Treating Traumatic Memories in Rwanda With the Rewind Technique: Two-Week Follow-Up After a Single Group Session

Traumatology
18(1) 75–78
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DOI: 10.1177/1534765611412795
http://tmt.sagepub.com
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Abstract

The Rewind Technique (RT) is an exposure based therapy for the treatment of PTSD. The RT is most often used in one to one clinical settings but it also has the potential to be used in a group setting. To date it has not been evaluated in a group setting. The results of a single intervention group therapy session with the RT applied to 21 survivors of the genocide in the East of Rwanda are reported. Results show a statistically significant reduction in scores for clients at 2 weeks. It is concluded that the RT could be a useful tool to incorporate where vast numbers of traumatized people are beyond reach on a one to one basis.

Keywords

traumatic memories, group therapy, rewind technique, posttraumatic stress disorder

In 1994, over a period of just 3 months, one million Rwandans (Tutsis and moderate Hutus) were horrendously and systematically killed at first by the government trained youth militia called *interahamwe* and then by friends, neighbors, and, in some cases, relatives. The population of Rwanda was around nine million at the time. There is no other country that has had systematic killings on this scale committed in such a short period of time.

Despite the initial flurry of support provided by the United Nations and other NGOs, the present reality is that the people to date have received very little help on account of the scarcity of professional counselors in relation to the magnitude of the numbers suffering with the psychological impact of the trauma (Dyregrov, Gupte, Giestad, & Mukanoheli, 2000). There are only 282 clinical psychologists for a population of eight million. The current rate of PTSD in Rwanda is estimated to be 28.5% (Naason, 2010). This is not surprising when one considers that the key community-based findings of a 1995 psychiatric epidemiological survey of 1547 survivors aged between 8 and 19 found that more than 90% had witnessed killings and had their lives threatened (Neugebauer et al., 2009). As such, there is a need to establish effective interventions that can be used in contexts such as Rwanda.

One intervention that promises to be suitable cross-culturally is the *Rewind Technique (RT).* The RT was first introduced into the field of PTSD after a 2-year follow-up of 19 policemen treated showed that the initial improvement in symptoms was maintained (Muss, 1991a, 1991b). Subsequently, Hossack and Bentall (1996) treated five patients diagnosed with PTSD with the RT and relaxation. After two sessions, three patients showed an almost complete reduction in the frequency of their intrusive images and substantial changes on other measures of psychopathology. One patient showed partial improvement and one patient showed no improvement at all. Since these studies, the RT has become a widely known technique for the alleviation of PTSD (Muss, 2002; Schiraldi, 2000).

The RT is an exposure therapy. Exposure therapies have been the treatment of choice for many anxiety disorders for several decades. Based on the principles of Pavlovian conditioning, exposure therapies confront the patient with the fear-evoking stimuli to reduce fear and anxiety. Exposure-based therapies are the foundation of all trauma-based therapies (Rothbaum & Foa, 1999). Exposure therapies are either imaginal (i.e., where the patient talks repeatedly about the traumatic experience), in vivo (i.e., where the patient is exposed to the situations or objects normally avoided), or virtual reality (i.e., where patients wear a head-mounted display with stereo earphones which provide visual and auditory cues relating to the traumatic event).

The RT is different from other imaginal exposure therapies because survivors are not required to either verbalize or write their experience but rather to re-experience it in their mind just as it regularly re-presents itself to them. This key aspect of the technique allows the survivor to retain his or her dignity and privacy and at the same time reduces the risk of the counselor developing compassion fatigue. The possibility of reduced compassion fatigue is of particular relevance

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in contexts such as Rwanda where there are few therapists relative to the number of traumatized people and workloads are especially high.

Briefly, with eyes closed, the RT requires the patient to recall the trauma as two movies. The first movie: the patient is asked to imagine sitting in the movies observing himself or herself on the screen as if the event had, unknown to the patient, been filmed at the time. This allows the emotions to be dissociated and thus reduces the likelihood of the patient becoming unduly distressed. The patient is instructed that the movie should start off just before the traumatic event when he or she was in a peaceful, safe place. By so doing, avoiding reliving and just watching, this allows the patient to "review" the trauma without getting unduly emotionally distressed.

The second movie: The patient is asked to step into the movie when the first movie comes to the end. The first movie is then to be rewound at considerable speed so that it is not possible *to see and feel* the same amount of content as in the forward movie. The patient, during the rewind movie, is thus associated, that is, *seeing and feeling* the event and is being rewound to the safe starting point. Completion of the two moves in sequence, without saying a word, is indicated by the reopening of the eyes.

The RT does not ask the patient to reveal any details of the traumatic event to the counselor; this is a major benefit in that it minimizes the risk of retraumatization. The RT does not make it possible to forget the traumatic memories but rather it offers a way of stopping the involuntary recall by providing a metaphorical *box with a key* into which traumatic memories could be locked. Once locked, the recall: flashbacks; nightmares; ruminations, and involuntary recall due to triggers (places, people, smells, time of the year, dogs, and many, many others), would stop. If the box were to be voluntarily reopened, the memories would not have changed. This concept is important to convey, because for many, though the memories are distressing, they are part of their history. As RT requires minimal verbal exchange between client and therapist, it also promises to be useful as a group-based intervention.

In August 2008, under the auspices of the Voluntary Service Overseas (VSO), the senior author (DM) was sent to Rwanda. The purpose was to train the guides and the newly appointed clinical psychologist at the Kigali Memorial Centre in the RT, as every April, during remembrance week, a significant number of people attending events at the memorial centre become acutely retraumatized. Other organizations, hearing of this initiative, also expressed an interest in the training.

Method

Measure

Impact of Event Scale. The Impact of Event Scale (IES: Horowitz, Wilner, & Alvarez, 1979) is a 15-item self-report measure of the frequency with which intrusions and avoidance are experienced in the aftermath of a distressing event. The IES uses a four-point Likert-type format scale that is scored 0 = *not at all*; 1 = *rarely*; 3 = *sometimes*; 5 = *often* to record how frequently each item (e.g., pictures about it popped into my mind) was experienced during the past week. Scores on the IES have a potential range of 0 to 75, with higher scores indicating greater levels of intrusion and avoidance. The IES is one of the most widely used instruments in research on stress and trauma, with satisfactory psychometric properties as a measure of the subjective distress associated with the experience of trauma (Joseph, 2000).

Participants and Procedure

Following a previous training session of final year medical students at the elite Butare University, the students (who were also members of the Medical students Mental Health Association) kindly agreed to translate the IES and the training manual into Kinya-Rwandan. The translated versions were then translated back into English, to ensure for accuracy, by the coauthor (AU) who is fluent in English and Kinya-Rwandan. Twenty four clinical psychology students, known to the coauthor from her city Kibungo in the Eastern province of Rwanda, attended for the RT training session. The session was held in the local community centre. There were 11 male and 13 female participants. Ages ranged from 25 to 35. At the outset, the senior author (DM) also offered to treat all those attending as a group if they so wished. Consent for such an approach had been granted by the Ministry of Health whose counselors had in turn been trained by DM in the RT. Following the training session, all attendants expressed the wish to be treated and gave their consent. All 24 participants who gave their consent were recruited into the study. There was no further exclusion criterion applied.

Before beginning the treatment session, the participants completed the IES questionnaire and were urged to complete the questionnaire 2 weeks and 3 months later. A cut off score above 35 (Joseph, 2000) was used to indicate a clinically elevated stress response. The training and the treatment were conducted in Kinya-Rwandan by a simultaneous translator who was supervised by the coauthor. The attendees were encouraged not to take notes during the training session as at the end of it, the fully translated Kinya-Rwandan manual would be provided. The manual, in addition to describing how to implement the technique, contains various appendices which address frequently asked questions such as the following: what if the survivor had experienced more than one traumatic event; how long is it reasonable for the survivor to take to do the process; what if the survivor gets extremely distressed during the technique. Contact details of the trainer, who would be willing to assist by email should any difficulties be experienced by those implementing the technique, were included in the manual. The manual in Kinya-Rwandan was

subsequently emailed to all attendants. A reprint of the manual in either English or Kinya-Rwandan is available on request from DM.

Time taken to complete the training and treatment, allowing for simultaneous translation, was 3 hours. Dr. Utuza returned to the East region 2 weeks later and collected the follow-up data from all 24 who attended.

Results

For the 24 clients, full data on the IES were available at both times for 21 cases (see appendix); it is unknown why respondents 13, 14, and 15 did not provide the data prior to treatment. Of the 21 clients, 18 scored lower on the IES post intervention; 1 showed no change; and 2 scored higher on the IES post intervention. Thus, 85% of those attending appeared to benefit from the intervention. Of the 21, 12 scored above the cutoff of 35 preintervention indicating a clinically significant level of subjective distress. Of these 12, all but one scored lower than 35 post intervention.

For the 21 clients, the mean IES score prior to treatment (mean = 38.10, SD = 12.11) was higher (t = 5.97, df = 20, $p < .001$) than at 2 weeks post treatment (mean = 15.14, SD = 12.65).

Discussion

It has become only too evident that major disasters, both natural and manmade, are leaving in their wake huge numbers of survivors with psychological problems. After dealing with the immediate physical and social needs, there comes a point for many where processing the traumatic memories becomes a necessity to be able to function effectively socially and occupationally.

Particularly in those countries where psychological provisions were at best minimal in the first place, reaching out to those in need on a one to one basis is becoming increasingly difficult to achieve. For this reason and cost effectiveness, group therapy has its appeal as it is unlikely that there will ever be enough counselors to help the large number of traumatized people in such countries as Haiti, Northern Uganda, Sierra Leone, Bosnia Herzegovina, and Gaza.

These initial findings are the first of their kind to evaluate the effects of the RT employed as a single therapeutic session in a group setting. It is hoped that the Rwandan experience of using the RT as a one off group therapy session will stimulate workers in this difficult field to consider adding the RT to their armamentarium.

The RT used in a group setting has several advantages compared to conventional therapies. First, the use of the RT in Rwanda has shown that it is easily understood despite cultural differences; it requires very little time to explain and the individuals can easily be followed during the session to see if they have understood what to do by checking the speed with which the individuals open their eyes. Second, the fact that details of the traumatic event are not asked to be disclosed, in addition to providing privacy in the group setting, also allows for completing the session in a short time. Third, it is undeniable that fear and suspicion exists in the therapist–client relationship due to not knowing whether the one or the other is a Hutu or a Tutsi (even though this distinction is no longer officially recognized). Not having to disclose any details of the trauma using the RT, contributes to removing the distrust.

There were several limitations to the study. First, although a 3-month follow-up was planned this turned out not to be possible. The author (AU) who lives in Rwanda tried on various occasions to summon the original group back. Reasons given were in the main insufficient time and financial constraints. For this reason, we cannot be certain that the gains achieved at 2 weeks were maintained. Second, although the fact that most of those attending showed a significant improvement on the IES at 2 weeks is encouraging, no control group was used and so we cannot be certain that the reduction in IES scores was not simply due to a natural reduction over time. However, given that the study was conducted 14 years after the genocide of 1994, it seems unlikely that the reduction of scores on the IES was not due to the intervention. Third, although we used a standard back translation of the IES, it was not possible to determine the validity of the translated version.

Despite these limitations, the pilot study offers encouraging data that the RT is an effective intervention that can be used cross-culturally, in a single session, and with groups. Most clients seemed to benefit from the intervention. However, it was noted that two clients scored higher on the IES post intervention and one client showed no change. As such, although the results provide sufficient evidence to warrant further research into group applications of the RT we would caution that it is necessary to design new research trials with this possibility taken into account. Although group interventions promise to provide much needed help to many people who would otherwise not receive help, we would caution that there might be a minority of people for whom such interventions are inappropriate.

Appendix

Raw Scores on the IES for Participants Prior to and Two Weeks Subsequent to Treatment

Participant	IES prior to treatment	IES two weeks after treatment
1	29	20
2	46	12
3	28	12
4	44	21
5	36	4
6	39	1

(continued)

Appendix (continued)

Participant	IES prior to treatment	IES two weeks after treatment
7	38	16
8	17	4
9	28	5
10	44	16
11	45	26
12	27	21
13	—	13
14	—	12
15	—	36
16	43	1
17	52	4
18	45	5
19	33	33
20	42	48
21	32	12
22	30	5
23	27	37
24	75	15

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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