

**The International Electronic Journal of Innovations in the Study of the  
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**Reflections on Active Ingredients in Efficient  
Treatments of PTSD, Part 1**

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**ABSTRACT**

This two-part essay summarizes the therapeutic procedures presented at The Active Ingredients in Efficient Treatments of PTSD Conference at Florida State University, May 12-13, 1995, and delineates some possible salient change-producing ingredients germane to these approaches.

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Four therapies for PTSD were presented at the Active Ingredients in Efficient Treatments of PTSD Conference, Florida State University, May 12-13, 1995. The conference was presided over by the principal investigators of the clinical demonstration study by the same title (Figley, C.R. and Carbonell, J., 1994). The methods included Eye Movement Desensitization and Reprocessing (Shapiro, 1995), Visual/Kinesthetic Disassociation (Bandler & Grinder, 1979), Traumatic Incident Reduction (Gerbode, 1995), and Thought Field Therapy (Callahan, 1985). Each method was summarized by the developers and/or representatives, preliminary results of the demonstration project were provided, workshops were presented and penetrating discussion ensued.

The four approaches were selected on the basis of nominations by traumatology professionals in response to the investigators' request, the Internet facilitating the process. Over a dozen nominations were initially received; however, most did not fulfill criteria for inclusion in the study: verification of effectiveness by

at least 300 licensed/certified clinicians who regularly treat PTSD clients; replicable under laboratory conditions at FSU; readily teachable to paraprofessionals; willingness of the principal developers to defend the approach to academic, clinical researchers at FSU; and willingness of the developers and/or principal practitioners to treat clients at FSU for a week under research conditions.

Four to six month follow-up's revealed that all of the approaches yielded sustained reduction in subjective units of distress relative to treated traumatic memories (although some rebound in SUD's was evident in many cases). The average pre-treatment SUD rating on a 10-point scale was between 8 and 9. Noting that the follow-up evaluation time frames and N's varied considerably across treatment conditions, notably imposing variables, respective Mean Group Treatment Times and Post-Treatment follow-up SUD ratings were as follows: TFT (N14) 63 mins, 3.60; V/K D (N11) 113 mins, 3.30; EMDR (N6) 172 mins, 2.64; TIR (N9) 254 mins, 5.67. (A variety of psychometric and physiologic measures not discussed in this article were also obtained.) While strict comparisons among the methods would not be valid due to varying client selection criteria across methods as well as other variables, preliminary results nonetheless support the contention of the nominating professionals that the methods are effective in reducing distress associated with traumatic memories.

What, then, accounts for the reduction in symptomatology? This paper succinctly describes each method and offers hypotheses as to active ingredients specific to and/or across methods. The hypotheses are not necessarily those endorsed by the developers of the methods but are presented for heuristic purposes.

### **EMDR:**

EMDR directs the client to attend to traumatic memories while 'tracking' eye movements, in response to the therapist's prompting. The client also internally rehearse an associated negative belief (e.g., 'I'm powerless.') initially and sometimes intermittently during the eye movements, and attends to emotional and physical factors stimulated during the process. SUD's are monitored, while the therapist follows the client in a fairly non-directive manner, prompting eye movements as relevant material emerges. After this results in significant reduction in SUD's, the client rehearses an appropriate positive belief (e.g., 'I'm worthwhile.') during eye movements, in order to 'install' the belief. It should be noted that during EMDR associated memories, evidence of a greater memory network, often emerge and are treated in a similar manner. Other phases of

treatment include 'body scan' to evaluate progress and determine targets for additional sets of eye movements if necessary, and 'closure', which includes assessment of safety, client debriefing, etc. Forms of stimulation other than eye movements, including tones, light, and physical tapping, have also been found to be effective.

Shapiro believes that the stimulation triggers 'a physiological mechanism that activates the information-processing system' (1995, p.30). She lists various mechanisms that may be responsible for activating and facilitating processing: '...dual focus of attention...to present stimuli and the past trauma; 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; [and] deconditioning caused by a relaxation response' (p.30). The traumatic material is assumed to be processed to an adaptive resolution via accelerated information processing. It is proposed that this tends to occur naturally with lesser issues, but is frequently blocked when one is exposed to intense experiences such as trauma. EMDR serves to activate this natural mechanism.

### **V/K D:**

V/K D assists the client in disassociating from the negative feelings associated with the traumatic memory by visually reviewing the event from a different perspective (Cameron-Bandler, 1978). One approach to V/K D is to direct the client to visualize a snap shot of a moment immediately prior to the event, and then to introduce disassociation by having the client watch himself in that past scene. Disassociation can be further enhanced by having the client maintain a perceptual position that entails an additional level of dis-association as contained in the instructions: 'Watch yourself watching the younger you over there in the past going through [the trauma].' Most clients are able to achieve this perceptual shift with assistance. While disassociation is maintained, the client is directed to allow the 'movie' of the memory to unfold and to become aware of understandings or resources needed in order to promote resolution. For instance, it may become evident to the client that 'It is over and I survived.' The client is then asked to 'share' this knowledge with the 'past self', the one who suffered the trauma.

The sharing obviously takes place in imagery. This often results in significant reduction of negative affect with any future recall of the memory.

V/K D is a Neuro-Linguistic Programming (NLP) technique. NLP is a method of modeling and not a theoretical position. It entails patterning the internal and

external behaviors of people who have been able to achieve consistent results in various activities, including psychotherapy. V/KD was likely modeled from the behavior of hypnotists such as Milton H. Erickson, MD. It is based on the recognition of synesthesia patterns, S-R bonds between sensory systems. For example, an external or internal visual stimulus can result in an unpleasurable kinesthetic response. When employed to treat trauma, the focus is on interrupting the synesthesia pattern by introducing dis-association while the client attends to the memory. This creates a revised S-R bond. That is, since the individual no longer recalls the trauma in an associated manner, negative emotionality is removed from the memory.

This process should not be confused with the global dissociation that is characteristic of conditions such as PTSD; dissociative amnesia, fugue, and identity disorder; depersonalization disorder; etc. While these disorders involve severe disruptions of various integrative functions, VK/D merely entails a shift in one's perception of a memory from associated (i.e., as if one is reliving the experience) to dis-associated (i.e., not experiencing the memory in an associated manner).

### **TIR:**

TIR is a method whereby the client, referred to as 'viewer', visualizes the traumatic incident while the therapist provides instructions. The viewer locates an incident that is believed by the therapist to be resolvable within the course of the session, which may require several hours. The viewer is instructed to choose a most 'interesting' traumatic event, since it is assumed that 'interest' signals the capacity and inclination to learn. Once an incident is located, the viewer is instructed to note any awareness just prior to the event unfolding. Next the event is viewed silently from beginning to end, after which the viewer reports what was observed. This process is repeated until the viewer arrives at a resolution. It is assumed that there are gaps in the viewer's awareness and that by repeatedly viewing the event, this information comes to the fore, thus resulting in alleviation of negative emotions and cognition associated with the event. The resolution of an earlier associated trauma, the awareness of which may emerge during this process, is also assumed to be relevant in this regard.

### **TFT:**

TFT directs the client to attend to a disturbing traumatic memory or other emotionally charged condition while physically tapping on specific acupuncture meridian points. The therapist often follows a diagnostic process

involving a muscle testing procedure to discern a specific sequence of meridian points needed in order to achieve therapeutic results. Another TFT diagnostic procedure, the Voice Technology, determines a sequence by electronically evaluating frequencies in the voice. A standard TFT trauma algorithm, derived from diagnostic procedures, has the client attune to the traumatic memory, determine a SUD's rating 1-10, and then briefly tap on each of the following potent meridian points (i.e., major treatments) in sequence: beginning of an eyebrow above the bridge of the nose, directly under an eye orbit, approximately four inches under an armpit, and under the collarbone next to the sternum. After these treatments are completed, the SUD rating generally dropping by several points, the client is directed through the Nine Gamut Treatments (9G), which involves simultaneously tapping between the little and ring fingers on the back of a hand while doing the following: eyes closed and opened, eyes down left and down right, eyes in clockwise and counterclockwise directions, humming notes, counting, and humming again. At this point the SUD's are generally lower yet, and the client is directed to repeat the major treatments. Frequently at this phase, all or most distress associated with the memory has been alleviated. If the SUD rating is not down to a 1, repeating the treatments will often achieve the desired results.

Sometimes associated memories emerge when treating a targeted traumatic memory. The TFT treatments are then merely directed at the new material, which is generally treated just as quickly and effectively as the target memory.

Also at times a client evidences a condition referred to as psychological reversal (PR), which blocks the treatments from working. It is hypothesized that PR entails reversed energy flow in the meridians which results in a negativistic, self-sabotaging state. PR treatment often quickly corrects this condition so that therapy can proceed successfully. While a variety of PR's have been identified, the most common form is corrected by having the client simultaneously tap on the little finger side of a hand while repeating an affirmation such as, 'I accept myself even though I have this problem.' TFT is based on the assumption that psychological problems are manifestations of isolable active information (Bohm, D. and Hiley, B.J., 1993) energetically coded within 'thought fields.' Callahan (1994) defines a thought field as follows: '... the specific thoughts, perturbations and related information which are active in a problem or treatment situation. In order to diagnose and treat effectively the appropriate thought field must be attuned.'

Examples of thought fields include traumatic memories, thinking about or being in proximity of phobic object, or even the thought of an elephant. A

perturbation is defined as 'the fundamental and easily modifiable trigger containing specific information which sets off the physiological, neurological, hormonal chemical and cognitive events which result in the experience of specific negative emotions' (Callahan, 1995). By removing the perturbation(s) from the thought field, distress associated with the traumatic memory, the phobia, or the thought about an elephant (if one is phobic of elephants) is alleviated.

Thus Part 1 comes to a close. Part 2 of these reflections will delve into various mechanisms that may account for the therapeutic efficacy of these "power" therapies.

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For references, see bottom of part 2, which follows on next page.

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**Reflections on Active Ingredients in Efficient  
Treatments of PTSD, Part 2**

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**ABSTRACT**

Part 1 of this essay summarized data and summarized the methods studied in the 'Active Ingredients' Project. Part 2 explores possible change-producing ingredients germane to each as well as across the methods.

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Part 2 of this paper focuses on possible active, change-producing elements of the four therapies for PTSD included in the Active Ingredients Demonstration Project (Figley, C and Carbonell, J., 1995). The methods studied were Eye Movement Desensitization and Reprocessing (Shapiro, 1995), Visual/Kinesthetic Dissociation (Bandler & Grinder, 1979), Traumatic Incident Reduction (Gerbode, 1989), and Thought Field Therapy (Callahan, 1985). While detailed research is indicated toward clarifying the extent of treatment effects, as well as the necessary ingredients involved, momentarily allow some speculation as to the active ingredients. The following is not intended to be a comprehensive compilation but rather a highlighting of some feasible ingredients. It is hoped that this will prove of heuristic value toward advancing understanding of active ingredients, stimulating research, and promoting the evolution and utilization of effective means of treating trauma-based conditions.

At the onset it is evident that a significant contribution of the Active Ingredient Project is in its exploration of several methods that appear to efficiently treat trauma. The methods are unique and are predicated on revolutionary theoretical positions. It is therefore evident that there are a variety of ways to efficiently treat the same condition. While this is hardly earth shattering, it nonetheless affords reference points for deciphering the ingredients responsible for the methods' efficacy. That is, what commonalities account for the efficiency of these methods? Perhaps more importantly, when a method excels in some respect, what are the particular ingredients that account for this?

## **1. EXPOSURE AND ATTUNEMENT**

Exposure has been a primary method for treating trauma, clinical experience and research supporting the position that in vivo and imaginal exposure to relevant stimuli over an extended period of time can result in the extinguishing of negative affective responses. So, too, some degree of 'exposure' appears to be an ingredient in the methods reviewed. Each requires the subject to 'think about' the trauma, this being necessary toward later desensitization or extinguishing of associated symptoms. While the developers of the methods proffer varying theoretical positions, not always favoring terms such as 'extinguish' or 'desensitization,' this is understandable and permissible in light of the rapidity of treatment effects and the significant departure of these methods from traditional procedures. In this respect it is evident that exposure alone cannot adequately account for the efficacy of these therapies; otherwise, flooding would prove equally efficient. Additionally the degree of exposure induced with some of the methods is so minimal that 'attunement', a term preferred by Callahan (1994), should perhaps be substituted. This term does not indicate intense vivification that is generally implied by 'exposure'. In instances of exposure as generally understood, it should be borne in mind that the subject willingly maintain an unwavering level of attention to the trauma. This is entirely distinct from traumatic material emerging spontaneously, the subject being the victim of such events. Conscious choice in this manner may frequently serve to create a sense of self-efficacy that further figures into the resolution formula.

## **2. DISSOCIATED OBSERVATION**

An "outside observer" position is promoted directly with V/KD (Cameron-Bandler, 1978), while the other methods may provide this ingredient indirectly. In this respect the subject is no longer "in" the memory but "outside," looking at it. Such a shift stimulates the acquisition of other understandings while

emotionality is reduced. The associated distinction becomes clear as a memory is recalled in a similar manner in which the event was initially experienced. In this instance the image is 'seen' through the individual's eyes, as though it is presently occurring. If affect is associated with such a memory, its intensity is readily perceivable when associated. Dissociation, on the other hand, entails recalling the event with the internal image including the observer, an event that could not have occurred at the time of the original event. This position yields significant decrease in affective intensity relative to associated recall.

With V/KD, this perceptual shift appears to be a primary causal factor in promoting relief from the trauma. It should be emphasized, however, that dissociation is a temporarily induced aspect of the procedure, as the patient is later directed to re-associate and maintain the 'learning's' acquired during the dissociation phase.

### **3. SUBMODALITIES AND TRANSMODAL REATTUNEMENT**

Besides viewing from a dis-associated position, trauma neutralization can also be promoted via change in other facets of internal sensory representations, referred to as 'submodalities' (Bandler, 1985). For example, the visual modality can be analyzed in terms of elements such as perspective, proximity, movement, etc. V/KD induces alteration of such elements by having subjects see themselves seeing themselves in the scene. Given this shift as well as others prescribed during the process, additional imagery changes frequently follow. This may entail the memory shifting from a movie to a snap shot, from colorful to achromatic, from clear to vague, etc. Also changes in the visual modality often result in transmodal reattunement. For example, closer appearing images may entail a louder auditory component as compared to more distant appearing images. The other methods often appear to produce similar shifts. Shapiro sites the case of a Vietnam veteran treated with EMDR reporting that the auditory component of the memory silenced, the visual aspects became like "a paint chip under water," and affect calmed (Shapiro, 1995, p. 4). The author has also obtained similar reports from patients treated with TFT as well as EMDR. For instance, some patients report that the memory appears "more distant" or "vague" after treatment is completed. This is not a hard and fast rule, however, since others report being able to distinctly or even more distinctly recall the trauma, albeit without the previously reported negative affects. Of course, recalling a memory clearly does not exclude the presence of other submodality alterations. Additionally there may be a distinction between cause and effect regarding these factors, depending upon the method involved.

These phenomena warrant closer scrutiny.

#### **4. DUAL ATTENTION**

Dual focus of attention is assumed to be a primary ingredient of EMDR (Shapiro, 1995) and possibly TFT as well, in that both entail physical stimulation while the subject attends to the traumatic memory. However the manner in which such simultaneous stimulation occurs is likely significant. For a subject to attend to elements within the environment while simultaneously attending to a traumatic memory, a distraction which certainly occurs even when therapeutic efforts are not being made, may not sufficiently provide this ingredient. Specific eye movements, hand tapping and finger snapping (Shapiro, 1995, p. 67), listening to unique bi-lateral sounds (Yourell, 1995), and tapping at specific acupuncture meridian energy points (Callahan, 1985) and are modes of stimulation likely to be most effective in this regard.

#### **5. BIOENERGY**

TFT is the only therapy represented that addresses the bioenergy system directly by having the client tap on specific acupuncture meridian points in sequence while accessing the trauma (Callahan, 1985, 1995). This procedure is entirely distinct from other methods of simultaneous stimulation and may reasonably account for the rapid treatment effects of TFT as compared to many other methods. Callahan's position is that such stimulation transduces kinetic energy into the bioenergy system, thus removing perturbations or 'active information' (Bohn and Hiley, 1993) from the specific thought field (i.e., which includes a memory of the trauma). Perturbations are hypothesized codes which cause the energy system to activate negative affects.

If all fundamental change entails transformation at the energy level, then other effective methods may also treat the energy system in distinct ways. Perhaps EMDR primarily stimulates a neurologic process that accelerates information processing while balancing the energy system, thus alleviating negative affect and other sequelae associated with the trauma. V/KD may accomplish this same effect via reframing and alteration of internal sensory representations, which are facilitated through reduction of negative affect via temporary dissociation. TIR possibly accomplishes this same end by assisting the patient in accessing interest and promoting the acquisition of repressed information.

#### **6. PARADOX**

Choosing to recall a trauma entails paradoxical elements that have been observed to be curative among a variety of therapeutic systems. Consider Victor Frankl's paradoxical intention, Milton Erickson's double binds, and the Zen Master's koans. As the subject attends to the disturbing memory, perhaps there is a suspension of usual ways of experiencing, thus permanently altering the experience of the trauma. Bear in mind, however, that this may only be a side feature, since it does not appear that paradoxical procedures have generally been as rapidly effective as the methods presented.

## **7. COMFORT**

Each method departs from pure exposure to varying degrees, assisting the client in feeling more comfortable during the course of attuning the trauma. The least divorced from flooding appears to be TIR, while the most removed and thus most comfortable for both client and therapist is TFT. Comfort is an important aspect of the most rapid means of alleviating trauma. The more comfort experienced during the procedure, the more rapidly neutralization is prone to occur. While it is not entirely accurate to compare the methods studied in the AIP, since the study was not structured to yield such comparisons, the data nonetheless favor such a hypothesis in that results were most rapidly achieved with TFT and least rapidly with TIR. (Although TIR represents a definite advancement over flooding in that it achieves results more efficiently by focusing on resolving the trauma within the context of a single session and by connecting the identified trauma with earlier associated traumas, it nonetheless appears to be in closest propinquity to flooding relative to the other methods.) While methods such as systematic desensitization inhibit anxiety via progressive relaxation while reviewing segments of the trauma (i.e., reciprocal inhibition), these newer therapies utilize other, more rapid means of interrupting associated negative emotionality. Eye movements, bilateral tapping and sounds (EMDR); tapping on meridian energy points (TFT); or dissociation (V/KD), each promote comfort by interrupting the intensity of negative affects. Comfort allows one to attend more easily on the trauma. Additionally comfort becomes associated with the trauma, quelling its effects. Again the reader's attention is directed to the fact that while comfort appears to be a relevant factor, it can hardly account singularly for the results evidenced with these therapies or efficient therapy in general.

## **8. POSITIVE EXPECTATION**

Expectations are promoted that the memory will be resolved within the context of the session, rather than perpetuating the notion that extended time is needed.

This challenges the subject's belief to the contrary, reinforced by the fact that distress has existed over an extended period of time. As Rosenthal and Frank suggested, "It may well be that the efficacy of any particular set of therapeutic operations lies in the analogy to a placebo in that they enhance the therapist's and patient's conviction that something useful is being done" (1956, p. 300). This may be a relevant ingredient with methods such as TIR and V/K D, but it is possibly less likely that odd-appearing TFT and EMDR would be conducive to promoting placebo effects. Subjects may be less inclined to believe that moving one's eyes or tapping at specific points on the body could neutralize trauma. While some may find this a plausible notion, likely most people in Western culture would be less inclined to experience positive expectation from such procedures.

## **9. READER'S CHOICE**

In the interest of assisting in the identification of active ingredients in trauma therapy, the reader is invited to explore the ingredients suggested in the efficiencies of the therapies presented and to evaluate other trauma therapies in accordance with these and other plausible ingredients.

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This paper can be found online at:

<http://www.fsu.edu/~trauma/art2v2i1.html>

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