THE RICHARDS TRAUMA PROCESS

trauma therapy redefined

Treatment Outcome Report 2019

Contents

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EXECUTIVE SUMMARY

The Richards Trauma Process (TRTP) is an innovative psychological intervention for dealing with trauma and other psychosocial problems, including anxiety, depression and substance abuse. TRTP utilises imagery rescripting to remove the emotional charge from traumatic memories that underlie psychological distress and mental illness. Anecdotal evidence from TRTP clients and practitioners suggests lasting reductions in distress and improvements in functionality.

This report outlines the rational for TRTP within the broader mental health industry and provides initial data on its effectiveness. The data analysed and discussed in this report comes from 715 clients who received TRTP during 2017-2018. On average clients received three TRTP sessions and pre- and post-treatment outcome data was collected by their TRTP practitioners. Data consisted of self-reported levels of stress, anxiety and depression measured by the Depression, Anxiety Stress Scale 21 (DASS21), a common 21-item questionnaire.

The results of the data suggest TRTP may be as effective and possibly more so than cognitive-behavioural therapy (CBT): the most common and effective psychotherapy. On average the clients who participated in TRTP experienced significant reductions in stress, anxiety and depression during their treatment. Furthermore, a subsample of clients who presented with pathological levels of depression, anxiety and stress had normal levels depression, anxiety and stress at the end of the TRTP.

The analyses also found that 92% of people who started TRTP with depression had normal levels of depression after their TRTP sessions, 89% of people with abnormally high anxiety had normal anxiety after TRTP, and 96% of people with abnormally high stress had normal stress after TRTP.

The effect size of TRTP was found to be greater than what is typically reported in the scientific literature for CBT. Effect sizes are a statistical value that are used to determine the impact of an intervention on its target construct, such as depression, anxiety and stress. Effect sizes of .2 are considered small, .5 are medium, and above .8 are large. TRTP effect sizes ranged from 1.46 to 1.78 whereas effect sizes drawn from the empirical literature for CBT ranged from .73 to 1.19.

This data provides strong justification for further research on TRTP to support its transition into the mainstream mental health industry. To achieve this further outcome studies will be needed on TRTP and these will need to be published as scientific papers. This should include case studies and a randomised control trial.

Randomised control trials are the gold-standard scientific experiment for demonstrating causality in medical and psychological interventions. They are however a large undertaking. Nevertheless, TRTPs short duration of 3 to 4 sessions and large treatment effect sizes mean that it has potential to be a highly cost-effective psychological intervention that can change not just the lives of thousands of people with mental illness but also the landscape of mental health.

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MENTAL HEALTH IN AUSTRALIA

Mental illness is a significant issue in Australia and the world. It is estimated that 15.5% of the world's population (1.1 billion) suffer from mental illness, with anxiety disorders, depression and alcohol use disorder being the most common conditions (Ritchie & Roser, 2018). Similarly, in Australia approximately 20% of the population experiencing mental illness per year, with 2-3% (730,000 people) having severe mental illness, 4-6% (1.5 million people) moderate mental illness and 9-12% (2.9 million people) mild mental health problems (Australian Institute of Health and Welfare [AIHW], 2019). In short, mental illness is a serious and common problem in Australia.

Suicide rates in Australians are also increasing (ABS, 2015). In 2015 there were 3,027 Australian deaths from suicide (the highest rate in a decade) which equates to 58 deaths per week (Australian Bureau of Statistics, 2015); however, this figure actually underrepresents the true prevalence because in some situations it can be difficult to confirm the cause of death (Senate Community Affairs Committee Secretariat, 2010).

In 2011, the most recent data available, mental illness was estimated to be responsible for 12.1% of the total burden of disease in Australia, placing it third after cancer (18.5%) and cardiovascular diseases (14.6%) (AIHW 2016.) The cost of mental health in Australia is in excess of $60 billion per year (Australian National Health Commission, 2016). Australian has been described as being in a "mental health crisis" (Hall, 2015) with new and effective psychological innovations in high demand.

CURRENT PSYCHOLOGICAL TREATMENTS

The primary evidence-based treatments for psychological disorders like mood disorders, anxiety disorders and trauma consists broadly of psychopharmacology, individual psychotherapy, group psychological intervention, online psychological intervention and hospitalisation. Mental illness is treated through a complex system including inpatient, outpatient, telehealth and online modalities. These are provided by both private and public services, though Australia is increasingly outsourcing its mental health care to the private sector.

Mental health interventions not only vary in format (e.g. inpatient admissions versus one-on-one counselling) but also in the theoretical approaches and interventions applied. Different forms of psychotherapy conceptualise clients' mental health problems differently and use different methods to treat them; however, determining which of these therapeutic approaches is the most effective for which mental illness is difficult, as different conditions respond differently across the therapeutic approaches. As a result, over the last three decades there has been an increased need for practitioners to adopt an evidence-based approach to mental health care, whereby the empirical literature guides the treatment practitioner's decisions. Currently, the "gold-standard" evidence-based psychological approach is cognitive-behaviour therapy (CBT). Psychopharmcology, such as antidepressants are also commonly used for mental illness.

Psychopharmacotherapy

Psychopharmacotherapy (aka prescribed medications) can be very helpful for many psychological conditions. Specific selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitor (SNRI) are often prescribed. These medications broadly act upon neurotransmitters affecting the reward, fear and anxiety circuitry of the brain. Studies show that a number of medications are helpful in regulating mood, anxiety and minimizing trauma-related symptoms, but it

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is also recognised that in some disorders, such as post-traumatic stress disorder, these medications provide symptom reduction rather than symptom elimination (Watts et al, 2013). Furthermore, clients are often reluctant to commence or adhere to medications because of stigma or side effects. Thus, psychological interventions fill a large gap in the treatment of mental illness.

Cognitive-behaviour therapy

Cognitive behaviour therapy (CBT) is a family of therapeutic approaches based on cognitive and learning theories of human behaviour. Typically, these approaches conceptualise mental illness as a result of unconscious beliefs, irrational self-talk and habitual avoidant behaviours. It also allows for skills deficits, such as assertiveness problems, to play a role in the onset and maintenance of mental illness. As an example, a CBT approach may conceptualise depression as being driven by core beliefs about worthlessness that result in unhelpful self-talk (e.g. "I'm useless") and withdrawal behaviours that lock a person into a cycle of worsening mood.

Cognitive behaviour therapy addresses disorders by teaching people to replace irrational self-talk with rational self-talk, to develop effective skills for daily living, relaxation strategies, and gradual exposure to feared situations. Cognitive behaviour therapy has been deemed effective for a range of psychological conditions, including depression, anxiety disorders and PTSD (Holfmann, Asnaani, Vonk, Sawyer & Fang, 2012; Mendes, Mello, Ventura, de Medeiros Passarela, de Jesus Mari, 2008).

The treatment of mental illness however is complex and even CBT has its limitations. For example, CBT has been criticised as being too analytical and impersonal because a great deal of session time is dedicated to clients engaging in academic-type tasks, such as keeping logs of their symptoms and writing down alternative thoughts while in session. It has been argued that CBT's emphasis on written tasks de-humanises the client (Gaudiano, 2008).

Secondly, research has shown that many of the cognitive elements of CBT do not actually contribute to treatment outcomes. Most notably, the reshaping of unhelpful self-talk that CBT champions (e.g. changing "I can't cope" to "I've coped with hard times before and I can cope again") has been shown to have little effect on treatment outcomes, throwing into question some of the most fundamental elements of CBT (Gaudiano, 2008).

Thirdly, CBT has been found to be ineffective against some mental health conditions such as schizophrenia and preventing relapse in bipolar disorder (Lynch, Laws & McKenna, 2010). Other research suggest it may add little benefit on top of antidepressant when treating severe depression (Wilkinson, Dubicka, Kelvin, Roberts & Goodyer, 2009) and though it is effective in the treatment of post-traumatic stress disorder, it is recognised that this may only be the case in 50% of clients (Byrant et al., 2008; Schottenbauer, Glass, Arnkoff, Tendick, Gray, 2008). For these reasons many mental health professionals question the usefulness of CBT despite the literature on its effectiveness.

It is certainly not just CBT that has limitations. While psychotherapy is generally seen as being beneficial for the treatment of mental illness, there is some research to suggest the empirical evidence for this is weak. For instance, Dragioti, Karathanos, Gerdle & Evangelou (2017) conducted a meta-analyses of published meta-analyses on psychotherapies. Meta-analyses examine the overall effectiveness of an intervention by combining the results of several studies into a single paper. They are used to make more sophisticated determinations of intervention effectiveness. Dragioti and colleagues took this process to an even more sophisticated level by doing a meta-analysis on 190 pre-

existing meta-analyses. They found that only 7% of the studies they examined had strong evidence for the effect of psychotherapy on mental health. If this indeed is the case it highlights the need for more innovative psychotherapies.

In summary, great advances in psychological intervention have been made in the last few decades, and there are many psychological and psychopharmacological treatments that are deemed effective for various psychological disorders. However, the treatment of mental illness is by no means perfect, with the various approaches having some shared and unique limitations. In the meantime, mental illness remains a significant problem in both Australia and the world. There is scope for further innovative approaches to mental health care.

THE RICHARDS TRAUMA PROCESS (TRTP)

The Richards Trauma Process (TRTP) is an innovative new therapeutic approach that is experiencing a growth in popularity thanks to its reputation for producing exceptional therapeutic outcomes and growing international community of TRTP treatment providers.

Similar to many mainstream therapeutic approaches, such as cognitive therapy and schema therapy, TRTP proposes that psychological distress and mental illness result from unconscious beliefs that create psychological and psychosomatic symptoms as well as problematic coping behaviours (e.g. high anxiety results in social avoidance or depression results in self-medication with substances). Sometimes quite subtle, these coping behaviours, and the unconscious beliefs underlying them, can also perpetuate themes and patterns that arise in a person's life. For example, a person who perceives themselves as unlovable may act in a needy way when in romantic relationships that results in rejection and confirmation that they are unlovable. The identification of these kind of patterns is common in most psychotherapies, however, unlike many mainstream psychological approaches TRTP places a great deal of emphasis on the power of the unconscious in shaping behaviours, psychological and physical ailments, whilst providing direct methods for accessing and reshaping these beliefs.

TRTP places a large emphasis on trauma as the cause of psychological distress and mental illness and as such is a trauma-focused therapy. Trauma being conceptualised as a spectrum ranging from minor interpersonal altercations (e.g. a child's parent yelling at them causing some perceived violation of safety in the world) all the way to physical abuse. TRTP not only utilises the common cognitive conceptualisation of mainstream psychology, i.e. unconscious processes of psychoanalysis and cognitive therapy, but also aligns itself with mainstream trauma theories that suggest trauma is the result of "hippocampal hijacking" where the memories of past traumas are locked into the hippocampal region of the brain and become activated, which in turn moves a person into a state of hyperarousal, hypervigilance or shut down (aka the fight, fright freeze response of the nervous system).

TRTP's power is in its precision and directness when addressing the unconscious beliefs and traumas underlying mental illness. Through imaginal rescripting TRTP helps clients explore and reconstruct their memories of traumatic experiences and unconscious beliefs resulting from them. In comparison to some other mainstream approaches the process of TRTP can seem simple, however, practitioners and TRTP clients passionately endorse TRTPs superiority over the mainstream approaches to anxiety, depression trauma and other mental health conditions. One of the greatest strengths of TRTP is its brevity, with the work usually being completed in just three sessions. Another major strength of TRTP

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is that it's a manualised treatment. Treatments that have a clear, standardised and manualised process are sought after when researching psychotherapies because they maximise the likelihood that the practitioners applying the intervention are doing so in a consistent manner.

Report aims

To date TRTP has been supported through anecdotal evidence from its practitioners and clients. The aim of this report was to analyse TRTP clients' outcome data to determine whether:

a) Reductions in depression, anxiety and stress are present after receiving TRTP
b) The effect of TRTP on mental illness in comparison to current mainstream psychotherapies
c) Provide recommendations for future research on TRTP

METHOD

Preliminary outcome data was collected from 28 TRTP therapists working in private practice throughout Australia. Each TRTP Practitioner had undergone TRTP therapist training. These therapists provided outcome data for 715 clients. The data was collected at two time points: the clients' first and last TRTP session. All clients received either 3 or 4 TRTP sessions, with the majority of clients participating in 3 sessions. The average number of sessions per client was 3.37 (SD = .78).

Outcome data was collected via the Depression, Anxiety and Stress21 Scale (DASS21). The DASS21 is a very common questionnaire that measures psychological distress in three domains: stress, anxiety and depression. The DASS21 is commonly used by medical professionals and psychologists to capture response to treatment. It is also commonly used in behavioural science research studies as it is a brief but reliable and valid measure of distress.

Analytical method

The material in the following "Results" sections is quite technical and may be confusing for some readers less familiar with statistics or scientific research methods. Therefore, in order to facilitate interpretation there are three concepts that need a brief introduction: significant change, clinically significant change and reliable change.

"Significant difference" (also sometimes called "significant change", "significantly different" or "significantly greater/smaller") means that a change in scores on an outcome measure like the DASS21 has moved from the first to the last TRTP session at a rate that is not likely to be due to chance. To be precise, it means there is a 95% chance the change in score is not just due to chance.

"Clinically significant change" goes beyond significant change. It means not just that the change is significant but that the change is likely to represent a change from a pathological or clinical population to one seen in a normal population. Theoretically, a person could experience significant reductions in anxiety but still have abnormally high levels of anxiety. Clinically significant change looks to see if the person has experienced significant reductions in a construct like anxiety that are not due to chance and are also large enough to place their scores back in the normal population range.

"Reliable change" represents the degree to which a change in outcome scores is likely to be reliable and not just due to the natural error of measurement found in all questionnaires. No questionnaire can measure a construct perfectly. People might interpret items slightly differently for example. This

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introduces “measurement error” into the data. The reliable change index assesses whether clients change scores are meaningful despite any measurement error in the scale used.

The calculation of clinical and reliable change requires reliability and normative data from comparison groups. Reliabilities for the DASS21 were drawn from Henry and Crawford (1999) and Antony, Bieling, Cox, Enns and Swinson’s (1998). Henry and Crawford’s (1999) normative data of general community members (n = 1974) and Antony, and colleagues’ (1998) clinical data from community outpatients (n = 258) was used to determine whether clinically significant and reliable change had occurred.

RESULTS

A series of analyses were conducted to determine: (a) if significant reductions in depression, anxiety and stress were seen across all those clients receiving TRTP; (b) if those presenting to TRTP with clinically high depression, anxiety or stress had normal levels after their TRTP sessions; (c) to determine how large an effect TRTP was having on depression, anxiety and stress; and (d) to determine whether any changes seen were truly reliable changes and not due to measurement error.

Depression

DASS21 depression scores at the clients’ first TRTP session (*M* = 20.08; *SD* = 11.14) were significantly greater than their scores in their last session (*M* = 5.96; *SD* = 6.65), *t*(682) = 36.27, *p* <.001. This shows that on average the whole sample of clients presenting for TRTP had reductions in depression scores that were more than would be seen if they just occurred by chance. These reductions in depression would be expected to be associated with improvements in daily functionality.

As well as looking at depression in the whole sample, changes in depression were also explored in a subsample of clients who presented for TRTP treatment with abnormally high levels of depression. Three hundred and twenty-five (325) clients commenced TRTP with depression levels in the clinically significant range (i.e. depression levels that would normally be expected of someone with a major depressive disorder) and 302 of these clients having normal depression levels at the end of their third session. In other words, 92% of those clients who started TRTP with clinical depression had normal levels of depression after their third TRTP session.

The DASS21 depression reliable change criterion was calculated at 10.70 which the DASS21 TRTP average was below, indicating reliable change was present. The average DASS21 depression score at TRTP session 1 moved from Henry and Crawford’s 99th percentile to the 81st percentile at the final TRTP session, also indicating clinically significant change and supporting the finding of clinically significant change in the previous paragraph. Hence, both clinically significant and reliable reductions in depression was seen after clients participated in TRTP.

Anxiety

DASS21 anxiety scores at clients’ first TRTP session (M = 16.25; SD = 9.70) were significantly lower at their final session (M = 4.82; SD = 5.38) *t*(683) = 34.23, *p* <.001, indicating significant reductions in anxiety had occurred across the TRTP treatment period.

It was seen that 359 clients presented to TRTP with clinically high levels of anxiety with 325 (89%) of these clients having experienced clinically significant reductions in anxiety that placed their anxiety in the normal range after TRTP. In other words, 89% those clients who had abnormally high levels of

anxiety, as would be expected in an anxiety disorder, had normal anxiety at the end of their TRTP treatment.

The reliable change criterion for the DASS21 anxiety scores was calculated between 9.69 and 11.41 depending on the DASS21 reliability statistics used. Regardless, the average change in DASS21 anxiety scores were below these reliable change criterions, indicating reliable changes in anxiety were present. The average DASS21 anxiety score at TRTP session 1 moved from Henry and Crawford's 99th percentile to the 89th percentile at the final TRTP session, indicating clinically significant change. In short, clinically significant and reliable reductions in anxiety were seen after clients' TRTP sessions.

Stress

The DASS21 stress scores at clients' TRTP first session (M = 23.64; SD = 9.17) were significantly higher than their scores in their final session (M = 9.34; SD = 6.70) $t(672) = 40.22$, $p < .001$, indicating that the difference in scores between their first and final TRTP sessions was meaningful and not just due to chance.

Three hundred and twenty (320) clients presented in their first TRTP session with significantly high levels of stress and 307 (96%) experiencing clinically significant reductions in stress after TRTP. In other words, 96% those clients who had abnormally high levels of stress had normal stress at the end of their TRTP treatment.

The DASS21 stress reliable change criterion was calculated at 8.04 which the average change in DASS21 stress scores was below, indicating reliable change was present after TRTP. The average DASS21 stress score at TRTP session 1 moved from Henry and Crawford's 99th percentile to the 86th percentile at the final TRTP session, indicating clinically significant change. Hence, both clinically significant and reliable reductions in stress were seen after clients participated in TRTP.

Treatment effect size

The effect size is the main finding of a quantitative study. While the *p* values reported above indicate whether a significant effect exists they do not reveal the size of that effect. The effect size statistic does exactly that. It represents the degree to which the intervention (i.e. TRTP) has effected the construct of interest (i.e. depression, anxiety or stress). There are many different types of effect size but in this report the Hedges *g* statistic is reported. These values can be interpreted in the following way. A Hedges *g* value of .2 or less is considered a small effect, a value of .5 is considered a medium sized effect and values of .8 or more indicate a large effect.

Effect sizes were calculated via the procedures of Ellis (2009) firstly for the whole sample and then again just for clients who had significantly high depression, anxiety and stress at session 1. The rationale being that this would provide an indication of treatment effect for a broad community sample, and then a second more specific indicator of effect for a subset of clinical clients.

For the entire sample, the results indicated that TRTP had a large effect on depression (Hedges g = 1.54), anxiety (Hedges g = 1.46) and stress (Hedges g = 1.78). These TRTP effect sizes were larger than published effect sizes of CBT for depression (Hedges g = 1.19) (Rubin et al., 2017), anxiety (Hedges g = 0.73) (Hofmann & Smits, 2008) and stress (Cohen's d = .79) (Ata & Dogan, 2018).

For just the clients presenting with clinical elevated levels of depression, anxiety and stress the effect sizes were even larger. For those with clinical levels of depression in their first TRTP session the effect

was Hedges *g* = 3.10, for those with clinical anxiety the effect size was Hedges *g* = 2.80, and for highly stressed clients it was Hedges *g* = 3.34. These effect sizes are much larger again than what is typically reported in the empirical literature for gold standard interventions like CBT.

Results summary

In summary the results of the analyses suggest that reductions in depression, anxiety and stress were present in the clients who participated in TRTP. On average, these reductions placed clients' depression, anxiety and stress levels back from the abnormally high range to the normal range expected in healthy members of the community. These changes were reliable and not likely to be due to chance or measurement error in the DASS21. In particular, 92% of people who started TRTP with depression had normal levels of depression after their TRTP sessions, 89% of people with abnormally high anxiety had normal anxiety after TRTP, and 96% of people with abnormally high stress had normal stress after TRTP. Though the data is preliminary, it shows that the effect of TRTP on depression, anxiety and stress are at least as strong and possibly stronger than what is shown in published scientific papers on CBT.

DISCUSSION

The data analysed and presented in this report is impressive. The differences in scores from clients' first to last TRTP were significant and possibly better than what is typically reported in mainstream effective treatments, such as CBT. Of particular note is the very large effect sizes shown for TRTP when only the clinical clients were examined. These effect sizes ranged from Hedges *g* = 2.80 to 3.34 which are very large in comparison to those typically reported for CBT interventions (e.g. CBT for depression, *g* = 1.19, anxiety, *g* = 0.73, and stress *d* = .79) (Rubin et al., 2017; Hofmann & Smits, 2008; Ata & Dogan, 2018). The fact that TRTP clients experienced these changes after only three to four sessions is also noteworthy when compared to the average 12 to 20 sessions that other approaches require to produce equal or possibly lesser results. Having just three to four sessions of therapy in comparison to the 10 to 20 of other processes that produces as good and possibly better treatment outcomes means that TRTP is potentially a very cost-effective approach for service providers and the community.

The preliminary data in this report indicates that TRTP has the potential to produce good outcome that many health professionals will find impressive. The data provides strong justification for further research on TRTP which will surely be needed to demonstrate its effectiveness to the broader professional communities. If the results of this initial study are replicated in randomised-control trials it would mark TRTP as a serious newcomer to the mental health industry.

Limitations

There are some limitations to this report that should be acknowledged. The most obvious being that the data used for the analyses was not collected as part of a randomised-controlled study. Instead, the data was collected for in house evaluation and can be best classified as a quasi-experiment study. As a result, there is no control group to compare the TRTP result with. Without control conditions it cannot be said for certain that it was the intervention itself that produced the changes seen. A second limitation is that there was no follow-up period beyond the final TRTP session. While TRTP practitioners endorse the TRTP method as revolutionary in its effectiveness, further studies with follow-up time points will be required to test these claims. Finally, the other limitation is that only the DASS21 outcome measure was used. The DASS21 is a very common outcome measure however in

order to measure conditions such as trauma, which TRTP specifically targets, alternative trauma specific outcome measures will be needed.

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