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TRAUMA AND LOSS:

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Trauma Relief Unlimited: An Outcome Study of a New Treatment Method

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Abstract: *The purpose of this study was to evaluate the efficacy of a new method for treating psychological trauma called Trauma Relief Unlimited (T.R.U.). The method uses kinetic hand movements and nonverbal techniques. Forty adult participants were randomly assigned to either an experimental or control group. The control group was time lagged to receive treatment after the completion of treatment by the experimental group. Each participant received three 45 minute T.R.U. treatment sessions in a one month period. Participants were pre and post treatment tested with a four month follow-up using Briere 's Trauma Symptoms Inventory and client self report. Study results showed that T.R. U treatments significantly reduced symptoms of post traumatic stress at both post treatment and the four month follow-up period, with no adverse after- treatment effects.*

It has been estimated that seven out of 10 Americans have experienced major traumatic events in their lifetimes, with up to 20 percent developing Post Traumatic Stress Disorder as a result (PTSD Alliance, 2000). Several methodologies have emerged to meet the therapeutic need resulting from traumatic events. Therapeutic interventions for trauma historically have been derived from two major theoretical categories: exposure therapy and cognitive therapy. Exposure techniques desensitize the client to the intense emotional reactions to the relived event by bringing that event repeatedly into consciousness (Emery, 1996; McFarlane, 1988; Piers, 1996; Rachman, 1966; Van der Kolk, McFarlane, & Weisaeth 1996). "Re-exposing the trauma victim to his experience has remained a core component of trauma intervention" (Steele & Raider, 2001, p. 10).

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Trauma and Loss:

A second historical approach has been cognitive therapy. The basic premise is that thoughts impact emotional states and by changing the thoughts one can alter the disturbing emotions. Theorists in this category include Beck (1976), Marks (1972), and Saigh and Bremrier (1999) among others. Thus,

disturbing, anxiety ridden, pathological emotional states are driven by dysfunctional thoughts. Cognitive therapy suggests that by changing the thoughts, the emotional states change... Cognitive therapy is used to provide a rationale for the victims to expose themselves to the pain of their experience. It is also used to reframe their perception of that experience and as a means of stopping¹ dysfunctional thinking (Steele & j Raider, 2001, p. 11).

More recently, two other trauma relief methods have gained recognition. Drawing, or art therapy, has been used largely with children, although, more recently with adult trauma survivors. With children the rationale appears to be that they lack the intellectual ability to express themselves and particularly to express the emotions of disturbing events. Children draw their experiences and the therapist interprets them. This method seems to be a hybrid exposure and processing method. The exposure occurs through creative expression and the cognitive therapy occurs through interpretation of these drawings. Several authors have attested to the efficacy of this treatment including Byers (1996), Magwaza et al (1993), Malchiodi (1998, 2001), Pynoos and Eth (1985), and Steele and Raider (2001). Another model. Eye Movement Desensitization and Reprocessing (EMDR), has also emerged. This, too, appears to be a hybrid model composed of both exposure and cognitive processing features. As Shapiro (1997) states: With EMDR we ask the person to think of the traumatic event, and then we stimulate the person's information-processing system so that the traumatic experience can be appropriately processed, or 'digested'. As this 'digestive' process takes place, insights arise, the verbal associations are made, what-

ever is useful is learned and the appropriate emotions take over (p. 29). All of the above methods have had varying degrees of effectiveness and have undergone various amounts of scientific testing.

The Trauma Relief Unlimited (T.R.U.) method was developed from Robert M. Cicione's more than 20 years of experience as a psychotherapist and visual artist. Cicione was distressed at the amount of time needed to achieve results from the above methods and concerned with the painful negative side effects clients could experience from reliving the event. Wanting to integrate the revitalizing power of art to bolster the human spirit, Cicione began developing the T.R.U. method seven years ago. T.R.U. was derived from and shares common features with traditional art or drawing therapy, and it integrates other elements of the aforementioned methodologies. Informal data collection from Cicione's private practice produced some of the first indications of T.R.U.'s effectiveness. Clients reported that PTSD symptoms were greatly reduced or eliminated with one to six T.R.U. treatments. Over 700 clients were treated with no or very slight, short term negative after effects such as mild fatigue or confusion. The T.R.U. treatment effects appeared to be unrelated to age, gender, or ethnicity.

In order to scientifically measure the efficacy of the T.R.U. method, a T.R.U. Pilot Project was conducted (Cicione, 2000). The pilot test used a pre-post treatment design with 10 trauma surviving children between 8 and 14 years of age. These multiple-episode survivors received three, forty-five minute T.R.U. treatments and were pre and post tested using Briere's (1996) Trauma Symptoms Checklist for Children-Alternative Version (TSCC-A) and a Symptoms Tracking Form (STF) developed by Cicione. Trauma symptom scores were significantly lower ($p < .01$) at post test on three (anger, depression, and post-traumatic stress.) of the five TSCC-A scales. The decrease in the anxiety and dissociation scores was not significant. More importantly, TSCC-A scores continued to decline without further T.R.U. intervention to the point that all five TSCC-A scores were significantly lower ($p < .05$) at the four month follow-up

in comparison to the pre-test levels. The STF collected frequency of client reported symptoms on a weekly basis. The total number of symptoms on the tracking form also fell markedly, from a mean of 8.58 per week pre-treatment to 0.4 per week after three sessions.

This research brief reports the results of the next phase of T.R.U. effectiveness assessment. The goals of this research study were three fold: (1) use an experimental and control group design with a larger sample; (2) measure the efficacy of T.R.U. with adults using a standardized trauma symptom instrument; and (3) assess the replicability of the method through the use of an independent therapist. It was hypothesized that T.R.U. would significantly reduce the symptoms of trauma in those treated and that these results would remain stable over time, regardless of who administered the treatment.

METHODOLOGY

Intervention

The T.R.U. treatment protocol consists of a series of kinetic exercises designed to activate the right hemisphere of the brain. The client is guided through a series of hand movements, using a 12"x 18" drawing pad and several multi-colored markers. Unlike traditional art or drawing therapy, the client is discouraged from drawing pictures. Cicione's clinical experience indicates that adults experience performance anxiety when asked to draw. Therefore, drawing pictures is not part of the T.R.U. protocol. The process is designed as a non-verbal one. In fact, verbal expression during treatment is discouraged, since it has been found to lead to distraction from, and avoidance of, more significant ongoing, internal therapeutic processes. This non-verbal aspect of the treatment spares the client the need to verbally express disturbing emotional material sometimes leading to anxiety, emotional upset, flashbacks, vomiting or other regressive effects of other trauma treatments.

Unlike EMDR, there is no regression to "child self experiences or distinctions made between adult and child self that may lead to fur-

ther fragmentation. Also, unlike EMDR there is no left brain, internal processing like "interlooping or interweaving" (Parnell, 1997). Thus, T.R.U. is a very safe method with no reported cases of regression requiring emergency intervention, medication or hospitalization in over 2100 treatment sessions. The T.R.U. client is simply guided through a series of 12 to 15 "exercises" in a forty-five minute clinical protocol. Once complete, the symptoms are eliminated.

The utilization of T.R.U. as either a "stand alone" therapy or in conjunction with other clinical processes is determined by the nature of the situation and the discretion of the providing clinician. In multiple episode trauma situations T.R.U. is used to address traumatic material while other clinical processes may address other therapeutic issues. Since T.R.U. does not interfere with other therapeutic interventions, T.R.U. treatment may be received in conjunction with those therapies.

In single episode trauma situations the T.R.U. process may consist of an intake evaluation, one forty-five minute T.R.U. treatment and a summary evaluation, if necessary. In these situations T.R.U. may be seen as a "stand alone" treatment. This compressed T.R.U. process offers promise for treating major catastrophes requiring immediate brief intervention such as natural disasters, terrorist attacks and similar events where longer interventions may be restricted or even precluded. Ideally, the goal is brief, powerful, and effective intervention without sacrificing relatedness.

T.R.U. is a promising trauma relief intervention and not a panacea for all psychological and personal problems. Although effective in reducing common symptoms associated with post traumatic stress, T.R.U. has limitations. T.R.U. is not effective with alcohol or drug abusing clients, although it has shown promise for supporting the recovery process. T.R.U. is not usually effective with personality disorders, although in several instances trauma symptoms have been reduced while leaving the personality disorder largely unchanged. T.R.U. is usually ineffective with borderline patients, although improvement has been observed in some cases.

Although verbal expression during the

Trauma and Loss:

T.R.U. protocol is discouraged for the reasons stated above, there is verbal exchange with the clinician during the evaluation, debriefing and summary reporting parts of the process. Moreover, the clinician may use traditional talk therapy to address other issues such as life style or relationships not directly related to trauma.

Participants

Participants were recruited through newspaper advertisements and professional referrals. To be eligible, they had to have experienced at least three episodes of trauma, have symptoms of post traumatic stress but no diagnosis of a major mental disorder or substance abuse, and be at least 18 years of age. Out of 61 applicants, 40 were eligible for the study and randomly assigned to an experimental group for immediate treatment or a one month delayed treatment control group. Of these recruits, two in fact had bipolar disorder and substance abuse was suspected in two others. Due to scheduling conflicts, 25 participants entered the immediate treatment group. Of the 15 in the delayed treatment group, three dropped out before receiving treatment, leaving a final N of 37 for statistical analysis. The average age was 44, with a range of 21 to 64. Of the 37 participants, 32 were women, 34 were white and three were black. Each participant received a 45 minute individual treatment session once a week for three weeks.

Instruments

Data collection instruments included the Trauma Symptoms Inventory (TSI) developed by Briere (1996) and a Symptoms Tracking Form (STF) developed by Cicione (2000). The TSI is a standardized 100 item self report questionnaire that measures post traumatic stress and related psychological symptomatology. It yields 10 clinical scales and three validity scales. A standard Trauma score (T-score) is calculated for each scale which can be compared to the Trauma scores of the participants in the instrument's standardization sample. Trauma scores have a mean of 50 and standard deviation of 10. A score of 65 and higher is used as a clinically sig-

nificant cut-off score.

The Symptom Tracking Form is a clinician interview form developed to measure the weekly frequency of specific post traumatic stress symptoms such as violent episodes, angry outbursts, nightmares, flashbacks, anxiety symptoms, and crying episodes. Clinicians also rated the participants' level of depression on a six point scale with 0 being no depression and 5 being a high level.

Data Collection

Both the experimental and the control group completed the TSI and STF at all data collection points. The experimental group participants were pretested as they came into the study, received three 45 minute weekly treatment sessions, and then post-tested at two weeks and at four months after their last counseling session. The control group participants were pretested at entry into the study and post tested four weeks later without any intervention. They then received three 45 minute weekly treatment sessions and were post tested at two weeks and at four months after their last session.

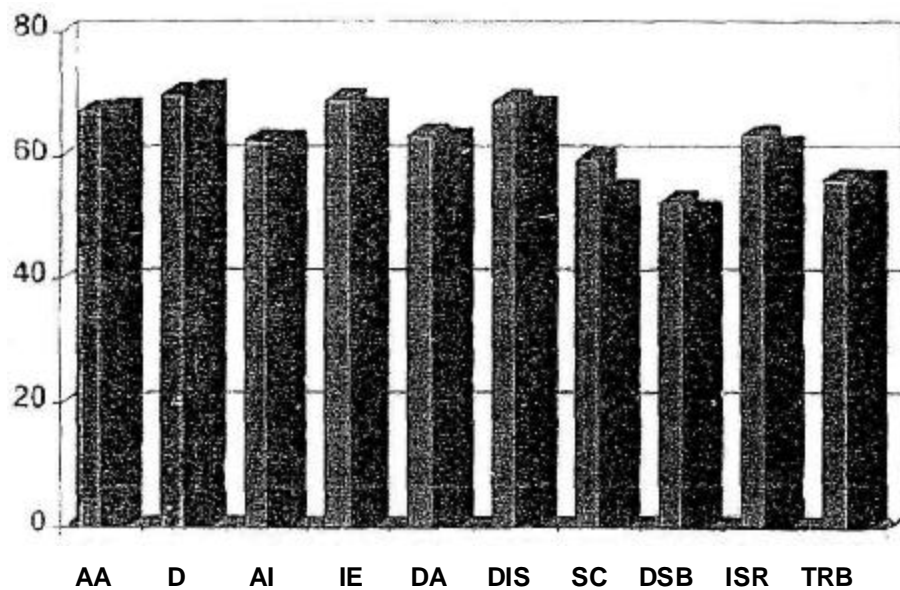
In order to assess possible experimenter bias, two clinicians conducted the interventions with the experimental group: the founder, an LICSW clinician and artist, and an LICSW clinician with 10 years of professional experience, but not in the field of trauma or art. The second clinician received eight 45 minute pre-study training sessions with the founder.

Analytic Procedures

All statistical analyses were conducted using t-tests. Standardized TSI scale scores were calculated and compared between experimental and control groups at baseline, and at post test 1. The two groups were then combined for a larger N of 37 and comparisons were made between pretest and after-treatment posttest scores, between pre-treatment and follow-up scores, and between posttest and follow-up scores. The mean number of reported symptoms from the STF was analyzed for the same time points and by clinician.

TSI Scale Item	Experimental Group Pre treatment pretest Mean (std dev) n=25	Control Group pretest Mean (std dev) n=15
Anxious Arousal	66.04 (10.47)	67.73 (5.82)
Depression	62.80 (10.30)	70.82 (5.40)
Anger/Irritability	58.28 (10.57)	62.36 (7.83)
Intrusive Experiences	66.24 (11.99)	67.73 (9.70)
Defensive Avoidance	63.56 (11.00)	62.82 (8.60)
Dissociation	64.40 (11.43)	68.18 (7.86)
Sexual Concerns	61.88 (14.75)	54.45 (6.25)
Dysfunctional Sexual Behavior	58.76 (17.03)	51.18 (5.98)
Impaired Self-reference	64.88 (10.43)	61.55 (5.50)
Tension Reduction Behavior	58.12 (14.60)	56.18 (5.10)

No significant differences occurred between groups



(left) **Figure 1.** Comparison of Trauma Symptom Inventory T-scores for control group baseline clinical scales

Baseline before Wait period

Baseline after Wait period

*No Significant Difference between Baseline Measurements

Trauma and Loss:

TSI Scale Item	Pre -Treatment Trauma Score Mean	s.d.	Post-Treatment Trauma Score Mean	s.d.	t-value pre-post test	Follow-up Trauma Score Mean	s.d.	t-value pretest-follow-up
Anxious Arousal	66.56	9.25	49.58	8.92	.93**	48.34	10.82	.48**
Depression	65.25	9.6	50.61	10.19	6.22**	49.69	10.43	6.36**
Anger/Irritability	59.53	9.89	45.0	8.98	5.40**	44.1	8.80	5.31**
Intrusive Experiences	66.69	11.22	50.9	12.23	5.68**	50.94	10.35	5.99**
Defensive Avoidance	63.33	10.21	50.14	9.11	5.9**	49.38	9.29	5.8**
Dissociation	65.56	10.51	50.56	10.39	6.09**	49.19	.61	0.431**
Sexual Concerns	59.61	13.13	49.19	8.50	3.40**	4.9	8.94	
Dysfunctional Sexual Behavior	56.44	14.89	4.6	5.42	3.32**	4.2	.40	3.11**
Impaired Self-reference	63.86	9.26	50.4	8.4	6.40**	49.16	8.58	6.**
Tension Reduction Behavior	55.3	12.42	48.3	6.53	4.14**	4.62	.16	4.08**

N = 3 ** p < .01 for all values at post treatment and follow-up

RESULTS

Trauma Symptoms Inventory

No significant differences occurred in the scores of the experimental and control groups at baseline on the TSI. See Table 1. Figure 1 indicates

no significant change occurred between the pre and post test scores for the control group as well.

As Table 2 indicates, a significant reduction (p < .01) occurred in the clinical symptoms on all 10 of the TSI clinical scales between pretest and posttest, confirming the hypothesis that T.R.U.

Table 3. Pre and Post Treatment Scores for Self-Reported Symptoms

Trauma Symptom	Pre -Treatment Mean	s.d.	Post-Treatment Mean	s.d.	t-value pre-post test	Follow-up Mean	s.d.	t -value pretest-follow-up
Violence	.32	1.19	0		1.63	0		1.63
Anger	0		0		-	0		-
Nightmares	1.55	1.91	.4	1.59	1.9	.69	1.9	1.92
Flashbacks	10.69	19.14	.0	2.38	3.15**	.44	2.4	3.22**
Anxiety	4.81	6.89	1.14	3.5	2.88**	.45	1.36	3.6**
Crying	2.3	8.1	.8	1.49	1.42	.28	.68	1.81
Depression	3.30	1.43	1.32	1.43	5.92**	.91	1.20	4.5**

N=3 **p<.01

would significantly reduce traumatic symptoms. Participants' scores were in the clinically higher than normal range (≥ 65) on four of the TSI scales (anxious arousal, depression, intrusive experiences and dissociation), but all scores were within normal range at post-test and at follow-up. Scores remained stable at the four month follow-up, with all trauma scores remaining significantly reduced from their pre-test level.

Symptom Tracking Form

Results from the Symptoms Tracking Form indicate scores decreased on all measures (see Table 3). Significant decreases ($p < .01$) occurred on three of the seven symptom ratings (Flashbacks, anxiety, and depression) at both post-test and follow-up. The mean number of symptoms

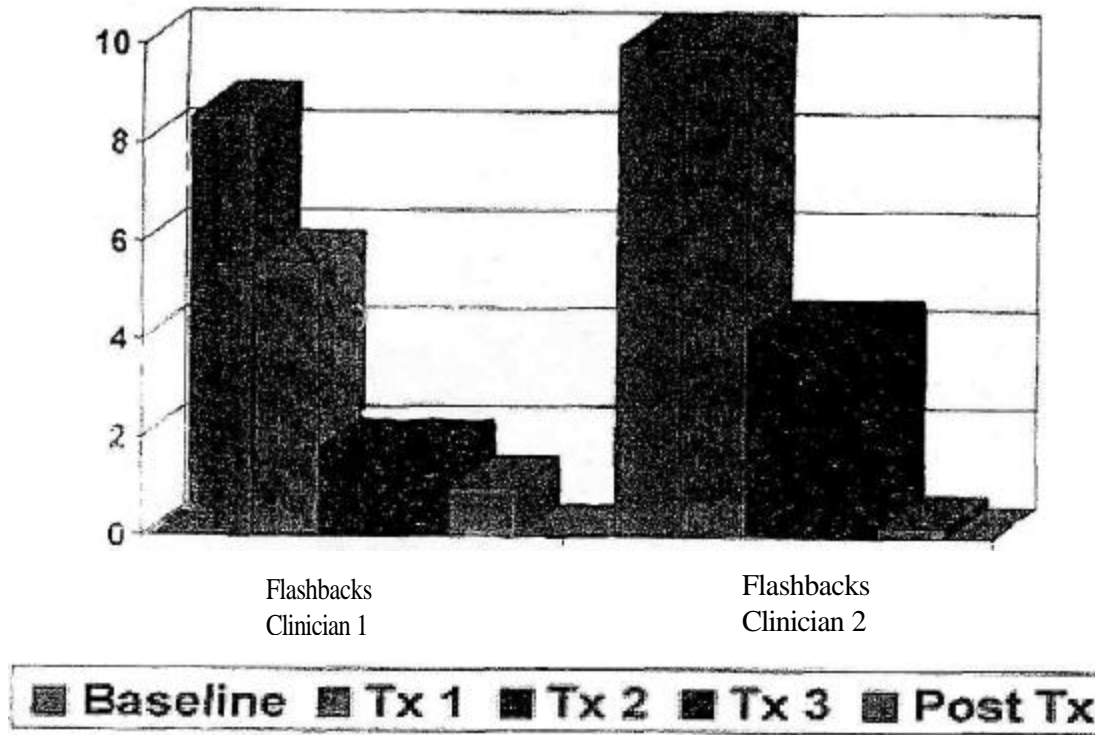
consistently dropped on all measures between post treatment and follow-up.

Clinician Comparisons

In the comparison of clinician interventions, the T.R.U. founder (clinician 1) treated 15 clients and clinician 2 treated 10 clients in the experimental group. The T.R.U. founder subsequently provided treatment to all the clients in the control group. The participant numbers were too small to reliably analyze the results of the TSI scores between the two clinicians. On the STF the frequency of self-reported symptoms was near zero at posttest for participants of both clinicians. Figure 2 illustrates the frequency of flashbacks reported to the two clinicians.

Trauma and Loss:

Figure 2. Frequency of self-reported symptoms



DISCUSSION

The Trauma Relief Unlimited brief intervention method shows promising results that demonstrate reduction or elimination of trauma symptoms without reoccurrence. It is a cost effective method that can be easily taught to other trained professionals who have little experience counseling trauma survivors. It has few, if any, negative side effects. Preliminary findings suggest that it works without regard to the severity of the symptoms expressed. Even the two participants with diagnoses of bipolar disorder who were allowed into the study demonstrated greatly reduced trauma symptomatology. Current understanding of brain functioning is not sufficiently developed to explain why the method works. Ongoing neurobiological research may better explain the dynamics of its

effectiveness. Future articles and research will address in greater detail the similarities and differences of the T.R.U. method to current psychological theory and practice (Cicione, in preparation).

The current research project was limited by small numbers of participants who were self-recruited through newspaper advertising. Random assignment to groups was hindered by scheduling conflicts and potential loss of an additional five participants if not scheduled for the experimental group. Larger numbers of participants would also have permitted more sophisticated statistical analyses and comparisons. Recommendations for future research on T.R.U. are as follows: Replicate the current study; increase sample size; particularly when using more than one therapist to administer the method; increase the diversity of the sample

demographically and for diagnostic categories; utilize instruments that measure the neurobiological impact of trauma and are sensitive to changes over time; extend the follow-up period to at least two years post test with quarterly or triennial data collection; and compare the effectiveness of T.R.U. to other trauma intervention methods. Such research will provide us with a better scientific understanding of the capabilities of the T.R.U. method and its long term effectiveness. The ultimate goal is to provide proven, research-based interventions to trauma survivors.

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