

From: [Paul Rieker](#)
To: [Booton, John CTR WSO-RWTF](#)
Subject: Conversation July 15 2013: Paul Rieker
Date: Monday, July 15, 2013 2:35:17 PM
Attachments: [DCoE_passed_scientific_review.doc](#)

John,

Thank you so much for our phone conversation.

I will send you a set of emails, each of a different facet of our conversation.

This email contains a set of letters.

The origin point is a communication with Colonel Anthony Cox of U.S. Army Medcom.

A request of a Video of Therapy and Commentary was made, which I responded.

The video was therapy of a 42 year old woman, who was molested by her older cousin, from the age of 4 to 13. 9 years this girl was molested. She related she was suicidal, and sought other therapy, which was unsuccessful in resolving her fears.

The therapy applied was deep relaxation therapy, where it could be viewed that she was placing emotional re-assignments to past events.

This therapy occurs when the individual is deeply relaxed, in rapid eye movement, where the emotional assignments can be made without the individual speaking. Due to not relying on human language, the underlying emotional fixation can be addressed.

The commentary of the video showed the emotional fixation being addressed at a high rate of speed, perhaps 4 to 6 minutes per fixation; thereby suggesting that 10 emotional fixations can be addressed in an hour.

Please review attached letters.

Paul Rieker
951-970-5641



From: Cox, Anthony L LTC MIL USA MEDCOM HQ
Date: Sun, May 22, 2011 at 8:48 PM
Subject: RE: letter from General Thomas
To: Paul Rieker <blessyourthoughts@gmail.com>

Paul,

From the review of your DVD, I think you have an interesting technique that merits more research.

As we've discussed over the past 6 months or so, the important next-step is for you to better research and document your findings.

The referral to MRMC is to put you in touch with experts who can review your proposal to see if it is viable for Army funding/assistance.

That area is outside my area of responsibility/expertise, and therefore I cannot comment on whether there is interest or money available.

VR,

LTC Anthony Cox
Deputy Chief, Behavioral Health Division
US Army Medical Command



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY

OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

April 1, 2011

Executive Office

Mr. Paul Rieker
42145 Lyndie Lane, Suite 124
Temecula, California 92591

Dear Mr Rieker:

Thank you for the opportunity to review your DVD regarding "Abreaction, Desensitization, and Emotional Reframing" as well as your concern regarding our Soldiers. I welcome and appreciate your efforts to enhance the care provided to our Soldiers.

The Army and the Office of The Surgeon General (OTSG) are always interested in innovative, evidence-based programs and methods that aim to enhance the behavioral health functioning of our Soldiers. Furthermore, the Army has invested a substantial amount of money and resources in the development and implementation of these programs and has a significant interest in identifying ways to support optimal Soldier functioning.

Information on conducting business with the Army Medical Department can be accessed at the following link: <http://www.armymedicine.army.mil/about/business.html>. Additionally, unsolicited behavioral health products/proposals requesting review should be directed to the US Army Medical Research Acquisition Activity (USAMRAA) of the Medical Research and Materiel Command (MRMC) at <http://www.usamraa.army.mil> and/or the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury's Ideas/Concepts Submission Form at http://www.dcoe.health.mil/idea_concept_form.aspx.

Again, thank you for your interest in the welfare of our Soldiers. Should you have additional questions or concerns, please feel free to contact LTC(P) Anthony Cox at (201) 221-6499 or email: tony.cox@us.army.mil.

Sincerely,

A handwritten signature in black ink that reads "Rw Thomas MD".

Richard W. Thomas
Brigadier General, US Army
Assistant Surgeon General
for Force Projection



TRICARE
MANAGEMENT
ACTIVITY

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS**

7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VA 22042-5101

JUN 19 2012

Mr. Paul Rieker
Bless Your Thoughts
42145 Lyndie Lane, Suite 124
Temecula, CA 92591

Dear Mr. Rieker:

Thank you for taking the time to submit your idea on Abreaction Desensitization and Emotional Reframing to the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). Your efforts to help our Service members are commendable.

Your submission was reviewed by our Scientific Review Officer, and based on the review of your submitted material, DCoE will keep your information in our database and contact you if a Department of Defense stakeholder may be interested in your idea. Since DCoE does not have a federal contracting officer on staff, we cannot offer technical guidance or advice. Technical guidance or advice can only be gained via the official federal contract submission process.

If you are seeking funding for your idea through the contracting process, we recommend reviewing current grant funding mechanisms available to researchers. Generally, grants relating to posttraumatic stress disorder and traumatic brain injury are released through Broad Agency Announcements and New Products and Ideas (http://www.usamraa.army.mil/pages/baa_forms/index.cfm), the Congressionally Directed Medical Research Program (<https://cdmrp.org>), and the www.grants.gov website.

Thank you for your interest to support our Service members, veterans and their families.

Sincerely,

A handwritten signature in blue ink, appearing to read "Col Christopher S. Robinson".

Col Christopher S. Robinson, USAF, PhD, MPH
Deputy Director for Psychological Health
Defense Centers of Excellence
for Psychological Health and Traumatic Brain Injury



Mon, Jan 9, 2012 at 12:50 PM, Friedman, Matthew J.

Dear Mr Rieker,

I have reviewed the CD, descriptive notes, statistical analysis and letters you have sent me regarding your Abreaction, Desensitization and Emotional Therapy treatment for PTSD. It is clear that you have devoted a great deal of thought and energy to developing this unique approach.

Although you impress me as a gifted therapist, it is unclear how much this approach is an idiosyncratic vehicle through which you achieve rapport with your patients, and how much it is a valid therapeutic approach in its own right. That is why a randomized clinical trial with a standardized treatment manual utilized by therapists other than yourself, as well as an appropriate comparison group, is essential.

As I told you during our first conversation, I am often approached by individuals who have developed a treatment which, in their hands, reportedly produces excellent results with PTSD patients. You'd be surprised how many such treatments have been proposed to me, let alone to others. In each case, I have to tell them what I've stated to you in the preceding paragraph. There is absolutely no substitute for rigorous randomized clinical trials.

I hope that you can find a collaborator to help you carry out such a trial. If so, please let me know the results when the research is completed.

Thank you for sending me the CD and related materials. I will ship them back to you since I know that you don't have any extras.

Best wishes,
Matt Friedman

Dr. Friedman is Executive Director of the U. S. Department of Veterans Affairs National Center for PTSD and Professor of Psychiatry and of Pharmacology at Dartmouth Medical School.

He has worked with PTSD patients as a clinician and researcher for over thirty years and has published extensively on stress and PTSD, biological psychiatry, psychopharmacology, and clinical outcome studies on depression, anxiety, schizophrenia, and chemical dependency. He has written or co-edited nearly 200 books, chapters and peer reviewed articles.

DVD Review (UNCLASSIFIED)

Weichl, William LTC MIL USA OCCH

Tue, Mar 22, 2011 at 11:53 AM

To: Paul Rieker <blessyourthoughts@gmail.com>

Classification: UNCLASSIFIED

Caveats: NONE

Paul -

Reviewed the DVD over the weekend. Awesome. I am already a proponent of the benefits of hypnotherapy and use of relaxation as a way to address deep-seated negative emotions. In my opinion, **a strength to this model is that there is no verbal communication necessary for client healing!** The traditional model is based on a more Freudian approach – reflective responses to client verbalization, etc. Is this **"non-verbal"** approach new?

The benefit of safety and 'heal thyself' is very powerful and may help to address the issue of stigma, embarrassment, fear, etc. YOU helping yourself - very powerful. In essence the client compels him/herself to feel safe since none of the dark 'secrets' are public, rather the individual deals with these within him/herself.

Some observations I made while reviewing the material:

- I understand the 1st and 2d sessions defined/shaped the setting of the safe child concept.
- Lots of rapid-eye movement reminded me of EMDR concepts.
- **Lots of non-verbal cues - breathing, swallowing (your previously sent info on esophagus and muscle constriction as pre/post markers was very helpful while observation.**
- Noticed participant's mouth pulling down - left/right at various times. Did not catch if this was related somehow to hand movement.
- Relaxation = slow respirations.
- Anticipation of a better tomorrow/of forgiving the past.
- Anger + Guilt = Depression. Nice defining of Anger as uncontrollable and depression as hopeless/sadness.

Some questions for my own edification:

- Do you use a standard patten/cues or do you constantly adjust based on individual responses?
- How do you know when to say, "There is something else that needs to be said, isn't there"? Is this also based on client cues - also experience, I am sure.

Seems like most human beings may experience some form of ego failure and this affects the ability to re-enter past emotional memories, hence continued unhealthy living. Your model may indeed provide a brief, effective way to help many folk experience a new birth.

By the way, I am **hand-carrying the DVD/Poster to CAPT Hammer tomorrow**, and am mailing the DVD etc. to the Family Life Chaplain Directors (3) the disc as well. Looking for some interesting feedback since not sure of their understanding of hypnotherapy.

God's Grace to you.

CH (LTC) Scott Weichl



TO WHOM IT MAY CONCERN

I've read the Manuscript written by Paul Rieker, regarding his Mother's Suicide and his personal experience of Hypnotherapy as it addresses Depression.

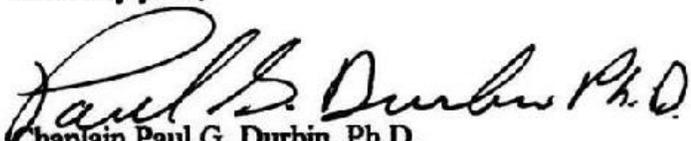
After being Professionally Edited and Presented for a more physician friendly approach, I believe this story could be a positive move forward for the following reasons:

- 1) Assist medical doctors to understand Hypnotherapy and it's applications
- 2) Medical Doctors to refer patients for therapeutic resolutions of what where considered medical problems as a compliment to their patient care.
- 3) Assist people with Depression to recognize this can be addressed
- 4) Help Dentists recognize that teeth grinding and TJM may have some emotional roots and that stress or an emotional experience from the past can ~~be~~ addressed by a clinical hypnotherapist as part of his/her patient care.
- 5) Help society to view Hair Pulling and other 'behaviors' as being resolved in hours rather than being a personality defect
- 6) Ultimately Paul Rieker's book helps people to understand the most important aspect: Letting go of bad feelings allows others to love themselves and to love the people around them.

I am currently Director of Clinical Hypnotherapy, Methodist Health System Foundation, affiliated with Methodist Hospital in New Orleans, LA.; Diplomat of International Medical and Dental Hypnotherapy Association (IMDHA), a member of the American Council of Hypnotist Examiners (ACHE), other hypnotherapy organizations and was inducted into the International Hypnosis Hall of Fame in 1992.

I am a retired Military Chaplain; who last served as Army National Guard Special Assistant to the Chief of Chaplain, Army with rank of Brigadier General. My website: www.durbinhypnosis.com has over 100 articles on hypnosis and related subjects written by myself and others.

Sincerely your,


Chaplain Paul G. Durbin, Ph.D.
7135 Parkside Court
New Orleans, LA 70127

Note: Paul Rieker may be contacted in Temecula, CA 951-970-5641

From: [Paul Rieker](#)
To: [Booton, John CTR WSO-RWTF](#)
Subject: Conversation July 15 2013: Paul Rieker
Date: Monday, July 15, 2013 2:46:46 PM
Attachments: [Complicated Grief.doc](#)

John,

Attached is a MS Word Document titled: Complicated Grief

Although titled "grief" the document speaks to a "Learning Process" with mechanisms which create "Emotional Fixations".

This document was written by myself and Dr. Roger Russell, former Chair of the Psychology Department of La Verne University, La Verne California.

The document titled "Grief" is actually a discussion of how the emotional fixation is created, the underlying cause of Post Traumatic Stress Disorder.

The document is an easy read.

The mechanisms are what I refer to as "Learning". As without the event the emotional assignments would not have been created, nor would the ruminating, that is the comparison process of sorting similar emotions of Anger and Fear would have been 'uninspired'. This describes how an anchor to an initial event is established, and how "Associations" of similar emotions are accumulated to an event, prior in the person's experience.

John, I learned these perspectives as an outcome of my experience after mother's suicide, October 8, 1976.

For the years after her suicide, I have attempted to understand the mechanisms of emotional assignment.

I have used a "clean piece of paper", non reliant on any existing theory of psychology, to create this document.

Although "Grief", replace the term grief with PTSD, and you may have a different perspective.

As we are dealing with "non-tangibles", we use discussion of "what's similar", and we use those terms to describe the theory, the effect and the cause of the disability.

I have done my best to describe the "un-tangible". My best isn't good enough. We need a study.

Paul Rieker
951-970-5641

Brief Grief:

Components and the means to reduce grief to the shortest period of time.

I. The trials of life:

There is no escaping pain in life, what Shakespeare's Hamlet refers to as "the slings and arrows of outrageous fortune."

No matter what, we all can and will at various times experience misfortune, or loss and an attendant pain. As the poet, Henry Wadsworth Longfellow put it over 150 years ago, when he pointed out that into each life some rain must fall:

The Rainy Day Henry Wadsworth Longfellow

Written at the old home in Portland

THE day is cold, and dark, and dreary;
It rains, and the wind is never weary;
The vine still clings to the mouldering wall,
But at every gust the dead leaves fall,
And the day is dark and dreary.

My life is cold, and dark, and dreary;
It rains, and the wind is never weary;
My thoughts still cling to the mouldering past,
But the hopes of youth fall thick in the blast,
And the days are dark and dreary.

Be still, sad heart, and cease repining;
Behind the clouds is the sun still shining;
Thy fate is the common fate of all,
Into each life some rain must fall,
Some days must be dark and dreary.

II. Description of Grief:

Grief is the normal human response to loss, something that everyone feels to some degree or another, depending upon the magnitude of the loss for the individual and the emotional coping repertoire of the individual for dealing with loss.

Such normal, uncomplicated bereavement may recur subsequent to a loss, but it does not obstruct the individual's capacity to move on in his, or her own life.

Why? Because, as Longfellow put it: *Be still, sad heart, and cease repining;*
Behind the clouds is the sun still shining.

There are, however instances where people are unable to see the sun shining behind the clouds, where grief becomes obstructive and dysfunctional, and this is the area of concern to be addressed here. The resolution to this continuance is also presented here.

III. TIME is important

When it comes to dealing with grief, time is an important factor, one that affects the person who is grieving and those around him, or her.

Time enters the picture two ways, in terms of duration of grief, and in terms of length of treatment. And it is valuable to remember the significance of time, for all of us, all of the time. And to keep that in mind when addressing grief and attempting to remedy issues that arise when grief goes awry.

When, grief becomes problematic for a person, time is one of the most important issues for him, or her, because grief can become interminable. Suffering under the burden of unresolved grief can result in prolonged misery and negative consequences for the person's functioning in every-day life.

The effects of interminable grief can extend to those around the grieving person. We know those family members and friends who care for that person in grief become concerned and take their positive actions. But, after a month or 90 days, or some limited time, offering to take that person to lunch, or when the offers to take that person to an activity is refused due to their grief, the good hearted person gives up. The friend or family member determines "I can't change his or her grief." When that abandonment occurs, the friendship slips away, the family events come and go without invitations. This doesn't take long, perhaps in less than a hockey season.

If friends, family members and business or career associations find they can't help, they disassociate. The loss of friends, family and career interactions can be profound. With this, life expectancy, retirement funds and planning, career can be nearly destroyed. But, we cannot predict to whom this may occur. And, we cannot predict the depth to which grief can become debilitating to each individual.

When such dysfunctional grief occurs, time becomes important in terms of finding relief and resolution. The longer treatment takes, the longer the person "clings to the mouldering past" (as Longfellow put it), and the longer he or she resides beneath a rain cloud, the more entrenched and difficult to treat the grief becomes, and any treatment that does not, at least initially, seek speedy relief, can fail.

This is not an usual or new idea. In fact, there already exist treatments designed to produce speedy relief. Unfortunately, they are all psychopharmacological. Medications can indeed change a persons mood, but unfortunately they do not resolve the basic psychological issues underlying and sustaining the grief. Any mood altering medication can be palliative and can be as interminable as the grief itself.

But there is another way, one that does not involve medication, one that does lead to brief grief, and on that will be discussed fully here.

In acknowledging the affects of dysfunctional grief on career, retirement, friends and family, and the need for speedy assistance, we can agree Brief Grief is a significant and important goal to be acted upon, for a longer and more joyful life.

IV. Description of Complicated/dysfunctional Grief:

There are times when grief does not function well, times when it becomes a problem for the individual, rather than a means for emotionally coming to terms with loss.

Two factors leading to complicated/dysfunctional grief: There are two general ways in which grief can be problematic; Duration (which we've mentioned above) and Intensity.

The worst situation is where the intensity is so high that it interrupts psychological functioning, and/or it lasts so long that it leads to behavioral and emotional failures (such as, loss of employment and interpersonal relationships).

Components of *Complicated/dysfunctional Grief* are:

A response to an Initial *Sensitizing Event* (it may be the loss that leads to all grief, such as *the* death event, or it may be a prior death event, or it may be some other event not involving death but one that creates a basis for the dysfunctional response to a death, a basis for a dysfunctional grief)

The continuance of Ruminating Conversations (internal mental dialogues), without end, thereby obstructing other, more productive and positive experience and action.

Dysfunctional emotionality:

Anger and Fear (especially fear arising from *not feeling safe*) that are not working for the person

Emotions of Anguish, Despair, Anger and Fear placed in **human learning**, *without human language* while transitioning into sleep.

Universality of components:

Regardless of personal background and different circumstances, clinical experience indicates the above description is present in different measures for each person who experiences complicated/dysfunctional grief.

In other words, we know that people differ but within a common framework. Take our physical bodies. Unless something removes them (such as an automobile accident), we all have two arms and two legs, but the length of our arms and legs may vary.

Utility of this approach:

This description of Complicated/dysfunctional Grief is offered, because it is the foundation for the possibility of change, in the shortest time, perhaps as little as 30 days.

As we shall see, when each of these components is addressed, and feeling safe is restored, grief can become brief.

There are those who categorize grief as a “process without specific interdictions.” In which case, each instance of complicated/dysfunctional grief has to be dealt with individually.

The approach taken here acknowledges the variations in individual psychological make-up and history, but maintains that in general if all the factors discussed above are addressed in general terms, grief can be brief and beneficial.

This presentation is to achieve these outcomes, so joy can again live.

V. How complicated/dysfunctional grief arises

When we think of grief, and when we include time factors, we see that a full understanding of when and why grief may become complicated and dysfunctional must be understood in terms of the past, the present, and the future.

Out of the Past: The process of growth and development

We human beings live and develop through processes, as all living things. All living things have growth and development.

Please consider the process of an acorn growing to a mature oak tree. Germination, the growth of a sapling. Receiving sufficient light, water and nutrients. Culminating in a large

oak tree creating a new acorn. This process *can be* interrupted. It can be enhanced. It can be brought to completion faster with positive intervention only if...

We understand germination, photosynthesis, geotropism, and the other aspects of tree growth and mature reproduction of trees, we have the ability to affect the outcome.

The same is true in terms of human growth and development.

When grief is complicated and/or dysfunctional, it is a result of a process of development that can lead to fixation(s) that prolong grief and preclude people from moving onward in their lives, from finding the sun behind the clouds, from embracing the future and the opportunity to experience joy and fulfillment.

There are several components to the formation of complicated and dysfunctional grief. These arise in the process of growth and development. They include the Initial Sensitizing Event, the Anchor, Fixations, Repressed Memories, a Sorting Process, and the Transition into Sleep, all are discussed below.

Understanding what these components are and how they arise creates the foundation for Brief Grief, a process whereby complicated/dysfunctional grief can be treated and resolved.

Initial Sensitizing Event

The process that eventually leads to a grief experience, that is dysfunctional, begins with an initial sensitizing event, which can have occurred prior to the death that is leading to grief, or in some cases can be the death event itself.

The initial sensitizing event is NOT in itself a bad feeling or debilitating when it occurs. Rather, this event appears to be a primer for future **learning associations**. This is an event, which can cause us to bring future emotions to anchor on that initial learning. This seems to be the human learning process. Not only to make association with intellectual growth, but to make associations with emotional disappointments.

The human learning process is not without, emotion.

This initial sensitizing event is the psychological basis for the eventual difficulty dealing with grief.

The Anchor

The Initial Sensitizing Event has the capacity to become an anchor to which other experiences, thoughts and feelings can be attached. It serves as the central, focal point for the perpetuation of moods and beliefs, some of which can be dysfunctional, and some of which can lead to prolonged and complicated grief.

Understanding the development of fixations

If we understand the emotional fixations of anger and fear, grief can be made brief. These factors can establish our understanding to make grief brief.

1. If we understand the process of initial sensitizing events and how they create **a learning of Anger/Fear**.
2. If we recognize and agree that emotional **responses are learned**.
3. If we understand that in **learning an emotion and review of that emotion causes our increased ability and skill to practice and participate in it**.
4. If we understand that over time all this psychological material can become unconscious and repressed.

These components of grief can be changed.

But, without this recognition, it's possible the focus of attention may not be re-directed to joy.

Working definition of Fixation: A strong attachment to a person, thing, or psychological event, especially such an attachment formed in childhood and manifested in immature thoughts and feelings and behaviors that persists throughout life.

- Arrested development: an abnormal state in which development has stopped prematurely
- Obsession: an unhealthy and compulsive preoccupation with something or someone. Possible sensitizing event/psychological trauma

Repressed Memory

Over time, the Initial Sensitizing Event, the Anchor, and Fixations can come to reside in the unconscious. That is, they arise over time and out of the past, initially with full awareness, but eventually becoming unknown to the person, such that they influence both the present and the future, as that person deals with grief.

The repressed memory is *not* created in that moment. In other words, it is not the case that the moment an ISE occurs, or knowledge of a death occurs, is the moment it becomes repressed.

Further, a repressed memory many times *may not be* a terrible event, but rather a small event, perhaps in itself an event of seemingly no consequence.

The repressed memory is a 1st learning, established by learning to associate the emotions of Anger and or Fear to that event.

In fact, it is most likely that a repressed memory is more the LEARNING to associate anger and fear over time, rather than the single event in itself. (Yes, of course it's possible to have the huge event which is repressed, but for the most part the process of review with anger and fear causes the ISE not only to be debilitating, but also precludes other processes from accessing the issue on a cognitive basis—that is, prevents conscious resolution.)

The repressed memory is an accumulation of anger or fear or both, until such that the wrappers of anger and fear are so available, the emotions which are accumulated makes one blind from intellectually knowing the causation event of the emotional learning. This is what I refer to as wrapping an event or thought or belief with the “wrappers of anger or fear”.

The Sorting Process

This learning is the beginning of the SORTING PROCESS the human mind uses for our incremental education. Behaviorist refer to this as associational learning, whereby the individual recognizes and organizes current events in relation to past learning, thereby facilitating the learning—it's easier to learn something that can be seen as relating to something already learned, than to learn something that is so new it cannot be related to prior learning. So the mind sorts learning and incorporates new material within that process of sorting.

There is both a benefit and a detriment to this sorting process. The sorting and comparison process makes future recall extremely fast. But, this speed of recall, through this sorting process comes with a price. That price is the emotional hurt, accumulating over time, with the cause hidden from the conscious mind.

Grief, which is not in that single event itself (the death of a person), can become a real debilitation over time through the process of the continual opening and reviewing the event *and other conversations like it*. “Like it” is the sorting process, the comparison which compounds anger and fear.

Transition into Sleep

Another factor that can lead to a dysfunctional grief is the nightly transition into sleep, a time when that which has been sorted and that which has components of anger and fear can become even more embedded in the unconscious. When this transition occurs over and over, with anger and fear associated with the loss, the grief, it moves toward dysfunctional bereavement.

The state of sleep, known as Hypnagogic within the 1st 30 minutes is when we embed emotionalized life experience of the prior hour or two into our subconscious. Concert violinists and other professional musicians utilize this, practicing immediately before sleep. Practicing the emotions of grief embed when sleep is entered. This is a significant action which creates the displayed behavior with the emotions of fear, despair, anguish, helplessness and anger, creating fixations which preclude the ability to focus on other life events, all interpreted as grief.

We typically do not recognize these mechanisms. They cause grief to become dysfunctional. The **transitioning into sleep, learning despair and anguish**, anger and most of all fear is the **primary learning** contributing to malfunctioning grief. Too often, people expect the use of language alone to break these wrappers of anger and fear.

Therefore, since they are implanted without language, use of language alone will not lead to resolution and freeing from fixations. Since there is a strong emotional component (i.e., anger and fear), it is necessary to move in the direction of healing the emotions, rather than masking or ignoring the emotion.

Interestingly, it is this transition into sleep that points toward the resolution of complicated grief that will be discussed here, for the hypnagogic state that leads to the creation of dysfunctional grief can also be utilized to reverse this process.

The emotions of Anger and Fear are implanted without language; therefore, the use of language alone will not lead to resolution and freeing from fixations. Since there is a strong emotional component (i.e., anger and fear), it is necessary to move in that direction, and as will be discussed later, abreaction and the emotional reframe, is the releasing modality to enable this shift.

This “prior learning” is described in the Centers for Disease Control’s ACE Study. This study is of Adverse Childhood Experience. <http://www.cdc.gov/ace/index.htm>. These are the experiences, which are embedded into learning with anger and fear.

VI. The Present: The day-to-day experience of grief

It is normal and appropriate for people to experience grief when loss is large. In the case of uncomplicated grief, this daily experience leads gradually but reasonably quickly to the point where the grieving person can find joy, optimism and expectations of future rewards.

But when the stage has been set for dysfunctional grief, this daily experience does not result in eventual resolution. Instead, it is at risk of becoming interminable and debilitating, preventing the person from reaching joy, optimism and expectations of future rewards.

VII. The Future: Grief over time

Time, as noted above, is important, and when the present remains unchanged and stretches far into the future, grief can become a dysfunctional process.

As noted above, part of this dysfunctionality has to do with past learning, but it is also created by future expectations.

If one expects grief to be a process without intervention:

It is often the case that current conceptions of the process of grief can lead to the expectation that there is no need for any intervention.

And this may well be true for uncomplicated grief.

BUT it is NOT true for those caught in a dysfunctional grief, especially those who (for reasons discussed above) cannot and do not recognize their situation. For them, this expectation is highly damaging, because they keep waiting for their grief to reduce, and *it doesn't*.

Consider today an individual who has broken their arm. Which is your expectation?

- A) Do you expect an intervention which identifies where and how severe the break, the setting of the bones, and the repair of the associated tissue. The immobilization of the arm until it heals. Or,
- B) An arm debilitated, which no longer functions as it normally did prior to the break?

With modern knowledge of medicine and healing which do you expect?

The worst possible consequence of the expectation that there is no need for intervention is the further expectation that grief is indeed endless and that a person simply needs to learn to live with it.

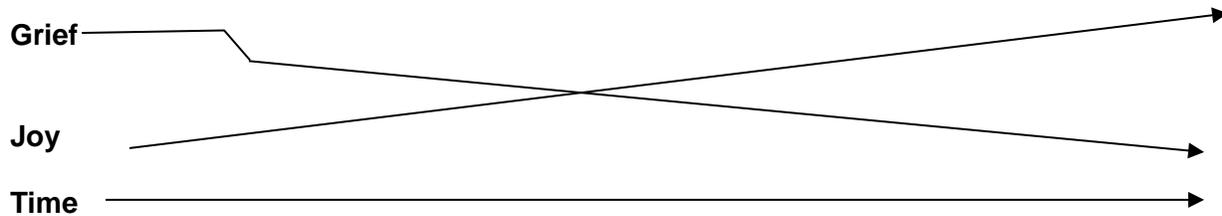
For this reason:

- It is important for all people who are grieving to be aware of possible dysfunction. Possible complications may prolong their grief indefinitely, perhaps resulting in all manner of life difficulties in addition to the lost of joy.
- It is important for all to know that intervention is possible and indeed highly beneficial
- It is important to have options available to the grieving person, so she, or he can do more than passively experience pain and despair.

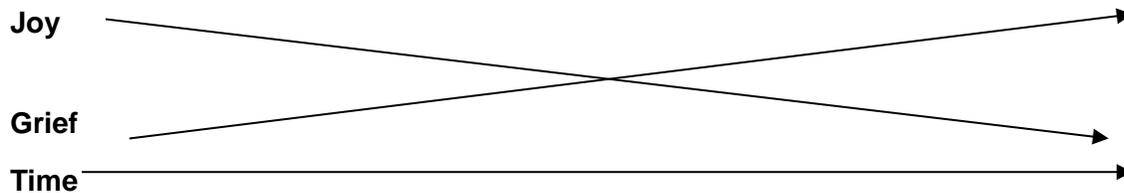
It is unfortunate that those people who have become so deeply despairing have the expectation that despair will continue. There are those who may actually become angry with anyone who offers the possibility of joy and forgiveness, due to the significant and often severe conflict of the continued rumination of anger, fear and despair—they are rooted in the *status quo*.

VIII. Brief Grief: Treating complicated/dysfunctional grief

Perhaps, the most important consideration is once again that of time. In uncomplicated grief, there may be a gradual movement toward resolution that may take several weeks and months and even extend into years, but with a gradual return to joy, optimism and expectations of future rewards starting within a very short time, somewhat like this



This is all well and good for the person whose psychological resources enable grief to be uncomplicated. But what about the person who isn't able to experience grief this way, the person whose has the difficulties discussed above that result in grief wrapped in anger and fear? For them, the picture is more like this:



Given the hazards the person in the midst of complicated grief faces, it is important to encourage early intervention, to assist all (even those whose grief is uncomplicated) in knowing that Brief Grief is available.

This may seem like a radical proposal, but there is value in all who enter into grieving to seek some form of assessment and assistance, in the possible event that they might be vulnerable to a prolonged and problematic grief.

Current conceptions of the grief process:

Perhaps the most prevalent view of grief is to see it as a process involving stages. Here are two that have been suggested:

The stages Elizabeth Kubler-Ross identified are:

- Denial (this isn't *happening* to me!)
- Anger (why is this happening to *me*?)
- Bargaining (I promise I'll be a better person *if...*)
- Depression (I don't *care* anymore)
- Acceptance (*I'm ready* for whatever comes)

The stages Dr. Roberta Temes identified are:

- Numbness (mechanical functioning and social insulation)
- Disorganization (intensely painful feelings of loss)
- Reorganization (re-entry into a more 'normal' social life.)

Both of these formulations may offer understanding of how people move through an uncomplicated bereavement.

However, there is a DANGER lurking within them, one that has already been mentioned. This is the implication that these stages tell us there is no need for action, no call for intervention, when grief occurs. But, as noted above, this can lead to a highly detrimental expectation for those who actually are experiencing a dysfunctional grief.

For those in a dysfunctional grief, the continuing accumulation of anger and fear may NOT be stopped, if the person simply waits for the next stage to appear...and it doesn't appear. Instead, the next "stage" allows **the transition into sleep, with despair and other sad emotion cause the learning and rehearsal of those emotions** placed on new thoughts, rather than permanent interruption. The permanent interruption is in breaking the anchors created due to the initial sensitizing event(s).

Therefore, while the notion of stages of grief may have utility and we may not discard it entirely, we need to recognize the potential for this approach to actually do more harm than good—not always, perhaps, but often enough that they should not be automatically applied in ALL instances.

It is the wrappers of anger and fear, which precludes us from knowing the sun is behind the clouds. Similar to the hiding of the initial sensitizing event, when the wrappers of anger and fear are opened the sun can again be *expected* to shine.

While there are those who address the grief process, there is limited discussion of how and when it fails, and the process becomes stuck. Some see it as shifting into depression, and while that may be the case, it doesn't necessary address the fundamental grief issues, and can lead to a longer than necessary treatment approach. In contrast, the approach taken here does two things:

- (a) Focuses on the core problems (fixated anger and fear), and
- (b) By doing so makes it possible to address and resolve dysfunctional grief much faster than typical depression treatments.

Unfortunately, many people have the mistaken concept: "If I didn't have grief, I would not have all these bad feelings." This is simply not correct. It is being captured in multiple emotional thoughts, which cause the displayed behavior interpreted as grief.

Different Approach: A path to resolving grief in the shortest possible time

Since the stage approach has shortcomings, another approach is desirable, one that calls for an assessment of the grief a person is experiencing, and based on that assessment, a process of intervention for those in dysfunctional grief.

The healing of grief comes through:

Abreaction	Emotional release
Desensitization	No longer a point of emotional focus
Emotional Reframing SM	To believe the best, over the worst; emotionally

This is because Grief is based upon:

- Multiple:** More than one
- Compounded:** Interleafed and cannot stand alone
- Emotional:** Not logic, not repaired with a spreadsheet or education
- Fixations:** Totally fixed, unmovable

The above is established and re-enforced through:

- Negotiation: Bringing the points to focus

Agreement: Agreement to focus *or* not to focus on these aspects
Expectation: The future will hold the aspects of the agreement

Essentially, grief is the negotiation to feel fear and/or anger associated with an event. It is the agreement to accept that negotiation and it leads to the EXPECTATION the next time that thought/memory/experience is reviewed, the agreed emotion will live. The NAE is the powerful mechanism, which drives the placebo outcome.

The imbedding in the subconscious, transitioning into sleep with despair (and emotions described with other words), creates the repressed memory. This is the basis of severe and complicated grief. Remarkably enough, also the cause of short and limited grief. The shift out of this condition is the focus of this document. This document is *not* to teach how a psychological condition is created. This document is to focus on the positive shift, the techniques and the possibilities of joy.

The ultra brief shift available is through this process. Abreaction, Desensitization, Emotional ReframingSM.

In the emotional reframe, the safe feeling can be created so the balance of the emotional fixations can be resolved so joy can again become a choice over the ruminating stories of anger and fear.

The emotional reframe is the outcome, significant for these reasons:

Brief application –this can be applied with positive results with as short as 4 hours.
Not a non-specific loose formulation applied to everyone, but rather specific to the individual's impasse - The anchors of rumination becomes exhausted so future emotional cross linking cannot occur.

A word about abreaction

The Administration and Management of 10 “Emotional Shifts”, also known as abreactions, in deep relaxation in a single session, *is within* ‘the state of the art’ in advanced counseling techniques. Reframing the emotional fixations in a profound and healing method, breaking grief and the behavior associated is available. This approach is the most significant shift in breaking grief in a short time.

But; Abreaction is often misunderstood. When we see someone in the midst of an abreaction, our first impulse may be to do something to help them stop; it often appears so powerful that we erroneously assume it is bad for the person. So we want to put our arms around that person, perhaps to comfort them, and stop what we see as an event from a memory, which appears to hurt.

The idea that an abreaction is actually an 'abnormal reaction' is incorrect. Probably people have thought of it this way because:

1. Observation rather than personal experience: As noted above, those who observe and abreaction without having ever experienced one, may incorrectly conclude that it is harmful and bad. But those who have actually experienced an abreaction, in the appropriate circumstances, know of its benefits.
2. Incomplete knowledge and education: The assumption that "abreaction" is a contraction of "abnormal reaction" can arise from such incomplete knowledge. But, in fact, the true, dictionary definition of abreaction is: releasing (repressed emotions) by acting out, as in

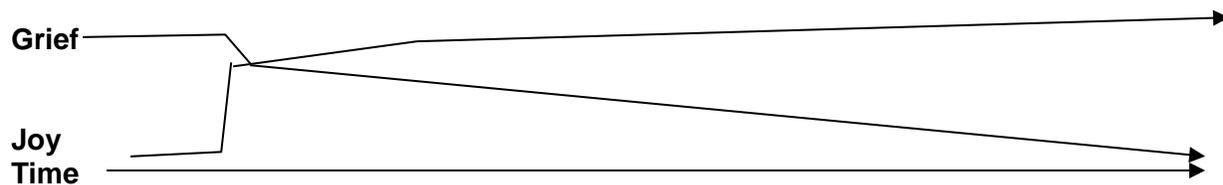
words, behavior, or the imagination, the situation causing the conflict (for a healthy resolution).

3. The abreaction is a component of the human experience. This is around the **learning, and then unlearning of anger and fear**. The ruminating conversations increase the emotions which hide the intellectual occurrence of the ISE, Every human has this in their life experience, but unfortunately it has been thought that this is 'special' only in unique therapies.

Abreactive response can also occur outside of this specific process, but not typically. Although other therapies allow abreactive emotional shifts, this may be the only approach where the emotional release is actually managed and administrated. With adequate knowledge of what the term means, this is one subject where, classes, lectures and reading assignments actually fall short of full learning. This is one learning experience, which can only be understood through personal experience. Practice enhances skill in administration of this process.

The participant in the abreaction does not feel the hurt. The feeling is more like the passing through that thought, even if an observer sees tears and perceived pain. At the end, there often is a feeling of relief. This relief is as if a large burden has just been put down, and a reservoir of emotion, which the person has avoided or been unaware of, has been drained. The openness to new joyful thoughts can occur.

Abreaction and the emotional reframe process release the grieving person from the wrappers of anger and fear, and allows the re-focusing on present life events, and living in the now.



The above chart shows the short time which Emotional ReframingSM can break the wrappers of the continuance of anger and fear. The possibility of 30 emotional reframes can occur in 3-5 sessions inside of a month, or less, depending on the commitment of the facilitator and the person who desires the shift to be attained. The specific 'details' and time is in the hands of the individual.

Dealing with Anger and Fear

As humans, we are limited in the volume of anger and fear we can contain. We are limited to the maximum amount of anger and fear we can endure. Breakdowns occur when we approach the limit. When the emotional release occurs, joy can become available. Afterward, actions can be seen in behavior shifts. These actions can be interpreted as forgiveness and offerings of love. Love and care for others can be realized through this process.

Without Human Language:

The **learning of grief is without human language**; the healing of grief must become the 'reverse' of this process. Reversing of the grief lesson may have to be accomplished **without intellectual learning**. With emotional shifts, the healing of grief comes with the emotional release and breaking the wrappers of anger and fear.

To make comparison, stopping a woman from giving birth due to her screams of agony, would stop her from the joy on the other side of the labor. Would you preclude the joy of childbirth?

What occurs on the other side of the "labor" of the abreaction is for joy to accumulate new thoughts and actions, no longer in the anger and fear of the past.

Delivery device

Insulin is delivered past the skin with a syringe. A woven mesh is installed over a hernia with a scalpel, moving tissue aside. Without scalpels and syringes getting past the natural barriers for medical intervention could be impossible. Passing through human defense of the intellectual mind and language requires trance. This is utilized as a delivery device. Time efficient and comfortable resolutions to fixated emotional conflicts can be achieved. Hypnotherapy and hypno-analysis enables both an exploration and assessment of the potential unconscious aspects of grieving and a technique for assistance in the event these unconscious aspects are leading to dysfunctional grief.

What exactly is involved when hypnosis is the principle tool to resolve issues? To understand this it is important to know just what hypnosis is NOT as well as what it is.

- *First, hypnosis does not involve control.* Contrary to what appears to be the case when a stage hypnotist performs, there is NO control of one person over another in hypnosis.
- *Second, hypnosis involves choice in the context of refined attention.* There are two elements to hypnosis, trance and suggestion. The first, trance, is a mental state in which all peripheral distractions are eliminated in order for the person to achieve and address ONE thought at a time. Relaxation and focused attention permit this to happen. There is not "sleep," any more than there is "control." Suggestion is just that. It does not involve commanding, or demanding, both of which would be controlling. In fact, it must never involve such control, since such psychological intrusions on the person have been instrumental in creating the dysfunctional grief in the first place.
- *Third, hypnotherapy is not radically different from any kind of psychological therapy.* All therapies seek to establish a safe environment. All therapies seek to relieve emotion via its expression. All therapies work toward reframing. And all therapies involve suggestions on the part of the therapist. Hypnotherapy simply offers is an opportunity to do all these things in a concentrated and swift manner.

Creating the 'safe feeling' in an emotional reframe over what was perceived and remembered as an angry or fearful experience can occur with this 'vehicle'. This is time efficient, low cost and unless the individual re-traumatizes himself or herself, potentially a permanent resolution. This is within current state of the art psychological counseling and behavioral change. It is our great opportunity to share the facts of this 'delivery device'.

Showing love, care, and feeling safe, are the opposite display of Anger and Fear. Living with the focus on 'now', working, learning and doing are the opposites of Anger and Fear.

To understand these concepts, one cannot solely, read a textbook, or take class. Although class work is important and many aspects are learned through learning and sharing thoughts, it is the participation in one's own shift, in this process for that person who is in pursuit of learning to apply this ultra brief therapy application to others in their care.

IX In Conclusion:

Grief: Components Contributing to Briefness and Healing-
Paul Rieker and Roger Russell, PhD © 2007, 2008, 2009, 2010, 2011, 2012, 2013

Changing the individual's impasse and encouraging the shift to occur in the shortest period of time, to again live in joy and optimism is available through these processes.

For further information, contact Paul Rieker
Temecula, CA
951-970-5641

PTSDHypnotherapy@gmail.com

Note:

Dr. Roger A. Russell is a clinical psychologist and the former Chair of the Psychology Department of La Verne University, La Verne California.

Paul Rieker is a Practicing Hypnotherapist, beginning 1985. This process was introduced by Mr. Dan Roden, practicing since 1964.

From: [Paul Rieker](#)
To: [Booton, John CTR WSO-RWTF](#)
Subject: Conversation July 15 2013: Paul Rieker
Date: Monday, July 15, 2013 2:52:28 PM
Attachments: [COSC ADER 50% stats.pdf](#)

Attached: 19 clients

John, This is not a medical study, but requests a study.

This document points to:

50% reduction of PTSD symptoms in 30 days with 5 to 20 hours therapy.

The Lt. Colonel Moore interview speaks to a higher performance. Moore requests a medical study. Link to his interview in separate email.

Dr. Richard Nahin is interested in a team to manage a study of :

Abreaction, Desensitization and Emotional Reframing.

As I am only a therapist and not a researcher, we need a study manager, and administration.

Dr. Nahin suggested I work with Samueli, but I was informed their do not have available resources.

Please review attachment.

Paul Rieker
951-970-5641

Statistical Analysis

Requested by Behavioral Health Program Manager, US Army.

[ADER: Abreaction, Desensitization and Emotional Reframing SM](#)
PTSD Checklist (PCL) Weathers et al., 1993

	Before	After	Time (Hours)	Calendar Days
Client 1	69	40	2	1
Client 2	63	42	12	16
Client 3	65	40	9	30
Client 4	65	40	0	1
Client 5	61	26	1	1
Client 6	65	34	4	14
Client 7	73	40	6	
Client 8	67	30	2	
Client 9	37	11	3	1
Client 10	63	33	4	10
Client 11	50	29	4	10
Client 12	45	29	6	
Client 13	65	30	2	1
Client 14	68	28	5	24
Client 15	70	31	6	16
Client 16	70	28	6	27
Client 17	70	26	4	16
Client 18	76	31	3	1
Client 19	75	35	4	14
Totals	1217	603	83	183
Average	64	32	5	10
	16.72	Two tailed T-test		

Greatest Impact: 2 hour sessions and multiple sessions per week appear to be most beneficial and time efficient. Values "post hoc" unless noted
Case Study report is available for each client.
<http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp>

TIME IS IMPORTANT

Trance State Therapy: In deepest relaxation, addressing Initial Sensitizing Events, building ego to compel forgiveness and resolution.

Management and Administration of the Abreaction:

Critical Care Intervention: Based on a document written by Paul Rieker with Roger A. Russell PhD

<http://www.BlessYourThoughts.com/ComplicatedGrief.doc>

- Objective: Compel the individual to "feel safe" in past events
- Behavior failures are believed to be based on Multiple Compounded Emotional Fixations through associational learning/sorting of emotions as response to sensitizing events, rather than "Systemic Breakdown", genetic failure or personality disorder.
- Trance Definition: elimination of peripheral distractions to achieve a single thought at a time.
- Trance state is achieved through management of respiration with other techniques.
- Sessions: accelerated and compacted
- Session includes sleep-time Emotional ReframingSM, applied in parallel.
- Therapy may be required due to, and after, years of emotional sorting/associational learning.
- Session best not limited to a simple schedule of 1 session per 1 hour per one week. Session may take as long as necessary to address the fixations, which become available during session.
- "Relapse" is misinterpreted. The reminder of an event a fixation, *which has not yet been addressed*, can trigger behavior failure.
- Potentially a permanent healing, unless of course, the individual could possibly become re-traumatized.
- Creates new and more brilliant emotional assignment to past hurt.

Bring the Study: We wish to further demonstrate research data for ADER (Abreaction, Desensitization and Emotional ReframingSM) to Post Traumatic Stress Disorder (PTSD) clients. Access to potential participants for the study, as well as a site for providing treatment and recording pre and post treatment outcomes. Please contact us using the information provided below.

Abreaction Desensitization and Emotional ReframingSM

SAFE CHILD: Leading the individual to Feel Safe in the memories contributing behavior of Post Traumatic Stress, Suicide, Complicated Grief and Depression.

5 Hour therapy program: Breaking as many as 40 emotional fixations, the possible change of behavior in the shortest period of time.

Treatment Research Opportunity

Paul Rieker Clinical Hypnotherapist (Practice beginning 1985)
Southern California 951-970-5641

www.BlessYourThoughts.com
BlessYourThoughts@gmail.com

Copyright 2011 Paul Rieker

From: [Paul Rieker](#)
To: [Booton, John CTR WSO-RWTF](#)
Subject: Fwd: Study Manager : Abreaction, Desensitization and Emotional Reframing
Date: Wednesday, July 17, 2013 10:36:21 AM

John,

Please feel free to distribute this email within your Task Force, noting the distribution list. This email relates the offices I have been communicating.

As a Therapist, bringing a medical study is difficult or impossible. The attached is an email to the VA, IOS and NIH NCCAM.

Lt. Col Moore, <https://vimeo.com/67768311> at marker 7:15

A session on Hypnotherapy,
Oh, what a difference it made
I quit having nightmares.
I can watch the news now
It really changed my life.
Other, some issues I had from my childhood,
that had been bothering me all my life,
that I didn't really realize, it helped out on those too.

marker 9:20

I've talked to a lot of different guys
that have the same problem,
they've not been able to cure it like I have.
In fact, I've suggested to some of them, that they might try hypnotherapy,
and see if they can get out of it. Because it's a horrible thing
I think, it would be, there should be studies to judge the effectiveness,
I know it helped for me.

The submitted "Time" document, the data suggests 50% symptom reduction in 30 days. Please understand, I specifically did not claim "cure", as any claim would be of such contradiction to current data, that I would not have an 'acceptable presentation', and I would be dismissed out of hand.

Lt. Colonel Moore said the word "cure". Perhaps for some folks a 50% reduction of symptoms, and some individuals, more. Or, for others their choice to not enter this style of therapy.

I am only communicating to this task force, the difficulty I have experienced, only to bring a scientific evaluation of Abreaction, Desensitization and Emotional Reframing.

What can your organization suggest?

Regards,

Paul Rieker

----- Forwarded message -----

From: Paul Rieker <ptsdhypnotherapy@gmail.com>

Date: Wed, Jul 3, 2013 at 11:04 AM

Subject: Study Manager : Abreaction, Desensitization and Emotional Reframing

To: "Nahin, Richard (NIH/NCCAM) [E]" <nahinr@od31em1.od.nih.gov>, "Erdtmann, Rick" <RErdtmann@nas.edu>, "Matthew Friedman MD, PhD" <Matthew.Friedman@va.gov>

Doctors Nahin, Erdtmann and Friedman,

I have not been able to identify and attract a study manager for Abreaction, Desensitization and Emotional Reframing, to bring a medical study.

Even after some 7 years of communication to Universities in California and other States, there seems to be an impasse, which is not truthfully shared, from perspective of the persons who I have spoken with, for the purpose of a medical study.

As we are together somewhat experts, leaders or responsible parties to an outcome of resolving PTSD, and the perspective of opening the emotional fixation and changing the emotional assignment has yet to be scientifically evaluated...

I am introducing us together, to bring an outcome of a medical study for Abreaction, Desensitization and Emotional Reframing.

How we interact for this outcome, from this introduction is somewhat out of my hands, as I am only a therapist.

Bringing back to focus: <https://vimeo.com/67768311> Lt. Colonel Moore's Comments.

What do we need to bring as an action item from this point?

Best Regards,

Paul Rieker
951-970-5641

From: [Paul Rieker](#)
To: [USARMY NCR MEDCOM USAMRMC DCOE Mailbox DCoE Concept Submissions](#)
Cc: [Booton, John CTR WSO-RWTF](#)
Subject: Re: Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Concept Submission: Treatment Submission
Date: Wednesday, July 17, 2013 10:52:57 AM

Citing how this current submission differs:

In the video interview of Lt. Colonel Moore:

Lt. Col Moore, <https://vimeo.com/67768311> at marker 7:15

A session on Hypnotherapy,
Oh, what a difference it made
I quit having nightmares.
I can watch the news now
It really changed my life.
Other, some issues I had from my childhood,
that had been bothering me all my life,
that I didn't really realize, it helped out on those too.

marker 9:20

I've talked to a lot of different guys
that have the same problem,
they've not been able to cure it like I have.
In fact, I've suggested to some of them, that they might try hypnotherapy,
and see if they can get out of it. Because it's a horrible thing
I think, it would be, there should be studies to judge the effectiveness,
I know it helped for me.

The submitted "Time" document, the data suggests 50% symptom reduction in 30 days. Please understand, I specifically did not claim "cure", as any claim would be of such contradiction to current data, as to be difficult to resolve against current "standard of care".

To clarify why the re-submission was made, is based on Lt. Colonel Moore's statement regarding a "Cure".

I don't know the authority of your office or of the action capacity of your charter. I assume the claims of 50% reduction of symptoms in 30 days and of Moore's "Cure" should escalate to medical study.

Paul Rieker

On Tue, Jul 2, 2013 at 11:05 AM, USARMY NCR MEDCOM USAMRMC DCOE Mailbox DCoE Concept Submissions <usarmy.ncr.medcom-usamrmc-dcoe.mbx.dcoe-concept-submissions@mail.mil> wrote:

Mr. Rieker:

Thank you for your submission to the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Concept Submission Program. The program processed a similar submission with the same title in May 2012. Could you please outline if and how this current submission differs or provides updates to the May 2012 submission?

Thank you for your interest in supporting our Service members, veterans and their families.

Sincerely,
Concept Submission Program
Defense Centers of Excellence
for Psychological Health and Traumatic Brain Injury
<http://www.dcoe.health.mil>

-----Original Message-----

Subject: Treatments, interventions Concept Submission via DCoE website

Treatment/Intervention Name:
Abreaction, Desensitization and Emotional Reframing

Funded by the VA or the DoD?:
Other

Description of Other Funding:
Paul Rieker: Self funded

Referred by: DCoE

By whom: Christopher Robinson

Organization Name:
Paul Rieker

Lead Individual Name:
Paul Rieker

Phone:
951-970-5641

Email Address:
PTSDHypnotherapy@gmail.com

Website:
<https://vimeo.com/67768311>

Address:
42145 Lyndie Lane
Suite 124,
Temecula, CA 92591

Topics Area:
Suicide Prevention, PTSD, Depression, Domestic Violence,

Population who would benefit from program, service:
Active Duty, Veterans, Families, Primary Care Providers,

Goal of program or activity:

Addresses the Emotional Basis of the Initial cause, the root of the emotional assignments.

The basis of this therapy is to compel the individual to feel safe.

Feeling safe in the past event, compels the individual to stop the emotional assignments of anger and fear.

Treatment/Intervention Components:

Intervention is 5 to 20 hours, depending on the individual's experience of emotional assignments.

This 5-20 hours can be accomplished in 30 days.

During the 30 day period 50% of the diagnosis/disability of PTSD can be eliminated.

Demographics:

The individuals who have experienced trauma.

This definition of trauma is of those individuals who have made sufficient emotional assignments of anger and fear of past events.

The behavior breakdowns diagnosed as PTSD, Dissociative Disorder, Hyper-vigilance, and other DSM identified behavior diagnosis, with components of anger and fear respond well.

Current populations you have already served with your program/tool:

To answer this question:

I am the sole practitioner of this process.

Mother's suicide of 1976 compelled me to seek alternative assistance, as I was suicidal in 1984.

Dan Roden, resolved my suicidal depression in 2 weeks.

Contraindications for Treatment/Interventions:

This intervention compels emotional assignments:

Feeling Safe

Love, Joy, Happiness, Optimism

Forgiveness and moving forward

Therefore, all humanity, regardless of level of function, can benefit.

There are no populations which are not recommended.

Future activities/plans:

I intend a medical study.

As I am a therapist and not a researcher, I need a research team.

Additional descriptive information:

ADER facilitates and addresses as many as 10 emotional fixations per hour, at a rate of 4-6 minutes each.

This is the ONLY process where the concept that time efficiency, and productivity is recognized to be important.

Randomized Controlled Studies:

None at this time.

Accreditations (e.g. Joint Commission):

This note:

Dr. Richard Nahin of NIH NCCAM is considering funding research of ADER.

A team is necessary for this study, as I am a therapist and without "recognized research credential".

Approvals for Third Party Reimbursement (i.e. insurers who have approved):

NONE

Case Studies/Anecdotal Evidence:

<https://vimeo.com/67768311>

and

<http://blessyourthoughts.com/COSC%20ADER%2050%25%20stats.pdf>

From: [Paul Rieker](#)
To: [Booton, John L CTR \(US\)](#)
Subject: Trauma: Change in DNA
Date: Wednesday, November 06, 2013 12:50:49 PM

John,

I'm hearing some conversations regarding Trauma changing DNA.

I'm bringing this to your attention as this is a claim of a Genetic Modification due to an external stimulus, which was experienced with an emotional assignment:
must be examined and extinguished.

An external stimulus, without emotional assignment, may be seen as only an event. But, an event with the emotional assignment of anger and/or fear, becomes potentially a traumatizing event.

All Genetic Modifications require a change of the Double-Helix; specifically this change must remove, or insert or otherwise re-sequence ACGT, in such a process that the helix is broken and then repaired in the area of the break. If the break is not repaired, further replication of that strand is impossible.

A genetic modification if in the egg or testes, can produce a change in the offspring, and create a modification which could possibly be seen as a response to environment, which potentially coincides with evolutionary change, supports evolutionary change, or affects the zygote in a manner which may indicate the change during the growth to maturity. This is a mutation of what the genetic material "would have originally produced".

Over many incidents, centuries, ions, of change in DNA, this "CLAIMED" process of trauma to effect the reproduction of cells should have already been identified as a mutation. And this "recent" identification of damage to DNA is insufficiently grounded.

Mutation can be indicated in many ways, additional toes, reduced growth, perhaps behavior change.

It is unlikely that a fearful event could change only the DNA of behavior, but not DNA associated with eye color or other physically identified attribute, to be viewed as mutation.

I am of the belief that TRAUMA results in behavior change based on "Associational Learning" aspects, where once an original event has an assignment of anger and/or fear, that emotional assignment is then compared, through conversation and experiences, where the "language" of what occurred is precluded, as "fear" has no language.

I feel strongly, those people who are pointing to TRAUMA making an effect on DNA are presenting bad science.

This therefore is an example of making a "stab" at a theory, where the specific Nucleic Acid Sequence of the four bases (adenine, cytosine, guanine, thymine) could NEVER be identified pre/post trauma, so therefore no solid evidence could be obtained to prove or disprove this claimed theory.

I feel so strongly in this, that your organization should bring this discussion to medical experts, to confront this, so that the now MINIMAL RESEARCH DOLLARS for PTSD not be directed to this - implausible- assertion of DNA Modification through fear.

Confronting this:

"Yelling the word BOO, cannot re-sequence adenine, cytosine, guanine, thymine".

I know basic research comes from people citing "I don't know" but being experts in their field, and as this, they look for other "experts" who may support research funds. So, therefore if multiple DNA Researchers are looking for funds to support their career, they may make an application to NIH for funds to review "I don't know, maybe trauma changes DNA". NIH is good at funding theories of : "I don't know, but I'm an expert."

Radioactivity changes DNA, age is seen as failure to accurately reproduce previous sequence, can change DNA.

Although I am not a Geneticist, I can not find any argument to support the use of research funds for this "bad science".

I am asking your organization to confront this:

- * Either CONFIRM at the earliest point : DNA can be change by fear
- * DNA can NOT be change by fear
- * Prohibit research money from flowing down another black hole

To be kept in the front of our objective: people are committing suicide on (an almost) hourly rate. I take this as a serious subject.

I apologize for repeating myself, I believe PTSD and Depression, is an associational learning process, where when sufficient emotional assignment is accumulated, the individual breaks under the weight of that accumulation.

Paul Rieker
951-970-5641

From: [Paul Rieker](#)
To: [Booton, John L CTR \(US\)](#)
Subject: Chaplain Weichl (retired) notes:
Date: Thursday, November 07, 2013 8:31:55 AM

John,

Please note this email to your members.

Thank you.

----- Forwarded message -----

From: Scott Weichl <wscottw1@googlemail.com>
Date: Thu, Nov 7, 2013 at 5:16 AM
Subject: Re: Passed DCoE Review
To: Paul Rieker <ptsdhypnotherapy@gmail.com>

Paul - that is what it looks like and they only admit 'new approaches' after much proof and competition.

My sons unit in El Paso was in the field last week and a Sergeant Major appears to have committed suicide. A pretty senior rank.

Is there perhaps another venue can market and utilize this approach with sine the obstacles (natural and man-made) continue to thwart our efforts with DOD?

Sent from my iPhone. Blessings, Scott

From: [Paul Rieker](#)
To: [Booton, John L CTR \(US\)](#)
Subject: Fwd: Passed DCoE Review
Date: Thursday, November 07, 2013 8:45:15 AM

Weichl's son:

----- Forwarded message -----

From: Scott Weichl <wscottw1@googlemail.com>
Date: Thu, Nov 7, 2013 at 5:38 AM
Subject: Re: Passed DCoE Review
To: Paul Rieker <ptsdhypnotherapy@gmail.com>

Yes, my son and many are affected by this tragedy. Multiply that by the myriad of other tragedies occurring in the DOD and in society and the resultant pain and suffering is incalculable.

I understand the arguments about intense competition for funding, etc. between competing good approaches yet my understanding from your exhaustive efforts have not been focused on the monetary gain for you or others, rather an intense desire to provide this healing those in need BECAUSE IT WORKS! Imagine that.

Sent from my iPhone. Blessings, Scott

On Nov 7, 2013, at 8:28, Paul Rieker <ptsdhypnotherapy@gmail.com> wrote:

I was doing session with a woman who was raped.... her friend brought her ...

Her friend, watching the tears fall, the emotions being released- so moved by the appearant healing said to me:

This is so profound, you're not moved by this?

My reply was, "it is just a thought".

Scott, you telling me this story of the Sergeant Major, brought tears to me. I am so sorry.

I don't know how I can afford to travel to meet with rwtf.defense.gov <<http://rwtf.defense.gov>> meeting in DC, per John Booton's invitation. Somehow.

I need the 2 minute speech to move them off their "assumptions".

On Thu, Nov 7, 2013 at 5:16 AM, Scott Weichl <wscottw1@googlemail.com> wrote:

Paul - that is what it looks like and they only admit 'new approaches' after much proof and

competition.

My sons unit in El Paso was in the field last week and a Sergeant Major appears to have committed suicide. A pretty senior rank.

Is there perhaps another venue can market and utilize this approach with sine the obstacles (natural and man-made) continue to thwart our efforts with DOD?

Sent from my iPhone. Blessings, Scott

On Nov 7, 2013, at 6:29, Paul Rieker <ptsdhypnotherapy@gmail.com> wrote:

From: [Paul Rieker](#)
To: [Booton, John L CTR \(US\)](#)
Subject: Insight by former DCoE Reviewer
Date: Thursday, November 07, 2013 7:48:04 AM
Attachments: [DCoE_passed_scientific_review.doc](#)

John,
Christopher Burke is a former reviewer at DCoE.

What I hear:
Burke describes the VA has no rules to bring highly effective therapy to the VA, the DCoE is not capable of research...

And the status quo of suicides and loss of humanity to the disability of PTSD will continue.

How else should this be interpreted?

----- Forwarded message -----
From: Christopher Burke <southpaw47@gmail.com>
Date: Wed, Nov 6, 2013 at 7:30 PM
Subject: Re: Passed DCoE Review
To: Paul Rieker <ptsdhypnotherapy@gmail.com>

Paul,

The question is what do you want people to do for you with regards to the treatment you developed. Understand that the competition for federal money to pay for treatment of soldiers is intense, fierce and cut-throat. DCoE is not in the business of funding research - what they do is use previously verified EBTs, make sure they are appropriate for use in military and veteran populations, and attempt to encourage their use through their outreach efforts. They will not be interested in developing a series of studies to outline the potential benefits of your treatment. They get tons of requests similar to yours every day, and it is not possible for them to advocate for them. They have a hard enough time with advocating for things like Prolonged Exposure, an EBT that has a very long history of effectiveness in clinical trials. Also, of note, endorsement of a treatment by DCoE is of limited use. Most VA's and military behavioral health programs already have set procedures and protocols, and do not take kindly to suggestions of a new form of treatment. It beats not having it, but it is no indication that your treatment will get greater acceptance with professionals who treat the military.

Good luck with all of this. It is a very difficult field, and there are a lot of people fighting very hard - (and sometimes dirty) - to get at that money earmarked to treat soldiers. I hope you are successful.

Chris Burke

On Wed, Nov 6, 2013 at 4:44 PM, Paul Rieker <ptsdhypnotherapy@gmail.com> wrote:

Chris,

As you were formerly with DCoE...

<https://vimeo.com/67768311>

Can you offer insight as to what these documents mean, in light of Lt. Colonel Moore's statements, and the review by Colonel Cox?

Kind regards,

Paul Rieker

From: [Paul Rieker](#)
To: [Booton, John L CTR \(US\)](#)
Cc: [Nagorka, Joseph CTR WHS \(US\)](#)
Subject: Re: FW: Meeting Schedule
Date: Wednesday, November 13, 2013 10:56:26 AM
Attachments: [ACE_pyramid.gif](#)
[Complicated Grief.doc](#)

John and Joseph,

Thank you for this opportunity to present, and to be considered.

Based on the interview of Lt. Colonel Moore:
<https://vimeo.com/67768311>

I would like to bring this: www.cdc.gov/ace/ <<http://www.cdc.gov/ace/>> Centers for Disease Control's ACE Study: Adverse Childhood Experience.

The study suggests the outcome of Adverse Childhood Experience reduces longevity.

Without citing which Pentagon Chaplains, there are some who believe service member's PTSD is a result of, or more accurately, PTSD is more acute in those people who have experienced childhood emotionalized events, and have continued to compare and accumulate the similar emotional assignments of anger and fear over time.

Bringing your attention to the ACE PYRAMID graphic attached:

It is my opinion, Missing Scientific Data, is the "association of emotions" which when they collect, the failures of behavior is identified, and becomes detrimental to the individual and people around them. This is the causation of the loss of longevity, due to emotional assignments to initial sensitizing events.

The Initial Sensitizing Event, is the primer for future associations of emotions, per the "Complicated Grief" by Dr. Russell and myself. This word "grief" when replaced with PTSD, hyper-vigilance, dissociation, depression, the mechanisms are universal. A universal mechanism has been missed. I hope to bring clarity through medical study.

Paul Rieker
951-970-5641

On Wed, Nov 13, 2013 at 6:30 AM, Booton, John L CTR (US) <john.l.booton.ctr@mail.mil> wrote:

Joe,

I will be forwarding you all the information I have received from Mr. Rieker, please print and save in the December 9-10th San Antonio Public Forum for the Task Force.

BR,

John

-----Original Message-----

From: Paul Rieker [<mailto:ptsdhypnotherapy@gmail.com>]

Sent: Thursday, November 07, 2013 9:54 AM

To: Booton, John L CTR (US)

Subject: Meeting Schedule

Hello John

I recall our conversation there is a meeting in December at Crystal City.

I looked at the website, and somehow I didn't see the date.

I would like to attend, if circumstances permit.

Please link me to the dates of future meetings.

thank you

Paul Rieker