

## **A Review: Is Human Givens Rewind a form of trauma-focussed imaginal exposure?**

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Human Givens (HG) Rewind treatment for Posttraumatic Stress Disorder (PTSD) has not been described in peer-reviewed journals. The National Institute for Clinical Excellence guidelines (NICE, 2005) recommend trauma-focussed CBT, including imaginal exposure, as an effective treatment for PTSD. However, HG therapy has kept itself distinct from Cognitive Behaviour Therapy (CBT), and as such the Rewind technique has often not been considered to be a form of trauma-focussed CBT that is approved by NICE (NICE, 2005). This paper will argue that the Human Givens (HG) Rewind technique is a form of trauma-focussed imaginal exposure as described by NICE, and will look at the evidence for its effectiveness to support this idea.

In early CBT literature, Brom, Kleber and Defares (1989) found that systematic desensitisation was an effective treatment for PTSD, and this was later developed into Prolonged Exposure (PE) by Foa (1992). Since then there have been a number of different versions of trauma-focussed imaginal exposure treatments, such as Narrative Exposure Therapy (NAT) where clients write down the details of their trauma(s) (Robjant & Fazel, 2010), repeated reading of the trauma account in Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2010), Virtual Reality Exposure Therapy (VRET; eg Watts, et al., 2013) in which people are exposed to a simulator version of the trauma, imagery rescripting (eg Arntz et al., 2007; Grunert et al., 2007) and Muss' version of the Rewind technique (Muss, 1991; Utuza, Joseph, & Muss, 2012). While each of these techniques is distinct, they all involve exposure to the trauma memory using the imagination rather than actually being in the same location where the trauma occurred.

This article will consider whether the HG Rewind can be considered to be trauma-focussed imaginal exposure. There is a description of the technique and a brief history. Comparisons will be made between Rewind and CBT imaginal exposure protocols. Some of the additional benefits of the HG Rewind in relation to CBT will be considered, and whether it is beneficial for HG therapy to be kept as distinct from CBT therapy. If HG Rewind is to be considered to be an imaginal exposure technique like those approved by NICE (2005), there should be some evidence of its effectiveness, which will also be considered. However, it is beyond the scope of this article to consider the detail of HG theory and physiological mechanisms that make the treatment effective.

### **Description of HG Rewind**

Rewind is one of the HG treatment techniques for trauma. Human Givens is a biopsychosocial set of organising ideas for therapy that was established by Joe Griffin and Ivan Tyrrell (Griffin & Tyrrell, 2004) that integrates effective components from other therapies but with a different theoretical framework. See Yates and Atkinson (2011) for a more detailed description of basic HG techniques. HG therapy is a brief solution-focussed therapy, which includes anxiety management strategies, goal setting, graded exposure, informally challenging negative thoughts, and uses imagery, imagery rescripting, an understanding of the trance state, metaphors, and the use of language. Key theoretical principles include the role of REM state, the importance in reducing

emotional arousal in treatment, helping people to meet their innate emotional needs, the assumption that the fight and flight response is fundamentally adaptive (rather than being problem-focussed) and the good use of our natural resources to respond to this. Because these underlying principles are different particularly to first generation CBT, HG's application of methods (eg. not requiring the structured approach with an agenda for each session and written thought diaries that are an integral part of CBT). and emphasis in treatment are different to those in CBT.

HG Rewind evolved from the NLP Visual Kinaesthetic Dissociation (VKD) technique (Bandler and Grinder 1979), who in turn have acknowledged the influence of Milton Erickson's hypnosis therapy (Rossi 1985) and the work of Erich Fromm (Koziey and McLeod 1987) in VKD's shaping. While the Rewind is very similar to VKD, Griffin and Tyrrell (2001) manualised the technique for HG, emphasising those aspects that they felt were important and gave it a theoretical framework with both physiological and psychological components. It is interesting that HG Rewind bears similarities to, but is different from David Muss' version of Rewind that was also developed from VKD in the UK as a trauma treatment technique ((Muss, 1991; Utuza, Joseph, & Muss, 2012). The Rewind technique involves graduated imaginal exposure to the trauma(s), while keeping arousal levels very low to help the brain process the trauma(s) more easily.

Stages of the rewind technique

1. Briefly explain the procedure and create an imaginary 'video' that will be used later in the process. The video starts with a good memory. Then for each trauma or trigger, the video starts before and ends when the incident is over, and then the video ends with a recent good memory.
2. Help the person to become deeply relaxed, including imagining being in a relaxed place.
3. Double dissociation exposure. The person watches themselves watch the video with the traumas backwards and forwards until they feel calm when watching themselves, while in that relaxed place in their mind's eye.
4. Dissociative exposure. The person watches the imaginary video with the trauma memories backwards and forwards until they are calm when watching it, while in that relaxed place.
5. If relevant, the person visualizes themselves reacting in a more helpful way in future.
6. The person is re-oriented to the present.

### **Similarities between Rewind and CBT exposure protocols**

Keane and Kaloupek (1996), describing CBT treatment for PTSD, state that "imaginal exposure therapies for PTSD typically involve some form of graduated exposure to trauma-relevant cues, a procedure which may or may not be accompanied by attempts to maintain fear-antagonistic state such as relaxation". HG Rewind uses relaxation, double dissociation, contextualization, and dual processing to help reduce arousal during the imaginal exposure to the trauma or trauma cues. While the HG Rewind protocol is not specifically mentioned in any CBT manuals, it uses well-known CBT trauma-focused techniques in a specific way.

### **Psychoeducation**

Like in CBT, a brief rationale of the technique is often given before the treatment commences, although this is not mandatory in the HG version. This can be considered to be a psychoeducational component of the treatment, and obviously would differ in content from CBT formulations because the theory is different as mentioned above. Sometimes the biological explanation can be given after the treatment to help the client understand why they feel differently after treatment when they recall the trauma memories.

### Repeated exposure

In CBT exposure treatments, the imagined scene can be repeated multiple times, sometimes even as homework (eg Foa, Hembree, & Rauthbaum, 2007), until the anxiety has subsided. In HG Rewind, the imaginal recall of the trauma memory is repeated forwards and backwards repeatedly until the anxiety has subsided too, but this happens within one treatment session. An interesting aspect of HG Rewind is that the exposure tends to speed up as the imaginal exposure progresses. It is not clear whether the memories speed up because they are getting processed, or if they need to speed up to facilitate the processing. This aspect of repeated exposure in traditional CBT is usually not commented on, perhaps because the exposure often happens over a period of weeks rather than in one session.

### Graduated exposure

In HG rewind, not only is the trauma repeated but graduated exposure to the traumatic event(s) is built into the protocol. Initially, the exposure is to watching themselves watching a video of the trauma. When they are no longer anxious doing this, they then watch themselves in a imaginal video of the traumatic event(s), again, until they are relaxed while watching the trauma. Keane and Kaloupek (1996) acknowledge that graduated exposure to trauma-related cues is a typical part of trauma-focused exposure in PTSD treatments (eg. see Foa, 1992).

### Imaginal exposure

In the original CBT imaginal exposure protocols, the client imagines the scene and describes it verbally in detail to the therapist. More recently, this has also been done in writing (Robjant & Fazel, 2010) too. However, in HG Rewind, the client does not need to verbalise any details of the trauma, and instead they replay the memory of the trauma in their imagination. Because it is in their imagination, it can easily include sensory aspects of the trauma memory such as sounds, smells and sensations, all of which can be part of traumatic recall. In this sense, HG Rewind could be considered to be a more pure form of imaginal exposure than other verbal or written CBT versions because it is not limited by language. Being non-verbal, the exposure is able to happen more quickly because it is not constrained in speed by the use of language. Only relatively recently has imagery been seen to be a significant feature of emotional memories with in CBT (eg Hagenaars & Holmes, 2012).

### Relaxation

Before commencing exposure therapy, clients in the CBT versions may be trained in coping strategies such as controlled breathing and relaxation to help them cope

afterwards with any anxiety that was induced during the exposure (e.g. Foa, Hembree, & Rothbaum, 2007; Lyons & Keane, 1989). In HG Rewind, the client is helped to relax, usually using controlled breathing and imaginal relaxation but can use any method of relaxation. In the HG protocol while it is important for the fear template to be activated, it is particularly important to ensure that arousal levels do not increase too high during the imaginal exposure, thereby helping their brain to process the memories. Thus, one could say that one difference between CBT and HG is that in HG exposure it is important to use techniques to keep arousal levels low during the imaginal exposure. Whereas in CBT, the emphasis is more on keeping the arousal levels low after treatment for the comfort of the client and the ethics of not leaving the client in a vulnerable emotional state after treatment, rather than relaxation being an integral part of the trauma memory processing. NICE (2005) does not recommend relaxation alone as a treatment for PTSD, but more detailed research is needed as to whether it enhances processing or user experience of exposure treatment.

### Observing self

The step of watching oneself watch the video is a form of double dissociation, which also helps to keep emotional arousal low. Sloan et al. (2012) and Sloan et al. (2013) ask the client to write about their most distressing traumatic event from a distanced perspective without reading the account to the therapist. Thus, distancing the client from the event during exposure is also used in other forms of CBT imaginal exposure for PTSD.

### Contextualise memory

Rewind uses other strategies to help reduce arousal, which are common to other CBT techniques, but aren't usually cited as being an active component of the treatment. Each trauma that is remembered in the HG Rewind starts before the trauma happened and continues until the trauma is over and the client feels safer again. The impact of this is that it also ensures that arousal is reduced after each exposure. It also has the effect of putting the trauma into context, which is in contrast to the fragmented trauma memories. Putting the trauma into context is one of the aims of verbal and written CBT exposure too. HG rewind achieves this contextualisation of the trauma memories non-verbally by including the pre and post trauma in the imaginal exposure.

### Grounding, or safe, place

HG Rewind also uses grounding techniques by having the client vividly imagine themselves in a safe and contented place prior to the exposure to reduce their arousal prior to exposure, and continuing to return to that place in their mind's eye in between exposures to keep their arousal lower during exposure. Rewind uses mindfulness type of techniques by getting the client to vividly use all of their senses to focus on their 'nice' place in the imaginal relaxation phase. Clients typically really enjoy this part of the treatment protocol. Using grounding techniques to reduce arousal, distress, manage flashbacks are a common part of CBT trauma-focussed treatment (eg. Keane & Kaloupek, 1996). While grounding techniques are used in trauma-focussed CBT, particularly to help with flashbacks, they tend not to be used in this specific way to help keep arousal levels lower during imaginal relaxation.

## Dual processing

Rewind uses dual processing to help reduce arousal during the exposure to the trauma memories. Part of the HG protocol is for the client to think of the memories backwards in a therapist directed way, which is where Rewind gets its name. By thinking of the memory backwards, the client needs to be thinking of the process of how a memory would look like backwards in the present while experiencing the trauma memory from the past. One can only think about one thing at a time (Levitin, 2014) and multi-tasking is actually quick switches of attention. It is likely that dual processing occurs in trauma-focussed CBT when a person is experiencing their fear at the same time as looking at the evidence or considering what they know now. This means that there is slightly less attention on the trauma memory during exposure which reduces arousal. This could be seen as similar to the eye movements in EMDR, where a person's attention is split while recalling the memory. It is likely that the dual processing while recalling the trauma memory is one of the mechanisms that helps trauma therapy be effective (Griffin & Tyrrell, 2005), but it is beyond the scope of this paper to discuss this further.

## Reduced arousal levels

While the Rewind protocol uses many ways to reduce arousal, the exact means of reducing arousal is less important than just having the arousal reduced. HG theory would postulate that it is because the arousal levels are lower when re-experiencing the trauma memory that the memory gets reprocessed and the anxiety reduces. Emotional arousal can be reduced in many ways in other therapies, which may help to make them effective. For example, emotional arousal is reduced by trust in the therapeutic relationship, or through distraction via the eye movements in EMDR, or through the use of propranolol (eg Donovan, 2010), or even playing Tetras (eg. Holmes, James, Kilford, Deeprose, 2010). The reduced arousal during the imaginal exposure in rewind may make the treatment more tolerable and even enjoyable for some clients.

For severely traumatised clients, it has been recognised within the NICE guidelines exposure to the traumatic event might be initially too overwhelming, and that time may be needed to establish a relationship and learn coping strategies before starting exposure work. This is usually achieved in the HG Rewind through the discussion prior to the Rewind treatment and this first stage of exposure. While observing themselves watching the video of the trauma(s), the client is not only observing that their anxiety will subside, but also how to relax by focussing on the grounding place between exposures. Thus, the Rewind protocol helps the final exposure to the trauma be less overwhelming.

In summary, HG Rewind has all of the components of imaginal exposure for PTSD; recalling the trauma memory in the imagination including sensory information, repeating the exposure until the anxiety subsides, and starting prior to the trauma and ending when the trauma is over. Similar to other CBT exposure paradigms, HG Rewind has a graded component, distancing, and includes relaxation strategies and a grounding place to help reduce arousal. Thus, HG Rewind is a trauma-focused imaginal exposure paradigm which incorporates many CBT techniques. But why should HG and CBT be kept as distinct?

### **Benefits to keeping HG and CBT distinct**

Adams (2008) points out a danger of new treatments being labelled as a form of CBT; new techniques can be used if they are called a version of 'CBT' without any evidence of effectiveness. NICE further confounds the issue by using the term 'CBT' as an abbreviation of 'psychological therapy' (eg NICE 2013). Some of the second and third generation CBT therapies like mindfulness and acceptance and commitment therapy bear no resemblance to the original proven CBT techniques, but initially were able to be used and accepted because they were versions of CBT. The practice of new techniques being considered as part of CBT and therefore approved by NICE can verge on being unethical, leading people to believe that there is evidence for effectiveness when there may or may not be.

CBT and HG therapy have complementary but different theories of what makes treatment effective. For example, CBT places more of an emphasis on modifying negative thoughts and HG theory places more of an emphasis on, reducing emotional arousal during exposure, using the REM state, meeting our innate emotional needs, and the good use of imagination. Consequently, there is also a different emphasis in the use of techniques. As a result of keeping theories and therapies distinct, this can generate more research questions and eventually greater understanding on the mechanisms and the active ingredients of therapy (eg. Tolin, 2009). For example, is modifying negative thoughts essential for improvement in PTSD? Or is it the reduced arousal as a result of the reduced perceived threat from modifying the negative thoughts that produces change? While research has compared these two techniques and found both to be effective (eg Jonas et al., 2013; Marks et al. 1998; Watts et al, 2013), it would be interesting to test the significance of reduced emotional arousal. While the negative thoughts are not specifically addressed in the Rewind, it could be that negative thoughts are modified during Rewind, like in behavioural activation for depression that does not directly address negative thoughts but has been shown to modify the negative thoughts nonetheless (Jacobson, et al. 1996). Is it the contextualising and reorganising the memory that can happen through hippocampal processing (eg Brewin, 2011), facilitated in Rewind because the protocol includes pre and post trauma in the exposure? Could this be more important than emotional arousal or modifying negative thoughts? Or does hippocampal processing happen due to reduced arousal (LeDoux, 2002)?

Finally, if every psychological therapy is called CBT, it means that identifying the helpful differences between the therapies could be lost. If Rewind were to be considered a version of CBT rather than a trauma-focussed imaginal exposure in its own right, some of the specific benefits of HG Rewind theory and protocol could be lost.

### **Additional benefits of HG Rewind treatment for PTSD**

Unlike other NICE recommended treatments for trauma, imaginal exposure in the Rewind protocol is done by recalling the trauma(s) through visualizing, rather than verbalizing or writing down the details of the trauma. This has several implications: the person does not need to talk about their trauma in detail, which could have

benefits for both clients and therapists, and many traumas can be effectively treated in one session.

### Accessibility of treatment and attrition for shame-based trauma

As many as 30–60% people who have been exposed to trauma do not seek help, refuse CBT approaches, drop out of treatment, or are not significantly helped by them (e.g., Bradley et al., 2005; Schottenbauer et al., 2008). For those who are very avoidant of the trauma, or for whom the trauma is a source of great embarrassment or shame, not having to talk about the trauma in detail may make treatment more assessable to those who might otherwise avoid treatment. Particularly for honour-based cultures, being able to access treatment for shame-based traumas may be important.

Indeed, within the refugee population, it has been proposed that embarrassment or distrust may have potentially led participants not reporting rape or sexual abuse (e.g., ter Heide, Mooren, Kleijn, de Jongh, and Kleber, 2011; Tankink & Richters, 2007). Spinazzola, Blaustein and Van der Kolk (2005) found pre-treatment attrition rates to be 35-37%, and Paunovic and Ost (2001) found pre-treatment attrition rates of 41.2% with asylum seekers and refugees, indicating that a large proportion of populations with potential shame-based traumas may not access treatment. Adams (2013) found preliminary evidence suggesting that when client's know that they do not need to discuss the details of their trauma, some of them who were not going to access treatment are able to do so.

The process of having to talk in detail about incidents that bring shame may increase the sense of shame, and may also lead to withdrawal from treatment. Kilpatrick and Best (1984) and Pitmann et al, (1991) suggested that high treatment attrition rates may be as a result of high levels of anxiety initially induced by exposure to the trauma memory. However, Foa et al. (2002) found that while anxiety and depressive symptoms could increase after the start of imaginal exposure in PTSD, this was not associated with attrition rates. In a review of 25 studies of the treatment of PTSD, Hembree et al, (2003) did not find significant differences in attrition rates between exposure and other trauma focussed treatment protocols. However, these studies did not look at whether shame-based traumas like rape had higher rates of attrition, or whether ethnicity was relevant. Also, in the protocols that were looked at, there was not a treatment protocol that did not involve talking in detail about the trauma. In a pilot study with refugees, ter Heide, and her colleagues (2011) found that one person dropped out of EMDR treatment early because they were feeling better and one person stopped treatment because they did not want to speak about their past. It may be that the attrition rates in trauma-focussed treatments may be due to some people finding it difficult to tolerate talking about details of the trauma to a therapist, and would be interesting to note if attrition rates are lower for Rewind.

### Reduced secondary traumatic stress in therapists

In addition, when a therapist does not hear the details of the trauma it likely to have a positive impact on secondary traumatic stress in therapists. Estimates of the prevalence of secondary traumatic stress vary from 6% to 26% in therapists working with traumatised populations (Bribe, Hatcher & Humble, 2009; Craig & Sprang,

2010; Ewer, Teesson, Sannibale, Roche, Mills, 2014; NCTSN, 2014). Indeed, the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed.) (DSM-V; APA, 2013), repeated or extreme indirect exposure to aversive detail of the event(s) in the course of professional duties is acknowledged as a qualifying event for PTSD. The amount of exposure to traumatic material in therapy has been linked to compassion fatigue and burnout (Craig & Sprang, 2010), and secondary traumatic stress (eg. Baird & Kracen, 2006; Ewer, Teesson, Sannibale, Roche, Mills, 2014). More research will clearly be needed to investigate whether the use of techniques that do not require the details of trauma reduce secondary traumatic stress, vicarious trauma, burnout, and compassion fatigue in therapists.

### Potential cost effectiveness

The process of visualising or remembering an event is faster than describing it verbally. As a result, a single trauma can have many exposures in one session, rather than needing several sessions as in prolonged exposure. Multiple traumas can also be treated in one session. The implications of this are that treatment can be completed in fewer treatment sessions (see below). Not only does this mean that the clients recover more quickly and have less distress, but the potential cost savings of this are enormous.

If Rewind is a trauma-focussed exposure treatment like NICE (NICE, 2005) recommends, then there should be some evidence of its effectiveness.

### **Evidence of HG Rewind's effectiveness**

Corps (2008) did a literature review of Rewind therapy and found that early evidence for the HG Rewind technique was based on individual case reports and a small study that were not scientifically rigorous. Ashton (2005), Bishop (2007), and Griffin and Tyrrell (2006) and all described brief cases indicating the possible effectiveness of a single rewind session in reducing flashbacks and improving mood and relationships. However, none of these early reports used standardized measures.

More recently, Yates and Atkinson (2011) presented three case examples of adolescents being treated with HG therapy, including rewind. Each had six treatment sessions with their anxiety, depression, and self-esteem measured by the Beck Youth Inventory, Second Edition (BYI-II; Beck, et al, 2001) before and after treatment, and at 3 month follow-up. All cases improved after treatment and the improvement continued at follow-up. Those who were 'above average' pre-treatment for anxiety and depression were 'below average' post treatment.

In an earlier study of 30 people with a diagnosis of PTSD, Guy and Guy (2003) reported increased confidence, positive mood, and a new ability to speak about the trauma without difficulty after the rewind treatment. Eleven people in this sample were treated for multiple traumas. While these reports did not use standardized questionnaires, they nonetheless indicated that multiple traumas could be treated in a single session, and that flashbacks, mood, confidence, and relationships could be improved.

In 2007, Murphy looked specifically at the efficacy of the rewind technique on

PTSD in 47 people who were treated in a trauma center in Northern Ireland. None of them met the criteria of PTSD after treatment was completed. Of this sample, 27 only had one rewind treatment session, and 10 of those were treated for multiple traumas. Those 20 people who had further treatment, these included different types of treatment like CBT and art therapy. This study suggests that a single rewind session could be effective and treat multiple traumas, and that a single Rewind treatment session can also effectively be followed by other types of therapy.

Guy and Guy (2009) treated 97 clients with PTSD with HG therapy in 6 treatment sessions each. Pre and post-treatment scores on the Impact of Events-extended version (IES-E) were compared, with average scores reducing from 68 (severe) to 18 (normal). On the IES-E, 50+ is severe (probable PTSD), 40-49 is moderate and probably needing treatment, 30-39 is mild and < 30 is in the normal range. These results show very significant improvement in both mild and severe cases within 6 treatment sessions.

Bishop and O'Callaghan (2010) presented research with 34 war veterans. Average scores on the IES-E reduced from 67.24 (severe) to 28.88 (normal) in eight sessions or less (3.11 sessions average). In 94% of the veterans, the trauma(s) happened over 5 years before treatment, with 76% having multiple traumas, suggesting that HG treatment for PTSD can be effective for chronic and multiple traumas, using an average of less than 4 treatment sessions.

Dale (2012) looked at both quantitative and qualitative data on war veterans treated with HG Rewind. 43 veterans were treated, with an average pre-treatment score on the IES-E of 65.65 (severe) and an average post treatment score of 33.84 (mild). Of those treated, 13 could not be contacted or did not meet the inclusion criteria. Eleven people were interviewed and three additional people returned the follow-up questionnaire but declined to be interviewed. Of those interviewed, seven (64%) were very clear that before treatment their alcohol misuse was linked to their PTSD symptoms, and four (57%) stopped drinking when their PTSD resolved and three (43%) reported using alcohol to a lesser extent to manage life stressors after treatment. All eleven people said they found HG therapy improved their ability to cope. Nine (82%) said they found the sessions helpful and were not longer troubled by the traumas, and two (18%) said they found them partially helpful. Six (55%) people said they found current stressors that were not related to the military to be problematic. Ten (91%) felt that it was unnecessary for the therapist to have a military background. Nine (82%) said that they had experience of other therapies prior to HG treatment. Seven out of nine (78%) said they found a lack of understanding from GPs or NHS counselors, three people found talking therapies unhelpful, two found EMDR unhelpful, and two found group therapy unhelpful. One found mindfulness helpful, three found relaxation to be helpful, and one found meeting others in a group to be helpful. Some found some past treatment to be partially helpful; one found CBT to be partially helpful, one anger management, one medication, and two group therapy. While the numbers are not sufficient to draw definite conclusions, it would appear at the very least that HG therapy can be helpful for those for whom other trauma treatments have not been effective.

Andrews (2013) reported on evidence independently collected through the Practice Research Network for PTSD Resolution, a national organization that treats war veterans using HG therapy. Over a three year period, 130 cases were assessed by 51 HG therapists. 131 people completed the IES-E, and average scores reduced from 54 (severe)

pretreatment to 24 (normal) post-treatment. 111 people completed the CORE-10, with average pretreatment scores of 23 (severe) and post-treatment scores of 10.4 (normal range). 83% had 'reliably improved' on the CORE-10 and 56% were below the clinical cut-off at the end of treatment. With regards to the number of treatment sessions, 80% had 6 sessions or less, 52% had 5 sessions or less, and 30% had three sessions or less, with a maximum of 13 treatment sessions.

Adams, Allen and Bristow (2013) reported on a pilot trauma clinic in which 27 people were treated with a single rewind session; 37% did not need further treatment, 37% did not require further specialist psychological treatment but were be 'stepped down' to be treated by less expensive services for comorbid disorders like depression, anxiety and low self-esteem. Only 24% required continued specialist treatment. These results from the pilot study indicate a potentially significant cost savings while allowing more people to be treated with the limited resources. The majority of people said that they would prefer to have access to the trauma clinic for a single specialist treatment than to have to wait longer without any treatment for a course of specialist treatment. Preliminary results indicated that the rewind technique made treatment for shame-based traumas more accessible because people do not need to discuss the details of the trauma(s).

Adams, Allen, and Palmer (2015) presented a study in which 44 people were treated with a single rewind session. 20 people received the rewind in the first treatment session and they were compared to 14 others who received treatment-as-usual in the first treatment sessions and rewind in the second treatment session. On the Clinical Outcomes of Routine Evaluation (CORE-10) questionnaire, improvement of 6 is considered to be clinically significant and a score of 11 or less is considered to be within the normal range. Those who received the rewind treatment session, improved with an average of 6.1 (clinically significant improvement) in just one session from an average score of 17.8 to 11.7 (near the 'normal' range). The treatment-as-usual group for the same session improved by only 1.3 to an average score of 16.1. Those same people had the rewind in the following session and improved by an average of 4.0 after the rewind session, with the average score reducing from 16.1 to 12.1. These results also indicated that a single rewind session could be effective in treating severe, chronic (over 5 years since the trauma), and multiple traumas.

With regards to HG therapy, Andrews, Twigg, Minami, and Johnson (2011) treated 124 patients referred by a GP practice, with an average of 3.75 treatment sessions. CORE-10 scores reduced from 18.5 to 8.8 for those who finished treatment and 22 to 14.5 for those who did not complete treatment. Those who finished treatment showed clinical significant improvement and were in the normal range by the end of treatment, and even those who did not complete treatment still showed a clinically significant improvement. This sample included PTSD patients, but did not specify the number of people with this diagnosis. Nonetheless, people again showed a significant improvement following HG therapy in an average of 3.75 treatment sessions.

In the Sandwell Primary Care Trust, 19 GP practices referred moderately depressed patients into a study (Tsaroucha et al., 2012). 106 people receiving HG treatment for depression were compared to 70 receiving standard interventions as the 'control' group (ie counseling with or without medication). Standardised questionnaires

measuring clinical outcomes (CORE), life satisfaction (Outcome Rating Scale) and emotional needs (ENS) were completed four, eight and twelve months after treatment. The majority of patients needed an average of one to two HG therapy sessions, while the control group needed four to six sessions. Pre-treatment scores were similar for HG and the control group, and both showed a similar improvement in spite of routine treatment needing more sessions. Whether or not patients were on antidepressants made no difference to HG outcomes. Researchers at Staffordshire University concluded that HG therapy would be a cost effective treatment choice for the NHS.

In another practice-based study, Andrews, Wislocki, Short, Chow, and Minami (2013) reported on 3,885 people who were treated by 46 therapists at multiple sites in the UK, using HG therapy (including rewind). 71% of people had 'reliably improved' on CORE and 54% were below the clinical cut off (ie. 'recovered') by the end of treatment. This exceeds the UK Department of Health's target for IAPT services for a 40% 'moving to recovery' (IAPT, 2012). Andrews et al. (2013) compared their results to a similar practice-based study with IAPT using CBT (Clark, et al. 2009), and found HG therapy to be at least as effective as CBT. In addition, average numbers of sessions were slightly larger for the IAPT study (6.35 sessions) compared to 4.69 sessions for the HG therapy to get a similar result.

While there have been several studies on the effectiveness of HG therapy and Rewind there have been no RCTs and only two studies with a control group. Adams (2008) suggested that RCTs were designed to work well for pharmaceutical therapy and are less accessible for psychological treatments. Most of these studies used rigorous practice-based evidence, in which clients are evaluated every session using standardised questionnaires. There are several benefits to this methodology. Firstly, unlike RCTs, the most complex cases have not been excluded and the sample is representative of the types of clients referred for treatment. In RCTs, typically very severe clients with suicidal ideation need to be excluded for ethical and reasons, as they cannot be safely randomly allocated to a waiting list control group. Also, clients with co-morbidity are excluded and these can be more complex to treat. Finally, in the protocol for RCTs, data from those who choose not to participate or drop out of treatment are not included. In rigorous practice-based evidence where data is taken every session, ending data is available on those who do not complete treatment, thereby making the data more accurate than many RCTs because it uses intention-to-treat analysis. With sample bias due to inclusion criteria and attrition rates in typical RCTs (Dossing et. al., 2014), results become potentially less reliable and generalizable than the results from a rigorous practice-based study.

The Rewind results above include different services, different populations and different therapists. One cannot conclude that the improvements were as a result of extraneous variables, if all the results show similar effectiveness. Thus, by introducing variance (in the therapist and location) one can control for the effect of extraneous variables and be more confident with the results. In severe and chronic cases, where the trauma(s) occurred more than 5 years before treatment, if clients show a significant improvement during the treatment and had not done so in the past 5 years, one can more confidently assume that the improvements are due to the treatment and not the natural course of the disorder. If the improvements are similar to those found in RCTs, then one can more confidently conclude that the treatment is effective.

Thus, while there are no controlled studies demonstrating the effectiveness of Rewind and no RCTs on HG therapy, the rigorous practice-based evidence suggests that the Rewind is an effective treatment for trauma, thereby supporting the notion that they can be considered to be a form of trauma-focussed imaginal exposure that could be approved by NICE.

### **Summary**

This article has argued that while HG Rewind is different to other CBT trauma-focused exposure treatments, all the aspects of the treatment protocol do fall within CBT treatment techniques, and it could be considered to be a trauma-focussed imaginal exposure CBT technique. In spite of this, there are benefits for HG therapy remaining distinct from CBT therapy. Seeing them as distinct may help to generate more research questions and further help broaden the understanding of PTSD treatment. Rewind differs from other trauma-focussed CBT techniques in that people do not need to talk about the trauma(s) in detail and multiple traumas can be treated in one session. The potential benefits for shame-based traumas, reducing vicarious therapist trauma, and cost-effectiveness were briefly considered. Finally, while the evidence does not have any RCTs, the preliminary evidence would suggest that HG Rewind is an effective treatment for trauma, although more research is clearly needed.

Taken together, HG Rewind is a trauma-focused imaginal exposure technique. Both the protocol and empirical support the notion that HG Rewind could be considered to be effective trauma-focused CBT. Nonetheless, there are many benefits to HG Rewind remaining a similar and yet distinct therapy.