

Energy Psychology Treatment for Posttraumatic Stress in Genocide Survivors in a Rwandan Orphanage: A Pilot Investigation

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Abstract

A team of four energy therapy practitioners visited Rwanda in September of 2009 to conduct trauma remediation programs with orphan genocide survivors with complex posttraumatic stress disorder (PTSD). The program consisted of holistic, multi-dimensional rapport-building exercises, followed by an intervention using Thought Field Therapy (TFT). Interventions were performed on three consecutive days. Data were collected using the Child Report of Post-traumatic Stress (CROPS) to measure pre- and post-intervention results, using a time-series, repeated measures design. $N = 48$ orphans at the Remera Mbogo Residential High School Or-

phanage with clinical PTSD scores completed a pretest. Of these, 34 (71%) completed a post-test assessment. They demonstrated an average reduction in symptoms of 18.8% ($p < .001$). Seven students (21%) dropped below the clinical cutoff point for PTSD, with average score reductions of 53.7% ($p < .001$). Follow-ups are planned, to determine if participant gains hold over time. Directions for future research arising out of data gathered in this pilot study are discussed.

Keywords: energy psychology, TFT (Thought Field Therapy), genocide, children, Rwanda, rapport

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A strategy for government-sponsored genocide against a minority group in Rwanda called Tutsis was in the planning stages for several years before it occurred. Evidence mounted in early 1994 that the Hutu majority government leaders had made lists of every minority Tutsi in the country, and were plotting systematic extermination of this group (Adelman, & Suhrke, 1996; Smith, 1998). General Dallaire, the commander of the UN peacekeeping force, urgently requested reinforcements, and permission to intervene. His request was denied by the UN (Dallaire, 2003).

With the assassination of the Rwandan president April 6, 1994, a bloodbath began that started with moderate Hutus. "...Anyone who publicly opposed the genocide, by word or deed, risked being executed or condemned to kill a victim on the spot. Everybody had to participate in some way...." (Hatzfeld, 2003). Gourvevitch (1998) reported that, "Although the killing was low-tech—performed largely by machete—it was carried out at dazzling speed: of an original population of about seven and a half million, at least 800,000 people were killed in just 100 days. Rwandans often speak of a million deaths, and they may be right."

The genocide left scores of men, women and children devastated, mutilated and/or infected with HIV/AIDS, and an entire country suffering from posttraumatic stress (Mukamana, & Brysiewicz, 2008; Brown, 2006). Some 24.8% of the population is estimated to have PTSD (Pham, Weinstein, & Longman, 2004). Eight hundred thousand of the survivors were orphans. Hundreds of thousands of these orphans witnessed their families being tortured and murdered, leaving them with no parents, no place to live, and no means of support. Some orphans aged six through 16 became orphan heads

of households, caring for two to six other orphans, while trying to cope with the complexities of survival in a war-torn country with no supervision or resources of any kind. Now, 15 years later, these same young adults struggle emotionally, physically, educationally, vocationally and financially (Boris, Brown, Thurman, Rice, Snider, Ntaganira, & Nyirazinyoye, 2008). The trauma of the genocide continues every day as orphan heads of households seek to meet basic survival needs such as food, shelter, and safety. Once they graduate from high school, the orphans in this pilot project will face the same survival needs. Without intervention, these young people are likely to continue to live with PTSD symptoms, including intrusive memories, nightmares, outbursts of anger, concentration problems, and fear and hopelessness about their futures (Geltman, 1999; Bolton, 2001).

The Remera Mbogo Orphanage is a boarding high school with a strong Christian emphasis that currently houses 550 students and has 10 teachers. The school-orphanage is located two hours north of Kigali in the district of Rulindo, one of the areas hardest hit by the genocide. It is one of the poorest schools in Rwanda. In 2008 the Grace Process International trained a group of 50 student leaders at this orphanage in team-building, stress reduction, The Grace Process, Emotional Freedom Techniques (EFT), and Tapas Acupressure Technique (TAT), both to help themselves and other students. The Dean of Students reported that prior to the 2008 visit the orphanage could not get through a single week without an eruption of violent or erratic behavior triggered by trauma flashbacks, with the affected students being confined to the infirmary. At one point, 22 students were all triggered at once, and the school had to call in the military to restore order. The headmaster of the orphanage reported a 90% decrease in outbreaks of emotionally-triggered behavior at the school following this 2008 intervention.

Thought Field Therapy (TFT), developed by Roger Callahan in the 1970s (Callahan, 2000) and its derivative Emotional Freedom Techniques (EFT), developed in the early 1990s by Gary Craig, are part of a group of therapies collectively referred to as the new field of energy psychology (EP). These therapies stimulate points on the energy meridian system described in Oriental Medicine while traumatic memories are recalled. If one puts a needle into an acupoint, the process is called acupuncture. If one presses on the point, the stim-

ulation is called acupressure. Craig (2009) summarizes clinical procedures and research findings for using EFT as a treatment for traumatic stress.

A clinical consideration in trauma work is that recalling traumatic memories may retraumatize a client, a factor emphasized by Van der Kolk (2007). Highly traumatized clients are often reluctant to access memories with an extreme emotional charge, e.g., a Rwandan orphan not wanting to revisit the memory of witnessing his or her parents being hacked to death with machetes because of fear of emotional flooding. EP helps to reduce emotional charge even with these highly-charged memories (Church, 2009a; Mollon, 2007). Meridian therapies that activate acupoints by tapping or holding are useful in treating posttraumatic stress because clients are reported to release the emotional disturbance without re-experiencing the full emotional impact of the trauma—one only has to think about it, not feel it. Because EP methods minimize the danger of emotional flooding (Mollon, 2008), they may be the treatment of choice when dealing with emotionally charged memories (Flint, Lammers, & Mitnick, 2005; Schulz, 2009).

Recent research is establishing EP as an evidence-based treatment for a variety of psychological disorders including posttraumatic stress disorder (PTSD), anxiety, and phobias (Feinstein, 2008a). EP therapies often report success with survivors of disasters with single sessions (Sakai, 2007; Johnson, Shala, Sejdijaj, Odell, & Kadengjika, 2001; Green, 2002; Folkes, 2002; Feinstein, 2008b). Six sessions have been efficacious in populations of veterans with PTSD symptoms, and subjects typically move from clinical to subclinical levels within this short timeframe (Church, Hawk, Brooks, Toukolehto, Dinter, Wren, & Stein, 2009; Church, 2009a; Church, Geronilla, & Dinter, 2009). A review of recently-developed trauma clearing therapies by Carbonell and Figley (1999) also found EP interventions efficacious in short timeframes.

Investigation of the efficacy of various therapies by several institutions, including the American Psychiatric Association, the US Veterans Administration, and Britain's National Institute for Clinical Excellence (NICE), show eye movement desensitization and reprocessing (EMDR), cognitive behavior therapy (CBT), and exposure therapy to be effective (Seidler, & Wagner, 2006; Bradley, Greene, Russ, Dutra, & Western, 2005; NICE, 2005; van Etten, & Taylor, 1998; Benedek,

Friedman, Zatzick, & Ursano, 2009; Institute of Medicine, 2006/2007). TFT and EFT utilize elements from these therapies like exposure and cognitive restructuring, adding a somatic element, having the subject (or the therapist if the subject is unable) stimulate an acupoint with tapping or holding, sometimes adding a positive cognitive statement which counteracts the trauma.

Stimulating an acupoint during exposure to traumatic memories has been shown to calm a person and reinforce cognitive change (Diepold, & Goldstein, 2008; Lambrou, Pratt, & Chevalier, 2003; Lane, 2009). A randomized controlled trial found stimulating an acupoint just by putting pressure on it, without using needles, as effective as inserting a needle (Cherkin, Sherman, Avins, Erro, Ichikawa, & Barlow et al., 2009).

Two theories of the mechanisms that make acupoint stimulation effective include boosting serotonin production (Ruden, in press) and activation of stress-dampening genes in the hippocampus and hypothalamus (Church, 2009b). The limbic system is designed to protect us, and when we recall traumatic events, this threat-assessment mechanism provides strong emotional cues that overwhelm cognitive processes (LeDoux, 2006). When the current environment includes therapeutic cues from EP treatment, a subject may be able to reconsolidate traumatic memories without triggering hyperarousal of the amygdala (Lane, 2009). Interventions including somatic stimulation seem to be able to reduce negative affect better than those that do not include this element of touch (Baker, Carington, & Putilin, 2009; Waite, & Holder, 2003).

The meridian therapies pair the memory of a highly traumatic event (exposure) with a statement of self-acceptance. An example would be, "Even though I lost all of my family in the genocide (exposure), I deeply and completely love and accept myself." This is a cognitive shift. Stimulating acupoints while holding the trauma in mind is observed to reduce emotional distress. Subjects rate their own disturbance level on a scale of 0 to 10, called Subjective Units of Disturbance or SUD (Wolpe, 1973). They can make the rating with numbers, or by demonstrating with the space between their hands (large space for great disturbance, small or no space for no disturbance). Such a variant is often used with small children or when language barriers are present.

These characteristics make the meridian therapies suitable candidates for empirical investigation

with populations of highly traumatized subjects because of their safety, efficacy, and brevity of treatment required to reduce distress.

Methods

Subjects were assessed pre- and post-intervention using the Child Report of Posttraumatic Stress (CROPS) test, Kinyarwanda language version (Greenwald & Rubin, 1999). The CROPS survey lists 26 symptoms of PTSD and asks how often the person has experienced each item in the past week: 0 for none, 1 for some, and 2 for a lot, yielding a maximum possible score of 52. A CROPS score of 19 or more indicates posttraumatic stress disorder; those who scored 18 or below on the initial survey were excluded. Before the study team arrived, the orphanage administered the CROPS test to 80 students they identified as having the most disturbed behavior out of the school population of 550. The headmaster gave the team permission to collect data and provided informed consent for the students the school selected for the study.

The orphanage organized the students to come for individual 15- to 30-minute therapeutic interviews, arriving with their completed CROPS test in hand. The team had time to interview only 56 of these students individually to establish rapport, assess needs, identify high-priority emotional issues, and encourage participation in the group treatment work, which was optional. The remaining students who had taken the initial CROPS test also attended a group session, although the team did not receive their pretests. Of these 56 students, 48 had CROPS scores of 19 and over, indicating PTSD.

The average age of the students was 20.2 years, due to the delays in their education caused by the genocide and its aftermath. The average initial score of this group was 33.6, indicating a high level of trauma. CROPS has been used to study the population of another Rwandan orphanage; the average pretest score in that study was 23.7 (Sakai, 2006). Demographic results are presented in Table 1.

Scores Indicating PTSD	Age Range	Average Age	Average Initial CROPS score
n = 48 out of 56	17-24	20.2	33.6

The interventions were performed collectively with two groups of approximately 40 students each on consecutive afternoons. Five high-risk students received supplementary individual treatment sessions. The orphanage helped the team gather posttest scores for as many of the students as they could identify and locate a week after the initial intervention. Of the 45 posttests returned, some had missing pretest scores, and some students were excluded from the study because their initial scores were below the cutoff. Thirty-four of the 48 qualifying students completed a posttest.

The authors performed interventions on Monday through Wednesday of the first week. The first day the team consulted with the headmaster to review the treatment plan, and some individual interviews were performed. The following day individual interviews were continued, supplemented by a two-hour group session. The third intervention day, additional students were interviewed and a new group received a 90-minute group session. In addition, the student leaders that had been identified and trained during the 2008 site visit received a two-hour training. Two team members returned the following Monday to gather CROPS posttests.

Group sessions began with rapport-building exercises prior to the intervention, including Laughter Yoga, gratitude lists, song, and dance. Corrections for “neurological disorganization” (Callahan, 2000; Craig, 2008) were done first, since this condition has been identified as an obstacle to successful treatment. They included diaphragmatic breathing, yoga stretching, prayer, heart self-massage, and an exercise called the Basic Unswitching Procedure which they called a “Focusing Exercise.” Then, a Thought Field Therapy (TFT) protocol for trauma was administered (Stone, 2009). The protocol was the same as that used by Sakai (2007), but added the acu-

points for rage and for sexual trauma (see Appendix). Meridian acupoint treatment permits the use of either tapping with the fingertips on acupressure points, or touching them while breathing (called TAB or touch and breathe). Most students preferred to use TAB.

Practitioners used a variety of energy psychology methods during individual sessions, based on the priority treatment method for the individual issue, including but not limited to EFT and TFT.

Results

Of the 48 students who completed the pretest, 34 (71%) completed the posttest assessment. The average drop in score on the posttest was 18.8%. To examine change over time in the CROPS scores between pretest and posttest, a repeated measures general linear model (paired t-test) of the results was conducted. The CROPS score interaction showed changes that were statistically significant ($p < .001$). Table 2 analyzes the score changes.

Sample Size	CROPS Pretest	CROPS Posttest	Score Difference	Average % Drop	Significance
$n = 34$	34.5 ± 7.7	28.0 ± 11.2	6.53 ± 8.75	18.8%	$t = 4.348$ $p < .001$

Of the 34 subjects completing both pre- and posttest, seven (21%) dropped below the cutoff point for PTSD. These results are presented below in Table 3. A separate analysis (paired t-test) of the scores of these subjects was conducted. Their average CROPS score drop was 53.7%. Thus the observed results were both statistically and clinically significant.

$n = 7$ out of 34	Average Pretest Score	Average Posttest Score (one week later)	Average Number of Points Dropped	Significance
(20.6%)	27.4 ± 4.8	12.7 ± 3.9	14.7 ± 7.06 (53.7%)	$p < .001$

$n = 7$ out of 34	Average Pretest Score	Average Posttest Score (one week later)	Average Number of Points Increased	Significance
(20.6%)	34.4 ± 4.99	39.4 ± 4.58	5.0 ± 4.16 (12.6%)	$p < .02$

The scores of seven students (21%) went up on the posttest. All seven were above the PTSD cutoff pretest, and remained so posttest. The average rise in their scores was 12.6%. These results are presented in Table 4.

Case Reports

Julie, Age 19: Julie's mother and father were murdered in the genocide and she also "lost all hope for the future." As the oldest of four surviving siblings, Julie felt responsible for her younger brothers and sisters. Their lives were miserable, having no stable place to live and nobody to help them.

Although Julie believed that talking relieves a person, when someone asked her to share her problems, she would dissociate and become unable to talk. The weight of this trauma made her "heart heavy all the time." Julie was very surprised to find herself accepting the invitation to join a group session. She felt a positive shift after the group and asked for an individual session, knowing that her internal work was not yet complete. Initially, she rated her Subjective Units of Disturbance (SUD) over her genocide trauma as a 10. After clearing limiting beliefs and using a customized meridian tapping sequence for trauma, rage and anger, her SUD level went down to zero. She left with a huge smile on her face. As the team left, she exclaimed in English, "Now I have hope!" Her initial CROPS score was 39, and her posttest score was 24.

Steven, Age 19: Steven witnessed the brutal murders of both parents when he was just five years old. The genocidaires cut his arms and legs with a machete and threw him into a pit of bodies. Before they left, they threw his parents' bodies on top of him. Soaked in his own blood and the blood of his parents, he lay there for a day until someone found him and treated his wounds. Later he found out that he and his sister were the only ones who had survived that massacre. Their family home was destroyed, and the killers took over their land. Telling his story was extremely difficult for Steven because the memories were so agonizing. As he tried to think about what happened, his memories overwhelmed his emotional control. When asked what troubled him the most, Steven responded, "Remembering how my parents were killed right in front of me. I feel it would have been better for me to die. I am nothing. I am alone in the world even though I live with so many (in the orphanage)."

During the initial interview session, Steven was treated with breathwork and heart meridian work. The interviewer did not ask for a SUD rating, believing that telling his story was painful enough, and Steven indicated he did not want to be interrupted. Originally Steven was opposed to participating in group work, however, after his initial interview, he felt more hopeful and agreed to come to group. Steven received an individual treatment session of hands-on meridian therapy. He experienced a sense of physical release during the session and reported that his body felt lighter and more relaxed. He also participated in two group sessions. His initial CROPS score was 43, and his posttest was 35.

Discussion

The study had a number of limitations. No attempt was made to control for non-specific effects such as the expectancy effect, or the effect of sympathetic attention. The study had no randomization or blinding of either participants or practitioners, and no method of distinguishing the effects of the rapport-building exercises as opposed to the intervention. The pilot investigation was further limited by available time, by differences in cultural beliefs about emotional healing, by the lack of an observer-rated measure, and by the language barrier.

Collecting posttest data was difficult because of understaffing at the orphanage, which did not have electricity, computers, or a secretary. The study team was constrained by time limitations, and concluded that more time establishing group and individual rapport would yield better treatment results. More time would have allowed the team further individual follow-up sessions with the students whose posttest scores rose. One student told the headmaster that before the visit, she had been able to dissociate her genocide memories. Talking about the genocide during the intervention brought up the trauma again, a clinical consideration emphasized by Van der Kolk (2007).

Secondly, the team observed that Rwandans generally believe that to heal, one must tell one's story beginning to end, letting out one's feelings—the model of traditional talk therapy. Many of the orphans studied stated that they had never told anyone what happened to them in the genocide. As much as the team wanted to hear all the participants' stories, they did not have time to listen

to everyone to the extent that the participants deserved. Also, the concept that tapping on meridian points while mentally attuning to their memories of the genocide could reduce the emotional triggering attached to genocide memories seemed initially very strange to participants. Most members of the group also believed that prayer was the most powerful and helpful form of emotional healing, so the team began and ended group sessions with prayer, and otherwise attuned their therapeutic plan to the cultural sensitivities of the participants.

The CROPS test has an observer-rated correlate assessment, called the Parent Report of Post-traumatic Stress (PROPS). Using both PROPS and CROPS increases the validity of measurement, since children tend to be poor observers of their own behavior (Greenwald, & Rubin, 1999). Sakai (2006), with a similar population at another orphanage in Rwanda, showed that when the Parent Report (PROPS) survey was added, only 72% of the students identified by their caretakers as having PTSD had reported scores above the cutoff. In the case of the population in this study, without parents, the PROPS could not be completed. In the Sakai study, the orphanage completed the PROPS; however, nobody at the understaffed Remera Mbogo orphanage knew these students well enough to answer the questions on the PROPS.

Rwanda's official language is Kinyarwanda, and French is widely spoken as a second language. Few people speak English. The language barrier presented problems both in email communication to set up team activities and in finding enough translators fluent in English, which also added to the cost of the study.

The predominant religion in Rwanda is Christianity, and the orphanage has a strong Christian emphasis. At the beginning of the intervention period, one translator sometimes added his own interpretation of the situation—e.g., reframing the anger a student still had toward the person who killed her parents as the work of the devil trying to keep the student in the bondage of anger. During the course of the three-day intervention, the translators developed a greater understanding of the process of healing that EP offers.

Rwanda is a challenging environment for research, and the study team was required to adapt its plans and protocols flexibly, in response to actual conditions. The orphanage staff has been requested to obtain CROPS scores three, six and 12 months post-intervention.

Recommendations for Future Research

Build rapport. Rapport is the first step in establishing a therapeutic alliance, and even more important when crossing language, cultural and trauma barriers. Since the 1994 genocide, many researchers from Western nations have come to Rwanda to study the causes and effects of the genocide. Some Rwandans who have participated in research conducted by Western researchers have expressed negative feelings about their participation, including feeling like they are being used and observed like “rats in a cage,” and in some cases, participation in research has left them more traumatized from recalling traumatic events without receiving resolution. Empathy and compassion are essential in overcoming this history and establishing the trust needed to build the rapport that allows healing to happen.

Extend Treatment. An intervention team large enough to work with subjects in greater depth, and with the budget to follow up with repeat visits, should help participants maintain their gains.

Gather Data Systematically. A team member dedicated solely to gathering and managing data, as opposed to delivering treatment, would result in a larger subject pool, higher compliance, and greater statistical significance of the results.

Plan Research to Avoid Retraumatization. Because of the very real possibility of retraumatization of subjects in a population with complex PTSD, research designs that focus on delivering a sense of emotional resolution to subjects are important. After gathering posttest data, it is important to deliver individual sessions to subjects whose scores go up. If randomized controlled designs are used, a crossover design, with the wait list control group receiving the intervention after the experimental group, is ethically imperative to avoid compounding trauma.

Acknowledgments

The authors extend sincere gratitude and deep respect to the dedicated staff at the Remera Mbogo Orphanage: Rev. Thoms, Rev. Seth, and the wonderful teachers for their help with the visit and the amazing work they do in a challenging situation. The team extends the same admiration and appreciation to the equally amazing staff at Solace Ministries who set up a two-day training for the team

in Kigali working with orphan head of households. Their personal genocide survival stories were moving and inspirational. Special thanks go to the translators, who made communication possible. Warm thanks go also to Vidyasagar Pampati, MSc, for analyzing the statistics.

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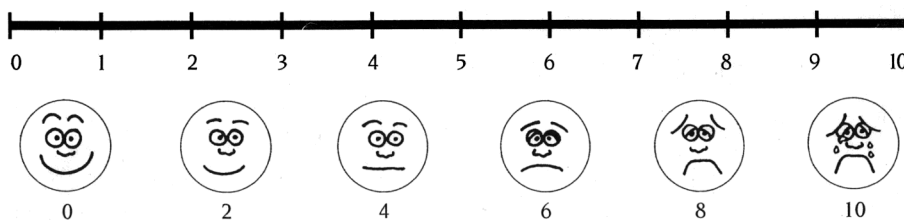
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Appendix: Thought Field Therapy (TFT) Treatment Protocol for Trauma

1. Rate how much the Problem you have Selected Hurts:

Show how much it hurts, either by showing with how far apart your hands are (close together is not very much pain, wide apart is a lot of pain) or by picking a number below from 0-10.



2. PRAY, asking God for help and asking Jesus into your heart to help heal the problem.

3. HEART CIRCLE

Put the right hand over the heart and go around clockwise while saying,

- I accept all of my feelings about all of my problems.
- I love and accept myself (or I wish I could love and accept myself).
- God loves and accepts me.
- Jesus loves and accepts me.

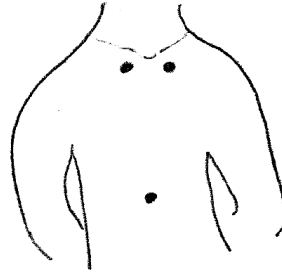


4. Focusing Exercise

Put a finger in the bellybutton and at the same time tap or rub

- Both collarbone points, then
- Under the nose and
- Under the lips

(you can do under the nose and under the lips at the same time)



5. Eliminating Blocking Beliefs:

Tap the side of the hand while saying several times,

- Whether or not I feel getting over this trauma is possible, I love and accept myself, and God loves and accepts me.
- Whether or not I feel getting over this trauma is safe for me and/or for others, I love and accept myself, and Jesus loves and accepts me.
- Whether or not I feel I deserve to get over this trauma, I love and accept myself, and God loves and accepts me.



6. TAP this Series of Points:

Emotion Treated	Tapping points	Optional affirmation for the first round	Optional affirmation after the 9-Gamut
Trauma	Eyebrow Under Eye Under Arm Collarbone	“It’s over now.”	“It’s over now.”
Rage	Outer Eye Collarbone	“I accept all of my rage about what happened.”	“I forgive myself for not being able to stop it.”
Anger	Little finger Collarbone	“I accept all of my anger about what happened.”	“I forgive myself for not being able to stop it.”
Sexual Assault	Middle finger Collarbone	“I call back my life energy/ power from the past!”	“I call back my life energy/ power from the past!”
Guilt	Index finger Collarbone	“I accept how guilty I feel for surviving.”	“I forgive myself for feeling guilty. It was not my fault.”

7. Do the 9-Gamut Treatment:

- Tap the gamut spot with
- Eyes closed
- Eyes open
- Eyes down to the right
- Eyes down to the left
- Eyes circling in one direction
- Eyes circle in the opposite direction
- Hum a few notes
- Count to five out loud
- Hum a few notes

8. TAP the same series of points again: (eyebrow, under eye, under arm, etc.)

9. Rate how much the problem hurts now.

10. Next Step:

If the problem still hurts quite a bit, you can do this whole process over again. If the problem is a lot better, then pray and thank God for the healing!

