Traumatic Incident Reduction: Brief Treatment of Trauma-Related Symptoms in Incarcerated Females

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Statement of the Research Problem

Conducted in a Federal Correction Institute (FCI) in the southeastern United States, this experimental outcome study examined the effectiveness of Traumatic Incident Reduction (TIR) (Gerbode, 1989) in treating trauma-related symptoms of previously traumatized female inmates. TIR is a brief (in this case, one session), straightforward, memory-based, therapeutic intervention most similar to imaginal flooding. A memory-based intervention implies that the symptoms currently experienced by a client are related to a past event and that lasting resolution of those symptoms involves focusing on the memory rather than focusing on symptom management. TIR is straight forward in that the roles of both the client and therapist are very clearly defined and strictly followed.

TIR is both a client-respectful and therapist-directed intervention. TIR is client-respectful in that the client's perception of the traumatic incident takes precedent over the therapist's perception of the incident. For example, should the client have multiple traumatic events in her past, she would decide on which event to focus in the one-session TIR intervention, and her version of the event would be undisputed by the therapist. Additionally, an event is considered traumatic if the client so deems it. In other words, the client, not the therapist, is considered the expert regarding the client's life and the impact of the traumatic event on her life. TIR is a therapist-directed technique in that the therapist acts as a facilitator, ensuring that the session has structure and focus. The therapist acts as a guide, not an interpreter, evaluator, or problem solver. Both the non-intrusive stance of the therapist and the client's work of confronting the painful incident combine to empower the client (Valentine& Smith, 1996).

The study specifically examined the effectiveness of TIR on symptoms of posttraumatic stress disorder (PTSD), depression, anxiety, and low expectancy of success (i.e., low self-efficacy). Symptoms of PTSD include intrusion, avoidance, and arousal (American Psychological Association, 1994; Waldinger, 1990). Intrusion involves

nightmares, recurring thoughts, and flashbacks. Avoidance speaks of numbing of feelings, avoiding places associated with the event, and attempts to refrain from thinking about the event. Arousal, among other things, pertains to an exaggerated startle response and hypervigilance. The diagnosis of PTSD means that the symptoms are more present after the traumatic event than they were before the event, and that the symptoms have existed for at least four weeks.

The theoretical underpinnings of TIR are considerable and are closely related to the etiology of trauma-related symptoms. Psychodynamic theorists explain trauma-related symptoms as consequences of unresolved emotional processing that occurred during a traumatic episode (Gerbode, 1989). Behaviorists write of classical conditioning and seek treatment that reveals the stimuli associated with a particular traumatic event (Resnick, Kilpatrick, & Lipovsky, 1991). Cognitive theorists speculate that one's basic beliefs about the world were shattered during the traumatic event and that the shattered beliefs cry out to be restored (Janoff-Bulman, 1992). Cathartic theory, on which TIR is primarily based, agrees with each of the above theories. It also asserts that a heightened physiological state (much like the state experienced in the original incident) must be recreated to finish the emotional processing and to reveal the associated stimuli and/or the distorted cognitive schema (Straton, 1990). TIR is structured so that the incident is viewed repetitively, non-intrusively, and in an open-ended time frame. The structure is designed to elicit a heightened physiological state so that the client can process the event to its completion (Gerbode, 1989). Key to that structure is the open-ended time frame that allows the client to emotionally engage in the memory without fear of being cut off.

The reasons for studying the influence of TIR on previously traumatized female inmates are several. Since 1950, the rate of family homicide has increased fivefold (Joffe, Wilson, & Wolfe, 1986). Women are the target of much violence, as illustrated by the following: 75% of adult women have been victims of at least one sexual assault, robbery, or burglary (Resnick, et al., 1991); and 53.7% are victims of more than one crime. Abundant data exist that suggest that PTSD can result from having been a victim of crime or having witnessed a violent crime (Astin, Lawrence, & Foy, 1993; Breslau, Davis, Andreski, & Peterson, 1991; Resnick, et al., 1991). Therefore, the number of women affected by PTSD is growing as violence and sexual abuse increase in society as a whole (Ursano & Fullerton, 1990). There is a lack of empirical research on the traumatic effects of interpersonal violence (e.g., robbery, rape, incest, physical assault). Since inmates are typically victims of interpersonal violence (Gabel, Johnston, Baker, & Cannon, 1993), the inmate population studied was particularly suitable for TIR.

Another reason for studying the influence of TIR on previously traumatized female inmates is the increased number of female prisoners in the last decade (Gabel, et al., 1993; "As Inmates Pay, so do Kids," 1995). This increase is due to a boost in drug-related arrests and sentencing. Between 1980 and 1989, 25% of women arrested were arrested for buying drugs; whereas among men, drug purchases accounted for only 10% of the

arrests. More arrested females regularly use drugs than do their male counterparts. Among women incarcerated for violent crimes, a 1991 study (United States Department of Justice, 1991) found that 61% of female inmates had victimized a male and that 36% had close relationships with their victims (Gabel, et al.). Violent offenders with a history of physical or sexual abuse are more likely to have killed relatives or intimates than strangers. Female inmates with no prior history of abuse were more likely to have victimized a stranger while committing a robbery. These statistics suggest a connection between female victimization and women who victimize. The impact of unresolved trauma needs to be explored.

The traditional treatment of inmates seldom incorporates the influence of prior traumatic events on current behavior (A. McNeece, personal communication, April 18, 1995). Furthermore, most trauma treatment is lengthy and nonspecific, making it difficult to reach conclusions about treatment efficacy. The above reasons mandated the need for this study.

Finally, while both clients and therapists throughout the United States report that TIR alleviates trauma-related symptoms (Valentine & Smith, 1996), little experimental research has been conducted to substantiate such claims. By conducting an experimental outcome study on the effects of TIR on traumatized, female inmates, knowledge is built pertaining to (1) the effectiveness of TIR, and to (2) the treatment of victims of interpersonal violence.

Research Questions

The research questions that this study addressed are the following:

1. How does TIR influence PTSD-related symptoms in incarcerated females?
2. How does TIR influence intrusion?
3. How does TIR influence avoidance?
4. How does TIR influence arousal?
5. How does TIR influence anxiety?
6. How does TIR influence depression?
7. How does TIR influence sense of control?

Methodology

Subjects in the study were recruited from the Federal Correction institute (FCI), Tallahassee, Florida. The sample was drawn from the total number of inmates at the facility (N = 730). The population (N = 730) filled out a Participation Questionnaire to indicate interest in the study. This questionnaire was used to determine eligibility based on whether inmates (1) had experienced a prior trauma in their lives, and if so, the nature of the trauma; (2) had experienced one or more of the trauma-related symptoms; and (3) were willing to further discuss their traumatic experience with a mental health professional. Two hundred, forty-eight inmates met the initial criteria. The inmates were brought together, in groups of approximately 12, to have the study explained to them and to have them sign consent forms when they chose to participate. One hundred, forty-eight agreed to participate and were randomly assigned to either treatment or control conditions. Twenty-five subsequently withdrew from the study, leaving 123 subjects.

An experimental control group design was used to evaluate the efficacy of TIR on 123 female federal inmates. The primary hypothesis of the study follows: Those inmates receiving TIR will experience significant reduction in one or more of their self-reported PTSD-related symptoms, while those in the control conditions will not.

While all subjects completed pretest, posttest and follow-up tests, additional steps were required of those in the experimental condition. Those steps were: (1) having a one-on-one orientation to learn the nature of TIR and the roles that the inmates and the mental health practitioners would play, (2) receiving a session of TIR, and (3) completing a debriefing session.

The instruments used to determine the efficacy of TIR on trauma-related symptoms were the Posttraumatic Symptom Scale (PSS), The Beck Depression Inventory (BDI), the Clinical Anxiety Scale (CAS), and the Generalized Expectancy of Success Scale (GESS). These instruments were administered in a pretest, posttest, and three-month follow-up format.

Results

To analyze the data, an ANCOVA (with the pretest as the covariate) was conducted on each of the above measures, as well as on the three subscales of the PSS: intrusion, avoidance, and hyper-arousal. Analysis revealed that TIR shows significant differences at the .05 level on the PSS, the BDI, the CAS, and the GESS at both posttest and the three-month follow-up. In other words, at both the posttest and the three-month follow-up, the experimental condition showed a statistically significant *decrease* in symptoms of posttraumatic stress disorder (and its related subscales) and of depression and anxiety, while those in the control condition remained approximately the same. Subjects assigned

to the experimental condition *improved* on the measure of self-efficacy at a statistically significant level, while subjects assigned to the control condition did not. The null hypothesis was rejected, and the research hypothesis confirmed.

Although the results of this study were promising, care should be taken in generalizing to larger populations. For example, while this study demonstrated TIR's effectiveness in treating trauma-related symptoms in female inmates, it would be a mistake to assume that TIR is effective with male inmates, or with female inmates in different institutional settings, or with persons outside a prison setting. Additional studies should be undertaken with other populations before definitive conclusions are drawn about TIR's efficacy with those populations. Besides testing TIR's effectiveness on different populations, TIR should be compared against other brief trauma treatments. Finally, research implications involve testing TIR's effectiveness on different ethnic groups and discovering the variables associated with training therapists to deliver TIR to a variety of ethnic groups.

Implications for Social Work Practice

The implications for social work practice are multiple. Social work's knowledge base is increased in realizing an effective trauma intervention with female inmates. The knowledge base would be increased further by researching (1) TIR's effectiveness with other populations; (2) TIR as compared with other brief trauma interventions; (3) and the implementation of TIR with various ethnic groups .

One primary practice implication pertains to the accessibility of TIR to social workers in a variety of settings. TIR is an unfranchised therapeutic intervention. While social workers should be trained to deal with clients' traumatic memories, Gerbode (1989), the originator of TIR, does not require licensure nor certification to practice TIR, making TIR more accessible to a greater number of social workers. Furthermore, TIR training usually costs a fraction of the price of other trauma-focused interventions.

Another practice implication is the applicability of this technique to the population with whom social workers are engaged. Many clients are oppressed and have likely been traumatized; yet, few psychosocial interview protocols exist that focus on having experienced prior traumatic events. Therefore, the demonstration of the effectiveness of TIR with previously traumatized female inmates should have several practice implications: (1) inclusion of a history of prior traumatic events in assessment of client problems; (2) inclusion of prior traumatic events in the treatment plan designed for the client; (3) encouragement of social workers to be trained to administer brief treatment to traumatized clients; and (4) practice of TIR by agency-based social workers, understanding that TIR has demonstrated effectiveness against trauma-related symptoms in incarcerated females. This study has shown TIR to be effective in the treatment of traumatized federally incarcerated females and renders TIR a promising intervention that begs further research.

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