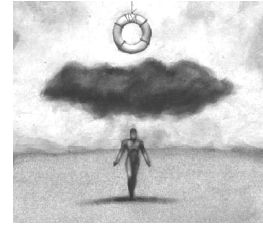


# 3

## Grief and Loss



---

### Relieving the Traumatic Aspects of Death with TIR and EMDR

by Teresa Descilo, MSW, Victim Services Center, Miami  
dakini11@bellsouth.net

Excerpted and adapted from an article originally published in C. Figley (Ed.) *The Traumatology of Grieving: Conceptual, Theoretical, and Treatment Foundations*. London: Taylor & Francis. Reproduced with permission of the author

#### 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, 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 post-traumatic stress, and that telling one's story over and over again brings relief. I would wager that their cultural practice prevents post-traumatic 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. Although she was defining trauma for children, the definition seems to describe what we all experience. This definition serves to explain how death could produce post-traumatic stress.

In our Western culture, where we tend to view death as an 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.

***In our Western culture, where we tend to view death as an option, we are ill-prepared to deal with the reality of a death, no matter what the circumstance***

– B. Smith

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.”

## **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 (*Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*) of post-traumatic 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, 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.”

According to Potocky, 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.

Most of the interventions described in the literature reviewed were group interventions. Potocky's 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.

### **Evidence of Effectiveness**

There is a large body of literature which supports the efficacy of EMDR. 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 post-traumatic stress. The improvements 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 Exposure (DTE) 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 than 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**

This case was actually presented by a student who was taking my TIR workshop class. The student volunteered to address the death of her mother. I normally don't address deaths in this classroom, 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.

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 again. From this point, the grief was less frequent and less and intense. When she indicated that the incident felt the same at the 19th time, 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, at 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.

## Summary

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.

## Selected References

Bisbey, L. B. (1995). “No longer a victim: A Treatment Outcome Study for Crime Victims with post-traumatic stress disorder” (doctoral dissertation) California School of Professional Psychology. (see p. 256 to order).

Coughlin, W. E. (1995). TIR: Efficacy in treating anxiety symptomology. (doctoral dissertation), Union Institute (see p. 256 to order).

Doka, Kenneth J., Ph.D. (1996) *Living With Grief After Sudden Loss: Suicide, Homicide, Accident, Heart Attack, Stroke.*

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children*. New York: Lexington Books.

Potocky, M. (1993). "Effective services for bereaved spouses: A content analysis of the empirical literature". *Health Social Work*, 18, (4), 288-301.

Valentine, P. V. (1997). "Traumatic incident reduction: Brief treatment of trauma-related symptoms in incarcerated females." (doctoral dissertation) Florida State University. (see p. 256 to order)

Valentine, P. (1995). "Traumatic incident reduction: A review of a new intervention." *Journal of Family Psychotherapy*, 6, (2), 79-85.

---

## Future TIR: A Conversation with Marian Volkman

*Future TIR is a technique taught in the TIR Expanded Applications course (see Appendix C)*

**VV:** I understand there is a technique called Future TIR (FTIR) that is used to handle traumas that a client knows is going to happen but hasn't happened yet, or that could happen. How does that work?

**Marian:** How it works is that we have the person take a look at the worst possible scenario of what he's worried about happening. As you say, that could be something that's very likely to happen. For example if he has a parent terminally ill in the hospital then it's likely that he is going to experience the loss of that parent. It's still possible that he could get run over by a bus before his parent dies, but it's pretty likely that he will experience that loss.

Or you can have something extremely unlikely to happen. One of the ways this can manifest is a mother who is obsessively worried that something is going to happen to her children. She controls and smothers them because she is trying to protect them from really unlikely events that she can't stop picturing and worrying about. She could be worried about losing her job and she could have real reasons for worrying about that. Or she could be worried about her job when there is no apparent reason for worrying about that. It doesn't matter; we can address it either way, likely or unlikely.

We always start with the worst scenario because that's where peoples' attention magnetically goes. They're not worried about the little stuff; they're worried about something really terrible happening. By allowing the person to go through the dreaded future experience, likely or unlikely, as if it's a real experience, you actually are able to reduce charge and resistance from future events. That's how it works; it works pretty fast, faster than addressing an actual traumatic incident because we are addressing a possible future incident rather than one the client has already lived through.

You go through all the worst scenarios the person can imagine and you kind of work your way back to "not as bad" scenarios. As many times as he needs and

wants to go through the worst scenarios, you do. Eventually, the person gets to feeling like he's ready to confront whatever happens. It's very relieving.

**VV:** How does this apply to bereavement?

**Marian:** It's certainly not the only application of FTIR, because I use it for many circumstances. I do find it to be enormously beneficial to deal with bereavement, because you can address a loss such as "death of a loved one" with TIR and definitely get some relief but often where most of the charge is in fact, in the future as the person is looking at going on through her life without this person. This could include loss of a love relationship, a pet that is very dear, a job, or what have you.

I'll give you one example. I had a woman who lost her husband and she really felt that her life was over. Her companion was gone and she had no life. What we did is we talked about it and got the parameters set up. In TIR we want quite a specific incident; we don't want big long incidents. With Future TIR, it's different. When you're dealing with a situation that hasn't happened, you can be a little freer. I said "OK, I want you to imagine the whole rest of your life going through it exactly how you feel now and it never gets any better." She went through that a couple of times and it was really real to her the first couple of times. Then it started to lighten up a little. After 4 to 5 times through it, she said "This is ridiculous, I don't have to live like that. It's going to be work; I need to get out there and make myself do things and take an interest in things and meet new people. I've got the rest of my life -- probably 40 years or so." She was starting to feel excited and extroverted and like life was worth living. At the point where her attention shifted from the loss outward on to the rest of her life that was the end point.

I have to tell you, I was pretty floored by that. It was early on when I had just developed this technique. Since then, I've used it with lots of people and different types of losses. A woman had lost her dog and to her she had lost her best friend. It was extremely traumatic and we did TIR on the actual loss and everything that led up to the death of the dog and the experience of that. Sure enough though, the future looked bleak. She needed to look at her life for the next year without the dog. It took a while with her, it was a big deal. She did shift and feel like, "Yes, I'll never have this particular special being here with me" She had to face that and get through it. When she did, she really got to the point of feeling "Yes, life is worth living even though I don't have this wonderful dog with me anymore."



**VV:** The dog had already died and you were doing the future without the dog?

**Marian:** Yes. You can address either an impending loss or the future aspect of a loss that has already happened. I think it's important to mention pets when we talk about bereavement. She was almost apologetic for feeling so much emotion about this. Many people might have difficulty understanding the magnitude of the loss of a pet. It can be devastating. I would say that in any incident of loss where the person feels that his future is compromised, that he's lost his future in a certain sense, it would be really useful to address that with FTIR.

**VV:** After Future TIR, how does the future occur to that person in light of the loss?

**Marian:** There are a lot of ideas about how bereavement has to go. Hospice training traditionally tells you: be careful, don't rush people, it takes as long as it takes, and there's no wrong way to grieve. I agree with that but at the same time if we can do something to help the person be in her own experience, be in her own life, and be OK with that, we want to do that. Why spend years getting there if we can facilitate the healing? A loss is still a loss; she's going to miss that person, but we don't have to have the client suffering for a long, long time, I strongly feel that.

At the same time, I wouldn't ever push somebody to do this if he didn't want to do it. Suppose we've addressed the loss of a loved one, I'd say "Are you interested in taking a look at the future having your life go on without this person being here?" Most of them will say "Yes!" without any hesitation. But some will say "It's OK" or "I don't want to do that" or they have an idea about how their grieving is supposed to go. I would never argue with somebody, I would never say "Oh come on, you can get over this." Nothing like that, as it would not be person-centered. Offered the chance to improve their outlook, most people say yes and are amazed at how much better they can feel.

In the case of the woman who lost her husband, you know every day she gets up and thinks "He's not here." She does something that they used to do together and thinks about that. She can think about him and maybe feel sadness, but not have that kind of debilitating grief that just ruins your life.

I worked with a woman who was very, very close to her father. She said:

"I've told all my friends that when my father dies, I'm going to be a basket case for months. Don't even call me or expect anything of me. I'm going to be hopeless for months because it's going to be so depressing."

It was really clear in her mind that that was how it was going to be. Her father had had ill health for many years and it was obviously an impending loss. We did Future TIR with her and just a couple of months later her father did die. It was quite a sudden death even though her father had been through many ups and downs with his health in the preceding years.

The really fascinating thing is that she was the one who pulled the family together. This was one of those difficult families with the stepmother and stepchildren and the biological children, and so on. She pulled everybody together and got out his old pipe, slippers, and hat and passed them around in a circle and everybody told stories, laughed, cried, and bonded. She was the one who made that happen instead of being incapacitated. Far from being a basket case, she was not only able to handle it for herself but she had brought about a really wonderful opportunity for the rest of the family to get together and celebrate her father's life. It gave her a feeling of contentment that probably nothing else would have.

---

### Loss of a child – Session Notes from Sharie Peacock

There are few losses so shattering as the loss of a child can be, especially through something as unpredictable as SIDS. Often marriages do not survive such a loss, as the case below illustrates. This is a slightly edited transcript of an actual session given by Sharie Peacock, a Certified TIR Facilitator. Observing this woman's progression through various layers of emotion and reaction as she repetitively views this huge loss demonstrates clearly the "magic" of TIR at work. Be sure to notice how details of the incident change and the emotional content progresses through each viewing. Names have been withheld and the facilitator's precise questions removed.

SIDS (Sudden Infant Death Syndrome) is the death of an apparently healthy infant that remains unexplained after a thorough autopsy and death scene investigation. There appears to be no suffering in most cases; death occurs very rapidly, usually during sleep. SIDS is the leading killer of infants between one week and one year with an approximate rate of two per thousand live births (1 in 500). 6,000-7,000 babies die of SIDS every year in the US. The peak age is around two to four months and the majority of the deaths occur during the winter months (October to April in the Northern Hemisphere). Researchers believe that SIDS probably has more than one cause, although the final process appears to be similar in most cases. SIDS can not predicted, prevented, or reversed. (Source: Maraget Gibbs, misc.kids FAQ)

### **1st Time-through the incident:**

(Eyes closed. Tom, her husband, picked their 6 month old son Jeremy up out of the crib - it was 5 AM.) Jeremy wasn't breathing, blue. I called 9-1-1 (tears). I kept telling Jeremy to wake up. The ambulance got there and they couldn't do anything. I rode to the hospital in the back of the ambulance. I sat at the hospital holding him. They kept telling me he wasn't going to wake up, it was time for me to let him go. I kept thinking, it was all a dream, he was going to wake up. I did everything the doctors told me to do. I was mad at them! Jeremy was healthy, gaining weight. They finally took him from me. Did an autopsy. They said SIDS. I said, SIDS?! Then I thought, stupid asshole Tom did coke! (Now looking at me) He killed my baby! [Ed. Note: parental drug use is considered a major risk factor] I couldn't go back to that apartment. (Head down, eyes closed). We moved to another apartment. I kept hearing Jeremy. It went on for a year and a half. Tom kept on saying stop crying (looking at me). I think he hated Jeremy. He loved James (his other child) but not Jeremy! I threw a block at

Tom and hit his speaker when he had the music cranked and Jeremy was trying to sleep. I dream about Jeremy. It was so real. He's growing. Don't want to have those dreams any more. At the wake I didn't want to leave him there either. They put make-up on him. Didn't look like him. I know hate's a strong word but I HATE Tom's family! Jeremy was so beautiful, so healthy. I miss him so much. I feel guilty because I can't go to his grave - I talk to him all the time though.

## **2nd Time-through the incident:**

(Eyes closed, tears, hands on face, feels dizzy) Tom got up to get Jeremy. He was blue, wasn't breathing. I was screaming out the window for someone to call an ambulance. Kept telling him to wake up. Oh, God, I was getting mad at them. He wouldn't wake up. We went to the hospital. I remember sitting in the waiting room waiting to come and hold him. Seemed like it was taking forever. They wrapped him up. I sat in the chair rocking him, telling him to wake up. (Viewer reports feeling dizzy). They just kept telling me I had to let him go and I didn't want to. And I let them take him. Went to the wake. I remember them trying to take him away from me there too and it hurt so bad, it hurt. I remember Tom telling me to stop crying so much, like he didn't even care. I didn't care about nothing, just going to sleep at night so I could be with him. I remember screaming at Tom telling him it was his fault. He did something, the coke or pot or something.

## **3rd Time-through the incident:**

(Eyes closed, slightly less emotion) He brought him in to me like every other morning and said he wasn't breathing, he was all blue. I was screaming, screaming. I held Jeremy trying to warm him up. He was so cold, he was so cold. I remember rocking him in the chair. I know everyone was trying to help me, my friends. We stayed at Tom's mother's house. Just couldn't go back to that apartment. They baptized him, he was supposed to be baptized. Oh, God, I just wanted to pick him up, take him home. Part of me felt like he was still alive. I just couldn't let go. We moved into the apartment. Things between Tom and I were bad. I hate drugs. All I wanted to do was sleep and not wake up so I could be with Jeremy. Eventually the dreams just stopped. I started getting hold of myself, going to school. My friends helped me.

## **4th Time-through the incident:**

(Eyes open, looking at me at times, less emotion) They woke me up, told me

Jeremy wasn't breathing. Something was wrong. My neighbor Marie called an ambulance. They said he died in the middle of the night. I remember he slept through his feeding. The doctor had said that "When they start growing that they sleep longer". I blamed Tom; I blamed myself. When the dreams stopped I kept trying to make them come back. It was like I was forgetting, like I was letting go. I don't know if it was Tom's fault. I blamed myself. I should have woke him up to feed him. I just don't understand about SIDS. I think that's what bothers me the most, I just don't understand.

### **5th Time-through the incident:**

(Even less emotion, voice clearer, looking at me) Every morning Tom would wake Jeremy up for his morning feeding and I remember something was wrong, he wasn't breathing. I remember him running outside for someone to call 911. I just couldn't wake him up, didn't want to let him go. Maybe moving out of the apartment helped, maybe it didn't. That's when the dreams stopped. I want to know what causes SIDS. I want to understand. I don't want to hate Tom, I just want to understand. I said he didn't love Jeremy but I know he did. When Jeremy was born he was so proud, his whole family was proud. (smiling)

### **6th Time-through the incident:**

Tom went to get Jeremy up like he always did before. Getting ready for work. It was hot that night. It was so hot that night I slept on the couch and must have crawled into bed in the middle of the night. He went out and got him. He went outside screaming. He ran outside screaming. I was holding Jeremy at the hospital - knew he wasn't going to wake up. I was so angry at everyone, angry at myself. I was angry at God. I hated God. And I read everything, everything, I read everything about SIDS. This causes SIDS, that causes SIDS. It was just frustrating. I do remember Tom telling me he loved Jeremy and he was so sorry because he wished he could bring him back to me. I do feel guilty for blaming him. I don't know. How can you blame somebody when you don't even know? I just needed someone to blame. I blamed him, I blamed myself, I blamed the doctors. That's why it's so hard for me. I still need to know what causes SIDS. Until I know, I think I can feel better as far as what even happened. Am I a bad person for blaming everybody? He was a good Dad (smiling). A kid will get colicky. Tom would pick him up and burp him, and feed him, and change his diaper. It's just when his stupid friends would come over.

**7th Time-through the incident:**

(Very short run-thru) Tom got him up and brought him to me. I knew by the look on his face something was wrong. He ran out first, started screaming for someone to call an ambulance. I was banging on the wall. (sighing) I kept screaming at Tom. I hated him and told him I hated him. I wish I never said that. I didn't really hate him. I told him I didn't want to go back to the apartment and he understood. We stayed at his Mom's. They did *everything* for me just to make it comfortable. They were trying to help.... but I was pushing everyone away instead of letting them help.

**8th Time-through the incident:**

Tom found Jeremy, not breathing. He put Jeremy in my arms, said he was gonna get help - screaming for me to call an ambulance too. They came, did what they could do. The hospital did what they could do. Let me hold him. They were really nice. I knew he wasn't coming back. Just wish I could apologize to everybody, especially Tom. Because I know he felt guilty too.

**9th Time-through the incident:**

Like every morning, Tom got up and brought Jeremy to me. I noticed Jeremy was not breathing. Tom gave him to me, said he was going to get help, and then he tried comforting me, he tried, in his own way. He was my best friend. I remember blaming myself, blaming him. The only thing he would say was it wasn't my fault, I was a good mom, always told me my babies came first. I just don't want him to think that I blame him. I know Jeremy is up there (smiling). Tiffany (4 year-old daughter), knows about Jeremy but doesn't know the whole story yet. I want all my kids to know about their brother. Alex and Daniel (her other sons) call him their little angel in heaven (smiling), that's what I call him. I remember Alex asking me why he died and I said, well, "God gave him to us for a little while and took him back." I close my eyes and I see him up there, you know. A beautiful little baby. Just wish I had his pictures. Mike (present boyfriend) says we're taking a trip down to get everything for Alex and Daniel. Their baby pictures, their birth certificates, Jeremy's death certificate. I need that for closure.

**10th Time-through the incident:**

I remember they were giving me Jeremy. The first thing Tom did was put him in my arms. Said he would get help and he did. He stayed right there with me by the rocking chair. Tom's family was all there for me, telling me, "Anything I needed, anything." A lot of times I do think of him and I talk to him (laughter). I wish him Merry Christmas and happy birthday (smiling). I tell him I'll see him someday, hopefully. He was so beautiful. (Voice louder, smiling, laughing. Facilitator asked, "How does it seem to you now?"). I feel like a lot of that anger is gone, the blame is gone. There's a warm feeling here (hand on chest), if that makes sense, like he's there. It used to feel empty. I feel bad sometimes because I can't remember what he looks like, but I can actually see him, he looks so much like his father. I guess it's a good thing. He's right there (hand on chest) - my angel. They always say put the baby on his side, put the baby on his back, but, there's a lot of things they don't know. I just know he's in a good place. I've always known he's in a good place. I always felt bad I couldn't go to the grave but that's just his body. Jeremy is right here, anytime I want to talk to him (smiling). That's what I tell my kids. I don't know if it's the right thing to do but that's what I tell them. It's just something I have to try to accept - not something I can keep going on. But I can talk to Jeremy anywhere I am. That's what I believe. A comforting feeling (smiling). I'm just real relaxed, almost like a lot of stuff's been lifted off my shoulders. I was starting to feel sick to my stomach going through it but it's gone. His birthday is next month (smiling). He was a perfect little baby. I wish you had met him. OK, I feel good (smiling).

Facilitator: "OK, let's leave it at that."

This procedure was followed by Communication With a Departed Loved One in which the viewer recalled pleasant memories of her lost baby and expressed very positive and loving feelings for him. [This procedure is taught in both TIR Expanded Applications and Case Planning for TIR and Life Stress Reduction workshops – see Appendix C] She left smiling and laughing after thanking me and giving me a hug.

---

