

Treatment of PTSD in Rwandan Child Genocide Survivors Using Thought Field Therapy

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Abstract: *Thought Field Therapy (TFT), which utilizes the self-tapping of specific acupuncture points while recalling a traumatic event or cue, was applied with 50 orphaned adolescents who had been suffering with symptoms of PTSD since the Rwandan genocide 12 years earlier. Following a single TFT session, scores on a PTSD checklist completed by caretakers and on a self-rated PTSD checklist had significantly decreased ($p < .0001$ on both measures). The number of participants exceeding the PTSD cutoffs decreased from 100% to 6% on the caregiver ratings and from 72% to 18% on the self-ratings. The findings were corroborated by informal interviews with the adolescents and the caregivers, which indicated dramatic reductions of PTSD symptoms such as flashbacks, nightmares, bedwetting, depression, isolation, difficulty concentrating, jumpiness, and aggression. Following the study, the use of TFT on a self-applied and peer-utilized basis became part of the culture at the orphanage, and on one-year follow-up the initial improvements had been maintained as shown on both checklists. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 41-50].*

Key words: *Adolescents, genocide, child survivors, PTSD, Rwanda, TFT, Thought Field Therapy, trauma*

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The dire psychological consequences of war and organized violence have been extensively reviewed and reported (e.g., Kienzler, 2008; Miller, et al., 2006; Ziegler, 2010). The incidence of posttraumatic stress disorder (PTSD) in children of war is particularly high (Ehnhold & Yule, 2006; Thabet & Vostanis, 2000). In a study of orphans ten years after the 1994 genocide in Rwanda that left more than one million children without parents, 44% of a sample of 68 orphans still met the full criteria for PTSD, based on structured interviews (Schaal & Elbert, 2006). Knowledge about effective treatments for populations devastated by war, however, is limited, especially with children and adolescents. The present study investigates the use of Thought Field Therapy (TFT) with 50 adolescents who had been orphaned during the genocide in Rwanda twelve years earlier and who met criteria for

PTSD on a standardized PTSD checklist completed by their caregivers at the start of the study.

TFT combines the manual stimulation of acupuncture treatment points, the mental activation of targeted symptoms and traumatic memories, and related procedures. Developed by clinical psychologist Roger Callahan (Callahan, 1981; Callahan, 1995; Callahan, 2001; Callahan & Callahan, 2000), TFT can be taught by a therapist in a clinical setting and is self-administered by the client in clinic and in the client's own settings.

TFT has been used in the treatment of PTSD with refugees (Folkes, 2002), survivors of war trauma (Johnson, 2001), and survivors of natural and human-made disasters (Feinstein, in press). While such reports suggest that TFT may be an unusually effective treatment for PTSD in the aftermath of catastrophic events, few controlled investigations have been conducted. Two recent randomized controlled trials treating PTSD using a derivative of TFT called Emotional Freedom Techniques have, however, produced strong favorable outcomes (Church, Piña, Reategui, & Brooks, 2009; Church et al., 2010). The current study, based on multiple case data (after Kazdin, 1982), investigated outcomes of TFT treatments with childhood survivors of genocide. The study was conducted in the context of a trauma relief deployment by invitation of the staff at an orphanage in Rwanda.

METHOD

Participants

The study, conducted in April 2006, included 50 students (27 male; 23 female), ages 13 to 18, attending a day school that was part of an orphanage in Rwanda. Of the 400 students attending the school, 188 were old enough to have been survivors of the 1994 genocide in Rwanda 12 years earlier. All completed a PTSD symptom inventory. Those with the most severe symptoms were also rated by their caregivers on a standardized PTSD checklist. Of these, the 50 given the highest scores on the caregiver checklist were selected to be in the study. The 27 males in the study were residents at the orphanage; the 23 females lived with foster parents.

These 50 adolescents were treated by four practitioners over a three-day period. The practitioners included a licensed psychologist, two licensed clinical social workers, and a paraprofessional with extensive training and experience in both TFT and disaster relief procedures.

Measures

A review of psychological interventions for post-traumatic reactions in children and adolescents suggests the importance of utilizing both child and parent measures in clinical studies (Stallard, 2006). In conformance with this suggestion, two standardized checklists to assess participants' PTSD symptoms were utilized: one completed by the participants and one by their caregivers. The Child Report of Post-Traumatic Symptoms (CROPS) and the Parent Report of Post-Traumatic Symptoms (PROPS; Greenwald & Rubin, 1999) were translated into the native Kinyarwanda language according to recognized standards for test translation and approved by the test's first author (Greenwald) in 2006.

Because the students were orphans, their teachers—who also served to guide, discipline, and counsel them and in many cases were their only caregivers—did the parental assessments. The PROPS inventory is still valid, according to its first author, if scored by “any adult who is with the child frequently and knows him/her well” (R. Greenwald, personal communication, March 2, 2006). The three caregivers doing the PROPS ratings selected students with whom they were most familiar, and the same caregiver rated the same students on immediate pre- and post-treatment assessments, as well as on each of the follow-up assessments.

The CROPS self-inventories were administered the day before the start of treatment in a group setting and then immediately upon the completion of the treatment sessions. The students completed the inventory independently if they were able to read and understand it or with staff assistance if they required help. The therapists were not involved in the administration of either inventory. Another measure, used by the students, was a verbal Subjective Units of Distress (SUD) self-rating (Wolpe, 1973). Students were asked by the therapist to rate their level of distress relative to a traumatic memory or other concern that was a focus of the treatment, on a scale of 0 to 10, at various points during the treatment session as a process measurement.

Procedures

Informed consent content was developed with the school/orphanage staff and presented to the students at an assembly so all received identical information and heard the same answers to the many questions that were asked. The students were told that the visiting therapists were going to

see if they might be able to help them with intrusive memories from the genocide, and that they would also be teaching them some ways that might help them to better relax and sleep. They were also told that the therapists wanted to learn from them what was helpful, thus the questionnaires. Participation was completely voluntary. Students were asked to raise their hands to indicate that they understood the intent of the program and that they were willing to participate. There was 100% agreement and ultimate participation. The therapy team was there at the invitation of the orphanage's director, who was also a university professor in Kigali. While the complications of attempting to obtain Institutional Review Board (IRB) approval in Rwanda at the time made a formal IRB process unfeasible, the possibility was explored and the protections provided by an IRB were all discussed with the director and built into the study.

Of the 188 students at the orphanage who were survivors of the genocide, the 50 selected for the study, based on their scores on the PROPS caregiver inventory, each exceeded the PTSD cutoff score, which is 16 (Greenwald & Rubin, 1999).

Thus 100% of the adolescents in the study were rated as being above the PTSD cutoff on the PROPS inventory prior to treatment. These 50 participants were administered the CROPS self-rating inventory one day prior to their first treatment session. Only 72% of these students (36 of 50) met the criteria for PTSD prior to treatment. While this might give the appearance that the caregivers overestimated the students' level of distress (rating 100% in the PTSD range), discussion of this question with the caregivers led to possible alternative explanations, such as that some of the students may have dissociated from the genocide events or been in denial about or concealing their symptoms on the self-inventory.

The 50 participants were each provided an individual Thought Field Therapy (TFT) treatment session of 20 to 60 minutes duration. No pre-set time-limit was established, and the session was able to continue as long as the therapist judged appropriate. The participants were treated with TFT for multiple traumas, anger, rage, guilt, grief, and chronic pain. The TFT *basic algorithm* level of treatment was utilized, with corrections for *psychological reversals* as needed. The basic treatment algorithms and psychological reversal corrections utilized in the study are described in Callahan's (2001) *Tapping the Healer Within*.

Each therapist was randomly assigned approximately one-fourth of the participants, and each therapist saw each of

his or her participants on three consecutive days. On one of those days, the TFT session was administered, on another day a four-minute progressive relaxation technique was taught during a five- to ten-minute session that also involved supportive counseling, and on the other day, a two-minute diaphragmatic breathing technique was taught during a five- to ten-minute session that also involved supportive counseling. The order for each treatment condition was pre-selected and varied among the students. Kinyarwanda-English translators were used in all sessions.

This design was a last-minute deviation from the original plan, which was to have three TFT sessions administered to each participant on three consecutive days. However, a contingent of three of the seven-member therapist team was unexpectedly called to another part of the continent to assist in an emergent situation, making it impossible for the remaining four therapists to provide three extended treatment sessions to each of the 50 participants within the three days available.

The brief progressive relaxation and diaphragmatic breathing sessions were introduced to make it possible for each of the participants to still have the intended three sessions with a therapist. In this revised design, the relaxation and breathing sessions were conceived of as placebo conditions—with each of the three treatments provided in random order—allowing the participants to act as their own controls. The data collection strategy, however, improvised at the last moment to accommodate the new developments, was not adequate for an analysis that would allow that objective to be fulfilled. The study is, therefore, properly understood as a systematic investigation of clinical outcomes without a comparison condition.

The CROPS inventories were re-administered immediately following the diaphragmatic breathing and progressive relaxation sessions as well as after the TFT treatment. The PROPS inventories were re-administered within a day of the end of all three sessions, allowing the caregivers time to observe and interact with the students they were responsible for rating. Follow-up assessments were conducted at 3 months, 6 months, and 12 months post-treatment.

RESULTS

Scores on both the PROPS and CROPS inventories were significantly reduced at the end of treatment, with reductions holding at one year follow-up. Table 1 shows the mean scores

on both inventories prior to treatment, immediately following the treatment sessions, and at one year. Standard deviations and probabilities that the pre- and immediate post-treatment differences were by chance are also presented. Table 2 shows the percentage of students who were above the PTSD cutoff for each inventory pre-treatment, immediate post-treatment, and on one-year follow-up. Table 3 shows a pre-treatment SUD (subjective units of distress) score on the most disturbing traumatic memory and a post-treatment score. Other SUD scores were taken throughout the treatment for specific areas of focus (fear of dark, anger, discomfort with other adolescents, etc.), but the table is limited to scores on the most disturbing memory which was, by design, taken at the start and end of the TFT treatment session.

DISCUSSION

Although each participant received only a single TFT session rather than the three TFT sessions originally planned, all outcome measures exceeded the .0001 level of confidence that the symptom reduction was related to the treatment. These scores were corroborated by informal interviews with the adolescents and the caregivers which indicated dramatic reductions of symptoms such as flashbacks, nightmares, bedwetting, depression, withdrawal, isolation, difficulty concentrating, jumpiness, and aggression. While these scores and impressions from informal interviews provide a faithful accounting of measurable, observable, and reported subjective effects of the treatment, therapists not familiar with TFT and related clinical approaches may find these outcomes improbable. They are, however, consistent with reports

Table 1.
Pre- and Post-Treatment and 1-Year Mean Scores on Caretaker and Child Reports of Posttraumatic Symptom Inventories in Adolescent Rwandan Genocide Survivors (N = 50)

Inventory	Pre-Treatment Mean (SD)	Post-Treatment Mean (SD)	p-value for Paired t-test	1-Year Follow-Up Mean (SD)
PROPS*	35.20 (8.09)	8.18 (4.04)	< .0001	8.51 (5.10)
CROPS*	23.70 (8.90)	11.42 (8.94)	< .0001	10.69 (7.18)

* Cut-off scores for PTSD: PROPS = 16, CROPS = 19

Table 2.
Percent Meeting PTSD Criteria Pre-Treatment, Post-Treatment, and at 1-Year (N = 50)

Inventory	Pre-Treatment (%)	Post-Treatment (%)	1-Year Follow-Up (%)
PROPS	100	6	8
CROPS	72	18	16

Table 3.
Subjective Units of Distress Scores in a Single Thought Field Therapy Session with Adolescent Rwandan Genocide Survivors (N =50)

Measure	Start of Session Mean (SD)	End of Session Mean (SD)	p-value for Paired t-test
SUD score	7.58 (2.29)	0.31 (0.73)	< .0001

from other deployment teams using similar interventions (see Feinstein, 2008). Clinicians who have not worked in a setting where trauma at the level of the Rwandan genocide is the common background of an entire community may also find comments about the social context within which the treatment was administered to be informative.

Social Context

Each year, beginning on the anniversary of the start of the genocide, Rwandans observe a one-week mourning period (sometimes longer for survivors, and observed as a two-week mourning period at the orphanage). They stop work and school, attend programs of solemn remembrance, and perform personal commemorations for loved ones lost, while refraining from singing, dancing, and other forms of celebration. Many visit the Kigali Memorial Center, which was opened in April 2004 on the 10th Anniversary of the Rwandan genocide. The Center is built in the city of Kigali on a site where an estimated 250,000 victims of the genocide are buried in mass graves. The Center includes exhibitions of all the major genocides around the world while emphasizing the Rwandan genocide, where close to one million died during 100 days of continuous murder and torture. The memorial includes thousands of photos of babies and children who were lost, as well as graphic descriptions and photos of the actual genocide. Upon visiting the memorial, the American team involved in the current study found themselves using TFT to self-treat for the traumatic experience of viewing the haunting images, mass graves, and other evidence of a massacre of such unimaginable magnitude

While the Kigali Memorial Center and annual mourning period are part of the country's healing and determination that lessons be learned so such human atrocities never happen again, visits to the Center and the concentrated focus on the genocide can also be re-traumatizing for those who lived through the horrors. Many of the orphans experienced intensification of their symptoms during the orphanage's two-week annual observance. Cultural beliefs may also unwittingly intensify symptoms. For instance, Rwandan psychiatrist Dr. Athanase Hagemimana observed that the Rwandan reaction to trauma is often somatic and frequently involves panic symptoms such as shortness of breath (Wulsin & Hagemimana, 1998). In Rwandan culture, shortness of breath may be interpreted as having been caused by an ances-

tor who never received proper burial. During the genocide, proper burials were often not feasible, so normal reactions to re-experiencing the trauma during the two-week observance could resurface and exacerbate the unsolvable dilemma that loved ones had not received proper burial, as well as to engender a sense of powerlessness in the presence of the symptom (Hagemimana et al., 2003). While previous studies have shown that TFT can be helpful in addressing the somatic manifestations of trauma (Sakai et al., 2001), such cultural dynamics must be understood by the therapist.

The current study and its one-year follow-up were, by design, both carried out during the two-week anniversary observance. Besides the practical matter that the orphans were then available for treatment, planning the follow-up assessments during the mourning observances allowed a more robust test of the durability of the treatment outcomes because any reactivated PTSD was likely to be at its height during this period. An interesting observation at the one-year follow-up interviews and assessments was that participants who reported a return of trauma symptoms at the start of the anniversary observance consistently demonstrated to the team, unsolicited, how they had self-treated using TFT and described how their symptoms remitted.

A finding that provides context for the current study is that of the initial CROPS self-ratings for the 188 orphans old enough to have been survivors of the genocide, 63% (118) met or exceeded the PTSD cutoff score prior to treatment. While very little data is available that provides reliable estimates of the proportion of the more than one million genocide orphans that are still suffering from PTSD a decade or longer after the genocide, this percentage is considerably higher than the 44% found by Schaal & Elbert (2006) of 68 orphans interviewed using a structured format based on DSM PTSD criteria. But even the lower figure represents a sobering glimpse into profound suffering that goes largely untreated in Rwanda even though, as the current study suggests, treatments that are apparently efficient and effective are available.

Illustrative Case Vignettes

Two accounts of the 50 TFT treatment sessions (both cases treated by the first author as part of the current study) illustrate PTSD treatments using TFT within this social context.

First case.

A 15-year-old girl, one of the few survivors from her village, was three at the time of the genocide. Her family and other villagers had taken refuge inside the local church. At dusk men bearing machetes stormed into the church and started a massacre. The girl related how her father told her to run and not look back for any reason. She started to run as fast as she could. However, she heard her father yelling and screaming in a frenzied, frantic way, “like a crazy man.” Even though she remembered that he had said not to look back, she kept hearing him scream and turned to see what was happening. She watched, horrified, as a group of men with machetes murdered her father.

Every day following the attack, which had occurred 12 years earlier, she had flashbacks (“daymares”) of seeing her father being killed as well as unrelenting nightmares about the scene. As we added tapping on the specific acupuncture points to her telling of the story, her heart-wrenching sobbing and depressed affect suddenly transformed into smiles. When I asked her what happened, she reported having accessed fond memories. For the first time she could remember her father and family playing together. She said that until now she had no childhood memories besides the genocide.

Then I directed her back to her feelings when she thought about what had happened in the church. The interpreter, who was a pastor, looked at me hesitantly, as if to ask: “Why are you bringing it back up again when she was doing fine?” But we needed a complete treatment. The girl started crying again as she remembered seeing other people being killed. She recalled how she had escaped, and she realized that her father’s quick thinking had saved her life by getting her to run while distracting the perpetrators’ attention.

We continued to work through each of the traumatic events using the same tapping protocol. She cried upon re-experiencing each of the horrors she witnessed while hiding outside with another young child. After about 15 or 20 minutes focusing on and treating the intense disturbing affect brought up by this and a number of other scenes, she started laughing. I asked her what was coming up for her and she talked about her father. Her mother didn’t want the children eating sweet fruits because they were not good for their teeth. But her father would sneak them home in his pockets and when her mother wasn’t looking, he would give them to the children. She was laughing wholeheartedly, and we laughed with her. We processed a number of additional scenes. Finally

when asked “What comes up now as you remember what happened at the church,” she said thoughtfully, and without tears, that she could still remember what happened, but that it was no longer vivid as if it were still happening. It was now faded in the distance, like something from long ago. She started to talk about other fond memories. Her depressed countenance and posture were no longer evident. When she was seen again during the next two days, she described how for the first time she had no flashbacks or nightmares and was able to sleep well. She looked cheerful and told us how elated she was about having happy memories about her family.

Second case.

A 13 year-old-boy related that he was terrified of the dark. There were no electricity or lights at the orphanage, so he would sit on his bed when the sun went down and tremble. He would be shaking and scared until the other children went to bed. Genocide traumas often occurred at dusk. We focused on his fear of the dark, and the genocide stories he had been told by older survivors. He grinned from ear to ear as the TFT treatment algorithm was completed. He proudly announced at the end of the session, “I am not afraid of the dark any more.”

When we arrived the next day, he excitedly greeted our bus and was bubbling over with joy. He had been able to play with the other children after dusk until bed time the night before. He was “high fiving” the treatment team with exuberance and a broad, triumphant grin. Not being able to play with the others after dark had made a huge difference in the quality of his life at the orphanage. He said he wanted to show how he felt inside, and he did a somersault and said he finally felt free! He was so appreciative of what he referred to as “getting my life back” that when we were leaving Rwanda, he tried to give me one of his three marbles as a gesture of appreciation. His only possessions were his clothes, his slippers, his blanket, and three marbles.

Follow-up Assessments

The 3-month, 6-month, and 12-month assessments all used PROPS and CROPS ratings as well as informal interviews. The elimination or strong reduction of nightmares and flashbacks were frequently mentioned. The three teachers who did the original ratings were available for all three subsequent assessments and each rated the same students they

had rated immediately before and after the treatment. All 50 adolescents were also available for each of the subsequent assessments (a few were no longer at the orphanage but were notified and voluntarily returned for the assessments).

Follow-up mean scores were significantly lower than pre-treatment scores on all measures. At one year, they were almost identical to the scores immediately following treatment (PROPS mean score of 8.52 immediately after treatment and 8.24 a year later; CROPS mean scores of 10.68 and 11.71, respectively). However, at the 3-month follow-up, the orphanage was in a crisis that might have led to its having to close. This had the orphans, as well as their caregivers, under a great deal of fear and stress. This fear and stress was reflected in the 3-month ratings, which spiked to 16.69 on the PROPS (still, the pre-treatment score was 35.23) and 17.08 on the CROPS (pre-treatment score was 23.55). By the 6-month follow-up, the crisis had passed and the mean scores had come down to close to the immediate post-treatment scores (PROPS 8.86; CROPS 14.70).

These follow-up ratings, however, reveal very little about the lasting impact of the initial treatment sessions. After working with the 50 adolescents that were part of this study during the first three days of the two-week mourning period, the treatment team turned its attention to the remaining 350 children. Since the initial 50 had the greatest signs of psychological disturbance, and also because they were participants in this study, they all received individual treatments. Group sessions were often used with the remaining children, while individual sessions were reserved for those whose responses in the group sessions indicated a need for individualized attention. As a result, tapping for psychological difficulties, whether traumatic memories or problematic emotions, became part of the community's culture. If a boy woke up screaming in the middle of the night, his bunkmates would guide him in tapping to help him go back to sleep. Sometimes one child would start self-tapping for an undisclosed problem and seven or eight others would start self-tapping as well. This mutual support was particularly evident to the treatment team upon returning for the one-year follow-up, seeing and hearing about the students helping one another with reactions to the genocide anniversary. The low scores on PTSD symptoms at one-year follow-up suggest that a) the initial TFT session or b) the subsequent self-application of TFT helped preserve the gains recorded immediately after the first treatment session, but it is not clear which, or if the combination was necessary.

Limitations of the Study and Implications for Further Investigation

The current investigation was an uncontrolled outcome study utilizing a standardized self-report inventory, a standardized caregiver inventory, both patterned after DSM IV criteria for PTSD, and SUD self-ratings. Statistical analyses were restricted by the study limitations. A randomized controlled trial that compared TFT with a wait-list control and a recognized PTSD treatment such as CBT, using the same measures, would be a next step for future investigations.

In the current investigation, the therapists who provided the treatment also designed the study, selected the assessment instruments, supervised the data collection, chose the person who performed the statistical analysis, and wrote the final narrative. While scientific procedures were adhered to faithfully, allegiance to the approach being studied and other biasing factors may have influenced the findings.

Outcome assessments were based on self-reports by the participants (SUD and CROPS ratings) and on subjective reports (PROPS ratings) by teachers or caregivers who were involved in the lives of each participant, lending themselves to subjective bias. Confidence in the current findings could have been strengthened if independent observer-assessors had been used or if the outcome assessments were supplemented by more in-depth measures. Possibilities to consider for subsequent research might include (a) formal interviews structured around PTSD criteria or (b) behavioral measures such as school grades or frequency of incidents where disciplinary action was required.

The relaxation and breathing sessions, initially introduced to control for placebo effects and other artifacts, ultimately became confounding variables. While there is no evidence or logic suggesting that four minutes of training in a relaxation technique and two minutes of training in a breathing technique would reverse severe longstanding PTSD, their influences on the clinical outcomes could not be ascertained. However, at the one year follow-up, there were no reports of self-administered progressive relaxation or diaphragmatic breathing, with the participants reporting and demonstrating use of TFT when asked what they found to be most useful to them.

A minor confounding variable in the study was that after the participants received their TFT session, they became enthused about the relief they experienced and spontaneously

shared what was helpful to them with their classmates or bunkmates. As a result, some of the participants were already familiar with and had preconceptions about the treatment protocol before receiving their TFT session. In addition, the field conditions were such that, although the participants were beyond hearing distance while waiting to be treated, they could observe those being treated at the far end of the warehouse classroom. As they watched crying, depressed, or angry classmates come into smiles and laughter, they keenly observed what they were doing that seemed to bring about these changes. The meridian tapping was visible, and a few of the children learned the basic procedure as they waited for their turn. This and the sharing of the method with peers who had not yet had their treatment session may have created an unmeasured expectation effect in a small proportion of the participants.

The meaning of the one-year follow-up CROPS and PROPS scores is unclear. The increase in PTSD symptoms at the three-month follow-up and the reduction down to post-treatment levels by the one-year follow-up may have been a result of the crisis that was occurring at the orphanage at the time of the three-month follow-up, as speculated above, but the trend may have been due to entirely different, unknown factors. Moreover, since use of tapping procedures for emotional difficulties became part of the culture at the orphanage, the impact of the initial treatment cannot be separated from the impact of the change in culture which perpetuated the use of TFT as a self- or group-initiated psychological relief measure. The combination, however, seemed potent and it is standard procedure that following TFT treatments, clients are taught to use the method on a self-help basis routinely or as-needed.

CONCLUSIONS

The last-minute change in design, where only a single TFT treatment session was administered, instead of the three that were initially planned, seemed likely to compromise the study. In the end, however, it provided the basis of one of the most striking dimensions of the study's findings: a single TFT session of 20 to 60 minutes brought about a marked reduction in symptoms of a large majority of adolescents who had suffered with severe PTSD symptoms for more than a decade. Controlled research studies are now needed to substantiate these preliminary findings.

A recent randomized controlled trial referred to earlier (Church et al., 2009) also used a one-session treatment design, working with 16 institutionalized adolescent boys in Peru, all of whom had been abused and showed symptoms of PTSD on standardized inventories. The reduction in PTSD symptoms, following a single session of a derivative of TFT for the 8 participants in the treatment group, was highly significant ($p < .001$) while none of the 8 participants in the wait list control group showed a significant change on subsequent testing. Neither the authors of this study nor of the Peru study (D. Church, March 21, 2010, personal communication), however, are recommending that a single session is the ideal format for treating longstanding PTSD. The single-session design in both cases was done for expediency, and both teams of investigators were surprised by the strength of the outcomes. Both teams also recognized that additional sessions might have benefited an unknown proportion of the participants.

As a postscript, after the treatment team completed the initial two-week individual and group treatments with the 400 children and adolescents, they trained the caregivers so they could follow up as needed as well as introduce the approach to children new to the orphanage. Reports have been encouraging that the skills could be successfully transferred from the treatment team to the staff to the children. With the wounds of massive and wide-scale trauma appearing in so many parts of the world, an approach that appears unusually effective and that can be readily taught to and implemented by community leaders would seem worthy of intensive investigation.

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The Association of Traumatic Stress Specialists is an international multidisciplinary organization founded to educate and professionally certify qualified individuals actively engaged in crisis intervention, trauma services and response, and the treatment and healing of those affected by traumatic stress. The Certification Board represents individuals who have practical experience in providing direct support to trauma victims and survivors.

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