The Rewind Technique

Adapted by Courtenay Young

This is a description of the "**rewind technique**", sometimes called the "visual-kinesthetic dissociation technique" (v-k dissociation / vk dissociation). This approach has been proposed as a successful treatment for post-traumatic stress disorder (PTSD), and essentially consists of a set of instructions for 'imaginal exposure', with suggestions for separation / distance / 'dissociation' from the image of the actual events. It is not a verbal re-telling of the traumatic event: this can possibly re-traumatise.

Empirical evidence for the use of this 'imaginal exposure' technique in the treatment of trauma is, to date, quite limited. The use of 'imaginal exposure' as part of a treatment plan implemented by suitably a qualified professional however is supported by the data. The description here is of a technique similar to that used in a 1996 study by Hossack and Bentall. It has been adapted and built-on by a number of practitioners since then.

It must be emphasised that this technique – as well as other methods of working with trauma – should only ever be practiced by an experienced and qualified psychotherapeutic practitioner. Traumatised people are extremely vulnerable and it is all too easy for them to become re-traumatised. This technique – and others – should not be done as a "one-off" or a "quick fix", but only as a part of an on-going series of psychotherapy sessions.

Another 'caveat' is not to ignore the person's feelings, especially those that were existing in or shortly after the trauma – and might have been supressed by the trauma. Allowing these to come out – and to be expressed – is essential for discharging and 'normalising' the trauma.

1. Use appropriate relaxation exercises before beginning the 're-living' or 're-wind' technique, or (if qualified) use a hypnotic induction technique.
2. Start with an introduction along the lines of: *"I'm going to ask you to do certain things which will help to relieve the distress caused by recurrent images. I will give you directions one part at a time and then I want you to 'go inside' and follow these directions. At each point, I will ask you to nod when have done what I ask.*
3. *If you feel that you can't or don't want to continue, then just shake your head (instead of nodding) or say, 'I want to stop now' and we will stop. I may also suggest that we stop or slow down the process, in order to allow you to give yourself a chance to feel some of the feelings that accompanied the trauma.*
4. I want you to imagine that you are sitting in the middle of a small, cosy, private cinema. It is dark and there is no-one else there, as the cinema has been hired just for you. There is a comfortable seat, the cinema is warm, and you feel quite safe. (Nod when you are there).
5. On the cinema screen, you can only see a black and white snapshot, a 'still' in which you see yourself like a photo taken just before the traumatic event; just before you had the traumatic experience. (Nod when you are there).
6. Now, I want you to imagine that you are floating out of your body, up to (say) the projection room in the cinema, from where you can watch yourself, watching the traumatic events that will appear on the screen. From this position, you will be able to see the whole cinema, including your head and shoulders sitting in the middle of the cinema, and you can also see yourself in the still picture on the screen. (Nod when you are there).
7. When I say so, I want you to imagine turning the projector on (notice the switch), so that the snapshot on the screen turns into a moving film, and watch it at a normal pace (speed) from the beginning to the end. You may see (and may even feel) what occurred at the time, and this might include sounds, smells and other experienced phenomena. When you get past what is the worst point of the experience, or where the memory begins to fade, and you feel relatively safe. Then, I want you to stop the film and allow it to become a still picture again.

8. Now, start the projector and start watching the moving film, now, and begin to see what actually happened. You can stop the film – if, or whenever you want to – as you are standing by the projector, with your hand on the switch. (Nod when you have completed this). If your feelings become too strong, or overwhelming, just stop the projector – and we'll talk about what has happened and what is happening now for you.

9. Allow the film to get to the end – even if we do this in stops and starts. Then, we will rewind the film. It doesn't matter how long this takes; or how many stops; or how emotional you get. This is just the first round. We have to get through this first bit – and it may not be easy.

10. As and when I ask you to go through this again, from your position in the cinema, I want you to go down to the screen, right up to the still picture, and jump into it: jump inside the experience, seeing everything as if it were happening now. Feel the temperature of the air around you, notice what is going on, be aware of any sound, smell, or taste. Embody the experience – fully and, especially, notice any of your feelings.

11. Paying attention to your emotions is a significant and necessary part of the de-traumatisation. It is important that you do not allow yourself to become too upset: too distraught. It is important that you do not re-traumatise yourself, emotionally. If you find yourself getting upset, just slow things down; take a few moments and calm yourself; pause in your process of remembering and re-winding; and then continue with the process.

12. Then, go back to the 'projector room', and run the film backwards at about four times normal speed, so that all the people will move backwards very quickly, everything will move in reverse, just like rewinding a film, except that you are now still – to an extent – inside this film, and you will experience everything happening in reverse.

13. I now want you to do this again and again. The film is now in colour. I want you to experience this traumatic event as accurately as you can. When I say so, go down to the still picture at the beginning and jump inside the experience, go forward to the next 'still' point, and then begin rewinding. (Nod when you are back at the beginning again).

14. Go back to the still picture (at the beginning) again now, jump inside it, and begin letting it run and then, at the end, rewinding it backwards. You can vary the speed, as you like, just like using the playback button on the TV remote.

15. Repeat this experience, covering all the different aspects of the events, if necessary. Go back and forth several times. The still picture is, of course, You – You at the beginning (before the trauma) and You at the end (having survived the trauma). You are now much more in charge of this memory process. You can even do it by yourself, at home. After a reasonably short time, this re-winding process should have de-traumatised the event quite reasonably. If you still feel some strong emotions, or some traumatic effects, then just repeat this several more times.

16. **Suggestion:** Whenever your memory of the trauma becomes re-triggered, you can bring the 'Rewind Technique' in to play, until you get back to the safe starting point and you are left with a good image and then forward to the end point, where you are also now safe.

    You should now be able to get back to normal activities, quite quickly.

Hossack, A. & Bentall, R.P. (1996). Elimination of posttraumatic symptomatology by relaxation and visual kinesthetic dissociation. *Journal of Traumatic Stress, 9(1), pp. 99-110.*

The Rewind Technique

In short, people are asked to imagine floating to one side, out of body, and watch themselves watching the screen on which there is a ‘film’ of the traumatic incident, but without actually seeing the picture (double disassociation). They watch themselves watching a 'film' of the **traumatic** event that is still affecting them.

Counsellors who use it know that the rewind technique is fast, safe, painless and effective for dealing with trauma.

Description

The ‘rewind technique’ is also sometimes referred to as the ‘visual-kinesthetic dissociation technique’. It is an imagery technique used by some therapists in the treatment of traumatic memories. The Rewind Technique worksheet contains therapist instructions for the technique as described in a paper by Hossack and Bentall (1996).

Therapists should be aware that there are many good evidence-based techniques for processing intrusive traumatic memories. These include: prolonged exposure, reliving with updating (enhanced reliving), and eye-movement desensitisation and reprocessing (EMDR). It is believed that a key ingredient in all of these techniques is the component of exposure to the traumatic memory. In theory, therefore, the rewind technique might be helpful given that it contains the element of exposure – like any exposure technique it may be helpful if it helps clients feel safe enough to approach a traumatic memory.

However, therapists should be aware that the evidence for using the rewind technique in isolation is very much weaker – there are no RCTs exploring the use of this technique. It is strongly recommended that an evidence-based treatment approaches for PTSD, informed by an appropriate therapeutic model (i.e. CBT or EMDR) be attempted as first line treatment. Therapists should be cautious regarding unwarranted claims made on the internet regarding the rewind technique – it is unlikely to be a ‘cure all’ or ‘magic bullet’. Clients should be cautious if their therapist is only proficient in the rewind technique and does not have trauma-specific CBT or EMDR training.

"The treatment was like magic.” These were the words of a euphoric client after treatment with Keith for symptoms of **trauma** which had been affecting his life for the past three months. He worked as a gravedigger and had been present during an exhumation. He was plagued by the memory of a dead face grinning at him and of having to handle and walk through a decaying corpse.
"I had started to get nightmares. I didn't sleep very well and I had flashbacks at night. Or, when mowing the grass, something would trigger off the incident," he said. In just one session, using the rewind technique, the panic and anxiety which had dogged him was gone. "I went from not being able to function to functioning. It took the fear and anxiety away."

It is reactions like this, repeated by client after client (see **case study)**, that have made us so keen for the **rewind treatment** to become better known and widely available. Our research study into its effectiveness is, we hope, a first step that will encourage other researchers to test it more rigorously, preferably against other forms of therapy, so that the benefit of rewind can be more forcefully communicated to the thousands of practitioners who need to know about it.

Although Keith had long had an interest in working with trauma and was trained and experienced in using the debriefing model devised by psychologist and former firefighter Jeff Mitchell, it was only when he learned the rewind technique at a MindFields College (now **Human Givens College**) workshop two years ago that he realised trauma could be treated both quickly and reliably, with the minimum of distress to sufferers.

Debriefing, of which there are now many versions, was designed as a group technique, in which trauma victims were encouraged to talk through their experience and impressions of the trauma, with the ‘de-briefer’ guiding them in their exploration of associated facts, thoughts and feelings. Many elements of the debriefing have repeatedly been called into question, including the tendency to offer it very quickly after a traumatic incident occurred. It is always inappropriate to attempt to debrief people who are highly aroused or distressed. Also, as international trauma expert Noreen Tehrani has pointed out, group debrief sessions may be harmful to highly imaginative participants, who become traumatised by the visualisation of others' experiences, and are unlikely to help those with severe trauma reactions. [1] However, just as worryingly, many debriefers have simply adapted group debrief models for individual use. The rewind technique, in contrast, does not require people to go into detail about their experience in order to neutralise its impact and, we have found, is consistently effective.

How it works

The rewind technique, also known as the "fast phobia cure", evolved from the technique developed by Richard Bandler, one of the co-founders of Neuro Linguistic Programming (NLP). He called it the 'VK dissociation' technique (the V stands for visual and the K for kinaesthetic — feelings). The **version recommended** by the European Therapy Studies Institute has been refined and streamlined, as a result of its own research into why and how best it works. [2] It is highly useful for individuals who, after exposure to traumatic events, have developed PTSD or lesser forms of the condition. When Keith began practising the rewind technique with traumatised clients, he found it consistently effective, almost immediately.

Simply described, the technique works by allowing the traumatised individual, whilst in a safe relaxed state, to reprocess the traumatic memory so that it becomes stored as an 'ordinary', albeit unpleasant, and non-threatening memory rather than one that continually activates a terror response. This is achieved by enabling the memory to be shifted in the brain from the amygdala to the neocortex.

The amygdala's role is to alert us to danger and stimulate the body's 'fight or fight' reaction. Normally, all initial sensations associated with a threatening experience are passed to the amygdala and formed into a sensory memory, which in turn is passed on to the hippocampus and from there to the neocortex where it is translated into a verbal or narrative memory and stored. When an event appears life-threatening, however, there can be sudden information overload and the sensory memories stay trapped in the amygdala instead of being passed on to, and made sense of by, the neocortex. While trapped in the amygdala, the trauma memory has no identifiable meaning. It cannot be described, only re-experienced in some sensory form, such as panic attacks or flashbacks. The rewind technique allows that sensory memory to be converted into narrative, and be put into perspective.

The Rewind Technique:

The rewind technique should be carried out by an **experienced practitioner** and is only performed once a person is in a state of deep relaxation.

When they are fully rested, they are encouraged to bring their anxiety to the surface and then are calmed down again by being guided to recall or imagine a place where they feel totally safe and at ease. Their relaxed state is the deepened and they are asked to imagine that, in their special safe place, they have a TV set or other device with a screen, and a remote control.

They are asked to imagine floating to one side, out of their body, and just watch themselves watching the screen, without actually seeing the picture (double disassociation). They watch themselves watching a 'film' of the traumatic that is still even affecting them. The film begins at a point before the trauma occurred and ends at a point at which the trauma is over and they feel safe again.

They are then asked, in their imagination, to float back into their body and experience themselves going swiftly backwards through the trauma, from safe point to safe point, as if they were a character in a video that is being rewound. They then watch the same images, but as if on a TV screen, while pressing the fast-forward button (disassociation). All this is repeated back and forth, at whatever speed feels comfortable, and as many times as needed, till the scenes evoke no emotion from the client.

If the feared circumstance is one that will be confronted again in the future - for instance, driving a car; or using a lift - the person is asked, while still relaxed, to see themselves doing so confidently.

Besides being safe, quick, and painless, the technique has the advantage of being non-voyeuristic. Intimate details do not have to be made public.

Rewind Technique? What's that?

We were both so impressed by Keith's initial results when working with the technique that we were quite stunned to discover rewind is not used routinely in the UK to treat trauma. We carried out a literature review and found only one research paper, which appeared in the British Journal of Clinical Psychology in 1991 and was an account of a very successful use of rewind with traumatised officers in the West Midlands police force. [3] An internet search found only one UK practitioner, a UK-based American GP, Dr David Muss, who is involved in trauma work and was the author of the one research paper we had found. We next telephoned the main trauma hospitals including The Maudsley in South London and various hospitals in the Priory group, which specialise in treating post-traumatic stress. None of them was using rewind. Finally, we contacted police forces, fire services and occupational health services in seven counties and none had even heard of it.

It would seem that the European Therapy Studies Institute is the only UK body actively promoting and, through MindFields College, offering training in rewind but still relatively few professionals know about it. As Keith

was at the time working for Coventry City Council, offering a counselling service to its employers, and thus had access to very many clients, we decided to conduct a long-term study. Our aim was to establish empirically the efficacy and applicability of rewind, with the intention both of challenging the use of less effective established treatments and promoting the routine use of rewind as a trauma treatment.

Coventry City Council has over 17,000 employees working in a wide range of capacities. They include, for instance, secretaries, managers, refuse collectors, cemetery operatives, social workers, teachers and university staff. Coventry is forward thinking in that it recognises that it is not only problems directly related to work that adversely affect **work performance**, but problems that spill over from personal life. As a consequence, the counselling service would deal with the whole gamut of life-affecting experience, from bullying, **relationship problems** and **alcohol dependence** through to **depression**, phobias and **panic attacks**, whatever the causes.

Our study

Thirty people took part in our study (26 women and four men). They comprised all the council's employees who attended for counselling in the two-year period between 2000 and 2002, having been diagnosed as suffering from post-traumatic stress disorder (PTSD) or partial PTSD. Their ages ranged from 25 to 62, with an average age of 42. They differed widely in terms of jobs and seniority, but teachers accounted for the highest number in any single occupation (13 per cent). Fortythree per cent held clerical positions.

Twenty-nine people had experienced a single or multiple traumatic event(s) that had continued to impact upon their well-being. (Four fulfilled the accepted diagnostic criteria for PTSD, [4] while 25 were experiencing partial symptoms.) Eighteen clients were treated for one trauma, while 11 were treated for two to five traumas. The remaining person had a phobia about heights (thus also a fear of flying) and enclosed spaces such as lifts.

The traumas treated had occurred, in one case, as recently as one month ago and, in another, as long as 46 years ago. Types of trauma included psychological bullying, physical and sexual assaults including rape and sexual abuse, car accidents, muggings, the witnessing of critical incidents, being trapped in lifts and the London Underground, and war experiences (one man was a Falklands veteran). The most common traumas were assaults and muggings.

All participants were asked if they were experiencing difficulties in other aspects of their lives as a result of the trauma or phobia. Almost all reported experiencing problems in at least one area, the three most common being relationships, family or, particularly, work. One man had a history of mental ill health, which included clinical depression; 27 per cent of the women had also experienced depression but the rest had no previous history of mental ill health. Eight per cent reported previous significant physical health problems.

Earlier treatments sought

Seventeen people had sought treatment for their trauma symptoms prior to rewind. Eleven had been prescribed antidepressants and/or sleeping tablets and/or tranquillisers (and two more were offered medication but refused it). Of those who took medication, two found it helpful, and another four found it helpful to some degree but made comments such as, "It did not make me happy"; "It didn't stop the dreams"; "They are only useful for the short term"; and "It was some help".

Eight clients underwent counselling, three of whom found it helpful, although one added that it helped only in the short term and didn't solve the problems being experienced. Three clients said that the counselling they received did not work at all and actually made them feel worse. Two didn't comment. Three clients received psychiatric help, and three sought complementary treatments, which included hypnotherapy, aromatherapy and a herbalist massage. The aromatherapy was perceived as helpful but only in a very limited, short term way. No client was offered rewind by their GP, the psychiatric services or private counsellors they went to.

Each client underwent an assessment session to allow Keith to determine suitability for rewind, to establish rapport and trust, and to explain the purpose of the study and how rewind works. Before having the rewind treatment (see box on page 32) they were asked to rate their wellbeing on a scale of 0 to 50, where 0 is poor and 50 excellent.

The questionnaire

We devised a questionnaire which all of the participants in our study agreed to complete seven to 10 days after treatment, with a final section to be completed between three and six months later. Besides asking the questions which enabled us to find out the information described above, we also asked people to scale from 1 to 10 (where 1 is poor and 10 is excellent) how they had been affected since the trauma, and to scale the level of distress they were experiencing. We asked them to scale their willingness to try rewind; the physical,

emotional, social, personal and behavioural effects on them of rewind; and their rating of the technique. We hoped to establish:

- overall success rate of rewind, as measured by clients in terms of their physical, behavioural, emotional, social and personal lives
- success rate correlated to how long ago the trauma had been experienced
- success rate correlated to type of trauma
- success rate correlated to number of traumas experienced
- success rate correlated to the having or not of previous treatment relating to the trauma
- success rate correlated to unrelated problems in client's life
- success rate correlated to client's openness to treatment.

The completed questionnaires were analysed by an independent research company.

The findings are exciting

Forty per cent of clients rated rewind as extremely successful; 53 per cent rated it as successful and seven per cent rated it as acceptable. No one rated the method poor or as a failure.

Prior to rewind, clients on average rated their well-being as 12 out of 50. Seven to 10 days after treatment, the average score was 30.3 out of 50. Three to six months later, the average score was 32.2. This represents an improvement of 167.4 per cent on their original ratings.

On a scale of 1—10 (1 is unwilling, 10 is very willing), clients on average scored 9 on willingness to try this type of treatment. The average level of distress immediately prior to treatment on a 1—10 scale (10 highly distressed) was 6.2.

On a scale of 1—10 (where 10 is excellent), the degree of relaxation induced by the counsellor (Keith) just prior to treatment was 7.8.

Age, sex, occupation, type of trauma and length of time since trauma was experienced did not affect the efficacy of rewind.

Seventeen clients needed one session of rewind, 11 clients needed two, and two clients needed three sessions. However, in no case did the same trauma need to be treated twice. All clients with a single trauma needed only one session. On average, clients needed four rewinds in each session.

In general, the presence of other areas of difficulty in clients' lives did not affect the efficacy of rewind. There were two exceptions: in one case there was an outstanding claim for compensation and in another an outstanding inquest. Outcome from using the technique was probably least satisfactory for these two people.

The client treated for fears of heights, flying and enclosed spaces has fully overcome them. She had been transferred to the 13th floor at work and had previously been planning to resign. She is now not only able to work high up in the building but also to use a lift. She recently flew to India with no difficulty.

Quite evidently, rewind is a consistently successful trauma treatment, with dramatic improvements in clients' wellbeing, self-esteem and capacity for a more fulfilling life, sustained over time. It consistently works in one session, although multiple traumas may need additional separate sessions.

Clients were able to clearly understand and measure their own increase in wellbeing and decrease in unwelcome symptoms. The most commonly mentioned effects that rewind had on the client' lives were:

- increased confidence
- no more flashbacks
- more positive mood
- ability to speak about the trauma without triggering alarm or difficulty
- no more fear

The fact that the treatment was quick, easy and painless was commented on by very many and most said they would recommend the method to others. No other treatment was deemed to equal its success. One client's comment, we think, sums up exactly what rewind aims so successfully to achieve in the treatment of trauma: "I can still recall the picture but it doesn't have the emotional punch. It doesn't hold emotional power any more."

We must profess ourselves unable to understand why rewind is not a routinely available trauma treatment, or indeed cure. The only caveats seem to be that, if there is "unfinished business" which makes the trauma ongoing (such as compensation claims or, of course, continued abuse), this can over-lie a client's ability to move on from trauma.

Back in perspective

It is our sense that trauma is often seen within the mental health profession as a long-term problem, and is perhaps more often misdiagnosed than diagnosed. Some of the symptoms, such as dissociation, hallucinations and intrusive memories, can be mistaken for symptoms of **psychosis**, and treated accordingly.

Also, certain treatments — those which encourage the reliving of the trauma — can deepen it and further embed it. Rewind, however, puts a trauma into perspective very neatly. The treatment takes only a short time, perhaps close to the length of time the incident took to occur — a terrible experience but a tiny part of an entire life. By relocating the traumatic memory from one part of the brain to another — the place where it was meant to end up in the first place, it re-balances the experience within a person's life.

Most of the people we work with just want to put their experience into proper perspective, not suffer symptoms any more, and get on with their lives. Rewind is not only powerfully effective in that respect but side effect free. It is also suitable for use with children. We are determined to press for rewind to be recognised and adopted as a first line treatment for trauma symptoms, accessible to all who need it.

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Case Study - They Came in the Night:

How a modified version of the rewind technique helped heal the emotional wounds of a family subjected to savage violence in a country torn by civil war.

Elena, Tom and three-year-old Anna were sleeping in their small home in a war-troubled country. Tom woke at the noise and roused Elena, who dressed quickly, tied Anna to her back and, at Tom's urging, tried to escape through the kitchen window while he went out to face the government troops. Elena was caught after only a few yards and was roughly brought to the front of her home and thrown to the ground.

The soldiers beat her husband, accusing him of belonging to the opposition party. They then turned their attention to Elena and, with a semi-conscious Tom pinioned and forced to watch, they gang-raped her. Anna was still strapped to her mother's back for most of the attack, which ended with a rape with an AK47. The soldiers then climbed back into their government vehicle and drove away. Villagers appeared from their hiding places and took the family to the nearest clinic where they were treated. Elena took a long time to heal physically. She is now HIV-positive.

The traumatised family was brought to me for counselling. Anna would not allow her father anywhere near her and screamed and went rigid if he tried to connect with her. Presumably, she blamed him for not protecting them and now grouped him with 'the bad men'. Elena and Tom both responded to the **rewind technique** (a way of removing emotional over-arousal associated with a traumatic experience by 'rewinding' and 'fast-forwarding' through it, while relaxed) and it was clear that Anna also badly needed help to overcome the terrible trauma. But how could a three-year-old without the language skills be led through the technique? I hit on the idea of using actors to enact the sequence of events, simulating the rewinding and fast -forwarding of the scenario.

Elena and Tom belong to a culture that employs trance states regularly and the shaman has an important position in the community. After discussions, the local shaman agreed to assist in this variation of the rewind technique with Anna. As I had been involved with the counselling of victims of political torture in the area, I had had many past dealings with this shaman and knew him to be 'safe' in terms of his political affiliations.

I asked for the help of a troupe of actors with whom I had close ties and whose integrity could be trusted. Tom and Elena rehearsed them for accuracy and they had to perfect rewinding and fast-forwarding the action. I showed Anna a tape of The Lion King (she had never seen a television or video before) and we rewound and fast-forwarded it, showing her how to use the remote control. Like any three-year-old, she took great delight in playing with the tape and making things move the wrong way or speeding them up! I then taught her to rewind or fast-forward at my instruction. Elena explained to Anna that I had removed their fear about the horrible men and now we were going to take her pain and fear away too. Then the shaman put Anna into a deep state of relaxation.

We used my garden, after dark, lighting a fire and placing Anna close to it, as the shaman used the movement of the flames to help induce and maintain the trance. The shaman then showed her herself (a young actor dressed as Anna) watching the enactment of the traumatic scene, starting before the soldiers arrived and ending with their rescue and arrival at hospital. He ensured she relaxed again, and kept her as calm as possible throughout the scene. She was given the remote control and told she should wind it backwards from the arrival at hospital. I watched from behind and, as she pressed the button, I indicated to the actors, who went into fast rewind. When they got to the beginning, she was told to fast-forward, and again I indicated to the actors. It took nine sequences before Anna could watch the scene without any emotion.

Then the acting area filled with 'smoke' (dry ice) and the shapes of the actors slowly disappeared, as if by magic! Before bringing Anna out of the trance, the shaman told her that her father was a very brave man and was trying to stop those bad people from hurting others. When she was returned to normal consciousness, Anna ran to her mother and then, tentatively at first, took her father's hand. They returned to their village, a proper family once more. The actors all said they would never give such a satisfying performance again — ever!

It is evident that the rewind technique is very flexible and can be adapted to any cultural situation. As in this case, one can even weave actual and imagined portrayals of events together. We also mixed media, with a remote control changing real actors' movements. As in dreams, nothing is too bizarre to be believable. The shaman continues using the rewind technique for post-traumatic stress treatment in the villages. And I hope and pray that the soldiers never returned to that little family.

All names, including the author's, have been changed to protect the identity of the subjects.