1 TIR As a Companion to Critical Incident Stress Management & Debriefing

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[Ed. Note: this set of two papers was originally presented in the Proceedings of the Rocky Mountain Region Disaster Mental Health Institute's annual conference in 2005.]

Robert H. Moore, Ph.D. wrote *Traumatic Incident Reduction: Primary Resolution of the Post-Traumatic Stress Disorder*, the article which follows this introduction, in 1992. He has been a staunch supporter of Traumatic Incident Reduction (TIR) from its development in the mid-1980s, when he and TIR's developer, psychiatrist Frank A. Gerbode, M.D., introduced it to mental health professionals here in the US and abroad.

Even though there are trained TIR facilitators in Canada, Europe, South Africa, Israel and Australia, there are still too few, even here in the US, to meet the demand for skilled trauma rehabilitation services. It is my hope that Dr. Moore's article will inspire you to consider becoming trained as a TIR facilitator yourself. As a crisis responder, you doubtless will see many opportunities to use TIR's uniquely efficient and effective clinical protocol, not only to restore trauma victims to full functionality but to facilitate their subsequent personal growth.

What Dr. Moore does not mention specifically in his article is where TIR fits in with Critical Incident Stress Management and Debriefing; that is what I most want to address in this introduction.

Dr. Gerbode's purpose in developing TIR was to put into the hands of any caring and competent helper a structured technique for completely resolving PTSD, its

sequelae and other trauma-related disorders. The technique had to be easy to teach, easy to learn, as well as highly effective in a short period of time. And he succeeded beyond all reasonable expectations. TIR's integrative and thoroughly client- or person-centered protocol fulfills the promise and is uniquely appropriate for use by lay practitioners as well as by mental health professionals. It is now the core procedure of "Applied Metapsychology."

Metapsychology facilitators neither interpret nor judge people's behavior and beliefs. Nor do they label them. They simply help people rid themselves of their personal anguish with a systematic approach to personal development that draws upon the common elements of human experience. They offer a practical, cross-culturally applicable program for self-improvement based on an understanding of the ways in which habits, reactions, attitudes and their associated mental "baggage" are acquired.

Whereas traditional psychology focuses mainly on reconstructing cognition, emotion and behavior, Metapsychology addresses internalized pain, confusion and thwarted intentions. The cumulative impact of life's mishaps, abuses, over-control, losses and deprivations is often expressed as negative personality and character traits. Applied Metapsychology identifies such mishaps and abuses, resolves them and revises the otherwise destructive pattern of failed coping and compensation that so often sabotages the best efforts of those who already have been injured or victimized. The result: a person who is truly and spontaneously happy and productive, a victim no more.

As you know, recovery is the longest phase in getting back to normal following a crisis… not only after area-wide events, like the recent tsunami or the hurricane that struck New Orleans, but when someone has endured a

personal tragedy. CISM responders see it all. They do a tremendous job in supporting individuals during and immediately following both personal crises and large-scale disasters. But what happens to the victims in need of follow-up after the crisis has passed and the CISM teams leave? And how do CISM team members handle secondary trauma and support each other?

Crisis responders need to be able to recover quickly both to maintain a sense of normalcy in their lives and to be ready to respond to the next crisis. And they need to be able to return to their families confident that the people they have briefly helped will get whatever additional help and support they need to normalize or adapt. This is where TIR shines.

It would be ideal if every crisis responder could resolve his or her own past traumas before engaging in crisis work. More realistically, an effective crisis responder will have the ability to function proficiently even when he personally has experienced a negative reaction during deployment. The ability to remain "grounded" and functional in a crisis is strengthened by TIR training, as are communication skills. At no other time are the clarity and presence of mind typical of a trained TIR facilitator more vital than when a crisis has thrown others into disarray. As critical incident responders, we need to have our wits about us. TIR training gives us the opportunity.

Critical Incident Stress Management & Debriefing units that include well-trained TIR facilitators are better equipped to provide the kind of follow-up service that both victims and responders sometimes need after the crisis has passed. As a TIR facilitator, a CISM team member's effectiveness in relieving traumatic stress and resolving PTSD is greatly enhanced.

To find out when and where your nearest TIR professional skills workshop is being presented or to arrange for the TIR workshop to be presented at your facility, you are invited to visit www.TIRTraining.org.

TIR: Primary Resolution of the Post-Traumatic Stress Disorder

Robert H. Moore, Ph.D.

[Ed. Note: This is an adaptation of a book chapter introducing Traumatic Incident Reduction[1]. This chapter is not a guide to clinical application of the procedure nor is a training manual per se. Regardless of one's prior training and experience, we feel that successful clinical application of TIR requires a minimum of four days of training plus a brief supervised internship.]

Problem Profile

In recent years, significant media attention has been given to the Post-Traumatic Stress Disorders (PTSD) of Vietnam veterans, whose post-war "nervous" problems (i.e., sleep disturbances, hypervigilance, paranoia, panic attacks, explosive rages and intrusive thoughts) were known to veterans of earlier campaigns as "battle fatigue," "shell shock," and "war neurosis" (Kelly, 1985). As any number of mugging, rape, and accident victims have demonstrated, however, one need not have been a casualty of war to experience the problem (APA, 1987). PTSD appears in children as well as adults (Eth & Pynoos, 1985) and has been attributed to abuse, abortions, burns, broken bones, surgery, rape, overwhelming loss, animal attacks, drug overdoses, near-drownings, bullying, intimidation and similar traumata.

The PTSD reaction is most easily distinguished from emotional problems of other sorts by its signature flashback: the involuntary and often agonizing recall of a past traumatic incident. It can be triggered by an almost limitless variety of present cognitive and perceptual cues

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

Like emotional problems of other sorts, however, PTSD is not accounted for solely in terms of antecedent trauma and classical conditioning. In order to provoke a significant stress reaction, as Ellis (1962) and others observe, an experience must ordinarily stimulate certain components of an individual's pre-existing belief system. Veronen and Kilpatrick (1983) confirm that the rule holds for trauma as well as for more routine experience. Errant beliefs—related to the tolerance of discomfort and distress; beliefs about 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 premorbidly hold such beliefs in a dogmatic and rigid fashion are at greater risk of developing PTSD and experiencing more difficulty coping with the resulting PTSD symptomatology" (Warren & Zgourides, 1991, p. 151). Also activated and often shattered by trauma are assumptions regarding personal invulnerability; a world that is meaningful, comprehensible, predictable and just; and the trustworthiness of others (Janoff-Bulman, 1985; Roth & Newman, 1991). Such pre-existing beliefs and assumptions, plus the various conclusions, decisions and attitudes specific to a particular traumatic incident (especially when held as im-

peratives) constitute the operant cognitive components of PTSD.

PTSD is as diverse in its symptomatic expression as in its experiential origin (see Table 1-1). It manifests as a wide range of anxieties, insecurities, phobias, panic disorders, anger and rage reactions, guilt complexes, mood and personality anomalies, depressive reactions, self-esteem problems, somatic complaints, and compulsions (Dansky et al, 1990). Because of the considerable breadth of its symptomatology, "PTSD" alone does not constitute a fully adequate diagnosis. The current PTSD-related diagnostic lexicon allows us to designate a case only as either chronic/delayed or acute (APA, 1987). It does not enable us to communicate either the specific features or the psychodynamics of a case. Assuming, for example, that a telltale flashback or some other clinical indicator properly identified them, each of the following case presentations could easily qualify as PTSD:

- The father who explodes in violent rages at his two year-old's spills and messes (combat veteran with delayed onset PTSD)
- The graduate student who gets so panicky at exams and interviews that he can barely function (severe childhood sports injury)
- The housewife who is bored to tears by her dull routine but can't get motivated to start a new activity (physically abused as a child)
- The college co-ed who desperately makes and breaks love relationships at the rate of three or four a semester (date-raped in her teens)
- The ten year old who gets nauseated and faint at the mere suggestion that he get into a car (parents killed in an auto accident)

TABLE 1-1: Diagnostic criteria for 309.89 Post-Traumatic Stress Disorder

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently re-experienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)

(2) recurrent distressing dreams of the event

(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)

(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

(1) efforts to avoid thoughts or feelings associated with the trauma

(2) efforts to avoid activities or situations that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma (psychogenic amnesia)

(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)

(5) feeling of detachment or estrangement from others

(6) restricted range of affect, e.g., unable to have loving feelings

(7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.

Specify delayed onset if the onset of symptoms was at least six months after the trauma

The designation "PTSD," then, is not associated with any particular symptom, symptom cluster, or stressful current circumstance but denotes, instead, the historic mechanism by which any of a broad range of conditioned responses, along with their cognitive structures were incorporated into a client's repertoire.

Primary and Secondary Trauma

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

tion" of the primary trauma, that constitutes the painful secondary experience we recognize as PTSD (Foa, 1989).

In the Pavlovian model, the occurrence of the restimulator (triggering stimulus) equates to the ringing of the bell; the stress reaction itself equates to salivation. The mechanism is almost indefinitely extendible by association. Once the dog has been conditioned to salivate to the ringing of the bell, for example, the bell may be paired with a new perceptual stimulus—say, the flashing of a light—so that the dog will then salivate to the light as well as to the bell. If one next flashes the light and pulls the dog's tail, the dog will learn to salivate when his tail is pulled (Hilgard, 1962). By sequencing stimuli so as to create a "conditioned response chain" in this manner, we expand the domain of stimuli that will elicit the salivation response[2].

Since the laws that govern the construction of the conditioned response chain in the laboratory are exactly those that govern the development of the post-traumatic stress disorder in vivo, this simple mechanism—the expansion of the secondary restimulator domain by association—has very significant implications for clinical practice. It is responsible for the longevity of many PTSD cases, for the persistence of PTSD symptoms in the absence of flashbacks (Moore, 1990), for many apparent compulsions (Goodman and Maultsby, 1974), and for the fact that any secondary PTSD experience can itself be restimulated and thus function as a traumatic incident (Kilpatrick et al, 1985).

This process may be illustrated by the following common example: A veteran originally injured in an artillery attack (the primary trauma) will often tend to be restimulated, even years later, by such things as smoke and loud noises. So it's no surprise when he panics, post-war, in response to fireworks. However, should he happen to be triggered into a full-blown panic reaction by a fireworks

display while eating fried chicken at a picnic in the park, he is likely thereafter, as strange as it seems, to get panicky around fried chicken (whether he flashes back to the park at the time or not). In such a circumstance, fried chicken gets added to the domain of toxic secondary restimulators of his war experience, and the "picnic in the park" incident acquires secondary trauma status and is itself subject to later restimulation. If, for instance, fried chicken subsequently gets (or previously had gotten) associated with his mother-in-law (who prepares it for his every visit), his contact with her also becomes subject to PTSD toxicity by association. The dynamic effect of such repeated reactions over a period of time is a gradual increase in the client's toxic secondary restimulator domain. This, in turn, produces a corresponding reduction of his day-to-day emotional stability and an inability both to comprehend and to break out of his increasingly volatile reactive pattern (see Hayman et al, 1987).

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