# The Benefit of Early Intervention with RIM After a Traumatizing Event.

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## Introduction

A traumatic event can be everything from being abanded emotionally or physically to being sexually abused and/or threatened on ones' life. It is estimated that almost everybody, sometime though out their life, is exposed to a traumatic event and yet far from everyone develops physically reactions like intense stress, depression, or an anxiety disorder like for example PTSD (Post Traumatic Stress Disorder). Why do only some people develop symptoms or even PTSD? And why does it sometimes seem like it only takes a relative small issue to develop symptoms? Two questions that are discussed and often are the comments for the people who do not believe in the PTSD diagnose. In this paper I will shed light on these questions as I answer my overall question: Does it have any long-lasting benefits to treat people with RIM early after they have been exposed to a traumatic event?

After a traumatic event I had the possibility to work with a few people who suffered different cognitive symptoms. In this rapport I will compare the results from two of these clients with one client who was diagnosed with PTSD 7 years ago. These findings I will compare with research done on the same topic.

## Definition of a traumatic event

A traumatic event is an experience that causes physical, emotional and/or psychological distress or harm. It is an event that is perceived and experienced as a threat to one's safety and/or to the stability of one's world consciously or unconsciously. A traumatic event may involve: anxiety, death of a friend, family member or pet, divorce, fear, hospitalization, lack of trust, pain, physical injury or illness, separation from a parent (if a child), moving to another location, terrorism or mass disaster, violence or war etc. Throughout life we have many experiences that can be perceived as a traumatic event. For our body to perceive it as a traumatic event, it involves not feeling safe, being unable to escape and intense emotions.

PTSD is one diagnosis you may be given after a traumatic event but other symptoms are just as troublesome, such as: Intense anxiety, Panic Attacks, Severe sleep-disorder, Phobias and different cognitive symptoms like lack of memory, disturbed focus and concentration, disturbed ability to structure etc. Our minds are very complex and therefore different individuals' reactions vary faced with the same situation. So far it has not been possible to predict who are going to experience mental symptoms or the ease of their recovery.

## Connection between emotions and memory

The word emotion comes from the Latin word mövere that means, "to move". The word emotion has also been translated into "energy in motion". Both terms are similar and describe the most important thing about emotions as: letting your emotions flow though you allowing them to move out, so that they don't get stuck.

When an event happens that is perceived as traumatic, those emotions get stuck and increase the intensity of that memory on a deep cellular level. These stuck emotions are later reactivated by flashbacks, intense body reactions etc. There is a difference between a non-traumatic memory and a traumatic memory. The traumatic memory is usually very vivid and associated with intense emotions and somatic responses. Traumatic memories are often accurate and immutable over time and it is believed that they are fixed in the unconscious mind. Non-traumatic memories on the other hand can change; they are not as vivid or connected with intense emotions and body language.

The persistence of a traumatic memory is still puzzling. We know that the amygdala is activated by a perceived threat and one possible explanation may be that the prefrontal cortex is inhibited from sending an inhibitory signal to the amygdala. This inhibitory signal is known to release GABA in the amygdala. When GABA is not released into the amygdala then the traumatizing moment stay stuck and unable to move though and out. The event is then synoptically encoded as a traumatization because there is no perceived escape.

Treating the traumatized memory requires discovering the origin of the encoded emotional core of the traumatization. In the book "The Past Is Always Present" Ronald A. Ruden suggests that, "Since the emotionally distress from recall of a traumatically encoded moment is experienced as if it were occurring for the first time, this suggest that if a neurobiological equivalent of safety can be generated after emotional activation, the pathway can be disrupted." This is aligned with RIM and is one explanation why RIM is very effective with traumatic memories. In RIM, our most important step is to create safety in whatever way is needed for the client and from a place of safety the client creates a new, emotionally safe memory.

One of the discussions about the diagnosis of PTSD is about the fact, that not all combat soldiers develop PTSD even though they are all in very intense situations.

There are probably several reasons for this. One factor is how whole they are on a psychological level before leaving for combat. Another is the important role their buddies play by offering a safe place to talk though their actions and events. Also, the debriefing after each combat experience, and the availability of the army chaplain, who allows expression of emotions, is important factors.

Colonel Hackworth in his book *About Face: The Odyssey of an American Warrior* describes, "I perceive every soldier as an empty bottle. You never know when it gets full and once it spill over this soldier will never be able to go in combat again." What is likely to happen is that with each event a little more emotion get stuck, and at any given moment this bottle may reach it's limit and the collected emotions results in psychological distress. The soldiers receive what I call a 'out-side in' approach. Here the talking is relieving the soldier, but it does not remove every stuck emotion.

Using talk therapy, debriefing etc. can be useful but might not get to the stuck emotions and unravel these. One PTSD client of mine stated it this way "After 3 years of psychology treatment, I felt like there was established a highway connection between my body and my brain, but still I did not have access to all the side roads. I knew it was time for me to shift from a 'out-side' in approach to a 'in-side' out approach". Another client started having physical reactions with her whole body shaking, as we went into an episode that she had talked about again and again with a psychologist, but not until the RIM session did she get access to the stuck emotions, and was able to create a new emotionally safe memory.

We need more research on the effect of traumas and how to heal. But it seems to me that a 'out-side in' approach is not enough to fully heal on a cellular level and does not unravel the emotions. Like in the case with the Soldiers, where the 'out-side in' approach support them deal with the ongoing traumatic events to a certain level, and at one point the "bottle spill over."

## Research on early intervention after a traumatic event

I have not been able to find clear research results around intervention directly after a traumatic event. The common trend in what I have found is that talk therapy does not have a clear effect, but EMDR and EFT has shown some effect. The effect varies in each research, and it is commonly agreed that more research is needed.

The Danish Center for Psychiatric Traumatology states in their latest newsletter that "Even recent studies have signs that traumatic experiences should be expressed and not suppressed and that targeted treatment decreases the risk of later development of serious mental illness, there is no systematic tests of early traumas."

Today most of the people offered psychological treatment are those directly involved in an attack or accident. Many are never offered help directly after the

traumatic event occurs; rather, when they experience severe symptoms, they seek help. By this time they may not relate their symptoms to the original traumatic event.

Since there is no clear research about cause, I decided to take a different approach and dig into the research done on people who are diagnosed with PTSD and other physical illnesses. On this topic several studies have been done. Below is some extracts from research findings I uncovered.

A study done by Judith Herman and Bessel van der Kolk shows that 81% of people suffering from Borderline Personality Disorder (BPD) had reported severe history of child abuse and/or neglect. Also research has found that PTSD and BPD commonly co-occur as stated in the findings published in the *American journal of Psychiatry* "Axis I Comorbidity of Borderline Personality Disorder." "*Our second major finding is that PTSD was found to be a common disorder among borderline patients. Overall, 56% of the borderline patients met DSM-III-R criteria for this disorder, with 61% of the female and 35% of the male borderline patients meeting criteria for PTSD."* This indicates that people with BPD have a history of abuse and neglect, which also would be true for people with PTSD.

An article by Samantha Pratt published by *NYU Applied Psychology OPUS* (Online Publication of Undergraduate Studies) entitled, "The impact of Childhood Adversity on Later Anxiety" also state a connection between childhood experience and later development of mental illness:

> "*In addition, abuse, loss, and academic achievement were all predictive of anxiety. Physical abuse, sexual abuse, and emotional abuse were aspects of abuse associated with increased odds of anxiety (Benjet et al., 2010; McLaughlin et al., 2009). Academic achievement difficulties were also linked to higher anxiety, especially in adolescence and those in early adulthood (Grover et al., 2005; McLaughlin et al., 2010). Similarly, loss of relationships was highly predictive of issues with anxiety across various stages of life. Death of a family member or friend, parent separation, sibling separation, and hospitalization of family members are all components of the loss construct (McLaughlin et al. 2010; Grover et al., 2005).*
>
> *As the research has shown, childhood adversity increases issues with stress and anxiety later in life. The rise in levels of adversity also increases stress sensitivity and likelihood of developing an anxiety disorder. Current research uses both longitudinal studies and retrospective self-reports to establish correlations, but the cause and effect of early life adversity on anxiety and stress is not clearly established because of the issues with comorbidity with other psychological disorders due to childhood stressors. The limitations of previous studies demonstrate a need to understand why childhood adversities and anxiety are related. Future studies should clearly establish directionality. They should also control for comorbid psychological disorders."*

The above article reports findings that our early experiences increase our risk of developing stress and anxiety later in life. The example below demonstrates the outcome when there is no intervention to children after an attack:

70 years ago, the French School in Copenhagen was accidentally bombed by the British, and many children were traumatized. During that time doctors told the parents, "Do not talk about the event, then it will be forgotten more easily." The result has been that most of the survivors developed mental illness or other symptoms in their life. Those children with parents who "broke the rule" and talked with them, felt more at ease and had fewer symptoms. There is no actual study showing the direct effect of the absence of treatment for these children, but when the students meet 50 years later it became clear many where suffering from different levels of anxiety, high stress, sleeping problems, and other symptoms. At this gathering many had their first chance to talk about their experience and process memories of the event.

The next example is a long-term study done on the effect of being bullied in childhood. This study was done at King's College in London UK. The result was published in the *American Journal of psychiatry* in 2014 in an article entitled "Adult Health Outcomes of Childhood Bullying Victimization: Evidence From a Five-Decade Longitudinal British Birth Cohort." The result are described:

> *"Being bullied (occasionally or frequently) was associated with higher levels of psychological distress at age 23 and also at age 50, almost 40 years after exposure. Being frequently bullied was associated with an increased risk of both depression and anxiety disorders at age 45. Children who were occasionally bullied were at increased risk of depression. The increased risks of adult mental health problems among bullied children were similar in magnitude to those risks faced by participants who had been placed in public or substitute care in childhood or who reported multiple childhood adversities."*

Once more it is proven that there is a correlation between early life experiences and later mental issues. When one is being bullied it is often perceived as if there is not escape. You are forced to go back to your school or wherever you are being bullied. Rarely does one get bullied from a total stranger.

## Case studies

I have included 3 RIM case studies. Case # 1 and # 2 are clients, who in the 2 weeks before the first session were indirectly involved in a traumatic event. Both are very involved with the attacked community. It is found in several research studies, that people who hear and see pictures of the traumatic event are more likely to get anxiety, depression and even PTSD. The closer you are to the involved community and/or involved persons the higher the risk.

In case #1 and Case #2 there are fewer personal identifiers to protect the privacy of the clients due at their request.

## Client #1

Data Client # 1

Client was interviewed before the first RIM session and one week after it doing a follow-up telephone interview. The client was asked to rate the level of severity of each symptom from 1 to10 with 10 being most severe. For example a "1" rating means the client feels good.

| Symptoms: | Before RIM Level of Severity with "10" being highest | 1 week after RIM Level of Severity with "10" being highest. |
|---|---|---|
| Anxiety | 7 | 2-3 |
| Focus | 7 | 2 |
| Memory | 6 | 2 |
| Energy | 6 | 2 |
| Ability to plan activities | 5 | 2 |
| Appetite – sugar craving | 5 | 1 |
| Tiredness | 7 | 3 |
| Stomach ache | 7 | 2 |
| Inner worrying | 5 | 3 |

In general the client states that she is now able to focus at work, feeling much better and has energy to be with her daughter.

## Client #2

Data client #2

Client was interview before the first RIM session and one week after the second RIM session in a follow-up telephone interview. This client did not resonate well with measuring using the number scale as the client used above. Rather she described her feelings as inserted below.

| Symptoms | Before RIM 1 | Follow up one week after RIM 2 |
|---|---|---|
| Energy level | Low | Almost normal |
| Mood | Get easily irritated and angry | Almost normal |
| Liability | Tendency to cry often | Gone |
| Heaviness in chest | Feeling a heavy block | Gone/comes back a little once in a while but not severe. |
| Sensitive | Can't listen to music and all noise a problem | Can listen to music. Still a little reaction to other noise |

| | | |
|---|---|---|
| Concentration | Can't concentrate and feel she can't remember things | Only a little impact on memory still – almost normal |
| Sleep disorder | Can't sleep | Sleeps well |
| Students upcoming exam | Can't focus and feel bad about it | Feel she have gained the strength to do it and can focus on it |
| Driving | Can't drive | Feel safe driving |

In general the client states that she is now able to focus at work and is feeling freer and not as nervous as in the beginning. There are still a few symptoms not back to normal, but otherwise she is feeling much better.

### Client # 3

This client is diagnosed with PTSD. One very measurable symptom that the client uses for tracking her own recovery level is her strong reactions to things. These reactions can be uncontrolled anger, anxiety, and dizziness all the way to a full blackout (rare).

I worked with this client one time last spring, introducing her to RIM by giving her a free session. In February she came back and bought 5 sessions up front. Up until now she has worked with different healthcare professionals each providing her with the next level of healing.

Below are my client's own measurements of her reactions from two weeks before our first session in February. In the two first sessions we worked intensively with the triggering traumatic event. In the third session the client started to dig into her childhood and intergenerational layers. In the last 2 sessions the client worked with issues from childhood and up.

The triggering event for this client was the traumatic experience where she had to protect her own children with the youngest being less than a year old. This event had to be processed in order to access the underlying issues. And as shown in the research, this client had traumatic events in her childhood that might have caused the last event to develop into PTSD.

Data client # 3

This client is experiencing what she calls "reactions" She has been making a diary, logging the level of her feelings. The reason she stared RIM sessions was because these reactions had become more severe lately, probably with the death of her dad just prior to Xmas. To give a brief overview of the findings I have logged her numbers as a summary of daily reactions. The scale goes from 1 = just a little reaction till 10 = total black out. I have used the logs that the client was already making and that she allowed me to see. These logs also contain her description of what happens, these descriptions the client asked to be for my eyes only, but have been beneficial for me to get an awareness about what the client is experiencing.

My client logged her reactions in 5 possible scores:
1-3 meaning all reactions that is a number 1, 2 or 3.
4-7 meaning all reactions that is a number 2, 5, 6 or 7.
Reactions that are measured is a number 8, 9 or 10 is logged separately.
For easy comparing the logs, I have divided the amount of reactions with the number of days recorded. Equal the number of days between our sessions.

| Level of daily reactions | Before RIM 1 | Before RIM 2 | Before RIM 3 | Before RIM 4 | Before RIM 5 |
|---|---|---|---|---|---|
| 1-3 | 14+ * | 1.5+ * | 0.66 | 0.71 | 0.83 |
| 4-7 | 8.50 | 1.46 | 0.31 | 0.14 | 0.38 |
| 8 | 1.82 | 0.92 | 0.45 | 0.14 | 0.11 |
| 9 | 1+ * | 0.54 | 0.45 | 0.29 | 0.16 |
| 10 | 0.05 | 0.00 | 0.04 | 0.00 | 0.11 |
| Total sum of daily reaction | 25.37 | 4.42 | 1.91 | 1.28 | 1.59 ** |

* The "+" indicates that the client had so many reactions doing one day that she lost track of the number.
** The level of daily reactions went up in the period between the 4th and 5th RIM session. This was due to a couple of very stressful days for the clients and most of the reactions where in this period of time.

Progress for the client from RIM 1 though RIM 4:

- After the 2nd RIM session my client no longer experienced days with ongoing reactions.
- The severity of the reactions has gone down.
- After the 1st RIM session my client experienced 2 days with no reactions at all over a 14 days period of time. After the 4th RIM session my client experienced 8 days over an 18 days period of time with no reactions.
- Today my client primarily experience reactions on days that is stressful in some way and she is especially having reactions at times with deadline and exams.
- Another big benefit my client has noticed, is the way that she copes, when she has a reaction. She is now able to breath though it and be present in the situation. As well as she bounces back more quickly. This has had a positive impact not only on my client but also in regard to her family.

## Summary

It seems likely that the risk of traumatization increases with what we have experienced earlier in life. Several studies, as well as in other literature, shows earlier traumatic experience in one way or another impacts the client. From the outside these experiences might not seem extreme, but what counts is how the child/adult is experiencing the event. This also explains why some people experience a seemingly small event and develop PTSD or other mental illness while others don't.

My experience working with clients both directly after a traumatic event and after developing a psychiatric disorder shows the same trend.

In case # 1 the effect of the traumatic event was directly related to the things that happened in the situation even though she was only indirectly involved. She experienced severe cognitive symptoms, however she recovered profoundly after one RIM session. At the follow-up she stated, "I am now aware that if anything comes up it is important to deal with it and I will reach out for support." This client became emotionally clear.

In case # 2 the client again was only indirectly involved. In this case, a traumatic event was the trigger uncovering hidden emotions of earlier events. After the first session she was definitely feeling better and able to function. After the second she was able to relax more, feel mostly at peace and enjoy her recent holiday trip.

In case # 3 the client was diagnosed with PTSD. After the first 2 sessions we started to go back into her childhood experience and at the third session she worked at the intergenerational level. After the fourth session there was clear recovery signs despite having a deadline coming up, and feeling some anxiety about it.

## Conclusion

It is my belief that early intervention with RIM does have an ongoing effect in preventing chronic psychiatric diseases to develop.

Research until now shows that people who develop PTSD and other psychiatric diseases often have a history of traumatic events that range from neglect to rape and other forms of violence.

This pattern shows in these cases as well, where the degree of severity was related to the amount of trauma. For example, in case #1, the client released most of her stuck emotions quickly as they had developed over the past few months. Client #2 had a bit longer intervention needed to work though issues from her past and in Client # 3 more sessions were needed to work though issues from her childhood.

Both client # 1 and #2 might have recovered fully by themselves over time, however intervention with RIM clearly speeded the healing. In both cases they would probably have stuck emotions if no intervention had been done, leaving them vulnerable to more severe problems if they faced future stressful situations or traumatic events.

To answer my overall question: Are there long-lasting benefits to treating people with RIM early after having been exposed to a traumatic event? As shown in both the mentioned research as well as in the case studies it seems very likely that it is possible to treat people preventative after a traumatic event. Working though

the stuck emotions, creating safety for the client and a possibility to react, release the stuck pathway and let the emotions flow freely again.

I will definitely recommend early intervention whenever possible to prevent any long term stuck emotions

## List of literature


Books:

- *When The Past is Always Present - emotional traumatization, causes, and cures.* By Ronald A. Ruben
- *Scared Sick – The role of childhood trauma in adult disease.* By Robin Karr-Morse
- *The Body Keeps the Score – Brain, mind, and body in the healing of trauma.* By Bessel Van der Kolk, M.D.
- *Post- Traumatic Stress Disorder Malady or Myth*
- *About Face: The Odyssey of an American Warrior* By Colonel Hackworth

Research and articles:

- Psychology of Terrorism, Condensed Edition – Coping with Continuing Threat. Edited by Chris E. Stout.
- Trends of Probable Post-Traumatic Stress Disorder in New York City after September 11 Terrorist Attacks
- Psychological outcomes following the Victorian Black Saturday bushfires.
- Challenges and Successes in Dissemination of Evidence-Based Treatments for Posttraumatic Stress: Lessons Learned From Prolonged Exposure Therapy for PTSD.
- A Review of Psychological Debriefing After Extreme Stress
- Adult Health Outcomes of childhood Bullying Victimization: Evidence From a Five-Decade Longitudinal British Birth Cohort.
- The impact of Childhood Adversity on Later Anxiety