do whatever is necessary for a resolution.

Sometimes, none of the above will "bring a client out of it," and the client may still seem emotional or out of the present at the session end. If this occurs, use a technique to bring a client back into the "here and now."

One technique to bring a client's focus back into the present consists of repetitively telling a client, for example, to look at a room object. The clinician would pick 10 to 15 different room objects. The following can also be done:

Point out something that you haven't noticed before.

Touch that ______ (room object.)

Look around here and find something that isn't reminding you of _______ (someone the client lost.)

After doing one of the above techniques, ask the client how they are doing now.

Any coping technique which relaxes a client or brings them into the here and now would be appropriate to do at the end of any session which does not reach an end point.

What Can Go Wrong With EMDR

Some of the difficulties encountered with EMDR include:

1. A client is unable to find a picture to represent the trauma or issue. Don't attempt EMDR. TIR may be effective in this case or other approaches which build awareness and strength.
2. A client cannot easily formulate or positive or negative belief. Again, EMDR should not be pursued.
3. There is no change of affect or content during reprocessing. The client requires another approach.
4. The client loops with the material. In other words, the same material presents itself during EM and the SUDs rating doesn't diminish. Change the direction of the EM if that is the method of reprocessing. Otherwise, ask the client if there is an earlier beginning to the material being addressed or for an earlier similar incident.
5. The abreaction doesn't subside or a client wants to stop at any point. First try sending the client to their safe space. I would then use an anchoring or relaxation technique. Supervision would be advised. At the very least, I would not attempt EMDR until less traumatic issues had been resolved and ego-strength had increased.

When to Use TIR and EMDR

If a client needs to build ego-strength, start with TIR. Some of the indicators that a client needs to build ego strength are as follows: the client has attempted or seriously considered suicide; the client is not functioning well in life and the client has no support system and cannot build one. However, when in doubt, utilize an appropriate scale which measures ego strength, such

as the MMPI. If a client is unable to find a target, if the client has difficulty formulating a negative or positive cognition, use TIR instead. If a client has an intense interest in recovering forgotten pieces, utilize TIR.

One of the easiest ways to determine which approach to utilize is to ask your client. Let her experience both approaches and determine which one addresses issues best for her.

I encourage you to do more than a weekly session when working with a client with an extensive trauma history or who has the identifying factors for complicated mourning (Rando, 1996). With both approaches, a fragile client will have a difficult time between sessions. It is far better for the client's well-being to have more frequent sessions until the majority of the trauma work is done.

When TIR and EMDR Cannot Be Used

There are certain situations wherein these approaches are not appropriate. These circumstances include:

- If a client is currently abusing drugs or alcohol;
- When a client is taking certain psychotropic medications which prevent him from accessing memories;
- Any client who is psychotic;
- A mandated client, whether the mandate is from the court or a parent (unless a client agrees to the treatment, it is not likely to be effective);
- With EMDR, any client who has a dissociative disorder;
- With TIR, client who is too young to understand the process or to focus long enough for a resolution to occur and
- A clinician who doesn't apply the micro skills and rules described in this chapter.

Further Cautions Regarding EMDR (Shapiro, 1995)

Do not use eye movements with someone who as epilepsy or eye problems. Use an alternate method such as tapping the clients knees or hands or a sound device.

Don't use EMDR on clients with Dissociative disorders. A client with a Dissociative disorder can become stuck in a high level of disturbance with EMDR. Please consult the DSM IV for the indicators of DD. (TIR may be more appropriate to use with these cases because the approach narrowly focuses on one type of affect or traumatic event. However, if in doubt, seek supervision.)

If you have no previous experience with a trauma approach, it is strongly recommended that you begin by utilizing TIR. Because of its narrower focus, both client and clinician have more control of the process. Once certainly is gained with TIR, utilize EMDR. In the best of all worlds, learning both approaches would be done under supervision.

Additional Steps for Dealing with a Death

Sometimes a death will have no earlier beginning and there will be no earlier incident, yet the incident doesn't reach a point of desired relief. In this case, do the following steps:

1. If the full end point is still not present, have them run the death from the deceased person's point of view. Many times when a deep

empathy bond has existed between two people, it is not unusual for a person to have fully imagined the death through the eyes of the deceased.

2. Use TIR or EMDR to address the loss of the future one had planned with the deceased. In many cases, the bereaving person is also mourning the loss of future plans - from growing old together, to enjoying grandchildren to taking a dream vacation. Either of the approaches can be effective in relieving any intense sense of grief that is experienced due to the loss of future plans.
3. Tell the client to imagine that the deceased person is in the room. Direct the client to talk to the person, as though they were there, telling the person all of the things that they had meant to say, wanted to say, needed to say. Tell the client to imagine that the deceased person acknowledges all of his communications.
4. Next have the client imagine that the deceased person is communicating what was left incomplete for her. Have the client report to you what is being said and tell the client to acknowledge the communication received.
5. Ask the client how distressed they feel about the death now, giving a SUDS rating as described previously.
6. If the client hasn't reached a point of relief, ask what unwanted emotions or feelings the client experiences when he or she thinks of the death now. Write the emotions and feelings on a charged areas list and ask the client to assign points to each. Next ask which item most holds their attention. Use thematic TIR on these items, ensuring to ask the client if an incident exists for each CD.

Evidence of Effectiveness

There is a large body of literature which supports the efficacy of EMDR. Some of the research conducted with EMDR includes: Tinker, Wilson, and Becker, 1995 on traumatized individuals; Solomon and Shapiro, in press, bereavement due to loss of a loved one or to line-of-duty deaths and Levin, Grainger, Allen-Byrd, and Lulcher's (1994) controlled study of 45 Hurricane Andrew victims.

There is a growing body of research with regards to the efficacy of TIR. The most recent work completed utilizing TIR, is an impeccable outcome study of 123 female inmates at FCI Tallahassee. Valentine, 1997, utilized a single session of TIR, given after a brief intake and followed by a session for closure and post testing, compared to a waiting list control group. Her measures included those for depression, anxiety, and learned helplessness, which are primary symptoms of posttraumatic stress. The improvement in all measures following treatment were statistically significant. Further, at a three month follow-up, all measurements showed a significant improvement for the treatment group from the first post-test.

Bisbey, 1995, completed the first experimental study utilizing TIR on 64 crime victims in England. She compared TIR to Direct Therapeutic Expose and a waiting list control group. All subjects were screened for a positive diagnosis of PTSD. Bisbey reported that

> In this study, as hypothesized, both treatment groups experienced a significant decrease in trauma symptoms while the control group did not. In fact, most of the members of both treatment groups no longer qualified for a diagnosis of Post-traumatic Stress Disorder at the conclusion of the study. It was hypothesized that the Traumatic Incident Reduction group would show a larger decrease in incident specific symptoms that the Direct Therapeutic Exposure group. This turned out to be correct.

Coughlin's, 1995, quasi-experimental design study looked at the efficacy of TIR in treating 20 subjects diagnosed with panic and anxiety symptoms. She wrote that:

> Clinical and statistic differences post-treatment have been confirmed. Yeaton and Sechrest (1981) define "cure" as the point "when the deviation from the norm has been eliminated (p. 163)" Fourteen participants had state anxiety scores more than one standard deviation above the mean on pretest. Deviations from the norm (+ - one standard deviation) were eliminated for eleven participants at one-month follow-up and nine participants at three-month follow-up. Thirteen participants had trait anxiety scores more than one standard deviation above the mean on pretest. Deviations from the norm were eliminated for ten participants at one-month follow-up and nine participants at three-month follow-up. The data supports the effectiveness of TIR. 64% of participants with

clinically significant state anxiety remained "cured" at three month follow-up and 69% of participants who had clinically elevated trait anxiety remained "cured" at three month follow-up. TIR satisfies Yeaton and Seckrest's definition of a successful treatment. (p 64-65)

Case Example

The case example I will give to demonstrate various aspects of both approaches, is one from a workshop given wherein both EMDR and TIR were taught. I usually give live demonstrations of both techniques. My experience has been that if someone self-selects, she will be ready for the experience.

TIR is taught first in the course of the workshop. The volunteer wanted to address the death of her mother. I normally don't address deaths in this forum, but after interviewing the participant, I decided that it would be appropriate to pursue. Her mother had died six months earlier in a car accident. The client, who was in her 40's, hadn't stopped crying since then. I began the approach by asking her when it happened, and the questions given earlier when one is addressing a new incident. I then had her return to the beginning of the incident, move through the incident and tell me what happened. During the second recounting, the client began crying. I had the client review the incident 37 times in total. The client recounted different aspects to the event most times. Her sadness peaked and waned. She became angry. She began to present the theme that because of what she was taught in her upbringing, it was not OK to cry and be weak. After the 15th recounting, the client gave her first smile and laugh. However, during the next time through, she began crying. But from this point, the grief was less frequent and less and intense. When she indicated that the incident felt the same at point 19, I asked her if the incident was getting lighter or heavier. From her indication, I continued to cycle her through the incident. Her recounting of the incident continued to change in content and emphasis until the 33rd time through, as which point, her affect improved and the content remained the same. After the 37th recounting, I asked her if she made any decision at the time of the incident. Her reply was "That was a sad time, but that's what it was – that was then and this is now." She had successfully completed the trauma and I ended the session there. The entire session took a little more than an hour.

The next day, I asked her how she was doing. She said she felt better but that she was still crying frequently. I arranged to give her another session that day. This session began with an exploration to find if the TIR we had done the day before was incomplete. She felt that the traumatic aspects of the death had resolved. I continued to explore and discovered that she had many unresolved issues with her mother, with the primary issue at this point being her mother's edict to always be strong and never to cry. It was an idea that had permeated her life. I decided to utilize EMDR for this issue.

After completing the initial EMDR steps, I asked her for the presenting issue. Her answer was her mother enforcing the idea to be strong and never to cry. I asked her "What picture represents this issue?" and she immediately responded with an incident that happened when she was four. She threw her

first and only tantrum, as her parents response was so swift and forceful, that she never attempted to show that type of emotion again. When asked for her negative belief about herself now when she looked at that picture of herself at four, she replied, “I must not be very strong.” When asked what positive belief would she like to have about herself now when looking at that image, she said, “I'm very strong.” I then asked her “When you think of that picture, how true does ‘I'm very strong’ feel to you now on a scale of 1 - 7, where one feels completely false and seven feels complete true?” Her answer was one. When next I asked her what emotions or feelings she experienced when she looked at the picture, she replied “anger and helplessness.” When asked to rate how strong the feelings were, she rated them with a SUDS of 10. She felt the disturbance in her solar plexus. Next I directed her to hold the image, the negative belief that “I must not be very strong,” and the feelings of anger and hopeless together the best that she could and to follow my fingers. I initially started with 24 eye movements (EM). During the course of the next hour, I utilized longer or shorter EM sets depending on her affect. She cried less during the EMDR. The client brought up information from all parts of her life that had to do with the themes of being strong and not showing emotions. Three times during this stage, when the client had no change of content or affect for two sets of EM, I asked her to look at the original image and give me a SUDS rating. The first time her response was 3, the second was 1 - 2, and the last was 0 - 1. The client said, referring to the original picture, “It's funny.” I ended the EM phase there. When asked if the positive belief “I'm very strong” still fit or if there was another positive statement she felt would be more suitable, she responded with “I'm as strong as I need to be.” I had her think about the original incident and the new positive belief and asked her how true the belief seemed to her now. She replied, 7. I installed it once with EM, it remained at 7. The final step entailed the body scan. She did not feel anything, so we ended there. I let her know I would be available for another session if she needed it and that I would refer her to someone in her home town for follow-up. She was bright and smiling at the end of the session. The session was an hour and 30 minutes in length.

I called her three months after these sessions to ask for permission to write the above. She told me our work had “…opened the door and helped me through the trauma part of it.”

No Magic Bullet

While there is no panacea for all levels of suffering in all situations, TIR and EMDR have proven to be very effective tools for relieving trauma-related symptoms in many different populations. Most people require an intensive four-day training to be proficient in these approaches. These approaches require different skills than those utilized in traditional therapeutic settings. I have never trained a group that didn't require considerable time in mastering the Clinical Traumatology skills. At the very least, as in all disciplines, these tools require practice and, ideally supervision, for competence. If you try the

approaches without training, follow the instructions! Both approaches have been developed over years and the form they have evolved to represents thousands of hours of clinical trials.

When applying these techniques to those who have lost loved ones, if you can open the door and help them through the trauma part of it in the brief time it takes to apply one of these approaches, you will have accomplished more than has been the norm in the past.

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