Special Issue
Commemorating EMDR’s 25th Anniversary by
Highlighting EMDR Humanitarian Projects

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Commemorating EMDR’s 25th Anniversary by Highlighting EMDR Humanitarian Projects

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This editorial introduces the special issue of the Journal of EMDR Practice and Research that commemorates the 25th anniversary of eye movement desensitization and reprocessing (EMDR) therapy by highlighting EMDR humanitarian programs around the world—in North America, Europe, Africa, the Middle East, Asia, Latin America, and the Caribbean. EMDR therapy is a valuable and appropriate intervention in humanitarian crises, given its effectiveness as a brief individual treatment, consecutive-day application, and group therapy. There are many compelling clinical vignettes in this issue, including some from a refugee camp in Syria, a hurricane in South America, and earthquakes in India and Italy. The authors in this issue bring years of experience to their articles, and their commentary on the challenges, future needs, and concerns is illuminating and thought-provoking.

Keywords: editorial; eye movement desensitization and reprocessing (EMDR) therapy; clinical vignettes; humanitarian assistance programs

This special issue of the Journal of EMDR Practice and Research commemorates the 25th anniversary of the first publication (Shapiro, 1989) of eye movement desensitization and reprocessing (EMDR) therapy by highlighting EMDR humanitarian projects around the world. EMDR therapy is a valuable and appropriate intervention in humanitarian crises, given its effectiveness as a brief individual treatment, consecutive-day application, and group therapy. EMDR humanitarian work has generally been focused on teaching EMDR to local therapists so they can provide the treatment to those suffering in their own communities. Projects are usually conducted by invitation and in collaboration with local agencies and/or national and international aid organizations.

Beginning in the United States in 1995, after the Oklahoma City bombing, EMDR therapists have created organizations to treat survivors following disasters and to build local capacity. This issue of the journal documents the development and achievements of EMDR humanitarian assistance programs around the globe, from the United States (Alter-Reid, Colelli, & Simons, 2014; Gelbach, 2014) to Europe (Farrell, 2014; Fernandez, Callerame, Maslovaric, & Wheeler, 2014; Mattheß & Sodemann, 2014) to Africa (Zimmermann, 2014) to the Middle East (Zaghrou-Hodali, 2014) to Asia (Mehrotra, 2014) and to Latin America and the Caribbean (Jarero, Artigas, Uribe, & Miranda, 2014). The humanitarian work reflects a rich diversity of language and dialects, cultural heritage and traditions, ethnicity and race, religion and beliefs, socioeconomic status, and politics. Different types of humanitarian crises are represented, including natural disasters, man-made disasters, wars, terrorism, poverty, and violence. Some crises are acute, others are entrenched in years of struggle. Shapiro (2014) and Carriere (2014) discuss the inherent benefit in treating traumatized individuals with EMDR therapy...
to reduce/eliminate the debilitating effects of unprocessed memories on psychological, physical, and relational health. Carriere (2014) calls for a “global trauma therapy plan” using EMDR to confront “the world’s burden of traumatic stress.”

Ultimately, this special issue is about people: people in extreme crisis, in sorrow, pain, and despair. And it is about people reaching out, relieving suffering, providing hope, and building healthier futures. Some of the many compelling clinical vignettes in this issue come from a refugee camp in Syria (Zaghrout-Hodali, 2014), a hurricane in South America (Jarero et al., 2014), and earthquakes in India (Mehrotra, 2014) and Italy (Fernandez et al., 2014).

The authors of the articles in this issue share their first-hand knowledge about working on the front lines and about developing humanitarian organizations. They bring years of experience to their articles, and their commentary on the challenges, future needs, and concerns is illuminating and thought-provoking. Seven of the 11 first authors do not speak English as a first language, and some had the gargantuan task of collecting and collating information and reports from multiple international contributors, many of whom spoke different languages. The authors are all busy professionals, and it was difficult for them to find time to write such complex articles. Sections of various articles were written at an airport in Kigali, Rwanda, on a flight to Indonesia, and after returning from a conference in New Delhi—or in the midst of dealing with a new unexpected humanitarian crisis. Each article represents a different perspective of the nature of the humanitarian work and its inherent challenges and rewards.

This special issue is about hope, inspiration, and generosity. We see individuals who have volunteered to travel around the world to help others; to administer EMDR treatment; and to teach, train, and provide long-term consultation to local clinicians. We see other therapists who have found opportunities to contribute in their own neighborhoods, responding to community needs or national crises. And we see the effectiveness of EMDR therapy in its varied applications as the treatment brings relief from suffering to many thousands of hurting people, living in compromised situations around the world.

As a postscript: Readers, if you are inspired by the material in this special issue and would like to become personally involved, you can contribute time, effort, expertise, and/or funds. Simply contact your national EMDR association or local humanitarian assistance program to get started. Working together, we can make a difference.

References


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EMDR Therapy Humanitarian Assistance Programs: Treating the Psychological, Physical, and Societal Effects of Adverse Experiences Worldwide

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The negative effects of trauma and other adverse life experiences have been shown to interfere with individual, family, and societal functioning. Eye movement desensitization and reprocessing (EMDR) therapy is empirically supported and recommended as a frontline treatment for psychological trauma in numerous practice guidelines. It provides both effective and efficient treatment without the need for detailed descriptions of the disturbing event or homework. This allows field teams to provide culturally sensitive therapy on consecutive days for those in remote areas and in crisis situations. Humanitarian assistance organizations have conducted projects internationally to provide EMDR therapy after both natural and manmade disasters and have helped develop sustainable mental health resources worldwide. This brief introduction provides an overview of current programs, treatment rationale, and a call for future action.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; humanitarian assistance programs; trauma; adverse experiences; adaptive information processing model
importance of effective treatment for survivors of political violence, imprisonment, and torture with clinical descriptions of people treated in a refugee camp in Palestine, a Syrian refugee camp in Jordan, and from a war zone in Libya.

In the two decades since the initial response in Oklahoma, the expansion of EMDR therapy training worldwide has been paralleled by the inauguration of humanitarian associations based outside the United States. EMDR Europe Humanitarian Assistance Program (EMDR Europe HAP; see Farrell, 2014), national EMDR associations in Europe (see Fernandez, Callarame, Maslovaric, & Wheeler, 2014), and Trauma Aid/Humanitarian Assistance Program Germany (see Mattheß & Sodemann, 2014) have extended aid both locally and outside of Europe. Starting in 2007, despite many challenges, EMDR therapy training throughout Africa has been conducted by TR/HAP, Trauma Aid, EMDR Europe HAP, and members of various European EMDR national associations (see Zimmernann, 2014). In Asia, EMDR therapy training and treatment began in 1998 in response to calls for assistance after various natural disasters. Significantly, through the humanitarian projects and efforts of the United States and European-based organizations, many Asian national and regional associations have been created, and in 2010, we welcomed the establishment of EMDR Asia. Its members have assisted thousands of people through both training and disaster response (see Mehrotra, 2014). In 1998, members of the EMDR HAP in the United States responded to a call for collaboration after a hurricane in Mexico. Subsequent to this project, extensive humanitarian assistance throughout Latin America and the Caribbean has been provided by the Mexican Association for Mental Health Support in Crisis and the Latin American & Caribbean Foundation for Psychological Trauma Research, as well as HAP organizations from Argentina and Brazil (see Jarero, Artigas, Uribe, & Miranda, 2014).

Members of all of these organizations have provided pro bono EMDR therapy training and treatment to populations in need throughout the world. Consequently, the cross-cultural applicability of EMDR therapy is clear, with successful projects throughout Africa, Asia, the Caribbean, Europe, Latin America, the Middle East, and the United States. Project evaluations have demonstrated positive effects with both individual and group protocols (e.g., Aduriz, Bluthgen, & Knopfler, 2009; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero, Artigas, & Hartung, 2006; Konuk et al., 2006; Silver, Rogers, Knipe, & Colelli, 2005; Zaghrout-Hodali, Alissa, & Dodgson, 2008; see also Farrell, 2014; Jarero et al., 2014). In addition to crisis treatment, an emphasis is placed on building sustainable mental health treatment resources with local agencies. All projects are invited collaborations with close attention paid to cultural differences and psychosocial needs.

EMDR Therapy

Although initially viewed with skepticism, EMDR therapy has now been validated by more than two dozen randomized controlled trials (see http://www.emdrhap.org/content/what-is-emdr/research-findings/) and numerous meta-analyses (e.g., Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Watts et al., 2013). An additional 20 randomized trials and a recent meta-analysis (Lee & Cuijpers, 2013) have demonstrated the positive effects of the eye movements, including rapid declines in emotional distress. Importantly, EMDR therapy has been recommended as an empirically validated effective trauma treatment by a wide range of organizations, both domestically (e.g., Department of Veterans Affairs & Department of Defense, 2010; Substance Abuse and Mental Health Services Administration, National Registry of Evidence-Based Programs and Practices, 2011) and internationally (e.g., International Society for Traumatic Stress Studies; Foa, Keane, Friedman, & Cohen, 2009). According to the recent World Health Organization (WHO; 2013) Guidelines for the Management of Conditions Specifically Related to Stress, trauma-focused cognitive behavioral therapy (CBT) and EMDR therapy are the only psychotherapies recommended for children, adolescents, and adults with PTSD. As indicated in the WHO guidelines, [EMDR] therapy is based on the idea that negative thoughts, feelings, and behaviors are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework. (p. 1)
of more severe child maltreatment is associated with screaming, grabbing, shoving, slapping, hitting in the absence of physical punishment [i.e., pushing, shoving, slapping, hitting] in the absence of corroborating evidence. Harsh physical punishment is typically associated with negative outcomes for children, including psychosocial trauma, and fear inherent in the disorder. Unsurprisingly, research has demonstrated that “harsh physical punishment” is a risk factor for several of the leading causes of death in adults” (Felitti et al., 1998, p. 251). These mortality risks included physically debilitating conditions such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The recognition that childhood traumatization can have lifelong mental and physical effects should be a major incentive for placing a spotlight on the global health crises confronting us all and to start comprehensively addressing them.

**Interpersonal Effects of Unprocessed Trauma**

As indicated by the AIP model, untreated trauma and other adverse life experiences have profound individual and interpersonal effects (Shapiro, 1995, 2001, 2014). Research has revealed grave and lasting consequences across the life span. Given the prevalence of traumatization generated worldwide by direct, natural, structural, and cultural violence (see Carriere, 2014), the need for timely trauma treatment is clear. Intergenerational effects include lack of bonding and disrupted attachment because of the anger, depression, anxiety, and fear inherent in the disorder. Unsurprisingly, research has indicated that mothers who have PTSD are more likely to maltreat their children (Chemtob, Gudiño, & Laraque, 2013). The implications of this fact are profound when one considers research demonstrating that “harsh physical punishment [i.e., pushing, grabbing, shoving, slapping, hitting] in the absence of [more severe] child maltreatment is associated with mood disorders, anxiety disorders, substance abuse/dependence, and personality disorders in a general population sample” (Afifi, Mota, Dasiewicz, MacMillan, & Sareen, 2012, p. 1). Other research has revealed a positive correlation between various forms of maltreatment and psychotic symptoms in children (Arseneault et al., 2011; Varese et al., 2012). Research has also indicated that “discordance in psychotic illness across related individuals can be traced to differential exposure to trauma” (Heins et al., 2011, p. 1286). In sum, although predisposing genetic factors may be involved, “contrary to long-held beliefs among biologically oriented researchers and clinicians, the etiology of psychosis and schizophrenia are just as socially based [e.g., early-life adversity] as are non-psychotic mental health problems such as anxiety and depression” (Read, Fosse, Moskowitz, & Perry, 2014, p. 73).

Given the general impairment and potential for aggression and violence in this population (Douglas, Guy, & Hart, 2009), the individual, familial, and societal risk factors are clear. All of this research indicates the need for effective and efficient treatments such as EMDR therapy to address both present and intergenerational traumatization. Fortunately, EMDR therapy has also been demonstrated in preliminary research to successfully reduce both PTSD and auditory hallucinations in those suffering from psychosis (van den Berg & van den Gaag, 2012).

The need for timely and effective treatment becomes even more pressing when considering the results of the Adverse Childhood Experiences (ACE) Study, which evaluated more than 17,000 participants and “...found a strong dose-response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults” (Felitti et al., 1998, p. 251). These mortality risks included physically debilitating conditions such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The recognition that childhood traumatization can have lifelong mental and physical effects should be a major incentive for placing a spotlight on the global health crises confronting us all and to start comprehensively addressing them.

**Societal Effects of Unprocessed Memories**

As indicated in the article by Carriere (2014), it is vital that sufficient attention and resources be provided so that treatment can be given to the millions of people impacted globally. The detrimental effects of untreated trauma have grave societal implications.
Although numerous organizations are dedicated to offering services to assist low-income countries in their development and to advance educational goals, untreated mental health issues can severely hamper their attainment. For instance, the reported effects of trauma and other adverse experiences also include alcoholism, drug abuse, and depression (Felitti et al., 1998), which can clearly prevent people in crises-prone regions from taking advantage of the development opportunities (e.g., jobs, schooling, health services) offered by various United Nations agencies, civil society, donor agencies, and business enterprises. Addiction—trauma coping strategies interfere with positive motivations and contribute to anger and aggression. These, in turn, have important societal implications because widespread and unrelieved traumatization can foster both familial dysfunction and a pervasive culture of distrust and discord. Viewed through the lenses of the AIP model, unprocessed memories have also contributed to generations of ongoing violence fueled by the distrust, anger, pain, fear, and hypervigilance inherent in traumatization. In addition to these effects on the individuals most directly involved, the retelling of previous humiliations and physical assaults can result in vicarious traumatization for ensuing generations (e.g., Bombay, Matheson, & Anisman, 2013). Children are not only affected by their parents’ distress, but in hearing such stories, they can picture themselves as having experienced the historical trauma and react accordingly. As indicated by the AIP model, any subsequent reminders of the trauma can trigger the negative emotions, physical sensations, and beliefs engendered by the event and color the perception of the present. This may result in ongoing antagonism toward “others”—ethnic, religious, racial, class, or caste groups—designated as adversaries because of historical trauma (e.g., Bombay, Matheson, & Anisman, 2014). Attempts to mediate peaceful solutions can also be hampered by these automatic responses because the evaluation of other people “at the table” is colored by the anger, fear, humiliation, and shame instilled by past experiences. In addition, mediators, service providers, disaster relief workers, and peacekeepers can be psychologically impaired because of vicarious traumatization from the detailed descriptions of past events. As indicated in numerous studies, the automatic effects from unresolved traumas can be resolved through the standard EMDR therapy protocols (Shapiro, 2001), which target (a) past events, (b) current situations that trigger negative responses, and (c) needed skills for future adaptive functioning. Importantly, research has also indicated that those with PTSD have difficulty disengaging from threatening cues (Pineles, Shipperd, Mostoufi, Abramovitz, & Yovel, 2009), which would clearly hamper those attempting to mediate positive solutions. Fortunately, preliminary research (El Khoury-Malhame et al., 2011) has indicated that EMDR therapy can result in a normalization and elimination of the negative attentional bias. Although more research is needed, these findings indicate that the availability of timely and effective trauma treatment may assist in bringing about reconciliation, peaceful coexistence, and the potential for nonviolent development. This further underscores the need to increase efforts to provide mental health services that address the debilitating effects of trauma through expanded care opportunities, comprehensive collaborative efforts, and supporting research (Carierre, 2014).

Commitment to Action

Over the last two decades, volunteers in the various EMDR humanitarian assistance programs have dedicated themselves to the alleviation of suffering in underserved populations worldwide. They have recognized that the fear, depression, anxiety, anger, and pain from unprocessed trauma experiences have debilitating effects on the individual that can derail any hope of a happy and productive life. They also recognize the negative impact on families, as the individual’s pain can result in domestic violence and the intergenerational transfer of dysfunction through inadequate bonding, aggression, or withdrawal. This awareness has motivated them to reach out to those in underserved areas throughout the world, both in their home countries and abroad. And finally, they have recognized the societal impact, including the unending pain caused by generation after generation of ethnopolitical violence. This has motivated them to offer EMDR training and treatment in locations such as Northern Ireland, the Balkans, and the Middle East in the hopes of aiding reconciliation and peace.

These dedicated volunteers recognize that trauma can be effectively and efficiently treated, and they have committed themselves to bringing healing to those in need. They have done so tirelessly and with the determination that no one should be left behind. They recognize that effective mental health treatment should be available to all and not merely those in the more affluent regions of developed countries. We honor them as well as those who have supported the projects through their donations and those who have helped open the doors to timely treatment by
establishing the efficacy of EMDR therapy through their dedication to rigorous research. This anniversary issue of the *Journal of EMDR Practice and Research* provides readers an overview of the healing accomplished through these humanitarian projects and an incentive to do whatever is needed to expand outreach to the millions more in needless suffering worldwide.

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Scaling Up What Works: Using EMDR to Help Confront the World’s Burden of Traumatic Stress

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The profound importance of addressing the global problem of trauma can hardly be overestimated—for human and world development and even for world peace. The contribution large-scale trauma healing could make to enhance social, economic, and cultural productivity, as well as individual educability, creativity, and well-being, could well be historic. Effective trauma treatment could stop immense and insidious silent inner suffering, which includes posttraumatic stress disorder (PTSD) but goes well beyond that:

As indicated by the adaptive information processing (AIP) model (F. Shapiro, 1995, 2001, 2014; Solomon & Shapiro, 2008) that guides EMDR therapy’s clinical applications, the recognition that unprocessed memories are the basis of a wide range of pathology highlights the urgency of treating victims of trauma and other adverse experience because of debilitating effects that range far beyond that of simple PTSD. These unprocessed memories of adverse events affect both mental and physical health, as well as the ability to learn, and the quality of personal and work relationships. (F. Shapiro, 2014, p. 183)

Moreover, effective treatment could help break the causal chains of violence begetting violence and abuse begetting more abuse transmitted from generation to generation.

Scale of the Problem

Statistics on the worldwide extent of current accumulated untreated trauma are incomplete. Many countries have barely begun to measure trauma occurrence, and the World Health Organization (WHO) only began to collect prevalence data in the late 1990s. PTSD lifetime prevalence rates range from a low of 0.3% in China to 6.1% in New Zealand and between 6.8% and 7.8% in the United States (Gradus, 2011). These sometimes surprising variations may be explained by the use of different definitions, population subgroups, or methodologies, making these statistics...
were killed until the year 2000 (Leitenberg, 2006). Survivors of these atrocities live on with lifelong disability, sorrow, anger, guilt, and trauma. They number in the millions. Most of us rarely consider their daily predicament and silent suffering, sometimes lasting for decades.

More visible perhaps, at the end of 2012, some 45.2 million people were “forced displaced” (refugees and internally displaced people). That figure is on the rise in 2013 “due to unusually large numbers of new refugees and internally displaced people” seen by the United Nations (UN) refugee agency (United Nations High Commissioner for Refugees [UNHCR], 2013). This statistic is almost certainly part of the earlier cited statistics on political and criminal violence.

One-third of all women in the world experience sexual, physical, or other abuse in their lifetime (Advocates for Human Rights, 2012). Much of this happens in the form of domestic violence by intimate partners or nonintimate partners (WHO, 2013c). Gender violence against women worldwide takes on many forms, for example, in war and armed conflict, in the name of “honor,” against girl children, dowry-related, female genital mutilation (FGM), and trafficking. It is no wonder then that women are more than twice as likely as men to suffer from PTSD and other trauma-based disorders.

Accidents kill over 1.2 million people a year and injure and disable tens of millions more (WHO, 2010); accidents, although not intended to harm, are a form of direct violence that traumatizes survivors, relatives, and first responders.

Natural Violence

Natural violence is both unintended and unavoidable. It comes in the form of earthquakes, tsunamis, floods, wildfires, volcanic eruptions, hurricanes and storms, drought, and extreme temperatures (now often symptoms of man-made climate change) and usually gets only momentary attention and relief aid, although its adverse consequences may linger for years.

Worldwide, an annual average of 268 million people are affected by natural disasters (EM-DAT: The International Disaster Database, 2012). Natural disasters caused by climate change are becoming a recurring pattern and in the foreseeable future are likely to affect even larger populations.

Loss of loved ones, something everyone experiences several times in a lifetime; for example, in 2012, an estimated 56 million people died...
that justify violence. Although cultural violence per se may not traumatize in large numbers, it leads to structural and/or direct violence; therefore, it must still be confronted at a deeper level to bring about more effective primary prevention of trauma altogether by eliminating or mitigating its sources. Although common and widespread, no statistics are available to quantify the extent and severity of this type of chronic adversity.

This quantification of the four violences, we may conclude, lends credence to the assertion that global statistics on PTSD and other trauma-based disorders are probably considerably underestimated. In any case, it is clear that the world faces a trauma problem of truly epidemic proportions.

Many of these categories of traumatic experiences or events overlap, often adding insult to injury and putting millions of people in double jeopardy by causing multiple traumas. Of course, not all traumatic experiences will lead to PTSD, although many of those who spontaneously “recover” from trauma continue to live with some residual scarring showing up soon after the event or sometimes much later (delayed onset).

Challenges of Preventing and Treating Trauma

The magnitude of this challenge may, by itself, cause a sense of being overwhelmed among those charged with the responsibility to mobilize responses. But need it be?

Ideally, traumas would be prevented altogether, and in fact, many different policies and actions are already under implementation to prevent or mitigate traumatizing conditions. These include disaster preparedness, initiatives against domestic and collective violence, zero-tolerance codes (e.g., against bullying, sexual harassment), strengthening resilience, promoting a culture of peace and nonviolence, poverty alleviation, protection of human rights and civil liberties, disease prevention, disarmament, and many others. But given the fact that many traumatizing circumstances are often beyond direct control of those (potentially) affected, it would only be realistic to expect that the number of new cases of trauma, PTSD, and other trauma-based disorders in the world each year will remain high and may even increase. This means that the prevalence of trauma and serious disorders such as PTSD will only come down if the world succeeds in effectively treating its victims on a large scale.

Structural Violence

Structural violence occurs when a social structure harms people and prevents them from meeting their basic needs. Although we do not usually think of poverty as a form of violence, it, too, harms and hurts—indirectly and largely—unintentionally. But structural violence is not inevitable because ultimately it is caused by human agency. Built into the structure of the world sociopolitical–economic system, it adds another dimension to the genesis of trauma.

- According to The World Bank (2014), worldwide, some 1.22 billion people lived in extreme poverty on $1.50 a day in 2010; in all, 2.4 billion lived on less than $2 a day that year.
- These are obviously traumatizing circumstances: Poverty as a pervasive and insidious social-global reality constitutes a traumatic condition of chronic adversity with devastating consequences for mental health (Desjarlais, Eisenberg, Good, & Kleinman, 1995). If you have ever walked through the slums of Dhaka or the favela in Rio, the risk of lifelong trauma to the local inhabitants will be instantly clear.

Cultural Violence

Cultural violence often lies at the root of direct and structural violence. It manifests in prevailing attitudes and beliefs about power and “necessity” of violence—ideas taught since childhood and surrounding everyone in daily life. It comes in many forms: apartheid, discrimination, oppression, colonialism, exploitation, and racism—each of which exerts a chronic stress that may lead to trauma (Rich et al., 2009). “Just” war theory, ideas about honor killings or the need for capital punishment, are some examples of the cultural beliefs worldwide (WHO, n.d.). Mortality leaves countless millions bereaved each year.

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Meanwhile, for most of the world—and especially for low-income countries—the huge individual and global burden of trauma and traumatic stress has remained largely hidden: It is undiagnosed, unrecognized, and therefore untreated. The unmet need for trauma treatment of people living with PTSD worldwide remains enormous.

It may therefore seem surprising that trauma therapy as a topic was not included in the UN Millennium Development Goals (MDGs) for 2015. In fact, until more recently, mental health altogether (including trauma and PTSD) has not been an explicit global policy priority despite its high disability-adjusted life year score. Mental disorders account for about 160 million lost years of healthy life per year (WHO, 2001)—a huge economic burden. In practical terms, worldwide mental health receives around 2.8% of health budgets; for high-income countries, it is 5.1%, but low-income countries allocate much less: under 0.5% of already small health budgets (WHO, 2011). What may be left for trauma therapy is absolutely not in proportion to the extent and severity of the problem.

Opinions differ regarding the reasons why such a massive world problem has not come into sharper focus and moved higher on the world agenda. Perhaps financial and human resources are not allocated because of (a) a lack of understanding among policy makers and donors. Indeed, other “pressing” health concerns get higher priority, such as HIV/AIDS, immunizations, and infectious or chronic physical diseases. One exception is the budgets for military veterans of some countries, and there are some encouraging signs that increasingly include trauma therapy in (short-term) donor aid for disaster and humanitarian relief.

But lack of proper appreciation is only one factor. There are several other obstacles: (b) social stigma or people’s sense of fatalism, resulting in failure to seek trauma treatment; (c) difficulties with diagnosis, measurement, and recognition, especially in different cultural settings; and (d) poor coordination and limited integration of mental health into public health services, which may prevent trauma victims from getting proper treatment. All these reasons are undoubtedly important and play a role.

That said, perhaps the most pertinent reason for not addressing trauma, PTSD, and other trauma-based disorders on a scale commensurate with its extent, severity, and significance is a general belief that there is not much we can do about trauma—that we can neither prevent nor effectively treat it—or the belief that no effective, recognized trauma therapies are available that are also affordable and scalable. These beliefs may well explain why the worldwide action response to trauma up until now has been so lukewarm. And they may also clarify the lack of good statistics (“why bother collecting baseline prevalence rates if no large-scale interventions are planned or possible?”).

Although these beliefs may have been valid until recently, today, they are no longer. The time has therefore come worldwide to stop neglecting traumatic stress (and/or being fatalistic about it) and start acknowledging that there are treatments that work. This is where eye movement desensitization and reprocessing (EMDR) therapy comes in.

To Scale With EMDR Therapy

In 2013, the WHO conferred to EMDR formal recognition as an effective evidence-based therapy, putting it on par with trauma-focused cognitive behavioral therapy (CBT), noting that “Like CBT-T, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT-T, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure or (d) homework” (WHO, 2013a).

With EMDR, the world now has a new efficient and effective therapy against the damaging effects of traumatic stress, one proven to be quick, low-cost, and widely applicable in a range of crisis settings and cultural milieus.

The comparative strengths of EMDR therapy bode well for treatment on a very large scale. Here I would highlight three of EMDR’s special characteristics that are a sine qua non for going to scale.

First, its rapid positive results and treatment effectiveness: EMDR requires only minimal contact time to be effective, measured in hours and (consecutive) days, not weeks and months. Moreover, the use of group protocols (Artegas, Jarero, Alcala, & Lopez Cano, 2009) currently receiving research validation will make it possible to reach larger numbers in a shorter period of time. These offer a huge operational advantage in resource-poor conflict and disaster settings.

Second, its acceptability: EMDR is minimally intrusive and minimally dependent on verbalization of the trauma experience—two more plusses—that
In this regard, promising efforts are underway to design and adapt existing EMDR protocols (Jarero, Amaya, Givaudan, & Miranda, 2013; Luber, 2014) so that they can be used as part of PFA and/or after it has been administered: as a kind of psychological second aid delivered by paraprofessional staff working in the referral system as a link between PFA and mental health professionals at the tertiary level. This “task shifting,” which in its details would vary from context to context, would help rationalize the use of scarce professional resources through timely and proper referral when higher skills are called for. Throughout, utter care must be exercised to minimize risks and manage referrals when needed.

Under the acronym SUNDAR (Hindi for “attractive”), Patel (2012) summarizes this idea as follows:

Simplify the message
UNpack the treatment
Deliver where people are
Affordable and available human resources
Reallocation of specialists to train and supervise

In this regard, promising efforts are underway to help lower the access barrier to services and reduce cultural resistance to treatment. Moreover, various simple and readily acceptable techniques to deal with the early phases of trauma are now available (E. Shapiro, 2013).

And third, its potential as a primary (and also secondary) care intervention: EMDR lends itself well to be incorporated not only into community-based psychological first aid (PFA; WHO, World Vision Australia, & War Trauma Foundation, 2011) done by volunteers (the two bottom tiers in the intervention pyramid) but also potentially into a higher level response for mild to moderate disorders undertaken by a specially trained paraprofessional cadre to whom well-defined roles could be assigned (the third tier in the intervention pyramid; see Figure 1). The book Getting Past Your Past (F. Shapiro, 2013) lists several techniques that could readily be taught in the context of psychological first and “psychological second aid” (including stabilization, education, and psychosocial work), and there is further potential scope of incorporating other modified EMDR procedures.
This restructuring is vital because the most immediate and pervasive constraint to scaling up trauma treatment is undoubtedly (and will remain in the future) the severe and chronic shortage of qualified professional and even paraprofessional personnel, especially in the developing world—even more so in situations of crises (disasters and violent conflict). Current WHO estimates are that over 1.7 million mental health professionals will be needed around the world to close the treatment gap for mental, neurological, and substance use conditions (WHO, 2011). This number includes professionals treating trauma but does not include the number of primary mental health care frontline workers needed.

Having been involved for 30 years as a development professional with United Nations Children's Fund (UNICEF) and The World Bank in the design and implementation of large-scale public health and nutrition programs in the developing world, I have no illusions about the challenges associated with going to scale with non- or paraprofessional workers in a selective primary health care setting. But involving non- and paraprofessional is imperative, a sine qua non, one that will also demand “solutions” to many practical policy and political issues and even ethical dilemmas that will come to the fore.

Risk-Benefit Analysis and Ethical Policy

As we have seen, tens of millions of people are traumatized each year; most of them will have no access to treatment. Now is the time to be bold and responsible in our efforts to take on the trauma epidemic: to achieve maximum trauma reduction in the shortest possible time. This requires that the principle of “do no harm” be recontextualized to include the acceptance of some calculated and manageable risks that inevitably occur when (a) projects are scaled up to programs and (b) some selected tasks, involving the use of simplified EMDR and trauma-focused CBT, are shifted down from professional to paraprofessional and community workers. That is the only way in which we can begin to tackle the very large number of traumatized people.

Lest we forget: Treatment deferred is treatment denied. In ethical terms, the act of omission may in this case, in fact, be far more serious than the act of commission. The existence of effective treatment modalities makes it unconscionable to allow traumatized people to continue suffering and families, communities, and societies to be harmed as a result.

At the occasional, manageable risk of misdiagnosis or mistreatment, vastly more trauma cases could be treated if paraprofessionals, equipped with intermediate yet appropriate skills, were allowed to share the work burden now facing the inadequate numbers of psychologists, psychiatrists, and other professionals dealing with mental health issues. This makes it vital that emphasis be placed on a careful analysis on the characteristics of individuals that can be selected for this task and judiciously evaluating the application of simplified EMDR protocols by paraprofessional providers. A rigorous evaluation of outcomes in settings supervised by licensed mental health professionals can ensure timely treatment for all on site during the development process.

Doing the Doable Now

The huge scale of the trauma problem and the enormous challenges it presents may themselves cause overwhelm, cynicism, and even paralysis. But that should not be the take-away message of this article—quite the contrary. EMDR itself is a big cause for optimism about the possibilities for scaling up trauma therapy, and the world can undoubtedly find responses to the new challenges it generates. For example, WHO’s recently approved Comprehensive Mental Health Action Plan 2013–2020 (WHO, 2013b) would be supported by EMDR (together with other trauma therapies).

Although the “psychology community” can define the mental health problems and their potential solutions, it cannot solve these problems by working alone. Therefore, although a leadership role would naturally fall on the many professional organizations of psychologists, psychiatrists, and other mental health specialists, it would have to be shared with experts in many other disciplines, such as communications and social marketing, training and pedagogy, statistics and epidemiology, monitoring and evaluation, resource mobilization, advocacy, and others. No one can do it alone.

Meanwhile, what are some of the things that can be done more immediately by representations of the various EMDR therapy organizations? Here are some manageable activities that could now be undertaken to great advantage for the cause:

- Systematically map all significant stakeholder organizations, including pertinent UN agencies (UNHCR, Red Cross, UNICEF).
- Design a grand partnership strategy for (and with) each of them.
• Plan the first global conference on trauma therapy bringing together principal stakeholder representatives.
• Organize strategic planning meetings at national, regional, and global levels.
• Identify and approach potential champions, goodwill ambassadors, and celebrities of national and global appeal for policy advocacy and to support the cause.
• Begin work on an authoritative annual State of the World’s Trauma Report.
• Produce a powerful advocacy film on EMDR and other trauma therapies.
• Design a plan to set up EMDR courses at psychology departments or medical faculties of universities worldwide (with focus on the developing world).
• Systematically explore funding possibilities and develop a strategy for resource mobilization.
• Create a cadre of EMDR diplomats to insert “trauma therapy” as a topic in national and international meetings on humanitarian, peace and security, development, productivity, economic growth, disaster, mediation, and other issues.
• Establish a global humanitarian assistance coordinating capacity with a secretariat close to potential users of EMDR services (pro bono, contractual, retainer), with “EMDR” offering the following:
  • EMDR training at different levels, tailored to the needs of organizations, for groups (e.g., counselors, human resource (HR) managers, paraprofessionals), under contractual arrangement
  • To support online trainings, including facilitation and new language versions (with focus on the developing world)
  • To provide standby treatment services to meet staff needs at the headquarters or field offices of organizations
  • To provide rapid deployment treatment in the field, some as pro bono actions, most understanding contractual arrangement
  • To support ministries of health with setting up national trauma treatment capacity
  • To advocate in UN fora through EMDR’s Humanitarian Assistance Program’s (HAP) recently acquired consultative status with UN Economic and Social Council (ECOSOC)
  • To undertake priority research

Research Needs

Exactly how EMDR or any other therapy works remains a mystery that further research will ultimately reveal. But that is no reason to delay application, on a large scale, of what we already know works. Guided by appropriate research, evaluation, and monitoring systems to manage, steer, and refine large-scale EMDR programs, we should build the ship while sailing. Because with other health innovations, many refinements need to be explored for which research and evaluation are indispensable.

Practical research needs require more urgent attention for purposes of program refinement—especially whom and when to treat and whom to train in what—already the subject of extensive study (E. Shapiro, 2013). To this research agenda, I would add several other research priorities: (a) cost-effectiveness studies (comparing different treatment approaches), (b) a cost-benefit analysis (for purposes of high-level advocacy), (c) risk-benefit studies (to guide fuller use of frontline workers and paraprofessionals in primary health care settings), (d) training research (to optimize task shifting and to maximize use of e-learning and blended training opportunities), (e) formative evaluation for mass communications campaigns, (f) baseline population surveys (to better gauge needs and track progress), and (g) innovations in large-group treatments and healing of collective trauma. Better information is also needed about risk screening, referral, and the best protocols for triage, especially at the level of psychological first and second aid. Furthermore, the role of cultural and contextual factors in trauma treatment needs to be better understood. Finally, appropriate applications of Web-based telecounseling and the use of mobile technology (including smart use of so-called dumb phones to which many of the world’s poorest now have access) and trauma apps need to be further studied, developed, and applied. In general, future studies should ideally have larger sample sizes.

Changing the Global Face of Trauma

With a 25-year track record and an organizational base of some 60 national EMDR associations plus some 100,000 professional EMDR practitioners working, often pro bono, in one-third of the world’s countries (including all the most populous), there is now a critical mass that could make possible a quantum jump in scaling up. EMDR has the potential to change the face of trauma: from the lifelong destructive burden it now is for most of its victims to a transitory, treatable affliction in conflict, humanitarian, development, and “normal,” everyday settings. Given their enormous magnitude and devastating consequences, traumas should be one mental health challenge we now resolve to take on as a top priority, without
delay. Because trauma makes up a major part of mental health conditions, its treatment would make a major health contribution to the estimated 700 million people who suffer from a mental condition (Patel & Saxena, 2014). It is my conviction that EMDR could play a major role in that effort.

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EMDR Humanitarian Assistance Programs: 20 Years and Counting

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EMDR Humanitarian Assistance Programs (HAP) was created in 1995 by EMDR clinicians who had offered pro bono care and training for therapists in Oklahoma City after a terrorist attack. HAP set its mission to bring evidence-based trauma therapy to communities that were underserved or that had suffered disasters. HAP’s training programs, which are low-cost, are provided by volunteers and target clinicians in public or nonprofit agencies. HAP currently reaches about 2,000 trainees annually. Similar HAP training programs in developing countries reach about 200 clinicians annually and aim to build local communities of practice that are sustainable. HAP has responded to disasters worldwide, with both training and treatment, but increasingly directs most disaster aid to the United States as new sister organizations appear and respond to disasters in other regions of the world. In recent years, HAP has aimed to promote emergence of its Trauma Recovery Network (TRN)—local voluntary teams of clinicians who stress preparedness as a key component of disaster response. Three TRN chapters in 2010 had grown to 20 in 2013 and will soon double, providing new options for service to HAP’s more than 1,500 registered clinician volunteers.

Keywords: EMDR HAP; Trauma Recovery Network; EMDR training; capacity building; disaster response; volunteers

Humanitarian Interventions

Like all mental health clinicians, EMDR therapists are engaged in a caring profession. They cross a line into humanitarian action, as understood in this article, when they offer their services pro bono to an individual or community that is in great need for basic human resources but lacks the means to provide such resources for itself. The bombing of the Federal Building in Oklahoma City in 1995 was a local disaster that emerged suddenly and constituted a humanitarian crisis. It became the incident that also generated the EMDR HAP. Although that disaster was localized and evoked a swift response, it shared with all disasters the fact that it profoundly disrupted the normal means by which a community commonly managed to cope and to thrive. As the leaders and volunteers of HAP were to experience in the following years, not all disasters, with their attendant humanitarian needs, arise suddenly or recede rapidly. In many
societies, traumatizing conditions, whether natural or man-made, are long-standing and block human communities from coping or thriving with the means they have at hand. These conditions may be found in developing countries but also in large subsections of affluent societies, such as the United States. As we will show, HAP ultimately directed its humanitarian efforts at all of these types of human disaster.

Eye Movement Desensitization and Reprocessing

In 1995, eye movement desensitization and reprocessing (EMDR) was a relatively new psychotherapy. EMDR therapy follows a protocol and has given rise to specialized protocols that support early interventions for psychological trauma patients (Luber, 2009, 2013; Shapiro, 1995). These formulations made EMDR therapy relatively easy to teach to experienced clinicians and also supported the first generation of researchers to study it. Randomized controlled trials would accumulate in later years, confirming effectiveness and efficacy of EMDR therapy for treatment of posttraumatic stress disorder. But there were few systematic studies at that time. Clinical reports were favorable to EMDR therapy as a trauma therapy, however, as was personal clinical experience among HAP volunteers.

EMDR Therapy as a Humanitarian Intervention

From its beginning, EMDR HAP approached humanitarian aid on a dual track. In the first instance, HAP volunteers went to the scenes of a disaster to offer training in EMDR therapy to local clinicians who would remain to deliver care during the recovery period of months or years that follows major disasters. On the other track, the same volunteers provided direct clinical services to individuals and groups experiencing acute stress or posttraumatic stress disorder. Frequently, direct treatment was a briefly shared activity with the newly trained local clinicians to help them consolidate their new skills.

EMDR HAP has never been funded for the purpose of research, and research has rarely been an objective of a HAP humanitarian project. The studies that have been done include the largely unfunded efforts of volunteers who contributed their time and skill here as well. Several of these studies document the actions taken in early projects and attempt to measure their clinical impact in New York after 9/11 (Colelli & Patterson, 2008; Silver, Rogers, Knipe, & Colelli, 2005) and internationally in India (Matthess & Mehrrotra, 2008), Turkey (Konuk et al., 2006), and Mexico (Jarero, Artigas, & Luber, 2011).

Very soon after its founding, the scope of humanitarian effort by EMDR HAP expanded. Incidence and impact of psychological trauma after highly publicized disasters were often matched or exceeded by levels of untreated trauma in various disadvantaged but less publicized settings and communities. This led HAP volunteers to begin training clinicians at public and nonprofit clinics in the United States that serve populations with low incomes and high levels of untreated trauma. Such training became the primary ongoing service of EMDR HAP in the United States. Closely related was ongoing training of clinicians in the U.S. Department of Defense and Veterans Affairs, who were struggling to cope with massive incidence of combat-related trauma among military personnel and veterans. Early studies had begun to document efficacy of EMDR for combat trauma (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998), but official promotion of EMDR treatment was slow to develop (Department of Veterans Affairs & Department of Defense, 2010; Russell, 2008).

Transferring clinical skills to developing countries was not as simple as offering continuing education workshops in EMDR to clinicians working in U.S. nonprofit clinics. Many countries had long-standing traumatic histories already “baked in,” and disasters were both more frequent and more devastating, given low levels of resilience. World Health Organization (WHO) and development economists were increasingly aware of the association between mental health and rapid socioeconomic development (Carriere, 2013; WHO, 2010). Trauma and trauma-related mental health diagnoses were high on the WHO list of problems needing solutions. EMDR is a highly promising treatment choice, given its relatively low cost and rapid efficacy. But mental health service systems were underdeveloped, if not missing, in these countries. HAP projects would be short-lived unless they were sustained and integrated with larger indigenous efforts to build mental health service systems, as HAP has been striving to do in the West Bank, Kenya, and Ethiopia.

In the Beginning . . .

The bombing of the federal building in Oklahoma City in 1995 led to the first large-scale mobilization of EMDR clinicians to assist a community in crisis and, thereafter, to the founding of EMDR HAP as a nonprofit charity that continues to this day. For 6 months following the bombing, 186 HAP volunteers rotated into the city to treat the survivors and train clinicians.
Their free clinic treated more than 250 blast survivors, firefighters, and rescue personnel who had trauma symptoms. They also trained 300 clinicians, giving them the tools they needed to continue treatment.

1996–2006

Between 1996 and 2006, HAP clinician-volunteers from many nations responded to several domestic and international emergencies. The biggest projects were for flooding in Bangladesh and Indonesia in the early years, the 9/11/2001 attacks on Washington and New York, Hurricanes Katrina and Rita in 2005, and the tsunami in Southeast Asia in 2005–2006 (see Table 1). Many of the volunteers were facilitators or trainers for the EMDR Institute, and HAP began to train new facilitators and trainers to expand its capabilities. Training was based on the model of the EMDR Institute and conformed to the standards endorsed by the EMDR International Association. Clinicians who were trained in these early international projects learned basic EMDR but usually had limited opportunity to get further training in specialty areas or to meet with consultants.

Beyond disaster response, HAP domestic training events in basic EMDR therapy were growing in number during this period, from 7 or 8 events in 1996 to about 40 events in 2006, with an average of 20–25 participants in each (participants must complete two workshops to finish basic EMDR training). Training for Department of Veterans Affairs (VA) and military clinicians was a part of this total, with most of those events conducted by HAP volunteers who were themselves military or VA clinicians.

Although research was not a part of HAP projects, the publication of research studies supporting EMDR therapy during this period appears to have increased interest among nonprofit and public agencies to get clinical training in EMDR therapy. Another factor, frequently noticed in the HAP office by 2006, was the influence of clinicians newly promoted to the role of clinical director at their agency, who had been trained by HAP previously and now wanted their clinicians to have the same skill set.

### TABLE 1. Growth and Activity of EMDR HAP, 1995–2014

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Training Events (United States/Other locations)</th>
<th>No. of Therapists trained by HAP</th>
<th>New HAP Registered Volunteers</th>
<th>Major Disaster Responses</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>U.S. multiple</td>
<td>300</td>
<td>186</td>
<td>Oklahoma City</td>
<td>Bombing</td>
</tr>
<tr>
<td>2001</td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>India (Gujarat)</td>
<td>Earthquake</td>
</tr>
<tr>
<td>2004</td>
<td>21</td>
<td>336</td>
<td>?</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>30 U.S.; 3 other</td>
<td>730</td>
<td>50</td>
<td>India/Thailand/Sri Lanka/Louisiana, and Mississippi</td>
<td>Tsunami/hurricane</td>
</tr>
<tr>
<td>2006</td>
<td>49</td>
<td>1,268</td>
<td>318</td>
<td>Indonesia</td>
<td>Tsunami</td>
</tr>
<tr>
<td>2007</td>
<td>63 U.S.; 7 other</td>
<td>1,211</td>
<td>147</td>
<td>Indonesia</td>
<td>Tsunami</td>
</tr>
<tr>
<td>2008</td>
<td>55 U.S.; 11 other</td>
<td>1,261</td>
<td>101</td>
<td>Chengdu, China</td>
<td>Earthquake</td>
</tr>
<tr>
<td>2009</td>
<td>54 U.S.; 17 other</td>
<td>1,528</td>
<td>131</td>
<td>Chengdu, China</td>
<td>Earthquake</td>
</tr>
<tr>
<td>2010</td>
<td>80 U.S.; 24 other</td>
<td>2,156</td>
<td>165</td>
<td>Haiti/Joplin, Missouri; and Tuscaloosa, Alabama</td>
<td>Earthquake/tornadoes</td>
</tr>
<tr>
<td>2011</td>
<td>73 U.S.; 17 other</td>
<td>2,229</td>
<td>155</td>
<td>Sichuan, China</td>
<td>Earthquake</td>
</tr>
<tr>
<td>2012</td>
<td>100 U.S.; 5 other</td>
<td>2,157</td>
<td>222</td>
<td>Oklahoma</td>
<td>Tornado</td>
</tr>
<tr>
<td>2014 through</td>
<td>55 U.S.; 7 other</td>
<td>1,313</td>
<td>149</td>
<td>Philippines</td>
<td>Typhoon</td>
</tr>
</tbody>
</table>

Note. ? = incomplete data.
2007 to Present

Within the United States, the major activity of HAP in recent years has continued to be basic EMDR therapy training of clinicians at public and nonprofit agencies, which are the principal source of mental health care for socioeconomically disadvantaged communities in the United States. Annual numbers of participants have grown steadily to more than 2,000. A secondary benefit of domestic training has been the preparation of new facilitators and trainers to meet the demand for training. Most of these EMDR educators remain volunteers for HAP; some go on to become independent clinical educators or to work for the EMDR Institute. Many of these continue to function as HAP volunteers as well. In every case, they add to society’s resources for training clinicians in EMDR therapy.

Domestic disaster response has continued to be a major focus of HAP activity. Following the massive response to Hurricanes Katrina and Rita, however, HAP began to modify its approach to emergency response. Previously, major events, such as Oklahoma City, 9/11, and Katrina, had elicited strong support from the EMDR community in the form of donations and volunteers ready to travel to a scene of disaster. Each of these events, however, had compelled HAP to create a structure of coordination and procedure from scratch. Although earlier lessons had not been forgotten at the HAP office, they were unknown to each new crop of volunteers. Also, the cost of sending volunteers and supporting them in the field often far from their homes was prohibitive. At the same time, “lesser” disasters in local communities often failed to arouse strong interest from elsewhere in providing help.

In response to these difficulties, HAP launched a Trauma Recovery Network (TRN), consisting of local chapters whose EMDR-trained members would be prepared in advance of community need, would be networked with other local emergency responders, and would work to raise public understanding of trauma and its treatability during nonemergency times (Alter-Reid, Colelli, & Simons, 2014).

Local TRN volunteers would be ready to respond when emergency need arose, and TRN members in other communities would be available to join them if needed. Meanwhile, all TRN members would have a shared set of understandings about their role and their relationships with other emergency responders. Veteran volunteers from three locations, New York, Western Massachusetts, and St. Paul, formed the first TRN chapters after the major HAP project responding to Katrina in Louisiana. By 2014, there were 20 U.S. TRN chapters and two in Canada. Another 20 localities had TRN chapters in formation. The existing chapters have been highly motivated and responsive to emergencies in many locations where HAP previously would have been unable to mount a rapid response of adequate scope.

International engagement by HAP has also been evolving over the past 8 years. Throughout this period, strong national and regional EMDR associations have existed or been developing in Europe, Latin America, and Asia, most of them with a HAP-like component, which was ready to take on challenges on its own turf and to assist neighbors as needed. Where in the past, U.S. HAP might organize a disaster response and welcome volunteers from many other countries to participate, it increasingly made sense for nearby EMDR groups to respond and request help from other nations as needed. One major, but brief, collaboration of this sort was among the HAP organizations from the United States, France, and Belgium in 2011 to provide training in French to Haitian psychologists after the massive earthquake in Haiti. In another brief collaboration, HAP trained clinicians in Chengdu, China, after a massive earthquake in 2008, at the request of Germany’s Trauma-Aid group, which had trained clinicians in Beijing.

There remained several countries where HAP was asked by local leaders to sustain a training role over a long time frame. These engagements were typically for training EMDR therapists and sometimes for helping, as in India and the West Bank, to prepare outstanding therapists as EMDR trainers. Other countries where HAP has continued as a trainer of clinicians include Kenya, Ethiopia, Sri Lanka, Iceland, and Philippines.

Goals of EMDR HAP

Throughout its history, HAP has aimed to bring the benefits of EMDR therapy to individuals and communities that are enduring significant traumatization and that, for one reason or another, are not otherwise able to access effective care. The specific goals of EMDR HAP today derive from the reasons why effective care might be inaccessible.

First, in times of disaster, there may be an intensification of trauma coupled with a general disruption of normal pathways to treatment. For that reason, HAP has dedicated itself to responding to disasters. To increase the effectiveness of disaster response within the United States and to lower its cost so that more care can be provided, HAP has created and is working to expand a National Trauma Recovery Network of...
local volunteers who are committed to prior preparation for effective emergency response.

Second, in “normal” times, many communities within the United States experience persistently high levels of untreated trauma and its sequelae. Such communities may have low-cost clinics available, but the clinicians lack training in an evidence-based trauma therapy such as EMDR. For that reason, HAP has the goal of providing low-cost high-quality training in basic EMDR. For the same reasons, HAP has undertaken international projects, unrelated to a recent disaster, that aim at building the capacity of local caregivers to address widespread untreated trauma. In the absence of highly developed systems of mental health delivery, such capacity building efforts cannot be done rapidly. Rather than spread its efforts too thinly, HAP has become selective about the countries where it will seek to build capacity and has made efforts to work in those locations that aim to expand their service capacity over a long term. Basic EMDR training is offered repeatedly, but advanced specialty topics in EMDR therapy are also provided, and when possible, efforts are made to prepare local clinicians as trainers, facilitators, and consultants. These goals have been the foci of work in the West Bank (Zaghrou-Hodali, Alissa, & Dodgson, 2008), in Kenya, in Ethiopia (Errebo, 2010; Farrell, Keenan, & Basil, 2006).

Management of Programs and Services

Administration. EMDR HAP is overseen by a board of directors which sets basic policy and appoints an executive director to manage programs and services. Since 2003, the HAP office has been in Hamden, Connecticut. A flexible data system linked to e-mail and a website (http://www.emdrhap.org) together enable a small staff of seven full-time-equivalent personnel to manage a volunteer base of over 1,500 clinicians (including 150 from outside the United States), schedule and staff more than 100 training events each year, enroll and track more than 2,000 training participants, support a growing number of local TRN chapters (currently 20), solicit financial support, market literature on EMDR to clinicians, and provide public education on EMDR, trauma, and HAP.

Funding. Donations to HAP, a public charity under the U.S. Internal Revenue Code Section 501(c)(3), are tax deductible. Donations tend to increase at times of major emergent humanitarian need, but over the long haul, more than 80% of HAP’s revenue comes from its low-fee training services. HAP pursues an active program of grant seeking as well as soliciting individual contributions.

Volunteer Training. Training events are staffed by volunteer trainers and facilitators who have met the standards of the EMDR Institute and the EMDR International Association (EMDRIA). In domestic training projects, participants are expected to secure qualified consultation privately. In international training, when EMDR is just being introduced in a country, HAP makes flexible ad hoc provision for consultation, either by visiting consultants or via Skype and/or telephone conference. A large number of current trainers and facilitators became qualified for this work to meet HAP’s need. Candidates for these roles are offered mentors (for facilitators) or special workshops (for trainers) before shadowing experienced volunteer educators at multiple training events and being observed in their initial practice as EMDR educators.

The emergence of the TRN chapters has provided expanded roles for EMDR therapists who are not facilitators or trainers. All chapters are committed to ongoing training in specialty protocols related to early treatment of trauma and special populations as well as in psychological first aid as supported by Red Cross and other emergency response organizations. All TRN chapters are committed to including an EMDRIA-certified consultant in their membership. TRN members have completed basic EMDR training at a minimum and are encouraged to become EMDRIA-certified clinicians. HAP has also provided workshops, in TRN communities and elsewhere, on Recent Traumatic Event Protocol (RTEP).

Project Logistics

Project Selection. Enrollment in domestic training events, in EMDR Part I or Part II, is limited to licensed clinicians engaged in full-time (30 or more hours per week) clinical work at a public or nonprofit agency. Typically, an agency sponsors the training and provides a venue capable of accommodating at least 25 participants who meet the criteria, although they may work at different agencies. Both low fees and the fact that the training team comes to the participants’ community for the 3-day event help to make the process affordable. Specialty training is offered rarely, except for workshops such as RTEP which serve the preparedness goals of TRN chapters.

International projects are selected and defined in a more complex and ad hoc manner. If the project is focused on training, in whole or in part, HAP looks for evidence that the potential trainees are
adequately prepared as clinicians to absorb the training. If translation of the instruction is required, HAP looks for evidence that translators are available and skilled in translating in this technical domain. Because this is often difficult to ensure and because translation slows down the pace and accuracy of training, HAP today favors projects that can be conducted in the shared language of the training team and the participants without need of translators. In most cases, international training projects are paid for by grants, donations, or other third-party payers rather than by the participants.

Selection of projects focused on direct service to first responders and survivors of a disaster is affected by many considerations: funding to support transportation and maintenance of clinical teams, shared language or available clinician/translator, and sponsorship or endorsement of the project by a local governmental or health agency. Early in its history, U.S. HAP was a provider or co-provider of most international disaster relief projects involving EMDR and aimed to support EMDR clinicians from other countries to develop similar humanitarian organizations. Because such organizations have emerged, HAP’s involvement in disaster response internationally has been reduced, whereas HAP’s focus on capacity building in developing countries has increased. In capacity building work, as in the West Bank, Kenya, and Ethiopia, project selection is jointly designed with local partners to support their progress in expanding knowledge of EMDR and integrating EMDR therapy into their national health-care systems. Focus is typically on training and consultation, developing indigenous consultants and educators, and bringing in specialty training, always constrained by availability of third-party funding.

Supporting Volunteers in the Field. For domestic training projects, volunteers are selected with an eye to their proximity to the site, to reduce travel costs, and consideration of the match between areas of special expertise among the training team and any special focus of the sponsoring clinic (e.g., if the clinic serves mostly children or individuals with chemical dependencies). Volunteer specialties are also considered in staffing international projects. By definition, HAP volunteers serve without pay in the projects they agree to join. They typically make their own travel arrangements and are directed to lodging that is convenient to the project site. HAP reimburses travel, food, and lodging costs.

Volunteers typically work in teams and organize their activity in the field to take account of any special circumstances in their work. In training projects, the trainer is considered the “captain of the ship,” authorized to take final decisions after the team has explored any problem. In TRN projects, each chapter endorses shared standards listed on the HAP website, but beyond that, each chapter is autonomous and designates its own coordinators of the voluntary work. TRN chapters are encouraged to attend to secondary stress on volunteers (Alter-Reid, Evans, & Schaefer, 2010).

Services That HAP Provides

Disaster Response. Because HAP projects are time-limited, volunteer teams away from home are usually eager to train local clinicians in EMDR. When the team leaves, they aim to leave behind local clinicians who can continue to provide effective treatment for trauma. For this reason, EMDR training is often a component and by-product of disaster response projects. In other cases, and where a domestic TRN chapter is responding in its own community, there are six principal functions (discussed later) that constitute the services expected of TRNs.

Conditions at a disaster site require flexibility. Group treatment has been used in post-tsunami projects in India (Farrell et al., 2006), Thailand, Sri Lanka, (Errebo, Knipe, Forte, Karlin, & Altayli, 2008), and other settings. Group psychoeducation followed by brief individual counseling was provided to 600 first responders and additional local caregivers in Louisiana after Katrina. When it has been feasible to train local clinicians in EMDR as part of a project, HAP teams have then supported them in their initial field use of what they had learned, as in Haiti, India, Sri Lanka, and Turkey.

Training for Military Clinicians and United Nation Therapists. The military and United Nation use their clinical staffs to support the mission of their field personnel. In the case of the U.S. military and VA, HAP has trained nearly 1,000 clinicians over many years. However, there are tens of thousands of clinicians in these services. Research has supported use of EMDR for combat trauma (Carlson et al., 1998). EMDR is now recognized officially by the VA as a recommended therapy, but decisions to train clinicians and to use EMDR are made by local commanders and administrators. Local military commanders shift every few years, and support for EMDR may decline or increase based on who is in charge. Russell (2008) has analyzed traditions of resistance to treating combat trauma. It is the perception of HAP that support for EMDR from higher echelons has grown slowly, and in some services, there is now support for developing their own EMDR trainers with expertise in combat trauma.
WHO (2013) has endorsed EMDR as an effective therapy in disaster mental health. HAP has trained WHO clinicians in the course of its project in Haiti after the earthquake of 2010, and WHO continues to seek HAP’s services to train their therapists in disaster settings.

**Capacity Building as a Goal.** Although HAP’s first humanitarian ventures involved teaching EMDR to local therapists who would be seeing traumatized people after a disaster, it was soon apparent that the early aftermath of a disaster is not the best time frame for introducing caregivers to intensive training events and trying out new skills. Both at home and internationally, HAP has developed improved approaches that focus on building clinical capacity during ordinary times instead of trying to revise skill sets in the midst of emergencies. At home in the United States, the growth of HAP’s regular training program for nonprofit and public agencies was the single greatest mode of capacity building. The next step in domestic projects was the emergence of local TRNs, discussed later.

As for countries where there are major disasters, these occur disproportionately where mental health service and other sources of resilience are generally underdeveloped (Gelbach, 2008). Teaching of EMDR is therefore a valuable support to these countries, but trying to teach it in the immediate wake of disaster is inefficient. Realizing this, HAP has attempted to develop model training projects in a small number of countries where clinicians are motivated and not in crisis mode, where training includes specialty topics, and where HAP encourages the emergence of local trainers and consultants to sustain capacity once it is attained.

**Capacity Building in Action.** In the West Bank, collaboration with two Palestinian clinics—the East Jerusalem YMCA in Beit Sahour and the Treatment and Rehabilitation Center in Ramallah—led to training of more than 200 Palestinian EMDR clinicians in a 6-year period. Several Palestinians became consultants and facilitators, and 4 became trainers, eliminating the need for translators thereafter. Many of the new clinicians work in teams to address periodic intensifications of traumatic events. One of the trainers has already conducted EMDR training in Arabic in four other countries and is currently training Arab clinicians in Beirut serving Syrian refugees. In Ethiopia and Kenya, multiyear HAP projects have expanded the number of clinicians with both basic EMDR and advanced specialty workshops. National EMDR associations are in formation in each country.

**Trauma Recovery Network.** To ensure readiness for response to disasters in the United States, to expand the reach of emergency mental health services, and to reduce the costs of reinventing response projects and reconnecting with local emergency management systems, HAP has been building the TRN, a coalition of local/regional chapters linked to a National Trauma Recovery Network office at HAP and sharing a common vision and mission. At the local level, TRN chapters consist of EMDR clinicians, including a qualified clinical consultant and one or more locally chosen coordinators, who maintain a level of preparation and of liaison with other elements of their local emergency preparedness system, such as the public health department; police, fire, and emergency systems; hospitals; Red Cross chapters; and others. At the national level, HAP develops liaison with national governmental and nongovernmental agencies that define and support emerging standards of preparedness, response, and recovery. HAP also assists local TRN chapters to meet these standards and connect with local, regional, and national sources of support.

Six key functions define the optimum to which local TRN’s aspire:

1. **Professional development**, comprising advanced clinical training in standard psychological forms of first aid that can precede or combine with EMDR early treatment protocols; mastery of EMDR applications designed for response and recovery phases of emergency care, including group treatment and care of special populations such as children (many relevant protocols are found in Luber, 2013)
2. **Local networking** between the TRN chapter and other components of the local emergency planning and management system, with all parties aware of the TRN’s capabilities and how to use them in an agreed on manner when needed
3. **Community education** before emergencies to inform mental health agencies, community leaders, and the public about the nature of trauma, how it can be treated, and how individuals can promote resilience in themselves and their family
4. **TRN networking** to maintain ongoing dialogue among TRN chapters and with the National Trauma Recovery Network to share news, concerns, and lessons learned and to ensure that all chapters embrace a common set of standards and policies
5. **Local emergency response** wherein the TRN chapter undertakes the actions it has practiced and prepared, in coordination with other local actors
6. **Nonlocal response** wherein a TRN chapter calls on sister chapters for additional volunteers when the scale of a local emergency merits reinforcements

**Trauma Recovery Networks in Action.** In 2012–2013, Hurricane Sandy dealt a devastating blow to the
New York/New Jersey/Connecticut shoreline. TRN chapters in three states went into action immediately. Each TRN was composed of clinicians who had prepared for such an eventuality. A few months later, a lone gunman entered Sandy Hook Elementary School in Newtown, Connecticut, and killed 20 children and six educators. For the surviving children and teachers, the families, and first responders, the traumatic consequences were massive. A TRN chapter developing in the county went immediately to work, providing psychoeducation and brief therapy over the following months. Across the country, devastating forest fires in California and Arizona had traumatic effects on residents and first responders. Two local TRN groups went into action. A TRN chapter negotiated a model memorandum of understanding with a local Red Cross chapter, and another responded to bombing of the Boston marathon. Twenty established TRN chapters will soon be joined by 20 more in other cities. The advantages of informed local initiative when disaster strikes are substantial. HAP is increasingly able to concentrate on seeking outside resources to sustain these networks and on enabling the chapters to communicate quickly and learn from each other.

Looking Forward...

The original impulse to form EMDR HAP in 1995 has led to remarkable works around the globe. There are now many sister HAPs in other countries. EMDR training has reached clinicians and agencies serving communities with high levels of need. These needs are far from met, but research has brought growing recognition of EMDR’s efficacy and effectiveness for an expanding array of conditions. And the motivation of therapists who have been empowered by EMDR to “pay it forward” in volunteerism has only grown. The challenges facing HAP today are (a) to ensure that EMDR clinicians serving the most vulnerable populations are adequately supported to develop mastery and apply it where most needed and (b) to use the scarce resources available for disaster response in the most efficient and collaborative way, with expanded attention to preparedness as the key to success.

These challenges pertain both in the United States and in developing nations abroad. The common vision is to build and strengthen through collaboration a worldwide TRN.

A Final Note. In 2013, the board of directors changed the name of their organization to make its focus more immediately apparent to the general public. The new name is Trauma Recovery/EMDR Humanitarian Assistance Programs.

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**Author Note.** The author served as consultant to and later as executive director of EMDR Humanitarian Assistance Programs from 2002 to 2011.

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EYE movement desensitization and reprocessing (EMDR) is a comprehensive, integrative psychotherapy approach developed by Francine Shapiro, PhD, in 1989. EMDR therapy contains elements of many effective psychotherapies in structured protocols that are designed to maximize treatment effects. EMDR psychotherapy is an information processing therapy and uses an eight-phase approach to address the experiential factors that have set the groundwork for pathology; the current situations that trigger dysfunctional emotions, beliefs, and sensations; and the positive experience needed to enhance future adaptive behavior and mental health (Shapiro, 2001). EMDR therapy has been shown to be an effective, efficient, and well-tolerated treatment for posttraumatic stress disorder (Bisson & Andrew, 2013; Schubert & Lee, 2009; Ursano et al., 2004). EMDR treatment has been used in disaster areas and during crisis intervention to treat acute stress disorder and to build resilience (Maxfield, 2008; Solomon, 1998; Zaghrout-Hodali, Alissa, & Dodgson, 2008).

The EMDR Humanitarian Assistance Program (now known as Trauma Recovery/Humanitarian Assistance Program [TR/HAP]), established in response to the Oklahoma City bombing in 1995, is composed of volunteer EMDR clinicians who educate the public about trauma and EMDR treatment, provide support for professionals working with underserved populations, and treat victims after disaster. In the aftermath of disaster, TR/HAP clinicians...
present EMDR basic training, traumatology workshops, and early emergency intervention protocols for local community mental health agencies. Primary clinical interventions have treated children, adults, and first responders, using various EMDR protocols for recent trauma (Alter-Reid, Evans, & Schaefer, 2010; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero, Artigas, & Luber, 2011; Konuk et al., 2006; Luber, 2009, 2013; Shapiro & Laub, 2008; Shapiro, 2009). Published accounts of humanitarian EMDR clinical interventions in Mexico, Argentina, the United States, Indonesia, India, Israel, Italy, and Turkey have been detailed in case reports (e.g., Colelli, 2003; Colelli & Patterson, 2008), descriptive narratives (e.g., Errebo, Knipe, Forte, Karline, & Altayi, 2008), and research projects with various protocols (e.g., Adúriz, Bluthgen, & Knopfler, 2009; Fernandez, 2007).

### Trauma Recovery Networks

#### Relationship With TR/HAP

Trauma Recovery Networks (TRNs) in the United States developed out of a local need and local initiative. The original TRN, established in New York City (NYC) after 9/11, was called the Mental Health Recovery Network (MHRN). The NYC MHRN provided pro bono EMDR treatment for 1 year to civilians and first responders directly affected by the 9/11 attack on the World Trade Center. Operating under the umbrella of TR/HAP, the TRN chapters that followed were composed of EMDR clinicians who organized in their own communities on a grassroots level to develop a viable corps of volunteers to prepare for response to local disasters. In a 2008 summary of TR/HAP work, Gelbach (2008) outlined six areas that TRN chapters could choose to address among them: trauma education, relationship building with key emergency response organizations, and postdisaster treatment. Since that time, 19 local TRNs are formed nationwide, many recently in response to violence in schools and natural disasters. An assessment of the impact of direct volunteer services provided after the 9/11 demonstrated the effectiveness of immediate and delayed EMDR treatment (Silver et al., 2005). To date, chapters work independently, free to develop their own organizational structure. TR/HAP has begun to propose policies along with a viable infrastructure to support TRN chapters called the National Trauma Recovery Network (NTRN). A review of these suggestions from TR/HAP (Gelbach, this issue) focused on the larger organization’s interface with key disaster response networks.

#### TRN Chapter Organizational Structure

TRN chapters develop their own infrastructure, create their own mission statement, and make decisions regarding team membership criteria, trainings to provide to ensure response readiness, what disasters to respond to, and how to develop and use a TRN team in a community disaster. As such, in this article, the opinions about optimal functioning of a chapter are based on the authors’ own experiences. A TRN manual that is under development by the TR/HAP office is available as a guide for the individual chapters. Coordinators of regional chapters informally discuss standards and share their best practices. There is consensus that a minimal standard of competency for providing treatment should be EMDR International Association (EMDRIA) certification and training in recent events protocols. Other EMDR clinicians provide administrative and logistical support during a disaster. Many TRN chapters focus on first responders and caregivers as the recipients of their services. After a disaster, the first response system of that community is greatly impacted; EMDR treatment for this population can be an optimal means toward restoring the health of the community.

#### Leadership

Coordinators of TRN chapters volunteer to take on the leadership role and devote their skill and time to the development and running of the local chapter. They develop the organizational structure and network, establish specific teams, oversee community outreach, interface with other disaster response networks, make assessments and referrals for treatment, assess the viability of conducting EMDR research during interventions, and tend to team members’ emotional well-being. They serve as liaisons to TR/HAP, appraising the office of their disaster response and requesting help to arrange local EMDR trainings.

TRN chapter coordinators need to be well-organized, think on their feet, get along well with people, be upfront, and like to take charge. Their ability to delegate tasks, ask for help, and be a good communicator will enable the TRN team to be at optimum value and longevity. Coordinators should make their team members aware of the emotional short- and long-term impact of emergency work on the body and soul.

#### Composition

TRN clinicians who will respond on-site to a disaster require certain characteristics: (a) therapists
comfortable with being uncomfortable; (b) calm under pressure, centered, thoughtful, and a good sense of humor; (c) in good health; (d) can think on their feet and do “emergency room assessments” and triage for dissociation; and (e) the ability to follow instructions from the coordinator who is aware of all the moving parts at the disaster site.

Team members can take on specific roles. There needs to be a designated clinical consultant who will answer all questions that pertain to clinical matters, a research specialist, and a member in charge of “Caring for the Healers” to monitor team members’ proper self-care.

Funding

All TRN chapters provide their outreach, educational, and treatment services pro bono. Today, the overall operational costs of a TRN are covered through volunteers and fundraising efforts, such as training materials, travel costs for treatment and education, client forms, invited guest speakers and experts for training the team, and website maintenance and development.

TRN Responses to U.S. Disasters

In this article, we describe responses by two TRN chapters to back-to-back U.S. disasters in 2012. Hurricane Sandy hit the U.S. East Coast on October 29, 2012, destroying hundreds of miles of coastline and thousands of homes, leaving hundreds homeless. The NYC TRN response to hurricane Sandy included treatment of citizens, key public officials and community leaders, and first responders in the Rockaways and Staten Island (areas hit hard by the storm) as well as EMDR basic training. On December 14, 2012, 20 first grade schoolchildren and 6 adults were killed at the Sandy Hook Elementary School by a 20-year-old lone gunman. This shooting took place in a bucolic Connecticut neighborhood and was the largest mass murder school shooting in the United States. The Fairfield County TRN (FCTRN) response to the Sandy Hook shootings involved treatment of area therapists, families, children, teachers, and first responders as well as basic EMDR training. Other examples of TRN responses cited in this article refer back to the author’s experiences in responding to 9/11 and the 2005 hurricanes Katrina and Rita in Louisiana.

Following descriptions of elements of our team responses, we share lessons learned from the inside out from the viewpoints of two TRN coordinators. Our goal is to illustrate key intrapersonal and interpersonal issues that need attention in TRN work. With TR/HAP plans for a NTRN, policies and procedures can be incorporated that address these issues, leading to increased capacity and efficacy of local disaster response. Lessons learned include (a) the need for solid preparation—a mental health “boot camp” if you will—for our own first responder TRN team members, (b) the importance of effective and calm leadership from within a team in coordination with logistical and emotional support from TR/HAP leadership and the EMDR community, and (c) the need for consistent attention to the mental health needs within the team during disaster interventions, at the completion of a mission, and at 6-month and 1-year follow-ups.

Initial Responses to a Disaster

**Invitations.** Optimally, TRNs are invited by official or civilian contacts in the disaster-impacted community to provide EMDR training and treatment. After the 2005 hurricanes in Louisiana, TR/HAP was invited to provide pro bono services to the staff of the Louisiana Probation and Parole Department, ensuring maximum response because the invitation was made from the highest level and every employee was provided with the opportunity to receive services. This project lasted 3 months, using teams of volunteer EMDR clinicians from around the country; travel expenses for volunteers were paid for by TR/HAP. Each employee participated in a psycho-educational group on trauma and was offered treatment. The key components to successful intervention included (a) being invited, (b) the organization of TR/HAP teams from around the country communicating about this project, and (c) having the space to provide treatment.

Other TRN responses evolved in different ways. The initial response in the Rockaways by hurricane Sandy was initiated by local EMDR clinicians who had contacts in the community. A NYC TRN team provided direct treatment to local officials, disaster responders, and civilians at a Federal Emergency Management Agency (FEMA) and Red Cross designated area. On Staten Island, a borough of NYC that had 26 miles of coastline affected by the storm, a long-term response to provide direct treatment was set up at a local parish church staffed by TRN team members. More than 200 first responders and civilians were treated in both locations by NYC and Boston TRN members.

After the Sandy Hook shootings, the FCTRN made contact with the small contingency of area
EMDR therapists to offer personal and professional assistance. At the outset, there were no formalized connections in place to a larger disaster organization. As an outgrowth of the team’s assistance to the local clinicians, the coordinator received requests for training and treatment of area mental health clinicians and key first responders. Word of mouth about EMDR early intervention effectiveness led to FCTRN’s connections to the town’s mental health agency and the Connecticut State Police. More than 250 children, law enforcement, clinicians, teachers and parents were treated within a year, and 20 new local EMDR clinicians were trained in basic EMDR.

At present, there are no official guidelines or standards set for how TRN teams respond to community disasters. Although sanctioned by TR/HAP, there is no infrastructure yet in place that makes liaisons for TRNs within the United States with federal, state, or local organizations. In the past year, some headway has been made by several individual TRN chapters with larger disaster response organizations. For example, San Diego, NYC TRN, and FCTRN are entering into agreements with their area Red Cross office to allow EMDR referrals to their TRN teams after a regional disaster. The FCTRN has been invited to be part of a regional U.S. Department of Health and Human Services response team and continues to affiliate with other emergency response teams as we widen our scope of trauma trainings at the local and state levels.

**Logistics.** Once approval is received or the team decides—in conjunction with TR/HAP—to proceed with a disaster intervention, the TRN is activated under the direction of the coordinators. TRN team members are contacted by e-mail/text/phone. Clinician availability is monitored by a designated representative. Regular TRN team meetings are held to provide ongoing support, training, and updates. Coordinators assess ongoing needs and their team’s response capacity.

There are two different response teams in a disaster. One team is trained to go on-site and provide services, and another team provides services at their offices or at designated counseling space within the disaster community. When a team is activated to respond on-site, travel arrangements and accommodations must be made in advance. Ideally, TR/HAP provides funding for travel and accommodations. This occurred when hurricanes Katrina and Rita in New Orleans, Louisiana, required bringing in teams of clinicians from around the United States. After 9/11, services were provided in clinician offices and at the firefighters training facility in NYC so travel and accommodations were not necessary. Hurricane Sandy required travel to a remote area of NYC where public transportation was not available because of the storm’s devastation; travel took between 1 and 4 hours for therapists to arrive in the area. During the Sandy Hook shooting TRN response, therapists traveled up to 1 hour to provide treatment in donated space in mental health agencies, private area clinicians and physicians’ offices, synagogues and churches.

**Physical Safety Considerations.** After 9/11, there were designated areas to support the first responders and volunteers. These areas provided food, shelter, counseling, massage, chiropractic, and general support. The NYC TRN coordinator was concerned about air quality and made the decision not to send a team to the area to provide treatment but rather provide treatment through therapist offices. Fortunately, the right decision was made because many responders at Ground Zero contracted numerous medical conditions including respiratory illnesses and cancer. During hurricane Sandy, the challenges and conditions were different. The provision of EMDR services in the Rockaways were rearranged at a local parish church that was the center for FEMA, the Red Cross, and other responders to gather. However, there were no electricity, heat, or land lines, and public transportation and businesses were unable to open. The focus was on putting a team together that could work under limited conditions. In contrast, in the borough of Staten Island, a grant secured by two area clinicians to provide services to residents allowed for EMDR treatment in a parish church and art gallery where it was warm and dry.

**Emotional Safety Considerations.** The FCTRN team lived up to an hour’s distance from Sandy Hook. Although not part of the primary grieving community, TRN therapists responded to their own shock and horror at the news of the tragic shootings. Many were triggered by issues concerning the safety and vulnerability of their own children. Areas of heightened vulnerability unique to a disaster require extra support and attention to specific emotional safety concerns of team members.

In the immediate aftermath of this tragedy, individuals and groups poured into the small town of Sandy Hook, camping out to offer services ranging from psychotherapy to “giving free hugs.” Driving through the...
town, team members confronted many tributes to the “26 angels’” lost, and examples abounded of empathy for private grieving being overridden by attempts to cope with one’s own sense of powerlessness. Mindful of this phenomenon, FCTRN team members reminded each other to stay grounded, respectful, and nonintrusive by reflecting on their own fight/flight/freeze responses to trauma exposure.

Being witness to horror and to the best and worst of people in the aftermath of disaster is a running thread throughout TRN work. Most mental health professionals are confronted with a wide range of human responses in the course of their careers. It is helpful for team members to bear in mind that personal and collective struggling with the many dimensions of human behavior, both within a TRN member and team, and in the community/nation at large, can be exacerbated from the outset during disaster work. Space needs to be made for intrapersonal and interpersonal reflection to do maximally effective work.

Therapist Experiences

The following recollections from team members relate to emotional and physical safety and well-being concerns in the initial stages of disaster response:

When asked to describe my emotions during the year I treated survivors of the Sandy Hook massacre, I hardly knew where to begin. Initially, there was the terror . . . at the thought of presuming to know how to deal with the pain these people were suffering . . . what gave me the “right” to be an “expert?” Of course, there was grief and sorrow, not to mention the rage. Then there was all the translation of this toxic matter into the body, mostly in the form of intense abdominal discomfort, which was then thankfully reprocessed by a dear and trusted colleague.

When the tragedy in Sandy Hook happened, the question of what the emotional toll might be on me was not on my radar; fortunately, there were members of the team who brought this to the forefront and reminded me that I did not have to muscle through alone. I thought that I would be “fine,” that I could handle the work and wouldn’t need help. I had not suffered what “they had,” I shouldn’t have a hard time or feel what I was feeling; I struggled to deal with expectations of myself to be okay.

After being in New Orleans for a few weeks in the aftermath of Hurricane Katrina, a probation and parole officer took me to the Ninth Ward to see the destruction, I had already spent all my time in a city without potable water, eating military rations, and sleeping in a shelter. I was ready to go home but didn’t think I was particularly stressed. But when I stood in the midst of the devastation, what struck me as the most upsetting was the lack of sound. It was surreal to see houses pushed up against each other like doll houses and a bus and a boat piled in the mix but the lack of sound was like nothing I had experienced before. There was no life and it was hauntingly real.

Defining Who the Team Will Treat

Each TRN is responsible for deciding who they will treat, whether in an initial or long-term response. This clinical matter has far-reaching implications. The NYC TRN used the following recommended guidelines: (a) Treat people who can be helped in one to five sessions; (b) treat people who are medication-free without history of psychiatric hospitalizations; and (c) treat people who do not have dissociative, bipolar, or personality disorders because they may require more treatment than the model allows; and (d) referrals for those who cannot be treated on the ground are made through the EMDRIA website to find EMDR clinicians in their areas.

Attention needs to be paid to varying guidelines by states for referrals. For example, in New York State, in order for the referral source not to be held responsible for the outcome of treatment, three referrals must be given. After 9/11, a referral service was set up, which screened for referral criteria and gave the phone numbers of three clinicians in their area to be seen in therapist’s offices. Victims were provided with five sessions, and if they required more sessions, the case was discussed with the clinical supervisor to determine the next course of action.

The FCTRN initially focused on first responders—fire, police, EMDR and mental health clinicians—as recipients of TRN pro bono treatment. For their Sandy Hook response, they broadened their definition of first responders to include Sandy Hook family members (children and adults directly impacted by the shooting), teachers, and clergy. The original provision of five pro bono sessions was cut back to three sessions because of time and emotional resources available from the team. A careful list of EMDR clinicians throughout the state of Connecticut was available for those treated after three sessions when thought to benefit from longer
term treatment. When working in the immediate aftermath of a disaster, intense bidirectional bonding between therapist and client is natural and expected. Making referrals at the completion of the pro bono sessions was not always easy for team clinicians but a necessary component of fulfilling the team’s larger mission.

Implementation of Disaster Response

Time Issues: Deciding on Length and Extent of TRN Chapter Intervention

At the initial stage of a disaster, it is difficult to define when your team will enter and when they will leave. Each disaster has unique qualities, but it is important to address the question of when the initial response ends and whether and how long the response plan will be executed. The initial decision regarding how long a team will work in the field and whether it will become long-term is based on the nature of the disaster, the number of people to treat, the space needed for treatment, and the stamina of the team.

The 9/11 response’s referral system ran for a year, approximately 6 months after they closed down searching for body parts at Ground Zero. For hurricanes Katrina and Rita, the initial response lasted approximately 3 months and ended when all of the employees of the State Department of Probation and Parole were provided with services. For hurricane Sandy, the initial response in the Rockaways was limited by the space available to provide treatment and the closing of the FEMA and Red Cross tent. The initial response on Staten Island ended when the coordinators could no longer provide the time and turned their efforts to putting together an EMDR training for local clinicians. In Sandy Hook, the initial stage of intervention lasted 6 months. This stage of intervention ended when (a) many of the goals set for provision of recent event treatment to the defined population were accomplished, (b) EMDR training of local clinicians had been completed and capacity had been built within the community to treat their own with EMDR, and (c) the coordinators sensed that signs of emotional and physical fatigue were beginning to show on team members despite ongoing self-care. Confronting the inevitability firsthand of extended periods of hyperarousal’s impact on team member’s functioning, this period required particular attention to the team’s anticipatory grief and loss of densely packed meaningful and spiritual work. In addition, differentiating between traumatic reactions and grief/mourning in Sandy Hook clients was stressed in terms of keeping the TRN to the defined mission and level of expertise. A critical component of ending the Sandy Hook initiative was to invite a HAP volunteer in to do a group protocol with the team to gain closure as a TRN group on this chapter of the work. This allowed for expression of feelings ranging from deep appreciation and love for fellow TRN members to suppressed rage at the shooter, from pride in accomplishment to soul shattering and spiritual uplifting.

The Long-Term Response: Assessing Needs of the Area and Building Capacity

A TRN chapter can be an initial response and, if committed, help establish capacity in an area. This requires time and commitment to do outreach and establish liaisons to community agencies. Each area affected by a disaster needs to be assessed for the number of available EMDR-trained clinicians and their availability to provide pro bono services. If there are plenty of EMDR therapists in or near the disaster site, TRN chapters can organize an efficient referral system for services. After 9/11, there were many available clinicians in the area directly affected by the tragedy and most people in the Towers had private insurance and/or financial resources to seek treatment for themselves through their own referral systems.

If there are no or only a few EMDR clinicians available, an EMDR basic training needs to be scheduled to establish the service in the area. Following hurricanes Katrina and Rita and hurricane Sandy, successful outreach programs locating agencies interested in trauma training resulted in EMDR basic trainings. In Sandy Hook, the FCTRN established a relationship with the local community mental health agency, which was the hub of mental health referrals for the tragedy. This enabled EMDR basic training to be set up for agency clinicians and surrounding area therapists within 3 months after the disaster. Newly trained clinicians were then provided ongoing support and consultation in their work.

Building capacity happened in other ways as the TRN built on the relationships they formed with other first responder groups. One example is the long-term impact that the team’s work has had on the Connecticut State Police and FBI. The team continues to be invited to speak at various state law enforcement events and trainings regarding trauma
and EMDR treatment. Many first responders have come forth for treatment since, whether for trauma symptoms related to Sandy Hook or other “calls” over their careers. Hence, TRN work in the immediate aftermath of a disaster has many potential healing ripple effects.

Therapy for Therapists

The FCTRN offered one to three pro bono sessions to trainee clinicians prior to their EMDR basic training. This “Therapy for Sandy Hook Therapists” project was borne out of a prior “Therapy for Therapists” project in New Orleans. During HAP’s ongoing efforts in 2007 to provide training and consultation to Gulf Coast clinicians for several years after hurricanes Katrina and Rita, a HAP training team (Evans, Alter-Reid, and Murray) was approached to provide EMDR treatment for them. The EMDR-trained clinicians reported suffering from what we later came to identify as “shared traumatic reality” (Baum, 2010). This occurred as a result of treating clients for the same trauma symptoms as the therapists had been experiencing. Intensive three times per week sessions were offered to the clinicians with EMDR treatment. Although this treatment was provided 2.5 to 3 years after the hurricane, treatment results were significant and provided posttrauma symptoms relief (Alter-Reid et al., 2010). The implications of this project included the following suggestions: (a) Build resilience of clinicians through resourcing and trauma treatment, (b) identify and educate responders about shared traumatic realities, (c) bring in clinicians from outside the community to treat the local therapists who may also have been primary trauma sufferers, (d) provide EMDR treatment to clear out trauma before Part I training so that learning can be optimized rather than compromised by traumatic stress, and (e) model effective EMDR treatment by seasoned EMDR clinicians to optimize EMDR training and learning.

Therapist Experiences

The following are recollections of the emotional and spiritual impact of treatment sessions delivered during Sandy Hook TRN work:

The most meaningful lessons were taught to me by the adult sister of one of the Sandy Hook victims, and I will be forever grateful to her. We did some recent event EMDR treatment, and then we stopped, as there seemed to be no further place for it. I could only bear witness to her grief and pain as she explored her own religious faith and spirituality. During one of the sessions, my client believed that she heard the words “I love you” from a family member for the very first time. She continued to share other spiritually oriented meditations and writings, succeeding in opening my heart to ongoing struggle with my faith and spirituality. As we continued this work together, we mutually came to a place of peace and relative rest, freeing me from my sense of helplessness and futile need to rescue her. I will never forget her or the gift she gave me.
There were dreams and imagines of what I had listened to. Telling the stories in the TRN groups became more difficult. In working with first responders, I’ve learned that the men of steel also struggle to find the courage to face their vulnerabilities. I was moved by their compassion and respect for the victims and their families. Letting down their guards to face treatment for their trauma is as foreign to them as running into a fire or facing a shooter is to me. Engaging them in the possibility and importance of getting help continues to be a very important part of our TRN work.

It is very difficult to capture and measure the true impact of working in Sandy Hook. I continually ask myself this question and attempt to analyze the true impact on who I am and how I changed as a result of one of the most horrific events we as a nation have ever faced. To say that I view life and its precious moments in a different light is an understatement . . . I find myself loving people more and accepting flaws more easily . . . tomorrow is not promised to us.

As coordinator of Caring for the Healers, I held and contained team members’ raw emotions of disgust, exhilaration, existential angst, and deep pride. In the end, what has stood out is the capacity of the human spirit to reach deep inside and connect to spiritual and other deeply held resources to help them through. These experiences as a team member and clinician certainly helped me through times when we also witnessed other types of primal emotions in the aftermath of disaster—greed and denial of others’ pain—when people seem to behave poorly for fear of being left out of the herd, even when the herd is victims with unimaginable loss. Getting through disaster work, you want a herd of trusted colleagues who encourage the bearing witness to humanity for better and worse and help you heal from the inside out.

Lessons Learned and Recommendations

To ensure the continuation of TRN chapters and the healing of so many, resulting from early EMDR interventions, circles of support are essential during all stages before, during, and at the close of TRN missions. The national and international community of EMDR clinicians is invaluable in providing these resources and keeping up team morale. Volunteer run teams need administrative and financial support from TR/HAP and other funding sources to mitigate the toll on the already strained emotional and physical resources of team members.

Each team needs the overall support of more experienced team and would benefit from a regular training to share experiences and resources. Providing training from outside national emergency and disaster organizations would be valuable. Solid preparation for TRN members can be done with a mental health “boot camp” model, led by the team coordinator or TR/HAP representative. Members can run through “drills” of scenarios to prepare for (a) scenes they might encounter in working in a community struck by natural or man-made disaster and/or violence; (b) deep connections, disruptions in attachments, losses, and separations they may encounter during time-limited early EMDR interventions; and (c) spiritual and existential issues that may arise. Using future templates can be encouraged in individual and group format to help TRN members identify potential areas of vulnerability and triggers. This can help clinicians to identify needed resources, identify EMDR targets, or help clarify whether they are suited to, or ready for, disaster work.

During TRN disaster response, treating one’s own team as first responders in need of the same degree of self-care that we promote in our work in the field is essential. Each TRN clinician should have a self-care plan that they review at least monthly with a team member designated as in charge of Caring for the Healers. TRN coordinators should make sure they remain in good mental and physical health themselves so they can model self-care from the top down; requesting assistance from other TRN chapters is recommended.

Ending rituals at the closure of a TRN mission are important. Bringing in a group protocol EMDR specialist can help the team process their experiences and identify any remaining EMDR targets. Educational information about the long-term impact of trauma exposure should be reviewed so that early detection is enhanced.

Reaching beyond the EMDR community to offer EMDR treatment to the mental health community at large in a disaster area can help stabilize and strengthen the local therapists’ capacity to provide therapy within their stricken community. The Therapy for Therapists model that emerged from hurricane Katrina and used effectively in the Sandy Hook disaster can have efficacy in future TRN applications. In addition, providing stabilization techniques and recent trauma protocols to clinicians before they are EMDR trained has the benefit of optimized learning.
of the adaptive information processing (AIP) model and EMDR treatment, and likely increases the efficacy of the EMDR services they then provide to their community.

Finally, relationship building is at the heart of having an optimum disaster response. Being able to transfer clinical skills from the office to being an ambassador for EMDR in communities takes passion, a “can-do” attitude, and resiliency.

Conclusion

Interest in starting TRN chapters has increased significantly in the recent past. Experiences of EMDR-trained disaster teams since the Oklahoma bombing in 1995 have contributed to development of a cohesive infrastructure within TR/HAP to help guide teams in the years ahead. Continuing feedback and communication from chapter to chapter and from chapters to TR/HAP will be vital to expanding and refining mental health delivery of disaster services. From the top down, particular attention needs to be paid to the physical and emotional well-being of TRN members throughout disaster work to deliver efficient, meaningful, and impactful EMDR interventions.

References


**Acknowledgments.** Portions of this article were presented at the 2013 EMDRIA Conference (Colelli, Alter-Reid, & Simons, 2013). The authors wish to thank Michael Crouch, LCSW; Linda Rost, LCSW; and Bonnie Rumilly, LCSW, for sharing their recollections for this article.

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The media through radio, newspapers, magazines, and the Internet bring us devastating news daily of catastrophic events that impact entire communities, deeply wounding all those lives involved in such events. There have been many natural and man-made disasters that are increasing in frequency and affect a high number of people exacting a toll on the social, psychological, and economic well-being of entire communities. Disasters all over Europe such as bus accidents; airplane crashes; large entertainment event disasters (Love Parade in Germany); natural disasters such as earthquakes, tsunamis, and floods; terrorist events such as bombings and school shootings have posed great challenges for the European community. This article reports on Europe’s eye movement desensitization and reprocessing (EMDR) therapy humanitarian projects following such several critical events.

EMDR Europe Humanitarian Programs: Development, Current Status, and Future Challenges

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The efficacy of eye movement desensitization and reprocessing (EMDR) therapy has been well established by numerous scientific studies over the past 25 years. The ability to achieve a rapid resolution of trauma symptoms often after only a few EMDR sessions allows clinicians to treat many survivors in a very short period of time. This makes EMDR an ideal intervention after a catastrophic event. The main objective of this article is to describe how European EMDR Associations have provided interventions in emergency situations. Natural and man-made disaster relief projects in Italy, Greenland, and the Netherlands are highlighted. EMDR Europe Humanitarian Assistance Program (HAP) projects sponsored by Austria and Sweden in the Ukraine and Estonia have provided trainings for clinicians. National EMDR Europe associations have developed initiatives in many other areas of the world, such as in Vietnam (EMDR Italy), Cuba (EMDR Spain and Italy), in Pakistan (EMDR United Kingdom and Ireland), in China (EMDR Germany), and in Kenya (EMDR Germany). These projects illustrate the resilience of the populations affected and the generosity of the EMDR Europe community.

Keywords: eye movement desensitization and reprocessing (EMDR); EMDR Europe; Humanitarian Assistance Programs (HAP); EMDR early intervention; disaster relief

Humanitarian Interventions

Many survivors develop acute stress responses as well as depressive symptoms after a traumatic event and seek help from their families, communities, and other support systems. The principal focus of emergency psychological interventions after a traumatizing event for individuals, families and groups, according to World Health Organization (WHO; 2013) is to (a) supply consolation and concern to reduce hypervigilance states (create a safe environment) and (b) provide secure information to all those involved. Early interventions are thought to be important to prevent the onset of future debilitating psychopathologies such as posttraumatic stress disorder (PTSD; APA, 2013) so they can take control and to assist victims toward alleviating symptoms to take control of their lives as soon as possible. Evidence demonstrates that
acute stress responses after a disaster are universal, whereas the person’s culture determines the way these responses are manifest (National Institute of Mental Health [NIMH], 2014).

The field of disaster and crisis psychology has rapidly developed in the past few years and is now recognized by the Council of Europe. The Council established that European citizens have the right to receive psychological support during such emergencies, and the training of an expert network is promoted within all member states (Bonanno, Brewin, Kaniasty, & La Greca, 2010). The goal is to train psychologists in all countries, including those with fewer resources, and therefore, guidelines have been developed regarding support and social interventions. Undoubtedly, this is a most urgent issue in all European countries, and pursuing this goal is a priority for the next few years.

**EMDR Research**

EMDR is a well-validated treatment for traumatic memories. More than 27 randomized controlled studies have demonstrated the efficacy of EMDR for victims of trauma (EMDR International Association [EMDRIA], 2014). According to the recently published practice guidelines of WHO (2013), trauma-focused cognitive behavioral therapy (CBT) and EMDR are the only therapies recommended for children, adolescents, and adults with PTSD. However, major differences exist between the two treatments: "Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework" (WHO, 2013, p. 1). These factors make EMDR therapy particularly helpful in a disaster situation.

In addition to the WHO Guidelines, EMDR therapy is included in many other international practice guidelines: Australia, France, Israel, Northern Ireland, the Netherlands, Sweden, United Kingdom, and United States for the treatment of trauma (EMDRIA, 2014). These treatment guidelines endorse EMDR for the treatment of PTSD as a result of many randomized clinical trials. Only two international practice guidelines endorse EMDR for use with clients with acute stress disorder, the American Psychiatric Association (2003) and the Australian Centre for Posttraumatic Mental Health (2007).

Less research has been conducted in emergency situations for acute stress responses for numerous reasons; some of which include the lack of a research infrastructure in place, the disarray of community supports and resources in times of crisis, and the fact that clinicians who are helping the victims are naturally reluctant to collect data in disasters. The priority should be and has been to provide services and alleviate suffering as soon as possible.

Most of the researches on early EMDR interventions are field studies or case studies. A field study (Jarero, Artigas, & Luber, 2011) found the EMDR protocol for recent critical incidents (EMDR-PRECI) efficacious following an earthquake, reporting a significant decrease in posttraumatic symptoms after one EMDR session which was maintained at 12-week follow-up. It is important to note that achieving such a rapid resolution after one session allows many survivors to be treated in a very short time after a catastrophic event. Previous research has indicated higher distress levels for those who delayed treatment, but comparable treatment effects have been found whether EMDR therapy was used as an early intervention or 5–48 weeks after the 9/11 terrorist attack (Silver, Rogers, Knipe, & Colelli, 2005). In addition, several case studies support the importance of early intervention in the aftermath of a traumatic event (Ichii & Kumano, 1996; Russell, 2006; Tofani & Wheeler, 2011).

**EMDR Therapy: A Humanitarian Intervention**

There is a growing consensus and recognition that the best way to help survivors after a catastrophe is to offer psychological first aid with EMDR. A comprehensive book on EMDR early mental health interventions (Luber, 2014) demonstrates the depth and breadth of specialized EMDR protocols that are used with increasing frequency after a crisis to ameliorate traumatic symptoms. Field studies indicate that early interventions with EMDR can be easily implemented. However, it is important to coordinate with institutions and local services so that EMDR therapy interventions become part of the institutionalized assistance to populations after a disaster. A team of EMDR clinicians can work in the disaster sites on consecutive days in different settings and conditions. The processing of the traumatic experience can occur without obstacles, even under unstable chaotic conditions, which are very common in these circumstances.

Using recent events protocols such as Shapiro’s protocol for recent traumatic events (Shapiro, 2001, 2006), the recent-traumatic episode protocol (R-TEP; Shapiro & Laub, 2008), the integrative group trauma protocol (IGTP; Artigas, Jarero, Alcala, & Cano, 2014), or the PRECI (Jarero et al., 2011) for processing traumatic experiences have been essential in disaster situations. After processing the recent traumatic experience of the event and present triggers, future templates can then be successfully completed even if the disaster is ongoing. EMDR interventions offer...
The request for EMDR interventions after a community, a school, or a mass disaster is increasing. One reason for this growing request may be that EMDR therapy is becoming well-known among psychologists and clinicians so that when a disaster occurs, professionals ask for help from EMDR associations, EMDR teams, or EMDR clinicians. Thus, it appears that word of EMDR’s efficacy is spreading and requests occur sometimes immediately after the event, on the same day, or the day after. This allows EMDR teams to organize to intervene in the very early part of the stress reaction.

Early intervention is consistent with the WHO comprehensive mental health action plan and guidelines for the treatment of stress-related disorders (WHO, 2013). It is useful to start planning for the middle- and long-term interventions from the very beginning. EMDR work is easily implemented within the community for different segments of the population exposed to the event (parents, neighbors, school personnel, authorities, etc.). To make treatment possible, it is essential to coordinate with the national health service, with the town hall, hospitals, and schools, in order to organize meetings, to inform, and to provide outreach to those affected so that specialized psychological help is available. Local institutions provide outreach so groups and meetings can be organized prior to EMDR interventions. A constant exchange of information, collaboration, and planning by all parties is needed while working in the field to adapt EMDR therapy to the different needs that arise in such unstable settings.

**Disaster Response: Humanitarian Assistance Projects Conducted by the Italian EMDR Association**

Over the past few years, Italy has suffered several natural disasters as well as violent acts, forcing entire communities to struggle to get back to their normal life. Very often, emergency situations are initially viewed from an economic and social perspective. Yet, once people are back to their normal life, many individuals suffer the long-term sequelae of trauma that includes numerous risk factors for mental and physical health. The Italian EMDR Association has been working to develop awareness in institutions and agencies involved with populations exposed to extreme stress.

For more than 10 years, a network of EMDR clinicians working pro bono has been activated immediately after the catastrophic event. This has happened many times in different disasters, with different characteristics, from tremendous earthquakes to events such as those following domestic violence.

Depending on the request and on the seriousness of the event, EMDR interventions are structured and directly coordinated by the Italian EMDR Association. Psychosocial help is offered, as well as EMDR therapy through individual and group sessions. Table 1 summarizes interventions conducted by the Italian EMDR Association in the past years in disasters and crises. Following is a summary of two of these projects; after a natural disaster (Molise earthquake) and after a domestic violence event.

**Molise Earthquake.** The earthquake on October 31, 2002, affected various regions of Italy but occurred primarily in the Molise area. It was a devastating event, sadly remembered for the collapse of an elementary school in which children lost their lives under the rubble. This tragedy caused survivors to be exposed to an extreme situation that not only threatened their own lives but also killed some of their schoolmates. Indeed, the subsequent posttraumatic consequences were not “just” associated to the stress of having experienced a real threat to one’s life but also the grief of losing one’s friends, cousins, and/or siblings as well as prolonged exposure to corpses under the rubble (from 1 to 10 hours). The sad report consisted of 32 children who had survived and 27 dead (mostly 6 years old). In addition to these highly traumatizing factors, many of these little survivors had lost their homes, their everyday life, and their friends. The combination of these factors increased the chances of developing PTSD. As recommended by the National Institute for Clinical Excellence Guidelines (2005), all those individuals who were at high risk of developing a PTSD following a mass disaster were screened within 1 month after the catastrophic event and treated with EMDR therapy.

All EMDR treatment was coordinated by the national health system and the Italian EMDR
Parents were also given education to understand their own and their child’s posttraumatic stress responses. Parents were trained how to support their children in the aftermath of the trauma. During these meetings, therapists measured stress reactions and symptoms before starting to work with the children. Parents were interviewed to assess their child symptoms, informed about the type of intervention the child was going to be provided with, provided

Association working closely with the local health administration. The teaching staff and other members of the school staff were supportive in every phase of the intervention. The entire staff received the opportunity for psychological support, which consisted of individual consultation, group debriefing, psychoeducational meetings on stress responses in children, lessons on handling the class, and some critical aspects that had emerged during everyday life in the aftermath as well as individual EMDR sessions targeting their own personal experience. Parents were also given education to understand their own and their child’s posttraumatic stress responses. Parents were trained how to support their children in the aftermath of the trauma. During these meetings, therapists measured stress reactions and symptoms before starting to work with the children. Parents were interviewed to assess their child symptoms, informed about the type of intervention the child was going to be provided with, provided

### TABLE 1. EMDR Italy Disaster Interventions

<table>
<thead>
<tr>
<th>Project</th>
<th>No. of Treated</th>
<th>EMDR Treatment</th>
<th>Outcomes</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Disasters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molise, Italy, earthquake 2002 (Fernandez, 2007)</td>
<td>32 children age 6 years</td>
<td>Six EMDR sessions</td>
<td>Children’s PTSD symptoms dropped from 63.6% to 28.6%.</td>
<td>6 months later, maintained and improved to 9%</td>
</tr>
<tr>
<td>Capoterra (Sardinia, Italy) flood 2008</td>
<td>128 children with PTSD</td>
<td>Six EMDR sessions</td>
<td>94% had no PTSD 1 week after EMDR</td>
<td>5 months later, children who had not received treatment, had high level of PTSD symptoms.</td>
</tr>
<tr>
<td>L’Aquila, Italy, earthquake 2009</td>
<td>17 children with PTSD</td>
<td>Six EMDR sessions</td>
<td>After treatment, only 5% still suffered from typical posttraumatic stress symptoms.</td>
<td></td>
</tr>
<tr>
<td>Emilia, Italy, earthquake 2012</td>
<td>629 adults</td>
<td>One to a maximum of four EMDR sessions</td>
<td>The group that was not presenting symptoms anymore after treatment rose from 13.3% to 57.6%.</td>
<td></td>
</tr>
<tr>
<td>Man-Made Disasters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milan, Italy, airplane crash 2002 (Fernandez, Gallinari, &amp; Lorenzetti, 2003)</td>
<td>236 children 6–11 years old</td>
<td>EMDR-IGTP (Jarero et. al., 2008)</td>
<td>No further posttraumatic stress responses</td>
<td>No dysfunctional behaviors nor any posttraumatic stress responses at the beginning of the new school year</td>
</tr>
<tr>
<td>Stroppiana, Italy, school bus accident 2007</td>
<td>30 children 25 adults</td>
<td>Three to eight EMDR sessions</td>
<td>One week after EMDR treatment, 81% did not present PTSD symptoms.</td>
<td>Three months and 1 year after treatment, results were maintained.</td>
</tr>
<tr>
<td>Viggiù, Italy, car accident 2008</td>
<td>16 adolescents</td>
<td>Three to six EMDR sessions</td>
<td>Children treated in acute phase had a significant difference in symptomatology compared with those with delayed treatment.</td>
<td></td>
</tr>
<tr>
<td>Turin, Italy, schoolbus accident 2010</td>
<td>78</td>
<td>R-TEP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. PTSD = posttraumatic stress disorder; EMDR-IGTP = EMDR integrative group treatment protocol; R-TEP = recent-traumatic episode protocol.
information concerning EMDR therapy, and informed consent was obtained.

Each child received six EMDR therapy sessions. The intervention focused on the most disturbing moments of the earthquake, on the current triggers that were still causing distress and fear of the future. EMDR treatment was carried out with the standard protocol (Shapiro, 2001). Every child received EMDR sessions for 50–90 minutes. One week before and after EMDR interventions, children and their parents were given a questionnaire to monitor the trend of their psychological distress and the outcomes of the treatment. Between the second (January 2003) and third (February 2003) EMDR treatment cycle (six EMDR sessions), the children’s PTSD symptoms dropped from 63.6% to 45.5%. This result demonstrated that the children were beginning to feel better. A further improvement in their symptoms was registered after the EMDR sessions received in February 2003 (45.5%). In November 2003, despite no further treatment, results kept improving (28.6%). These results are consistent with the EMDR therapy guidelines indicating that the effects of trauma reprocessing continue after EMDR sessions. One year after the event (December 2003), a last measurement showed another significant symptom reduction (9.1%) after a last cycle of EMDR sessions. EMDR treatment proved to be effective with this population, and subjects did not endorse a PTSD diagnosis or a subclinical PTSD diagnosis after an average of six sessions (Fernandez, 2007).

In 2012, 10 years after the earthquake, a group of adults that had not had any psychological support at the time of the disaster were contacted and treated by a team of clinicians of the Italian EMDR Association together with a group of researchers from Tor Vergata University (Rome) and from the National Research Center (Pagani et al., 2012). The aim was to assess brain activity upon exposure to the traumatic memory of the earthquake. Cortical activation differences between this group of psychologically traumatized clients was compared to healthy controls. Electroencephalography (EEG) was used to monitor neuronal activation throughout the bilateral stimulation phase of EMDR sessions. The EEG signals of 20 subjects still suffering psychological trauma 10 years after the earthquake as well as those of 20 controls were compared between the first EMDR session (T0) and the last one after reprocessing the index trauma (T1). EEG findings showed a significantly higher activity in orbitofrontal and anterior frontal cortex at T0 shifting at T1 toward posterior associative regions (fusiform and lingual cortex). This finding was confirmed by the comparisons with controls. EEG monitoring was enabled for the first time to illustrate during the reliving of the traumatic event through the neurobiological activities of people with chronic symptomatology 10 years after a mass disaster.

**Domestic Violence and Infanticides.** Tabloid columns frequently report crimes committed within the domestic walls or against children. For instance, in Lombardy, Italy, there have been crime emergencies that have shocked entire communities. A double infanticide (children ages 2 and 9) was committed by their father, and in another town, a mother killed all three of her children. These events created an emotional upheaval not just in the people directly involved but in entire communities. To deal with these tragedies, the local town administrations took action and requested help from the Italian EMDR Association. Clinicians specialized in emergency interventions were requested to provide psychological support to teachers, students, parents, first responders, and others in the community.

The EMDR clinicians implemented interventions for these events that had caused a major psychosocial impact, not only on the families involved but also for many members of the community. EMDR group sessions were offered to all the victims who had been exposed to the traumatic event. In particular, psychologists intervened in 11 classes of 3 different schools offering EMDR group sessions in the classrooms. Psychoeducational interventions were provided to parents and students to explain which responses to stress are considered normal when facing critical events. All of these interventions were conducted on-site by dedicated volunteers certified by the Italian EMDR Association.

**EMDR Humanitarian Projects Within European Countries**

EMDR Denmark has been conducting a Humanitarian Assistance Program (HAP) project in Greenland to reach traumatized children and adults. Child abuse in Greenland has been considered an important issue and there is a relatively large group of children who have been victims of incest, neglect, and other kinds of violence. Violence occurs in the families. Often, these are families who live in small communities in remote and inaccessible places, so there is specific need to address this issue in an appropriate manner. Psychological treatment is sparse and apparently very expensive because of the large distances and inaccessible locations. The vision of EMDR Denmark is that by implementing EMDR therapy, it would be easier to provide treatment to these populations because of EMDR therapy’s
effectiveness, making it faster and cheaper than other resource intensive therapies.

Another intervention from Europe is reported by Carlijn de Roos and colleagues (2011) with disaster-exposed children in the Netherlands. A randomized clinical trial was conducted to evaluate the treatment of trauma-related symptoms. The sample consisted of children exposed to the explosion of a fireworks factory who were randomly assigned to either CBT or EMDR to compare the effectiveness and efficiency of these two approaches. All children received up to four individual treatment sessions, and symptoms were assessed both pre- and posttreatment and at 3 months follow-up. Results showed that both approaches (CBT and EMDR) produced significant reduction of symptomatology, but EMDR produced these results in fewer sessions.

The main objective of EMDR HAP is to respond to community-wide disasters. To work toward this goal, the specific HAP focus is to help local therapists treat traumatized people by training them in EMDR therapy. To intervene promptly in case of mass traumatization and disasters, it is extremely important that there are specialized trained clinicians who are ready to intervene at the time of the crisis to alleviate suffering and stress reactions in the acute phase of trauma. This has always been HAP’s main goal: to spread EMDR knowledge and train as many therapists as possible. EMDR HAP in Europe has worked hard helping countries with a very low socioeconomic status to have EMDR training available. For example, low-cost EMDR trainings have been organized to allow local therapists to participate, or in some cases, training was provided free. HAP trainings have allowed many therapists to receive not only basic training in EMDR but also have taught clinicians how to use EMDR with specific clinical populations. This is essential and enables the creation of a psychological first aid culture. See Table 2 for a summary of EMDR projects sponsored by European Associations.

**Detailed Cases of HAP Training Projects.** Since 2006, the trainer and supervisors of EMDR Institute Austria have conducted and supported EMDR therapy and stabilization techniques trainings in Ukraine. Three phases of the project have taken place since its beginning, each one 22 days long. Also, colleagues

**TABLE 2. EMDR Training Projects Offered By European Associations**

<table>
<thead>
<tr>
<th>Country Receiving Training</th>
<th>European EMDR Organization Providing Training</th>
<th>Time Frame</th>
<th>Number of Therapists Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>Switzerland, France, Norway and Sweden association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baltic countries</td>
<td>HAP Sweden</td>
<td>2004–2014</td>
<td>20</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>HAP United Kingdom</td>
<td>Since 2005</td>
<td>161 therapists</td>
</tr>
<tr>
<td>China</td>
<td>Trauma-Aid Germany</td>
<td></td>
<td>20 supervisors</td>
</tr>
<tr>
<td>Cuba</td>
<td>EMDR Italy and Spain associations</td>
<td>2008–2014</td>
<td>340</td>
</tr>
<tr>
<td>Haiti</td>
<td>Trauma-Aid Germany</td>
<td>2012–2013</td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>EMDR Europe HAP</td>
<td>Since 2010</td>
<td>125 therapists</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Trauma-Aid Germany</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slovakia</td>
<td>Trauma-Aid Germany</td>
<td>Since 2003</td>
<td>More than 70 therapists</td>
</tr>
<tr>
<td>Thailand, Cambodia, and Indonesia</td>
<td>Trauma-Aid Germany</td>
<td>2010–2013</td>
<td>30 therapists and 15 supervisors</td>
</tr>
<tr>
<td>Ukraine</td>
<td>EMDR Institute Austria and Germany</td>
<td>Since 2006</td>
<td>73</td>
</tr>
</tbody>
</table>

Note. HAP = Humanitarian Assistance Program.
from Ukraine took part in trainings in Vienna, Austria (by invitation of EMDR Institute Austria and EMDR Institute Germany).

The projects were financed by the following means:

- **Participants Ukraine**: small participation fee for translation, copies, accommodation trainers (in apartments rented from private persons)
- **Participants Austrian EMDR seminars**: free donations for material and travel costs for the trainers/consultants after presenting the project
- **Trainers/supervisors**: no fee for the seminars

The 22 days of seminars were focused on the basics of psychotraumatology, stabilization, EMDR basic training, supervision, and practice on EMDR, complex trauma, dissociative disorders, EMDR advanced training, and acute trauma. To date, 73 psychotherapists have been trained through this project. One consultant was trained in London, supported by EMDR United Kingdom and Ireland and by EMDR Institute Germany.

In 2009, the EMDR Association Ukraine was founded and its members have attended EMDR Europe conferences. The process of building an association, the certification process, and connecting EMDR Ukraine to EMDR Europe was supported and facilitated by the EMDR Institute Austria, a few colleagues from EMDR Association Austria and HAP Austria (2010–2013). It is an ongoing collaboration and process. It is more important than ever, given the ongoing crisis in the Ukraine, for education on psychotraumatology, traumatherapy, and EMDR trainings.

In the Baltic countries, HAP Sweden conducted EMDR therapy trainings in Estonia with participants from Estonia and Latvia. Along with the development of the countries in the Baltics and thanks to the HAP education, EMDR in Estonia is now functioning independently.

**“Adopting” a Country in Europe.** National associations belonging to EMDR Europe have consistently been supporting other associations by “adopting” them. Support to newly formed associations is given, apart from HAP trainings by helping them to constitute their national association, supplying guidelines and experience, and providing free consultation to their members and pro bono advanced trainings. Countries that have been supported in their development are Spain, Poland, Portugal, Russia, Finland, and Serbia.

In addition to these projects, other EMDR Europe projects have been developed in many other areas of the world, such as in Vietnam (EMDR Italy), Cuba (EMDR Italy and Spain) in Pakistan (EMDR United Kingdom and Ireland), in China (EMDR Germany), and in Kenya (EMDR Germany). There are most likely other projects that these authors are not aware of.

**Lessons Learned**

International guidelines underline the importance of early and specialized intervention within emergency contexts and in subsequent stages to ensure the best help to reduce distress and prevent future psychological and/or psychosomatic disorders in victims. In the past 10 years, EMDR Europe Associations have successfully supported interventions in the aftermath of various emergencies. In these contexts, the rationale is that all people have the right to benefit from the best specialized help available to alleviate their distress.

Children, people with disabilities, and older adults are especially at risk and highly vulnerable in the event of disasters. This is especially true for mass trauma, where the level of complexity and criticality increase exponentially (de Roos et al., 2011; La Greca, 2008). The National Institute of Mental Health of the United States (NIMH, 2014) says that the parents’ responses toward a violent event or disaster influence directly the recovery capacities from trauma of their children. Parents who have a child who is a victim of a trauma often find it difficult to deal with their own emotions. When possible, the intervention focus should be extended to parents and other significant people in the child’s life, such as teachers, educators, and school personnel.

EMDR’s rapid efficacy in treating children with PTSD symptoms makes it an ideal intervention in a disaster. In many cases, collaborating with official agencies (local, school and health administrators, police forces, etc.) has proved to be helpful to avoid the spreading of panic in the community. EMDR interventions have also been given to the representatives of agencies to reduce their emotional responses, helping them to become more able to support themselves and their community.

The humanitarian projects described in this article demonstrate support for the effectiveness of EMDR treatment with children as well as with adults in the aftermath of a mass disaster. A large percentage of the population involved in these events participated in EMDR treatment. If we compare the number of people who participated in treatment with other studies published in the literature (Stallard, Salter, & Velleman, 2004), the high representativeness of the
populations described here suggests that EMDR therapy is generally accepted. We also found pretreatment that PTSD and subclinical PTSD rate are usually higher than that reported in other studies. We consistently observed that acute posttraumatic stress symptoms do not subside 3 months from the event as described in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; APA, 2000), but lacking specialized treatment symptoms further increase in children. The results obtained after treatment have been significant and highlight the effectiveness of the EMDR approach, both immediately, mid-crisis, and post trauma. This confirms findings published in the literature especially regarding the efficacy of EMDR therapy with children (Chemtob, Nakashima, & Carlson, 2002; Gillies, Taylor, Gray, O’Brien, & D’Abrew, 2013; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009).

Traumatic stress reactions may persist for several months without spontaneous remission in survivors. Symptom development is different in adults than children. Children seem to experience higher stress reactions as confirmed by the results of our field studies. The number of PTSD diagnoses at pretreatment for adults points to the need to intervene with EMDR treatment with parents and adults as well. Most parents immediately allowed their children to receive EMDR therapy provided by the team of the local health service and EMDR clinicians. Teams of EMDR clinicians were fundamental in managing the emergency situation in the immediate aftermath of the events. These clinicians met with survivors and provided support to deal emotionally with the critical event. They also provided psychological first aid to promote coping skills and resilience. Most projects were supported and enhanced by town halls and their mayors, by the school principals and personnel, and by the national mental health public services.

In fact, thanks to the excellent collaboration and cooperation, it was often possible to work with the children in a setting familiar to them such as their school. The availability of this setting certainly facilitated the acceptance of such a large number of children and fostered the emotional reactions normalizing the process. Finally, both the epidemiological data on the incidence of PTSD in children stemming from our studies and the results obtained with six EMDR sessions on average with the victims support the importance of a specialized intervention in the acute, as well as in the chronic phases of postdisasters. The data drawn from surveys with parents and adults on the effectiveness of the EMDR treatment programs support the strong need for a specific intervention also for the caregivers of children surviving mass disasters.

**Future Plans and Challenges**

Since the 2013 WHO endorsement for EMDR after a traumatic event for PTSD, it is likely that requests for EMDR will increase and early interventions in disasters will become more commonplace and specialized. In fact, the WHO recommends EMDR as an advanced treatment for trauma and says that EMDR should be more widely available and that more research, training, and supervision is needed. Given the increasing number of natural and man-made catastrophes globally, the EMDR community faces significant challenges in the dissemination of training and support for ongoing treatment. Many of the countries where EMDR is most needed are often where resources and mental health clinicians are scarce.

Every disaster is unique and presents unique challenges, so planning the intervention must be based on partnership and connection with the affected community, collaboration with local officials, a thorough analysis of the event and of the population exposed, assessment of the level of distress, stabilization, and appropriate treatment. It is also necessary to plan continuous monitoring and follow-up to verify the well-being of survivors.

It is important that an infrastructure for research be developed to understand which protocols are best in which situations, for which population and when is the best time to intervene. Designs such as a waitlist/control may be feasible in such situations, but clear instructions need to be detailed for clinicians who are most likely not researchers to accomplish this. Instruments that are valid and reliable in chaotic situations need to be identified and made available to those providing the treatment and training. Because most clinicians are not researchers, research guidelines need to be clear, specific, and detailed enough to provide empirical results without interfering with the humanitarian aid offered. Along with these research considerations, attention and sensitivity to the victims must remain the priority. The immediacy of data collection in a chaotic situation in a timely way is challenging. A user-friendly toolkit should be made available to EMDR national and humanitarian associations so that outcome data can be collected, coded, and entered on a database that is shared globally to advance the science of EMDR therapy’s efficacy for recent trauma. An international collaboration is currently underway to develop such a resource.
Securing funding for the treatment of those affected by disasters, the training of clinicians, and for conducting research is of paramount importance. The initiatives described here illustrate the generosity of clinicians and members of the EMDR community. Perhaps other EMDR associations in the world could follow EMDR Europe’s lead and “adopt” a country to provide the needed resources to support training and assist in the development of the adopted country’s own EMDR association. It is essential to provide the opportunity to people, groups, and nations to overcome traumatic experiences and relieve the suffering, grief, anger, and resulting psychiatric disorders. It is EMDR Europe’s mission to reach more people and populations to offer the possibility to live without suffering unduly from trauma in the future and for future generations’ health.

References


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This article discusses the development of Trauma-Aid, a German nonprofit organization that conducts trauma therapy trainings, especially in eye movement desensitization and reprocessing (EMDR), in countries where people cannot themselves afford specialized trainings. Starting with small projects at first, and teaching mainly in cooperation with local experts, Trauma-Aid successfully implemented three big projects between 2007 and 2014: the Aceh-Project (2007–2010) in Indonesia; the Mekong-Project, combining project-parts in Indonesia, Thailand, and Cambodia (2010–2014); and the Haiti-Project (2010–2012). During this period, Trauma-Aid was also able to access funds to employ trained therapists in the treatment of traumatized clients in the respective countries.

Trauma-Aid, Humanitarian Assistance Program (TA-HAP) Germany’s core training approach uses EMDR therapy, an innovative and integrative clinical treatment developed in the late 1980s by Dr. Francine Shapiro, a psychologist and senior research fellow at the Mental Research Institute in Palo Alto, CA (Shapiro, 1989, 2001). EMDR is an evidence-based psychotherapy for posttraumatic stress disorder (PTSD) and is also successful in treating other psychiatric complaints, mental health problems, and somatic symptoms. EMDR theory rests on what Shapiro termed the Adaptive Information Processing (AIP) model (Solomon & Shapiro, 2008), postulating that most psychological distress symptoms relate to the maladaptive encoding, or incomplete processing, of traumatic incidents or adverse life experiences. This weakens the client’s ability to integrate these experiences in an adaptive way (Shapiro, 2012).

EMDR is a comprehensive therapy integrating many of the successful elements of other therapeutic approaches, combining them with eye movements or other forms of bilateral stimulation (Shapiro, 2001). The goal is to stimulate the brain’s information processing system to reprocess dysfunctionally stored memories toward more adaptive resolution.

EMDR is one of only two treatment methods recommended for trauma by the World Health
Establishment of the First EMDR Humanitarian Assistance Programs in Europe

After the huge success and fast development of EMDR therapy and trainings in the 1990s (Maxfield, 2009a, 2009b; Shapiro, 2002), EMDR spread rapidly in many European countries, especially at first in Germany, Italy, France, Spain, The Netherlands, and United Kingdom. Around the turn of the century, European EMDR practitioners resolved to follow their EMDR colleagues in the United States, where what was first called EMDR-Humanitarian Assistance Program (EMDR-HAP) is now known as Trauma Recovery, and set up nonprofit humanitarian assistance programs aimed at alleviating the traumatic distress of natural or man-made disaster and crisis in countries elsewhere in Europe and in Asia and Africa. Working not only internationally in crisis areas but also on a national level and offering nonprofit trainings in EMDR and in the treatment of trauma victims, the shared purpose of HAP organizations is to help people overcome the psychological consequences of calamity, disaster, or violence and regain emotional stability and mental health. Activities focus on those countries that do not yet have the necessary knowledge and education in psychotraumatology and EMDR.

Under European law, donations to nonprofit and nongovernmental organizations are tax-deductible only in the countries in which they are made, so each nation in Europe has had to develop its own national HAP. TA-HAP Germany was founded in 2000 as the first European HAP organization. Because there were colleagues from other European countries already taking part in TA’s first projects, the idea arose to spread HAP’s work more widely in Europe, intensifying each country’s individual efforts, synchronizing national plans for the nonprofit teaching of EMDR, and all leading to the establishment of an umbrella organization in the form of HAP Europe.

During an EMDR conference in Frankfurt in 2002, a 12-nation international group founded EMDR Europe, with structure and bylaws at first accredited in Germany and then moving in 2007 to Switzerland. Many other European HAP organizations followed, including Belgium, Denmark, France, Israel, Italy, Norway, Spain, Sweden, Switzerland, The Netherlands, United Kingdom, and Ireland. Some of the national therapists developed their own infrastructures, with separate constitutions and articles of association, whereas others formally associated with their national EMDR organizations or operated just as private persons doing humanitarian work.

Today, EMDR Europe HAP is an organizational network responsible for the promotion and development of EMDR as an evidence-based and empirically supported psychotherapy, in assisting communities affected by the consequences of psychological trauma.

Trauma-Aid

As one member of the European HAP network, TA Germany links with partner organizations to enable and/or coordinate the teaching and learning of EMDR as a humanitarian intervention by training experienced mental health workers in communities experiencing psychological trauma in the aftermath of conflict or disaster and encouraging research in ways to break through cycles of violence.

An important principle for the good choice and planning of TA-HAP projects is the solid support from colleagues in cooperating countries as well as from local health workers and nongovernmental organizations (NGOs). These will function as multipliers in their country, either as trainers or supervisors, and they can also be supported in pursuing academic tracks and/or collaborating with local universities or nonprofit organizations.

Historical Development

Starting with the first projects, the participants of the first HAP Europe meeting in 2002 discussed different types of trainings for humanitarian EMDR projects, ranging from simple practical support to the provision of funds or manpower. At all times, responsibility for projects lays with licensed clinicians trained in EMDR therapy and with experience of work with a wide range of trauma diagnoses. Because the emphasis lay on transferring skills and knowledge of trauma therapy to countries with perhaps a different cultural background, teaching teams were made up of experienced therapists and trainers who already had a rich background of group work and supervision. All persons active in the HAP projects work on a
voluntary basis, without payment from their sponsoring organizations.

The first EMDR trainings were held in countries that already had at least partially developed psychiatric and psychotherapeutic education and trainings. Consequently, teaching focused on two-part EMDR trainings for therapists and medical practitioners already versed in the establishment of psychotherapeutic relationships and the practice of therapies in general. TA has also taken training to countries without a tradition or practitioners of psychotherapy. Encouraged in this by the German-speaking branch of the International Society for Traumatic Stress Studies, TA started to offer training in the basics of psychotraumatology besides EMDR itself; for example, in assessment and diagnostic skills, awareness, and stabilization techniques, aiming to give a broad perspective of skills in general trauma therapy. Part of this approach is continuing education and supervision after the end of the initial trainings.

Besides direct teaching in workshops for psychotherapists, locally trained colleagues and HAP activists from abroad offer psychoeducation and promote presentations, meetings, and publications about the effects of trauma on mental health, especially aimed at conflict prevention. There has also been good and fruitful cooperation and exchange of information with other humanitarian organizations outside the immediate trauma-focused community.

Trauma-Aid Humanitarian EMDR Projects
Selecting Projects

TA finds that the success of a project depends critically on careful evaluation in advance and on the project partners in the recipient country. It is therefore essential in the early stages to find out as much information about the following on an institutional level:

Will the Project Have Political Backing? This is important on both national and local levels because the degree of political support impacts on logistics, workshop facilities, visa invitations, and other relevant permissions being granted. It is also critical on an institutional level, in terms of impact on cooperation with universities, medical institution, and so on.

Can the Project Partner Make a Long-Term Commitment? Is the project partner and/or institution willing to commit to the project long term? All project participants will need more than 5 years of personal development to become skillful and experienced teachers with the appropriate local credibility to take EMDR forward.

Can the Project Partner Liaise With Other Organizations? Is the project partner willing and able to network with other interested associations and organizations within the country because this has to be the basis for development and cooperation with NGOs, political institutions, professional clinical groups, and other organizations promoting traumatology. It is counterproductive to focus on one group of practitioners only; for example, on psychiatrists at the expense of psychologists.

Qualities and Competencies for Direct Cooperation Partners

In cooperation with other HAP organizations, TA developed a list of qualities and competencies for direct cooperation partners. First and most important is professional integrity and professional qualifications, combined with a good reputation in the host country. An academic background with university links and already-established contacts with professional community/organizations in the host country are always helpful. We seek multipliers who are motivated to spread learning in the area of traumatology and EMDR. Sometimes, it is not easy to find a colleague who is not too egocentric or in search of personal gain, either financial or reputational. Because most team support comes from abroad, internationally oriented individuals are required who are good at languages and team players as well as team leaders with the good social skills essential for developing and establishing constructive relationships with TA trainers and participants alike.

Because projects last always several years, TA Germany depends on responsible and reliable cooperation (e.g., prompt responses to e-mails), and on committed individuals good at organizing and capable of choosing appropriate participants for trainings and involvement in projects.

Logistics

As with any human undertaking, problems and pitfalls are part of the development of any project, so TA aims to work with at least two contact persons in each country/region, ideally with teams from professional organizations such as universities or NGOs.

Project Objectives, Designs, and Funding

Funding agencies in Germany (Terre des Hommes), together with the German Ministry of Cooperation, focus their humanitarian and developmental aid work
on populations in need, mainly women and children. TA projects center therefore on this client-oriented objective, seeking to build efficient services for these populations within a defined time frame, usually 3–4 years. Cooperation and networking with local institutions and NGOs, private and official, supports the sustainability of project objectives after the end of the financing period. For the maintenance of psychological services, appropriate supervision must be in place, with qualified therapists as project staff—and this in turn requires sufficient funds and a monitoring team to accompany the process effectively. A reliable local partner organization is essential for the management of funds and the longer term implementation process.

Agencies, and especially government institutions, have, of course, their own funding priorities and definitions for developmental aid; and, as well as that, natural disaster or conflict can sometimes mean money is prioritized for particular countries or events. For TA, this means adapting to events and seizing opportunities as they unfold, as with Aceh after the 2004 tsunami and Haiti after the earthquake. Once significant sums have been committed, and projects successfully implemented, there is a greater likelihood that funding will be continued.

For successful funding, good personal contacts to the staff of the funding agency are critical. Otherwise, even with an excellent project, the best proposals might end up in the dustbin. It is also an unfortunate fact that development agencies are still reluctant—although this is changing slowly—to commit funds to “psychological help” because mental health continues to be positioned lower on development aid priorities.

Ensuring a match between TA’s project ideas on the one hand and the objectives and budget lines of different funding agencies on the other is hard work, requiring much patience and a willingness to adjust TA priorities toward opportunities offered. A good prior knowledge of the region and of the local situation is also essential, highlighting the value of preliminary needs assessments in the support of all project initiatives. As a result, the most successful of TA’s projects tend to be those which combine training and therapy treatment for a period of at least 3 years.

Humanitarian Training Programs

The major aim of TA is to improve the quality of trauma treatment for people who have been exposed to violence and other forms of extreme psychological distress. To achieve this, TA focuses on the training of therapists in countries where so far no sufficient training in psychotraumatology is available. European standards of training and therapy are taken as the relevant quality level.

The basic course in psychotraumatology introduces psychotherapists to the specific problems related to coping with traumatic events. Trainees learn about diagnostic techniques (including specific tests), systemic perspectives, and new insights from neurobiology. This first phase also focuses on the stabilization of the client as the basis for all further treatment, using, among other things, imaginative and hypnotherapeutic methods. Some specific techniques using a more confrontational approach are also introduced.

The second training phase includes information on differential diagnostics, comorbidity, and learning to tell the difference between simple and complex traumatic stress symptoms. EMDR is at the heart of this training, introducing bilateral stimulation via eye movements, sounds or physical “tapping” with the hands, both for the mobilization of positive psychic resources, and for the processing of stressful (traumatic) events. These are often found to be the root cause of a much wider range of mental illness than just PTSD. Moreover, to enhance significantly the effectiveness of therapeutic treatment, EMDR integrates elements from other psychotherapeutic methods, including psychodynamic, cognitive behavioral, interpersonal, and body-oriented therapeutic approaches.

The third training concentrates on complex traumatic disorders. As well as diagnostics for complex trauma and dissociative disorders, trainees learn more about neurobiology and practice a range of hypnotherapeutic and other techniques to address the trauma directly within the EMDR method. For highly dissociative clients, some potential modifications of these techniques are introduced, such as working with fragmented memories or inner parts of the personality.

To ensure the continued quality of therapeutic skills and treatment, trainees are required to attend regular supervision between the training events, allowing them to refine further the methods they are learning. As with all good supervision, trainees present the cases they are personally working with and discuss how they are integrating EMDR into their own therapeutic approach. Diagnostic findings, treatment plans, and therapeutic interventions are discussed and fine-tuned to the specific case of the client.

To qualify as a supervisor themselves, therapists must have a firm grasp of the theoretical basics as well as several years of experience and a high degree of confidence in using various techniques with a wide spectrum of diagnoses. They need good didactic
teaching skills and sensitivity in working with clients from differing cultures and traditions.

The next step in the training sequence is to become a facilitator. Here, supervisors are taught how to instruct and support most effectively small groups of therapists during training seminars.

The last step in training is to become a trainer oneself. This requires as a rule many years of experience as a therapist and an excellent command of the underlying theoretical knowledge, not only regarding traumatology. Very few participants reach this level because trainings are carried out according to extremely strict European standards.

Participants for HAP Trainings

The selection of the participants in TA trainings is crucial for the success of a project. Selection criteria depend on one hand on the specific demands of the project and on the potential that professionals in the respective country can offer. In discussions among HAP organizations, it was agreed that HAP trainers need to have some input into selecting participants for HAP trainings. TA has to depend largely on the project partner in the host country, but our experience shows that, without guidance, participants are sometimes chosen inappropriately.

If the project consists of the first two EMDR training units only, in general, the organizing hosts will select the participants. If the project is more complex, for example, extending over several years (as with projects in Indonesia, Thailand, and Haiti), TA conducts an assessment before starting the selection process. The following guidelines were drawn up following discussions within the HAP Europe group.

- Candidates for HAP trainings should provide a detailed curriculum vitae (CV) in English, supplied by the national organization supporting the training and as a responsibility of the project partner.
- Trainees should be licensed and are mental health practitioners in their own countries, and of course, TA-HAP has to accept the rules and criteria of the host nation and accrediting bodies.
- In countries where there are no organizations that set professional standards (e.g., in some countries in Africa and Asia), TA takes responsibility for assessing levels of knowledge and clinical experience at the beginning of the process.
- In some countries, training focuses first on basic knowledge, personal experience, and basic counseling skills, rather than on EMDR.
- The most important criterion is that participants should be chosen and trained in a manner that ensures they will at least cause no harm to potential clients. This might mean that they are instructed to abstain from using the standard EMDR protocol until both they and the client are ready.

China Project

In the People’s Republic of China, despite its long experience of profound natural and man-made trauma (floods, earthquakes, political turbulence and revolution, famine, mine accidents, and much more), psychotherapy is not yet fully developed nor the consequences of frequent traumatization sufficiently diagnosed and treated.

Through private contacts, the Psychological Institute at Beijing University approached TA Germany, inviting them to conduct the first EMDR trainings in the Chinese capital. These began in August 2002 with 37 participants. Three years later, in 2005, 34 of these received their certificates as EMDR trauma therapists. TA-HAP Germany worked with HAP United States to deliver three further courses in Sichuan Province from 2008 to 2010. Two further TA-HAP Germany–funded courses were run in Beijing and in the northern city of Harbin between 2009 and 2011.

Since then, more than 300 therapists have completed EMDR training in China. Since 2009, what is formally titled the Chinese EMDR and Trauma Therapy Working Group, or more briefly EMDR China, has operated under the roof of the Chinese Mental Health Association. EMDR China’s aim is to organize further high-standard EMDR trainings locally, to disseminate knowledge about this therapy method, and in the longer term to found an organization such as TA in China. Since the founding of EMDR-China in 2009, all qualified therapists are certified by EMDR-China; supervisors and trainers are still certified by EMDR-Europe and/or EMDR International Association. When the Chinese training began in 2002, knowledge of trauma and trauma treatment was at a low level. But as the training developed, that began to change, and many TA workshop participants brought their new expertise in stabilization, psychoeducation, psychological first aid, and early intervention to bear during the severe acute respiratory syndrome (SARS) flu epidemic and later after the Sichuan earthquake in 2008. Public opinion and the media in China now appear to understand rather better the importance of addressing the psychological consequences of disaster and tragedy.

Parallel to the basic trainings, there are also workshops for counselors (supervisors), facilitators, and trainers took place. At first, Chinese colleagues came to Germany and were trained alongside other
would-be trainers from other countries where TA and HAP have been working. More recently, counselors and therapists have been trained in China itself. Nowadays, about 20 supervisors are trained. In the meantime, China got its own traumatology organization; there are three EMDR trainers trained.

Furthermore, a comprehensive training for EMDR with children was conducted. The content of the seminar reached from attachment problems, basic neurobiological knowledge of trauma in children, and stabilization to EMDR with children and youngsters, focusing on practical exercises with all participants. Following the tradition of TA, teachers from Germany as well as from Thailand and from India supported the training with presentations and supervision of the small working groups.

Slovakia Project

There is a great need for trauma therapy in Slovakia, reflecting the country’s own eventful history, the radical changes after the collapse of the Eastern Bloc and the breakup of former Czechoslovakia and separation from what is now the Czech Republic. Psychiatric clinics are overcrowded while being strapped for funds and notoriously badly equipped. And although Slovakia has since joined NATO and the European Union and now uses the Euro as its currency, when TA-HAP Germany started work here, the country still fell short in many ways of the standards of its West European neighbors.

Through personal contacts with a group of committed Slovak psychotherapists in Trencin, TA-HAP Germany was able from 2003 to 2005 to carry out first general training programs in traumatology. Forty local therapists underwent three trainings and several weekend supervision workshops. Since then, Slovak colleagues have established their own organization for psychotraumatology and EMDR, with one local trainer and several counselors and supervisors. Some of these colleagues have since then taken part in trainings elsewhere in Europe and have attended European trauma conferences. A second and third training round with a further 40 participants took place between 2007 and 2013 and saw the active involvement of the first Slovak trainer, supervisors, and facilitators. Some of our Slovak team members have also been involved in other projects in Asia.

Rwanda Project

In October 2010, TA-HAP Germany concluded its first 2-year training in Rwanda, building on psychodynamic and resource-oriented trauma therapy. The participants were clinical psychologists, social workers, and psychiatric nurses. The course included five 3-day training sessions in the capital Kigali, which included skills and theory teaching and case discussions. Among other themes, the courses covered the basics of psychotraumatology, symptom diagnosis following trauma, therapeutic counseling techniques, understandings of psychodynamic relationship, distancing, strategies to activate patients’ personal resources, and techniques for relaxation and reassurance. The participants successfully learned and began to practice new resource-activation strategies, developing and adapting these to fit with local culture. Despite some initial skepticism, several experienced remarkable success with imaginative stabilization techniques. Two TA-HAP Germany–sponsored Rwandan counselors completed their psychotraumatology and EMDR training during TA courses in Thailand in 2011 and 2012 and joined also the trainings in Haiti. They now work for the project in Rwanda.

In early 2012, TA-HAP began a new 2-year course in Rwanda for 30 trainees in psychodynamic resource-oriented trauma therapy. From the graduates of this course, 12 “prospective experts” will be selected who show a special aptitude for further training as trainers, and this will take place in the third year. Rwandan colleagues may also join in as participants and facilitators in a new TA Germany project starting in Kenya. In addition, teachers and priests who work daily with the consequences of Rwanda’s trauma history have been instructed on how to deal with traumatic crises. Aside from higher level training, TA carries out basic 2-day coaching in psychotraumatology, targeting not experts but occupational groups. So far, eight of these coaching events have been held.

Southeast Asian Projects

Aceh: 2007–2013. After the 2004 tsunami and needs assessments study the following year, TA-HAP Germany began a 3-year project in Indonesia’s Aceh province. The assessment had highlighted an urgent need for psychosocial support, reflecting not only the impact of the tsunami but also the consequences of more than 30 years of civil conflict. The project focused therefore on equipping Indonesia’s educational system with awareness and knowledge of treatment options, especially EMDR, for the posttraumatic stress of victims of crisis and catastrophe.

In the first instance, 90 social workers were trained as psychosocial health assistants, able to identify the symptoms of posttraumatic stress, to coordinate professionally and give basic psychological support, and to refer clients as required to project therapists. Because
Asian EMDR congress in Bali in 2010.

of Indonesia in Jakarta and also to organize the first Association Indonesia, which went on to hold further and implemented the project, establishing the EMDR (the Indonesian Psychology Association) managed had all reached the same internationally recognized year of the project, therapists from all three countries these countries illustrates their dedication. By the third and supervision. The high number of clients treated in almost immediately able to understand and apply the better understanding of the training content and were educational system, participants from Thailand had a far advantage. Some also took time to appreciate how the role of the therapist differs from that of traditional healer, medical doctor, or religious specialist.

Mekong Project: 2010–2014. The Mekong Project, covering Indonesia, Thailand, and Cambodia, started during the last year of the Aceh project, allowing for particular efficiencies because Aceh therapists who already knew each other well brought their new expertise to bear in the added regions. Over 4 years, psychosocial services were established across the three countries, with 39 EMDR and trauma-trained therapists’ altogether; 9 from Cambodia, 14 from Indonesia, and 16 from Thailand. Two supervisory trainings were held in addition. As a result, 14 independent supervisors trained to international standards were able to start work in the different project regions.

Trainer training took place in two seminars, with three therapists being accorded trainer status, one of those additionally as trainer for using EMDR with children. Altogether 850 social workers from all three countries were trained as health assistants in 21 workshops throughout the project region. Half of these health assistants went on to join a second advanced training. More than 5,000 patients were treated during the course of the project. In Thailand, as well as in Cambodia, local EMDR associations were set up alongside the one already established in Indonesia, and all three have themselves since organized further trainings.

A significant gap was noted right at the beginning of the project between the educational levels of the Indonesian and Cambodian therapists and their colleagues from Thailand. Thanks to their better educational system, participants from Thailand had a far better understanding of the training content and were almost immediately able to understand and apply the treatment and training methods. For the participants from Cambodia and Indonesia, highly motivated as they were, there was a need for intensive repetition and supervision. The high number of clients treated in these countries illustrates their dedication. By the third year of the project, therapists from all three countries had all reached the same internationally recognized standard, evidence that with appropriate training and resources, even vast differences in initial educational backgrounds can be successfully leveled out over time.

All participants had an educational background in psychology, psychiatry, and/or psychotherapy and were eager to learn and on the whole to accept the training content, based as it was on a Western scientific paradigm. There were, however, some challenges regarding cultural and religious attitudes and some components of the training. Training schedules had to take into account prayer times for Muslim participants, and this had to be accepted by the other participants. To start with, some participants found it difficult to be individually evaluated and criticized during supervision sessions. A couple of training sessions were needed before they felt confident that this worked to their advantage. Some also took time to appreciate how the role of the therapist differs from that of traditional healer, medical doctor, or religious specialist.

Haiti: 2010–2013. After the 2010 earthquake in Haiti, which killed approaching quarter of a million people, TA was granted funds for psychosocial care of the population. A local partner organization was identified, and trainings organized over a 3-year period, using the same design and principles already established in former projects. Twenty trained therapists were employed as staff and built up a psychosocial service in the different camps and institutions. Various trainings were successfully held in psychotraumatology, EMDR, EMDR for children, systemic approach, and family violence and dealt with large numbers of complex trauma cases in a society marked by extremely high levels of interpersonal violence directed against women and children.

Trauma-Aid’s Future Plans

TA looks forward to continuing its work around the world in the training and support of future EMDR therapists. In particular, we have plans for Burundi, Cambodia, Kenya, Myanmar, Indonesia, Rwanda, and Thailand and will focus also on offering training for EMDR supervisors and trainers.

In conclusion, we would like to thank all international TA team members for their dedication and time in supporting our projects.

References


**Acknowledgments.** We write this text on behalf of all Trauma-Aid project teamers, who invested much time and power to support our projects. We are grateful for the support of Mark Brayne, who has given a lot of effort to correct our English text.

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Developing EMDR Therapy in Pakistan as Part of a Humanitarian Endeavor

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The empirical justification for the use of eye movement desensitization and reprocessing (EMDR) therapy as part of the repertoire of interventions used in response to humanitarian endeavors continues at a pace. A devastating earthquake, measuring 7.6 magnitude on the Richter scale, occurred in Northern Pakistan in October 2005. In response, the first EMDR Humanitarian Assistance Program to be facilitated by an academic institution was established. This article highlights how 3 research projects assisted in the continued development of EMDR therapy in Pakistan to the point where presently more than 125 Pakistani mental health professionals have now been trained; it now has its own EMDR National Association and is an active participant within EMDR Asia.

Keywords: EMDR therapy; humanitarian assistance; Pakistan; research; therapist training

The empirical justification for the use of eye movement desensitization and reprocessing (EMDR) therapy as part of the repertoire of interventions used in response to humanitarian endeavors continues at a pace. The World Health Organization’s (2013) endorsement of EMDR therapy recognizes its empirical status as a psychological trauma intervention for the treatment of posttraumatic stress disorder (PTSD). Similarly, the United Kingdom National Institute for Health and Care Excellence (2005) recommends EMDR therapy for those with PTSD and perinatal PTSD. The need for such treatment is underscored as the rise in psychological trauma populations continues unabated.

EMDR Therapy

EMDR therapy was formulated and introduced to the international mental health community by Francine Shapiro following her seminal doctoral research in 1987. Shapiro’s initial formulation perceived the intervention as a form of desensitization. Although its initial taxonomy was eye movement desensitization (EMD), Shapiro subsequently concluded that the process was much more than desensitization and that an integral aspect of this phenomenon involved the reprocessing of distressing memories, through eye movements or other forms of bilateral stimulation, to a more adaptive and functional resolution (Shapiro, 1995, 2001, 2007, 2012; Solomon & Shapiro, 2008). To date, EMDR therapy is a strong, evidence-based, multifaceted psychotherapy, which as a consequence of its empirical justification has led to a surge in its use as a psychological trauma therapy as part of humanitarian assistance programs (Farrell, Keenan, Knibbs, & Hicks, 2013).

EMDR Europe Humanitarian Programs

EMDR therapy within a humanitarian context is necessitated either through traumas of human design or natural disasters, although both have the potential for causing widespread human suffering, and material and environmental damage. EMDR Europe Humanitarian Assistance Programs (EMDR Europe HAP) is an umbrella organization of National EMDR HAP organization from within Europe with generally projects being developed, coordinated, and acted on nationally, rather than at a European level.

Humanitarian Crises

During the last decade, most natural disasters has affected some 2.5 billion of the world’s population. Trends suggest that the impact of natural disasters is intensifying, resulting in third world nations more vulnerably exposed because of factors such as population growth,
increased urbanization, poor urban and rural planning, environmental degradation, regional conflict, and poor governance. Over the last decade, China, the United States, Philippines, India, and Indonesia constitute together the top five countries that are most hit by natural disasters, with Asia accounting for 64.5% of global disaster victims (Guha-Sapir, Hoyois, & Below, 2013).

Humanitarian crises are initiated in response to human conflict and man-made disasters. As Bowden (2003) outlines

What we now face, at the beginning of the 21st century, is a continuing rise in the demand for humanitarian assistance, not just as result of natural disasters, but also because of an upswing in the number of countries affected by conflict. The nature of conflict itself has changed in recent years...on almost a daily basis, we in the humanitarian community encounter the evident impact and insidious effects of trauma on both the populations we assist and among our own peacekeeping and humanitarian personnel. (p. 213)

Pakistan

The Islamic Republic of Pakistan is a part of the world that houses some of the earliest human settlements. Pakistan stretches from the Arabian Sea toward the majestic reaches of the Himalayas and has a population of more than 180 million. It is a modern state born out of partition in 1947 when Indian Muslims wanted their own homeland. Since its birth, Pakistan has been involved in political upheaval oscillating between both military leadership and civilian governments, with the political dynamics in Pakistan polarized between Islamic militancy and more modern secularization.

The official language of Pakistan is English; however, the country’s national language is Urdu. Although less than 8% of Pakistanis speak Urdu as a primary language, following the separation from India and to accommodate Pakistan’s considerable ethnic and cultural diversity, Urdu was chosen as a “language of unity” because approximately 94% of the Pakistan population can at least understand it. Most educational institutions and universities within Pakistan use English, rather than Urdu, as the primary means of instruction, particularly in medicine, psychiatry, and psychology training (Farrell et al., 2011). Although from an academic context this may be understandable, the intrinsic subtleties of cultural context might determine that these inevitable nuances are better captured by primary rather than secondary language.

The Kashmir Earthquake. A devastating earthquake occurred in Northern Pakistan in October 2005. Measuring 7.6 magnitude on the Richter scale, it collapsed mountains, altered the course of waterways, and wiped out entire villages. Some 400,000 houses were destroyed, more than 86,000 people perished including some 35,000 children, tens of thousands of families lost an entire generation, and more than 138,000 were injured, mostly women, children, and older adult (Farrell et al., 2011). One of the reasons the death toll was so high for children was that the earthquake struck at a time when children were at school, with many of the school buildings themselves being of poor architectural design and construction. One year after the earthquake, the World Bank estimated that the reconstruction and rehabilitation cost after the earthquake for Pakistan would amount to $3.5 billion (Mumtaz et al., 2008). The social, ethnic, and linguistic diversity of Pakistan, coupled with low levels of education, literacy, and wealth, meant that managing the fallout from the earthquake was a major strategic and logistical problem (Gadit, 2003, 2007).

Other Humanitarian Crises in Pakistan. During the last 7 years, the political landscape of Pakistan has changed considerably, moving from military to civilian government. Importantly, over this same period, the level of threat and insecurity has increased rather than decreased, with examples such as the following:

- Four hundred suicide bombings responsible for the deaths of 6,038 people and the injuring of 12,565
- The 2,610 people killed through U.S. drone attacks
- In 2011, 20,154 deaths through road traffic accidents
- According to Human Rights Watch (2009), estimated between 70% and 90% of women in Pakistan suffered some form of abuse
- Five thousand women killed per year from domestic violence (Hanser, 2007).

Figure 1 also highlights the dramatic increase in the numbers killed and injured from 2007 to 2013 in Pakistan.

EMDR Europe HAP Project in Palestine: Response to the Kashmir Earthquake

A consistent feature with EMDR humanitarian projects is that the access into a country is triggered through either a natural disaster or incidents of human design. Following the Kashmir earthquake, a decision was made by EMDR Europe HAP to respond to this disaster. It was virtually impossible for Pakistan’s approximate 400 psychiatrists, 480 psychologists, 600 mental...
EMDR Trainings in Pakistan

contained a specialized critical care unit. Although the college agreed to host the training, they also sought assurances that the project would be different from their experiences of several nongovernmental organizations (NGOs) that had worked in the region but quickly left, “promising much, but delivering little.” Several meetings were had with the hospital medical directorate explaining the principles of EMDR therapy as a psychological trauma treatment, the nature of the project, and an outline of the intended project timetable. With the assurances given, the hospital agreed to support the project.

An essential part of the HAP project was in ensuring effective communication, support, and clinical supervision of the Pakistani participants and providing reassurance that the commitment toward the project was more long-term. Experience in Pakistan had identified apathy toward “outside organizations,” and in some cases, anger and resentment in that some NGOs had arrived in Pakistan yet quickly disappeared. In the integration of theory and practice, clinical supervision and consultation is important. Because of the geographical distance between Pakistan and the United Kingdom, electronic communication in between EMDR therapy training events were used including Skype videoconferencing, webinar, e-mail support, donation of computer equipment, teaching and learning resources, and textbooks. In addition, each of the Pakistani mental health workers were allocated a volunteer British and Irish clinical supervisor and were encouraged to keep in regular contact with them. Many EMDR British and Irish EMDR Europe consultants and practitioners were extremely generous with their time and energy. This made a huge difference in the success of the project because the Pakistani mental health social workers, and less than 100 psychiatric/mental health nurses to satisfactorily manage the deep psychological traumas that tens of thousands of Pakistanis suffered as a consequence of the earthquake. EMDR Europe HAP realized that the best assistance that they could provide was to train a cohort of Pakistani health-care workers in effective psychological trauma-management—that is, EMDR therapy—and then to cascade this training down to health carers at the local level.

Securing the necessary funding to carry out such a major project proved challenging. It also required approval from the United Kingdom university responsible for coordinating the project. The university had never embarked on project such as this. Major assurances were sorted before an agreement was secured. This was the very first time that an EMDR HAP had ever been facilitated by an academic institution. Eventually, the University of Birmingham agreed to take full responsibility for the overall coordination of the project.

Consequently, this took some considerable time. As a result, the first trainings took place some 18 months after the earthquake in March 2007. This EMDR Europe HAP project, in conjunction with the University of Birmingham and assisted by Edge Hill University, was set up in Abbottabad, Northern Pakistan, to train 21 mental health workers (4 consultant psychiatrists, 8 trainee psychiatrists, 4 clinical psychologists, 4 medical officers, and 1 female health worker) in EMDR therapy. Abbottabad was chosen as a suitable destination for the training because it was the city closest to the epicenter of the earthquake. The major hospital in Abbottabad was Ayub Medical College, which although a broad-spectrum health facility, it also

health workers felt supported in between each of the training visits.

EMDR therapy basic training consists of integration between theory and practice. To enhance understanding in EMDR, training participants are required to partake in practicum sessions where they gain vital experience of being both an EMDR clinician and an EMDR client, with the client participants working on their own experiences and disturbing material. During these practicum sessions, the EMDR training team noticed that much of the material worked on by trainees did not relate to the earthquake but instead focused on other disturbing issues such as fear of terrorist attacks, suicide bombings, religious extremism, acid attacks, domestic violence, and oppression. These were issues that affected all of Pakistan and not just the earthquake-affected areas. The subsequent interest in developing EMDR in Pakistan quickly resulted in EMDR trainings then being carried out in Rawalpindi, Karachi, and Lahore.

**EMDR Europe HAP Projects in Rawalpindi, Karachi, and Lahore**

**Three Initial Research Studies**

The development of EMDR therapy training in Pakistan could not have happened without the support of the Pakistani military, and in particular, the Centre for Trauma Research and Psychosocial Intervention at the military hospital in Rawalpindi. However, they took some initial persuading. Three research studies played a major part in providing robust integrity of the entire project: a case study with seven military personnel injured in a suicide bombing (Bilal & Rana, 2008), the validation of the Impact of Events Scale-Revised (IES-R) in an Urdu translation (Tareen et al., 2012), and Q-methodology study of the experience of Pakistani trainees (Farrell et al., 2013).

**Case Study: Rawalpindi.** A Pakistan army psychiatrist who was an EMDR trainee in the first cohort in Abbottabad carried out the first study (Bilal & Rana, 2008) with the data being presented at two international conferences (Farrell et al., 2011). The seven participants were the direct survivors of two separate suicide bomb blasts that took place in Rawalpindi, the military headquarters in Pakistan. They were armed forces personnel and were residing in regimental premises at the time of the suicide bombings. Both blasts entailed a huge death toll as well as extensive physical injuries to many military personnel. Survivors were rescued by military health professionals and evacuated to a tertiary hospital for immediate surgical interventions and rehabilitation. The initial inpatient stay was dominated by important surgical interventions, and because of the extent of people’s injuries, many life-saving protocols were deemed necessary.

The postsurgical provision for mental health rehabilitation was also carried out at the same Centre for Trauma Research and Psychosocial Interventions as mentioned earlier. Each of the seven individuals selected for this study fulfilled the International Classification of Diseases 10 (F43.1) diagnostic criteria for PTSD at pretreatment. They were provided with six sessions of EMDR by a consultant psychiatrist trained in EMDR therapy. At posttreatment, they were assessed as subclinical (see Figure 2, which highlights the scores on the IES-R before and after EMDR therapy for each of the seven participants). The EMDR therapy sessions were supervised by an EMDR Europe accredited consultant.

This data was essential in demonstrating not just the effectiveness of EMDR therapy as an intervention within Pakistan with military populations but also the value of a psychological treatment. Pakistan is a country where psychological treatments are not readily available or easily understood. Psychiatry itself is a limited resource with pharmacological treatment featuring strongly. That a psychological treatment could bring about such change was indeed welcome, yet not surprising, data. Politically, this local evidence was more powerful than any international data that could have been presented. An appearance on a national, prime time Pakistan television news program bore testament to this.

**Translation of the IES-R Into Urdu and Related Reliability Study: Abbottabad.** An integral aspect of the EMDR HAP project in Pakistan was to encourage and develop research potential and evaluation of
the project as a whole. Consequently, the intention was to use psychometrics that enabled effective comparison between psychological trauma populations in Pakistan and the West. The IES-R is probably the most widely used self-report measure in the field of traumatic stress. In the Bilal and Rana (2008) study, recruitment relied on participants being English-speaking and therefore used the English version of the IES-R. Developing and validating an Urdu version of the IES-R was desirable. Many of the scales used in cross-cultural research have been developed in Western settings; however, to what extent, translations of Western psychometrics perform the same function across culture has often been debated (Tareen et al., 2012). Permission was granted to perform the validation study of the IES-R Urdu version. The original IES-R English version was professionally translated into Urdu and then another professional translation company performed a back translation. The final version was then tested with 188 medical students, conversant in both English and Urdu, at Ayub Medical College, Abbottabad. The reliability scores demonstrated internal consistency between the English and Urdu versions of the psychometric measure (Tareen et al., 2012).

The development of the Urdu version of the IES-R created a valuable tool, useful in both clinical and research work. It also facilitates more direct comparison between EMDR researches in Pakistan with the rest of the international community. In addition, the validation methodology that was used for this study is now a template used to validate other Urdu psychometrics.

**Q-Methodology Study: Karachi.** The third study, which contributed toward the development of the project, was a Q-methodology study of experience of the Pakistani EMDR facilitators/consultants (Farrell et al., 2013). EMDR Europe HAP and the coordinating university considered it essential to ensure that local Pakistani professionals could take over the function of providing effective EMDR clinical supervision; it was also imperative that the practicum components within the EMDR trainings could be conducted by skilled indigenous facilitators. Consequently, six Pakistani colleagues were identified for a “fast-track” EMDR consultant/clinical supervisor and facilitator training. After their training was completed, this study undertook an in-depth evaluation of the effectiveness of their EMDR therapy training. Q methodology was chosen because it permits the systematic study of subjective experiences by combining a richness of qualitative protocols with the rigor of quantitative analysis and consideration (Merrick & Farrell, 2012). From the concourse statements, degrees of consensus and contention are determined. Four superordinate themes were identified:

- **EMDR clinical practice**
- **Cultural application of EMDR**
- **EMDR research and development**
- **Facilitator’s subjective experiences of their EMDR therapy training**

Results were then subjected to factor analysis of which the factors themselves are then interpreted. Within the correlation matrix, two factors emerged:

- **Factor 1:** Theory practice integration and scientific enquiry—neurobiology of EMDR therapy, psychotraumatology, EMDR therapy skills and development
- **Factor 2:** Attunement and cultural context—therapeutic relationship in EMDR therapy, cultural sensitivity and application

The Q-methodology study (Farrell et al., 2013) provided the Pakistani teams and EMDR Europe HAP with greater understanding about the processes of being trained in EMDR, of teaching EMDR, and of practicing EMDR therapy in Pakistan. They also spoke about the value and usefulness of EMDR therapy in Pakistan.

**Regarding the experience of being trained in EMDR:**

- EMDR training to contain more practicum sessions because these were considered the most important part of the training
- Importance of regular EMDR clinical supervision to consolidate teaching and learning

**Regarding the experience of providing EMDR therapy:**

- Therapeutic relationship plays an important part in successful EMDR outcome.
- Participants considered that EMDR was definitely not another form of trauma-focused cognitive behavioral therapy (TF-CBT) and a distinct psychotherapy in its own right.

**Regarding the experience of teaching EMDR:**

- EMDR facilitator training was seen as an ideal opportunity to support and empower other Pakistani mental health workers.
- Importance of including traumatology, memory, and neurobiology into the EMDR HAP training
- Understanding the neurobiological mechanisms of EMDR was actually very important to the future integrity and development of EMDR.
of concern expressed by Pakistani EMDR supervisee’s was that their clients bring issues such as fear of terrorist activity, suicide bombings, religious extremism, domestic violence and abuse, and so forth. These aspects highlight a much wider perspective of the trauma fabric of Pakistan. It was for this reason that the geographical range of the EMDR trainings widened to include Rawalpindi, the old capital, Karachi, and then Lahore.

Conclusion

Developing a sustainable EMDR training program in Pakistan was always going to be challenging in a current environment were security risks are increasing, and most of those killed or injured continues to rise. What is encouraging is the evidence to suggest that those Pakistani clinicians trained in EMDR therapy are incorporating it into their clinical practice.

The ultimate aim of this project continues unabated to create a self-sustaining provision of training in EMDR therapy in Pakistan:

- Develop indigenous EMDR clinical supervisors, facilitators, consultants, and trainers.
- Promote high-quality research and development in EMDR therapy including a doctor of philosophy (PhD) research, multicenter projects, and so forth.
- Establish collaborative academic parties between Pakistan and United Kingdom universities.

To embark on a project such as this requires huge amounts of time, commitment, and energy. Entry into a country as part of a humanitarian response should always have a very clear exit strategy. The mission itself should have clear objectives that are measurable and tangible. The ultimate objective is to carry out impact studies to determine how effective EMDR therapy is locally within communities—ideally this should include health economic data.

Seven years into this project—and some 14 visits to Pakistan to date—the fruits of this endeavor is profoundly evident. More than 125 Pakistani mental health clinicians have now been trained in EMDR therapy including 6 Pakistani EMDR consultants/clinical supervisors and 2 Pakistani EMDR trainers in training. Although the project commenced in March 2007, the commitment to Pakistan remains. The 16th day of August, 2009, witnessed the establishment of the EMDR Pakistan Association. Not only was this a momentous occasion but also the development of EMDR in Pakistan has contributed toward the emergence of EMDR Asia Association as a growing, thriving organization. Furthermore, Pakistani

Rationale

EMDR Europe HAP Projects in Rawalpindi, Karachi, and Lahore

Prior to 2007, EMDR therapy was not a practiced psychological treatment intervention in Pakistan. These three research projects provided much needed empiricism based entirely on national subjects. A valid question, however, if the earthquake occurred in the north of the country, why were the EMDR therapy trainings carried out in the south and east of Pakistan? As the studies demonstrate, the psychological trauma of the Pakistani population was not just restricted to the earthquake area in Kashmir. The EMDR Europe training team, in conjunction with the British and Irish EMDR Europe consultants supervising Pakistani colleagues undertook a content analysis of the issues raised within EMDR clinical supervision. Results highlighted that very few of the client’s trauma issues, of those receiving EMDR therapy, were actually centered on the earthquake itself. The main areas

- Anxiety about EMDR HAP training being taught in Urdu. Participants considered that the training needed to stay in English as all basic training as medical doctors and psychologists are taught in English.
- EMDR trainers and facilitators need to be especially sensitive to the issues of gender, touch, and cultural dress in Pakistan.
- Recommendation that EMDR HAP training in Pakistan to be longer in duration

Regarding the value and usefulness of EMDR therapy in Pakistan:

- Recognition that EMDR can be applied across all cultures within Pakistan
- EMDR has great potential to be used in Pakistan far more than with just trauma populations.

What this Q-methodology study demonstrated was the relationship between professional background and experience in showing the degree of engagement with EMDR therapy and positive outcome in terms of clinical benefits, achievement of targets, and patient well-being in Pakistan. The study also highlighted that it is possible to develop Western provenance therapeutic techniques that adapt well and are appropriate and effective for mental health practitioners of other cultures (Farrell et al., 2013). However, there needs to be attention to cultural sensitivity and application as to using EMDR therapy in Pakistan and the teaching and learning mindful of both language and literacy.
mental health workers have presented their work at several EMDR Europe and EMDR Asia conferences. Despite the ongoing problems facing Pakistan, the potential for EMDR therapy in the country remains positive. The Pakistan founder, Muhammad Ali Jinnah, declared if Pakistan is to prosper, then attention needs to be given toward the well-being of its citizens. EMDR therapy can have some part to play in this.

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Eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2001) is a global psychotherapy, with tens of thousands of EMDR practitioners spread over six continents. Randomized controlled trials document the efficiency of EMDR therapy (Carlson, Chemtob, Rusnak, Hedlund, & Murakoa, 1998; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002), and the method has been flexible enough to incorporate adaptations to specific cultures while keeping the integrity of the treatment.

In response to humanitarian crises (e.g., Hurricane Pauline in Mexico in 1997, the earthquake in Algeria in 2003, the tsunami in Southeast Asia in 2004), different countries throughout the world have developed humanitarian assistance programs (HAPs) and created national EMDR HAP associations. These HAP associations offer free trainings in EMDR therapy and stabilization procedures to the local psychologists and promote the development of EMDR therapy in the specific country. The African continent has received attention from these organizations since 2007. However, because of many humanitarian crises, it is in need of more training projects. It is actually the continent (except Antarctica) where the fewest people are trained in EMDR therapy. This article shows the efforts undertaken to change this in the near future.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; humanitarian aid; Africa and African culture; posttraumatic stress disorder (PTSD); genocide; therapist training

Humanitarian Crises and Traumas in Africa

Africa and the Culture of Trauma

Africa is the second largest continent, stretching over 30 million km², more than 3 times the size of the United States. The history of Africa is a history of trauma. Harsh feelings remain in Africa regarding the experience of colonialism and the efforts of the colonials to abolish African culture, language, religion, and identity. Slavery was ubiquitous, and when the colonizers finally left, having looted the continent of so much of its resources, people, and strengths, Africa remained in a state of great unrest and instability.

Politics, War, and Economics

Apartheid in South Africa led to political prisoners spending their lives in prison, with the greatest example being the late Nelson Mandela. Africa’s natural resources continue to be exploited by other nations, with a loss of greatly needed wealth. The sense that available resources are being wantonly plundered creates a continuing atmosphere of conflict of interests, exploitation, and war. Tribal warfare, fueled in part by the divisive laws of the colonizers, has brought armed conflicts over the continent, resulting in genocide, child soldiers, refugees, and war traumas such
as mutilations, rape, torture, and so forth. Further increasing the tragic proportions of these actions, when rape victims become pregnant, they and their babies are often HIV positive (Cohen et al., 2009; Schaal, Dusingizemungu, Jacob, & Elbert, 2011); they are then rejected by their families, become single mothers, and forced to live in terrible conditions (Vlachová & Biasoň, 2005).

Social Issues

Traumatic events that have resulted in a traumatic impact on its people are ubiquitous. For example, 20 years after the 1994 genocide in Rwanda, the prevalence of psychological disorders is still extremely high. About 26% of the Rwandan population suffers from posttraumatic stress disorder (PTSD) and/or comorbid conditions (e.g., major depression, dissociative disorders, substance abuse), with much higher rates in special populations such as widows, orphans, and HIV-positive individuals (Cohen et al., 2009; Munyandamutsa, Mahoro Nkubamugisha, Gex-Fabri, & Eytan, 2012; Schaal et al., 2011). As nearly half of the population of Rwanda and Burundi is younger than the age of 15 years, most of them were traumatized during and after genocide in early childhood and now suffer from severe attachment trauma and multiple trauma-related symptoms. As a consequence of genocide, a huge number of children were orphaned or separated from their families (Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000). Today, most of these children live in child- or youth-headed households where they experience high levels of psychosocial distress (Boris et al., 2008; Brown, Thurman, & Snider, 2005).

On a social and cultural level, Africans are subject to female mutilation, family violence, violence against women, child abuse, and tribal conflicts. Also, the political regimes have a high level of instability, corruption, and a law system that does not guarantee imprisonment of perpetrators, so they continue to commit crimes. They are also subject to all of the normal traumatizing events of any continent, such as threatening diseases, traumatic childbirth, infertility, car accidents, and/or natural disasters.

Needs of a Traumatized Population

As described earlier, a high proportion of the African population suffers from the consequences of trauma, such as PTSD and comorbid conditions (major depression, dissociative disorders, addiction disorders, etc.). It is not a surprise then that many suffer from attachment disorders because of family violence and traumatized parents, which is so-called transgenerational trauma (Dellucci & Vojtova, 2014). There is little psychological or psychiatric help available to most.

As stated by Egeland (2004), United Nations Undersecretary-General for Humanitarian Affairs and Emergency Relief Coordinator from 2003 to 2006, the worst humanitarian crisis in the world is the forgotten crisis in the Great Lake region in Africa, including the countries of Democratic Republic of Congo, Rwanda, Burundi, and Uganda. The African continent is not to be seen as a unified one with similar needs from north to south and from east to west. Africa has more cultures and languages than any other continent. There are different needs and challenges in each of the nations, as each one faces different cultural, social, economic, political, and religious issues. The need for psychotherapeutic help is indeed of high importance.

EMDR Therapy in Africa

As a result of the issues discussed earlier, one may easily understand the massive need for trauma treatment. However, direct psychological help is lacking because there are few mental health providers and even fewer who understand about trauma and the need for treatment. EMDR therapy would be of immense help in the aftermath of catastrophes, during humanitarian crises, and for the treatment of any trauma-related disorders. Many studies and meta-analyses (e.g., Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Maxfield & Hyer, 2002) show the efficacy of EMDR therapy for trauma sufferers, and there is some evidence for its effectiveness with combat-related PTSD. Since 2013, the World Health Organization (2013) has recommended EMDR therapy and trauma-focused cognitive behavioral therapy (TF-CBT) as the two only psychotherapies for the treatment of PTSD in children, adolescents, and adults. It needs to be noted that EMDR therapy does not need hours of homework in-between sessions, as it is the case for TF-CBT, which makes EMDR therapy even more accessible to people in difficult socioeconomical environments.

The EMDR therapy protocol follows eight phases. According to Shapiro’s (2001) adaptive information processing model of EMDR therapy, the clinician helps the patient to identify and access the dysfunctional stored memories, which are considered to be the basis of pathology. These identified memories are reprocessed with the help of quick bilateral eye movements, known as bilateral stimulation, “facilitating dynamic linkages to adaptive memory networks, thereby allowing the characteristics of the memory to change as it transmutes to an adaptive resolution” (Solomon & Shapiro, 2008, p. 316). The rapid eye
movements (REM; bilateral stimulation) and structured procedures seem to have a positive impact on the traumatic material (Pagani, 2012). One theory states that eye movements are imitating the process during REM sleep (Stickgold, 2002, 2008), which seems to help events that occur during the daytime to integrate in to the adaptive memory networks during sleep at night.

The following clinical vignette illustrates the application of EMDR therapy. A young woman from a nomadic Kenyan tribe could not continue in school because of a chronic earache, which kept her from sleeping and concentrating. During EMDR therapy, it became apparent that the earache was part of an unprocessed memory of a tragic accident that had taken several children’s lives a year earlier. In spite of the limited communication between therapist and client during their work, the earache disappeared within two sessions of EMDR therapy. The young woman was ready to return to school and did so effectively.

The clinical vignette shows the rapidity of the healing process in a more “normal” traumatic event, a motor vehicle accident, but with main cultural differences (e.g., language issues). As in many African cultures, talking about what happened is difficult for survivors. One of the strengths of EMDR therapy is that people do not need to talk in detail of what happened. These facts make it obvious that the teaching of EMDR therapy to the local clinicians in a humanitarian context should be “state of the art.”

Humanitarian Assistance Projects Providing Therapist Training in EMDR Therapy

EMDR therapy was first introduced in South Africa. Since 2007, EMDR basic trainings have been held in Kenya, Uganda, Cameroon, Tanzania, Algeria, Ethiopia, Sudan, and Zambia, with upcoming projects in Rwanda, Burundi and Democratic Republic of Congo, and Togo. Trainings have been provided by various EMDR HAP associations such as HAP United States (Trauma Recovery Network), HAP France and HAP Suisse-Romande, and Trauma-Aid Germany (see Matthé & Sodemann, 2014). In addition, some individual EMDR trainers from Europe and the United States have been or will be providing courses. The following are examples of humanitarian trainings.

Algeria. In Algeria, since 2007, HAP France has sponsored three trainings (Level 1, Level 2, and consultation), with a total number of 59 Algerian therapists completing Level 2. A first child training took place in December 2013. Most of the trainees engage in consultation and are reporting great results and success in applying the therapy.

Training and treatment challenges in Algeria are related to cultural issues. There is a lot of sexual trauma in Algeria, and therapy is complicated by restrictions within the Muslim culture about addressing this topic. Algerian colleagues must be supported and encouraged to treat sexual issues with confidence, realizing that in EMDR, it is not necessary for the patient to describe the scene in detail, and there can remain a discrete distance from the facts. In Algeria, instead of talking about emotions, people describe physical sensations. Therefore, colleagues are assisted in working with somatic symptoms and helping patients to identify and name emotions. Therapists also seek ways to use EMDR with addictions because this is a growing problem among the youth, who seek to reduce anxiety, defend against internal feelings, and escape from social pain. There is also an urgent need to treat those who are parents to prevent the transmission of trans-generational trauma and so reduce the psychological problems of the next generation (Dellucci & Vojtova, 2014).

Ethiopia. HAP United States has been providing therapist trainings in Ethiopia for many years. With ongoing HAP support, the EMDR program there has achieved the goal of sustainability, with some Ethiopian therapists able to provide consultation to new EMDR trainees. In January 2014, the focus was on helping therapists who were previously trained in EMDR to become more proficient. HAP offered the Part 2 training (15 participants) plus two specialty trainings, one for working with children (17 participants) and one that focused on working with adults, especially those suffering from addiction (12 participants).

For 2015, HAP has been invited by Addis Ababa University’s Psychology Department to give an in-depth Part 1 training for all of their master’s students. The students will then, hopefully, do their semester practicum at an agency where EMDR-trained therapists are already working, who can provide them with consultation as they begin to use EMDR with clients. In addition, HAP United States has been approached by a nonprofit company who works with the refugees in the southern part of the country to train their therapists in EMDR. Three trainers will return from the United States in 2015 to work on these two projects if the grant application is approved. Funding for EMDR trainings is especially difficult in Ethiopia because the therapists cannot afford to contribute to the trainings. Even paying for bus fares to get to the training is a problem for some of them. Because of very limited numbers of psychological books, every year that the
U.S. trainer group goes to Addis, they take in 15–20 books that have been donated by Pennsylvania psychologists and other professionals, and a small library for any interested Ethiopian therapist is also now available. But with all of the problems, it is rewarding to hear the Ethiopian therapists present cases that illustrate how patients have responded to the use of EMDR therapy. Several of the EMDR therapists now have their own radio shows and regularly discuss trauma, addiction, and EMDR therapy with hundreds of thousands listeners. Progress is definitely being made.

Kenya. Within the region of East Africa and bordering Central Africa, Kenya plays a key role in providing mental health services in the area. It has several training institutions providing up to PhD-level psychology and counseling training and has counseling structures in place. Many international organizations provide disaster, trauma, and other humanitarian care in the region and employ Kenyan counselors for these services.

EMDR therapy was introduced in Kenya in 2007. Training was conducted by EMDR HAP United States, who continued to stay engaged, providing further training and Skype consultation over the subsequent years. From 2007 to 2010, HAP conducted 4 annual training blocks; 145 participants were trained in EMDR Level 1 and 65 in EMDR Level 2. Beginning in 2009, a mandatory day course of basic traumatology was added to the Level 1 training. Speciality workshops such as EMDR with children, acute trauma interventions, and EMDR in groups for adults and children were provided to 195 participants. Trainings stopped in 2010 because of a lack of funds. However, trainings are scheduled to restart in October 2014 and will be provided by HAP Europe and Trauma-Aid Germany.

In spite of the challenges and overwhelming needs, counselors have successfully used EMDR in individual and group settings throughout the regions. EMDR practitioners in the region use EMDR with street children, former child soldiers, victims of gender-based violence and tribal clashes, in reconciliation work, after terrorist attacks (Westgate Shopping Mall, Church Attacks), road accidents, spinal injuries, major fires such as oil pipeline accidents, soldiers with combat-related trauma, those affected by HIV, and so forth. Group work has been done with traumatized children, torture victims, civil war victims, and families affected by violence because of criminal activity. Kenya has many crises over its territory, and overall, much pro bono work has been offered by EMDR practitioners, supporting traumatized sectors of society and individuals.

Rwanda. Because of the difficult conditions, Trauma-Aid Germany, which is active in Rwanda, has considered it a priority to first teach stabilization techniques and crisis intervention before teaching EMDR therapy. Trainings are provided not only for professionals but also for nonprofessionals and emphasize the need to comprehensively teach general psychotherapy skills and resource activation techniques. Since 2009, about 50 professionals, most of them clinical psychologists, have been educated in stabilization and resource-activation techniques. During training periods of 1 or 2 years, 4–6 one-week teaching units took place. Imaginative techniques for resource activation and case supervision were important elements of the trainings. In addition, more than 200 nonprofessionals (teachers, pastors, social workers, nurses, policemen, etc.) attended education sessions to improve their coping with traumatic crises. The trainings were carried out by Trauma-Aid Germany in cooperation with the Protestant Council of Rwanda and supported by the German Development Service.

Since 2012, two Rwandan professionals completed international EMDR trainings (Level 1 and 2) in Bangkok/Thailand and Haiti. An EMDR Level 1 training will take place in Kigali/Rwanda in February 2015. The Protestant Institute of Arts and Social Sciences in Butare, Rwanda, in collaboration with EMDR HAP Suisse-Romande (Switzerland) and other local organizations, has planned to open an Academic Trauma Healing Center with a master’s degree in Trauma Healing in 2015, where EMDR will be part of the teaching. A “counselor degree” will be added for nonpsychotherapists (e.g., psychiatric nurses, priests, social workers), with the teaching of a “light” version of EMDR such as the modified protocol for paraprofessionals, developed by Jarero, Amaya, Givaudán, and Miranda (2013).

Tanzania. The first EMDR training (Level 1 and 2) in 2012 was initiated through accidental contact between a Swedish EMDR consultant and a teacher and founder of the first psychology graduate studies (Master of Arts) in Tanzania, at Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. Twenty-seven participants attended Level 1, and the great majority of these participants were fresh graduates and students from the two graduating classes. About a third were counselors and two oncologists. In general, the attitude toward psychotherapy was very pragmatic, as shown by statements such as, “Here, we only have 6 hours, exposure takes more time, maybe with EMDR I can get the job done.” This attitude permeated the practice of the psychologists, going into heavy cases with courage and seemingly good results.
Skype supervision has been done, and then a supervision day was held before Level 2.

Psychology is not a very prestigious study or practice in Tanzania, and there is no Psychology Department anywhere; psychiatry has a somewhat better standing, and at MUHAS, there is a Department of Psychiatry and Mental Health. Psychiatrists from that department sat in on some of the psychologists’ sessions, they were amazed, and then said, “we want it too!” Thus, a second training was organized by this department in 2014, mostly for psychiatrists and medical doctors doing their specialization in psychiatry. These 20 participants appeared to be less knowledgeable in the world of psychotherapy schools and brand but quite experienced in terms of psychiatric practice and phenomenology. There are possible plans to do another training at Sebastian Kolowa Memorial University, a university for mental health practitioners in northern Tanzania, in 2015.

Zambia. In Zambia, the first training program was initiated by HAP United States. The first traumatology and stabilization courses were conducted in February 2011 for 30 participants. A Level 1 training for 10 participants was held in February 2012 and then a Level 2 in February 2014. At this Level 2 training, disappointingly, many of those who did the Level 1 training in 2011 had not practiced because they did not have the consultation hours to qualify to do Level 2. So, at the moment, there are only a few practitioners in Zambia using EMDR, and they are all in private practice. However, they are all keen and are regularly using the practice on a day-to-day basis.

The same problem has arisen, as in other countries, in finding qualified therapists to train, who are working in community agencies. There is therefore a strong interest in developing suitable trainings for people such as nontherapists.

Future Plans and Challenges

Cultural Challenges Concerning the Use and Acceptance of EMDR Therapy in Africa

Cultural challenges present real tests to EMDR therapy in Africa. Some important examples are as follows.

Shame. Psychological suffering is either accepted as a fatality or a shame to talk about.

Religion and Voodoo. EMDR practitioners should be aware of certain African cultural ideas, such as the fear of being bewitched by eye movements. One EMDR trainee told her trainer during a stabilization exercise using eye movements that she did not want to do this because, “my God forbids me to do this.”

Language Issues. Many regional languages necessitate an interpreter for translation so that the practitioner and the client can understand one another.

Irregular Treatment. EMDR practitioners report that many clients are not used to ongoing regular counseling; the client attends only once or twice for treatment, which may not be enough.

Therapists and Trauma. Practitioners in Africa have their own trauma histories. Being exposed to many stories similar to their own, without working on their own material may lead to vicarious traumatization (Dellucci & Vojtova, 2014). A participant of a trauma workshop, and dean of a university in Rwanda, came up to the presenter of the EMDR presentation she attended and asked for immediate EMDR therapy, after reporting that she still suffered from traumatizing images following the Rwanda genocide 20 years ago.

Problems in Teaching EMDR Therapy in Africa

There are difficulties in the teaching of EMDR therapy in Africa as illustrated by the following examples.

Single Trauma Versus Complex Trauma. Many traumatized clients in need of treatment have long reaching histories of complex trauma because of early childhood neglect, lack of basic resources, and violence within and outside the home. Single trauma incidences, as recommended to beginners in practicing EMDR, are only very rarely seen in clinical practice, of the training of EMDR therapy.

Structure of the EMDR Therapy Eight-Phase Protocol. Emotion and cognitions, which are an important part of the eight-phase protocol of EMDR therapy, are culturally dependent. Concepts such as cognitions are very hard to comprehend, the ability to name emotions may be limited, and numbers are often unknown. This necessitates adjustments to the EMDR standard protocol, little of which has been researched in terms of these populations and outcomes.

Continuing Education. Additional challenges include the fact that in many countries, there are no continuing education programs other than those which are brought in by people from other countries. There are also very few books on clinical skills available for sale or for borrowing. Even the universities have limited numbers of psychology books in their libraries. Because of the cost of shipping books, more
emphasis is being placed on electronic books throughout Africa.

Consultation. Another huge challenge is that although consultants are willing to do consultation with their students via Skype, in many countries, the Internet is extremely slow and unreliable. Video connections are often impossible, and with unreliable audio connections, there may need to call back 5–10 times in a single consultation. Furthermore, the Internet is often down altogether for several days at a time and no communication at all is possible. Most therapists do not have access to computers after they leave work.

Training Background. Other challenges in training include the wide variety of training backgrounds, with a mix of experienced, highly trained counselors and many with very basic skills, necessitating emphasis on basic counseling skills as well as basic knowledge of psychotraumatology.

Issues in Establishing EMDR Therapy in African Countries

Territorial Struggles. Different groups and individuals offering EMDR trainings can lead to territorial struggles and splitting of counselors locally into different camps, leading to confusion and a waste of resources.

Historical Issues. Hostility against “Western” trainers can be caused by the heavy colonial history.

Networking. Anybody wanting to train in a region should seek support of counselors already working in the country/region and to national bodies of mental health providers, if they exist. Contact with government bodies involved in the provision of mental health needs, gender issues, children, reconciliation efforts, and so forth, is important to gain wide spread support.

EMDR “Light.” There will not be enough trained therapists to meet the need for posttrauma care in the continent for the foreseeable future. This raises the question whether parts of the EMDR therapy can be transformed to an EMDR treatment approach that can be successfully taught and safely, ethically, and effectively used by paraprofessionals (e.g., Jarero et al., 2013).

Mass Intervention. Actually, in an area where there are vast traumatized populations, group treatment may be the only way to give more people access to treatment (Jarero & Artigas, 2009). Again, development of those approaches and research for group trauma interventions in African populations is needed.

Special Considerations When Planning EMDR Therapy Trainings in Africa

Selection of Candidates. The following are different options when reflecting on the approach of how to select appropriate EMDR therapy trainees.

• One is a top-down approach, going for the university-educated psychologists and psychiatrists. The obvious advantages of this are how these people may influence the future of mental health care in the country. The flip side, especially regarding the psychologists, is that they, being the leaders, often end up in administrative positions. On the other hand, these administrators will influence future policy, and some of the others may become influential psychotherapy teachers.

• The other is the bottom-up approach, training the future consultants working in the field with patients. The problem with this option is that this is much more time-consuming and slower to get EMDR implemented.

A two-option strategy is surely the best solution.

Additional Aspects. Considering all of the mentioned points, it is suggested that a didactic therapy on oneself and more training on psychology and psychotraumatology topics should be added to any basic standard EMDR training in Africa.

The Future of EMDR Trainings in Africa

It has already been said that the need for EMDR training in Africa is great. As described earlier, many humanitarian crises and traumatic events occur frequently on cultural, sociological, political, natural, and individual levels, and an efficient and quick trauma treatment is quite lacking. EMDR therapy has a rapid impact on the psychological health of the suffering person and is capable of treating (a) a large number of people at the same time (group protocols) and (b) quickly after an event (recent traumatic event protocols; see also Luber, 2014). There should be more reflection on the possibilities of promoting EMDR therapy through large training programs to large numbers of psychologists and psychiatrists. Group treatment protocol should be promoted and taught. However, to meet more of the needs of the suffering population and to be able to contribute to a real healing of Africans, a development of EMDR therapy—maybe a so-called EMDR light—for paraprofessionals is urgent, especially for this continent.

One of the most urgent goals is the training of African professionals as consultants, facilitators, and trainers; this will enable Africans to provide their own
healing. Local trainers have a better understanding of the culture of the communities in which they are training. Local practitioners have the benefit of also remaining in the communities they work in, supporting and training other practitioners and eventually expanding their pool of skills in the local community to a point where they may someday provide all of their own training needs. This is among the better models used in development work, and it is recommended to be used in Africa too. Training can only be effective if people in that community are empowered to take ownership of the process.

Specific African Context for EMDR Trainings: Cameroon

In many African countries, there are very few psychotherapists or psychologists who have been trained in the Western tradition of mental health. The focus in Africa is more about philosophy and social psychology than the study of psychotraumatology, complex PTSD, dissociation, body-oriented therapy, hypnosis, or self-aimed work. Therefore, to provide EMDR trainings in Africa will be difficult when not adapting to the cultural sensibilities and needs. The project EMDR et Psychothérapies Intégrées dans les Traditions d’Afrique Centrale (in Cameroon) was created by practitioners of EMDR France Association. The project has five goals, which could be expanded to other African (and developing) countries:

1. Course of study: to create an EMDR course adapted to the culture and to EMDR standards
2. Research: to introduce the rules of a local autonomous training; to develop the use of research concerning EMDR therapy in African universities
3. Logistics: to help find the places of greatest need in the country and provide EMDR-trained therapists
4. Networking: to create an EMDR practitioner network in Africa
5. Trauma center: to implement a trauma center in every country to accommodate the needs of the population; to develop a “trauma center” network between the countries

Needs and Challenges, Visions, and Dreams

There seems to be no doubt about the need for efficient treatment for people suffering from PTSD and trauma-related symptoms. The steps described earlier are designed to promote trauma healing quickly and to a large spectrum, according to or including the local traditions. For this vision to become reality, ideally there would be a network all over the continent of Africa, conducted by African trainers and practitioners, and to become the reference for trauma healing in Africa.

“We cannot walk alone” (King, 1963). So, we have the dream that joint efforts of humanitarian and pro bono workers lead to a Pan-African network of trauma healing centers, providing the necessary help in humanitarian crises within its own borders and within other countries needing support to ease human suffering.

We have the dream, that in the near future, trauma sufferers have access to psychotherapeutic help if ever they consider it necessary.

We have the dream, that in the near future, having PTSD and other trauma-related disorders is no longer stigmatized and that reaching for psychotherapy is viewed as a self-evident competence.

We have the dream, that EMDR practitioners and well-disposed people all over the world are helping these dreams to come true.

References


**Acknowledgments.** The author would like to thank the following for their involvement and contributions to this article: Michel Allon (Israel), Pascale Amara (France), Dorothy Ashman (United States), Bjørn Assen (Norway), Alice Blanchard (Kenya), Michelle Depre (France), Sue Gibbons (United Kingdom), Gisela Roth (Kenya), Reyhana Seedat (South Africa), and Wolfgang Wöller (Germany). Appreciation is also expressed to Marilyn Luber (United States) and Thomas Renz (Switzerland) for their support.

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Palestine, Libya, Syria, and Iraq are areas of humanitarian need, including psychological as well as material help. Among the features of humanitarian work are the need for sensitivity to the culture and language in which survivors and therapists are living; the need for an effective and timely treatment approach; and the need to help people rebuild their lives in a sustainable, hopeful, and resilient way. Eye movement desensitization and reprocessing (EMDR), an integrative psychotherapy approach to the treatment of trauma, has provided a therapeutic approach that can meet those needs. It is culture sensitive, timely, and effective and has enabled people in humanitarian crises to rebuild their lives following natural disasters, ongoing conflict, and torture.

EMDR was devised by Shapiro (2001) and builds on her adaptive information processing model. It is an integrative psychotherapy with protocols that include the use of bilateral stimulation and focus on past trauma, present situations, and future possibilities in enabling the client to reprocess disturbing memories to an adaptive resolution. It is recognized as an effective treatment for posttraumatic stress disorder (PTSD) in national and international guidelines including the World Health Organization (2013), the United States’ Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices (2010), and the International Society for Traumatic Stress Studies (Foa, Keane, Friedman, & Cohen, 2009).

**EMDR Humanitarian Initiatives and Outreach**

This article focuses on an ongoing EMDR humanitarian project that began with the training of Palestinian therapists working in areas of ongoing conflict and developed into EMDR training in Arabic of therapists working in humanitarian projects in the Middle East and North Africa.

In 2005, the EMDR Humanitarian Assistance Program (HAP), in partnership with the East Jerusalem Young Men’s Christian Association (EJ YMCA), which provides humanitarian assistance throughout the West Bank, supported the training of 17 Palestinian therapists in EMDR. The purpose of the training was to work with existing nongovernmental and governmental HAPs to provide EMDR therapy in areas of need, including Palestinian refugee camps, and to train experienced EMDR practitioners as EMDR facilitators, consultants, and trainers. The humanitarian program had two strands. The first was in training therapists and trainers. The second was in providing direct pro bono clinical services to survivors of humanitarian crises and supporting those services with supervision and consultation.
EMDR was successful in this setting, and people saw positive changes in individuals and their communities. Other agencies, including those outside Palestine, asked for EMDR help, and it became clear that the most effective way to meet the increasing demand was to provide more training that would enable others to provide more direct humanitarian help to more people. To date, as a result of the initial HAP/YMCA project, 294 therapists have completed training and are working in humanitarian programs with refugees and others in situations of ongoing conflict, including Syria, Iraq, Libya, Lebanon, Egypt, and Palestine. Projects have been part funded by the EMDR Trauma Recovery HAP and EJ YMCA and by other agencies including EMDR HAP UK and Ireland.

The situation in the Middle East and in North Africa has seen a rise in the need for EMDR humanitarian work in the Arabic-speaking regions and, as one experienced trainee said at a recent training, EMDR is effective and quicker than traditional approaches. We have tried, where possible, to respond to requests for training and have completed 12 two-part trainings and consultation between 2005 and 2014. Trainees have included counselors, psychotherapists and psychoanalysts, clinical psychologists, and psychiatrists working in humanitarian settings.

The overall program does not have a formal structure. There is a core team of an EMDR trainer and consultants whose first language is Arabic and who provide trainings in Arabic and one-to-one support face-to-face or through e-mails and telecommunications. This support is vital to the success of the overall project, especially when developing EMDR in often remote and always troubled settings. Training in such settings is difficult. It has not been possible to provide training in Syria or Iraq, but this has been provided for therapists from those countries in Turkey and Jordan. Training in Libya has been under tight security and training in Gaza has not been possible. In the West Bank, the work is frequently disrupted or delayed because of roadblocks and checkpoints.

**Results of HAP Initiatives, Lessons Learned, and Ongoing Programs**

Some of the results of the humanitarian initiatives are an increased confidence that the therapists have in their work and effectiveness and increased motivation in their clients. Three of their clients' stories, each diagnosed with PTSD, are briefly presented here: from a refugee camp in Palestine, from a Syrian refugee camp in Jordan, and from a war zone in Libya. These illustrate the difference in outcome between EMDR and previous counseling, the importance of addressing earlier traumatic events in a person's life that feed into the present trauma, and the building of resilience and hope in situations of ongoing trauma. All were treated as part of humanitarian outreach programs.

**Clinical Vignettes**

*Raheem, a Young Man From Palestine.* Raheem is from Palestine. We worked with him in two phases: before the therapist had been trained in EMDR and 9 years later when the same therapist was an experienced EMDR practitioner.

When he was 11 years old, Raheem was injured in his face from a shooting by soldiers. It had a very bad impact on his life; his face was disfigured and he felt rejected, isolated, and unacceptable. He was not able to go back to school. In counseling, he worked on how to accept himself and was eventually able to return to school, but not to the place where he had been shot or near it. The second phase was when Raheem was 20 years old, following his release from prison where he had been held from the age of 16 years and had been tortured.

EMDR, working with the past, present, and future, includes identifying the "touchstone" event, an event in the person's life that strongly influences the person's sense of self (Shapiro, 2001) and often charges the impact of the more recent trauma with thoughts, feelings, and sensations from the past. For Raheem, the most disturbing thing in his life was not his recent experience of imprisonment but the shooting when he was 11 years old. Although at that time he had received counseling, it seems clear that this was only on the surface. EMDR enabled him to work on the earlier incident at greater depth, reprocessing the memory of the incident itself before working on the recent trauma. It was only after this that he could go back to the actual place where he had been injured when he was 11 years old, stand there, and feel all right. He could also now speak about the experience in a stable way, and he was able to reprocess his recent memories of detention and torture. Raheem's life has changed. He is happy: bright eyes, full of hope for the future, and plans to go to university. Although for so many years he had felt driven by what happened to him when he was 11 years old, now he is able to do things differently. He has hope.

*Karima, a Syrian Refugee in Jordan.* Karima is married with children. She was imprisoned, with her daughter, during the civil war in Syria. They were "tortured and made to watch others being tortured.” As a refugee in Jordan, Karima came to an EMDR
therapist who was trained as part of the humanitarian program. She did not feel any good in anything, worthless. Her anger used to erupt, like a volcano, in front of her daughter. She was very anxious that she would not be able to control this and distressed that she could not give her daughter the support she needed. There were also earlier incidents in her life. Her mother died when she was 5 years old, and she was abused by her stepmother, burning her with hot pans from the stove and hitting her violently. She felt, “I’m weak. I can do nothing. I am helpless.”

Although Karima had presented with her recent experience of imprisonment and torture, it was when she reprocessed the earlier abuse that she began to see positive changes and her belief about herself began to be “I’m strong. I’m strong enough,” and she was able to reprocess the recent memories of internment. As a result, she could see herself having strength and she was able to care for others. She could support her daughter and family, and people commented on the positive changes in her. At follow-up, Karima said, “As refugees, we are still facing very difficult circumstances and stresses, but I feel I’m strong and capable, able to confront anything I face and to go on with my life.”

Radwan, a Libyan Man in a War Zone. Radwan, a Libyan man, after the revolution was with his close friends in the war zone in the desert when there was an attack. “Bombing happened” all around him. The sand was “like the rain coming down because of the explosions,” and he could see that most of his friends, his closest friends, were killed. After what happened, he left his family and isolated himself from everybody because he was anxious about hitting others. He was in a constant state of arousal and experienced flashbacks and intrusive thoughts. He did not even want to go to his work because he would have had to pass through the desert, and wherever he could see the desert, it would bring the incident back to him.

After EMDR, the anger and intrusive images stopped, and he was able to go to work. He could walk through the area where the shelling and bombing had happened. He got engaged and is currently making plans for his house. Now, he wants to continue his study. He said, “I’m safe now; I’m still alive and I did not lose any part of my body. I now have lots of hopes for the future; I’ll go on to make them happen.”

Therapist Experiences

These experiences and others like them have enabled therapists to work effectively with survivors of political violence, imprisonment, and torture as well as other trauma. We asked three senior practitioners in Palestine, one in Libya, and a Syrian therapist working with Syrian refugees in Jordan about their experience of EMDR.

All the therapists said that EMDR had given them more confidence. It was more immediate, and it was possible to see subtle physical reactions during the course of therapy as well as often dramatic changes in their clients’ lives. Interestingly, although the protocol format was initially thought to be a difficulty, therapists commented that it made the work very clear, gave a sense of direction, and was easy to follow. EMDR was also deeper. “Before, we used to work on the symptoms of the problem, but now we are working on the problem itself, on its base. So the client knows from why and where the problem began. There is a mutual understanding between us. It seems that part of the process is educative. The client is educated about him or herself.”

Therapists also noted that survivors have often experienced things they do not want to talk about in detail and “with the EMDR, they can go to the incident, and they can see the details that they don’t want to speak about. It’s like a puzzle when they put them together, when they remember all the parts that they faced, then, only then they become more adapted, they become better. The client can remember the incident—and me as a therapist, I’m just helping her to pass through it.”

The Future

Now that there is EMDR training in Arabic in different countries, we are working toward an EMDR Arabic association whose purpose will be to maintain standards and support research. Two of the trainees intend to do PhDs on an EMDR topic, and there is current research in Palestine with ex-detainee children.

It is important to train experienced clinicians, and we have set criteria for accepting trainees. The next stage of the development is to train facilitators and trainers to provide training and supervision in the countries in which they are working and within their own structures. The trainees themselves often live in the same situation as their clients and face ongoing trauma. In training, it was difficult for them to find a simple incident to work on in practice and in the practical it takes more time, but the participants begin to feel for themselves what EMDR can do for them and for the people that they serve in humanitarian need.
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Acknowledgments. I express thanks to the therapists whose work is reported here, including Imad Alarda, Dr. Ghalia Alasha, Fatema Almaqrehy, Faten Alshobi, and Salam Hamarsheh, and the people who have helped me in writing this article.

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Humanitarian Projects and Growth of EMDR Therapy in Asia

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This article focuses on the accomplishments of humanitarian projects in Asia using eye movement desensitization and reprocessing (EMDR) therapy. The main thrust of EMDR humanitarian assistance programs has been to train local clinicians to provide EMDR to individuals suffering from the disaster. The article highlights the training projects and the experience of using EMDR therapy after earthquakes in China, India, Indonesia, and Pakistan; after Tsunamis in Japan, India, Indonesia, and Sri Lanka; and after accidents and terror attacks in Korea and Pakistan. Detailed descriptions are provided about the responses to the 2001 earthquake in Gujarat; the 2004 tsunami in India, Indonesia, and Sri Lanka; the 2005 earthquake in Pakistan; the 2008 earthquake in China; and the 2011 tsunami in Japan. In addition, the article discusses how Asian EMDR therapists are working together to provide training, respond to crises, and establish professional standards, so that EMDR therapy can be established in Asia and integrated into regular practice. Further, this article describes the creation of EMDR Asia, which brought several Asian countries together and share the development of EMDR therapy in their countries. The challenges faced by EMDR Asia today are discussed in detail.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; humanitarian assistance programs; Asia; tsunami; earthquake

Eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2001) is established as one of the most effective treatments for the psychological sequelae of traumatic life events. It is recommended for children, adolescents, and adults with posttraumatic stress disorder (PTSD) by the World Health Organization (2013). EMDR psychotherapy was developed to reduce symptoms resulting from disturbing and unresolved life experiences. Using a structured approach to address past, present, and future aspects of disturbing memories, it is an integrative therapy, synthesizing elements of many traditional psychological orientations, such as psychodynamic, cognitive, behavioral, experiential, physiological, and interpersonal therapies. Therapists providing EMDR require a clinical background because this is a highly specialized therapy, requiring supervised training for therapeutic effectiveness and client safety.

EMDR psychotherapy has been used successfully to resolve distress resulting from traumatic or stressful events, such as accident, rape, war, natural/man-made disaster, and childhood trauma. Widely used in United States, Europe, and many parts of Asia, EMDR psychotherapy has also been provided to address behavioral, adjustment, interpersonal, and emotional problems for children and adults.

Asian work supporting the use of EMDR in general psychiatric care includes its application for various populations: women undergoing traumatic divorce (Kannan & Mehrotra, 2010); athletes with severe anxiety (Kusumowardhani, 2014); patients with schizophrenia (Kim et al., 2010); students with test anxiety (Munshi & Mehrotra, 2014); patients with obsessive-compulsive disorder (Bhadlikar, 2014), acid burns (Tahir, 2010), nightmares (Woo, 2014), and grief (Liow, 2014). Research has also looked at the preparation phase of EMDR and safe place procedure (e.g., Direzkia & Syahriati, 2010). For example, Kusumowardhani (2010) determined that the safe place and light stream procedures used in EMDR’s preparation phase effectively increased stabilization.

EMDR and Humanitarian Interventions

Many studies (Shapiro, 2014) have evaluated the effectiveness of EMDR interventions when use to treat
the psychological consequences of humanitarian disasters. EMDR can be applied by a team of clinicians working in the disaster site and even under unstable conditions. It can be used as an early intervention, after some weeks and months, and even after some years, with an untreated population.

Several studies conducted in Asia have evaluated EMDR’s effectiveness in resolving symptoms related to humanitarian crises. In China after the Sichuan earthquake, the manifestation of PTSD symptoms was measured (Qian, 2010), and therapeutic effects were reported with significant reduction of PTSD scores after short EMDR therapeutic interventions (Zhang, 2010). In western India group, EMDR treatment using the butterfly hug was provided to children, with promising results, after an earthquake in 2001 (Mehrotra, Purandare, Tank, & Bhagwagar, 2013; Mehrotra, Raja, Samant, & Tank, 2001; Purandare, Tank, & Bhagwagar, 2010). In Aceh, Indonesia, a large study evaluating interventions for tsunami-affected people (Bumke & Sodemann, 2010) reported “dramatic improvement.” In Pakistan, Rana (2010) reported on the value of EMDR therapy in helping hundreds of soldiers and civilian survivors of the war against terrorism. More detail on some of these interventions is provided in following sections of this article.

The Development of EMDR in Asia

Initial disaster relief work often concentrates on physical rehabilitation. These needs are so extensive that psychosocial needs can be overlooked and/or dismissed as less urgent and less important. This was the situation in India after the 2001 earthquake when psychologists wanted to extend EMDR psychotherapy to traumatized population and were told by the authorities that there were no reported cases of PTSD. The explanation provided was that the people of Kutch (the province where the earthquake took place) were used to natural disasters and had developed coping skills to deal with them (Mehrotra, 2008). Similarly in China, it has taken a span of three decades for mental health professionals to gradually sensitize and convince the authorities of the imperative of including psychological interventions after disasters (Lv, 2010).

The history of EMDR therapy in Asia began with the natural disasters, starting with the devastating floods in Bangladesh during 1998 and the earthquakes in India in 2001. This was followed by the tsunami in 2004–2005, which struck India, Thailand, Sri Lanka, and Indonesia; the earthquake in Pakistan in 2006; and the earthquake in Sichuan in 2011. The tsunami in Japan in 2011 and constant terror attacks in Palestine are among the other humanitarian crises in which EMDR treatment was provided to survivors.

The main thrust of EMDR Humanitarian Assistance Programs (HAP) has been to train local clinicians to provide EMDR to individuals suffering from the disaster. HAP teams from the United States have trained clinicians in Bangladesh, India, Indonesia, China, Thailand, and Sri Lanka (Errebo, 2010). Other organizations which provided important contributions include Trauma-Aid Germany, HAP Europe, EMDR Institute, EMDR Germany, EMDR Netherlands, and EMDR Switzerland. Currently, EMDR therapists in Asia are working together with these agencies to provide training, respond to crises, and establish professional standards, so that EMDR therapy can be established in Asia and integrated into regular practice.

EMDR Humanitarian Projects in Bangladesh

In response to the 1998 floods in Bangladesh, EMDR HAP, with support from the United Nations Children’s Fund, sent a team from the United States in 1999 to train therapists and coordinate treatment for the flood-affected people in Bangladesh. Following this intervention, HAP sent several training teams to India and many mental health workers and professionals received EMDR training.

In February 2014, HAP Switzerland began a 3–5-year psychotraumatology training program in Bangladesh. This program is locally supported by members of the faculty of Educational Psychology and Counselling at the University of Dhaka, the Dhaka Shishu (Children) Hospital, and the Bangladesh Institute of Child Health. These workshops will be conducted by HAP Switzerland and financed by private donators from Switzerland; Trauma-Aid Germany will assist with EMDR training. The trainees are specialists from a range of organizations which care for adult and child survivors of traumatic incidents, as well as from the National Institute of Mental Health. The purpose of this long-term project is to establish effective treatment capacities in Bangladesh and to enable the specialists to set up a local self-sustainable organization for trauma therapy and EMDR.

EMDR Humanitarian Projects in India

The 2001 Earthquake in India. On January 26, 2001, as the entire nation was celebrating Republic day, the western part of the state of Gujarat experienced one of the most intense earthquakes in Indian history. Within a span of a few seconds, entire villages and
towns were flattened. The government responded immediately in terms of relief and rescue. The entire world shared the grief of the people of Gujarat, and massive aid was given in terms of rescue, makeshift shelters, medical help, clothing, food, and so forth. However, mental health was not a priority then.

EMDR-trained mental health professionals were looking for an opportunity to assist in the recovery of the earthquake victims. Five months later, when most of the physical recovery works was completed, an opportunity arose to address the psychological trauma experienced by survivors. Forty EMDR-trained Indian psychotherapists followed up over a period of 6 months by rotation using group and individual protocols with intensive work. The teams further split up into groups of four or five therapists, ensuring that a psychiatrist was present in each group should the need for medication arise.

Group EMDR protocols were developed adapting the “butterfly hug” from the work of Jarero et al. (2008) who had applied the method in Mexican floods. The team was able to reach out to 16,000 children from about 30 schools, a few hundred teachers, parents, and families. Most schools had 30–40 children in each class and had four to five sections. Group interventions were offered to entire classes from Grades 3 to 7. The team provided group therapy, conducting two to three sessions for each group, with follow-ups at intervals of 1, 2, and 3 months. Reports from the schools indicated the following positive changes in their trauma-affected students: Attention span and level of concentration had shown improvement. Absenteeism had decreased. There was increased participation in school activities. The children’s overall academic performance had improved, and fear, crying, and signs of nervousness were reduced. Teachers who themselves were manifesting the fear of closed places were also able to cope better and could return to the classes to teach without feeling panic (Mehrotra et al., 2013).

After completion of the work, the team was specially invited by local authorities to help a tribe in the interior of India, more than 100 km from Bhuj. The members of this tribe were still sleeping in the open because of fear of a recurring earthquake; in the evening, children were tying stones around their arms and legs and tying them around their mothers so that they could not be separated while sleeping. Members of this tribe showed the same response to EMDR therapy as in the larger intervention.

The 2004 Tsunami in India. With support from the Cerner Corporation’s First Hand Foundation, HAP United States again became engaged in India following the tsunami in 2004 and conducted four Level 1 and three Level 2 trainings, plus follow-up consultation. Tsunami relief work continued in the crucial locations, covering all the coastal villages, from Nagaipattinam to Vedaranyam. Group protocols for children were provided by trainees using butterfly hug. To initiate EMDR therapy at selected intervention sites, teachers, grass root–level social workers, primary care physicians, and orphan care providers were provided orientation of psychosocial impact of trauma post-tsunami and how EMDR could be used as psychotherapy to allow the victims for leading a health life. This field-level psychoeducation paved the way for EMDR-trained volunteers to work in small groups, as well as at individual level, using EMDR for psychotherapy and helping children to develop other soft skills needed to cope. Some psychiatrist also provided medicine and regularly monitored the progress.

Children who exhibited more severe symptoms that did not resolve with the group work were provided with individual therapy. The children underwent online review through telepsychiatric consultation facility. The children responded well to these measures and common problems such as fear of the sea, sudden tear proneness, lack of concentration at school, inattentiveness, bed-wetting (for fear of going to the beach for the nightly urination), panic, anxiety, and bereavement issues (over loss of parents, house, siblings, friends) remitted well with the therapy. More than 3,000 children benefitted from this project.

EMDR Humanitarian Projects in China

In 2002, the Psychology Department of Beijing University invited Trauma-Aid Germany to offer a basic training on psychotraumatology and EMDR therapy at Beijing University. The purpose was to build capacity to provide psychosocial relief for traumatized individuals. The original program was followed by more EMDR trainings in Beijing and in other Chinese cities; a small team of consultants and facilitators developed. After that, several formal training programs for practitioners were conducted with the support of HAP Europe, Trauma-Aid, and HAP United States.

After the devastating earthquake in Sichuan province on May 12, 2008, many children lost their parents. Two weeks after the earthquake, more than 500 children who lost one or both parents were temporarily moved to Rizhao, Shandong province. Child psychiatrists and postgraduates from the Institute of Mental Health of Beijing University and Xinhua Hospital of Shanghai Jiao Tong University provided psychological intervention for several months. After the interview and standardized assessments, approximately
8% were diagnosed with PTSD or posttraumatic stress syndrome (Zhang, 2010). Twenty-six children completed at least three EMDR therapy sessions as individuals or in groups. The scores of PTSD symptoms were significantly decreased. In the follow-up assessment, some children could do the safe place exercise and butterfly hugs by themselves, and said the skills were very useful.

In 2008–2010, faculty from Xinhua University, Chengdu organized a formal EMDR training program with the support of HAP United States and Trauma-Aid. The EMDR practitioners in Sichuan played an important role in organizing a humanitarian response following several serious earthquakes in 2011 and 2013. They used the stabilization techniques mainly in group interventions. The stabilization techniques of EMDR were also successfully used by local EMDR practitioners in interventions after the Yunnan earthquake in 2013 and Kunming terrorist attacks in 2014.

EMDR Humanitarian Projects in Indonesia, Cambodia, and Thailand

After the great tsunami of 2004 that hit the north of Sumatra (mainly Aceh province) leaving 165,000 dead in Indonesia alone, faculty from Jakarta University along with members from Trauma-Aid Germany met to plan a response. In 2005, they succeeded in starting a project together with Himpsy Jaya (the Indonesian psychological society), Terre des Hommes, the German Ministry of Cooperation, and Trauma-Aid Germany (Mattheß & Sodermann, 2014). The project was primarily designed to help the Indonesian partner set up clinics for trauma victims in the provinces that were hardest hit from the tsunami. In several weeklong multilayered trainings, an international team trained 14 young psychologists from Aceh along with other Indonesian therapists. They learned psychotraumatology, stabilization techniques, and EMDR.

Between 2005 and 2009, 3,228 trauma victims in Aceh, more than 50% of whom were children and adolescents, were treated by the Indonesian therapists (Bumke & Sodermann, 2010). The average number of sessions was two to three, but the relief was significant. Reports showed that the rate of PTSD and depression in the patients dropped significantly, and the schoolchildren had significantly better concentration (and could follow a curriculum again in school). Besides providing psychotherapies, the Indonesian colleagues also trained a large number of health promoters such as teachers and nurses and provided public information sessions in the media.

Trauma-Aid Germany initiated the Mekong Project covering Cambodia, Indonesia, and Thailand and trained a number of clinicians in EMDR (Mattheß & Sodermann, 2014). These basic trainings were designed as a two-day training related to understanding trauma work and stabilization techniques. They were aimed at building capacity of local Cambodian psychologists, professional and lay counselors, social workers, and frontline workers to understand more about trauma work and to be able to use basic skills in trauma treatment. Because Cambodians are gearing up to strengthen the EMDR Cambodia Association, three members are being trained as consultants. Research undertaken with the Mekong Project will be published shortly, which will highlight the accomplishment of joint activity of Thailand, Indonesia, and Cambodian EMDR Associations.

EMDR Humanitarian Projects in Hong Kong

Over the past decade, Hong Kong EMDR (HKEMDR) has been responding to major disasters within the region. The HKEMDR team offered treatment to the 2004 tsunami victims upon their return to Hong Kong; the positive treatment effects were evident when the injured victims returned to Thailand the following year for vacation. During the 2008 Sichuan earthquake in China, an emergency team was lined up to provide EMDR at the scene, and efforts were made together with the Hong Kong Baptist University to gain access to the area. Because of administrative difficulties, the delegation as a whole could not reach the site, but one of the HKEMDR facilitators successfully managed to provide EMDR therapy to children using the butterfly hug. The pre- and post-pictures painted by the children indicated the usefulness of the therapy in a short time after the disaster. To prepare more manpower for responding to cases of disasters, HKEMDR has recently teamed up with the Hong Kong Hospital Authority to provide EMDR training to its clinical psychologists who will join an emergency first-aid team when needed. Currently, HKEMDR is working to establish a center for trauma treatment and well-being in the city of Shenzhen, China, under the auspice of the Hong Kong Baptist University, to provide EMDR training courses and treatments and conduct research regarding the application of EMDR in cross-cultural settings.

EMDR Humanitarian Projects in Sri Lanka

It was after the catastrophic tsunami of 2004, EMDR was introduced to Sri Lanka. Around 35,000 people were killed and many were injured, and others were
displaced because of this unimaginable disaster. A team of EMDR therapists from HAP United States arrived in Sri Lanka in March 2005 to train mental health workers in EMDR to help those affected by the tsunami (Errebo, Knipe, Forte, Karlin, & Altayli, 2008). The positive experience of counselors using EMDR to treat those affected by tsunami (e.g., Jayatunge, 2008) gave them the confidence to use it for clients with other areas, such as anxiety, fears, sadness, and so forth.

EMDR Humanitarian Projects in Pakistan

EMDR therapy came to Pakistan in the backdrop of the 2005 earthquake, when HAP United Kingdom and HAP Europe provided EMDR training to 25 health professionals (Farrell, 2014). Working in the relief camps established for earthquake survivors in Abbottabad and Masehra, the trainees initial suspicion and skepticism were soon relieved when they witnessed the relief of PTSD symptoms among scores of patients treated with EMDR. After this, subsequent EMDR trainings were conducted at the Armed Forces Institute of Mental Health at Rawalpindi, Islamabad, the capital of the country. Training workshops were also held in Karachi, the megapolis, and Lahore, the cultural and educational capital. The practitioners of EMDR in Pakistan include doctors, psychiatrists, psychiatric nurses, and social workers.

EMDR Humanitarian Projects in South Korea

In 2007, a fire rescue demonstration at an elementary school in Seoul tragically ended up with accidental fall from a fire engine ladder of 20-m height causing two deaths that were witnessed by more than 240 children on the playground and 100 through the classroom window. Four days later, eight EMDR therapists delivered a 30-minute single session of group therapy modified from EMDR group protocol (Jarero, Artigas, & Hartnung, 2006). The 464 children received the treatment. An examination of treatment results for those children (N = 213) reporting initial scores of subjective disturbance of more than 4 (where 0 = no distress, and 10 = worst possible) found a pretreatment mean score of 6.6 (SD = 1.9). The score decreased significantly after EMDR treatment (M = 3.7, SD = 3.1, t = 16.3, p < .001). Although this study (Chung et al., 2014) was descriptive in nature, and without control group or follow-up evaluation, the results suggest that even a brief single session of EMDR therapy may bring benefits to recently traumatized children.

EMDR Humanitarian Projects in Japan

In 2011, victims of Tohoku earthquake and tsunami disaster were helped by a Japanese team of EMDR therapists. The Japanese Journal of EMDR Practice and Research published a special issue including 14 articles about helping earthquake and tsunami survivors with EMDR. The Japanese team visited the devastated area and successfully treated 10 survivors, provided resource development and installation for five people, and applied the recent traumatic episode protocol (R-TEP) protocol for two. Then, Japan EMDR Association organized EMDR training and consultation group sessions in a marginal area of the devastated area.

The Development of EMDR Therapy in Asia

EMDR therapy was formally introduced in Asia when Francine Shapiro conducted training seminars in Australia in 1993 and 1994. However, to a large extent, the credit for the teaching, acceptance, and growth of EMDR in Asia goes to HAP United States, HAP Europe, HAP United Kingdom, and Trauma-Aid, which mobilized resources from 1999 to train therapists and assist in trauma relief work following disasters in several parts of Asia. Senior trainers from these organizations provided generous voluntary support to train, supervise, and mentor Asian mental health professionals.

Although most training, capacity building, and mentoring were initially done by members of the American and European EMDR humanitarian associations, gradual transfer of learning and teaching has been simultaneously taking place. Asian trainers and facilitators are being trained along with technical support of training material for the new trainers. The continuing seminars and supervision with an interchange of EMDR team members from Indonesia, Thailand, China, and later Cambodia and Myanmar has helped to build a network of support that naturally flowed into the creation of EMDR Asia. Asian therapists have also worked together to respond to humanitarian crises. For example, based on experience and lessons learned post-tsunami in Thailand, a team of psychologists was trained in Cambodia and worked for 4 months to respond to the devastation from Typhoon Ketsana in 2009 (Lopacka, Ean, & Phoeun, 2010). Some Asian trainers jointly conducted a Part 1 EMDR training in the Philippines in early 2014, after Super Typhoon Haiyan in November 2013, with the support of HAP United States, 80 mental health workers were trained and provided supervision.
As we look to the future, most EMDR psychotherapists from Asia have voiced their desire to further strengthen EMDR and resources within Asia. Growing popularity and widespread use of EMDR psychotherapy has led to coordinated efforts for consolidating and establishing formal bodies in many Asian countries to oversee training, establish standards of practice, and coordinate various projects.

**Formation of National Associations and EMDR Asia**

National EMDR associations in some Asian countries have been established (Australia, Cambodia, China, Hong Kong, Indonesia, India, Japan, New Zealand, Pakistan, Philippines, Singapore, and Taiwan). In some other countries, association are in the process of being registered to gain legal status (Sri Lanka, Thailand), whereas in others (Myanmar, Nepal, Iran), therapists are exploring how to start a national EMDR organization.

During the 2008 London conference, EMDR Europe invited some Asian EMDR practitioners to a special meeting to discuss EMDR Asia formation. This idea was reinforced by Trauma-Aid while providing trainers’ training in Hilden, Germany (June 2008). It is essential to mention the contribution of Trauma-Aid (Germany) for getting Asian mental health professionals together and providing financial and technical support for the formation of EMDR Asia.

With additional support from EMDR Europe, HAP Europe, HAP United States, EMDR International Association (EMDRIA), and Trauma-Aid, some of the Asian EMDR practitioners came together and organized the first EMDR Asia Conference in Bali (July 2010). Things were not easy. There were many controversies, differences of opinions, lack of funds, and lack of experience; at times, painful challenges threatened us. Support came from all over, and the Bali conference was indeed a big success. Dr. Francine Shapiro came to bless us and boosted our morale. The conference successfully met its goal of bringing together EMDR therapists from all Asian countries. The following years led to organizing the second EMDR Asia Conference in Manila, Philippines, in January 2014.

The formation of EMDR Asia was initiated during the First EMDR Asia Conference in Bali in July 2010. EMDR Asia is an informal organization, and there is no formal registration and no legal office called EMDR Asia. However, the member nations cooperate through an elected governing board and are committed to maintaining high standards of EMDR therapy training, practice, and humanitarian assistance throughout Asia. This has resulted in national associations registering as nonprofits in their own countries and/or establishing relationships with academic institutions to conduct both trainings and research. The countries/regions that have joined EMDR Asia are Australia, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Japan, Korea, Pakistan, Palestine, Philippines, Singapore, Sri Lanka, Thailand, and Taiwan.

**Future Plans and Challenges**

As EMDR associations are being formed, there is an interest in establishing EMDR psychotherapy standards of practice such as those of EMDR International Association, United States of America and EMDR Europe. The creation of standards of practice is a challenging process. The task ahead is to reinforce comparable EMDR standards of practice across associations by developing accreditation procedures, standardization, and training standards including contents and duration. Furthermore, it is necessary to set selection criteria and requirements for the trainees and trainers and develop the certification process and curriculum and linkages with associations. In addition, methods of supervision and consultation will follow, so that EMDR practitioners may gain support in their therapeutic work. Although this is preliminary, it is a huge challenge in Asia. At this time, the training standards and required criteria for the trainees lack uniformity across Asia. The clinical practices are also not on a par with Europe and the United States and again, they vary within Asia as per the level of development of the country and its traditions. Also, qualified mental health professionals in Asia cannot be measured on a standard scale. Language and education levels are quite different. Lack of uniformity in economical and education levels are further challenged by cultural, religious, and language diversity.

Humanitarian efforts are hampered by the fact that there are insufficient mental health professionals in many Asian countries. Often, those practitioners are concentrated in metropolises, as are private practitioners who are not available for community-based outreach for trauma-related work. There are success stories of professionals coming together for trauma relief after the floods, earthquakes, and tsunamis in Bangladesh, China, India, Indonesia, Japan, Pakistan, and Sri Lanka. Although some of these efforts were responses to the emergencies by individuals or group of practitioners, others were organized by national or regional initiatives.
Although there are some important exceptions, a common problem faced in Asia is the lack of institutional support to promote mental health and related interventions. For example, after natural disasters, leading national and international health organizations focus on physical and social rehabilitation. The supply of food, clothes, medicines, and the restructuring of the destroyed area is thought to complete the requirements of basic needs. Acknowledging the importance of emotional and psychological well-being takes a backseat, and the possibility that untreated acute stress can lead to PTSD and other mental health problems is not understood.

EMDR therapy in Asia is still linked with man-made and natural disasters. The task ahead is to create an understanding that EMDR can be integrated with regular therapeutic practices to help in the psychosocial and mental health arena. Trauma does not only emerge from natural and man-made disasters. Traumatic stress–related mental health issues may stem from HIV, cancer, serious cardiac and respiratory illness, violence from social and familial conflicts, terrorism, sexual and gender related trauma, loss of loved ones, accidents, loss of self-esteem, and emotional conflicts. Yet, institutional support is lacking in developing countries to address these conditions, which can have lasting aftereffects on the general well-being of people. Humanitarian agencies engaged in worldwide physical and mental health could make a huge difference if they were to promote the efficacy of EMDR therapy for effective psychological health.

Through EMDR Asia, member associations will be able to engage in more coordinated efforts for research, training, and humanitarian projects. Other ideas for future discussion and growth in Asia involve the training of paraprofessionals and introducing EMDR therapy in regular curriculums of university programs. The strong foundation built in the past will strengthen the future of EMDR therapy intervention. We envision more organized efforts and more intercountry collaboration, so that we can provide outreach to all populations in need.

References


Acknowledgments. The author acknowledges the contributions from Arne Hofmann, Astrid Katzur, Atara Sivan, Bunna Phoeun, Daeho Kim, Dani Sadatun, Hanna Egli, Helga Mattheß, Jinsong Zhang, Jenet Nethisinghe, Masaya Ichii, Mowadat Hussain Rana, Matthew Woo, Pamela Brown, Rosalie Thomas, and Shalini Natarajan.

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EMDR Therapy Humanitarian Trauma Recovery Interventions in Latin America and the Caribbean

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This article presents an overview of the eye movement desensitization and reprocessing (EMDR) Humanitarian Trauma Recovery Interventions in Latin America and the Caribbean and provides the reader with clinical stories from the front lines. During our many years working in the field, we have observed that psychological trauma is a challenging consequence of the multifaceted situations confronting individuals and communities after disasters. In this article, we describe the EMDR humanitarian interventions provided since 1998 in Latin America and the Caribbean to address survivors’ psychological distress after natural disasters (e.g., flooding, landslides, earthquakes), man-made disasters, human massacre, and severe interpersonal violence. Treatment has been provided to child, adolescent, and adult survivors, often in community settings, and to first responders and cancer patients. The EMDR early intervention protocols are brief effective interventions that can be used in the field or emergency situations; there is a body of research supporting the use of modified EMDR therapy protocols to treat acute trauma in both group and individual formats (Jarero, Artigas, & Luber, 2011).

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; EMDR-integrative group treatment protocol (EMDR-IGTP); humanitarian trauma recovery programs; human massacre; cancer patients; severe interpersonal violence

Latin America has suffered natural disasters such as floods, hurricanes, catastrophic earthquakes, and volcanic eruptions. Since the 1970s, it has also fallen victim to enormous levels of political violence, which peaked in the 1980s and took form as wars, insurgencies, counterinsurgencies, and other civil conflicts. The consequences of these were extreme violence, massacres, ubiquitous disappearances, rapes, torture, and burning of villages (Norris, Murphy, Baker, & Perilla, 2004).

According to Biles and Cobos (2004), one of the most hazard-prone regions in the world is Latin America because of its geography located atop four major active tectonic plates with regular seismic activity. From 2006 to 2010 one-fourth of all natural disasters—442 of 1,915—happened in Latin America. The affected number of inhabitants was 48 million, which is 5% of the 904 million people affected worldwide (Pan American Health Organization, 2012).

In a recent survey of 858 students (aged 18–25 years) at four public universities in Mexico, in one of the many towns affected by the war between cartels for the control of areas where synthetic drugs are produced, researchers found a reported prevalence of 78% for traumatic events considered as shocking to respondents’ physical and emotional integrity. The most prevalent event was the sudden death of a family member and/or close friend (Mojica, Márquez, Guadarrama, & Ramos, 2013).

EMDR Therapy

Eye movement desensitization and reprocessing (EMDR) therapy was developed by Dr. Francine Shapiro (2001) and is an integrative eight-phase treatment approach guided by the adaptive information processing (AIP) model for the treatment of trauma, adverse life experiences, or psychological stressors. The AIP
treatment effects that could be used in the field or indicate that EEI is a brief intervention with rapid (Maxfield, 2008). Results of preliminary studies in-EMDR early intervention (EEI) has been extensive The clinical experience and work in the field with EMDR Therapy and Early Intervention

plaints (Shapiro, 2001; Solomon & Shapiro, 2008).

A wide range of other experientially based clinical complaints (Shapiro, 2001; Solomon & Shapiro, 2008).

EMDR Therapy and Early Intervention

The clinical experience and work in the field with EMDR early intervention (EEI) has been extensive (Maxfield, 2008). Results of preliminary studies indicate that EEI is a brief intervention with rapid treatment effects that could be used in the field or emergency situations (e.g., Jarero et al., 2011).

Research Initiatives

Randomized, controlled research is needed to investigate and to evaluate the treatment of critical incidents, so that effective therapies can be developed and provided to alleviate the suffering of the world’s many victims of disasters (Luber, 2009). Psychological distress arising from traumatic experience is challenging to treat in Latin America and the Caribbean; there is a lack of professional resources to adequately respond to large traumatic events, and there are few therapists with specific training in treatment of posttraumatic stress.

Also, the great mobility of disaster survivors makes it very challenging to conduct treatment outcome research. However, we have made it a priority to investigate the effectiveness of EEI protocols whenever the circumstances were appropriate for research. It is our belief that research can inform and direct inter-ventions, allowing us to improve and strategize treatment in these difficult situations.

The EMDR-Integrative Group Treatment Protocol. The EMDR-integrative group treatment protocol for early intervention (EMDR-IGTP; Artigas, Jarero, Alcalá, & López Cano, 2014) was developed by members of the Mexican Association for Mental Health Support in Crisis (AMAMECRISIS). It combines the eight standard EMDR treatment phases (Shapiro, 2001) with a group therapy model and an art therapy format and uses the butterfly hug (Artigas & Jarero, 2014) as a form of a self-administered bilateral stimulation and is a highly efficient intervention in terms of time, resources, cost, and lasting results. This protocol has been used in its original format or with adaptations to suit the cultural circumstances in numerous places around the world (Gelbach & Davis, 2007; Maxfield, 2008) for thousands of survivors of natural or man-made disasters (Jarero & Artigas, 2009, 2012).

Research evidence for its efficacy is provided in nine pilot field studies, which were conducted in humanitarian projects with both children and/or adults, after natural mass disasters in Mexico, Nicaragua, El Salvador, Colombia, and Venezuela (Artigas, Jarero, Mauer, López Cano, & Alcalá, 2000; Jarero, Artigas, & Hartung, 2006; Jarero, Artigas, Mauer, López Cano, & Alcalá, 1999). Additional case reports and field studies from around the world have documented its effectiveness with children and adults after natural or man-made disasters, during ongoing war trauma, ongoing geopolitical crisis, war refugee children, work accidents that produce acute stress disorder, rape victims, and children victims of severe interpersonal violence (e.g., Fernandez, Gallinari, & Lorenzetti, 2005; Jarero & Artigas, 2010; Zaghrout-Hodali, Alissa, & Dodgson, 2008).

Other EMDR Therapy Early Intervention Protocols. The EMDR protocol for recent critical incidents (EMDR-PRECI) is a modified EMDR individual therapy protocol. It was developed in the field to treat critical incidents (e.g., earthquake, flooding, and landslides) that were related to stressful events that continued for an extended period of time and where there was not a posttrauma safety period for memory consolidation. There is preliminary evidence supporting the efficacy of EMDR-PRECI in reducing symptoms of posttraumatic stress in adults and maintaining those effects despite ongoing threat and danger in a disaster mental health continuum of post-incident care context and as an early intervention for traumatized forensic personnel (Jarero et al., 2011; Jarero & Uribe, 2011, 2012). The EMDR individual protocol for paraprofessional use in acute trauma situations (EMDR-PROPARA) is an adaptation for paraprofessional use of the EMDR-PRECI and has preliminary support for its effectiveness in reducing severity of posttraumatic symptoms and subjective global improvement (Jarero, Amaya, Givaudán, & Miranda, 2013).

EMDR Humanitarian Interventions in Latin America and the Caribbean

EMDR therapy humanitarian trauma recovery inter-ventions in Latin America began in 1998 to address the
extensive need for mental health services after Hurricane Pauline had ravaged the coasts of the states of Oaxaca and Guerrero in the year 1997. The EMDR humanitarian team consisted of 17 Mexican clinicians and three clinicians; one from Canada and two from the United States (all of them members of HAP-USA) who were invited to collaborate with the Mexican team. When they arrived on site, they were overwhelmed by the numbers of survivors requesting treatment. The EMDR-IGTP and the butterfly hug were born during this project because it was impossible to provide individual EMDR therapy protocol to so many people in the short time frame available. During the 3 weeks that the team was there, they treated 273 survivors.

Organizations Providing EMDR Humanitarian Aid in Latin America and the Caribbean

AMAMECRISIS. AMAMECRISIS was legally created as a nongovernmental organization (NGO) under the Mexican laws in 1998. The mandate of the NGO program is to conduct humanitarian trauma recovery interventions (HTRIs) for populations with low resources. All the staff works pro bono, and the organization major funding comes from the Mexican EMDR Institute and EMDR Iberoamerica trainers who donate 50% of their trainings’ earnings. Over the years, AMAMECRISIS has conducted HTRI across the Mexican Republic, Colombia, Haiti, Nicaragua, El Salvador, Venezuela, and Spain and offered assistance to EMDR colleagues from other countries around the world to help those who have lived through disasters. Five years ago, AMAMECRISIS was affiliated with the Latin American and Caribbean Foundation for Psychological Trauma Research (Francine Shapiro Research Award winner) to strengthen their humanitarian trauma recovery program and also conduct research in a more efficient way.

Other Latin American NGOs. The EMDR communities in Argentina and Brazil have organized NGOs for the provision of humanitarian EMDR work. EMDR-HAP Argentina (Adúriz, Knopfler, Bluthgen, 2009; Adúriz & Salas, 2014), Centro de Psicoterapias de Argentina (Psychotherapies Center from Argentina; Salas, 2014), and EMDR Iberoamerica Brazil-HAP (Monteiro, 2014) have conducted and published their humanitarian interventions after natural disasters in their countries.

Types of Trauma Recovery Interventions Provided by AMAMECRISIS

Treatment. AMAMECRISIS humanitarian trauma recovery team members always provide pro bono on-site treatment services according to the unfolding phases of recovery and assessment of needs the survivors are experiencing. The team arrives on-site when the circumstances allow it (e.g., security, food, accommodation). Sometimes this could be 15 days after the critical incident and sometimes 3 or 4 months after it. AMAMECRISIS has a comprehensive system of post-disaster interventions that follows a continuum of care—a stepped progression of health care provided in an increasingly intensified manner. This treatment intervention model is based in two major approaches: critical incident stress management model (International Critical Incident Stress Foundation) and EMDR therapy protocols. Seasoned clinicians and trainees under their supervision provided the services. It is mandatory for all the team members to follow the Green Cross Academy of Traumatology (2008) Standards of Self Care Guidelines because “the ‘survivors’ heart-breaking narratives, the sights, smells, sounds and feelings that assault the sensorium of the mental health responders can range from uncomfortable to overwhelming” (Jarero & Uribe, 2014, p. 533) and could severely affect their lives.

Local Therapist Training. After the provision of the EMDR humanitarian early interventions, EMDR trainers from the EMDR Institute and EMDR Iberoamerica conduct pro bono EMDR therapy trainings (basic and advanced) addressed for local mental health professionals so they can offer long-term EMDR therapy in their communities. The trainers also support the trainees to organize their own EMDR National Organization, which can be affiliated to EMDR Iberoamerica. Because of space limitations, we are not able to describe our training initiatives in this article.

Clinical Stories From Field Work With EMDR Therapy After Disasters

Clinical Story #1: In a Mexican Town After a Hurricane

During a group exercise, the clinician asked the participants to do the butterfly hug and deep breathing. Two siblings (18 and 16 years old) were not involved in the exercise, but they were very attentive from a short distance. After the exercise has finished, the 16-year-old boy approached the clinician to tell her their story and to ask how his 18-year-old brother could do the butterfly hug with no arms. He said that all his family members, father, mother, and four children (5, 7, 16, and 18 years of age) were impacted one night by the river water running with great fury, raving everything in its path. First, the water dragged...
away the parents and their home. The 18-year-old son made every effort to rescue his three brothers but could only manage to rescue the 16-year-old brother because the water snatched the other two from his arms. This effort left him with enormous physical damage to his arms. After 2 days, the two boys were rescued, and when they finally reached the hospital, the boy arms were already gangrenous and were amputated.

The clinician asked him to take her to his brother to tell them how to do the butterfly hug. The clinician asked the 16-year-old boy if he believed that his brother did an enormous act of love to rescue him. He responded immediately and intensely with a “yes.” Then she asked him to be placed behind his older brother who remained seated in a wheelchair, so that one of his cheeks was in contact with his brother’s cheek and he embraced his brother from behind, crossing his arms over his brother’s chest. Then she asked both to breathe deeply and the 16-year-old boy to do the butterfly hug on his sibling’s chest.

The three of them worked with EMDR therapy to reprocess the traumatic memories while doing the butterfly hug for bilateral stimulation. There are no words to express the transformation in the siblings’ faces from despair to deep love. This is one of the greatest love acts the clinician has ever seen.

Clinical Story #2: In a Mexican Town After a Hurricane

A 17-year-old girl lost her house, her parents, and two younger siblings because of the hurricane. During body scan, she reported, “I have a hollow in my chest because I can’t remember my parents’ and my brothers’ voices.” The clinician asked her to do the butterfly hug testing rhythms with different speed and intensity. After a while, the client find four different rhythms and each one of them symbolized the voice of her loved ones resonating in perfect harmony in her body from his heart. At the end of the EMDR therapy, the girl mentioned, “I’ll never be alone and now I am able to face my future in a different and positive way . . .”

Clinical Story #3: In a Central American Town Devastated by a Hurricane

A 39-year-old woman told the clinician that when the powerful water came into their house, her husband helped her and their two sons to reach the roof, but when he tried to reach the roof, the water moved the refrigerator toward him and he was trapped between the wall and the refrigerator. She did not allow that their 10- and 7-year-old children to look at their father; however, she witnessed, in total impotence, looking at her husband’s terrified eyes the whole time, how the water rose and drowned him. Three days later, they were rescued.

She was in terrible pain; in addition to her traumatic stress reactions, she had not been able to see her children since the rescue day (3 weeks previously) because they triggered the awful memory of her husband’s death. She had left them at a sister’s house. She and the clinician worked with EMDR therapy. Three days later, the woman returned early in the morning with the clinician and introduced him to her two children. Thanks to the memory reprocessing she could connect with her children again without any traumatic memory trigger. She asked for treatment for the children and they were incorporated into a children’s group that worked with the EMDR-IGTP. At the end of the day, the woman and her children said goodbye and thanked the clinician, and they walked away holding hands.

Clinical Story #4: In a Caribbean Town Devastated by a Hurricane

A 59-year-old man specifically requested a male therapist. In the interview, he said that the reason for his request was that he did not want to cry in front of women. He explained that the waters devastated his poor and small ranch, killing his wife and all his animals. His only material possessions were the clothes he was wearing at that moment. He said that at all this time he had not wept, to give their adult children and grandchildren an example of strength, but that at this moment, the traumatic memories and the grief were overwhelming and he could not be strong anymore and was thinking about suicide. The clinician worked with EMDR therapy, and at the end of the session, the man said with energy and life in his eyes: “I’ll build my house again with my own hands, and I’ll get a good eggs-making hen, and with that, I’ll rise again and I’ll be an example for my children and grandchildren.”

Clinical Story #5: In a South American Town After an Earthquake

A 10-year-old girl named Maria was taking a shower when the earthquake struck. The glass from the shower door shattered and cut her body in many areas, especially her chest. She received multiple surgeries and painful treatments and received insults, such as “you are a monster” from the boys and girls in her school. She presented complex trauma symptoms when arriving for the first time looking for mental health care. She presented complex trauma symptoms when arriving for the first time looking for mental health care.
Clinical Story #6: In a South American Town After a Hurricane

In a shelter, a 12-year-old boy described to the clinician the worst image: “I was holding my 10-year-old sister’s hands but the water took her from me and I saw how she was fighting against the water before she disappeared.” The boy reprocessed that terrible memory with EMDR therapy, but no therapy could alleviate his sorrow and grief for his sister’s death.

Two days later, the clinician was in the local hospital using EMDR therapy to treat boys and girls who had survived the hurricane. During the EMDR therapy session, a 10-year-old girl told her that the water had torn her away from her 12-year-old brother’s hands. She found a tree branch and floated down the mountain river for 2 days and 1 night, finishing her trip in the ocean where she was rescued. In treatment, the girl processed her worst memory of almost drowning, her face sinking into the water every time she fell asleep. The therapist could not believe that the similarity of stories was a coincidence, so she asked the girl for her sibling and parents’ last names without telling her why. As soon as she finished, she went to the shelter, looked for the boy, and asked him his parents’ complete name. It was the same. She asked the boy to take her to his parents, and when they were all together, she said, “Your girl is alive and safe.” There are no words in any language to describe the emotions during that moment and in the hospital’s family reunion.

Clinical Story #7: In a Caribbean City After a Devastating Earthquake

A 39-year-old man with acute stress symptoms sought treatment with an EMDR clinician who arrived 12 days after the earthquake. He was hypervigilant and felt panic with each new aftershock. He experienced intrusive images, odors, and sounds from the initial earthquake and the rescue efforts in which he had participated over the subsequent days. He had repetitive nightmares about the earthquake, in which he and his family all died, although in reality all his family had miraculously survived. He and his family were living on the street in front of their destroyed house, and he was afraid they might be robbed or killed. “I’m losing my mind . . . I’m getting crazy . . . I can’t support this hell anymore,” he said to the clinician with panic in his eyes. The clinician used EMDR therapy for reprocessing. Only one session was provided by the clinician. In a subsequent trip 2 months later, the man asked for an appointment with the EMDR clinician. The interview lasted for 2 minutes because the man only wanted to say that for 5 days, after the initial session, he used the butterfly hug every time the intrusive symptoms arose; after this, the symptoms had disappeared. “It was a miracle . . . I’m not scared any more of the aftershocks and I was able to get a job . . . I want to let you know that every day I thank Jesus for bringing you here, and I asked Him to protect you and give you a long life to alleviate human suffering.”

Humanitarian EMDR Therapy Interventions

After a Man-Made Disaster

When a human-provoked mine collapse killed 65 mine workers in the Mexican State of Coahuila in 2006, the AMAMECRISIS team travelled to the location to treat traumatized and bereaved children. Sixteen children participated in EMDR-IGTP. Results showed a significant decrease in their scores on the Child’s Reaction to Traumatic Events Scale that was maintained at a 3-month follow-up (Jarero, Artigas, & Montero, 2008; see Figure 1).

After a 7.2-Magnitude Earthquake

This intervention was conducted subsequent to a 7.2-magnitude earthquake in North Baja California, Mexico. Treatment was provided according to continuum of care principles. One session of EMDR-PRECI (Jarero et al., 2011; Jarero & Uribe, 2011, 2012) produced significant improvement on symptoms of post-traumatic stress for both, the immediate treatment and waitlist/delayed treatment groups, which results were maintained at a 12-week follow-up, although frightening aftershocks continued to occur frequently.

After a Human Massacre

After a human massacre in the Mexican state of Durango, forensic personnel had the horrific task of recovering 258 mutilated bodies from clandestine graves; during this months-long process, they were continually exposed to horrific emotional stressors, including ongoing threats to their own safety. A single individual EMDR session was provided to 32 workers. Results showed significant improvement for both immediate treatment and waitlist/delayed treatment.
Interventions in Latin America and the Caribbean

reprocessing sessions (e.g., sports, soft gymnastics, hatha yoga, storytelling, painting, dance, theatre, and mindfulness) did not show a statistically significant reduction in PTSD symptom severity measured with the SPRINT scale (Jarero et al., 2014b).

For Patients With Cancer

In 2013, the first author (IJ) received the prostatic cancer diagnosis and developed symptoms of cancer-related posttraumatic stress that were successfully treated with EMDR therapy. Motivated by his personal experience and as a AMAMECRISIS co-founder, in 2014, he offered to the Pink Cross Mexican Organization to conduct a pilot research study and provide group EMDR treatment in Monterrey, Mexico, to 24 adult female patients with cancer of different types (e.g., cervical, breast, colon, bladder, skin, and breast). The women, aged from 36 to 68 years ($M = 54.2$), all reported symptoms of cancer-related posttraumatic stress and were in different stages of cancer treatment, with cancer first diagnosed between July 2006 and October 2013. The EMDR clinicians provided six sessions of the EMDR-IGTP adapted for ongoing traumatic stress on 3 consecutive days (one groups (Jarero & Uribe, 2011, 2012), on the Impact of Event Scale (IES) and Short Posttraumatic Stress Disorder Rating Interview (SPRINT; Connor & Davidson, 2001; Vaishnavi, Payne, Connor, Davidson, 2006).

For Victims of Severe Interpersonal Violence

During 2011, 2012, and 2013, AMAMECRISIS worked with Innocence in Danger-Colombia to provide 3-weeklong trauma recovery camps in Colombia for 89 boys and girls, aged between 9 and 17 years who were victims of severe interpersonal trauma (e.g., rape, sexual abuse, physical and emotional violence, neglect, and abandonment). These camps provided a multicomponent phase-based trauma treatment approach, which included EMDR standard individual therapy and a modified version of EMDR-IGTP adapted for severe interpersonal trauma. The results obtained with the SPRINT for all groups showed a significant statistical improvement after treatment, with continuing improvement at follow-up (Jarero, Roque-López, & Gomez, 2013; Jarero, Roque-López, Gómez, & Givaudán, 2014a, 2014b). The reduction in PTSD symptoms was attributed primarily to EMDR as activities conducted prior to EMDR therapy reprocessing sessions (e.g., sports, soft gymnastics, hatha yoga, storytelling, painting, dance, theatre, and mindfulness) did not show a statistically significant reduction in PTSD symptom severity measured with the SPRINT scale (Jarero et al., 2014b).

![Example of a child’s drawings before and during EMDR-IGTP treatment. The numbers represent the child’s self-reported subjective units of distress scale (SUDS) scores.](image)

**FIGURE 1.** Example of a child’s drawings before and during EMDR-IGTP treatment. The numbers represent the child’s self-reported subjective units of distress scale (SUDS) scores. Drawing A = The figures trapped inside the mine (his father one of them) are saying, “Ha,” “Help,” “Help us” (SUDS = 5). Drawing B = “Me” and “Picture of my Dad” (SUDS = 10). Drawing C = “My mother,” “me,” “Bertha,” “Martha” (his sisters; SUDS = 0). Drawing D = “My Dad” (SUDS = 0). Adapted from Jarero, I., Artigas, L., & Montero, M. (2008). The EMDR integrative group treatment protocol: Application with child victims of a mass disaster. *Journal of EMDR Practice and Research, 2*, 97–105. Reprinted with permission.
in the morning and one in the afternoon). Results showed a statistical significant reduction on the participant’s SPRINT scores between pretreatment and first follow-up and pretreatment and second follow-up at 3 months (Jarero et al., in press). At this time, AMAMECRISIS and the Latin American and Caribbean Foundation for Psychological Trauma Research are designing randomized control trial research projects for this population and their families.

For First Responders

In 2012, AMAMECRISIS provided treatment to 39 traumatized first responders on active duty who were randomly assigned to receive two 90-minute sessions of either the EMDR individual EMDR-PROPARA (Jarero et al., 2013) or of supportive counseling. Participants in the EMDR-PROPARA group showed benefits immediately after treatment, with their scores on the SPRINT showing further decreases at a 3-month follow-up. In comparison, supportive counseling participants experienced a nonsignificant decrease after treatment and an increase in the SPRINT scores at the second follow-up.

Discussion

An often overlooked cost of disasters is the psychological wounds that are not always visible, attended, or acute. For more than 10 years, experts have concluded that the psychological casualties of a disaster will outweigh the physical by an estimated 4:1 ratio (Evelry, Barnett, Sperry, & Links, 2010). The EEI protocols are brief intervention with rapid treatment effects that can be used in the field or emergency situations and which may reduce the number of psychological casualties.

Past, Present, and Future

Sixteen years ago, when we saw on TV the destruction and suffering Hurricane Paulina had caused to our Mexican brothers and sisters, we felt the overwhelming need to be with them and offer our help. We never imagined that leaving the comfort of our offices in Mexico City to go work with children under a mango tree at high temperatures would give us the most enjoyable experience of our professional lives. On our way home, we made the decision to dedicate our lives to alleviate the human suffering caused by psychological trauma. In that way, we have continued, either by working directly on-site or by helping colleagues from other countries around the world, to help those who have lived through disasters. We invite all our EMDR therapy colleagues around the world not to wait until a massive disaster to leave your offices. On this day, in your own city, exists what we call “urban disasters” (e.g., patients with cancer, immigrants, severe interpersonal violence). You can use the EMDR protocols that were born as a result of our on-site field work and that have been validated as effective (e.g., EMDR-IGTP, EMDR-PRECI), you only need to go where the survivors are suffering—they are waiting for you. We want to share with all of you the inspiring words that Dr. Francine Shapiro wrote to the AMAMECRISIS team the day we received the Francine Shapiro Award in the city of Brasilia in the year 2007:

... And if others will follow in their footsteps, and conduct the randomized research needed to solidify the work in the eyes of the world, to have it declared “empirically validated” by the large international organizations such as UNICEF, then thousands and thousands more will be healed in the coming years.

References


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EMDR et TCC chez des patients atteints de cancer : étude comparative de leurs effets sur l’ESPT, l’anxiété et la dépression

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Cette étude-pilote teste l’efficacité comparée de la thérapie EMDR (désensibilisation et retraitement par les mouvements oculaires) et de la thérapie cognitive comportementale (TCC) dans le traitement de l’état de stress post-traumatique (ESPT) chez des patients atteints de cancer, dans la phase de suivi de la maladie. Le second objectif de cette étude était d’évaluer si l’EMDR avait un impact différent sur l’ESPT pendant la phase active du traitement ou au cours des étapes de suivi de la maladie. On a assigné aléatoirement vingt-et-un patients en soins de suivi à des groupes d’EMDR ou de TCC, et dix patients en phase active de traitement ont été assignés à un groupe EMDR. Pour évaluer l’ESPT en pré-traitement et à un mois après traitement, on a utilisé l’Impact of Event Scale-Revised (IES-R) et la Clinician-Administered PTSD Scale (CAPS). L’anxiété, la dépression et les symptômes psycho-physiologiques ont également été évalués. Pour les patients en phase de suivi, l’absence d’ESPT après traitement était associée à une probabilité significativement plus grande d’avoir reçu de l’EMDR que de la TCC. L’EMDR était significativement plus efficace que la TCC pour faire décroître les notes à la sous-échelle des symptômes intrusifs de l’IES-R et de la CAPS, mais l’anxiété et la dépression étaient améliorées de façon semblable dans les deux groupes de thérapie. En outre, l’EMDR se montrait aussi efficace dans le traitement actif du cancer que dans la phase de suivi de la maladie.

Mots-clés : ESPT ; cancer ; TCC ; EMDR ; psychothérapie
Les études sur le stress ou les symptômes traumatiques des patients atteints de cancer ne sont pas nouvelles (Andersen, Kiecolt-Glaser, & Glaser, 1994 ; Butler, Koopman, Classen, & Spiegel, 1999 ; Mehnert & Koch, 2007). Cependant, depuis quelques années, les recherches se concentrent sur les types de stress propres à ces patients, et de nombreuses études ont avancé que cette population, face au diagnostic du cancer et aux difficultés de vivre avec la maladie, éprouve des stress tout à fait analogues à ce qu’éprouvent les victimes de crimes violents ou de catastrophes naturelles (Cordova, Studts, Hann, Jacobsen, & Andrykowski, 2000 ; Jackson et al., 2007).

L’état de stress post-traumatique (ESPT) qu’on associe couramment aux rescapés de situations traumatiques de cet ordre est actuellement en cours de documentation chez les patients atteints de cancer (Bruce, 2006 ; DuHamel et al., 2004).


Plusieurs études de l’ESPT, portant sur toutes sortes de cancers (mélanomes, maladie de Hodgkin, cancer du sein et cancers mixtes), ont eu lieu dans cette population, mais elles n’étaient pas homogènes dans leurs évaluations de l’ESPT ; certaines évaluait le patient par rapport au syndrome d’ESPT complet (c’est-à-dire remplissant tous les critères du DSM-IV) ou seulement par rapport à certains symptômes liés à l’ESPT (p. ex., les pensées intrusives mesurées par l’Impact of Event Scale-Revised ; IES-R ; National Cancer Institute, 2012a). Il est important de noter que l’ESPT est difficile à diagnostiquer dans n’importe quelle population, pour plusieurs raisons : d’abord, parce qu’on peut le confondre avec de nombreux autres troubles psychologiques, et ensuite parce que les symptômes peuvent apparaître de façon retardée dans le temps, dans certains cas bien des années après l’expérience traumatique. Chez les patients atteints de cancer, dans une phase particulière de la maladie, les symptômes peuvent rester juste sous la surface, et empêcher, même s’ils sont traités, une rémission complète. Une recherche récente, entreprise par le Duke Cancer Institute, est l’une des rares études, à ce jour, qui fournisse des informations valables après une période importante de suivi ; elle documente l’ESPT chez des patients atteints de lymphome non-hodgkinien sur une période moyenne de suivi de 12 ans et 9 mois (Smith et al., 2011). En fait, elle a montré que l’ESPT s’aggrave avec les années. Il n’a pas été développé, pour cette population, de stratégie psychothérapeutique unique pour l’ESPT ; cependant, la littérature, sur le sujet de l’ESPT, est riche d’exemples de nombreuses formes de psychothérapie efficaces, parmi lesquelles la thérapie cognitive-comportementale (TCC), comme l’ont montré des études internationales (Foа, Keane, Friedman, & Cohen, 2008 ; Rothbaum, Astin, & Marsteller, 2005 ; Taylor et al., 2003) et l’EMDR (désensibilisation et retraitement par les mouvements oculaires ; Shapiro, 1995, 2001). La thérapie EMDR a été reconnue par la Société internationale pour l’étude du Stress Traumatique (International Society for Traumatic Stress Studies ; Chtembob, Tolin, van der Kolk & Litman, 2000) et, en 2001, elle a été reconnue comme une forme de thérapie efficace de l’ESPT (classification A/B) par le Ministère britannique de la Santé (Bisson et al., 2007 ; Onofri, 2012). On l’utilise dans le monde entier depuis 1990, et elle s’est avérée efficace dans toutes sortes de formes de stress et de troubles d’origine traumatique, dont l’ESPT.

L’EMDR a traité efficacement des patients souffrant de maladies variées, comme la douleur chronique (Grant & Threlfo, 2002 ; Schneider, Hofmann, Rost & Shapiro, 2008), la fibromyalgie (Friedberg, 2004), et l’infarctus du myocarde (Arabia, Manca & Solomon, 2011). En particulier, une étude pilote récente a fourni une preuve préliminaire que l’EMDR était plus efficace que la thérapie par exposition imaginaire dans le traitement de patients rescapés d’un accident cardiaque mettant leur vie en jeu (Arabia et al., 2011). Notre étude pilote est le premier projet structuré de recherche en Italie qui étudie la TCC et l’EMDR chez des patients atteints de cancer traités à l’Institut national de cancérologie Regina Elena de Rome.

Dans la littérature de psycho-oncologie concernant la réaction de l’individu à sa maladie, on trouve deux hypothèses prévalentes : la première considère que le malade atteint de cancer est connecté à une série de crises qui se produisent au cours de la maladie et...
Les classifications psychopathologiques (Morasso, 2002). En se centrant sur une “maladie de crises”, on risque de n’avoir qu’une appréciation superficielle de la maladie psycho-oncologique, et de négliger l’impact traumatique de ce vécu ainsi que le mal-être psychologique lié au cancer, qui est tellement vécu comme “traumatique” qu’on peut arriver à un diagnostic d’ESPT — et cette perturbation est au cœur de la psychopathologie de la personne. Le cancer est objectivement traumatisant (Castrogiovanni & Traverso, 2006). Les classifications suivantes, tirées du DSM-IV-TR, montrent que la communauté scientifique reconnaît le puissant impact traumatique de cette maladie sur l’individu.

- Le cancer produit un sentiment de mise en danger de la vie de la personne, de la qualité de vie et de l’intégrité psychologique et physique de la personne et des autres, y compris sa famille (critère A1 du DSM-IV-TR ; American Psychiatric Association, 2000).
- Il crée une impression écrasante de vulnérabilité, de perte de contrôle et d’impuissance (critère A2 du DSM-IV-TR ; American Psychiatric Association, 2000).

Comme le précise le DSM-IV-TR (American Psychiatric Association, 2000), pour ce qui concerne le critère E de l’ESPT, les symptômes doivent durer au moins un mois, ce qui peut être le cas après l’annonce du diagnostic d’un cancer.

**Objectifs**

Le premier objectif de cette étude pilote était d’évaluer l’efficacité comparée de l’EMDR et de la TCC chez des patients atteints de cancer souffrant d’ESPT dans la phase de suivi de la maladie. Nous souhaitions évaluer l’efficacité de l’EMDR et de la TCC sur des mesures particulières d’ESPT, ainsi que sur les symptômes liés à l’ESPT : anxiété, dépression et réactions psychophysiologiques. Le second objectif était d’êtablir si l’EMDR avait un impact différent sur l’ESPT et ses symptômes, à deux phases différentes de la maladie (traitement actif du cancer/suivi post-traitement), pour aborder la question de ses éventuels bénéfices pour les patients atteints de cancer dans les phases antérieures de leur traitement médical.

**Méthodes**

**Participants**

Trente-et-un patients atteints de différents types de cancer (cancer du sein, du côlon, de l’utérus, de la thyroïde, du poumon, de l’estomac, et mélanome) ont été recrutés entre mai 2010 et juin 2012 dans les services de chirurgie digestive, de chirurgie thoracique et d’oncologie médicale (Service B) de l’Institut national de cancérologie Regina Elena de Rome. Le recrutement a été fait en incluant toutes les prises en charge adressées à la clinique psychiatrique par les unités oncologiques, qui satisfaisaient au diagnostic clinique d’ESPT (31 patients sur 623, soit 4,97%). Les 31 patients ont donné leur accord pour participer à l’étude.

Les critères d’inclusion étaient les suivants : a) remplir les critères diagnostiques ESPT du DSM-IV et b) ne pas avoir de traitement psychopharmacologique en cours.

Les critères d’exclusion concernaient : a) les patients déjà en psychothérapie et b) les patients ayant des troubles psychopathologiques préexistants au diagnostic de cancer.

Les patients ont été placés dans l’une ou l’autre étude en fonction de l’étape de la maladie où ils se trouvaient : dix étaient en phase active de traitement du cancer et vingt-et-un en phase de suivi post-traitement. Ces vingt-et-un patients ont été assignés au hasard à un groupe TCC ou à un groupe EMDR. Ceux qui étaient en phase de traitement (n = 10) ont été assignés seulement à l’étude sur le traitement EMDR. Au total, on a trois groupes de patients : un groupe de patients en phase de traitement faisant seulement de l’EMDR (n = 10), un groupe de patients en phase de suivi faisant de l’EMDR (n = 11) et un autre groupe de patients en phase de suivi faisant de la TCC (n = 10).

**Mesures**

Tous les questionnaires utilisés pour l’évaluation des participants à l’étude sont auto-administrés, sauf le Clinical-Administered PTSD Scale (CAPS), qui a été administré par un examinateur indépendant, en aveugle.

**Le Clinician-Administered PTSD Scale (CAPS).**

Le CAPS (Blake et al., 1995), sous sa forme Current and Lifetime Diagnostic Version (version DX) est un
entretien clinique semi-structuré fondé sur le DSM-IV-TR, qui est la référence pour l’évaluation de l’ESPT (Foa & Tolin, 2000; Weathers, Keane, & Davidson, 2001). Sa structure correspond aux critères du DSM-IV, avec une évaluation des symptômes B (intrusion), C (évitement) et D (hyperactivation) à la fois sur le plan de leur fréquence et de leur intensité ; les deux notes sont ensuite additionnées pour obtenir les évaluations de sévérité. Des questions supplémentaires évaluent les critères A, E et F.

L’*Impact of Event Scale-Revised (IES-R)*. L’IES-R (Weiss & Marmar, 1997) est un questionnaire en 22 questions avec trois sous-échelles (intrusion, évitement, hyperactivation) qui évalue la détresse subjective causée par les événements traumatiques. On demande au patient d’identifier un événement stressant particulier de sa vie, puis d’indiquer à quel point il a été perturbé ou ennuyé par chaque “difficulté” listée au cours des sept jours avant le test.

The *Psychophysiological Questionnaire—Brief Version (QPF-R)*. Le QPF-R (Pancheri, Chiari, & Michelin, 1985) a été utilisé pour évaluer les réactions psycho-physiologiques. Il comprend trente items, sur une échelle de Likert (de 0 à 4) qui se rapporte aux symptômes somatiques sans base organique démontrable.


L’*Inventaire de dépression de Beck (Depression Inventory-II, BDI)*. Le BDI (Beck & Steer, 1993) est un instrument auto-administré en 21 items évaluant la présence et la gravité de symptômes correspondant aux critères du DSM-IV.

Procédure

**Évaluation.** Les évaluations ont été menées avant le traitement et un mois après la fin des séances de traitement.

Pour le premier entretien, les patients arrivaient au centre adressés par un médecin hospitalier ou par un médecin généraliste. Quand la psychologue (L. C.) repérait des éléments cliniques pouvant évoquer un diagnostic d’ESPT, elle invitait le patient à rencontrer un évaluateur indépendant, travaillant en aveugle, qui utilisait alors le CAPS pour explorer un éventuel ESPT. Les évaluations comprenaient un entretien clinique avec le patient au sujet de son passé médical, entretien mené par le clinicien en charge du patient au cours du pré-traitement et du post-traitement. Ensuite, les patients chez qui le diagnostic d’ESPT était confirmé se voyaient demander de remplir les autres questionnaires psychologiques auto-administrés ; ces questionnaires leur étaient remis par un évaluateur indépendant, qui était également à leur disposition pour répondre à leurs éventuelles questions sur la compilation des questionnaires. Puis on leur proposait de prendre part à l’étude. S’ils étaient d’accord, ils discutaient du formulaire de consentement éclairé et le signaient.

Ceux qui étaient dans la phase de suivi de la maladie étaient aléatoirement assignés en thérapie EMDR ou en thérapie TCC. S’ils étaient dans la phase active de traitement de la maladie, on les assignait seulement en thérapie EMDR.

**Traitement.** Tous les participants, quel que soit le type de thérapie reçue ou la phase de la maladie où ils se trouvaient, recevraient huit séances de thérapie hebdomadaire. On conseillait à tous les patients présentant encore des symptômes au-delà d’un mois après la fin de la thérapie de poursuivre le travail avec leur thérapeute, même si l’étude était finie.

EMDR. Le protocole standard EMDR (Shapiro, 2001) en huit étapes a été administré, avec pour objectifs :

1. Stabilisation par la psychoéducation (sur l’adaptation émotionnelle face au cancer, les caractéristiques de l’ESPT et la thérapie EMDR) et "l’installation de ressources" (Shapiro, 2001) avec la technique du “lieu sûr” (Shapiro, 2001) pour stabiliser le patient et le preparer à la thérapie.

2. Identification et retraitement de souvenirs perturbants liés au cancer dans les trois dimensions de l’EMDR : événements passés et présents, identifiés lors du recueil de l’histoire de la personne et à l’aide de floatbacks (p. ex. l’annonce du diagnostic ou d’une récidive, l’annonce de complications dans le traitement, les effets secondaires du traitement) et modèles pour le futur, pour gérer les préoccupations et les peurs (p. ex. la crainte d’une détérioration du fonctionnement physique, la peur de l’avenir). On a suivi la totalité des huit phases de l’EMDR (Shapiro, 2001) et la thérapie a été uniquement centrée sur le cancer, à l’exclusion de tout événement traumatique antérieur.

3. Intégration : la réduction de l’anxiété et le développement de ressources ont été intégrés dans la vie quotidienne des patients pour améliorer leur adaptation à leur situation de rescapés de la maladie.
Toutes les thérapies EMDR ont été menées par un thérapeute ayant dix ans d’expérience clinique en EMDR.

TCC. On trouvera ci-après les techniques et les approches thérapeutiques utilisées en fonction des symptômes d’ESPST qui étaient le plus souvent rapportés par chaque patient, et en fonction des étapes de la psychothérapie. Voici les objectifs qu’on s’était fixés :


3. Pour les comportements d’évitement ou de fuite : désensibilisation systématique et exposition graduale par exposition imaginaire ou en vivo (personnes ou objets).

4. Pour la restructuration cognitive ou les pensées cognitives négatives en rapport avec le vécu traumatique : formes A, B, C, D, E de la Rational Emotive Behavior Therapy (REBT; Ellis, 1994) et dialogue socratique.

5. Pour le contrôle des fluctuations psycho-physiologiques et le maintien des nouveaux patterns comportementaux : travail personnel et journal de bord.

6. Pour l’observance du traitement : techniques de contrôle et redéfinition des alliances thérapeutiques. Toutes les thérapies TCC ont été menées par le thérapeute qui menait aussi les thérapies EMDR, qui a par ailleurs douze ans d’expérience de clinicien TCC.

Analyses statistiques

Les données ont été traitées et analysées à l’aide du Statistical Package for Social Sciences (SPSS) version 17.0 (Chicago, IL, USA).

Les différences d’origine des groupes ont été évaluées en utilisant une analyse de la variance à un facteur (one-way ANOVA) pour comparer les trois groupes sur le plan des mesures continues, et le test exact de Fisher pour les comparer sur celui des mesures catégorielles.

Le test exact de Fisher a également été utilisé pour évaluer le rapport entre le groupe thérapeutique (EMDR ou TCC) et le diagnostic d’ESPST au moment T1.

Le modèle linéaire généralisé (Generalized linear model, GLM) de l’analyse de variance multivariée par mesures répétées (RM-MANOVA) a été utilisé pour analyser les effets et les interactions essentiels pré- et post-intervention, à la fois entre les groupes EMDR et TCC et dans chacun d’eux, au cours de la phase de suivi du cancer. Des comparaisons par paires entre les groupes ont été faites par contraste simple et rapportées comme différence moyenne avec l’intervalle de confiance corrigé (IC 95%) de Sidak pour les comparaisons multiples.

Des analyses logistiques simples de régression ont été calculées en prenant la présence d’un ESPST après le traitement comme variable dépendante dichotomique, et en considérant isolément comme variables indépendantes l’âge, le sexe, le type de thérapie (EMDR/TCC), et les notes des variables cliniques du départ (QPF-R, STAI-1, STAI-2, BDI-II, IES-R total, critères B, C et D du CAPS) pour les patients qui se trouvaient dans la phase de suivi du cancer.

Comme résultat secondaire, on a utilisé une RM-MANOVA pour analyser les effets et les interactions essentiels pré- et post-intervention, à la fois entre les groupes selon les différentes phases du traitement anticancéreux (traitement actif ou suivi) et à l’intérieur de chacun d’eux, pour évaluer si la thérapie EMDR a un impact différent, suivant l’étape de la maladie où on la fait intervenir.

Enfin, un p < 0,05 a été considéré comme statistiquement significatif dans toutes les analyses.

Résultats


Comparaison entre EMDR et TCC dans la phase de suivi du cancer

On l’a dit, il y avait 21 patients en phase de suivi, parmi lesquels 11 ont été placés aléatoirement en thérapie EMDR (tous étaient des femmes) et 10 en thérapie...
TCC (huit femmes et deux hommes). L’âge moyen des patients était similaire dans les deux groupes (52,70 ; \( \sigma = 8,68 \) pour la TCC et 50,82 ; \( \sigma = 7,64 \) pour l’EMDR).

Il n’y avait pas de différences de variables cliniques entre les deux groupes au départ (Tableau 1).

Nous avons évalué si les deux différentes formes de thérapie (EMDR ou TCC) administrées aux patients pendant la phase de suivi du cancer avaient une incidence différente sur les variables psychologiques auxquelles l’étude s’intéressait.

Pour ce faire, on a réalisé une MANOVA par mesures répétées sur les notes cliniques avant et après la thérapie (QPF-R, STAI-1, STAI-2, BDI-II, IES-R Total, CAPS critère B, C, et D) en comparant les effets de groupe et de période et les interactions entre groupe et période.

Cette RM-MANOVA a montré un effet principal significatif pré-post (\( F[8,12] = 13,547, p < 0,001 \); \( \eta^2 = 0,00 \) et une interaction significative entre les mesures pré-post et la forme de thérapie (\( F[8, 12] = 4,855, p = 0,007; \eta^2 = 0,764 \)).

Des effets significatifs de la période ont été trouvés dans les deux groupes pour toutes les variables, excepté pour la STAI-2 (l’anxiété-trait), ce qui indique que les notes moyennes des participants se sont améliorées entre la période 1 (pré-intervention) et la période 2 (post-intervention) ; cf. Tableau 1.

Des effets de l’interaction groupe/période ont été trouvés pour les notes totales à l’IES-R (\( F[1, 19] = 14,041, p < 0,001 \); cf. Figure 1) et pour les notes du critère B du CAPS (\( F[1, 19] = 7,584, p = 0,013 \); cf. Tableau 1 et Figure 2).

Aucune interaction groupe/période n’a été trouvée pour les QPF-R, STAI-1, STAI-2, IES-R, CAPS-C, et CAPS-D, ce qui indique que les changements sur ces mesures étaient similaires pour les deux groupes de thérapie.

On a conduit les analyses post hoc prévues sur les effets simples pré-post par comparaisons GLM par paires en utilisant l’ajustement de Sidak pour les comparaisons multiples (cf. Figure 1). Les résultats ont montré que la note totale à l’IES-R, au post-traitemnt (m = 20,56 ; erreur type = 4,880), était significativement plus basse que la note au pré-traitemnt pour le groupe EMDR (m = 50,91 ; erreur type = 3,020), différence moyenne = −30,364 (IC 95% [−38,945, −21,782]) ; p < 0,001. Pour les participants qui avaient suivi le traitement TCC, il n’y avait pas de différence entre les notes post-traitemnt (m = 46,60, erreur type = 5,12) et les notes pré-traitemnt (m = 17,73, erreur type = 1,497), différence moyenne = −8,100 (IC 95% [−17,100, 0,900]) ; p = 0,075. Cela indique que les améliorations au fil du temps étaient significativement plus importantes dans le groupe de thérapie EMDR que dans le groupe TCC (cf. Figure 1). L’analyse des effets simples révèle aussi une différence significative entre les notes post-traitemnt EMDR et TCC à l’IES-R : celles du groupe EMDR (m = 20,55, erreur type = 4,88) sont significativement plus

### Tableau 1. Données cliniques des participants en phase de suivi du cancer

<table>
<thead>
<tr>
<th></th>
<th>Pré-traitement</th>
<th>Post-traitement</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TCC (N = 10)</td>
<td>EMDR (N = 11)</td>
<td>TCC (N + 10)</td>
</tr>
<tr>
<td>QPF-R</td>
<td>61,60 (15,71)</td>
<td>57,45 (13,55)</td>
<td>54,50 (13,24)</td>
</tr>
<tr>
<td>STAI-1</td>
<td>45,40 (4,95)</td>
<td>44,73 (5,42)</td>
<td>43,90 (5,55)</td>
</tr>
<tr>
<td>STAI-2</td>
<td>46,30 (5,34)</td>
<td>45,82 (6,15)</td>
<td>43,80 (4,10)</td>
</tr>
<tr>
<td>BDI-II</td>
<td>26,30 (8,73)</td>
<td>25,73 (10,89)</td>
<td>20,10 (9,24)</td>
</tr>
<tr>
<td>IES-R total</td>
<td>54,70 (10,62)</td>
<td>50,91 (9,45)</td>
<td>46,60 (14,13)</td>
</tr>
<tr>
<td>CAPS critère B</td>
<td>20,90 (7,71)</td>
<td>19,55 (8,15)</td>
<td>15,30 (5,87)</td>
</tr>
<tr>
<td>CAPS critère C</td>
<td>30,30 (8,13)</td>
<td>28,36 (12,19)</td>
<td>20,50 (7,59)</td>
</tr>
<tr>
<td>CAPS critère D</td>
<td>27,60 (6,22)</td>
<td>24,00 (8,15)</td>
<td>16,20 (9,16)</td>
</tr>
</tbody>
</table>

**Note.** Ces données sont des moyennes (écart-types). QPF-R = Psychophysiological Questionnaire—Brief Version ; STAI-1 = State-Trait Anxiety Inventory—anxiété-état ; STAI-2 = State-Trait Anxiety Inventory—anxiété-trait ; BDI-II = Inventaire de dépression de Beck-II ; IES-R total = Impact of Event Scale-Revised—note totale ; CAPS critère B = Clinician-Administered PTSD Scale—symptômes intrusifs ; CAPS critère C = Clinician-Administered PTSD Scale—symptômes d’évitement ; CAPS critère D = Clinician-Administered PTSD Scale—symptômes d’hypercactivité.

* : effet significatif pré-post thérapie, sans considération du type de thérapie (TCC ou EMDR)

§ : effets d’interaction significatifs en fonction du groupe (TCC ou EMDR) et en fonction de la période (pré-traitemnt ou post-traitemnt).
basses que celles du groupe TCC (m = 46,60, erreur type = 5,12), différence moyenne = −26,055 (IC 95% [−40,865, −11,244]), p = 0,002.

On a mené également les analyses post hoc prévues sur les effets simples pour la sous-échelle “intrusion” du CAPS (cf. Figure 2). L’analyse de ces effets simples a montré que la note au critère B, au post-traitement (m = 6,18, erreur type = 1,95), était significativement plus basse que la note pré-traitement pour le groupe EMDR (m = 19,56, erreur type = 2,40), différence moyenne = −13,364 (IC 95% [217,435, 29,292]), p < 0,001. Il y avait également une différence entre les notes au post-traitement (m = 15,30, erreur type = 2,04) et au pré-traitement (m = 20,90, erreur type = 2,51) pour les participants au groupe TCC, différence moyenne = −5,600 (IC 95% [29,870, 21,330]), p = 0,013.

Les deux groupes avaient certes connu une amélioration des symptômes intrusifs, mais la comparaison entre les notes au critère B du CAPS au post-traitement montrait des notes significativement plus

**FIGURE 1.** Interaction entre la période et le forme de thérapie pour la note totale à l’IES-R.
*Note. IES-R Total score = note totale IES-R ; CBT = TCC ; baseline = au départ ; after treatment = après la thérapie.*

**FIGURE 2.** Interaction entre la période et la forme de thérapie pour la note au critère B du CAPS.
*Note. CAPS Criterion B score = note au critère B du CAPS ; CBT = TCC ; baseline = au départ ; after treatment = après la thérapie.*
basses (m = 6.18, erreur type = 1.95) dans le groupe EMDR que dans le groupe TCC (m = 15.30, erreur type = 5.04), différence moyenne = -9.118 (IC 95% [-15.029, -3.207]), p = 0.004.

De plus, on a mené une analyse de régression logistique binaire pour détecter l’influence éventuelle du type de thérapie (EMDR ou TCC) et l’influence des variables cliniques sur la présence de l’ESPT après les huit séances de thérapie. On a pu montrer que la présence d’ESPT après la thérapie était significativement associée au type de thérapie seulement (EMDR ou TCC ; R² = 0.71; OR = 0.011, IC 95% [0.001, 0.205]; p = 0.002). L’influence des autres variables démographiques et cliniques n’atteignait pas un niveau statistiquement significatif. L’absence d’ESPT après la thérapie était associée à une probabilité supérieure d’avoir entrepris un traitement EMDR. Plus précisément, 10 des 11 sujets traités par l’EMDR n’avaient plus d’ESPT après leur thérapie, alors que 9 sur 10 des patients traités par TCC conservaient un diagnostic d’ESPT à l’évaluation post-intervention (Test exact de Fisher ; p < 0.001, η² = 0.809).

Efficacité de la thérapie EMDR aux deux étapes de la maladie (traitement actif du cancer ou phase de suivi)

En deuxième objectif, nous avons évalué si le traitement EMDR avait un impact différent selon que les patients étaient en phase de traitement médical actif ou en phase de suivi. Les 21 ont été divisés comme suit : dix d’entre eux (neuf femmes et un homme) étaient en phase active de traitement de leur cancer, les onze autres (toutes des femmes) en phase de suivi. L’âge moyen des patients était comparable dans les deux groupes (53.40, σ = 8.59 pour les patients en phase active de traitement et 50.82, σ = 7.64 pour les patients en phase de suivi). Il n’y avait pas de différence dans les variables cliniques entre les deux groupes au départ (cf. Tableau 2).

La RM-MANOVA a montré un effet principal pré-post significatif (F[8, 12] = 22.900, p < 0.001 ; η² = 0.939), alors qu’aucune interaction significative n’était trouvée entre les mesures pré-post et le fait de se trouver dans l’une ou l’autre des phases de traitement du cancer (traitement actif ou suivi) (F[8, 12] = 0.885, p = 0.555 ; η² = 0.071). Il a été trouvé des effets significatifs liés au temps dans les deux groupes, pour toutes les variables sauf pour STAI-2 (anxiété-trait), ce qui montrait que, indépendamment de la phase de la maladie, les notes s’amélioraient du moment 0 (pré-intervention) au moment 1 (post-intervention). Par conséquent, on peut dire que la thérapie EMDR est efficace quelle que soit la phase de la maladie.

Pratiquement plus aucun patient (20 sur 21, soit 95.2%) ne présentait d’ESPT à la fin de la thérapie EMDR.

**Tableau 2. Variables cliniques des groupes traités en EMDR (pré- et post-traitement)**

<table>
<thead>
<tr>
<th></th>
<th>Pré-traitement</th>
<th>Post-traitement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TCC (N = 10)</td>
<td>EMDR (N = 11)</td>
</tr>
<tr>
<td>QPF-R</td>
<td>58,50 (9,70)</td>
<td>57,45 (13,55)</td>
</tr>
<tr>
<td>STAI-1</td>
<td>43,70 (3,37)</td>
<td>44,73 (5,42)</td>
</tr>
<tr>
<td>STAI-2</td>
<td>46,10 (3,65)</td>
<td>45,82 (6,15)</td>
</tr>
<tr>
<td>BDI-H</td>
<td>27,00 (7,70)</td>
<td>25,73 (10,89)</td>
</tr>
<tr>
<td>IES-R total</td>
<td>48,50 (14,74)</td>
<td>50,91 (9,45)</td>
</tr>
<tr>
<td>CAPS critère B</td>
<td>20,70 (6,82)</td>
<td>19,55 (8,15)</td>
</tr>
<tr>
<td>CAPS critère C</td>
<td>22,50 (4,09)</td>
<td>28,36 (12,19)</td>
</tr>
<tr>
<td>CAPS critère D</td>
<td>19,90 (9,25)</td>
<td>24,00 (8,15)</td>
</tr>
<tr>
<td>TCC (N + 10)</td>
<td>48,30 (9,65)</td>
<td>48,45 (12,18)</td>
</tr>
<tr>
<td>EMDR (N = 11)</td>
<td>42,70 (3,50)</td>
<td>40,00 (3,41)</td>
</tr>
<tr>
<td></td>
<td>43,30 (4,55)</td>
<td>43,55 (5,70)</td>
</tr>
<tr>
<td></td>
<td>15,50 (8,33)</td>
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<tr>
<td></td>
<td>28,60 (9,38)</td>
<td>20,55 (17,85)</td>
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<td></td>
<td>6,20 (3,08)</td>
<td>6,18 (6,95)</td>
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<td></td>
<td>7,40 (3,89)</td>
<td>10,45 (7,54)</td>
</tr>
<tr>
<td></td>
<td>6,60 (4,22)</td>
<td>9,91 (5,61)</td>
</tr>
</tbody>
</table>

Note. Ces données sont des moyennes (écarts-types) ou N (%). QPF-R = Psychophysiological Questionnaire — Brief Version ; STAI-1 = State-Trait Anxiety Inventory — anxiété-état ; STAI-2 = State-Trait Anxiety Inventory — anxiété-trait ; BDI-II = Inventaire de dépression de Beck-II ; IES-R total = Impact of Event Scale-Revised — note totale ; CAPS critère B = Clinician-Administered PTSD Scale — symptômes intrusifs ; CAPS critère C = Clinician-Administered PTSD Scale — symptômes d’évitement ; CAPS critère D = Clinician-Administered PTSD Scale — symptômes d’hyperactivation.

* : effet significatif pré-post thérapie, sans considération de la phase de la maladie (traitement actif ou suivi)
Discussion

Efficacité comparée de l’EMDR et de la TCC dans la phase de suivi du cancer

Le résultat le plus significatif de cette étude est le fait que la plupart des patients traités par l’EMDR dans la phase de suivi du cancer ont pu surmonter leur ESPT après huit séances de thérapie ; au contraire, presque tous les patients dans la même phase de la maladie, mais traités par la TCC, avaient encore un diagnostic d’ESPT un mois après la fin de la psychothérapie.

L’EMDR a significativement réduit les symptômes de stress post-traumatique, mesurés avec la note totale à l’IES-R, la TCC non. Les symptômes intrusifs mesurés par le critère B du CAPS ont significativement baissé tant pour les patients traités par EMDR que pour ceux traités par TCC, bien que, dans le groupe EMDR, la baisse soit plus marquée : le groupe de patients traités par l’EMDR avait, à la fin de la thérapie, à la fois des notes plus basses à l’IES-R et à la sous-échelle des symptômes intrusifs du CAPS que le groupe TCC.

L’anxiété, la dépression et les réactions psychophysioligiques se sont améliorées dans les deux groupes, montrant que les deux types de thérapie sont efficaces sur ces symptômes avec un nombre limité de séances.

Efficacité de l’EMDR au cours des deux phases distinctes de la maladie (traitement médical actif/suivi)

L’EMDR a été efficace tant dans la phase de traitement actif du cancer que dans la phase de suivi de la maladie. Tous les patients ont montré un progrès clinique sur le plan de l’ESPT, l’anxiété, la dépression et les réactions psychophysioligiques.

Limites et conclusions

Cette étude souffre également de plusieurs limites. En premier lieu, le nombre des patients traités par EMDR ou par TCC n’est pas élevé.

Une autre limite réside dans le fait qu’il n’y a pas eu de vérifications de fidélité pendant les séances de thérapie. Enfin, tous les patients de chaque groupe ont eu le même thérapeute, ce qui laisse la possibilité que les résultats s’expliqueraient par des différences de compétences cliniques sur des variables non spécifiques, par exemple le développement d’une alliance thérapeutique ou d’autres facteurs encore.

Il pourrait être intéressant de mener une autre recherche pour aborder certaines des questions auxquelles cette étude n’a pas pleinement répondu et pour corriger les limites de cette dernière : par exemple, un nombre plus élevé de patients traités et davantage de thérapeutes dans chaque groupe de thérapie. Il faudrait aussi introduire des vérifications de fidélité. Enfin, il faudrait assurer un suivi d’au moins six mois après la fin de la thérapie pour montrer la stabilité des effets de celle-ci dans les différentes conditions des patients.

Si nos résultats ne peuvent être considérés que comme préliminaires, cette étude pilote suggère cependant que, chez des patients atteints de cancer en phase de suivi, l’EMDR a un avantage sur la TCC : elle élimine le diagnostic d’ESPT. L’EMDR a été significativement plus efficace que la TCC pour réduire les notes à l’IES-R et à la sous-échelle des symptômes intrusifs du CAPS, alors que les deux formes de thérapie apparaissent également efficaces sur l’anxiété-trait, la dépression et les réactions psycho-physiologiques.

Notre étude donne à penser que l’EMDR pourrait être une thérapie valable pour les patients atteints de cancer et ayant un diagnostic d’ESPT, tant dans la phase de traitement médical actif que dans la phase de suivi. Ces résultats positifs dans les deux conditions de traitement montrent qu’il est d’une importance capitale que les patients atteints de cancer aient accès à un soutien psychologique et à des formes de thérapie dont on a prouvé l’efficacité, pour leur permettre de gérer les nombreuses difficultés de l’adaptation au statut de rescapé du cancer, et pour les aider à entrer dans un processus positif de résilience psychologique.

Nos données peuvent contribuer à de meilleures connaissances, chez les médecins, des symptômes psychologiques qui peuvent être provoqués par le cancer et qui pourraient être des précurseurs d’un diagnostic d’ESPT. Avec ces informations, ils peuvent adresser rapidement le patient en psychothérapie.

Comme cette étude le montre, une psychothérapie EMDR ou TCC peut être efficace, même en un nombre limité de séances. Pour confirmer et élargir les résultats de cette investigation préliminaire, il faudrait de nouvelles recherches portant sur un échantillon plus grand de patients.

Pour conclure, notre étude suggère que l’EMDR et la TCC sont toutes deux efficaces pour traiter de nombreux symptômes psychologiques chez les patients atteints de cancer, mais nos résultats donnent à penser que l’EMDR pourrait être une forme de thérapie plus efficace que la TCC pour les patients ayant un diagnostic d’ESPT, en particulier pour les symptômes intrusifs, à la fois lors de la phase active du traitement médical et dans la phase de suivi de la maladie.
Références


Morasso, G. (2002). Nuove prospettive in psico-oncologia. In Formazione, psicologia, psicoterapia, psichiatria (pp. 2). Roma, Italy: Grin SRL.


Notre profonde gratitude va aux services de chirurgie digestive, de chirurgie thoracique, au service B d’oncologie médicale, et à l’UOSD de l’Area di Supporto alla Persona à l’IRE–ISG (Rome) pour nous avoir permis de travailler avec leurs patients et avoir informés ceux-ci de notre étude.
Nous remercions le Dr Diana Giannarelli (IRE–ISG, Rome) qui a traité les données recueillies et en a fait l’analyse statistique.
Les auteurs souhaitent enfin remercier Lesley Pritikin qui a revu le texte.

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El Protocolo de EMDR para Incidentes Críticos Recientes: Reporte de Seguimiento de su Aplicación en Situación de Masacre Humana

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El presente artículo reporta los resultados de seguimiento de nuestro estudio de campo (Jarero & Uribe, 2011), en el que se investigó la aplicación del Protocolo de Terapia de Reprocesamiento y Desensibilización a través del Movimiento Ocular para Incidentes Críticos Recientes (EMDR-PRECI) en una situación de masacre humana. Se aplicó una sola sesión de tratamiento a 32 empleados forenses de la Procuraduría General del Estado de Durango en México, quienes estaban trabajando con 258 cuerpos recuperados de fosas clandestinas. Los resultados pre y post-tratamiento mostraron una mejoría significativa, tanto en el grupo de atención inmediata (GAI), como en el grupo de atención demorada (GAD), en los puntajes de la Impact of Events Scale (IES) y en el Short PTSD Rating Interview (SPRINT). En este estudio reportamos la evaluación de seguimiento, la cual se realizó después de 3 y 5 meses de la aplicación del tratamiento. Los puntajes obtenidos en el seguimiento muestran que los resultados del tratamiento original se mantuvieron, y que continuó presentándose una disminución significativa de los síntomas de estrés postraumático y de TEPT auto-reportados, entre el post-tratamiento y el seguimiento. Durante el período de seguimiento, los empleados continuaron su labor forense con los restos humanos recuperados y estuvieron permanentemente expuestos a estresores emocionales aterradores y a amenazas constantes relacionadas con su seguridad. Lo anterior sugiere que el EMDR-PRECI fue una intervención temprana efectiva al reducir el estrés postraumático en un grupo de adultos traumatizados que continuaron laborando bajo estresores extremos en una situación de masacre humana. Parece ser que el tratamiento ayudó a prevenir el desarrollo de TEPT crónico y a aumentar la resiliencia psicológica y emocional.

Palabras Clave: EMDR-PRECI; Intervención Temprana con EMDR; EMDR y prevención del TEPT; masacre humana; salud mental; estrés postraumático; resiliencia.

La Terapia de Reprocesamiento y Desensibilización a través del Movimiento Ocular (EMDR) es una psicoterapia basada en la evidencia, utilizada para el tratamiento del trastorno por estrés postraumático (TEPT), con aproximadamente 15 estudios clínicos aleatorios (randomizados) que demuestran su eficacia en la reducción o eliminación de los síntomas del TEPT. Se ha demostrado que tiene resultados similares a los que se obtienen con los abordajes terapéuticos cognitivo conductuales focalizados en el trauma (Bisson & Andrew, 2007), con efectos que se mantienen en el seguimiento. También existe evidencia preliminar de su aplicación en el tratamiento de otros trastornos psiquiátricos, diversos problemas de salud mental y síntomas somáticos.

En su Modelo del Sistema de Procesamiento de la Información (Adaptive Information Processing [AIP] Model), Shapiro (2001) plantea que gran parte de la psicopatología es causada por una codificación...
desadaptativa en la memoria y/o por el procesamiento incompleto de experiencias de vida adversas, traumáticas o perturbadoras. Se piensa que esto afecta la habilidad del individuo para integrar estas experiencias de forma adaptativa. Se dice que la Terapia EMDR, la cual consiste en un proceso de ocho fases y tres etapas, facilita la reanudación del procesamiento normal de la información de estas experiencias, y la integración de las mismas en redes de memoria que contienen información adaptativa.

Esta aproximación terapéutica que se enfoca en la experiencia pasada, los detonantes (disparadores) actuales y los retos potenciales a futuro, puede frecuentemente dar como resultado el alivio de los síntomas presentes; con la disminución o desaparición de la perturbación relacionada a las memorias traumáticas reprocesadas; una imagen más positiva de sí mismo, el alivio de las molestias corporales, y la resolución de detonantes presentes, o los que se puedan presentar en el futuro (EMDR International Association [EMDRIA], 2011).

La Terapia EMDR y la Intervención Temprana

Los autores consideran que la intervención temprana con Terapia EMDR tiene un lugar natural en el contexto del continuo de cuidados de la intervención en crisis y la salud mental en desastres, y han argumentado que puede ser clave en la intervención temprana en la modalidad de tratamiento breve (Jarero, Artigas, & Luber, 2011).

En algunos incidentes críticos (ej. terremotos, inundaciones, deslaves, tsunamis), eventos estresores relacionados al mismo continúan por un período extendido de tiempo (frecuentemente por más de 6 meses). Hemos argumentado que esta falta de un periodo de seguridad post-trauma impide la consolidación de la memoria del incidente crítico original (Jarero et al., 2011).

Las memorias traumáticas acumuladas pueden ser un posible factor para que el individuo sea más sensible a detonantes dolorosos o amenazantes, dando como resultado el desarrollo de trastornos posteriores; aumentando la sensibilidad con el número de memorias reprocesadas y con la acumulación progresiva de memorias traumáticas o de vínculos negativos asociados (Tofani & Wheeler, 2011).

El Protocolo EMDR para Incidentes Críticos Recientes

El Protocolo EMDR para Incidentes Críticos Recientes (EMDR-PRECI) es una modificación del Protocolo para Eventos Traumáticos Recientes de Shapiro (2001). Tiene un formato de tratamiento individual para pacientes que sufren de trauma reciente en curso. Fue desarrollado en campo para tratar incidentes críticos en los que los estresores relacionados al evento original continúan por un período prolongado de tiempo, y en donde no hay un período de seguridad post-trauma para la consolidación de la memoria (ver Jarero et al., 2011 para una descripción detallada del Protocolo).

El EMDR-PRECI utiliza un protocolo de ocho fases. Las fases 1 y 2 se enfocan en la toma de la historia y la preparación, respectivamente. En la fase 3 se evalúan los fragmentos de la memoria perturbadora; con el cliente identificando: la imagen más perturbadora, la creencia negativa relacionada (NC), las emociones, la medición de las unidades subjetivas de perturbación (SUD, por sus siglas en inglés), y la localización de sensaciones corporales. No se pide creencia positiva (CP), ni la medición de validez de la creencia positiva (VOC, por sus siglas en inglés).

Durante la fase 4 (desensibilización), el paciente se enfoca en cada fragmento de la memoria; mientras que, al mismo tiempo, mantiene una atención dual en la estimulación bilateral (EB). Esta última se brinda utilizando movimientos oculares (MO) como primera alternativa, o el abrazo de la Mariposa (AM), como estimulación bilateral alternativa (EBA). Cada fragmento de memoria es procesado mediante el libre procesamiento asociativo de la fase de desensibilización del protocolo estándar de la Terapia EMDR.

La fase 5 se inicia cuando todos los fragmentos han sido reprocesados en la fase 4 y el paciente no identifica más perturbación. Esta fase se aplica para el evento en toda su extensión, con una creencia positiva (CP) global, desarrollada para todo el incidente. Durante la instalación de la CP no se mide frecuentemente el VOC, sino que se lleva a cabo un reprocesamiento completo con EB mientras existan cambios en la información.

En esta fase se realiza un paso suplementario para revisar toda la secuencia manteniendo la CP.

En la fase 6 se utiliza el procedimiento estándar de la Terapia EMDR. En la fase 7 se utilizan las estrategias para auto-modulación post-desastre de Jarero y Artigas (Jarero et al., 2011). Y en la fase 8 se utilizan los procedimientos estándar.
La resiliencia también ha sido descrita como un proceso dinámico en el que las personas muestran una adaptación conductual positiva cuando se encuentran ante la adversidad o un trauma significativo (Luthar, Cicchetti, & Becker, 2000).

De acuerdo con el Modelo del Sistema de Procesamiento de la Información (AIP) de Shapiro (2001), la resiliencia puede ser entendida como la manifestación de redes de información adaptativa, que incluyen memorias procesadas totalmente, de eventos adversos o traumáticos previos, que ya no son perturbadores.

Por lo tanto, una situación estresante subsecuente, estimula las memorias adaptativas, las cuales proveen una base de estabilidad, entendimiento y manejabilidad cuando se experimenta un nuevo trauma. En otras palabras, cuando las personas son confrontadas con una nueva adversidad o evento traumático, tienen la capacidad de accesar a la información adaptativa almacenada en sus redes de memoria para afrontar el reto.

En términos del modelo AIP (Shapiro, 2001), una falta de resiliencia se presenta cuando las memorias asociadas contienen información negativa; es decir, cuando experiencias perturbadoras pasadas no se han procesado completamente y se han almacenado de forma disfuncional en la memoria.

Cuando estas memorias negativas son activadas por estresores actuales, la persona re-experimenta la perturbación pasada y puede sentirse emocionalmente abrumada. Esto resulta en conductas desadaptativas, emociones negativas, creencias negativas sobre si mismo y una capacidad de afrontamiento disminuida. Por lo tanto, los efectos negativos de una capacidad de afrontamiento disminuida, se pueden almacenar en las mismas redes de memoria, disminuyendo la resiliencia; y por lo tanto, creando vulnerabilidad para situaciones estresantes futuras.

La Terapia EMDR está diseñada para identificar y procesar las memorias pasadas que subyacen a las dificultades de afrontamiento; para manejar las situaciones presentes que detonan la perturbación; y para permitir el desarrollo de un patrón de memorias positivas para conductas adaptativas en el futuro (Shapiro, 2001, 2006).

Se piensa que el reprocesamiento de las memorias pivotes, facilita una rápida experiencia de aprendizaje, que transforma la perspectiva y los efectos negativos en unos más neutrales o incluso positivos. Se dice que esto es la base de la resiliencia, pues incrementa la habilidad para afrontar efectivamente estresores subsecuentes.

De acuerdo con Jarero (2010), el reprocesamiento con Terapia EMDR de las memorias almacenadas disfuncionalmente que subyacen a las conductas desadaptativas actuales, puede llevar a una profunda reestructuración de la matriz intrapsíquica de la personalidad. Él ha propuesto que el reprocesamiento de las memorias perturbadoras, puede facilitar que el individuo emplee todo el potencial de su capacidad funcional y sus recursos personales, en futuras circunstancias adversas. Se tiene la hipótesis de que ahí donde el individuo era vulnerable a estrés psicológico, ahora tendrá el potencial de la resiliencia en situaciones de trauma repetido. El papel de la terapia psicológica en relación con la resiliencia, debe ser explorada con mayor profundidad (Alyarian, 2007).

Método

Antecedentes

Durante los últimos años, México ha sufrido de violencia debida al narcotráfico, la cual ha sido extraordinariamente intensa y aterradora, aún para los estándares del crimen organizado. Las organizaciones...
Los grupos criminales han mostrado una férrea voluntad para luchar contra los cuerpos policiales y las fuerzas armadas de México. Han mostrado una creciente ambición por controlar otros mercados informales e ilícitos y por extorsionar negocios legales.

Al encontrarse con que las fuerzas policiales mexicanas estaban invadidas por la corrupción y que no tenían la capacidad para lidiar con el crimen organizado, el presidente Felipe Calderón, envió a las fuerzas militares a las calles de México.

Sin embargo, a pesar de haber tenido algo de éxito al capturar importantes capos de la droga, las fuerzas militares han encontrado una enorme dificultad para terminar con la violencia y reducir la inseguridad para los ciudadanos mexicanos.

Las reformas institucionales que permitan mejorar las fuerzas policiales y el sistema de justicia, a pesar de ser cruciales para ampliar la soberanía de las leyes en México, han avanzado de manera lenta e ineficazmente. Mientras tanto, la paciencia de los mexicanos con respecto a la batalla contra los grupos criminales se está agotando (Felbab-Brown, 2011). El horror y la angustia y el terror.

En abril del año 2011, se descubrieron siete fosas clandestinas con 218 cuerpos mutilados y en descomposición en el estado de Durango en México. Se dijo que las fosas probablemente contenían los restos de personas pertenecientes a grupos delincuenciales ejecutados por sus rivales, víctimas de secuestro e incluso de policías. El trabajo de recuperación e identificación de los cuerpos fue llevado a cabo por peritos forenses de la Procuraduría General del Estado de Durango, quienes estaban fuertemente traumatizados por ésta masiva y aterradora tarea. Además, se convirtieron en el blanco de amenazas de muerte de los carteles de la droga.

En mayo de 2011, la Procuraduría General del Estado de Durango le solicitó a la Asociación Mexicana para la Ayuda Mental en Crisis (AMAMECRISIS), apoyo para atender a los peritos forenses que se encontraban trabajando en las fosas clandestinas y en la morgue (identificación de DNA, huellas dactilares, trabajo de antropología forense, etc.). La Comisión Nacional de los Derechos Humanos (CNDH) cubrió los gastos de traslado de los clínicos EMDR. Los clínicos aplicaron el EMDR–PRECI (Jarero et al., 2011). Se llevó a cabo un estudio de campo para evaluar la eficacia del tratamiento en este contexto (Jarero & Uribe, 2011).

Procedimiento


Las primeras tres fases se realizaron de mayo a julio de 2011 y los resultados se reportaron en una publicación anterior (Jarero & Uribe, 2011). El presente artículo resume los descubrimientos anteriores y reporta los resultados de las dos evaluaciones de seguimiento que se llevaron a cabo a los 3 y 5 meses después de la aplicación del tratamiento; en septiembre y noviembre de 2011.

Medidas

Se administraron la Impact of Events Scale (IES; Horowitz, Wilmer & Álvarez, 1979) y el Short PTSD Rating Interview (SPRINT; Connor & Davidson, 2001; Vaishnavi, Payne, Connor, & Davidson, 2006) en la línea de base, en el pre-tratamiento, en el post-tratamiento y en dos evaluaciones de seguimiento. La aplicación de las escalas la realizaron dos profesionales independientes.

La IES (por sus siglas en inglés) es un cuestionario de auto-evaluación utilizado ampliamente, que consta de 15 reactivos. Es una medida confiable para las reacciones de estrés postraumático (medidas de forma subjetiva), ante un evento estresante o traumático de vida. Las respuestas son evaluadas de acuerdo a una escala Likert, en la que: 0 = nunca, 1 = rara vez, 3 = alguna vez, 5 = frecuentemente.

Los puntajes entre 0 y 8 son considerados como subclínicos; entre 9 y 25 se les considera como de perturbación baja a leve; puntajes entre 26 y 43 se clasifican como perturbación moderada; y los puntajes entre 44 y 75 se consideran como perturbación alta o severa.

El SPRINT (por sus siglas en inglés) es un cuestionario de auto-evaluación de 8 reactivos, con sólidas propiedades psicométricas; que puede servir como una medida confiable, válida y homogénea para evaluar.
la severidad del Trastorno por Estrés Postraumático (TEPT), y del mejoramiento global. Es también una medida para la perturbación somática, el afrontamiento al estrés y el deterioro social, familiar y en el trabajo.

Cada reactivo está clasificado en una escala tipo Likert de 5 puntos: 0 (para nada), 1 (un poco), 2 (moderadamente), 3 (bastante), y 4 (mucho). Las puntuaciones entre 18 y 32 corresponden a síntomas marcados o severos de TEPT; entre 11 y 17 a síntomas moderados; entre 7 y 10 a síntomas leves; y las puntuaciones de 6 ó menos, indican que no hay sintomatología o que ésta es mínima.

El SPRINT también contiene dos reactivos adicionales para medir la mejoría global, de acuerdo a un porcentaje de cambio y a una clasificación de la severidad. Esta escala fue traducida de inglés al español y de español al inglés, y fue revisada y autorizada por uno de sus autores.

El SPRINT se desempeña de forma similar a la escala Clinician Administered PTSD Scale (CAPS), en la evaluación de las agrupaciones de síntomas del TEPT y en el total de la puntuación. Puede ser empleado como un instrumento diagnóstico (Vaishnavi et al., 2006).

Se encontró que en el SPRINT, una puntuación de corte de 14 o más, tenía un 95% de sensibilidad para detectar el TEPT y un 96% de especificidad para descartarlo, con una precisión global de asignación correcta del 96% (Connor & Davidson, 2001).

Participants

Al iniciar el estudio, se realizó una evaluación psicométrica preliminar a los 60 empleados de la Procuraduría General del Estado que estaban trabajando con los cuerpos. Esta evaluación estableció un criterio de selección para las siguientes fases y proporciónó las medidas de la línea de base.

Se aplicaron la IES y el SPRINT y los 32 empleados cuyas medidas de línea de base indicaron la presencia de estrés postraumático y síntomas de TEPT de moderados a severos, se asignaron a 2 grupos. Aquellos con puntajes severos se asignaron al grupo de atención inmediata: GAI (N = 18; 8 mujeres y 10 hombres). Los que obtuvieron puntajes moderados, se asignaron al grupo de atención demorada: GAD (N = 14; 8 mujeres y 6 hombres).

Los 28 participantes que obtuvieron puntajes bajos no recibieron ningún tratamiento, debido a que la investigación ha demostrado que la perturbación leve se puede resolver por sí misma o con intervenciones menos intensivas como la consejería en crisis (Norris, Hamblen, Brown & Schinka, 2008). Como se esperaba, existieron diferencias significativas en la línea base entre el grupo de atención inmediata y el grupo de atención demorada (Jarero & Uribe, 2011), tanto en los puntajes del SPRINT, como de la IES (ver figuras 1 y 2).

Después de recibir una sola sesión del EMDR-PRECI y de terminar la evaluación post-tratamiento, los participantes continuaron con su labor forense durante todo el estudio y siguieron expuestos a estresores horribles. Todos los participantes completaron las evaluaciones de seguimiento a los 3 y 5 meses. La participación en el estudio fue voluntaria. No se registró deserción alguna.

Tratamiento

Los miembros de los grupos de atención inmediata y demorada recibieron una sesión de tratamiento con el EMDR-PRECI. Cada sesión individual tuvo una

**FIGURA 1.** Puntuaciones promedio de la IES en la Línea de Base, Pre-Tratamiento, Post-Tratamiento y dos Seguimientos.
duración de entre 90 a 120 minutos (las fases 1 y 2 duraron de 30 a 35 minutos y la fase de reprocessamiento duró entre 50 y 65 minutos). Solo se aplicó una sesión de tratamiento; esta limitación se debió a la peligrosidad del entorno. El tiempo de estancia estuvo restringido por cuestiones de seguridad.

Resultados

Resultados de las Comparaciones Pre y Post-tratamiento

Los resultados reportados en el estudio del pre y post-tratamiento (Jarero & Uribe, 2011), mostraron que los puntajes en la IES y en el SPRINT aumentaron en los dos grupos al comparar la línea de base y el pre-tratamiento; observándose que los síntomas empeoraron antes de iniciar el tratamiento. La comparación estadística de los puntajes del post-tratamiento obtenidos por el GAI y los puntajes obtenidos en el pre-tratamiento por el GAD, indicaron que el grupo que recibió tratamiento (GAI) obtuvo puntajes significativamente más bajos que el GAD. Estos resultados se dieron aún cuando los puntajes de la línea de base del GAD fueron significativamente menores que los del GAI.

La comparación entre los puntajes obtenidos en el pre-tratamiento y el post-tratamiento, mostraron una mejoría significativa en las medidas de autoevaluación del estrés postraumático y de los síntomas de TEPT para ambos grupos. Estos resultados proporcionan evidencia preliminar de la efectividad del tratamiento del Protocolo EMDR-PRECI con una sola sesión (ver figuras 1 y 2).

Resultados de las Evaluaciones de Seguimiento

El presente estudio de seguimiento reporta los resultados de la fase 4 de la investigación de campo. Este incluye las evaluaciones de seguimiento de los participantes del estudio que se realizaron el 30 de septiembre y el 30 de noviembre del año 2011. En el período transcurrido entre las dos evaluaciones de seguimiento, se descubrieron otras dos fosas clandestinas con 40 cuerpos que requirieron la labor forense de los participantes. Estos últimos recibieron nueva mente amenazas de violencia por parte de los miembros del crimen organizado y padecieron la misma situación de estrés extremo y un ambiente de trabajo aterrador.

**Mejoría Global.** El SPRINT contiene dos reactivos para medir la mejoría global, uno evalúa el porcentaje de cambio y el otro el nivel de severidad: Reactivo 1: ¿Cuánto mejor se ha sentido desde que inició el tratamiento? En un porcentaje del 0 al 100. Reactivo 2: ¿Cuánto han mejorado los síntomas mencionados arriba desde que inició el tratamiento? 1 (empeoraron), 2 (sin cambio), 3 (mínimamente), 4 (mucho), 5 (muchísimo).

En el seguimiento, la media de las respuestas obtenidas en el reactivo 1 para el GAI fue de 80%, y para el GAD fue de 88%. Mientras que para el reactivo 2, la media de respuestas para el GAI fue de (4) mucho, y para el GAD fue de (5) muchísimo.

**Efectos del tratamiento a través del tiempo.** Se utilizó un análisis de varianza (ANOVA) para realizar las comparaciones entre las medidas repetidas para los...
dos instrumentos aplicados (IES y SPRINT), y para ambos grupos (atención inmediata y atención demorada). Los resultados indicaron un efecto significativo del tratamiento a lo largo del tiempo, tanto para el GAI como para el GAD. Para el GAI los puntajes del IES fueron $F(4, 65) = 494.12$, $p < .001$ y los del SPRINT: $F(4, 85) = 157.3$, $p < .001$. Para el GAD los puntajes del IES fueron $F(4, 65) = 174$, $p < .001$ y los del SPRINT: $F(4, 65) = 27.07$, $p < .001$.

La comparación Turkey post-hoc de las medidas de la IES del Tiempo 5 (seguimiento 2), indicó diferencias significativas en las múltiples comparaciones al nivel $p < .05$ (ver Figuras 1 y 2 y Tablas 1 y 2).

### Efectos del Tratamiento para Ambos Grupos entre el Pre-tratamiento y el Seguimiento.

Los investigadores utilizaron una prueba $t$ para muestras pareadas con el objetivo de determinar las diferencias en los puntajes de la IES y el SPRINT entre el pre-tratamiento y el último seguimiento. Dicha prueba se aplicó para el grupo de atención inmediata y para el grupo de atención demorada. Los resultados mostraron un decremento significativo en los puntajes de ambos grupos. Para el GAI, los puntajes de la IES fueron: $t(17) = 37.2$, $p < .001$ y los del SPRINT: $t(17) = 22.70$, $p < .001$. Para el GAD, los puntajes de la IES fueron: $t(13) = 27.88$, $p < .001$ y para los del SPRINT $t(13) = 10.84$, $p < .001$.

### TABLA 1. Puntajes Promedio y Desviaciones Estándar

<table>
<thead>
<tr>
<th></th>
<th>Tiempo 1 Pre-Tratamiento</th>
<th>Tiempo 2 Post-Tratamiento</th>
<th>Seguimiento 1 Tiempo 4</th>
<th>Seguimiento 2 Tiempo 5</th>
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<td></td>
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<tr>
<td>Grupo de Atención Inmediata (GAI)</td>
<td>59.22 (5.41)</td>
<td>65.17 (5.90)</td>
<td>32.17 (4.41)</td>
<td>20.72 (2.16)</td>
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<tr>
<td>Grupo de Atención Demorada (GAD)</td>
<td>31.29 (4.58)</td>
<td>38.21 (3.49)</td>
<td>21.71 (2.27)</td>
<td>14.14 (3.15)</td>
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<td><strong>Short PTSD rating interview SPRINT</strong></td>
<td></td>
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<tr>
<td>Grupo de Atención Inmediata (GAI)</td>
<td>23.83 (3.73)</td>
<td>26.39 (3.45)</td>
<td>14.83 (1.86)</td>
<td>11.05 (1.73)</td>
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<tr>
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<td>16.07 (3.83)</td>
<td>19.71 (6.58)</td>
<td>10.07 (3.95)</td>
<td>7.36 (3.10)</td>
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### TABLA 2. Comparación estadística entre los puntajes del Pre-Tratamiento y el Seguimiento para cada uno de los grupos.

<table>
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<tr>
<th></th>
<th>Tiempo</th>
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<th>$t$</th>
<th>$df$</th>
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<td></td>
</tr>
<tr>
<td>Pre-Tratamiento versus Seguimiento</td>
<td>Tiempo 2 vs. Tiempo 5</td>
<td>65.17 (5.90)/15.83 (1.82)</td>
<td>37.27</td>
<td>17</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Inmediata</td>
<td></td>
<td>38.21 (3.49)/10.85 (2.17)</td>
<td>27.88</td>
<td>13</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Demorada</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Post-tratamiento versus Seguimiento</td>
<td>Tiempo 3 vs. Tiempo 5</td>
<td>32.17(4.41)/15.83 (1.82)</td>
<td>18.37</td>
<td>17</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Inmediata</td>
<td></td>
<td>21.71(2.27)/10.85(2.17)</td>
<td>25.23</td>
<td>13</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Demorada</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short PTSD Rating Interview (SPRINT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Tratamiento versus Seguimiento</td>
<td>Tiempo 2 vs. Tiempo 5</td>
<td>26.39 (3.45)/9.27 (1.12)</td>
<td>22.70</td>
<td>17</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Inmediata</td>
<td></td>
<td>19.71 (6.58)/6.21 (1.96)</td>
<td>10.84</td>
<td>13</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Demorada</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-tratamiento versus Seguimiento</td>
<td>Tiempo 3 vs. Tiempo 5</td>
<td>14.83(1.86)/9.27(1.12)</td>
<td>8.22</td>
<td>17</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>Grupo de Atención Inmediata</td>
<td></td>
<td>10.07(3.95)/6.21(1.96)</td>
<td>6.32</td>
<td>13</td>
<td>$p &lt; .001$</td>
</tr>
</tbody>
</table>
**Comparación entre el Grupo de Atención Inmediata y el Grupo de Atención Demorada.** Se realizó una comparación de los puntajes del seguimiento entre los dos grupos y con ambos instrumentos, utilizando una prueba t para muestras independientes. El objetivo fue conocer el efecto del tratamiento en los dos grupos, mismos que iniciaron el tratamiento con diferencias significativas en las medidas realizadas (IES y SPRINT).

Se encontraron diferencias significativas en la IES: \( t(30) = 7.35; p < .001 \) (con igualdad de varianzas asumidas, de acuerdo a la prueba de Levene para igualdad de varianzas), y en el SPRINT, \( t(19) = 5.19; p < .001 \) (con igualdad de varianzas no asumidas de acuerdo a la prueba de Levene). Los puntajes de las medias de la Fase 4 en ambos instrumentos fueron significativamente menores para el GAD en comparación con el GAI (ver figuras 1 y 2).

**Mantenimiento de los Efectos del Tratamiento.** Se realizó un análisis estadístico para comparar los resultados del post-tratamiento de cada uno de los grupos con sus puntajes finales en el seguimiento. Lo anterior, para evaluar si existió algún cambio en los síntomas reportados entre el post-tratamiento y el seguimiento.

Se utilizó una prueba t de muestras pareadas para comparar los puntajes del post-tratamiento con los puntajes del último seguimiento en ambos grupos. Se encontraron diferencias significativas en la IES para ambos grupos. Para el GAI: \( t(17) = 18.37; p < .001 \) y para el GAD: \( t(13) = 25.23; p < .001 \).

También existieron diferencias significativas en el SPRINT para ambos grupos. Para el GAI: \( t(17) = 18.22; p < .001 \) y para el GAD \( t(13) = 6.32; p < .001 \). Los puntajes de las medias (ver Tabla 1) confirmaron que en los dos instrumentos que se aplicaron y para las dos condiciones de tratamiento (inmediato o demorado), los puntajes no solo se mantuvieron, sino que continuaron dismiuyendo significativamente para el seguimiento 2 (ver Tabla 3).

**Discusión**

Este estudio examinó los resultados del seguimiento de adultos traumatizados que trabajaban bajo circunstancias extremadamente estresantes y a quienes se les aplicó un tratamiento in situ como parte de una intervención enfocada a una necesidad. A estas personas se les aplicó el EMDR-PRECI en dos grupos: grupo de atención inmediata (GAI) y grupo de atención demorada (GAD).

Nuestro estudio anterior (Jarero & Uribe, 2011), mostró que el tratamiento produjo una disminución significativa de los síntomas cuando se comparó el GAI que ya había recibido tratamiento con el GAD. Así como, cuando se compararon los puntajes del pre-tratamiento con los del post-tratamiento.

El estudio actual muestra que los efectos positivos del tratamiento fueron evidentes en los seguimientos que se realizaron a los 3 y 5 meses posteriores a la aplicación del tratamiento, con una disminución significativa en los síntomas del estrés postraumático.

El EMDR-PRECI parece ser un tratamiento eficaz y efectivo para los síntomas del TEPT en situaciones de estrés extremo y en curso.

Antes de que el tratamiento comenzara, entre la evaluación de la línea base y el pre-tratamiento, los participantes mostraron un empeoramiento de los síntomas; lo cual, se reflejó en las mediciones de la IES y el SPRINT (ver Figuras 1 y 2). Esto pudo haberse debido a la continuidad de los eventos estresantes y a las constantes amenazas a las que los participantes de este estudio se encontraban sometidos. Lo que sugiere que sin el tratamiento, los síntomas no hubieran remitido naturalmente con el tiempo.

**Comparación entre el Grupo de Atención Inmediata y el Grupo de Atención Demorada**

Los dos grupos de tratamiento se conformaron colocando a aquellos participantes con puntajes más bajos en el grupo de atención demorada (GAD); y a aquellos

<table>
<thead>
<tr>
<th>TABLA 3. Comparación estadística entre grupos en el seguimiento</th>
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<tr>
<td></td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Impact of Event Scale</td>
</tr>
<tr>
<td>Grupo de Atención Inmediata versus Grupo de Atención Demorada</td>
</tr>
<tr>
<td>Short PTSD rating interview</td>
</tr>
<tr>
<td>Grupo de Atención Inmediata versus Grupo de Atención Demorada</td>
</tr>
</tbody>
</table>
que obtuvieron puntajes más altos y que correspon-
día a una sintomatología más severa, en el grupo de
atención inmediata (GAI). Esta división se realizó por
cuestiones éticas, para proporcionar un alivio rápido a
los que tenían un sufrimiento más intenso.

El presente estudio no tuvo la capacidad de exa-
minar las razones específicas por las que existió una
respuesta diferencial al trauma: la razón por la que
algunos participantes experimentaron síntomas más
severos que otros. Diversos factores pueden explicar
estas respuestas diferenciales. Probablemente aque-
llas personas que tuvieron síntomas más severos
tenían problemas psicológicos pre-existentes, facto-
res de personalidad o algunos otros factores de riesgo
que los hacían más propensos para desarrollar TEPT.

Quiza estuvieron expuestos de manera más intensa al
trauma en el lugar de trabajo, o tuvieron un impacto
más personal o directo por la masacre o por las ame-
nazas dirigidas a ellos o su familia. Se requiere mayor
investigación en el futuro para investigar estos posi-
bles factores.

Las diferencias entre ambos grupos se mantuvie-
ron a lo largo de todo el estudio. A pesar de que el
tratamiento fue eficaz para los participantes con sín-
tomas severos, sus puntajes no alcanzaron niveles
tan bajos como aquellos que empezaron con menos
perturbación.

La diferencia significativa entre los dos grupos fue
evidente en la línea base, en el post-tratamiento y en
los dos seguimientos; con el GAD mostrando consis-
tentemente síntomas menos severos. A pesar de que
una segunda sesión pudo haber sido muy benéfica
para los participantes con puntajes de síntomas más
severos, el tiempo de estancia de los clínicos estuvo
restringido por cuestiones de seguridad, consideran-
do el ambiente tan peligroso. Esto imposibilitó que se
aplicara más de una sesión de tratamiento a cada uno
de los participantes.

Es importante hacer notar que los resultados en los
que se observó que las personas con síntomas más se-
veros en la línea base, obtuvieron también síntomas
más severos en el post-tratamiento, son consisten-
tes con otras investigaciones que han estudiado los
predictores individuales en el curso longitudinal del
TEPT (ej. Ehlers, Mayou, & Bryant, 1998; Marmar
et al., 1999).

El EMDRI-PRECI y la Prevención del
TEPT Crónico

Cuando existe un trauma masivo, es relevante que se
haga una evaluación diagnóstica oportuna del TEPT
(Vaishnavi et al., 2006). Desafortunadamente, debido
a las limitaciones de tiempo (las entrevistas estructu-
radas algunas veces requieren hasta 45 minutos del
tiempo del clínico), en el presente estudio, los tera-
peutas no pudieron administrar una entrevista estructu-
rada como el CAPS, para realizar una evaluación
diagnóstica del TEPT.

Sin embargo, el SPRINT actúa de manera similar
al CAPS en la evaluación de las agrupaciones de sín-
tomas de TEPT y en los puntajes totales. El SPRINT
can ser usado como un instrumento diagnóstico
que sólo requiere de 5 a 10 minutos para ser respon-
dido. Se encontró que en el SPRINT, una puntuación
de corte de 14 o más, tenía el 95% de sensibilidad
para detectar el TEPT y un 96% de especificidad para
descartarlo, con una precisión global de asignación
correcta del 96% (Connor & Davidson, 2001).

Al inicio de este estudio (Jarero & Uribe, 2011),
las mediciones de línea de base se aplicaron a todos
los participantes como una herramienta de selección.
Aquellos participantes cuyos puntajes en el SPRINT
alcanzaron o excedieron el criterio de corte de 14, fue-
ron elegidos para el tratamiento.

Basándonos en el 95% de la sensibilidad del
SPRINT, podemos asumir que en el pre-tratamiento,
todos los participantes de los dos grupos presentaban
síntomas agudos de TEPT (duración de los síntomas
menor a 3 meses).

En las evaluaciones de seguimiento reportadas en
el presente estudio, los puntajes del SPRINT en
el Tiempo 5 (último seguimiento), fueron de 9.27 y
6.21. Esto indica que el TEPT crónico (duración de
los síntomas de 3 meses o más) ya no se presentaba
en ninguno de los grupos. Ningún participante tuvo
un puntaje mayor a 14, lo cual sugiere que ningún
hubiese alcanzado el criterio diagnóstico para TEPT
crónico.

Los resultados estadísticos y la sensibilidad del
SPRINT, permiten a los autores llegar a la conclusión
de que una sesión del EMDR-PRECI ayudó a prevenir
del desarrollo de TEPT crónico en la población de este
estudio.

Debido a que este fue un estudio de campo, no
era éticamente posible mantener un grupo control
sin tratamiento durante los 6 meses de duración del
estudio. Sin embargo, la comparación entre el GAI
antes de recibir el tratamiento, con el GAI después de
recibir el tratamiento, proporcionó un control limita-
dado para los efectos del tiempo. En este período de un
mes, los síntomas del grupo sin tratamiento se de-
terioraron y resultaron significativamente más altos que
los de los participantes del grupo que había recibido
tratamiento, los cuales mostraron una mejoría signifi-
cativa (Jarero & Uribe, 2011).
A pesar de que en estudios logitudinales (Orcutt, Erickson, & Wolfe, 2004), se ha observado un curso natural en la mejoría en los síntomas a lo largo de tiempo; en las circunstancias particulares de este estudio, los participantes estuvieron expuestos continuamente a los horrores de la masacre humana y sufrían de amenazas constantes por parte de los líderes de los cártels en pugna.

Se ha demostrado que la intensidad y duración de la exposición al trauma juega un papel importante en el desarrollo de los síntomas (Norris et al., 2002). Puede anticiparse que los participantes probablemente hubieran desarrollado TEPT crónico, el cual es persistente e inhabilitante (Kessler, 2000). El desarrollo de intervenciones para prevenir el TEPT es una necesidad de salud pública apremiante (Institute of Medicine of the National Academies, 2011).

Estos resultados son relevantes al compararse con la Terapia de Exposición Prolongada (TEP) o la Terapia Cognitiva (TC).

Shalev et al. (2011) llevaron a cabo recientemente un estudio con sobrevivientes de eventos traumáticos que cumplían con los criterios diagnósticos de TEPT en un contexto hospitalario. Los participantes no estuvieron involucrados en otros eventos estresantes. Recibieron 12 sesiones semanales con una duración de 1.5 horas por sesión de TC o TEP (con exposición imaginativa prolongada a las memorias traumáticas, más exposición en vivo a situaciones que evadían las y los participantes).

Los resultados mostraron que la proporción de participantes que continuaron teniendo el diagnóstico de TEPT, 5 meses después del evento traumático (y dos meses post-tratamiento), fue del 21.6% para la TEP y del 20% para la TC. Se registró una deserción total o parcial al tratamiento del 44.4% para la TEP y del 40% para la TC. Shalev et al., concluyeron que la TEP y la TC prevenían de manera eficaz el TEPT crónico en sobrevivientes de eventos traumáticos recientes.

Comparamos dichos resultados con los obtenidos en el presente estudio, en el que una sola sesión de terapia EMDR con el PRECI redujo significativamente los síntomas en los seguimientos realizados a los 3 y 5 meses, donde no se registraron deserciones y donde los puntajes del SPRINT de todos los participantes, se redujeron hasta llegar muy por debajo de las puntuaciones de corte para TEPT (ver la Tabla 4).

Los investigadores consideran que la terapia EMDR es más efectiva para aliviar los síntomas del TEPT que la TCC basada en la exposición; ya sea in vivo o imaginativa. Esto, tomando en cuenta sus rápidos efectos, la baja tasa de deserción y que se obtienen puntajes de perturbación menores después del tratamiento (Fleming, 2012).

El Protocolo EMDR-PRECI y el posible desarrollo de Resiliencia

Antes del tratamiento, los participantes expresaron que estaban agobiados por su labor con los cuerpos mutilados y en descomposición, y por los peligros a los que estaban expuestos constantemente en el contexto en el que estaban trabajando.

Al finalizar la sesión de terapia con el Protocolo EMDR-PRECI, los clínicos observaron importantes indicadores de cambio en los pacientes, tales como: distanciarse del trauma, tener acceso a información más adaptativa, la reducción de los afectos negativos, la reducción de los niveles de perturbación subjetiva y un incremento en la validación de las creencias positivas.

TABLA 4. Comparación entre el estudio de Shalev et al., y el presente estudio

<table>
<thead>
<tr>
<th></th>
<th>Terapia de Exposición Prolongada (TEP)</th>
<th>Terapia Cognitiva (TC)</th>
<th>EMDR-PRECI</th>
</tr>
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<tr>
<td>Análisis Estadístico</td>
<td>ANOVA</td>
<td>ANOVA</td>
<td>ANOVA</td>
</tr>
<tr>
<td>Seguimiento</td>
<td>2 meses post-tratamiento.</td>
<td>2 meses post-tratamiento.</td>
<td>3 y 5 meses post-tratamiento</td>
</tr>
<tr>
<td>Número de sesiones</td>
<td>12 (una a la semana)</td>
<td>12 (una a la semana)</td>
<td>1 sola sesión</td>
</tr>
<tr>
<td>Duración de las sesiones</td>
<td>90 minutos</td>
<td>90 minutos</td>
<td>90–120 minutos</td>
</tr>
<tr>
<td>Eventos estresantes</td>
<td>NO</td>
<td>NO</td>
<td>SI</td>
</tr>
<tr>
<td>post-incidentes en curso</td>
<td>NO</td>
<td>NO</td>
<td>SI</td>
</tr>
<tr>
<td>Exposición en vivo o tarea en casa</td>
<td>SI</td>
<td>SI</td>
<td>NO</td>
</tr>
<tr>
<td>TEPT después del evento traumático y del tratamiento</td>
<td>21.6%</td>
<td>20.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Abandono del tratamiento</td>
<td>44.4%</td>
<td>40%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Algunos ejemplos de creencias positivas mencionadas por los clientes durante la fase global de instalación del EMDR-PRECI fueron: “yo puedo”, “hago lo mejor que puedo”, “puedo elegir en quién confiar”, “soy fuerte”, “he aprendido de esto”, “meremézi vivir”, “meremézi cosas buenas”, “soy una buena persona”, “ahora tengo opciones”, “ahora tengo el control”, “puedo hacer saber mis necesidades”, “soy inteligente”, “pueden confiar en mí”, “meremézi ser feliz”, “soy honorable”.

Parece ser que esta confianza en el auto-control y la auto-eficacia continuó durante meses después de que terminara el tratamiento. Esto, a pesar de que continuaron laborando en el mismo sitio bajo nuevas amenazas del crimen organizado, se encontraron nuevasfosas clandestinas con más cuerpos y se mantuvieron las mismas circunstancias de estrés extremo y de un ambiente de trabajo aterrador.

Aunque la resiliencia no se midió directamente, los resultados estadísticos indican, que el seguir expuestos a un ambiente laboral traumático y la ocurrencia de incidentes similares sucesivos, no causó en los participantes los mismos síntomas perturbadores después de la Terapia EMDR. Por el contrario, crearon menos perturbación. Basados en estos resultados, podemos concluir que los participantes parecen haber desarrollado resiliencia psicológica y emocional.

Estos resultados también proporcionan evidencia preliminar que apoya la hipótesis derivada del Modelo de Procesamiento de la Información (AIP, por sus siglas en inglés) de Shapiro (2001). Este modelo plantea que la resolución adaptativa de memorias perturbadoras, puede llevar a un cambio en los síntomas, en las características personales y en la percepción de sí mismo.

Por lo tanto, un tratamiento efectivo de Terapia EMDR, debe permitir a la persona acceder a una gama más amplia de memorias y experiencias; así como, al potencial para la resiliencia en situaciones de trauma continuo.

De acuerdo a este modelo, cuando las memorias almacenadas de manera disfuncional se han procesado y asimilado en redes de memoria adaptativa, el aprendizaje que ha tenido lugar, se convierte en la base funcional para interpretar y responder a cualquier situación nueva.

La aplicación de este Modelo es indicada en este estudio: Parece ser que cuando los participantes que recibieron el tratamiento, enfrentaron de manera efectiva incidentes similares, la información se conectó con las redes adaptativas, expandiéndolas y ampliando el aprendizaje y los recursos positivos. Por lo que, en cada evento similar, los participantes respondieron con más y más recursos y con un sentido de auto-suficiencia y resiliencia. Esta hipótesis requiere ser probada de manera más directa.

El Protocolo EMDR-PRECI como una Intervención en una Situación de Trauma en Curso

Situaciones de trauma en curso, tales como los desastres urbanos de este estudio - guerra, violencia étnopolítica y desastres naturales o provocados por los humanos - pueden tener efectos nocivos y dolorosos. Los traumas relacionados a la guerra suelen implicar exposiciones repetidas. El impacto negativo que tienen en la salud puede ser más persistente y profundo a largo plazo; con el desarrollo de síntomas duraderos y sufrimiento por décadas. Identificar a individuos traumatizados al inicio de las secuelas y brindarles el acceso a cuidados de salud mental, si el sufrimiento persiste, puede prevenir efectos a largo plazo (Holgersen, Klöckner, Boe, Weisaeth, & Holen, 2011).

Los desastres son eventos traumáticos experienciados de manera colectiva, que tienen un impacto severo y que afectan a grandes cantidades de personas. Después de un desastre, los sobrevivientes pueden comenzar a sufrir alteraciones en su salud mental, tales como: TEPT, trastornos depresivos, abuso de substancias y trastornos de ansiedad (ej. Fobia específica).

Por ejemplo, Meewisse, Olff, Kebler, Kitchiner, y Gerson (2011); reportaron que dos años después de un desastre (explosión de gran magnitud en un depósito central de una fábrica de juegos pirotécnicos en Holanda), el 48.3% de los sobrevivientes cumplían con los criterios diagnósticos de algún trastorno mental, tales como: TEPT, trastornos depresivos, abuso de substancias y trastornos de ansiedad (ej. Fobia específica).

En un estudio que midió la prevalencia de la psicopatología, 3 años después del terremoto de 1999 en Turquía, los resultados obtenidos fueron similares: TEPT (11.7%), depresión (10.5%), y fobia específica (10.0%) (Onder, Tural, Aker, Kiliç, & Erdğöan, 2006).

Los sobrevivientes del terremoto de Haití del año 2010, tendrán que lidiar con las consecuencias los meses y años siguientes, mientras hacen frente a las secuelas de la destrucción (Jordan, 2010).

La posibilidad de utilizar el Protocolo EMDR-PRECI, como componente de un sistema amplio, para prevenir la psicopatología en aquellos que se encuentran en riesgo; y para desarrollar resiliencia y...
terminar con el ciclo de sufrimiento, tiene importantes implicaciones globales.

Algunos de los beneficios del protocolo son: que puede ser aplicado en diferentes escenarios y su sencillez para ser utilizado por practicantes de la Terapia EMDR, tanto novatos como experimentados. Además, es efectivo en cuanto al tiempo, ya que solo se requirió una sesión para lograr la remisión de los síntomas postraumáticos (Jarero & Uribe, 2011). No existe la necesidad de tarea en casa, lo cual facilita una corta duración del trabajo en campo. Es probable que el Protocolo EMDR – PRECI tenga la misma eficacia transcultural que el Protocolo Estándar de EMDR para TEPT (Maxfield, 2008, 2009).

Los resultados de este estudio, apoyan el punto de vista de que el EMDR-PRECI, puede ser utilizado como una intervención temprana efectiva, en el escenario natural de una situación de masacre humana, al ser aplicado a un grupo de adultos traumatizados, que trabajan en situaciones de estrés extremo, en las que no existe un periodo de seguridad post-trauma para la consolidación de la memoria.

Obteniéndose con la intervención: la reducción de los síntomas del estrés postraumático y del TEPT reportados en medidas de auto-evaluación, la prevención del desarrollo de TEPT crónico y el desarrollo de mecanismos de resiliencia psicológica y emocional.

Los autores recomiendan realizar mayor investigación en el futuro sobre la aplicación del EMDR-PRECI, con el objetivo de comprender mejor las fases tempranas del trauma, cuando parece haber una falta de consolidación de la memoria, debido a que no existe un periodo de seguridad post-trauma, mismo que evita la consolidación del incidente crítico original en la memoria; o en eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo traumático a vida enseñando a los aprendizajes de eventos de larga duración no resueltos (Ej. duelo

References


EMDRIA definition of EMDR. EMDRIA Newsletter.


**Reconocimientos.** Los autores agradecen a José Antonio Fernández, Alaide Miranda y Martha Givaudán su trabajo en este proyecto humanitario.

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La violencia infantil es un fenómeno multidimensional que debe ser atendido con respuestas diversas. Proteger a las niñas y niños contra la violencia es un asunto urgente. Durante siglos han sufrido de violencia por parte de los adultos que ha pasado desapercibida. Los niños y niñas deben ser provistos de una prevención y protección efectiva para desarrollar recursos psicológicos, y en el que se les administró el Protocolo Grupal e Integrativo con Terapia de Reprocesamiento y Desensibilización a través del Movimiento Ocular (EMDR-IGTP) y terapia individual de EMDR, para la resolución de las memorias traumáticas. Las sesiones de terapia individual de EMDR, se administraron a 26 niños y niñas que aún presentaban perturbación relacionada con las memorias traumáticas elegidas como blanco, después de la administración del Protocolo Grupal e Integrativo con EMDR. Los resultados mostraron una mejora significativa en la Escala Child’s Reaction to Traumatic Events Scale (CRTES) y en el Short PTSD Rating Interview (SPRINT) para todos los participantes. Estos resultados se mantuvieron en el seguimiento. Es necesario realizar más investigación para evaluar el Protocolo Grupal e Integrativo con EMDR y la terapia individual de EMDR, como parte de una aproximación terapéutica multi-modal para el tratamiento de niños que han sufrido violencia interpersonal severa.

Palabras clave: Protocolo Grupal e Integrativo con EMDR; EMDR con niños, trauma complejo, trauma interpersonal en niños, terapia multi-componente y en fases.

This is a modified translation of an article originally published as Jarero, I., Roque-López, S., Gómez, J. (2013). The Provision of an EMDR-Based Multicomponent Trauma Treatment with Child Victims of Severe Interpersonal Trauma. Journal of EMDR Practice and Research, 7(1), 17–28. Translated by Ignacio Jarero.
Aquellos que han sufrido de abuso, comúnmente desarrollan síntomas adicionales relacionados con la auto-eficacia y la sexualidad (Van der Kolk, 2002).

Un maltrato excesivo en la infancia, se asocia con diversos efectos biológicos que alteran el desarrollo neurológico (De Bellis & Van Dillen, 2005). Esta vulnerabilidad biológica genera déficits en el procesamiento de las emociones y en el funcionamiento ejecutivo, que lleva a una auto-regulación deficiente y a trastornos psiquiátricos posteriores, tales como TEPT, depresión y otros problemas emocionales (Van der Kolk, 2005). La investigación sobre Trastorno por Estrés Posttraumático entre jóvenes que son objetos de maltrato ha prosperado debido a la importante prevalencia del trastorno entre este grupo (Pecora, White, Jackson, & Wiggins, 2009).

**Tratamiento de Niños que han sufrido abuso**

Una aproximación multi-componente y en fases se recomienda ampliamente para el tratamiento del estrés traumático complejo (e.g. Courtois & Ford, 2009). La primera fase de tratamiento se focaliza en la seguridad del paciente, en la estabilización de los síntomas y en el mejoramiento de sus competencias básicas de vida. La segunda fase, incluye la exploración de las memorias traumáticas, reduciendo primero la perturbación emocional aguda causada por dichas memorias, y posteriormente re-evaluando su significado para integrarlas en una identidad positiva y coherente.

La International Society for Traumatic Stress Studies (ISTSS), condujo una encuesta entre clínicos expertos, sobre las mejores prácticas para tratar el Trastorno por Estrés Posttraumático (TEPT) Complejo (Cloitre et al., 2011). Las aproximaciones para la primera fase de tratamiento que recibieron la más alta calificación, fueron las estrategias focalizadas en las emociones y para la regulación de las mismas; mientras que, la educación acerca del trauma y la Atención Plena (mindfulness), obtuvieron el segundo lugar. Dentro de las aproximaciones para la segunda fase de tratamiento, la terapia individual fue identificada como de primera línea para el procesamiento de las memorias traumáticas y la conjunción del trabajo grupal con terapia individual, obtuvo el segundo lugar.

**La Terapia de Re procesamiento y Desensibilización a través del Movimiento Ocular**

La Terapia de Reprocesamiento y Desensibilización a través del Movimiento Ocular (EMDR, por sus siglas en inglés), es recomendada para el tratamiento del Trastorno por Estrés Posttraumático, tanto en adultos como en niños, por numerosas directrices internacionales como la Cochrane Review (Bisson & Andrew, 2007) y el National Collaborating Centre for Mental Health (2005). Existe también evidencia preliminar que apoya su aplicación en el tratamiento de otros trastornos psiquiátricos, para varios problemas de salud mental y síntomas somáticos.


Se piensa que esto afecta la habilidad del individuo para integrar estas experiencias de forma adaptativa. Se dice que la Terapia EMDR, la cual consiste en un proceso de 8 fases y tres etapas, facilita la reanudación del procesamiento normal de información y la integración de la misma.

Esta aproximación terapéutica que se enfoca en la experiencia pasada, los detonantes actuales y los retos potenciales a futuro, puede frecuentemente dar como resultado, el alivio de los síntomas presentes, con la disminución o desaparición de la perturbación relacionada a las memorias traumáticas; una imagen más positiva de sí mismo, el alivio de las molestias corporales, y la resolución de detonantes presentes, o los que se puedan presentar en el futuro.

El esclarecimiento y evolución de los mecanismos neurobiológicos (desconocidos para cualquier forma de psicoterapia) y de los modelos teóricos, está avanzando a través de la investigación y el desarrollo de la teoría (Asociación Internacional de EMDR [EMDRIA, por sus siglas en inglés], 2011).


Existen pocos estudios, que han investigado específicamente el tratamiento con terapia EMDR, en niños con traumas Tipo 2 (experiencias duraderas, como abuso sexual o guerra; Fleming, 2012).

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Un ensayo aleatorio controlado, realizado por Jaberg Maher, Rubin, Zands y Dolatabadi (2004), evaluó la administración de la Terapia EMDR o de la Terapia Cognitivo Conductual (TCC), a 14 niñas iraníes de edades entre los 12 y 13 años, quienes fueron abusadas sexualmente.

A pesar de que las niñas reportaban síntomas de trauma y el profesor reportó problemas de conducta, no se realizó ninguna evaluación diagnóstica. Las pacientes pudieron recibir hasta 12 sesiones de tratamiento. Hubo un mínimo de 10 sesiones para la TCC pero no para la Terapia EMDR, resultando ésta última significativamente más eficaz que la TCC. Se administraron medidas de auto-reporte, reporte de los padres de familia y reporte de los maestros, antes de recibir el tratamiento y dos semanas después del tratamiento. No existió diferencia significativa entre los tratamientos. Tanto la Terapia EMDR como la TCC, produjeron efectos de gran magnitud en los resultados de la sintomatología posttraumática y efectos de mediana magnitud en el decremento de los problemas conductuales en clase.

Wadda, Zaharin y Alqashan (2010), evaluaron la prevalencia de los síntomas del TEPT en niños que emigraron a Malasia huyendo de la guerra en Irak, y encontraron que el 68.5% presentaban dicha sintomatología. Los padres de 12 de estos niños (de edades entre 7 y 12 años) accedieron a que sus hijos recibieran 12 sesiones de terapia EMDR. En la medición realizada antes del tratamiento (pre-tratamiento), no se encontraron diferencias estadísticamente significativas en los puntajes de la evaluación del TEPT entre los dos grupos de niños (con tratamiento y sin tratamiento), sin embargo, en la medición post-tratamiento, los puntajes del grupo que recibió Terapia EMDR se redujeron significativamente.

**El Protocolo Grupal e Integrativo con EMDR**

El Protocolo Grupal e Integrativo con EMDR (EMDR-IGTP, por sus siglas en inglés), fue desarrollado por miembros de la Asociación Mexicana para Ayuda Mental en Crisis (AMAMECRISIS), para enfrentar la enorme necesidad de servicios de salud mental después de que el Huracán Paulina devastara las costas del oeste de México en el año de 1997.


Este protocolo ha sido utilizado en numerosos sitios alrededor del mundo, en su formato original o con adaptaciones para adecuarse a las circunstancias (Gelbach & Davis, 2007; Maxfield, 2008). Reportes de casos y estudios de campo han documentado su efectividad con niños y adultos después de desastres naturales o provocados por el hombre, durante trauma de guerra en curso y crisis geopolíticas (Shapiro, 2001; Jarero & Artigas, 2009; Jarero, Artigas, Jackson, & Hartung, 2006; Jarero, Artigas, Mauer, López Cano, & Alcalá, 1999; Jarero, Artigas, y Montero, 2008; Zaghrou-Hodali, Alissa, & Dodgson, 2008).

Una nueva aplicación de este protocolo para trauma interpersonal, fue probada en la República Democrática del Congo, en donde un estudio de campo mostró que después de dos sesiones con el Protocolo Grupal e Integrativo con EMDR, las 50 adultas que habían sido víctimas de violación, reportaron el cese de los síntomas de TEPT y del dolor en la parte baja de su espalda (Allon, citado por Shapiro, 2011).

**La Organización Inocencia en Peligro**

Inocencia en Peligro (Innocence un Danger, IID, por sus siglas en inglés; 2011), es un movimiento mundial para la protección de los niños contra la violencia y la explotación sexual. Es una organización no lucrativa y no gubernamental creada por un grupo de civiles el 15 de abril de 1999. Su objetivo es implementar el plan de acción de la Junta de Expertos de la UNESCO, convocada en enero de 1999 para tratar el abuso infantil, la pornografía infantil y la pedofilia en internet. Los comités de trabajo de IID se enfocan en aumentar la conciencia pública, a través de los medios, sobre el creciente problema de la criminalidad relacionada a la pedofilia y de dar apoyo directo a niños de los 0 a los 18 años que han sufrido abuso, a través de procedimientos terapéuticos y jurídicos (IID, 2011).

Inocencia en Peligro (IID) opera en 29 países por todo el mundo con socios que comparten los mismos objetivos. Reúne militantes que son especialistas en internet, abogados, tomadores de decisiones políticas, empresarios, medios de comunicación y grupos de acción nacional. Tiene agencias en Francia, Suiza, Alemania, Estados Unidos, Inglaterra y Colombia.

Cada agencia funciona como una asociación en su país y es independiente económicamente de las otras.

Desde 2008 Inocencia en Peligro-Colombia, inició sus operaciones en la ciudad de Cali, una ciudad ubicada en el suroeste del país. Su misión humanitaria, es proporcionar apoyo y tratamiento psicológico.
a niños y niñas víctimas de violencia y abogar por la protección de todos los niños, mediante la educación de la sociedad colombiana acerca del maltrato infantil en todas sus formas. IID-Colombia pretende ser una organización especializada en la atención y prevención de traumas y del estrés postraumático generado por violencia, particularmente sexual hacia niños y adolescentes. Se esfuerza por incluir a las familias y en desarrollar redes de apoyo que ayuden en este proceso.

Antes de este estudio y desde su creación, IID – Colombia había llevado a cabo tres campamentos de recuperación del trauma. Cada campamento fue de 7 días, durante los cuales los niños y niñas permanecieron en dormitorios en la Ciudad de Cali o con sus familias en diferentes ciudades de la región. En los 3 campamentos se administró tratamiento grupal con terapia EMDR a un total 70 niños y niñas (14 en el primer campamento, 24 en el segundo y 32 en el tercero) con edades entre los 9 y 14 años, quienes habían sufrido diversos tipos de abuso. El tratamiento incluyó actividades de grupo y Terapia EMDR. Las actividades se enfocaron principalmente en la expresión corporal y verbal, en contactar con sus emociones y en trabajar su potencial creativo a través del arte. Durante los tres primeros campamentos, se implementaron y probados los procedimientos, mismos a los que se les fueron haciendo modificaciones para optimizar la experiencia de los niños. Los resultados promisorios de esos campamentos alentaron a los autores a realizar un cuarto campamento como un estudio de investigación.

Método

Participantes

Al presente campamento de recuperación del trauma, asistieron 34 niños y niñas (18 niños y 16 niñas) con edades entre los 9 y 14 años. Todos habían sido víctimas de violencia interpersonal severa (e.g., violación, abuso sexual, violencia física y emocional, negligencia, abandono).

La mayoría (n = 32) habían sido víctimas de violación o abuso sexual. Un grupo (n = 19, 11 niños y 8 niñas) provenía de una institución acreditada por el Instituto Colombiano de Bienestar Familiar (ICBF). Estos niños habían vivido en la calle o habían sido separados de sus familias por su conducta problemática. El otro grupo (n = 15, 7 niños y 8 niñas), vivían con sus familias y habían sido víctimas de violación, abuso sexual y violencia física y emocional. Ninguno de los niños había recibido tratamiento especializado en trauma previo al campamento.

Procedimiento

El campamento de recuperación (CRT) del trauma se llevó a cabo del 1 al 7 de diciembre de 2011. La investigación se realizó en 8 etapas:

Etapas 1 al 7 de diciembre de 2011.

1. Previo al inicio del CRT, los psicólogos de la institución acreditada por ICBF, se reunieron individualmente con los niños y un miembro de la familia o de la institución, para elaborar la historia clínica y para escoger con los menores la memoria traumática que se reprocesaría durante el campamento.

2. Los niños y niñas recibieron un tratamiento para el trauma, que consistió en una aproximación terapéutica multi-componente y en fases. El 5 de diciembre se realizó la evaluación pre-tratamiento con Terapia EMDR, y el tratamiento grupal con terapia EMDR, fue administrado los días 5 y 6 de diciembre del 2011. Se realizaron los planes de dar terapia individual de EMDR a 26 niños cuya puntuación de Unidades Subjetivas de Perturbación (SUD, por sus siglas en inglés) no llegó a cero durante la intervención grupal.

3. Durante el CRT, los niños y niñas recibieron un tratamiento para el trauma, que consistió en una aproximación terapéutica multi-componente y en fases. El 5 de diciembre se realizó la evaluación pre-tratamiento con Terapia EMDR, y el tratamiento grupal con terapia EMDR, fue administrado los días 5 y 6 de diciembre del 2011. Se realizaron los planes de dar terapia individual de EMDR a 26 niños cuya puntuación de Unidades Subjetivas de Perturbación (SUD, por sus siglas en inglés) no llegó a cero durante la intervención grupal.

4. Los niños y niñas recibieron un tratamiento para el trauma, que consistió en una aproximación terapéutica multi-componente y en fases. El 5 de diciembre se realizó la evaluación pre-tratamiento con Terapia EMDR, y el tratamiento grupal con terapia EMDR, fue administrado los días 5 y 6 de diciembre del 2011. Se realizaron los planes de dar terapia individual de EMDR a 26 niños cuya puntuación de Unidades Subjetivas de Perturbación (SUD, por sus siglas en inglés) no llegó a cero durante la intervención grupal.

5. Después del CRT, entre los días 12 y 16 de diciembre de 2011, se administró la terapia individual de EMDR a 6 niños (los 11 que vivían en instituciones fuera de la Ciudad de Cali), cuyas puntuaciones de SUD para la memoria traumática elegida como blanco (diana), no alcanzaron 0 durante la intervención grupal. Dos niños recibieron una sesión individual de EMDR y 4 niños recibieron 2 sesiones.

6. Después del CRT, entre los días 12 y 16 de diciembre de 2011, se administró la terapia individual de EMDR a 6 niños (los 11 que vivían en instituciones fuera de la Ciudad de Cali), cuyas puntuaciones de SUD para la memoria traumática elegida como blanco (diana), no alcanzaron 0 durante la intervención grupal. Dos niños recibieron una sesión individual de EMDR y 4 niños recibieron 2 sesiones.

7. Después del CRT, entre los días 12 y 16 de diciembre de 2011, se administró la terapia individual de EMDR a 6 niños (los 11 que vivían en instituciones fuera de la Ciudad de Cali), cuyas puntuaciones de SUD para la memoria traumática elegida como blanco (diana), no alcanzaron 0 durante la intervención grupal. Dos niños recibieron una sesión individual de EMDR y 4 niños recibieron 2 sesiones.

8. Después del CRT, entre los días 12 y 16 de diciembre de 2011, se administró la terapia individual de EMDR a 6 niños (los 11 que vivían en instituciones fuera de la Ciudad de Cali), cuyas puntuaciones de SUD para la memoria traumática elegida como blanco (diana), no alcanzaron 0 durante la intervención grupal. Dos niños recibieron una sesión individual de EMDR y 4 niños recibieron 2 sesiones.

9. Después del CRT, entre los días 12 y 16 de diciembre de 2011, se administró la terapia individual de EMDR a 6 niños (los 11 que vivían en instituciones fuera de la Ciudad de Cali), cuyas puntuaciones de SUD para la memoria traumática elegida como blanco (diana), no alcanzaron 0 durante la intervención grupal. Dos niños recibieron una sesión individual de EMDR y 4 niños recibieron 2 sesiones.

10. Después del CRT, entre los días 12 y 16 de diciembre de 2011, se administró la terapia individual de EMDR a 6 niños (los 11 que vivían en instituciones fuera de la Ciudad de Cali), cuyas puntuaciones de SUD para la memoria traumática elegida como blanco (diana), no alcanzaron 0 durante la intervención grupal. Dos niños recibieron una sesión individual de EMDR y 4 niños recibieron 2 sesiones.
primer día, mientras que, los niños que provenían de alguna institución ubicada fuera de la Ciudad de Cali (n = 11) asistieron el segundo día. Estas jornadas consistieron en un día de actividades recreativas, artísticas y de Atención Plena (mindfulness). Su objetivo fue que los niños continúen el proceso de sanación interna y de recuperación psicológica que iniciaron en el campamento: practicar el contacto consigo mismos, estar abiertos a los otros y socializar de manera empática.

Etapas 8: Del 8 al 10 de febrero del 2012, se aplicó la evaluación de seguimiento.

Medidas

Aplicación de Escalas

Se aplicaron la escala Short PTSD Rating Interview (SPRINT; Connor & Davidson, 2001; Vaishnavi, Payne, Connor, & Davidson, 2006) y la Child’s Reaction to Traumatic Events Scale (CRTES; Jones, 1997) a los niños y niñas durante el CRT (Etapa 3), antes de administrar el Protocolo Grupal e Integrativo con EMDR y la terapia individual de EM. Estas medidas también se aplicaron en el post-tratamiento (Etapa 6) y en el seguimiento (Etapa 8). La aplicación fue realizada por psicólogos clínicos con experiencia en el Protocolo Grupal e Integrativo con EMDR. Estas medidas proporcionan puntajes para dos sub-escalas: intrusión y evitación.

La Escala Short PTSD Rating Interview

La Escala Short PTSD Rating Interview (SPRINT, por sus siglas en inglés; Connor & Davidson, 2001; Vaishnavi et al., 2006), es un cuestionario de auto-evaluación de 8 reactivos, con sólidas propiedades psicométricas; que puede servir como una medida confiable, válida y homogénea, de la severidad del TEPT y del mejoramiento global; así como una medida de la perturbación somática, afrontamiento al estrés y del deterioro social, familiar y laboral.

Cada reactivo está clasificado en una escala de 5 puntos: 0 (para nada), 1 (un poco), 2 (moderadamente), 3 (bastante), y 4 (mucho). Las puntuaciones entre 18 y 32, corresponden a síntomas marcados o severos de TEPT. De 11 a 17, corresponden a síntomas moderados. De 7 a 10, a síntomas leves, y las puntuaciones de 6 o menos, indican que no hay sintomatología o que ésta es mínima.

El SPRINT también contiene dos reactivos adicionales para medir la mejoría global, de acuerdo a un porcentaje de cambio y a una clasificación de la severidad. Esta escala fue traducida de inglés al español y de español al inglés, revisada, autorizada por uno de sus autores y adaptada a un lenguaje adecuado para niños.

El SPRINT se desempeña de forma similar a la Clinician-Administered PTSD Scale (CAPS), en la evaluación de las agrupaciones de síntomas del TEPT y en el total de la puntuación. Puede ser empleado como un instrumento diagnóstico (Vaishnavi et al., 2006). Se encontró que en el SPRINT, una puntuación de corte de 14 o más, tenía un 95% de sensibilidad para detectar el TEPT y un 96% de especificidad para descartarlo, con una precisión global de asignación correcta del 96% (Connor & Davidson, 2001).

La Child’s Reaction to Traumatic Events Scale

La Child’s Reaction to Traumatic Events Scale (CRTES, por sus siglas en inglés; Jones, 1997) se derivó de la Escala del Impacto de Eventos (Impact of Events Scale; Horowitz, Wilner, & Alvarez, 1979). Es una escala de auto-reporte de 15 reactivos, diseñada para evaluar las respuestas psicológicas a eventos estresantes de la vida. Las respuestas se clasifican en escala Likert: 0 (nunca), 1 (raramente), 3 (algunas veces) y 5 (frecuentemente). Además del puntaje total, el CRTES proporciona puntajes para dos sub-escalas: intrusión y evitación.

Los puntajes menores de 9 son clasificados como baja perturbación, entre 9 y 18 se considera perturbación moderada y de 19 o más, como alta perturbación. A pesar de ser una evaluación de auto-reporte, los adultos capacitados para apoyar a los niños, a quienes se les denominó el Equipo de Protección Emocional (EPE), leyeron las preguntas en voz alta a los niños más pequeños. Sus respuestas fueron grabadas por el EPE. Esta evaluación se aplicó a los niños antes del tratamiento (pre-tratamiento), una semana después del tratamiento (post-tratamiento) y en el seguimiento tres meses después.

Escala de Unidades Subjetivas de Perturbación

Se utilizó una modificación de la Escala de Unidades Subjetivas de Perturbación (SUD, por sus siglas en inglés; Shapiro, 2001; Wolpe 1958). En lugar de solicitar a los niños y niñas que simplemente reportaran su nivel de perturbación, se les mostraron dibujos de caras que representaban diferentes niveles de emociones negativas (de 0 a 10, en donde 0 no mostraba ninguna perturbación y 10 mostraba perturbación severa), y se les pidió que seleccionaran la que mejor representara su emoción y que escribieran el número correspondiente en el dibujo.
Para realizar esta actividad, los niños fueron apoyados por miembros del Equipo de Protección Emocional. Las puntuaciones de SUD son una parte integral del tratamiento con la Terapia EMDR (Shapiro, 2001), y su empleo ha sido demostrado en estudios de Terapia EMDR con adultos con trauma psicológico. Por ejemplo, se ha mostrado que la escala SUD tiene buena concordancia con medidas fisiológicas autónomas de ansiedad pre y post-tratamiento (e.g., Wilson, Silver, Covi, & Foster, 1996). La disminución en la excitación fisiológica y la relajación, se relacionaron con un decremento en las puntuaciones de SUD al final de una sesión (Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008). Asimismo, las puntuaciones de SUD fueron correlacionadas significativamente con una mejora post-tratamiento medida por terapeutas (Kim, Bae, & Park, 2008).

Tratamiento

Taller Pre-campamento para el Equipo que administró el tratamiento.

Antes de que iniciara este campamento de recupercación del trauma y el estudio de investigación, dos de los autores (SRL y JG) llevaron a cabo un retiro para capacitar a todo el equipo adulto que participaría en el campamento (psicólogos, trabajadores sociales, artistas, educadores). Se les brindó educación sobre el tratamiento del trauma, y sobre los aspectos teóricos de la Terapia EMDR. Se les explicó que en el tratamiento de memorias traumáticas complejas, la Terapia EMDR es un componente de un plan integral de tratamiento (Tinker & Wilson, 1999).

La capacitación también se centró en la importancia de reducir la sobre-excitación del sistema nervioso simpático. Se resaltó el valor de las actividades que se llevarían a cabo durante el campamento, ya que éstas fueron diseñadas para facilitar una experiencia de seguridad y estabilidad emocional (Courtois & Ford, 2009).

Se puso especial atención en informar a los miembros del Equipo de Protección Emocional, sobre la importancia de tener siempre una presencia profundamente respetuosa y amorosa en los momentos emocionalmente difíciles (Jarero et al., 2008). También se les explicó que este tipo de presencia, podría incrementar las redes de memoria de información positiva, convirtiéndose en un recurso para futuro para los niños y las niñas.

En el taller también se dio información acerca del tratamiento del trauma, y se revisaron las estrategias de focalización y regulación de las emociones, así como de la práctica de la Atención Plena (Servan-Schreiber, 2003).

Panorama General del Tratamiento

Durante el campamento se llevó a cabo un abordaje de tratamiento del trauma multi-componente y en fases. Esta aproximación para abordar el estrés traumático complejo fue recomendada por Courtois y Ford (2009). La primera fase de tratamiento se enfoca en la seguridad del paciente, en la estabilización de síntomas y en el mejoramiento de sus competencias básicas de vida. La segunda fase, incluye la exploración de las memorias traumáticas, reduciendo primero la perturbación emocional aguda causada por dichas memorias, y posteriormente re-evaluando su significado para integrarlas en una identidad positiva y coherente.

Los estudios empíricos que han incluido solo personas con historias de trauma complejo, han encontrado que el procesamiento de las memorias traumáticas es razonablemente bien tolerado y beneficioso, cuando se lleva a cabo de forma multi-componente (e.g., Chard, 2005).

Podría existir una ventaja al integrar la Terapia EMDR con otros tratamientos, cuando también se necesite abordar trastornos comórbidos o problemas sociales, que puedan influir en la respuesta al tratamiento (Fleming, 2012).

Tufnell (2005) concluye que la Terapia EMDR, cuando se utiliza en combinación con otros tratamientos, puede ser apropiada para niños y adolescentes con problemas de salud mental comórbidos.

En el presente estudio, la primera fase del tratamiento del trauma, incluyó una gama de actividades para desarrollar estabilización emocional y competencias de vida, en el contexto de un campamento terapéutico de recuperación del trauma. Esta investigación examinó la efectividad de la segunda fase del tratamiento del trauma, utilizando una combinación de terapia EMDR grupal e individual.

Primera Fase del Tratamiento del Trauma

Es importante señalar que la primera fase del tratamiento del trauma, corresponde a las Fases 1 y 2 de los procedimientos estándar de la Terapia EMDR y del Protocolo Grupal e Integrativo con EMDR. Esta fase incluyó la sesión de toma de la historia, la cual fue llevada a cabo por los psicólogos de la institución acreditada antes del campamento, y todas las experiencias, desde el día en que los niños y niñas llegaron, el 1 de diciembre, hasta el día en que dejaron el campamento, el 7 de diciembre.
Las actividades del campamento incluyeron lo siguiente:

Por la mañana, las niñas y los niños se despertaban temprano para practicar gimnasia suave y hatha yoga. El propósito de estas actividades, fue apoyar el proceso de salud mental (Patanjali, 1991). La práctica de yoga ha sido empleada como una intervención para tratar el estrés traumático, ya que facilita el incremento de un estado de ánimo positivo, la aceptación y una actitud de paz, a través del cuidado del cuerpo y el control de la respiración (Van der Kolk, 2012).

Durante cada día, los menores se involucraron en varias actividades y talleres. Por ejemplo, un día visitaron el Museo del Oro en Cali, Colombia, como una experiencia cultural y de participación en la vida de la ciudad. Cada noche, antes de ir a dormir, los niños y las niñas tenían una fiesta con historias, relajación con sonidos suaves y música infantil.

1. El arte en diferentes expresiones
   Se llevaron a cabo varios talleres de arte guiados por artistas profesionales para ayudar a los niños a contactar con su potencial creativo:
   (a) El taller de pintura “Recobrando al niño/niña que soy”, tuvo como propósito que los niños encontraran a “su niño interior”, que está más allá del dolor y del sufrimiento, y de esta manera, experimentar seguridad y confianza (Tafurt, comunicación personal, julio 3, 2011);
   (b) Se realizaron dos talleres de música: en el taller “Acercándonos a la música a través del ritmo”, los niños se dividieron en grupos para descubrir el concepto de ritmo y crear una pieza rítmica colectiva. En el taller “La música y mis sensaciones, yo creo una historia”, cada niño escribió una historia inspirada en lo que experimentaron con la música (alegría, tristeza, ternura, misterio, etc.);
   (c) En el taller de escultura, los niños descubrieron el barro como material, y después de escuchar una historia con animales como protagonistas, cada niño modeló a los animales que más le gustaron, los pintaron y decoraron;
   (d) En el taller de teatro, los niños presenciaron la escenificación: “El perro amigo del EMDR” (Meignant, 2007), con el objetivo de comprender la utilidad de las estimulaciones bilaterales. Este taller se realizó el mismo día que se aplicó el Protocolo Grupal e Integrativo con EMDR, pero antes del mismo.

2. Actividades Físicas
   Los niños y niñas se involucraron en varias actividades deportivas y recreativas, que tuvieron como propósito terapéutico alcanzar los bien conocidos beneficios del ejercicio físico, mejorar las habilidades sociales y ayudarles a reconciliarse con sus cuerpos y con el mundo que los rodea (Binswanger, 1971).

3. La práctica de la regulación emocional y la armonización
   El objetivo de estas actividades fue que los niños y niñas regularan sus percepciones, pensamientos, emociones y conductas para generar armonía interior. Estas prácticas se llevaron a cabo durante las siguientes actividades:
   (a) Historias y relajación siguiendo las recomendaciones de Lovett (1999). Al inicio, la historia presenta algo positivo con el fin de atraer la atención de los niños, posteriormente se describe un evento traumático y los síntomas relacionados, y al final, la historia concluye con la resolución del trauma y creencias positivas;
   (b) Los niños aprendieron la práctica de la Atención Plena (Mindfulness; Williams, Teasdale, Segal, & Kabat-Zinn, 2007), con el fin de aprender a observar la experiencia directa de su cuerpo, y para desarrollar una actitud compasiva hacia ellos mismos (Nhat-Hanh, 1974). También realizaron el ejercicio de coherencia cardíaca (Deglon, 2006);
   (c) En el taller de valores humanos, los niños y niñas usaron su imaginación y creencias positivas, para visualizar un futuro lleno de posibilidades realistas e integradas con valores humanos profundos;
   (d) La orientación espiritual se enseñó no desde una visión religiosa, sino alentando a los niños y niñas a cuidar de sí mismos y del mundo que les rodea;
   (e) Se les dieron masajes biodinámicos psicoterapéuticos a los niños, para favorecer la relajación y contribuir a que tuvieran sentimientos de seguridad dentro de su propio cuerpo (Boyesen, 1985).

4. Preparación específica para la Terapia EMDR
   Para prepararse para la Terapia EMDR, los niños realizaron una actividad teatral llamada “El delfín y la muñeca Lupita”, en donde aprendieron la técnica de la respiración abdominal y el reconocimiento de emociones. Ambas actividades se describen en el Protocolo Grupal e Integrativo con EMDR para niños (Jarero et al., 2008).
Las actividades de “crear su lugar seguro” y “normalizar las reacciones” (que tienen como propósito que los niños reconozcan, valoren y normalicen los signos y síntomas del estrés postraumático), se realizaron como se describe en el Protocolo Grupal e Integrativo con EMDR para niños. Miembros del Equipo de Protección Emocional, apoyaron a los niños en el aprendizaje y la práctica del Abrazo de la Mariposa (Artigas, 2011), y completaron el ejercicio de “las caritas de las emociones”, una herramienta empleada en el Protocolo Grupal e Integrativo con EMDR, para enseñar a los niños a observar y comunicar sus niveles de perturbación emocional y las puntuaciones de SUD.

Segunda Fase del Tratamiento para el Trauma

Es importante hacer notar que la segunda fase de tratamiento del trauma, corresponde a las Fases 3 a 7 de la Terapia EMDR (Shapiro, 2001). En el presente estudio se empleó el Protocolo Grupal e Integrativo con EMDR con los 34 participantes, y la terapia individual de EMDR con 26 participantes.

El Protocolo Grupal e Integrativo con EMDR estuvo incorporado dentro de las actividades del campamento. Las sesiones individuales de EMDR se administraron el último día del campamento, a 6 participantes que vivían fuera de la Ciudad de Cali, y para los otros 20 niños y niñas, se dio después de haber terminado el campamento.

Estas terapias se administraron de acuerdo a los protocolos estándar (Artigas et al., 2009; Shapiro, 2001) por tres terapeutas certificados en Terapia EMDR, quienes estaban capacitados y tenían experiencia trabajando con niños y poblaciones vulnerables.

El Protocolo Grupal e Integrativo con EMDR. La terapia grupal se administró a los 34 participantes en un solo grupo, y el tratamiento tuvo una duración de 6 horas. Se administró en tres ocasiones, a lo largo de tres días. En el primer día los menores completaron la fase preparatoria del Protocolo Grupal e Integrativo con EMDR, en el segundo día, hicieron las fases de 3 a 7 (primera medición del SUD); y en el tercer día volvieron a hacer las fases 3 a 7 (segunda y última medida de SUD).

Nota: Para no hacer daño (re-traumatizar) a los participantes, solo personas entrenadas formalmente en terapia EMDR y en el Protocolo Grupal e Integrativo con EMDR, pueden aplicar los protocolos.

Terapia Individual de EMDR. Las sesiones de terapia individual tuvieron una duración de 60 minutos. La memoria a trabajar fue la misma que se utilizó para las sesiones grupales. Se utilizaron dibujos durante la sesión, y también se les pidió a los niños que identificaran una creencia negativa. El tratamiento se llevó a cabo siguiendo los procedimientos estándar de la Terapia EMDR.

Resultados

Los fuertes efectos del tratamiento con el Protocolo Grupal e Integrativo con EMDR, resultan evidentes al observar el decremento de las puntuaciones de SUD (ver Figura 1). Los niveles de perturbación subjetiva en los niños y niñas disminuyeron durante la primera sesión, se mantuvieron, y redujeron aún más durante la segunda sesión.

Primer Estudio de Investigación de la Aplicación del Protocolo Grupal e Integrativo con EMDR a Niños Víctimas de Violencia Interpersonal Severa.

Además, todos los puntajes del CRTES en el seguimiento indicaron baja perturbación (Figura 3). Con el fin de evaluar los cambios en todo el grupo, y en cada grupo por separado, se llevaron a cabo pruebas t post hoc planeadas. Estas mostraron una reducción significativa en los síntomas para el CRTES ($t_{33}$ = 5.49, $p < .001$) y para el SPRINT ($t_{33}$ = 5.87, $p < .001$; ver Tablas 1 y 2, así como Figuras 2 y 3.

Los resultados confirman el efecto del programa y que éste se mantuvo durante el tiempo. Finalmente, la rápida variación en las puntuaciones de SUD durante las sesiones de procesamiento (Figura 1) es consistente con resultados anteriores.

Comparación de los efectos del Tratamiento en Dos Grupos Diferentes

Se aplicó un Modelo General Lineal, con el objetivo de conocer si las diferencias encontradas, se debían a la condición de los participantes (si provenían de familia o institución). Los puntajes de ambos instrumentos (CRTES y SPRINT) se compararon para las medidas repetidas (pre-tratamiento, post-tratamiento y seguimiento), en cada uno de los grupos (institución y familia). Los resultados no mostraron efectos significativos para la interacción entre puntajes de instrumentos y el tipo de grupo. Esto indica que los resultados del tratamiento siguen un patrón similar en ambos grupos (institución y familia).

El Análisis de Varianza (ANOVA), muestra un efecto significativo en el tiempo para los dos instrumentos, observándose que todos los participantes (N=34) tuvieron una mejoría en el CRTES ($F_{1, 33} = 250.26, p < .001$) y en el SPRINT ($F_{1,33} = 259.27, p < .001$).

Los efectos del programa completo fueron medidos con las escalas CRTES y SPRINT (Connor & Davidson, 2001; Vaishnavi et al., 2006), las cuales se administraron a los dos grupos de niños y niñas (provenientes de familia o de institución) en tres ocasiones: pre-tratamiento, pos-tratamiento y seguimiento.

Las Tablas 1 y 2, muestra las medias y desviaciones estándar obtenidas en ambos grupos para cada instrumento que se aplicó a lo largo del tiempo.

Comparación de los efectos del tratamiento en dos grupos diferentes

Se aplicó un modelo general lineal, con el objetivo de conocer si las diferencias encontradas, se debían a la condición de los participantes (si provenían de familia o institución). Los puntajes de ambos instrumentos (CRTES y SPRINT) se compararon para las medidas repetidas (pre-tratamiento, post-tratamiento y seguimiento), en cada uno de los grupos (institución y familia). Los resultados no mostraron efectos significativos para la interacción entre puntajes de instrumentos y el tipo de grupo. Esto indica que los resultados del tratamiento siguen un patrón similar en ambos grupos (institución y familia).

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**TABLA 1. Puntajes de la Media y Desviación Estándar de la Escala SPRINT.**

<table>
<thead>
<tr>
<th>POBLACIÓN</th>
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<th>Desviación Std.</th>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
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<tr>
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<tr>
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<tr>
<td>Post-tratamiento</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>19</td>
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<tr>
<td>FAMILIA</td>
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<tr>
<td>Total</td>
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</tr>
<tr>
<td>Seguimiento</td>
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<td></td>
</tr>
<tr>
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</table>

**TABLA 2. Puntajes de la Media y Desviación Estándar de la Escala CRTES.**

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<tr>
<td>Post-tratamiento</td>
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<td></td>
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<tr>
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<tr>
<td>Seguimiento</td>
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<td>INSTITUCIÓN</td>
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<td>3.641</td>
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<td>Total</td>
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<td>3.250</td>
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Tratamiento Multimodal

Los niños y niñas recibieron un tratamiento multimodal, en el que la primera fase del tratamiento terapéutico se realizó en el contexto de un campamento de recuperación del trauma psicológico. Como se ha descrito previamente, las actividades fueron diseñadas para incrementar la conciencia de sí mismos y la auto-aceptación. Los participantes aprendieron estrategias focalizadas en las emociones y para la regulación de las mismas, así como la práctica de la Atención Plena (mindfulness). Estas prácticas han sido evaluadas por expertos en que los niños y niñas tenían un nuevo sentido del placer y una mayor capacidad para disfrutar y divertirse.

**Discusión**

Los resultados obtenidos muestran efectos significativos del tratamiento con Terapia EMDR en todos los menores, independientemente de si éstos vivían con su familia o provenían de una institución. Los efectos del tratamiento se mantuvieron a lo largo del tiempo, como lo muestran los resultados de las mediciones realizadas en el seguimiento.


**FIGURA 3.** Cambios en los puntajes de la Child’s Reaction To Traumatic Events Scale (CRTES) después del tratamiento. 1. Pre-tratamiento, 2. Post-tratamiento, 3. Seguimiento.
La terapia multimodal que se aplicó en este estudio, abordó muchas de las diversas necesidades terapéuticas de los niños. Este programa con duración de una semana, parece ser suficiente, para que los niños y niñas pre-adolescentes con trauma complejo, experimenten cambios significativos, que les permitan seguir adelante en sus vidas, con nuevos sentimientos de fortaleza y júbilo.

Desde la perspectiva de la Teoría del Procesamiento de la Información (Shapiro, 2001), los autores consideran que uno de los beneficiarios clave de las diversas actividades que se realizaron, fue la creación y fortalecimiento de redes de memoria positivas. Estas redes estuvieron accesibles a los niños y niñas durante el procesamiento de sus memorias traumáticas con EMDR. Se tiene la hipótesis de que esto permitió a los niños y niñas reprocesar las memorias traumáticas, sin sentirse abrumados por perturbaciones emocionales.

Este estudio arrojó resultados positivos, a favor del tratamiento multimodal de una semana, que incluyó el Protocolo Grupal e Integrativo con EMDR y una o dos sesiones individuales de Terapia EMDR. Fue un tratamiento efectivo y limitado en tiempo que además, al tratar un mayor número de niños, ofrece ventajas en términos de costos.

Parece ser una alternativa eficiente al tipo de tratamientos que se utiliza normalmente con niños, los cuales incluyen sesiones grupales e individuales que se extienden por un período de 2 o 3 meses. La investigación ha demostrado que los niños con TEPT, mejoran sustancialmente en terapias con una duración de 9 a 12 semanas, y las respuestas de la encuesta ISTSS (Cloitre et al., 2011), sugieren un período más largo para el tratamiento de TEPT complejo.

Nosotros recomendamos que el tratamiento multimodal con el Protocolo Grupal e Integrativo con EMDR y la terapia individual de EMDR, sea considerado como una poderosa opción alterna a las aproximaciones tradicionales.

La Terapia EMDR y el Protocolo Grupal e Integrativo con EMDR

Los resultados del presente estudio, demuestran la efectividad de la combinación del Protocolo Grupal e Integrativo con EMDR y la terapia individual de EMDR, como una potente aproximación alterna a las aproximaciones tradicionales.
niñas colombianas que hayan sido víctimas de violencia interpersonal severa.

A la fecha, existen pocos estudios que analicen adaptaciones u otras alternativas de tratamiento diferentes a aquellas ya establecidas para tratar TEPT, específicamente en personas con historias de trauma complejo. Los autores recomiendan mayor investigación en el futuro sobre el uso de la Terapia EMDR, como parte de una aproximación multi componente y en fases para el tratamiento del trauma.

Referencias


Reconocimientos. Los autores desean agradecer a la Dra. Martha Givaudán su valiosa contribución en el análisis de datos de este estudio.

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Protocolo Individual de Terapia EMDR para uso de Paraprofesionales: Un Estudio Aleatorio Controlado con Auxiliadores

Ignacio Jarero
Carolina Amaya
Martha Givaudán
Alaide Miranda

Fundación Latinoamericana y del Caribe para la Investigación del Trauma Psicológico.

El Protocolo Individual de Terapia de Reprocesamiento y Desensibilización a través del Movimiento Ocular para uso de Paraprofesionales en situaciones de trauma agudo (EMDR-PROPARA), es parte de un proyecto desarrollado bajo la iniciativa de la Dra. Francine Shapiro. Este estudio aleatorio controlado investigó la efectividad del protocolo administrado por Terapeutas EMDR con experiencia. En el estudio participaron 39 auxiliadores traumatisados y en servicio activo, que fueron asignados al azar para recibir una sesión de 90 minutos, ya fuera del EMDR-PROPARA o de Consejería de Apoyo. Los participantes tratados con el EMDR-PROPARA mostraron beneficios inmediatos después del tratamiento; con un decremento de los puntajes de la Short PTSD Rating Interview (SPRINT), que continuó observándose hasta el segundo seguimiento a los tres meses. En comparación, los participantes que fueron tratados con Consejería de Apoyo, tuvieron un decremento no significativo después del tratamiento y un aumento en los puntajes del SPRINT en el segundo seguimiento. Las diferencias significativas entre los dos tratamientos proporcionan evidencia preliminar, que apoya la eficacia del EMDR-PROPARA para reducir la severidad de los síntomas postraumáticos y en la mejoría subjetiva global. Se recomienda realizar mayor investigación controlada para evaluar de manera más extensa la eficacia de esta intervención.

Palabras clave: trauma agudo; intervención psicológica temprana; auxiliadores; apoyo de pares.

La salud mental y el bienestar del personal de servicios de emergencia (auxiliadores) es importante para el individuo, su familia, la organización y para la comunidad en general (Scully, 2011; Shakespeare-Finch, 2011). Las discapacidades por trastornos de salud mental en los auxiliadores son asociadas a altos costos, tanto para el sector público como para la persona y pueden afectar de manera negativa su servicio a las víctimas y a los pacientes (Kleim & Westphal, 2011).

En el contexto de este artículo, utilizamos el término “auxiliadores”, para referirnos a un grupo heterogéneo de profesionales bajo contrato o voluntarios, que otorgan servicios críticos en emergencias (ej. el personal de apoyo a pares en grandes organizaciones). Las ocupaciones de los auxiliadores a lo largo de la historia han sido: policías, operadoras de líneas de emergencia, bomberos, personal de rescate y búsqueda, personal de ambulancias y personal de salas de urgencias. Estos puestos se caracterizan por un alto nivel de demanda y por estar constantemente expuestos a estresores traumáticos tanto físicos como psicológicos (Peñalba, McGuire, & Leite, 2008).
La investigación ha mostrado que la exposición a estresores traumáticos aumenta la probabilidad de desarrollar el Trastorno por Estrés Postraumático (TEPT), otros trastornos psiquiátricos y Burnout (Haugen, Evces, & Weiss, 2012). Los trastornos relacionados al trauma que se observan más frecuentemente en auxiliares, son el trastorno depresivo mayor y trastornos relacionados con las drogas y el alcohol (Benedek, Fullerton, & Ursano, 2007). Los auxiliares que no han recibido un entrenamiento especializado para el trabajo en situaciones de desastre, muestran tasas de prevalencia de TEPT más altas (Guo et al., 2004).

Clarificación de Términos para Situaciones de Trauma Agudo

A. Síndrome de estrés agudo: Un evento traumático agudo que ocurrió hace pocos días y se representa por niveles significativos de una serie de agrupaciones de síntomas (ej. sobreexcitación, evitación, disociación e intrusión) que no han remitido por varios días.

B. Evento reciente: Un evento traumático que ocurrió dentro de un período de 2 a 3 meses y en el que los participantes han tenido un período de seguridad.

C. Red de memoria por exposición al trauma acumulativo: eventos estresantes relacionados entre sí, que continúan por un periodo extendido de tiempo (normalmente por más de tres meses) y en los que el/la participante no ha tenido un período de seguridad.

Para Jarero y Uribe (2011, 2012), las situaciones de trauma agudo no se relacionan únicamente con un período de tiempo (días o meses), sino también con un período de seguridad. Ellos han argumentado, que la falta del periodo de seguridad impide la consolidación en la memoria del incidente crítico original, debido a que el continuo de eventos estresantes con información similar (ej. emociones, sensaciones físicas), no le dan a la memoria traumática estado-dependiente (van der Kolk & van der Hart, 1991), suficiente tiempo para consolidarse en un todo integrado. Por lo tanto, la red de memoria permanece en un estado de excitación continua, sensibilizándose y expandiéndose con cada evento estresante sucesivo en este continuo; tal como el efecto de las ondas concéntricas que produce una roca que cae en el centro de un lago. Con el riesgo de TEPT y trastornos comórbidos creciendo con el número de exposiciones.

Tratamiento de Auxiliares Traumatizados

En áreas con pobre o inexistente cuidado profesional del trauma psicológico (ej. países en desarrollo), los auxiliares que están expuestos en su ambiente laboral a trauma primario o secundario (desgaste profesional por empatía; Figley, 1995) y que tienen dificultad para recuperarse con el tiempo o después de una intervención en crisis; pueden beneficiarse al recibir un tratamiento de intervención temprana proporcionado por sus pares (colegas).

De acuerdo con Creamer et al. (2012):

“La razón para prover programas de apoyo entre pares, frecuentemente incluye el objetivo de cumplir con el deber legal y moral del cuidado de los empleados, así como, el de enfrentar las múltiples barreras para tener acceso a los cuidados estándar. Barreras como el estigma, la falta de tiempo, deficiente acceso a los proveedores de servicios, la falta de confianza y el temor a las repercusiones laborales” (p. 134).

Intervenciones Agudas

Se considera que la intervención temprana puede prevenir perturbación psicológica posterior o morbilidad psicológica a largo plazo (Scully, 2011). Existe una considerable controversia sobre qué tipo de intervención debe ser ofrecida después de la exposición a un evento traumático; así como, en qué momento y a quién (Roberts, Kitchiner, Kenardy, & Bisson, 2010).

Los expertos (ej., Bisson, Roberts, & Macho, 2003; Brewin et al., 2008), sostienen que las intervenciones deben dirigirse a aquellos que se encuentran en mayor riesgo de experimentar problemas psicológicos persistentes, después de la exposición a eventos potencialmente traumáticos.

Varios autores utilizan diferente vocabulario y términos en sus discusiones sobre los síndromes de estrés agudo y su tratamiento.

Intervención en Crisis es el término que utilizan Everly y Mitchell (2008) para describir el “cuidado psicológico o conductual urgente, diseñado para primero estabilizar y después reducir los síntomas de la perturbación o disfunción; así como, para alcanzar un estado de funcionamiento adaptativo, o facilitar el acceso al continuo de cuidados cuando es necesario” (p.8).
Ellos proponen que los objetivos de la intervención en crisis son: a) la estabilización del funcionamiento psicológico, cubriendo primero las necesidades físicas básicas y posteriormente las necesidades psicológicas básicas; b) mitigar la perturbación psicológica disfuncional; c) regresar a un funcionamiento psicológico adaptativo en la fase aguda; y/o facilitar el acceso al siguiente nivel de cuidados.

Intervenciones Psicológicas Tempranas es el término que utilizan Roberts et al. (2010) para las intervenciones que inician dentro de los 3 primeros meses después de un evento traumático, con el propósito principal de prevenir el desarrollo de TEPT o perturbaciones en curso, en aquellos con síntomas de estrés traumático, con Trastorno por Estrés Agudo (TEA), o que están en riesgo de sufrir TEPT o algún otro trastorno.

Otros autores (ej., Kehle et al., 2010) hablan de tratamiento temprano de salud mental, el cual se refiere a una intervención que incluye la psicoterapia y el tratamiento psicofarmacológico. Además, el Departamento de Asuntos de Veteranos y el Departamento de Defensa de los Estados Unidos (Department of Veterans Affairs and Department of Defense, VA/DoD, 2010), nombraron manejo del estrés postraumático a todas las intervenciones para estrés postraumático, para la reacción de estrés agudo (REA), el TEA y el TEPT agudo y crónico (Ver las Guías de tratamiento de VA/DoD [2010] para conocer las intervenciones actuales recomendadas y sus limitaciones).

Como se puede observar en estos ejemplos, la palabra intervención puede referirse a un amplio rango de actividades, que van desde abordar las necesidades psicológicas inmediatas hasta la terapia psicofarmacológica.

Varios estudios han aplicado un abordaje de ta

mizaje y tratamiento después de varios eventos traumáticos, con el objetivo de identificar sistemáticamente a aquellos que han desarrollado síntomas postraumáticos agudos y proporcionarles un tratamiento temprano (Brewin et al., 2008).

Las VA/DoD’s (2010) Clinical Practice Guidelines for Management of Post-Traumatic Stress, mencionan que la identificación temprana del TEPT y la referencia rápida para recibir tratamiento, puede aminorar el sufrimiento y reducir la severidad de la discapacidad funcional.

Se recomiendan intervenciones tempranas breves para los pacientes con niveles significativos de síntomas tempranos; así como, para aquellos que se encuentran incapacitados por síntomas agudos psicológicos o físicos.

Actualmente se utilizan diferentes abordajes para tratar el trauma en los Auxiliadores (ej., psicoeducación, manejo del estrés en incidentes críticos, Terapia Cognitivo Conductual (TCC), Terapia EMDR). Haugen et al. (2012), concluyeron que la literatura sobre el tratamiento del TEPT en Auxiliadores, era insuficiente para hacer recomendaciones basadas en la evidencia; ellos recomiendan llevar a cabo Estudios Aleatorios Controlados (Randomized Control Trials; RCTs, por sus siglas en inglés) empleado tratamientos como el EMDR.

La promoción de la salud mental positiva y del bienestar psicológico en el entorno laboral, se ha reconocido como una prioridad de investigación global (ej., Organización Mundial de la Salud, [OMS], 2002).

La Terapia EMDR, los Auxiliadores y la Intervención Temprana con Terapia EMDR

La Terapia EMDR es un abordaje terapéutico integrativo, que consta de 8 fases, guiado por el Modelo de Procesamiento de la Información a Estados Adaptativos (Adaptive Information Processing [AIP]; F. Shapiro, 2001). En esta psicoterapia integrativa, las memorias almacenadas de manera disfuncional, son consideradas la base primaria de la patología clínica que utiliza la Terapia EMDR como un tratamiento nivel “A”, co
correspondiendo este nivel a “fuerte recomendación para su aplicación por los clínicos en pacientes elegibles” (p. 6).

La revisión de la literatura sobre el tratamiento del TEPT crónico en auxiliares, arrojó la existencia de estudios de caso publicados, que utilizaron la Terapia EMDR con policías (Keenan & Royle, 2007; Spates & Burnette, 1995) y bomberos (Kitchener, 2004). Además de un Estudio Aleatorio Controlado con 62 oficiales de policía, en el que se comparó la Terapia EMDR con un programa tradicional de manejo de estrés (Wilson, Tinker, Becker, & Logan, 2001).

La experiencia clínica y el trabajo en campo realizando intervención temprana con Terapia EMDR (EMDR Early Intervention-EEI) es extensa (Maxfield, 2008). Los resultados de estudios publicados, indican...
que las intervenciones tempranas con terapia EMDR, son breves, con efectos de tratamiento rápidos y que pueden ser utilizadas en campo o en situaciones de emergencia.

Existe un cuerpo de investigación, que apoya el uso de protocolos de Terapia EMDR, modificados para tratar el trauma agudo, ya sea en formato individual o grupal (Jarero, Artigas, & Luber, 2011; E. Shapiro, 2012). La razón principal para las modificaciones, es que la consolidación de la memoria parece cambiar en las semanas o meses posteriores a un incidente crítico (F. Shapiro, 2001). Ver E. Shapiro (2012), para conocer más sobre los avances generales en el campo de la intervención psicológica temprana después del trauma, y el lugar de la Terapia EMDR en particular.

Jarero et al. (2011) han argumentado, que la intervención temprana con Terapia EMDR, tiene un lugar natural en la intervención en crisis y en el continuo de cuidados de salud mental en desastres, y puede ser clave en la intervención temprana como una modalidad de tratamiento breve. Los autores de este artículo, recomiendan que la aplicación de las intervenciones en la fase aguda, se lleven a cabo conforme se vayan presentando las fases de recuperación y con la evaluación de las necesidades de los sobrevivientes en cada momento (Solomon, 2008).

**El Protocolo Individual de Terapia EMDR para uso de Paraprofesionales en Situaciones de Trauma Agudo**

**Antecedentes**

El Protocolo Individual de Terapia EMDR para uso de Paraprofesionales en Situaciones de Trauma Agudo (EMDR-PROPARA), es parte de un proyecto desarrollado bajo la iniciativa de la Dra. Francine Shapiro (comunicación personal, Junio de 2012).

Hemos reconocido que los países en desarrollo, comúnmente carecen de recursos profesionales, para responder adecuadamente a eventos traumáticos de gran magnitud; y que la atención psicológica del trauma puede ser pobre o inexistente. Sin embargo, estos países con frecuencia tienen una estructura de paraprofesionales entrenados, que son los responsables de aplicar intervenciones y tratamiento. Existen antecedentes de intervenciones de TCC exitosamente aplicada por paraprofesionales (no profesionales de salud mental), con resultados comparables con profesionales (ej., Hepner et al., 2012; Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010).

En consecuencia, el primer autor (IJ) desarrolló un programa especial de entrenamiento, denominado ITEA por sus siglas en español, para enseñar a paraprofesionales especialmente seleccionados, entrenados y supervisados; cómo aplicar a sus pares (colegas) protocolos de Terapia EMDR (en formatos grupal e individual) en situaciones de trauma agudo.

El entrenamiento inicia con un mensaje de la Dra. Francine Shapiro enfatizando la seguridad de los pacientes, el cual es transmitido por los entrenadores del taller (Entrenadores de Entrenadores del Instituto de EMDR). La Dra. Shapiro alienta a los paraprofesionales, a poner especial atención en la fidelidad del tratamiento y en el rigor en la investigación; de tal forma, que los datos puedan ser recolectados de manera sistemática y evaluados científicamente, para así poder obtener información significativa.


Para el formato individual, fue desarrollado el EMDR-PROPARA por el primer autor (IJ). Para asegurar que el protocolo tuviera validez ecológica (aceptabilidad en el mundo real; Brewer, 2000), la fuerza de tarea de la Fundación Latinoamericana y del Caribe para la Investigación del Trauma Psicológico, condujo una evaluación de campo en Estados Unidos, México, Centroamérica, Sudamérica y España. El tratamiento se aplicó a diferentes poblaciones en fase de trauma agudo: personal militar y auxiliadores en servicio activo, civiles (víctimas de secuestro) e inmigrantes ilegales.

El EMDR-PROPARA, es una adaptación para uso de paraprofesionales del Protocolo de Terapia EMDR para Incidentes Críticos Recientes (EMDR-PRECI). Éste último, es una modificación del Protocolo para Eventos Traumáticos Recientes de F. Shapiro (2001). El EMDR-PRECI se aplica en un formato de tratamiento individual, a pacientes que sufren trauma en curso reciente. Fue desarrollado en campo para tratar incidentes críticos, en los que eventos estresantes relacionados entre sí, continúan por un período extendido de tiempo y donde no existe un período de seguridad post-trauma para la consolidación de la memoria (ver Jarero et al., 2011 para una descripción detallada del Protocolo).

Existe evidencia preliminar apoyando la eficacia del EMDR—PRECI en la reducción de los síntomas del...
El EMDR-PRECI se evaluó en un estudio realizado por Jarero et al. (2011) en el que se compararon dos grupos de tratamiento, uno inmediato y otro demorado; con 18 adultos que habían sido traumatizados por un terremoto reciente de magnitud 7.2, que ocurrió en Baja California Norte, México. Los resultados mostraron que una sesión (con una duración de 80 a 130 minutos) del EMDR-PRECI, produjo una mejoría significativa en los síntomas del estrés postraumático, tanto para el grupo de atención inmediata como para el grupo de atención demorada. Los resultados se mantuvieron en el seguimiento que se realizó 12 semanas después.

Un estudio de campo aplicando el EMDR-PRECI, investigó los efectos de la intervención temprana con auxiliares traumatizados (agentes judiciales y personal forense), que trabajaban en una situación de masacre humana, bajo estresores extremos y en donde no había un período de seguridad post-trauma para la consolidación de la memoria (Jarero & Uribe, 2011, 2012). Los resultados mostraron la reducción de los puntajes en las medidas de auto-evaluación de estrés postraumático y de síntomas de TEPT; proporcionando evidencia, que apoya el punto de vista de que la Terapia EMDR, puede ser utilizada efectivamente como una intervención temprana para auxiliares traumatizados. Parece ser que el EMDR-PRECI ayudó a prevenir el desarrollo del TEPT crónico y a incrementar la resiliencia psicológica y emocional de las y los auxiliares.

El Desarrollo del EMDR-PROPARA. Norris, Baker y Perilla (2004) hacen un llamado para “intervenciones tempranas y permanentes que proporcionen cuidados de salud mental a víctimas de desastres, buscando que sean culturalmente apropiadas y viables para lugares que tienen pocos profesionales de salud mental a quién recurrir” (pp. 290-291).

El EMDR-PROPARA fue diseñado para ser utilizado por paraprofesionales. Tiene el objetivo de reducir la severidad de los síntomas del estrés postraumático, así como los síntomas de las perturbaciones somáticas, del afrontamiento al estrés y de la disfunción laboral, familiar y social. Fue diseñado específicamente para abordar las tres manifestaciones clínicas, que se presentan comúnmente en aquellas personas que tienen problemas para recuperarse de situaciones de trauma agudo: a) Variantes abajo del umbral de TEA o TEPT agudo, b) discapacidad funcional y/o disfunción social y c) síntomas subclínicos de estrés traumático que afectan la calidad de vida.

Estas manifestaciones clínicas se pueden desarrollar a lo largo del tiempo o después de intervenciones tempranas (ej. después de que se han cubierto las necesidades físicas inmediatas, el apoyo social y espiritual, la psicoeducación, la normalización y primeros auxilios psicológicos). Basándose en la experiencia clínica y de trabajo en campo de los autores, se piensa que estas manifestaciones clínicas pueden derivarse de las tres situaciones de trauma agudo mencionadas al principio de este artículo: síndrome de estrés agudo, evento reciente y red de memoria por exposición al trauma acumulativo.

Debido a que la aplicación de protocolos de Terapia EMDR por paraprofesionales es una nueva modalidad, los autores consideran que el seguimiento después de la intervención con el protocolo EMDR-PROPARA, es primordial para determinar el estado del paciente. Nosotros recomendamos la utilización de una lista de chequeo validada y de auto–aplicación (ej. SPRINT) para asegurar un análisis sistematizado, estandarizado y eficiente de los síntomas del paciente y de la historia de exposición al trauma.

El uso continuo y rutinario de estas listas de chequeo, permite tener una evaluación de la respuesta al tratamiento y del progreso del paciente (VA/DoD, 2010). La calidad de los cuidados que proveen los paraprofesionales y los mismos paraprofesionales, deben de ser cuidadosamente monitoreados a través de supervisiones en un contexto positivo y no crítico.

Los pacientes que no mejoran o aquellos que por el contrario empeoran, deben ser referidos para recibir psicoterapia basada en la evidencia (ej. Terapia EMDR o TCC- focalizada en el trauma). En las áreas en las que no existe o es muy escaso el cuidado psicológico profesional, se debe considerar el uso de algún tratamiento auxiliar con modalidades alternativas de cuidados; tales como, medicina alternativa complementaria con tratamientos mente-cuerpo (ej. acupuntura, meditación, yoga, relajación). Que además, sean consistentes con los recursos disponibles y acordes al sistema de creencias del paciente (Strauss & Lang, 2012).

Método

La Comisión Evaluadora de la Fundación Latinoamericana y del Caribe para la Investigación del Trauma Psicológico aprobó el protocolo de investigación. Todos los participantes dieron su consentimiento informado por escrito antes de iniciar el protocolo. El propósito de la investigación fue el de evaluar la efectividad del EMDR-PROPARA, como una intervención para eventos traumáticos recientes. Consiguientemente, durante la evaluación y el tratamiento,
a todos los participantes se les pidió que se enfocaran en la peor experiencia de trabajo que hubieran vivido en los últimos tres meses. Para medir el impacto del EMDR-PROPARA, se llevó a cabo un diseño pre-post-seguimiento, en el que se comparó el EMDR-PROPARA con Consejería de Apoyo. Cuatro mediciones permitieron explorar los efectos del tratamiento de forma extensa.

Participantes

Participaron voluntariamente 39 auxiliares en servicio activo (20 hombres y 19 mujeres) del estado de Sonora, México. Fueron reclutados: paramédicos de la Cruz Roja (n = 15), operadoras de líneas de emergencia (n = 15) y bomberos (n = 9). Los participantes se dividieron aleatoriamente para recibir Consejería de Apoyo (n = 20) o el EMDR-PROPARA (n = 19).

Los criterios de inclusión fueron los siguientes: a) ser auxiliares, b) estar en servicio activo, c) tener edades entre los 18 y 60 años. Los criterios de exclusión fueron: a) tener ideaciones suicidas actuales; b) diagnóstico de trastorno psicótico o bipolar, trastorno mental orgánico o abuso de sustancias; c) ideaciones homicidas actuales y d) deterioro cognitivo significativo. Todos los participantes continuaron en servicio activo durante la realización del estudio. Su participación en el tratamiento no fue obligatoria por parte de sus empleadores y no existieron deserciones.

Medidas

El SPRINT se desempeña de forma similar a la Clinician-Administered PTSD Scale (CAPS), en la evaluación de las agrupaciones de síntomas del TEPT y en el total de la puntuación. Puede ser empleado como un instrumento diagnóstico (Vaishnavi et al., 2006). Se encontró que en el SPRINT, una puntuación de corte de 14 o más, tenía un 95% de sensibilidad para detectar el TEPT y un 96% de especificidad para descartarlo, con una precisión global de asignación correcta del 96% (Connor & Davidson, 2001).

Procedimiento

El reclutamiento se llevó a cabo del 6 al 30 de agosto de 2012. Este consistió en un proceso de dos fases:

a) Los investigadores se reunieron con los posibles participantes en sus Instituciones y les explicaron el estudio con los criterios de inclusión y exclusión.

b) Se obtuvieron los consentimientos informados escritos de los voluntarios y se recolectó la información demográfica.

Los participantes fueron evaluados con el SPRINT antes del tratamiento (Tiempo 1), después del tratamiento (Tiempo 2), en un primer seguimiento un mes después del tratamiento (Tiempo 3) y en un segundo seguimiento tres meses después del tratamiento (Tiempo 4). Todas las evaluaciones post-tratamiento y de seguimiento fueron aplicadas por profesionales neutrales (“blind-ciegos”) al estatus de tratamiento del grupo.

Tratamiento

Los participantes fueron divididos aleatoriamente en dos grupos: Consejería de Apoyo (n = 20) y EMDR – PROPARA (n = 19). Cada grupo recibió dos sesiones individuales de 1.5 horas, aplicada por uno de los cuatro terapeutas EMDR que trabajaron en este estudio (un Entrenador de Entrenadores EMDR, un Supervisor Certificado de EMDR y dos Terapeutas EMDR Certificados). Cada terapeuta EMDR fue capacitado en el EMDR-PROPARA por el primer autor (IJ). La adherencia al tratamiento se facilitó por un cumplimiento estricto de los protocolos de terapia.

EMDR-PROPARA

El EMDR-PROPARA consiste en las siguientes fases:

1. Preparación del lugar de trabajo.

2. Historia: a) Recolección de la información demográfica; b) preguntar sobre el incidente crítico; c) evaluación de los síntomas físicos, mentales, emocionales y conductuales; y d) administración del instrumento.

El SPRIN...
3. Preparación del participante: técnicas de auto-
modulación de afectos.
4. Facilitación del procesamiento de la memoria
traumática: a) evaluación de la memoria traumá-
tica; b) desensibilización; c) instalación/incremento
de la creencia positiva y d) escaneo corporal.
5. Cierre de la sesión.
6. Información sobre el manejo del estrés.
7. Reevaluación: a) evaluación de la sesión anterior y
b) reinicio de sesión.
8. Reevaluación antes de finalizar del tratamiento: a) 
estímulo presente; b) patrón a futuro; c) resolución
del síntoma; d) crecimiento postraumático; e) apli-
cación del instrumento.

La principal diferencia entre el EMDR-PRECI y el
EMDR-PROPARA es la estimulación bilateral (EBL)
durante el procesamiento de la memoria traumá-
tica. En el EMDR-PRECI, los movimientos oculares
son la primera opción de estimulación bilateral. En el
EMDR-PROPARA, el Abrazo de la Mariposa (AM) es
el único método que se utiliza.

Artigas y Jarero (2014), piensan que el control que
tienen los pacientes sobre su estimulación bilateral al
utilizar el Abrazo de la Mariposa, puede ser un factor
de empoderamiento, que ayuda a que mantengan la
sensación de seguridad, mientras que procesan sus
memorias traumáticas.

La hipótesis de los autores, es que durante la
estimulación bilateral con el Abrazo de la Mariposa,
el Sistema de Procesamiento de la Información a
Estados Adaptativos (AIP, por sus siglas en inglés:
Shapiro, 2001), está regulando la estimulación para
mantener a los pacientes en su ventana de toleran-
cia (Corrigan, Fisher, & Nutt, 2011), permitiendo un
reprocesamiento apropiado.

De acuerdo con Shapiro, el sistema de procesa-
miento de información intrínseco y las propias redes
de memoria asociativa del paciente, son los medios
más efectivos y eficientes para alcanzar efectos clíni-
cos óptimos.

Consejería de Apoyo

Las sesiones de Consejería de Apoyo incluyeron edu-
cación acerca del trauma, el desarrollo de habilidades
de resolución de problemas y una actitud de apoyo
incondicional por parte de la terapeuta. La Conseje-
ría de Apoyo específicamente evita la exposición a
las memorias traumáticas o técnicas para el manejo
del estrés. Esta intervención psicológica se seleccionó
como comparación, debido a que se ha utilizado de
manera repetida en estudios aleatorios controlados,
para evaluar la eficacia de la TCC focalizada en el
trauma, como una intervención psicológica temprana,
para el tratamiento de los síntomas del estrés trauma-
mático agudo (ej., Bryant, Harvey, Sackville, Dang,
& Basten, 1998; Bryant, Sackville, Dang, Moulds, &
Guthrie, 1999; Foà, Rothbaum, Riggs, & Murdock,
1991; Roberts et al., 2010).

Análisis Estadístico

Dado el diseño del estudio, se utilizó un Modelo Ge-
eral Linear de Medidas Repetidas (MGL) para eva-
luar los efectos del EMDR-PROPARA en los puntajes
obtenidos en el SPRINT. Las dos principales razones
para utilizar medidas repetidas fueron: a) incrementar
la potencia estadística y b) conocer los efectos del tra-
tamiento a lo largo del tiempo. Además del Modelo
General Linear, se realizaron pruebas t para comparar
los puntajes en cada tiempo de medición.

Resultados

Los datos muestran claros efectos del EMDR-
PROPARA en la reducción de síntomas de estrés
postraumático y en el mantenimiento de un decre-
mento continuo, a pesar de la exposición permanente
eventos estresantes similares, relacionados con
sús labores cotidianas. Los participantes fueron eva-
luados con el SPRINT en cuatro ocasiones: Línea
de base (Tiempo 1), post-tratamiento (Tiempo 2),
seguimiento después de un mes del tratamiento
(Tiempo 3), y seguimiento a los tres meses después
del tratamiento (Tiempo 4). La Figura 1 muestra una
diferencia global significativa entre la Consejería de
Apoyo y el EMDR-PROPARA. La Tabla 1 muestra los
puntajes de las medidas y las desviaciones estándar para
ambos grupos en los cuatro tiempos.

Equivalencia de los Grupos en la Línea de Base

La media (promedio) y la desviación estándar
(Tiempo 4), fueron iguales para ambos grupos en los
tiempos de medición. Además del Modelo Ge-
eral Linear, mostraron una diferencia global sig-
ificativa a lo largo del tiempo, entre el grupo tratado
embrionario y el grupo no tratado.

Efectos del Tratamiento a lo Largo del Tiempo

Los resultados de las medidas repetidas del Modelo
General Linear, mostraron una diferencia global sig-
nificativa a lo largo del tiempo, entre el grupo tratado
Los efectos entre-sujetos de ambos grupos, mostraron diferencias entre el grupo tratado con Consejería de Apoyo y el grupo tratado con EMDR-PROPARA, $F(1, 35) = 92.29, p = .001$. La interacción entre sexo y grupo no mostró diferencias significativas $F(1, 35) = 1.260, p = .269$. Esto indica que las mujeres y los hombres tienen los mismos patrones de respuesta. Las comparaciones inter-sujetos de cada grupo, demostraron una interacción significativa entre el tiempo y el grupo, $F(1, 35) = 524.87, p = .001$. Este efecto puede ser observado en la Figura 1, la cual ilustra un decremento consistente en los puntajes de las medias en el grupo tratado con el EMDR-PROPARA.

**EFECTOS DEL TRATAMIENTO A CORTO PLAZO**

Se realizó una prueba $t$ para muestras independientes con el objetivo de comparar los puntajes del SPRINT en el post-tratamiento para ambos grupos. Los puntajes del SPRINT para el grupo tratado con el EMDR-PROPARA, fueron significativamente menores que para el grupo tratado con Consejería de Apoyo $t(37) = 6.35, p = .001$ (ver Tabla 1). Estos resultados muestran la efectividad inmediata del EMDR-PROPARA.

**MANTENIMIENTO DE LOS EFECTOS DEL TRATAMIENTO**

Se compararon con un análisis estadístico, utilizando la prueba $t$ para muestras independientes, los puntajes de los tratamientos a largo plazo con el EMDR-PROPARA con el grupo de control con Consejería de Apoyo.

**Tabla 1. Medias, Desviaciones estándar (SD) y Comparación Estadística de los Puntajes del SPRINT**

<table>
<thead>
<tr>
<th>Tiempo</th>
<th>Medias y Desviaciones Estándar (SD)</th>
<th>Comparación Estadística</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consejería de Apoyo (N = 20)</td>
<td>EMDR-PROPARA (N = 19)</td>
</tr>
<tr>
<td>Línea de Base</td>
<td>17.70 (4.94)</td>
<td>17.26 (4.41)</td>
</tr>
<tr>
<td>Post-tratamiento</td>
<td>15.10 (4.59)</td>
<td>7.47 (2.54)</td>
</tr>
<tr>
<td>Primer Seguimiento</td>
<td>14.80 (5.34)</td>
<td>3.58 (1.61)</td>
</tr>
<tr>
<td>Segundo Seguimiento</td>
<td>16.15 (3.92)</td>
<td>2.36 (.83)</td>
</tr>
</tbody>
</table>

**FIGURA 1.** Puntajes de la Media del SPRINT. Tiempo 1 = Línea de Base. Tiempo 2 = Post-tratamiento. Tiempo 3 = Seguimiento a 1 mes. Tiempo 4 = Seguimiento a 3 meses.
obtenidos en el SPRINT para ambos grupos, en las dos evaluaciones de seguimiento (ver Tabla 1). En cada ocasión, las medias del grupo tratado con el EMDR-PROPARA, fueron significativamente menores que las del grupo tratado con Consejería de Apoyo, como era de esperarse.

**Mejoría Subjetiva Global**

El SPRINT contiene dos reactivos para medir la mejoría global. El reactivo 1 evalúa el porcentaje de cambio con la pregunta: ¿Cuánto mejor se ha sentido desde que inició el tratamiento? En un porcentaje del 0 al 100. Y el reactivo 2 evalúa el nivel de severidad del síntoma con la pregunta: ¿Cuánto han mejorado los síntomas mencionados arriba desde que inició el tratamiento? Los participantes deben responder de acuerdo a una escala Likert de 5 puntos (en la que: 1 = empeoraron, 2 = sin cambio, 3 = mínimamente, 4 = mucho, 5 = muchísimo).

En el seguimiento, la media de las respuestas obtenidas en el reactivo 1 para el grupo tratado con EMDR-PROPARA, fue de 91%; y en el reactivo 2, la media de las respuestas fue muchísimo. Estos resultados muestran una mejoría subjetiva global para este grupo. Por el contrario, la media de respuestas obtenidas en el reactivo 1 para el grupo tratado con Consejería de Apoyo, fue de 63%; y en el reactivo 2, la media de respuestas fue mínimamente.

**Discusión**

El presente estudio investigó la efectividad del EMDR-PROPARA –un protocolo de tratamiento individual diseñado para uso de paraprofesionales en situaciones de trauma agudo. Los participantes del grupo tratado con el EMDR-PROPARA mostraron beneficios inmediatos después del tratamiento, con los puntajes del SPRINT disminuyendo hasta el segundo seguimiento, que se llevó a cabo 3 meses después del tratamiento.

En comparación, el grupo control tratado con Consejería de Apoyo, mostró una disminución no significativa después del tratamiento y un incremento en los puntajes del SPRINT en el segundo seguimiento. Los resultados proporcionan evidencia preliminar que apoya la efectividad del EMDR-PROPARA en la reducción de la severidad de los síntomas postraumáticos y la mejoría subjetiva global.

En la medición de la línea de base, el puntaje promedio para ambos grupos de tratamiento, fue mayor de 14 – puntaje considerado como de corte para diagnosticar TEPT. Los puntajes para el grupo tratado con Consejería de Apoyo, a lo largo de las cuatro mediciones, nunca disminuyeron a menos de 14; mientras que para el grupo tratado con el EMDR-PROPARA, el puntaje promedio en la evaluación del post-tratamiento fue de 7.47.

La información recolectada durante las mediciones de los seguimientos, confirmó que los participantes de ambos grupos, continuaron con sus actividades laborales de la misma manera en que lo hacían antes del tratamiento. No se reportaron cambios relevantes en las condiciones de vida de los participantes. Por lo tanto, los resultados del estudio no se pueden atribuir al entorno laboral o a cualquier otro evento estresante.

En ninguno de los grupos se encontraron problemas psicológicos preexistentes o algún otro factor de riesgo, que los hiciera más vulnerables a desarrollar TEPT y que pudiera explicar las diferencias entre los grupos.

**Efectos a Largo Plazo en el Trauma y Beneficios del Tratamiento**

Las diferencias entre el grupo tratado con el EMDR-PROPARA y el grupo tratado con Consejería de Apoyo, se presentaron inmediatamente después de la sesión de tratamiento y se mantuvieron a lo largo del estudio. Este patrón es consistente, con investigaciones que han estudiado los efectos longitudinales de la Terapia EMDR, en sujetos que se encuentran expuestos permanentemente a eventos estresantes, por sus condiciones laborales (Jarero & Uribe, 2012) y que; por lo tanto, son más susceptibles a desarrollar TEPT (Orcutt, Erickson, & Wolfe, 2004).

La intervención con el EMDR-PROPARA puede ser un factor clave para proteger a los auxiliares de desarrollar psicopatología, al proveer un tratamiento breve que reduce efectivamente los síntomas agudos. De esta forma, ya no serían necesarios tratamientos más intensivos o difíciles de accesar, como terapia de exposición prolongada o medicamentos.

En situaciones en las que el número de víctimas que sufren de trauma es alto y el número de terapeutas experimentados en el tratamiento del trauma es limitado, el EMDR-PROPARA puede funcionar también como sistema de tamizaje, permitiendo que los esfuerzos de una terapia más intensiva, se dirijan únicamente a los pacientes resistentes, que son más susceptibles a estar en riesgo de padecer síndromes crónicos.

Considerando que en tiempos de crisis, la comunidad depende del servicio de los Auxiliares, es de primordial importancia la investigación acerca del trauma en esta población. Nosotros concordamos con Robert et al. (2010), quien recomienda mayor investigación, para identificar las maneras más
efectivas de proveer apoyo psicológico en las etapas tempranas después de un evento traumático.

**Agradecimientos.** A la Dra. Francine Shapiro por su guía y apoyo invaluable. A los miembros de la fuerza de trabajo que probaron en campo la validez ecológica del protocolo: Carolina Amaya, María Alicia Cavazos, Martha Givaudán, Cristina Jarero, Alaide Miranda, Shaila Romero, Susana Uribe, y Dinarah Villalobos. A Carolina Amaya y Mónica Ponzanelly por las encuestas a paramédicos y oficiales de policía, y a Cristina Jarero por su ayuda en la revisión al inglés.

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