GLOBAL SUMMIT CONFERENCE

EMDR Early Intervention and Crisis Response: Current Practices, Research Findings, Global Needs and Future Directions

20-22 April 2018, Natick, MA

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INTRODUCTION TO THE EVENTS

Rolf Carriere, MA

The Global Summit Conference *EMDR Early Intervention and Crisis Response: Current Practices, Research Finding, Global Needs and Future Directions*, held in Boston, USA 20-22 April 2018, was a unique event for several reasons.

It brought several pioneers in EMDR Early Intervention (EI) together with approximately 400 EMDR practitioners (half of them via livestream) keen to learn the current state of the art of the practice, its scientific validation, conditions of its application, and desirable future developments. The conference had also invited several outside experts, non-therapists, to articulate the urgent need, modalities and opportunities for EI to be applied at scale in order to contribute to the reduction of the heavy global burden of trauma. Many EMDR practitioners shared their insights and experiences in the use of EI, particularly in the context of natural and man-made disasters, both in the Global North and in the Global South. Several of these related to community trauma response networks of EMDR professionals and their work in recent traumatizing events. Twelve distinct EI-based protocols were described. Altogether 32 presentations were given, and their summaries are put forward below. Five Special Interest Groups (dealing with EI research; EI as a specialty; taking EI to scale; building EI community response capacity; and partnering with first-responders) added further opportunities for greater in-depth discussion. Summaries of these are also included below. Finally, preceding and following the conference, the two lead EI presenters (Nacho Jarero and Elan Shapiro) each offered training workshops about their protocols (on 19 and 23-24 April, respectively).

Francine Shapiro sent a welcome message and a Call to Action. "*We welcome you to our joint commitment to bring healing wherever it is needed worldwide. The possibilities are profound for the individual, society and generations to come… As a helping profession, we must take help to where it is most needed… We join together in a commitment to do our best to ensure that no one is left behind."* Her full message is included in this report.

Aim and Structure:

The overall aim of the conference was to broaden recognition, and to increase use, of EMDR Early Intervention worldwide. More specifically, the conference wanted to explore whether EI (which up till now has almost entirely been practiced by professionals, either as a therapy for individuals or groups) can play a truly global role to reduce the treatment gap and be used by various kinds of paraprofessionals or other non-specialists— and if so, where, in what form and under what conditions.

While the first two conference days focused on Early Intervention for traumatized Individuals and EI for groups of people, respectively, the third day largely concentrated on the potential contributions by, and collaboration with, allied professionals and paraprofessionals, including health workers and first responders. All along, evidence was provided for the effectiveness and appropriateness of the various protocols— with reference to both evidence-based practices and practice-based evidence. Further research needs were articulated, and networking arrangements resulted in new collaboration.

Notable Conference Features:

- All of the presentations took place in one auditorium. Unlike most other events where participants could pick and choose workshops, all were housed in the same place. This introduced a cohesion and sense of community that was distinct from other conferences.
- The interface with outsiders made this conference unique, and it revealed top global priorities and vital considerations as EMDR seeks to scale up to integrate into the broader global service community. We need EMDR goodwill ambassadors from other professions to help deliver our message and spread the word on the clinical robustness and power of our modality to not only heal but promote resilience and post-traumatic growth (PTG).
- The mix of *in situ* and livestream involvement boosted the total number of participants, broadened the conference's reach, and produced a valuable recording of the entire event. With continued promotional efforts and EMDR organizational support, the conference will continue to reach others in its recorded form.
- The Special Interest Group feature allowed for increased participant interaction during lunches and after hours, while at once demonstrating the depth of expertise, experience and commitment of all present.

Nine Conference Take-aways:

- **There is no reason to wait with EI's immediate and widespread application**. **EI is ready for scaling up**, in the Global North and in the LAMICs. The **further development and refinement of EI**, in all its variants and contexts, requires ongoing research and evaluation and greater involvement of universities.
- **Our credibility on the global stage has been impeded** by the disparity between clinical reported experience and **the lack of a consistent volume of research evidence**, especially from Randomly Controlled Trials. to back up our claims. This is an issue that must be put right.
- **The need for AIP-informed delivery of trauma care by paraprofessionals and allied health professionals** is imperative, and now is a good time to systematically operationalize this. Moving forward, **it is the mission of the global EMDR community** to determine how to practically achieve appropriate task-shifting/sharing, with what kind of delivery systems, funding, oversight, safety measures, and accompanying evaluative research.
- An immediate opportunity exists for the EMDR community to **formulate, produce, and field-test an innovative AIP-informed, EI-based trauma curriculum for the training of non-therapists and non-psychologists**.

The aim would be to get it recognized by, and incorporated in, the **World Health Organization's recently launched Low Intensity Intervention program** under its Mental Health Global Action Plan (mhGAP) which focuses on the training and mobilization of allied health professionals to undertake appropriate tasks related to eight specific mental health conditions—but PTSD and other traumas are insufficiently covered. This niche can now be filled with simplified EI-based interventions.

- A **more proactive internal and external leadership** from the local and global EMDR community is required in matters related to EI and the use of non-specialists and paraprofessionals—opening up EMDR by making its technology available to the outside world.
- The EMDR community needs to **focus more fully on developing effective and efficient delivery systems of care and partnering with existing health infrastructures.** Successfully scaling up mental health services requires

strengthening delivery systems (the 'how), and not just the intervention protocols themselves (the 'what').

All interventions must be adapted to the specific cultural context and the existing health system. Learning from, and partnering with, small and larger health infrastructures, organizations and projects will be essential to make that quantum leap in treatment availability.

- Since the name *EMDR* can appear alien to the uninitiated, a case can be made for **renaming and re-branding EMDR**. *How* EMDR presents itself to outsiders is important. A disconnect between how well the therapy works and how well EMDR presents itself to major NGOs, governments and those outside of the EMDR 'culture' points to a significant marketing problem.
- **Building rapid local response capacity through regional and community EMDR trauma care teams** (TRNs, CRNs), in the USA and elsewhere, is an important way to provide EI services to first-responders who are continually exposed to trauma and therefore at higher risk.
- Considerable enthusiasm exists for **another conference of this type and format**, allowing for time to have further discussion, experience exchange, and interaction as well with outside experts from the world of socio-economic development, humanitarian aid and peace operations.

Organization of the Global Summit:

The conference was initiated, organized and sponsored by two agencies, the **Global Initiative for Stress and Trauma Treatment** (GIST-T, www.gist-t.org) and **Advanced Training and Distance Learning**, LLC (ATDL, www.emdradvancedlearning.com), and was advised by a conference organizing committee of eight experts, who also prepared a **White Paper** on EI that laid out the leading issues. The purpose of this White Paper is to encourage the further development of EMDR-EI, to describe its uses and advantages, to identify questions and topics for priority research, and strategies to expand its use in low-and middle-income countries (LMICs). As such, it should be considered a work-in-progress.

The conference program allowed participating EMDR therapists to earn Continuing Education (CE) credits. Further details can be found on the conference website www.emdrearlyintervention.com.

Evaluation:

It is not possible to capture the essence of the experience of 400 participants, but it is fair to say that the conference objectives were fully achieved when judged by the responses from participants to the evaluation questionnaires. Two-thirds of respondents 'strongly agreed' that the Day-1 objectives had been achieved, with another one-third agreeing (only one respondent 'strongly disagreed'). These proportions held throughout Day-2 and even got better for Day-3. Here are some of their statements in response to questions.

What did you find most valuable?

- Engaging in discussion and learning from experienced professionals in the field about the impact early intervention has had and what it could have in the future
- Hearing about the need for trauma care from non-mental health professionals
- Information about using recent protocols with a variety of clients worldwide
- It was very meaningful to me to have people from so many different countries both present and in the live-stream. I also liked the focus on research and on experiences from the field. It was amazing to have such a rich day
- Networking with individuals who treat First Responders
- specifics on recent events protocols and larger vision for scaling up EMDR availability globally
- The presentation about the big picture/global problems and how scaling up EMDR is essential. Also, the research presentations were awesome

What future directions do you think are important?

- Continuing the conversation about ways to get EMDR into the hands of first responders and community health workers
- How to utilize non-mental health professionals to scale up EMDR. And how to conduct
- Research
- More research to convince the professional community of EMDR EI's value and efficacy.
- More research (probably in universities); more informed leadership in the US
- Training for paraprofessionals. Reaching out on a global scale.
- Continuing development and implementation of early intervention and trauma response networks

- Hope that their materials are made public and this catches on. That more places take a proactive view on trauma treatment
- How to utilize paraprofessionals in EMDR globally and how to conduct research on it
- Networking with WHO, Red Cross Int, etc.
- Understanding how paraprofessionals can be helpful in communities so that interventions can be ongoing, culturally appropriate, and sustainable with community ownership. EMDRIA needs to be clearer about the rules regarding this piece. There also needs to be flexibility in this regard
- Hearing from the presenters who directly work with first responders as well as the first responders themselves
- Seeing and hearing how well received EMDR EI has been received by first responders.
- Attempt to Get EMDR representation into world organizations
- EMDRIA leadership

Other comments or suggestions?

- Absolutely top job in planning, preparation, and execution of this important conference
- Please have this conference as often as possible in the future!
- The organization of the conference and of the day was awesome. Congratulations
- This conference was amazing. Perhaps the best I've ever attended in over 30 yrs! Great job on presenting an emerging field to address the need of global trauma relief
- Unbelievable training! Thank you so much
- Ask EMDRIA and other nationally & regionally based associations to recognize need for low intensity processing, esp. in group trauma situations
- Consider regular financial support for clinicians trained in EI/low intensity processing

Almost without exception, conference participants who responded to the evaluation questionnaire agreed, mostly 'strongly', that presenters were well prepared, well organized, clear in their explanations, responsive to questions, skillful in their presentations, and considerate and professional. The large majority of respondents also found presentations useful, or even very useful, they acquired new skills and knowledge, and they overwhelmingly found the content up to date, the teaching level appropriate, the materials (including audio-visual and handouts) well organized and helpful.

WELCOME

Mark Nickerson, LICSW

In his opening remarks, Mark Nickerson welcomed both those conference participants in the room and those who were taking part at a distance. He highlighted the reasons why this conference is significant: many people are doing a lot of hard work with Early Intervention, developing models, protocols, and applying them in humanitarian situations as well as in their own practices. This is the first time that these practitioners and practices are being brought together. Practitioners wanted to share their understanding and experiences with others. Mark pointed out that the full programme, the bios, abstracts and the conference White Paper are all available on the conference website. The White Paper serves as a launching pad for all presentations and discussions at the conference—it is our best effort to set out the current state of the art, what we know and what we don't know. While most participants are EMDR trained, the conference has the benefit of some global luminaries in the field of health and development, so this will give conference participants an opportunity to learn issues involved with scaling up and reaching a wider audience.

The format of the conference is somewhat unique since the conference will take place in one room, with plenty of opportunity for Q&A (including for those taking part off-site) and panel discussions. Mark then outlined the themes for each of the three days.

Mark then told the story about the winner of the recent Boston Marathon which demonstrated the power of working together, and he suggested that this be the spirit of the conference. "Trauma care is a marathon—and we need to make it sustainable"

Then he presented the call to action from Francine Shapiro, the developer of EMDR who had been supportive and encouraging of the theme and purpose of the conference.

Mark then introduced Udi Oren, who began by acknowledging the role of GIST-T over the past five year, and particularly the contribution of Derek Farrell and Rolf Carriere. He then highlighted the incredibly hard work put in by Mark Nickerson. He reiterated the unique contribution of Francine Shapiro. "None of this would have happened without Francine Shapiro. We are all standing on her shoulders"

Mark Nickerson, a psychotherapist in Amherst, MA for 30 years, is an EMDRIA approved consultant and an EMDR Institute trainer. He conducts advanced EMDR trainings nationally and internationally on topics including treatment for problem behaviors, problematic anger and violence, cultural competence, and the effective use of EMDR protocols. He has developed innovative programs designed to reduce and resolve interpersonal conflict and created the Cycle Model to assess and treat problem behaviors. He has served on the EMDRIA Board for six years and was President in 2014. He is editor/author of Cultural Competence and Healing Culturally-Based Trauma with EMDR Therapy: Insights, Strategies and Protocols (Springer, 2016) and The Wounds Within (Skyhorse, 2015), on challenges facing war veterans and their families.

GLOBAL RESPONSIBILITY

Francine Shapiro, PhD

We welcome you to our joint commitment to bring healing wherever it is needed worldwide. The possibilities are profound for the individual, society and generations to come.

The occurrence of psychological disturbance as the outcome of high stress (such as rape, combat, natural disaster) is well documented. Such disturbance, in turn, can lead to a cascade of negative effects. For example, it is generally recognized that people who have been exposed to high-stress events are likely to exhibit a variety of physical symptoms. Also of serious concern are the findings that, if left untreated, trauma and associated stress conditions can impair the physical and mental development of children and contribute to a generational cycle of violence.

There can be no doubt that many citizens of developing countries are seriously handicapped by the psychological and physical problems directly associated with stress reactions. Although the most obvious - effects of exposure to traumatic events include the intrusive thoughts and exaggerated startle responses that characterize PTSD, there are other consequences not so easily recognized, including mood volatility (such as hostile, passive, or depressed reactions), which, if left untreated, can lead to substance abuse, somatic illnesses and

accelerated aging, as well as memory and concentration problems that can seriously disrupt job and academic performance.

Whether individuals are suffering from traumata engendered in developing countries or within the inner cities of developed nations, there is evidence that violence begets violence and that some of our most prevalent social problems are correlated with trauma histories. Untreated traumas can have profound interpersonal and intergenerational consequences, as clearly indicated by research reporting that mothers suffering from PTSD have an increased likelihood of mistreating their children. Similarly, research has indicated that child maltreatment is associated with the development of mood disorders, anxiety disorders, substance abuse/dependence, and personality disorders. These findings clearly indicate the need to make effective trauma treatments available worldwide.

Internationally, it is vital to devote resources to the investigation of treatment options with individuals living in underdeveloped areas in the world, where mental health professionals and facilities are scarce. Research should be designed to determine which protocols and procedures can be safely provided by paraprofessionals as psychological first aid. Also of concern in these regions is determining the best ways to remove the stigma about mental health treatment so that it will be accepted in the same way that offers of physical treatment are embraced. This research has potentially important consequences for peaceful coexistence as attempts at reconciliation of people beset by ethnopolitical violence are often hampered by unprocessed memories of trauma. Research has identified a negative attentional bias in people with PTSD, which hampers the ability to disengage from threatening cues. Clearly, this can have a detrimental effect when attempting to forge agreement and understanding, since the very sight of individuals long viewed as the enemy can disrupt any attempt at reconciliation. Fortunately, preliminary research indicates that EMDR therapy can restore normal cognitive processing and eliminate the attentional bias.

As a helping profession, we must take help to where it is most needed. As a global network of committed clinicians and researchers, we must integrate our therapeutic practices and our scientific rigor in the service of humanity.

EMDR therapy has already helped to relieve suffering for millions of people and has affected many more through their association with friends and family. Nevertheless, there are many more who are suffering worldwide. There are many EMDR therapy associations providing pro bono services internationally. Consider reaching out to

participate in the humanitarian efforts. Seeing life and happiness return to those in need is its own reward.

We join together in a commitment to do our best to ensure that no one is left behind.

Francine Shapiro, PhD, originated and developed EMDR into one of the most important breakthroughs in the history of psychotherapy. After her accidental discovery in 1989 and subsequent validating research, she authored several books and many articles while training thousands of therapists. Her Getting Past Your Past offers an easy, entertaining read for anyone interested in the complex issues of psychological traumas, big and small, brain-mind interactions and self-care. Francine also gave leadership with the creation of several EMDR institutions, including the Humanitarian Assistance Program (now Trauma Recovery Network). These efforts resulted in EMDR's recognition worldwide, and Francine to receive many awards and honors.

INTRODUCTION TO THE CONFERENCE WHITE PAPER

Udi Oren, PhD

Udi Oren introduced the EMDR EI White Paper that had been prepared by the Conference Committee and was considered by them to be very much a work-in-progress. The White Paper was intended to serve as a starting point for this conference – to be added to, or otherwise modified in the light of discussions at the conference. Its purpose was to encourage the further development of EMDR EI and, by highlighting its uses and advantages, to identify priority topics for future research and strategies to encourage EI's greater use. The specific problem to be addressed at the conference and through the White paper is the 'treatment gap' - the shortage of mental health professionals in relation to the huge number of people needing help. This issue is a major concern.

Many variants of EMDR therapy, based on the AIP model, have been introduced and one of these is EMDR Early Intervention or EI. EI is intended to address trauma at the earliest possible opportunity, both as an individual and as a group intervention. Research studies have consistently shown a significant decrease in post trauma symptoms

when EMDR EI procedures have been applied within three months of an event. However, more research is needed to examine EMDR EI's usefulness in prevention, resiliency, remission and its comparative advantages.

EMDR EI procedures are known to reduce and/or eliminate symptoms of traumatic stress, depression and anxiety with results maintained at follow-up. It is safe and effective equally across different ages, genders, nationalities and ethnicities. EMDR EI's advantages include being easy to use, portable, accessible and a brief intervention which can be administered on consecutive days or twice a day. It can also be used as an efficient and inexpensive screening tool.

Thinking about future directions for EMDR EI, Udi highlighted the work of Rolf Carriere in drawing attention to the need for training and deploying large numbers of non-mental health professionals to address the largely unrecognised global burden of trauma. Non-mental health professionals are needed to extend mental health capacity, **not** to replace or compete with licensed mental health professionals. The WHO had recently announced its CBT-based Low Intensity Intervention (LII) programme for implementation by non-specialists, covering the whole range of mental health conditions. Its focus is on shifting and sharing tasks involving mental health interventions previously reserved for professionals. This topic had been discussed at length and with great emotion within the EMDR community – all sides having many good points to be considered. EMDR practitioners were all anxious to 'do no harm', but of course were equally concerned to be able to offer, in safety, the benefits of EMDR therapy wherever it is most needed – mostly, but not only in less-developed countries.

The goal of the conference, Francine's words, is: "(to) integrate our therapeutic practices and our scientific rigor in the service of humanity . . .(and) to ensure that no one is left behind."

Udi Oren is a clinical and medical psychologist who has been part of the EMDR community for the past 20 years. He provides EMDR trainings, as an EMDR Institute and an EMDR Europe trainer, in many countries in Asia, Europe and Africa, and has actively contributed to the growth of several EMDR national associations. Areas of greatest clinical interest include the field of combat-related PTSD (and other conditions) and stress/trauma related medical conditions. Udi has served as the Chair of the Israeli EMDR Association since its creation in1997, and as the President of EMDR Europe between 2007 and 2015.

WHITE PAPER: EYE MOVEMENT DESENSITIZATION AND REPROCESSING EARLY INTERVENTION (EMDR EI)

Developed by members of the 2018 EMDR Early Intervention and Crisis Response Summit Conference Organizing Committee:

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Introduction

The purpose of this White Paper is to encourage the further development of EMDR Early Intervention (EMDR EI), to describe its uses and advantages, to identify questions and topics for priority research, and to identify strategies to expand its use in low-and middle-income countries (LMICs). These topics will be discussed and explored in depth during the Global Summit Conference *EMDR Early Intervention and Crisis Response: Current Practices, Research Findings, Global Needs and Future Directions*, to be held in Boston, 20-22 April 2018. The White Paper will remain a work-in-progress before, during and after the Summit Conference, and will serve as the basis of a subsequent overview journal article.

Problem statement

Exposure to traumatic events and circumstances has a devastating impact on the lives of tens of millions of people around the world each year. The twin crises caused by man-made and natural disasters mean that the incidence of trauma is on the rise. Research has shown that the adverse effects of such events and circumstances go well beyond mental and physical health problems. Trauma also takes its toll on communities and nations, for example by reducing productivity, compromised educability, and an increased probability of violence, abuse and renewed trauma.

The treatment gap (defined as the difference between need for, and availability of/access to professional services) is almost certainly widening, especially in situations of violent conflict and natural disasters in economically under-resourced locations. The shortage of mental health professionals worldwide, that has severe negative impacts on communities already facing overwhelming challenges, is a major concern.

A substantial portion of Individuals experiencing recent traumatic events suffer from acute traumatic distress, with symptoms of intrusion, avoidance and hyperarousal, associated with significant impairment in daily functioning. Many will recover spontaneously, but some will go on to develop posttraumatic stress disorder (PTSD), a mood disorder, or other psychological and physical disorders, with associated functional impairments. Research suggests the possibility that early intervention, which reduces or eliminates acute distress, may prevent the development of subsequent disorders.

Many EMDR-based psychological approaches and protocols have been developed, with the goal of addressing acute distress and preventing the development of PTSD, other disorders, and future complications. Positive results have been reported with several EMDR-based interventions. However, many of these innovative approaches have yet to be adequately tested and supported by research.

Many questions remain unanswered and there is an urgent need to investigate how effective and efficient these protocols are, and how they compare to other early interventions. Further questions relate to conceptual and scientific issues, and still others focus on operational and organizational issues. See Appendices 4 and 5 for lists of published EMDR EI research studies.

EMDR therapy

EMDR therapy, originally developed for the treatment of PTSD, has evolved into a comprehensive psychotherapy approach to a variety of mental health and physical difficulties. It includes a standardized three-pronged protocol that should only be administered by licensed mental health professionals. It is based on the Adaptive Information Processing (AIP) model.[1] As EMDR therapy has evolved, a number of specialized adaptations and variants have come to the fore, all based on the AIP model. One of these is EMDR EI.

Definition of EMDR EI

The term EMDR EI is currently used in various ways. For the purpose of this White Paper, EMDR Early Intervention (EMDR EI)[2] describes the

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[1] Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures (3rd edition)*. New York: Guilford Press.

[2] Different presenters often use different terms to describe their own adaptations or variants of EMDR EI: EMDR-based EI, EMDR-EI, EEI, EI, Early Psychological Intervention or EPI, Early Psychological Preventive Intervention, Immediate EMDR Intervention, Early EMDR Intervention and early intervention(s), Low-intensity EMDR, and Restricted Processing Interventions. For the purpose of this White Paper, the term used is EMDR Early Intervention, EMDR EI, or simply EI.

use of several specific protocols[3], intended to address trauma at the earliest possible time. Sometimes administered within hours of a traumatic event, treatment is typically provided within the first three months after exposure. Some writers have suggested that EI need not arbitrarily be limited to that three-month period, but for the purpose of this White Paper we will use the three-month definition to focus our discussions. All EMDR EI protocols include the client focusing attention on the disturbing memory while experiencing bilateral stimulation, as well as other specific and unique procedural elements. See Appendix 3 for a list of EMDR EI protocols.

Use of EMDR EI

EMDR EI protocols include both individual and group interventions and are designed to reduce the negative impact of acute stress from recent events, or even from certain types of ongoing circumstances, by focusing on stabilization, symptom reduction, and reprocessing of trauma memories.

EMDR EI procedures have been explored in many settings and locations since the early days of EMDR therapy. They have been applied with children, adolescents, and adults, after man-made and natural disasters, in refugee camps, with first responders, medical and military personnel, in schools, and in many other circumstances. EMDR EI is increasingly being offered to trauma survivors throughout the world. It is provided by independent EMDR practitioners, by agencies and organizations, and by volunteer groups of EMDR practitioners. It is also being used as part of large-scale collaborative disaster relief services.

EMDR EI Research

There are at least 23 published research studies that have investigated the use of EMDR EI procedures in the treatment of posttraumatic stress, within 3 months following the traumatic episode. (See Appendix 4). These studies consistently showed a significant decrease in posttraumatic symptoms with results being maintained at follow-up. Fourteen studies were uncontrolled, three were non-randomized controlled studies, and six were randomized controlled trials (RCTs). All nine controlled studies evaluated the effectiveness of individual EMDR EI. Most used a waitlist control and all found a significant difference between the improvement noted for EMDR EI participants compared to those waiting for treatment.

[3] BLANK******

Three of the controlled studies compared an EMDR EI intervention to another therapy. An RCT[4] comparing one session of Francine Shapiro's Recent Event Protocol (REP) with Critical Incident Stress Debriefing (CISD) and another RCT[5] comparing three sessions of EMDR PROPARA with supportive counseling found the EMDR EI interventions to produce significantly reduced symptoms of PTSD, compared to the treatment control. Similarly, a matched control study[6] compared one session of URG- EMDR and eclectic therapy, reporting significantly superior results for URG-EMDR, compared to eclectic therapy. All results were maintained at 3-month follow-up. The effect of R-TEP on symptoms of depression was studied in two RCTs[7][8], finding a significant decrease in depressive symptoms, and, in one study, a significant difference between treated and waitlist participants. That study is also the only study to examine whether EMDR-EI increased resilience, but the results showed no significant effect.

These positive results are promising, and there is strong consistent evidence that EMDR EI reduces distress, with effects maintained at follow-up. However, no study has yet examined whether EMDR EI prevents the development of, or results in the remission of diagnosed PTSD or any other mental health disorder. No study has shown whether EMDR EI increases resilience. No study has compared EMDR EI to a trauma-focused CBT intervention. Future research is needed to investigate these and other critical questions. In addition, as innovative EMDR EI protocols are developed and applied, attention needs to be focused on conducting systematic research.

EMDR EI's advantages

Some EMDR EI procedures are known to reduce and/or eliminate symptoms of traumatic stress, depression, and anxiety, with results maintained at follow-up (usually about three months post-treatment). Adverse reactions have not been reported and EMDR EI's appear to be

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[4] Tarquinio, C., Rotonda, C., Houllé, W. A., Montel, S., Rydberg, J. A., Minary, L., et al. (2016). Early psychological preventive intervention for workplace violence: A randomized controlled explorative and comparative study between EMDR-Recent Event and Critical Incident Stress Debriefing. *Issues in Mental Health Nursing*, *37*(11),787-799.

[5] Jarero, I., Amaya, C., Givaudan, M., & Miranda, A. (2013). EMDR individual protocol for paraprofessional use: A randomized controlled trial with first responders. *Journal of EMDR Practice and Research,* 7(2), 55-64.

[6] Brennstuhl, M. J., Tarquinio, C., Strub, L., Montel, S., Rydberg, J. A., & Kapoula. Z. (2013). Benefits of Immediate EMDR vs. Eclectic Therapy intervention for victims of physical violence and accidents at the workplace: a pilot study. *Issues in Mental Health Nursing*, 34(6), 425-434.

[7] Shapiro, E., & Laub, B. (2015). Early EMDR intervention following a community critical incident: A randomized clinical trial. *Journal of EMDR Practice and Research,* 9(1), 17-27.

[8] Shapiro, E., Laub, B., & Rosenblat, O. (2018). Early EMDR Intervention following intense rocket attacks on a town: A randomised clinical trial. *Clinical Neuropsychology*.

safe and effective, with individuals of all ages, genders, and varied nationalities and ethnicities.

EMDR EI treatments are brief Interventions, which can be administered on consecutive days, and/or twice a day. They are easy to use, portable, accessible, and short-term treatments. They can be used in disaster zones, hospitals, emergency rooms, schools, clinics, agencies, refugee camps, and private therapy practices. They can be provided in a group format or to individuals.

EMDR EI interventions can also be viewed as efficient and inexpensive screening tools, providing a low intensity treatment that is adequate for the majority of sufferers, while simultaneously identifying individuals who require more intensive and costly treatment.

Any successful trauma treatment produces significant economic, social and cultural benefits for individuals, families and communities, although the efforts to quantify these benefits remain limited.

Possible future directions for the advancement of EMDR EI

The immense backlog of trauma, and the continuous addition of new cases, challenges the world's capacity to deal with this largely unrecognized global burden of trauma. EMDR EI holds the promise to make a significant contribution, by professionals, towards the elimination of this burden.

But bridging the treatment gap altogether requires the creation of additional capacities. There is a need for training and deploying large numbers of non-mental health professionals as well as fully trained and licensed professionals. This shortage of mental health personnel is particularly apparent following large- scale crises in low- and middle-income countries (LMICs). Non-mental-health professionals (see Appendix 1) are needed to extend mental health capacity, not to replace or compete with licensed mental health professionals.

The WHO has recently rolled out its CBT-based Low Intensity Intervention (LII) program[9] for implementation by non-specialists, covering the whole range of mental health conditions, including depression, suicidality, epilepsy, substance abuse etc. This program, part of WHO's mental health global action plan (mhGAP), comprises a large-scale training and evaluation scheme aimed at the shifting and sharing of tasks involving mental health interventions previously

[9] WHO, mhGAP Training Manual for the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings—version 2.0 (for field testing). References on pp. 466-470.

reserved for professionals. While this program is still in its test stage, it is based on earlier trials that provided scientific evidence of effectiveness. WHO has already developed guidelines and packages for the training, deployment and supervision of their LII non-specialists. For more information on Low Intensity CBT, see Appendix 2.

EMDR EI guidelines and implementation standards and procedures need to be further articulated and established. This should be followed by the development of recommended intervention packages designed for specific intervention conditions. Appropriate training methods for such interventions should be developed. Maximum use should be made of the new possibilities offered by the new technologies (MOOCs, apps, social media, etc.)

Reports and research regarding the value of EMDR EI should be gathered and evaluated, including those related to medium- to large-scale intervention projects. Presentations at the Summit Conference will bring together many new studies. A series of research questions, both scientific and conceptual are listed below, together with some operational and implementation issues.

Open questions regarding EMDR EI

Research is needed to answer the following clinical questions.

- What is the potential impact of EMDR EI following a traumatic event? Does it reduce development of physical or psychological symptoms? Reduce the number of problematic behaviors, such as substance abuse? Prevent the development of PTSD? Increase resilience? Positively impact quality of life? Assist in economic recovery for individuals and communities?
- What is the optimal utilization of EMDR EI? What is the optimal timing of interventions, choice of protocol, selection of participants, length of intervention? What data can readily be collected in time of crises?
- How do the EMDR EIs compare with other early mental health interventions? Data is needed regarding safety, effectiveness, ease of delivery, and ability to utilize non-mental health professionals as part of an intervention team.

Conceptual or policy questions

- Access: How can EMDR EI services be better known and more easily accessed by agencies, organizations, first-responders, individual consumers?
- Disaster and crises response in low and middle-income countries (LMICs). What is the best way to identify mental health needs and gain community support for intervention?
- Can EMDR EI services extend their reach and be implemented effectively by task sharing with trained non- specialist health care providers? To build capacity in LMICs, what is needed to ensure that such services are sustainable and of sufficient quality? Is the provision of EMDR EI economically efficient? What is the benefit/cost ratio for EMDR EI when compared to other interventions, or to no mental health intervention?
- Should EMDR EIs be included in large-scale and ongoing intervention models around the globe? If so, how can EMDR EI methods be integrated with comprehensive health and mental health care services globally?

9 April 2018

Appendix 1. Categories of non-mental-health professionals

It is not easy to delineate who is included in the term non-mental-health professional, given the differences in needs, resources, settings and cultures. WHO now uses the term non-specialist health care provider. This term can be considered to cover the following three groups:

(i) allied professionals-- medical professionals, including doctors, nurses, midwives who come in frequent contact with traumatized people

(ii) first-responders-- including emergency service providers, firefighters, police and military, who have first-hand involvement with traumatic events and affected people, and who are increasingly prepared to offer early psychological treatment to their colleagues and peers, and to others

(iii) paraprofessionals-- trained, skilled and supervised caregivers (but not licensed mental health professionals), including religious counsellors, voluntary health workers, trusted community caregivers and elders, and others.

Where there are no better alternatives, all these non-mental-health professionals are the best 'mental health people' available in low-resource settings and crisis situations.

Appendix 2. Low Intensity CBT

Low-intensity CBT (LI CBT) is a relatively new, empirically-supported, cost-effective treatment intervention that aims at 'improving access' by ensuring availability, utilization, effectiveness, equity, efficiency and client-centeredness.[10] It is delivered in a variety of different forms, including guided and unguided internet-based formats, CBT group interventions, and self-help strategies. In addition, it utilises several delivery formats and platforms, including telephone, email, SMS, as well as face-to-face sessions. These formats can be either personalised or automated.

Paraprofessionals trained in LI CBT are supported by licensed mental health workers to ensure treatment fidelity, provide support (particularly with difficult/challenging clients), enhance skills, and reinforce application. LI CBT paraprofessional training involves LI CBT programme delivery models; developing safe and effective working relationships; promoting self-help and providing support; developing and fostering relationships with key collaborative partners and stakeholders and conducting risk assessment, triage and referring on. The advantages of LI CBT include improving speed of access and the total number of people who can access evidence-based treatment interventions, flexibility in service delivery, capacity building, improved responsiveness, promoting client choice and informed decision making, and cost- effectiveness of services.

Appendix 3.

EMDR EI PROTOCOLS

Rosalie Thomas, Ph.D., Psychologist

Stabilization protocols (Use within minutes or hours)

- EMDR Emergency Room (EMDR-ER) Guedalia & Yoeli (2003)
- Emergency Response Procedure (ERP) Quinn (2005, 2009)
- Immediate Stabilization Procedure (ISP) Quinn (2018)

[10] Bennett-Levy, J. et al (2010) *Oxford Guide to Low Intensity CBT Interventions*. Oxford: OUP.

EEI protocols for individual treatment (Use from 24 hours to 78 hours)

- URGent EMDR Treatment Protocol (URG-EMDR) Brennstuhl et al. (2013), Tarquinio, C. et al. (2012)

EEI protocols for individual treatment (Use from two days to six months)

- Recent Event Protocol (REP) F. Shapiro (1995, 2001, 2018)
- EMDR-Recent Traumatic Episode Protocol (EMDR R-TEP) E. Shapiro & Laub (2008)
- EMDR Protocol for Recent Critical Incidents (EMDR PRECI) Jarero & Artigas (2011)
- EMDR Individual Protocol for use with Paraprofessionals (EMDR – PROPARA) Jarero, Amaya, Givaudan, & Miranda (2013)

EEI protocols for group treatment (Use from two days and beyond)

- EMDR Integrative Group Treatment Protocol (EMDR IGTP):
  - Adult - Jarero & Artigas (2000)
  - Adolescents (Between 14 and 17 Years) and Adults Living with Ongoing Traumatic Stress Artigas & Jarero (2009)
  - Early Intervention with Children Artigas, Jarero, Alcalá, et al, (2008)
- Group Traumatic Episode Protocol (G-TEP) E. Shapiro (2013)
- Imma Group Protocol (Based on IGTP for children 5 years and older). Laub & Bar- Sade (2009, 2013)

Descriptions of these protocols may be available in related research studies listed in Appendix 4. For more information, please contact the developers, or see :

Thomas, R., (2014, 2018). *EMDR Early Intervention and Crisis Response: Researcher's Toolkit*. Retrieved from www.emdrresearchfoundation.org/toolkit

Luber, M. (2014). *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets*. New York, NY: Springer Publishing Co.

Appendix 4.

RESEARCH ON EMDR EARLY INTERVENTION PROTOCOLS

Louise Maxfield, Ph.D., Psychologist – April 2018

Part A: Studies in which treatment was provided within 3 months post-trauma

Individual Treatment

Recent Event Protocol (EMDR-RE) Developed by Francine Shapiro	
RCT	Tarquinio, C., Rotonda, C., Houllé, W. A., Montel, S., Rydberg, J. A., Minary, L., et al. (2016). Early psychological preventive intervention for workplace violence: A randomized controlled explorative and comparative study between EMDR-Recent Event and Critical Incident Stress Debriefing. *Issues in Mental Health Nursing, 37*(11),787-799. DOI: 10.1080/01612840.2016.1224282
Case Studies	Buydens, S. L., Wilensky, M., & Hensley, B. J. (2014). Effects of the EMDR protocol for recent traumatic events on acute stress disorder: A case series. *Journal of EMDR Practice and Research, 8*(1), 2-12. https://doi.org/10.1891/1933-3196.8.1.2
	Silver, S. M., Rogers, S., Knipe, J., & Colelli, G. (2005). EMDR therapy following the 9/11 terrorist attacks: A community-based intervention project in New York City. *International Journal of Stress Management, 12* (1): 29-42. 1541. DOI: 10.1037/1072-5245.12.1.29.
	Wesson, M., & Gould, M. (2009). Intervening early with EMDR on military operations: A case study. *Journal of EMDR Practice and Research, 3*(2), 91-97. https://doi.org/10.1891/1933-3196.3.2.91
Recent Traumatic Episode Protocol (R-TEP) Developed by Elan Shapiro and Brurit Laub	
RCTs	Shapiro, E., & Laub, B. (2015). Early EMDR intervention following a community critical incident: A randomized clinical trial. *Journal of EMDR Practice and Research, 9*(1), 17-27. http://dx.doi.org/10.1891/1933-3196.9.1.17
	Shapiro, E., Laub, B., & Rosenblat, O. (2018). Early EMDR Intervention following intense rocket attacks on a town: A randomised clinical trial. Clinical Neuropsychology.

Controlled Study	Saltini, A., Rebecchi, D., Callerame, C., Fernandez, I. Bergonzini, E., & Starace, F. (2017). Early Eye Movement Desensitisation and Reprocessing (EMDR) intervention in a disaster mental health care context. *Psychology, Health & Medicine.* http://dx.doi.org/10.1080/13548506.2017.1344255
EMDR Protocol for Recent Critical Incidents (EMDR-PRECI) Developed by Jarero et al.	
RCTs	Jarero, I., Artigas, L., & Luber, M. (2011). The EMDR protocol for recent critical incidents: Application in a disaster mental health continuum of care context. *Journal of EMDR Practice and Research, 5*(3), 82-94. https://doi.org/10.1891/1933-3196.5.3.82
	Jarero, I., Uribe, S., Artigas, M., & Givaudan, M. (2015). EMDR protocol for Recent Critical Incidents: A randomized controlled trial in a technological disaster context. *Journal of EMDR Practice and Research, 9*(4), 166-173. https://doi.org/10.1891/1933-3196.9.4.166
Controlled Studies	Jarero, I., & Uribe, S. (2011). The EMDR Protocol for recent critical incidents: Brief report of an application in a human massacre situation. Journal of EMDR Practice and Research, 5(4), 156-165. https://doi.org/10.1891/1933-3196.5.4.156
	Jarero, I., & Uribe, S. (2012). The EMDR protocol for recent critical incidents: Follow-up report of an application in a human massacre situation. *Journal of EMDR Practice and Research*, 6(2), 50-61. https://doi.org/10.1891/1933-3196.6.2.50

EMDR Protocol with Paraprofessionals in Acute Trauma Situations (EMDR-PROPARA) Developed by Jarero et al.	
RCT	Jarero, I., Amaya, C., Givaudan, M., & Miranda, A. (2013). EMDR individual protocol for paraprofessional use: A randomized controlled trial with first responders. *Journal of EMDR* *Practice and Research, 7*(2), 55-64. https://doi.org/10.1891/1933-3196.7.2.55

Urgent EMDR Treatment Protocol (URG-EMDR) Developed by Cyril Tarquinio & Marie-Jo Brennstuhl	
Controlled Study	Brennstuhl, M. J., Tarquinio, C., Strub, L., Montel, S., Rydberg, J. A., & Kapoula. Z. (2013). Benefits of Immediate EMDR vs. Eclectic Therapy intervention for victims of physical violence and accidents at the workplace: a pilot study. *Issues in Mental Health Nursing, 34*(6), 425-434, DOI: 10.3109/01612840.2012.759633
Case Study	Tarquinio, C., Brennstuhl, M. J., Reichenbach, S., Rydberg, J. A., & Tarquinio, P. (2012). Early management of rape victims and presentation of an emergency EMDR treatment protocol. *Sexologies, 21* (3), 147-156. https://doi.org/10.1016/j.sexol.2011.11.012

Group Treatment

EMDR Integrated Group Treatment Protocol (EMDR-IGTP) Developed by Jarero et al.	
	Adúriz, M. E., Knopfler, C., & Bluthgen, C. (2009). Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. *International Journal of Stress Management*, *16*(2), 138–153. http://dx.doi.org/10.1037/a0014719
	Allon, M. (2015). EMDR group therapy with women who were sexually assaulted in the Congo. *Journal of EMDR Practice and Research, 9*(1), 28-34. http://dx.doi.org/10.1891/1933-3196.9.1.28
	Fernandez, I., Gallinari, E., & Lorenzetti, A. (2003). A school-based eye movement desensitization and reprocessing intervention for children who witnessed the Pirelli building airplane crash in Milan, Italy. *Journal of Brief Therapy, 2* (2). 129-36.
	Jarero, I., & Artigas, L. (2010). EMDR integrative group treatment protocol: Application with adults during ongoing geopolitical crisis. *Journal of EMDR Practice and Research*, *4*(4), 148–155. https://doi.org/10.1891/1933-3196.4.4.148

Case Studies	Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative treatment protocol: A post-disaster trauma intervention for children & adults. *Traumatology*, *12*, 121–129. https://doi.org/10.1177/1534765606294561
	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. https://doi.org/10.1891/1933-3196.2.2.97
	Korkmazlar-Oral, U., & Pamuk, S. (2002). Group EMDR with child survivors of the earthquake in Turkey. Association of Child Psychology and Psychiatry (ACPP). Occasional Papers No. 19, 47–50
	Maslovaric, G., Zaccagnino, M., Mezzaluna, C., Perilli, S., Trivellato, D., Longo, V., & Civilotti, C. (2017). The effectiveness of Eye Movement Desensitization and Reprocessing Integrative Group Protocol with adolescent survivors of the Central Italy Earthquake. *Front. Psychol*. 8:1826. DOI: 10.3389/fpsyg.2017.01826
	Zaghrout-Hodali, M., Alissa, F., & Dodgson, P. (2008). Building resilience and dismantling fear: EMDR group protocol with children in an area of ongoing trauma. *Journal of EMDR Practice and Research, 2*(2), 106-113. doi:10.1891/1933-3196.2.2.106

Appendix 5.

RESEARCH ON EMDR EARLY INTERVENTION PROTOCOLS

Part B: Studies in which EMDR EI treatment was provided for "ongoing" or historical trauma

Individual Treatment

Recent Traumatic Episode Protocol (R-TEP) Developed by Elan Shapiro and Brurit Laub	
RCT	Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M. Gulen, B., & Cuijpers, P. (2016). The efficacy of eye movement desensitization and reprocessing for post- traumatic stress disorder and depression among Syrian refugees: Results of a randomized controlled trial. *Psychological Medicine, 46*(12), 2583-2593.

	https://doi.org/10.1017/S0033291716001070

Group Treatment

Group Traumatic Episode Protocol (G-TEP) Developed by Elan Shapiro	
RCT	Yurtsever, A., Tükel, F., Konuk, E., Çetinkaya, M., Zat, Z., & Shapiro, E.D. (2018). An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees with posttraumatic stress symptoms: Results of a randomized controlled trial. *Frontiers of Psychology.* https://www.frontiersin.org/articles/10.3389/fpsyg.2018.00493/full
Field Study	Lehnung, M., Shapiro, E., Schreiber, M., & Hofmann, A. (2017). Evaluating the EMDR Group Traumatic Episode Protocol (EMDR G-TEP) with refugees: A field study. *Journal of EMDR Practice and Research 11*(3). https://doi.org/10.1891/1933-3196.11.3.129
Case Study	Roberts, K. A. (2018). The Effects of the EMDR Group Traumatic Episode Protocol, G-TEP with cancer survivors. *Journal of EMDR Practice and Research, 12*(3), 105-117. DOI: 10.1891/1933-3196.12.3.105.
EMDR Integrated Group Treatment Protocol Adapted for Adolescents and Adults with Ongoing Traumatic Stress (EMDR-IGTP-OTS) Developed by Jarero et al.	
RCT	Jarero, I., Givaudan, M., & Osorio, A. (2018). Provision of the EMDR IGTP OTS to female patients with cancer-related PTSD symptoms. *Journal of EMDR Practice and Research, 12*(3), 94-104. DOI: 10.1891/1933-3196.12.3.94.
Controlled Study	Jarero, I., Artigas, L., Uribe, S., García, L. E., Cavazos, M. A., & Givaudan, M. (2015). Pilot research study on the provision of the eye movement desensitization and reprocessing integrative group treatment protocol with female cancer patients. *Journal of EMDR Practice and Research, 9*(2), 98-105. https://dx.doi.org/10.1891/1933-3196.9.2.98
Case Study	Jarero, I., Roque-López, S., & Gomez, 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.

https://doi.org/10.1891/1933-3196.7.1.17

Clare Blenkinsop studied Sociology at Durham University, followed by Business Management at the London School of Management Studies. Having worked in UK theatre management for almost ten years, Clare re-trained to work in business promotion in developing countries. She lived for 25 years outside Europe, including in Indonesia, Malaysia, Bangladesh, Zambia, Myanmar, Nepal and Dominica, working with both national and international NGOs (Consumers International, Save the Children), and UN agencies, the longest period being with UNICEF for 15 years working in advocacy and communication fields. In 2016, having worked in Geneva for several years, she joined Rolf Carriere to establish and run the Global Initiative for Stress and Trauma Treatment (GIST-T).

Rolf Carriere studied development economics and philosophy at Groningen University, Netherlands. From 1971 till 2005 he worked with UNICEF and the World Bank, mostly in health and nutrition in Asia, including nine years in India. His last positions were UNICEF Country Representative in Bhutan, Myanmar, Bangladesh and Indonesia. In 1985, he co-founded the Iodine Global Network (ICCIDD). In 2002, Rolf established and managed the Global Alliance for Improved Nutrition (GAIN) in Geneva. In 2016, he founded the Global Initiative for Stress and Trauma Treatment (GIST-T). Rolf currently serves on the Boards of Nonviolent Peaceforce and the Free Yezidi Foundation.

Derek Farrell is Principal Lecturer in Psychology at the University of Worcester (UK), where he is course director of the world's first MSc EMDR Therapy programme. Derek is involved in trauma capacity building projects in Pakistan, Turkey, India, Cambodia, Myanmar, Thailand, Indonesia, Philippines, Lebanon, Poland, Palestine and Iraq. Derek is an EMDR Europe Approved Trainer and Consultant, as well as a Chartered Psychologist with the British Psychological Society, and an Accredited Psychotherapist with the British Association of Cognitive and Behavioural Psychotherapies (BABCP). He is President of EMDR Europe Trauma Aid Programme, and Vice-President of EMDR Europe. In 2013, he received the David Servan- Schreiber award.

Marilyn Luber is a licensed clinical psychologist in Philadelphia, Pennsylvania. She specializes in EMDR Therapy and has presented at

national and international conferences and has undertaken workshops in the United States, Europe, Middle East and China. She edited a series of six books on different uses of EMDR protocols and procedures. She has published articles in professional journals and regularly contributes two columns to EMDRIA's newsletter. She has received the Francine Shapiro Award, the EMDRIA Award for outstanding contribution and service to EMDRIA, and the EMDR Humanitarian Services Award. Currently, she is a facilitator for the EMDR Global Alliance supporting the standards of EMDR Therapy worldwide.

Louise Maxfield is a clinical psychologist and EMDRIA consultant. After becoming an EMDR therapist in 1993, she was an investigator in four EMDR research studies and has consulted on many international research projects. She has published more than 20 scientific articles and chapters about EMDR, is the co-editor of Handbook of EMDR and Family Therapy Processes, and has presented six plenary addresses at EMDRIA and EMDR Canada conferences about EMDR research. She is the founding editor and Editor-in-Chief of the Journal of EMDR Practice and Research. Dr. Maxfield has received the Outstanding Research Award from both EMDRIA and EMDR Canada, and EMDRIA's Francine Shapiro Award.

Mark Nickerson, a psychotherapist in Amherst, MA for 30 years, is an EMDRIA approved consultant and an EMDR Institute trainer. He conducts advanced EMDR trainings nationally and internationally on topics including treatment for problem behaviors, problematic anger and violence, cultural competence, and the effective use of EMDR protocols. He has developed innovative programs designed to reduce and resolve interpersonal conflict and created the Cycle Model to assess and treat problem behaviors. He has served on the EMDRIA Board for six years and was President in 2014. He is editor/author of Cultural Competence and Healing Culturally-Based Trauma with EMDR Therapy: Insights, Strategies and Protocols (Springer, 2016) and The Wounds Within (Skyhorse, 2015), on challenges facing war veterans and their families.

Udi Oren is a clinical and medical psychologist who has been part of the EMDR community for the past 20 years. He provides EMDR trainings, as an EMDR Institute and an EMDR Europe trainer, in many countries in Asia, Europe and Africa, and has actively contributed to the growth of several EMDR national associations. Areas of greatest clinical interest include the field of combat-related PTSD (and other conditions) and stress/trauma related medical conditions. Udi has served as the Chair of the Israeli EMDR Association since its creation in 1997, and as the President of EMDR Europe between 2007 and 2015.

Rosalie Thomas is a licensed psychologist in Washington State. Now retired, she offers consultation and training in EMDR. Rosalie served as Board Member, Treasurer and President of the EMDR International Association. She is an EMDRIA Certified Clinician and Approved Consultant and currently chairs the EMDRIA conference committee. Rosalie is also a facilitator and trainer for the EMDR Humanitarian Assistance Program, and facilitator for trainings given by the EMDR Institute. She has participated in training programs throughout the United States, Japan, Bangladesh, and India. In 2006, Dr. Thomas was the recipient of an award for Special Recognition of her leadership in EMDRIA and she was the recipient of the Francine Shapiro Award in 2007.

EARLY PSYCHOLOGICAL INTERVENTION FOLLOWING TRAUMA (EPI): CURRENT STATUS, ISSUES AND THE CASE FOR EARLY EMDR INTERVENTION (EEI)

Elan Shapiro, MA

This presentation drew attention to the status and challenge of Early *EMDR* Intervention (EEI) in the context of Early *Psychological* Intervention (EPI) in general and what it uniquely has to offer to this important field that is still seeking solutions to many unanswered questions. The ironic situation in which so many EMDR practitioners are involved with early intervention all over the world, yet the paucity of systematic data collection and suitable controlled studies and consequently the lack of recognition of EEI in international guidelines, underlines Francine's plea that without published research what we are doing is only 'buckets in the ocean'.

One of the major challenges for EMDR Early Intervention (EEI) is to be recognised in international guidelines. For this we need to look at Early *Psychological* Intervention (EPI) in general and the guideline requirements, for example of the Cochrane studies and World Health Organization (WHO). When we look at the broader picture and developments in the field, we need be aware of prevailing attitudes and policies such as 'watchful waiting' during the first 1-3 months following trauma (Recommendation of the UK National Health Service based on NICE guidelines). Is there clear evidence for prevention? A large outreach study examining prevention effects of early intervention of five conditions (CBT, PE, SSRI, Placebo, declined treatment.) found

that the outcomes at a 3-year follow-up that they were all at about the same level of PTSD symptoms (about 20%) showing no long-term difference among all the conditions. The conclusion was that we are not preventing PTSD at all in the long term, as is also evidenced by the little changed prevalence of PTSD level in national comorbidity surveys over the years despite apparently effective treatments in the short term.

Could EMDR have fared better? The advantages of EMDR were outlined: EEI can be presented as a brief user-friendly routine Adaptive Information Processing (AIP) check-up.

Requiring no homework, it can be conducted on consecutive days.

EEI and Prevention:

For preventing the accumulation of Trauma memories.

EMDR and self-affirmation, outcomes suggest it can be seen as a 'Value Added Treatment' (VAT) that may strengthen resilience and assist Post Traumatic Growth (PTG).

The neurobiological aspects of PTSD may be more suitably addressed by the various non-verbal and established neurobiological effects of EMDR and Bi-Lateral Stimulation.

Supportive evidence is emerging from initial controlled studies.

There is a range of powerful individual and group EEI protocols

The need for scaling up the availability of EEI in large scale emergency situations was noted and a hierarchical Early EMDR Intervention strategy proposed.

Elan Shapiro is a psychologist in private practice with over 30 years of experience working in a community psychological service in upper Nazareth. He came to EMDR Therapy in 1989 after attending one of the first trainings Francine Shapiro ever gave. In 1994 he became an EMDR Institute facilitator and was among the founding members of EMDR Europe. He is an accredited consultant and past Secretary of EMDR Europe. Recipient of the Servan-Schreiber award, from the University of Lorraine, Metz, in November 2012, and also the Servan-Schreiber award for contributions to EMDR Therapy at the EMDR Europe Conference, The Hague, June 2016.

RESEARCH ON EMDR EI: CURRENT STATUS

Louise Maxfield, PhD

At least 23 published research studies have investigated the use of EMDR EI procedures in the treatment of posttraumatic stress, within 3 months following the traumatic episode. Fourteen studies were uncontrolled, 3 were non-randomized controlled studies, and 6 were randomized controlled trials (RCTs). All controlled studies were conducted with adults, none with children or adolescents.

There is strong consistent evidence that EMDR EI significantly reduces symptoms of PTSD, with effects maintained at follow-up.

Nine Controlled Studies Have Investigated Five EMDR EI Protocols

Francine Shapiro's Recent Event Protocol (REP, aka EMDR-RE)	Cyril Tarquinio et al.	1 RCT
URG-EMDR	Marie-Jo Brennstuhl & Cyril Tarquinio	1 controlled study
Recent Traumatic Episode Protocol R-TEP	Elan Shapiro & Brurit Laub	2 RCTs 1 controlled study
EMDR Protocol for Recent Critical Incidents, EMDR-PRECI	Ignacio Jarero et al.	2 RCTs 1 controlled study
EMDR Protocol for Paraprofessionals EMDR-PROPARA	Ignacio Jarero et al.	1 RCT

Effect Sizes

All 9 studies produced large effect sizes, with Hedges' g ranging from g=0.92 to g=4.08. There was an indication that larger effect sizes may be more common when treatment was provided soon after the event. Effect sizes were also larger when the sample was homogeneous with low variance.

Participants
The participants in the controlled studies were adult survivors of workplace violence, earthquakes, a factory explosion, and missile/rocket attacks. Studies were conducted in France, Israel, Mexico, and Italy.

Where are the Group Protocols?
There are two EMDR group protocols, commonly used for early intervention: Jarero et al.'s EMDR Integrated Group Treatment Protocol, EMDR-IGTP and E. Shapiro's Group Traumatic Episode Protocol, G-TEP. There are nine case studies that investigated Jarero's EMDR-IGTP. Seven of these studies were conducted with children and adolescents. The research took place in disaster/crisis settings in Argentina, the Congo, Honduras, Italy, Mexico, and Palestine. All studies reported decreases in posttraumatic symptoms following treatment.

No controlled studies have been conducted, for recent trauma, using either group protocol. Controlled studies have been done for chronic and ongoing trauma, with refugees and cancer patients, using both G-TEP and 'EMDR-IGTP-adapted for adults and adolescents experiencing ongoing traumatic stress', EMDR-IGTP-OTS. Those treatments produced significant improvement in posttraumatic stress symptoms.

Future Research
Future research is needed to determine whether individual and group EMDR EI

- Are effective for children and adolescents in decreasing symptoms of PTSD
- Prevent the development of PTSD
- Increase resilience
- Improve quality of life
- Decrease symptoms of depression and/or anxiety
- Improve somatic complaints

Future research is also needed to

- Compare EMDR EI procedures with trauma-focused CBT
- Compare R-TEP and PRECI
- Compare G-TEP and IGTP
- Compare EMDR EI individual treatment with group procedures
- Evaluate treatment outcome and economic costs, comparing the provision of individual EMDR EI with EMDR EI group treatment.

Louise Maxfield is a clinical psychologist and EMDRIA consultant in Ottawa Canada. After becoming an EMDR therapist in 1993, she was an investigator in several EMDR research studies and has consulted on many international research projects. She has published more than 20 scientific articles and chapters about EMDR, is the co-editor of Handbook of EMDR and Family Therapy Processes and has presented six plenary addresses at EMDRIA and EMDR Canada conferences about EMDR research. She is the founding editor and Editor-in-Chief of the Journal of EMDR Practice and Research. Dr. Maxfield has received the Outstanding Research Award from both EMDRIA and EMDR Canada, and EMDRIA's Francine Shapiro Award.

GLOBAL NEEDS AND OPPORTUNITIES FOR EMDR

Rolf Carriere, MA

Recalling Francine Shapiro's vision to bring EMDR healing to this traumatized world as fast as feasible, this presentation makes a strong case for scaling up trauma care trainings, with a focus on the use of simplified EI protocols by trained and supervised paraprofessionals working and living in low- and middle-income countries (LMICs). Such innovations should always be accompanied by evaluative research to validate, adjust and build new knowledge.

Worldwide, the prevalence of trauma-based disorders and diseases is seriously underestimated due to lack of country prevalence studies and measurement challenges (shifting definitions, deliberate underestimations, and stigma). An indirect estimate for global prevalence, 500 million people living with PTSD, is made plausible when reviewing reliable statistics on exposure to direct, structural, natural and cultural violence. The most stunning statistic is that over the past 15 years, no less than 3.34 billion people have been exposed to violence—that is almost half the world population! Reasons are also presented why the trauma problem is likely to get worse before it may get better.

Underestimation of prevalence, low mental health budgets and shortages of professional staff explain why the devastating consequences of trauma have not been addressed in a way commensurate with its extent and severity. Because trauma is a driver of poverty and a driver of violence, it poses a direct threat to two of the world's core agendas: its development agenda and its peace

agenda. In fact, trauma undermines both. Therefore**,** trauma should also become the concern of non-mental health professionals: economists, diplomats, parliamentarians, educationists, business people, journalists, peace negotiators.

It's no exaggeration to say that trauma has helped shape history, because history is replete with traumatic events and circumstances that have left their unseen imprint on the memories of many, many millions in the past. That same process continues to this day, only on a larger scale. Therefore, trauma will remain a momentous, negative force that will shape our future. Unless… Unless, we can get past our traumatic past, on a global scale. The sooner, the better. Scaling up trauma care would make a truly historic contribution, and would open up a much, much brighter future for us all!

The world today has the technical tools available to tackle trauma (EMDR, TF-CBT and PFA). In addition, the global communications and skills revolutions of recent decades make possible the scaling up of outreach services on an unprecedented scale. **So, while the global burden of trauma gets heavier, the conditions for a successful trauma care revolution are more favorable than ever. But use of paraprofessionals will be a *sine qua non*!**

In that context, the World Health Organization (WHO) has begun rolling out an ambitious CBT-based Low Intensity Intervention program for non-specialist health personnel in LMICs, covering eight mental health conditions. Surprisingly, trauma/PTSD does not figure prominently in this program. This creates an important niche for EMDR, because EI—and especially a simplified variant for use by paraprofessionals— holds a unique potential and promise to confront the trauma epidemic at scale.

Therefore, it is recommended that EMDR global leadership initiate a dialogue with major stakeholders about a World Plan to Combat Trauma.

Rolf Carriere studied development economics and philosophy at Groningen University, Netherlands. From 1971 till 2005 he worked with UNICEF and the World Bank, mostly in health and nutrition in Asia, including nine years in India. His last positions were UNICEF Country Representative in Bhutan, Myanmar, Bangladesh and Indonesia. In 1985, he co-founded the Iodine Global Network (ICCIDD). In 2002, Rolf established and managed the Global Alliance for Improved Nutrition (GAIN) in Geneva. In 2016, he founded the Global Initiative for Stress and Trauma Treatment (GIST-T). Rolf

currently serves on the Boards of Nonviolent Peaceforce and the Free Yezidi Foundation.

PEACEBUILDING AND TRAUMA: WHAT DO EMDR-EI, MEDICAL PERSONNEL AND MEDIATORS HAVE IN COMMON?

Louisa Chan Boegli, MD

High incidence and prevalence of Acute Stress Disorder (ASD), PTSD and other trauma disorders have long been observed in war-ridden societies. Psychological trauma has been documented in all contemporary wars from Afghanistan to Bosnia, from Cambodia to Rwanda. The scale and the impact are predictable when wars are increasingly deadly, and when extreme violence, including gender-based violence are used as a weapon of war. Despite the predictable humanitarian and peacebuilding consequences, the response has repeatedly come up short.

In the case of Syria, the WHO led mental health response to the crisis was introduced three years into the war that started in 2011. The central strategy is to train general practitioners in handling mental health and neurological disorders. Even with international collaboration from humanitarian organisations, the race to meet the immense needs in Syria is far from over. It is estimated that eleven million children, adolescents and adults are at risk of psychological trauma. What is required? Early response using therapeutic interventions that are rapidly effective, can be applied in groups, and used across cultures for children, adolescents and adults.

There is well-documented evidence that EMDR is effective in disaster contexts. A robust strategy is needed to enhance the surge capacity of trauma interventions ahead of crises. The EMDR community can collaborate on a focused effort to adapt existing EMDR-EI protocols for training of non specialised medical personnel in 'fragile countries' with high levels of violence, countries that are prone to armed conflict. Using the primary health care model would further ensure wartime trauma care coverage by trained personnel. Trained specialists, either on site, or by remote means, must provide supervision. One other consideration for the EMDR community is to scale up research so that the practice may be integrated into existing platforms such as WHO's (World Health Organisation) mhGAP-IG (Mental Health Global Action

Plan – Intervention Guide) which is available as smart phone Apps for low- and middle-income countries (LMICs). Other platforms include GIST-T (Global Initiative for Stress and Trauma Treatment) e-learning platform based on the Resource Kit for trauma self–care targeting humanitarian workers; or MPW (Medical Peace Work) MOOC and open access online courses on health and peace studies.

Trauma care is central to peacebuilding, not only in the prevention of cycles of violence, but also in enabling dialogue and reconciliation such as in peace processes. Mediators and participants in these processes are confronted with stress, emotional exhaustion, and vicarious trauma. Integrating EMDR-EI into mediation processes would prevent trauma related obstacles to continued dialogue and engagement by the parties involved in the process.

The EMDR community can play a significant role in both humanitarian and peacebuilding responses to violent conflict which affect millions of people today.

Psychologists involved in peacebuilding are not new. The following institutions are involved in peacebuilding activities.

- International Psychologists for Social Responsibility http://www.inpsysr.org/
- American Psychological Association Peace Psychology Division http://peacepsychology.org/
- Australian Psychological Society's Psychologists for Peace
- Germany Friedenspsychologie

Louisa Chan Boegli studied medicine and public health in the US and UK, and worked most of her professional life with the ICRC and WHO in war-torn countries. In the last 10 years, she became involved with peacebuilding. With Humanitarian Dialogue, Geneva she initiated the mediation of peace processes in Aceh, Indonesia, and in Myanmar. This then led to capacity building of national medical professionals in humanitarian and peacebuilding work. This work has been documented in Conflict, Medicine and Survival and in Healing under Fire – the Case of Southern Thailand, 2014. Louisa is currently the Senior Adviser of 4Change (Italy) and Medical Peace Work (Norway), and Board Member of PeaceNexus, Nonviolent Peaceforce and GIST-T.

A WASTING ASSET
EMDR AND GLOBAL VIOLENCE

Nigel Roberts, MA, MPhil

The EMDR community has developed tools that could exert a profound influence on global violence - but too few people outside your circle appreciate this, and far too few trauma victims are benefiting from what you've got.

In 2013 the World Health Organization recommended EMDR and trauma-focused CBT as the two evidence-based treatments for PTSD. And yet, health professionals aside, relatively few people have even heard of EMDR, while TF-CBT, a treatment that most of you believe is less effective for trauma than EMDR, has established a niche for itself on the global mental health scene.

Part of the reason for CBT's greater prominence is the scarcity of compelling EMDR research. In the 30 years since Dr. Shapiro discovered EMDR, only 37 randomized controlled EMDR trials have been carried out. There are over 1,000 on CBT, and about 125 on trauma-focused CBT.

You also have a marketing problem. From a development specialist's perspective, even one who grasps the importance of trauma, EMDR is hard to grasp, bizarre even. You need to recognize this when talking to development policy-makers and financiers.

EMDR also needs to be scaled up - not simply through group protocols, but by using paraprofessionals. The extent of the problem and the feebleness of medical infrastructure means you cannot rely exclusively on licensed EMDR practitioners. Tackling the danger of paraprofessional dilution or misuse is a challenge that was resolved 40 to 50 years ago in the development business with regard to paramedics, agricultural extension agents and community infrastructure personnel. The keys to success are simple, clear protocols; rigorous training; a strict system of referral; and close supervision.

There are four steps you can take that could propel a breakthrough for EMDR in the international development arena.

- The first is a concerted effort to undertake randomized controlled trials that show the efficacy of EMDR in violent contexts. These trials should specifically compare EMDR protocols with other forms of psychosocial intervention, most particularly TF-CBT. Don't wait

for others to bankroll this research: once you have demonstrated EMDR's superiority, money won't be the problem.

- Second, choose a couple of high-profile conflict situations, send teams there, assess the problem, undertake some initial treatment work - and study it (possible examples: the Rohingya refugee camps in Bangladesh, cities in Iraq until recently part of the ISIS 'caliphate'). Again, you should commit to paying for the first couple of these exercises yourselves.

- Third is to embrace the use of paraprofessionals, and to set up and formalize the controls needed to ensure their success. You aren't going to interest potential financiers unless you convince then you have something that can make a dent on the scale of global trauma.

- And fourth, you need to do a much better job of selling EMDR. Even the name is a mouthful and makes little sense to the uninitiated. I would advise you to seek expert consultant help on this.

I suggest you think in terms of a 3-4 year program. You will need the time of a high-level committee, and money to enable you to initiate strategic research and treatment. You will need vision, high-level leadership and consistent effort. A great deal of international funding has been committed to countries in conflict - the World Bank now provides $5 billion each year - and you only need to capture a small slice to fund a truly global EMDR program. Unless you organize yourselves, though, the money that is out there today will continue to remain out of your reach.

After training at Oxford and Reading, Nigel Roberts worked in various capacities with the World Bank (1981-2011), including as country director in Nepal, Ethiopia, West Bank/Gaza and the Pacific Islands. Currently Nigel works as a consultant to governments (notably Myanmar and Somalia), bilateral donors and the World Bank, focusing on both implementing and re-evaluating the recommendations of the 2011 World Development Report on Conflict, Security and Development, which he co-led. Nigel is Chair of the UN Secretary General's Advisory Board for the UN Peace Building Fund; in that capacity, he has reviewed PBF field programs in Nepal, Somalia, Mali and Tunisia (for Libya). Nigel also serves on the advisory board of the Nordic International Support Foundation.

REACHING ALL WITH HEALTH INTERVENTIONS: LESSONS FROM GLOBAL PRIMARY HEALTH CARE

Jon Rohde, MD

Dr. Jon Rohde was a member of the team that developed oral rehydration therapy (ORT), described by the Lancet as '…arguably the most important medical advance of the 20th century.' By simplifying the therapy, ORT was taught to low-level health workers, Community Health Workers (CHWs) and even village mothers, carrying the benefits of modern medicine to the remotest villages. Over 50 million children have been saved from diarrhea deaths over the course of the past four decades. Dr. Rohde's work with the former leader of UNICEF, James Grant, by selecting a few impactful and simplified health interventions drove the Child Survival Revolution, saving millions of lives and leading to the UN commitment to the Millennium Development Goals.

Dr. Rohde shared with conference participants the lessons learned from this Revolution that could be applied to the challenge of scaling up EMDR services to treat global trauma. **"Professional reluctance was a major impediment… the challenge you have is to make this amazing technology more widely available throughout the world… Imagine the impact of five million trained first-responders to mental trauma."**

The invention of simplified, safe and easy to administer technologies and the transition of services FROM the doctors-to-nurses-to-paraprofessionals/community health workers-to-volunteers-to-mothers was the key to success in saving millions of lives. They showed through careful and rigorously controlled RCTs and blinded studies that this indeed was achievable. The preponderance of the evidence led to the eventual universal embrace of these methods by professionals, paraprofessionals, Presidents, Prime Ministers, Governments, NGOs, WHO and the United Nations. With a unified commitment they made the impossible happen.

The ORT team found that early intervention was a critical factor in averting fatalities. Can EMDR practitioners show that EI could avert PTSD? Dr. Rohde was cautious over the name of EMDR and suggested it might be repackaged in a simpler way – for example, 'Safe, Health Intervention For Trauma or SHIFT', or another term that is less intimidating and more memorable to the public.

Dr. Rohde's prescription and challenge for all involved with EMDR:

- *You must lead the way – who is the James Grant of EMDR?*
- *You must simplify – to make the essentials of EMDR easier to learn and remember.*
- *Rigorous research must be conducted and widely published.*
- *EMDR must join the WHO mhGAP community with open access online training and focus on trauma. This is a readily available niche for EMDR, if the message is appropriately and reliably simplified.*
- *The EMDR message needs to be carried more widely to the public and decision makers.*
- *Don't let up until you reach your goals.*

A Harvard-trained public health specialist and pediatrician, Jon Rohde currently teaches at several schools of Public Health in South Africa, Uganda and Bangladesh. He directed and advised the South African EQUITY Project (1997-2004) restructuring the national health care system. For 12 years he worked in India, lastly as Representative of UNICEF (1993-1997). As Global Advisor to UNICEF (1980-1995), Jon was the designer of the Child Survival Revolution known for its emphasis on Growth promotion, Oral rehydration, Breastfeeding and Immunization (GOBI). Before that, Jon held leading research, training and advisory positions in public health in Haiti, Indonesia and Bangladesh. Jon has published widely in the area of infectious disease, nutrition, information systems for health, community involvement and public health.

TAKING LOW-INTENSITY INTERVENTION TO THE FIELD

Alexandra Rose, MSc

Alexandra Rose outlined several of the mental health programs that Partners in Health (PIH) has pioneered in Rwanda, Lesotho, Peru, Haiti, Mexico and other low- and middle-income countries (LAMICs). Partners in Health is foremost a health organization focusing on health system strengthening in low resource countries. The principles they utilize are task-shifting to community health workers to compensate for the lack of trained specialists in order to bridge the global mental health gap. Task-shifting is broadly used in global healthcare settings that lack resources, have high rates of illness and, where commonly,

up to 90% of people requiring treatment have no access. PIH's main strategy has been to integrate mental health into primary health with strict monitoring and supervision support. To ensure patient safety each tier is supervised, mentored and monitored at their own level for quality control.

Alexandra Rose featured Rwanda as a case example to illustrate the kind of work and context in which PIH has successfully implemented its mental health program. They adopted a model of foundational training previously used in HIV work known as MeSH, Mentorship, Enhanced Supervision and Quality Improvement at Health Centers. They provide:

- *Preservice training*
- *Ongoing mentorship*
- *Supervision; with structured feedback sheets to track progress*
- *Continuous quality assessment*
- *Follow-up for community health workers to ensure treatment adherence, social support and to reduce stigmatization*

They used MeSH mental health to integrate low intensity psychotherapy into healthcare. Problem Management (PM+) was the WHO model used.

For more information please visit https://pih.org/programs/mental-health or http://www.mhinnovation.net/organisations/partners-health.

Lessons learned:

Individuals delivering mental health care must have the right personal qualities. Strong supervision structures are essential with an ability to absorb referrals for additional more intensive care, if indicated. Appropriate cultural attunement should go beyond language considerations and account for factors such as literacy rate. Appropriate leisure pursuits in certain contexts, the gender of the healthcare worker and the gender of the patient receiving treatment are examples of other factors that must be considered. Whether psychotherapy sessions should be conducted with a closed door and other culturally sensitive factors have been key considerations. Additionally, roll-out mechanisms, adequate screening and the scheduling of wait times must all be carefully managed to make the delivery viable.

The central message of the presentation for successful implementation of scaled up mental health services ws the importance of building the structure of the delivery system and not just the intervention protocols themselves. All

interventions must be adapted to the specific cultural context and the existing health system.

The EMDR Therapy profession has not yet developed its own effective delivery systems that can be taken to scale. Learning from, and partnering with, health organizations such as Partners in Health will be essential if we are to make that quantum leap in treatment availability.

Alexandra Rose is the Program Manager for Mental Health at Partners in Health (PIH), an international non-profit dedicated to health system strengthening. In her role at PIH, she provides project management and technical support in developing, implementing, and evaluating mental health services across all PIH sites, including Rwanda, Liberia, Lesotho, Malawi, Mexico, Peru and Haiti. Key projects include adaptation of Problem Management Plus (PM+) to the Rwandan context and implementation of Interpersonal Therapy (IPT) in the Haitian context. Prior to joining PIH, she received an MSc in Global Mental Health from the London School of Hygiene and Tropical Medicine and King's College London Institute of Psychiatry, Psychology, and Neuroscience and worked in health system strengthening in rural southern Malawi and social services in New York City. She will be starting as a doctoral student in the University of Maryland Clinical Psychology PhD program in Fall 2018, working with Dr. Jessica Magidson in the Global Mental Health and Addiction lab.

EXPANDING THE HORIZONS OF THE EMDR-BASED EARLY INTERVENTIONS: THE EMDR PROTOCOL FOR RECENT CRITICAL INCIDENTS AND ONGOING TRAUMATIC STRESS

Ignacio Jarero, PhD

Early psychological interventions traditionally have been understood as interventions that began within the first 3 months after a traumatic event. To Dr. Jarero, EMDR-based early interventions could be conceptualized as those interventions provided within a continuum of care context during the first 3 months after the adverse experience, or later in case of ongoing traumatic stress situations with no post-trauma safety period for memory consolidation.

During the conference participants were familiarized with the following topics:

- **Early psychological interventions definitions:** including those of Roberts et al. (2010), Scully (2011), and other authors (Kehle et al. 2010). Also, the US Dept. of Veterans Affairs and the Dept. of Defense (VA/DOD) called all interventions for post-traumatic stress, acute stress reactions (ASR), ASD, and PTSD, as management of post-traumatic stress (2010), or management of PTSD and ASD (2017). The word *intervention* therefore could refer to a wide range of activities from addressing immediate psychological need (e.g. PFA) to psychopharmacotherapy.

- **Recent trauma clinical presentations**: including Acute Stress Syndrome, Recent Event and Cumulative Trauma Exposure Memory Network. The important concept of post-trauma safety period was introduced.

- **Prevention of PTSD:** Jonathon Davidson (2002) categorized prevention in three ways – Primary is the prevention of exposure to trauma, Secondary is preventing the development of PTSD immediately after exposure to trauma, and Tertiary is the prevention of worsening once PTSD has emerged.

- **EMDR-based early interventions:** including Francine Shapiro's Recent Event Protocol (1989), Jarero, Artigas and Luber's Early EMDR Therapy Interventions (2011) and Elan Shapiro's EMDR-based Protocols for Early Interventions (2009), highlighting the different parameters for the different protocols' application.

- **AIP-model based Acute Trauma and Ongoing Traumatic Stress Theoretical Conceptualization:** a discussion of the Jarero and Artigas theory that, from a memory network perspective, acute trauma situations are related not only to a time frame (days, weeks or months), but also to a post-trauma safety period.

- **Expanding the horizons of the EMDR Early Interventions:** a discussion supporting the argument that the arbitrary first three months early intervention frame could now be extended to include ongoing traumatic stress situations with not post-trauma safety period for memory consolidation.

- **Expanding the EMDR Therapy healing power:** Could be expanded with EMDR-therapy based early interventions for individuals and groups specially designed for acute trauma and

ongoing traumatic stress situations. A complete article about this case conceptualization is at: http://revibapst.com (Vol 10, Number 1, 2018).

- **The EMDR Protocol for Recent Critical Incidents and Ongoing Traumatic Stress (EMDR-PRECI):** developed in the field to treat disaster survivors when related stressful events continue for an extended time and there is not a post-trauma safety period.
- **EMDR-PRECI research evidence and EMDR-PRECI Ongoing and Planned Humanitarian Trauma Recovery and Research Projects:** including descriptions of an ongoing study to understand the neurophysiological and neuropsychological effects of changes in female patients with cancer-related PTSD in Mexico, together with other studies relating to a human massacre situation and with first responders.
- **EMDR-PRECI Key Procedures:** details of the seven phases of this protocol.

Ignacio (Nacho) Jarero is an EMDR Institute and EMDR-Iberoamerica senior trainer of trainers and specialty trainer. He specializes in humanitarian trauma recovery and research programs on EMDR Therapy. He has conducted seminars and workshops with participants from 65 different countries, and since 1998 has provided field services around the world to natural or human-provoked disaster survivors, family members of those deceased, and first responders. He has received the EMDR-Iberoamerica Francine Shapiro Award, the EMDRIA's Outstanding Research Award, the International Critical Incident Stress Foundation International Crisis Response Leadership Award, the EMDR Colombia Jaibaná Award for Humanitarian Work, and the Argentinean Society of Psychotrauma (ISTSS Affiliate) Psychotrauma Trajectory Award.

EMDR RECENT-TRAUMATIC EPISODE PROTOCOL (R-TEP): THE ESSENTIAL R-TEP

Elan Shapiro, MA

EMDR has demonstrated effectiveness in treating chronic PTSD and old trauma memories, yet Early EMDR Intervention (EEI) protocols have not until recently received adequate attention from EMDR researchers and clinicians. It is proposed that EEI, while trauma memories have not yet consolidated or integrated, may be used not only to treat acute distress but may also provide a window of opportunity in which a brief intervention, possibly on successive days, could prevent complications and strengthen resilience. The rationale for EEI is reinforced by the work of McFarlane who described *PTSD as 'part of a complex psychobiological process that leads to the emergence of the disorder in the weeks, months, or years after the event*…..(noting that) *…exposure to traumatic stress leads to a general disruption of an individual's underlying homeostasis'* so that the absence of symptoms after trauma may not necessarily mean the absence of risk, since the system has been sensitized and is vulnerable particularly when there are additional exposures. This draws attention to trauma memories and consequently a promising role for Early EMDR Intervention for preventing the accumulation of trauma memories and promoting resilience.

EMDR Recent Traumatic Episode Protocol (EMDR R-TEP) was inspired by the seminal work of Dr. Francine Shapiro, originator of EMDR Therapy, and co-developed by Elan Shapiro and Brurit Laub in 2008. EMDR R-TEP was presented as part of a comprehensive approach to EEI. Its background and development were outlined noting its relationship with existing EEI protocols and novel conceptualization.

This is an integrative protocol that incorporates and extends existing protocols within a new conceptual framework, together with additional measures for containment and safety. The four key procedures of the R-TEP were described and illustrated with a video case.

Following a critical incident such as an accident or disaster we are mostly going to encounter normal people who have been exposed to abnormal situations and who have not come to deal with their relationship or other clinical issues, therefore the R-TEP suggests offering an initial current trauma focus therapy contract.

The main concepts and procedures are:

1] The Traumatic-Episode: This conceptualizes the focus not only on the original event but together with the aftermath. It includes all the experiences relating to the critical event up to today, seen as a trauma continuum.

2] The Episode Narrative: Telling the story of the Traumatic Episode out loud with BLS (Bi-Lateral Stimulation). During the intake

the client is deliberately not asked to recount the details of the trauma to avoid triggering activation prematurely.

3] The 'Google Search'/or 'Scan: for identifying the Points of Disturbance (PoDs)', which are the target fragments within the Trauma-Episode (concerning the original incident until today).

When a PoD (Point of Disturbance) is identified, a Phase III Assessment is conducted - if possible as usual - but with sensitivity and flexibility.

4] Focused Processing for the phase IV Desensitization. Two strategies are used to set boundaries for the associations: The EMD strategy (narrow PoD Focused associations) utilized when intrusions are the identified target; or the default EMDr strategy (going with associations that are current trauma episode focused).

It is noted that the PoDs are not necessarily chronological. There are usually about 3-5 PoDs identified since there is a generalization effect.

The 'Google Search' is repeated until no more PoDs are found.

Finally, published and current research projects were presented.

EMDR R-TEP RESEARCH SUMMARY

Studies published, submitted, in process 2017-18

- **Italy:** Early Eye Movement Desensitisation and Reprocessing (EMDR) intervention in a disaster mental health care context. Saltinia, et al. (2017), Psychology, health & Medicine,
- **Israel:** Early EMDR Intervention Following a Community Critical Incident: A Randomized Clinical Trial. Shapiro, E. & Laub, B. (2015). Journal of EMDR Practice and Research. 9(1)
- Early EMDR Intervention Following Intense Rocket Attacks on a Town: A Randomised Clinical Trial. Shapiro, Laub & Rozenblat, (In press, Clinical NeuroPsychiatry. 2018)
- **Turkey: The efficacy of Eye Movement Desensitization and Reprocessing for PTSD and depression among Syrian refugees: Results of a Randomized Controlled Trial. Acarturk, Konuk, et al. (*2016*) *Psychological Medicine. © Cambridge University Press***
- **France:** Prevention of Post-Traumatic Stress Disorder and "Post-Concussion-Like Syndrome" for patients presenting at the Emergency Room: A Randomized controlled study of early Eye Movement Desensitization and Reprocessing (EMDR) Intervention versus reassurance and usual care. Gils-Jardiné et. al., University Hospital of Bordeaux, (Journal of Psychiatric Research, 2018)
- In process: **France** -Multi-center comparison study of intervention in ER with injuries & accidents
- In process: **Hungary**- RCT with accident trauma victims
- In process: **Denmark**- RCT with rape victims
- In process: **Turkey-** studies with terror victims; with refugees

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Elan Shapiro is a psychologist in private practice with over 30 years of experience working in a community psychological service in upper Nazareth. He came to EMDR Therapy in 1989 after attending one of the first trainings Francine Shapiro ever gave. In 1994 he became an EMDR Institute facilitator and was among the founding members of EMDR Europe. He is an accredited consultant and past Secretary of EMDR Europe. Recipient of the Servan-Schreiber award, from the University of Lorraine, Metz, in November 2012, and also the Servan-Schreiber award for contributions to EMDR Therapy at the EMDR Europe Conference, The Hague, June 2016.

THE EMDR INTEGRATIVE GROUP TREATMENT PROTOCOL FOR EARLY INTERVENTION (EMDR-IGTP) AND THE EMDR INTEGRATIVE GROUP TREATMENT PROTOCOL ADAPTED FOR ONGOING TRAUMATIC STRESS (EMDR-IGTP-OTS)

Ignacio Jarero, PhD

The EMDR Integrative Group Treatment Protocol for early intervention was the first early EMDR group intervention. It was created out of necessity by members of the Mexican Association for Mental Health Support in Crisis, when they were overwhelmed by the extensive need for mental health services following Hurricane Pauline - which ravaged the coasts of Oaxaca and Geurrero in 1997.

In this protocol, the group setting allows for a group administration of individual EMDR treatment, ensuring that many individuals can be treated simultaneously. This is highly valuable in settings where resources are limited. Jarero et al., adapted the standard EMDR-IGTP for early intervention to treat populations living with ongoing traumatic stress and with no post-trauma safety period. This adaptation changes the way that the targeted memory is selected, and it was made to allow for the identification, targeting and processing of the continuum of multiple traumatic experiences faced by this population and not only one target per session.

With the EMDR-IGTP-OTS individual EMDR treatment can be provided in a group setting for small (3-15) or large (16-50) groups of patients who have been through:

- The same type of ongoing or prolonged traumatic events or circumstances (e.g. sexual abuse, victims of constant violence)
- At-risk personnel (e.g. agency or NGO staff dealing with natural disasters, emergency response personnel, military on duty)
- People undergoing life-changing experiences with ongoing traumatic stress or extreme stressors (e.g. refugees, IDPs, prolonged violent conflicts or terrorism)
- People with diverse ongoing traumatic histories with similar circumstances in common (e.g. chronic or severe illness, families within situations of ongoing domestic violence)

The EMDR-IGTP administers the eight phases of EMDR Individual treatment to a group of patients, using an art therapy format (i.e. drawings) and the Butterfly Hug, as a self-administered bilateral stimulation method to process traumatic material.

During the conference participants were familiarized with the following topics:

- EMDR-IGTP background.
- EMDR-IGTP and EMDR-IGTP-OTS Main Objectives: including using this protocol as part of a comprehensive program (the continuum of care) for trauma treatment; offering the patients support and empathy, and identifying those who need further treatment.
- EMDR-IGTP and EMDR-IGTP-OTS Advantages: including being able to deliver the treatment in non-private settings (difficult to find in emergencies) and sometimes in chaotic situations; a protocol which is easily taught to both new and to experienced EMDR practitioners; EMDR clinicians can be assisted by specially trained professionals (e.g. social workers, nurses, first responders, etc.); and, all treatment takes place in the affect-regulating presence of therapists (the emotional protection team)
- EMDR-IGTP and EMDR-IGTP-OTS Research: including a meta-analytic review by the University Hospital in Ulm, Germany, of 36 studies (n = 2260 children and adolescents) which found the EMDR-IGTP formats to be very effective in pre-post comparisons and more effective than the (waitlist) control groups, Also, highlights of ongoing and planned research projects for 2017-18, including studies in Argentina (with NGO staff members), Mexico (with cancer patients and primary care-givers), Spain, USA (with NGO staff, and a second study among victims of rape and domestic violence) and UK (with military veterans).

Ignacio (Nacho) Jarero is an EMDR Institute and EMDR-Iberoamerica senior trainer of trainers and specialty trainer. He specializes in humanitarian trauma recovery and research programs on EMDR Therapy. He has conducted seminars and workshops with participants from 65 different countries, and since 1998 has provided field services around the world to natural or human-provoked disaster survivors, family members of those deceased, and first responders. He has received the EMDR-Iberoamerica Francine Shapiro Award, the EMDRIA's Outstanding Research Award, the International Critical Incident Stress Foundation International Crisis Response Leadership Award, the EMDR Colombia Jaibaná Award for Humanitarian Work, and the Argentinean Society of Psychotrauma (ISTSS Affiliate) Psychotrauma Trajectory Award.

EMDR GROUP-TRAUMATIC EPISODE PROTOCOL (G-TEP): THE ESSENTIAL G-TEP

Elan Shapiro, MA

The accessibility of EMDR therapy in emergency and disaster situations is often limited by the shortage of trained clinicians immediately available when relatively large numbers of trauma victims are involved.

A new practical group application of the EMDR R-TEP, the G-TEP (Group-Traumatic Episode Protocol) was presented– with its worksheet format for simplified utilization in emergency situations.

This EMDR G-TEP protocol was inspired by the seminal work of Dr. Francine Shapiro, originator of EMDR Therapy, and developed by Elan Shapiro in 2013 as a group application of the EMDR R-TEP.

The issue of scaling up EMDR— making EMDR more available in emergency situations, was addressed.

The challenge of group EMDR and the EMDR G-TEP:

'Applying EMDR in a group setting with limited interactive possibilities requires compromise and flexibility and a trade-off between close monitoring and self-monitoring *reducing procedures to essentials.'*

The proven effectiveness of EMDR therapy for treating trauma invites creative solutions to this challenge.

Adaptive Information Processing (AIP) approach with emphasis on the process rather than the content and the spontaneous healing flow of the AIP that enables less monitoring (note blind to therapist protocol).

The task: as far as possible to keep the key procedures and concepts of the EMDR R-TEP protocol applied in a group context. The G-TEP was developed as a simplified adaptation of the EMDR R-TEP for use with groups of adults, adolescents & (older) children who have undergone recent traumatic experiences or life-changing events with on-going consequences.

The goal was to process each individual's Trauma Episode within a group framework with a group protocol that retains as much as possible of the depth and power of an individual EMDR protocol for recent events.

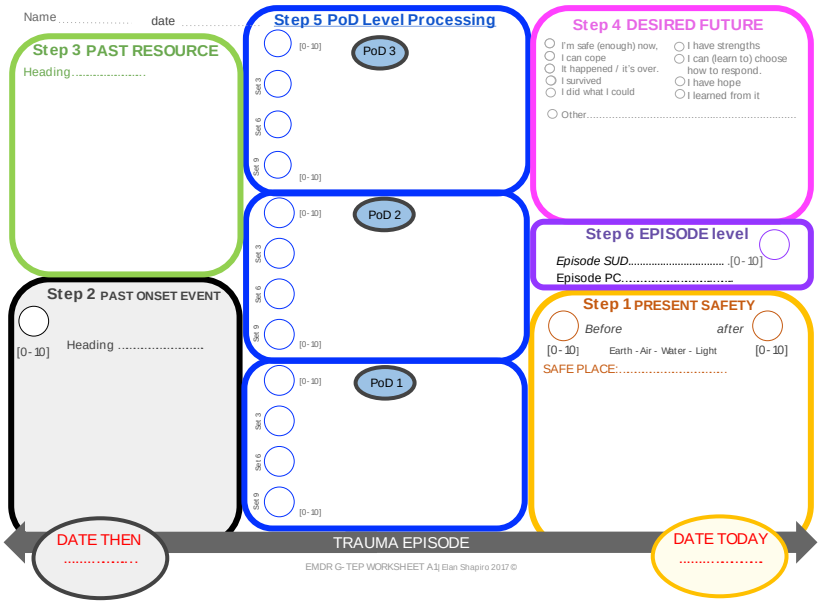
The Trauma Episode conceptualization of the G-TEP addresses the fragmented multi-target nature of non-consolidated/ non-integrated (recent) trauma memories

The construction and procedures of the SIX STEPS of the G-TEP Worksheet

was illustrated in animation and with video clips.

Materials: Participants work on a G-TEP Worksheet printed on a large sheet of paper. Colored pens or pencils. A silicon rubber wristband or sticker.

The G-TEP manual has the protocol script & all the instructions for the group leader.



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Setup: Designed for use with this single worksheet to guide the process step by step, the worksheet is Color-coded so that each of the steps has its own color to make it easier to follow.

1.**Step 1** of the G-TEP worksheet includes the Four Elements exercises with Safe/ Calm Place and can function as:

1- A first aid, stand-alone stabilization & stress management procedure suitable for all

2- An extended preparation

3- A screening diagnostic for readiness to proceed to trauma processing.

The Worksheet is also a meta-communication in which the trauma event is enveloped with present/ past /& future resources arranged spatially to physically convey that the event is in the past…... that they are safe now in the present……. & that there is hope for the future……

The group leader should have additional support staff to aid with logistics, monitor and support those who need assistance.

Summary of advantages of the G-TEP

Structured 'Toolkit' manual and color coded -Six-Step worksheet guiding the process Step by Step.

Built-in safety screening checks for readiness &/or for referral for individual treatment.

The Worksheet setup has the Trauma Episode enveloped with present-past & future resources.

The worksheet is a visual-spatial meta-communication /interweave: in which the past trauma event is differentiated from the present conveying that the event is in the past, they are safe(er) now in the present and there is hope for the future……

The G-TEP relates to the multi-target fragmented nature of recent trauma memories, identifying and processing several targets within a Trauma Episode.

The self-BLS is designed to include Eye Movements as well as tapping.

Focused processing is conducted using the containment of an EMD type strategy limiting to a short chain of three associations.

Relatively deep processing of three target Points of Disturbance (PoDs) and 27 sets of Eye Movements per session (3x9).

Appropriate application for groups who have experienced the same or different critical incidents.

The worksheet format can also be used for working with families or adapted for use with couples and even individuals

Possible use for self-care for mental health personnel and for first-responders

Finally, published and current research was presented.

EMDR G-TEP RESEARCH

Research is currently being planned, conducted & published

- **France:** Planned- Cecile **Bizouerne** -Action Contre la Faim (ACF – Action Against hunger) & Derek **Farrell** -University of Worcester**:** Multi-centre Comparative study with group CBT in Africa & As**ia;** Nicolas **Desbiendras –**refugees, first responders
- **Germany:** Published**-** Maria **Lehnung, et al.-** RCT with refugees **(**Journal of EMDR Practice and Research, Volume 11, Number 3, 2017); **Lehnung, et al -**multi-centre study in 3 Universities underway with refugees
- **Israel**: Planning- Elkins, Oren & Shapiro –study with the military
- **Iraq:** Ethics approval received- Derek **Farrell et al.** Comparative study with group CBT, ISIS terror victims,
- **Japan:** ongoing**-** Mitsuru **Masuda.** Earthquake victims
- **Turkey:** In Press (Frontiers in Psychology**)-** Emre **Konuk,** Asena **Yurstover et. al** RCT with Syrian refugees**;** further studies with refugees, terror victims
- **US:** Accepted for publication (JEMDR 2018)- Amanda **Roberts** –study with Cancer patients
- **UK:** Planning- Sharyn **Williams,** first responders; Emma **Robinson**, Ericka **Johanson,** NHS; Susan **Sissons,** use for self care with police…?

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Elan Shapiro is a psychologist in private practice with over 30 years of experience working in a community psychological service in upper Nazareth. He came to EMDR Therapy in 1989 after attending one of the first trainings Francine Shapiro ever gave. In 1994 he became an EMDR Institute facilitator and was among the founding members of EMDR Europe. He is an accredited consultant and past Secretary of EMDR Europe. Recipient of the Servan-Schreiber award, from the University of Lorraine, Metz, in November 2012, and also the Servan-Schreiber award for contributions to EMDR Therapy at the EMDR Europe Conference, The Hague, June 2016.

TREATING SURVIVORS OF HOMICIDE VICTIMS: RECENT EVENT PROTOCOL (REP) & VISUAL ASSESSMENT TOOL (VAT) HOW TO SUCCESSFULLY USE THESE TOOLS WITH CLIENTS

Donald F. deGraffenried, LCSW

The Recent Event Protocol was designed by Francine Shapiro, PhD and is outlined in her book, *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols and Procedures*. It is also in the Part I Manual, used in the basic training in EMDR therapy.

The Recent Event Protocol is designed to address traumatic events that have occurred in approximately the last 90 days and have yet to be fully consolidated into the memory network. Accordingly, for a recent traumatic event, the client will not have one primary presenting image (Target) of the event. Rather they will have a series of images that represent the event and therefore multiple targets that will need to be addressed to successfully desensitize the entire event.

The Visual Assessment Tool (deGraffenried 2016) was developed as a tool to support and encourage EMDR clinicians to more frequently use the Recent Event Protocol in their clinical practice.

Clinicians have expressed reluctance that, when developing image/targets using the Recent Event Protocol, too much painful information will be opened up for the client or that the process will take too long. So correspondingly some clinicians are reluctant to use the Recent Event Protocol with clients. The Visual Assessment Tool (VAT) brings a clear and contained process to develop the multiple images, by structuring the client's narrative of the traumatic event and recording it with the use of visual, geometric symbols. This also helps to avoid an emotionally overwhelming experience for the client, by gently limiting ventilation and focusing on targets and the narrative beginning, middle and end of the recent traumatic event.

The Visual Assessment Tool is in the form of a laminated card. At the top of the card it is titled: *Visual Assessment Tool for the EMDR Recent Event Protocol*. There are five separate horizontal columns, with the following symbols: rectangle, parallel lines, trapezoid, circle and banner. The Visual Assessment Tool is structured to assess four targets, a target sequence, within the Recent Event Protocol. If there are more than four targets the clinician will use an additional copy of the Visual Assessment Tool.

The symbols on the laminated card are used to record key assessment information and also help to limit the volume of painful information that the client verbalizes. Vertically down the columns, there is a square in which to write down the image, parallel lines for taking assessment notes, a trapezoid for writing down the negative cognition, a circle in which to write down the number for the Subjective Units of Disturbance (SUDs) and a banner to write down the place of the client body distress. Please note that this is not the full Phase III

assessment of the targeted memory, so all of those questions are not asked at this time. Once having identified a specific target to start to work on, bring the Visual Assessment Tool information into the full Phase.

Prior to using the Visual Assessment Tool to identify each image, negative cognition, SUDs and location of body distress, you have worked with the client to develop a safe place or some other effective affect management tool. There is a place on the back of the laminated card, to record both the safe place and the cue word that you develop with the client for the safe place. This provides safety and will prevent the client from feeling overwhelmed. If they put their hand up and ask for a time out, you can move them to their safe place experience.

You want to help the client to tell the narrative of what happened to them and you will use the parallel narrative lines to take notes on their trauma experience. You help prepare them for this narrative by being highly verbally supportive and helping them to understand that their traumatic event has a 'beginning, middle and end'.

Donald deGraffenried is a passionate advocate for expanding EMDR therapy into agency and community mental health settings and has started several agency-based EMDR programs. He is Senior Trainer for the Trauma Recovery EMDR Humanitarian Assistance Programs. He is also the lead consultant to all the Trauma Recovery Networks that are a part of TR/EMDR HAP. He has worked extensively using EMDR in community settings working with survivors of homicide and is the Coordinator of the Greater New Haven Recovery Network (GNH TRN). This provides up to 10 pro bono sessions to crime victims and survivors of homicide, who have been referred by the New Haven Police Department.

ANYONE CAN DO SOMETHING FOR 15 MINUTES… EVEN SELF-CARE!

Marilyn Luber, PhD

Mental health and private practitioners are often among the first to participate as mental health responders following both man-made and natural disasters. This presentation highlighted the importance of self-

care, and explored the types of things to think about, prepare for, and do when working in critical situations. The premise is that anyone can do something for 15 minutes – even self-care. Often therapists are too busy thinking about the people they are caring about and forget to also make sure that they are taking care of themselves.

The Green Cross Academy of Traumatology has Guidelines for Self-Care that emphasize the following:

1. Do no harm to yourself in the line of duty when helping/treating others.
2. Attend to your physical, social, emotional and spiritual needs as a way of ensuring high quality services for those who look to you for support as a human being.

This presentation highlighted the work of therapists working in the field reporting about their experiences and how they addressed self-care either didactically or with exercises:

Neal Daniels (2014): Fixed his 'peskies' by bringing up the image of the patient/difficult situation. Then he suggests doing 10-15 Butterfly hugs, noticing the positive cognition that comes to mind and installing the PC with the patient's image or the situation.

A.J. Popky (2009): Adapting Popky's work by creating an internal resource state where therapists remember a time when they felt healthy and their life was in balance. Then follows the steps for the 'Safe Place', to install it as a well-formed outcome.

Catherine Butler (2016): Use the Compassion Fatigue Awareness Project (www.compassionfatigue.org) so therapists can evaluate how they are doing and know the signs of when they are out of balance.

Derek Farrell (2014): Discussing signs of secondary PTSD to be alert to such as impaired judgment and decision making, decreased ability to self-regulate, loss of meaning, etc.

Karen Alter Reid (2014): Using her knowledge from the 'Therapy for Therapists Project' in New Orleans after Hurricanes Katrina and Rita, addressed the 'small joys of life' that are helpful to carry on when working in a Trauma Recovery Network (TRN) after the Sandy Hook shooting, including proper sleep, exercise, stress relief exercises, etc.

Ignacio Jarero and Susana Uribe (2014): Taking the 'Worst Case Scenarios', they discussed the types of suggestions such as before deployment (settle professional and domestic issues, do team preparation, get practical needed items, prepare a 'grab and run

suitcase' etc.), during the intervention (use spiritual practice, team debriefing, emotional self-care, etc.), and after the intervention (take time off, do emotional self-care, finish research, etc.). They also emphasize protection measures for shelters and communities such as safety first, how to travel, sleeping arrangements, etc.

The presentation ended with participants taking a pledge of self-care to themselves, and to me, exchanging emails with their neighbor so that they can check in with each other regularly.

References:

- Luber, M. (Ed.)(2009). *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations).* New York, NY: Springer Publishing Co.
- Luber, M. (Ed.) (2014). *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets* . New York, NY: Springer Publishing Co.
- Luber, M. (2016). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma-and Stressor-Related Conditions*. New York, NY: Springer Publishing Co.

Marilyn Luber is a licensed clinical psychologist in Philadelphia, Pennsylvania. She specializes in EMDR Therapy and has presented at national and international conferences and has undertaken workshops in the United States, Europe, Middle East and China. She edited a series of six books on different uses of EMDR protocols and procedures. She has published articles in professional journals and regularly contributes two columns to EMDRIA's newsletter. She has received the Francine Shapiro Award, the EMDRIA Award for outstanding contribution and service to EMDRIA, and the EMDR Humanitarian Services Award. Currently, she is a facilitator for the EMDR Global Alliance supporting the standards of EMDR Therapy worldwide.

THE FLASH TECHNIQUE

Philip Manfield, PhD

The Flash Technique was first introduced in a paper published in the November 2017 issue of the EMDR Journal of Practice and Research. Since that time, nearly 2,000 EMDR therapists have been trained to use it as a preparation phase addition to EMDR. It was discussed in a twenty-minute presentation at the Early Intervention Conference in April 2018 in Boston. During that twenty minutes, the technique was described, a full demonstration video was played of the technique being conducted, and a live demonstration was done with a volunteer from the audience whose SUDS started at 7 and ended at 0 after five minutes.

Philip Manfield has practiced psychotherapy in the San Francisco Bay Area since 1975. Most recently, Philip has developed the flash technique, a process used in the preparation phase of EMDR that permits overwhelmingly disturbing memories to be processed with virtually no pain. He has authored or edited five books about psychotherapy and EMDR and taught on six continents. Most of the cases in his two most recent books, Dyadic Resourcing: Creating a Foundation for Processing Trauma and EMDR Up-Close: Subtleties of Trauma Processing, have been included in a free website containing 35 full length clinical videos.

REACHING THE VERY FIRST RESPONDER WITH EMDR: EARLY INTERVENTION WITH EMERGENCY DISPATCHERS

Jim Marshall, MA, LLP

This session (which was presented briefly by Mark Nickerson on J. Marshall's behalf, due to technical difficulties with the video connection) sought to illuminate the psychological experience of 911 telecommunicators (also referred to as Emergency Dispatchers/EDs) as they interact with field responders and citizens in peril. Given the prevalence of natural and man-made disasters across the globe, it is critical for mental health clinicians to understand the ED's unique and

crucial role as the first link in the chain of emergency response in the world's developed and emerging nations.

EDs require a full continuum of assistance from clinicians including educational information about work-related stress risks, and access to evidence-based treatments for traumatic stress. Yet for practitioners to empower these EDs with this support, clinicians must become knowledgeable about the unique characteristics of this first responder sub-group. Accordingly, this presentation pursued four objectives:

Objective 1: Recognize the Emergency Dispatcher's unique role and stressors. There are nine such stressors including:

1. *No Warning Before Potentially Traumatic Calls*
2. *The big 'C' of 9-1-1—Lack of Closure*
3. *Telecommunicators are Psychologically On-scene but Physically*
4. *Unable to Reach It*
5. *9-1-1 Pros 'Send their Own' into Harm's Way*
6. *Limited Sensory Engagement with Those on Scene*
7. *High Call Volume and Frequency*
8. *The Crazy-Tasking Demand*
9. *Little to No Downtime to De-stress*
10. *Lack of Appreciation and Professional Respect*

Objective 2: Identify impacts of their work-related stress. Specifically, 24.6% of EDs have acknowledged symptoms consistent with PTSD.

Objective 3: Define steps that practitioners can take to effectively reach out and collaborate with emergency dispatch centers. Participants in this session were encouraged to visit www.911Training.net to learn about a Registry of EMDR Therapists as an example of an effort to bridge clinicians with EDs in the U.S. and which can be replicated in other countries.

Objective 4: Recommendations to achieve systematic mental health care and resilience of EDs. The 9-1-1 industry has established the Standard on Acute/Traumatic and Chronic Stress Management which defines the resources required to safeguard EDs' psychological wellbeing.

To achieve Objectives 1 to 4 and gain a thorough knowledge of the psychological experience and needs of Emergency Dispatchers, conference participants are referred to the text of the book *The Resilient 911 Professional: A Comprehensive Guide to Surviving & Thriving Together in the 9-1-1 Center* – April 20, 2018, by Jim Marshall and Tracey Laorenza.

References:

- Marshall, J., T. Laorenza (Editors). 2018. The Resilient 911 Professional: A Comprehensive Guide to Surviving & Thriving Together in the 911 Center (p. 28). South of Heaven Press.
- Lilly, M.M., & Allen, C.E. (2015). Psychological inflexibility and psychopathology in 9-1-1 Telecommunicators
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Jim Marshall is a certified EMDR therapist who has utilized EMDR since 1990. As Director of the 911 Training Institute, he educates telecommunicators in personal resilience and 911 call mastery. Jim served as Founding Chair/CEO of 911 Wellness Foundation (911WF) and co-authored the industry's first Standard on Acute/Traumatic and Chronic Stress Management. With Sara Gilman, he co-authored Reaching the Unseen First Responder With EMDR in Marilyn Luber's Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Treating trauma- and stress-related conditions (Springer, 2015). Jim is editor of The Resilient 911 Professional (in press).

SELF-TREATMENT IN SITUATIONS OF INTENSE STRESS (STIS)

Isabelle Meignant, PhD

This STIS protocol is meant to be used in crisis and emergency situations, with the following steps:

Step 1: Choose a part of the memory

Choose the most disturbing sensory part (picture, sound, smell, taste, tactile sensation) of the recent memory, the one that generates the most distress.

Step 2: Measure the Subjective Unit of Disturbance (SUD)

Measure the level of disturbance you feel now thinking about this specific sensory part of the memory. From 0 to 10, where 0 means you don't feel any disturbance at all, and 10 means the highest level of disturbance you know. This measure is called Subjective Unit of Disturbance (SUD). What is the level of disturbance you feel now? Write it down.

Step 3: Do Self Bilateral Stimulation (Self-BLS)

While thinking of this specific sensory part of the memory, do fast and rhythmic (2 to 4 stimulations per second) BLS (Bilateral stimulations) using tapping for one minute (60 seconds).

Tapping: Tap on one side then the other of your body. For instance when seated, with both feet on the ground, tap on your right knee with your right hand, and then tap on your left knee with your left hand. There are various ways of practicing Self-BLS

(see: https://youtu.be/7OJkjk0KtiM).

At the end of a whole minute of Self-BLS, take a deep breath, stretch and/or walk around a little. Then think again about the same sensory part of the memory and do a new set of fast Self-BLS. Repeat it twice, so as to complete three sets of Self-BLS.

Step 4: Reassess the SUD

At the end of the third set, measure the SUD level (0-10) of your experience when you focus on the sensory part of the memory you have chosen at the beginning (be sure not to change the focus). If the SUD level went down by at least two points, that is a positive outcome. Stop there.

If the SUD level did not change, after you first check that you really focus only on the sensory part of the memory that you have chosen at the beginning, re-do Steps 2 to 4 (once only).

Second time that you do Step 4: If the SUD went down by at least two points, that is a positive outcome. Stop and go to Step 5.

If the SUD level did not change, first check that you really thought only of the sensory part of the memory you have chosen. If it is the case, and nothing changed, trust that your brain will be doing the process it needs to be doing in the coming hours and days.

Stop, do some physical activity (e.g. a walk), and go to Step 5.

Step 5: Final evaluation of the SUD

At least two hours later, reassess the SUD again for the sensory part of the memory you have chosen at the beginning. Write it down.

Whatever the SUD is at this point in time, just remember that your brain will process this part of the memory. It may take more or less time, but it will eventually happen.

Your use of self BLS is facilitating this process. We recommend this protocol is not used more than once a day. The use of this protocol does not substitute a consultation with a professional of your choice.

Further recommendations

Only when, in Step 5, the first specific part of the memory doesn't activate a lot of disturbance anymore (SUD lower than two) it is possible to work the next day, on another part of the memory.

If you notice any flashbacks or intrusive images, you may choose to do this protocol again with one of them.

Following the advice of WHO, it is NOT recommended to use Benzodiazepine medications in the month that follows a difficult event. It is also not recommended to use alcohol and drugs. It is recommended to spend time in the company of others, be physically active, and try to go back as soon as you can to your usual daily activities. Our experience says that in most cases sleep will normalize within a week. We suggest that you trust the process of recovery that will probably lead to you getting better.

Remember that the event is finished now. It is over. You are alive.

To benefit from free advice or a free intervention of an EMDR practitioner, contact www.action-emdr-trauma.org.

This protocol is still under process of publication and has been written by Isabelle Meignant, Valériane Timmer, Nicolas Cazenave, PhD, and Didier Michel following Hurricane Irma, September 6th, 2017.

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Isabelle Meignant is a psychologist, psychotherapist, emergency interventions specialist, and an EMDR Europe Accredited Trainer. She heads the École Française de Psychothérapie EMDR (EFPE) and is the president of the humanitarian non-profit association 'Action EMDR

Trauma'. Isabelle undertook her first emergency group intervention using EMDR in 2003 and has been involved since then in emergency and humanitarian work. She is author of the children's book 'Buddy the dog's EMDR', illustrated by her sister Cécile.

LOW-INTENSITY, OPTIMAL-TIMING, VAGINAL BIRTH FOCUSED EMDR THERAPY (LOVE): REDUCING THE TRAUMA FACTOR IN CHILDBIRTH USING LOW-INTENSITY EYE MOVEMENT DESENSITIZATION THERAPY FOR PREGNANT WOMEN WITH POST-TRAUMATIC STRESS DISORDER OR FEAR OF CHILDBIRTH

Paul Miller, MD

Background: DSM-5 and ICD-10 recognize perinatal mental health disorders; elective Caesarean Section (CS) is increased where they are present. PATTCh state that a birth is considered traumatic if the woman was, or believed she or her baby was, in danger of injury or death and she felt helpless, out of control, or alone. This can occur at any point in labor and birth (Beck, 2004a). Notably, it is the woman's perception of trauma that is fundamental.

Normal healthy pregnancy ending with a vaginal delivery is the ideal. Increasing normal vaginal deliveries by reducing CS and encouraging Vaginal Birth After Caesarean section (VBAC) is a public health priority. Following one CS, about 75% of women with an uncomplicated pregnancy, who go into spontaneous labor, can give birth vaginally (RCOG, 2016). The multicenter OptiBirth study aimed to increase VBAC through enhanced patient-centered maternity care, but did not deliver psychological interventions. The OptiMUM study in the Netherlands is the first RCT to explore efficacy and cost effectiveness of EMDR therapy in pregnant mothers with these conditions and Ulster University seeks to generate similar data in an all-Ireland context.

Aims: To introduce '**LOVE**' – a Low-Intensity-EMDR therapy paradigm designed to empower experts in the perinatal period with AIP-informed interventions.

EMDR therapy is a transdiagnostic psychotherapy, recommended by WHO (2013) as a gold-standard therapy for the psychological impact of trauma. It is traditionally taught to licensed mental health workers. However, the global burden of trauma and the vast quantity of trauma populations, highlights insufficiency in global mental health provision

and raises the case for the utilization of paraprofessionals (Carriere, 2014). These 'paraprofessionals' may be professionals in a field other than mental health. Perinatal mental health champions already use mental health interventions and the 'LOVE' paradigm trains and mentors selected obstetricians and midwives in transdiagnostic, Adaptive Information Processing (AIP) model-informed Low-Intensity-EMDR training (LOVE), which can be meaningfully and safely added to existing midwifery skills. This allows for intervention at the optimal time, through the upskilling of appropriate staff, including midwives - some already trained as counsellors. LOVE is an intervention designed to be delivered by midwives rather than psychologists. The shortage of psychological professionals and access to psychotherapy is a recognized problem alongside stigma, with people proving resistant to seeing mental health professionals. By training, mentoring and supervising midwives, whose area of expertise involves working with pregnant mothers with comorbidities, a brief AIP-based intervention can be delivered in an acceptable and effective way. Parental choices are influenced by the presence of psychiatric disorders and the application of LOVE interventions empowers an informed choice. The hope is that this will decrease the number of elective CS and increase VBAC rates; resulting in a decrease in morbidity and mortality in addition to delivering healthcare savings.

Three areas of need are identified within the LOVE training, which build upon existing work by colleagues in Early EMDR Interventions (EEI) and it is informed by Prof Miller's work on complex trauma, including psychosis:

* **Acute trauma state during labor or a caesarean section**: this involves teaching skills in grounding and orienting to present safety.

* **Targeting postpartum day 1 after a traumatic or emotionally difficult delivery:** entails a protocol based upon restricted processing within EMD and EMDr.

* **Phobia protocol** to use in the office for patients that anticipate problems with vaginal exams or needle phobias.

Professor Paul W. Miller MD provides mentoring and support to the midwives and medical staff trained. Staff will be supervised following the training at the level of engagement in keeping with how actively they apply the intervention.

Contact: mirabilishealth@me.com

Paul Miller is a psychiatrist, accredited EMDR trainer-in-training within EMDR Europe and an EMDR Institute facilitator. He served as Chair of the training subcommittee, EMDR UK and Ireland Association, and introduced EMDR Therapy to psychiatry in Northern Ireland's National Health Service. In January 2011 he founded Mirabilis Health – a private psychiatrist-led clinic specializing in EMDR Therapy. Paul has presented at international conferences on topics including EMDR Therapy for psychosis. He is currently Visiting Professor, Faculty of Life and Health Sciences, School of Nursing, University of Ulster and is exploring the use of EMDR Therapy within The Centre for Maternal, Fetal and Infant Research (MFIR).

IMMEDIATE STABILIZATION PROCEDURE (ISP®) AND EMERGENCY RESPONSE PROTOCOL (ERP)

Gary Quinn, MD

Trauma manifests itself on both sides of the Israel-Palestinian conflict. A video of soldiers being run down by a truck was shown. ISP® was performed on a soldier and 15 minutes later he was leading his unit. Past and current recommendations of Acute Stress Reaction (ASR) were discussed. ISP® has not yet been published in a peer reviewed journal.

ISP®/ ERP was developed during and following manmade and natural disasters - including earthquake, tsunami, terrorist attacks and war. Although initially developed for use by EMDR therapists in the form of ERP (Emergency Response Procedure) it has evolved to be used by first responders as ISP® (Immediate Stabilization Procedure). It is used within minutes to hours following a disaster when victims are suffering from Acute Stress reaction with a SUDs of 7 to 10 and during 'silent terror'. It may be one of the first stabilization procedures (not treatment) utilizing **rapid** bilateral stimulation that fits into Psychological First Aid (PFA) Core Action 3-Stabilization.

Unlike other stabilization that produces change of **state**, ISP® appears to produce change of **trait**. ICD-10 recognizes as a disorder Acute Stress Reaction (ASR). DSM 5 considers ASR a normal reaction to an abnormal situation. However, DSM 5 indicates that those who develop Acute Stress Disorder (ASD), after three days to three months, had a high level of agitation in the preceding three days. Of those who were

diagnosed with ASD 80% develop PTSD at one year. Of all those who later developed PTSD - 33% of them had ASD.

United Hatzalah of Israel was started in 1991. It is a volunteer Emergency Medical Team (EMT) response unit with thousands of volunteers. United Hatzalah volunteers arrive by ambu-cycles, that can get through every traffic jam, within an average of 3 minutes to every place in Israel to save lives. It uses an app on smartphones to GPS finding the five closest volunteers and sends them by a navigational tracker. This organization is made up of all religions, races and ethnic groups to save all lives. It is now in New York city, Panama, Brazil, Mexico, India, Australia and South Africa.

In 2016 the Psycho-trauma unit of United Hatzalah was formed. They were trained in PFA and ISP® and now have more than 300 volunteer EMTs throughout Israel. Several hundreds of cases have been treated with ISP® with almost all cases reported to reduce SUDs within 5 to 15 minutes. The training and usage in routine ambulance cases, crucial on its own, also has these first responders trained for mass casualties. ISP® works where there is a false sense of current danger, lack of control, and issues of responsibility utilizing four positive true statements. By returning to the present - victims are stabilized to deal with that which follows.

A short, one-page initial contact sheet is filled out after the event. It can demonstrate validation of Subjective Units of being bothered- from 0 to 10 with quick identification with a colored chart by both an independent first responder as well as the stabilizing first responder. It also has objective measures before and after of pulse and blood pressure. Follow up with the PTSD Checklist for DSM-5 (PCL-5) at one and three months, done by an independent assessor, will be done to identify possible improvement of ASD and PTSD following this single stabilization intervention.

Other possible uses of ERP can be at any time in the eight phases of EMDR treatment.

Gary Quinn is a psychiatrist who specializes in crisis intervention, including anxiety and depressive disorders, and PTSD. He is currently the Director of the EMDR Institute of Israel. Gary trains in Israel, Europe, Asia, Africa, and the US, and for HAP in Turkey, Thailand, Romania, Cambodia and Zimbabwe. Gary is also an EMDR Institute Trainer of Trainers of Asia. He developed the Emergency Response Protocol (ERP) to treat victims of trauma with EMDR within hours of the incident. Gary has volunteered in hospitals and bomb shelters

treating patients after terrorist attacks and after the tsunami in Thailand.

UNDERSTANDING FIRST RESPONDERS

Roger M. Solomon, PhD

Several months ago, I was talking to a man I was just introduced to. When I told him about my work with police and veterans, he responded in a condescending tone, "Oh, you work with people who kill". This comment reminded me how much the public does not understand society's warriors specifically and first responders generally. It is important that mental health professionals understand the culture and mindset of first responders and go beyond the narrow minded, ignorant biases held by some people. There are differences among the various first responder groups (e.g. fire, rescue, and law enforcement). For example, police will joke that people wave at firemen with 'all five fingers'. But there are many commonalities among the culture of those who run into danger contrary to our instinct to run away.

First responders are resilient women and men on the healthier end of the mental health continuum. They tend to be action oriented, hate confinement, are comfortable giving and taking orders, and are responsibility absorbers. They value being in control (lack of control equals vulnerability), and are decisive, assertive, and willing to do the job in front of others. First responders have to actively run into danger, solve crises of all kinds, and deal with people and situations the rest of society would rather forget. First responders are not allowed fear, vulnerability, tears, or anger - they have to have the image of control. Consequently, emotions are compartmentalized, put on hold, and often viewed as unhealthy. Normal feelings of fear can be viewed by some peers as signs of weakness. There is often hesitancy to show emotions out of concern that fellow responders will think them weak and unable to perform. First responders are clannish, hesitant to trust outsiders. This is because they often feel misunderstood by the public and in times of danger only another first responder will be there for back up.

Given the above, the mental health professional must understand it takes a lot to ask for help, and little to turn them off. First responders

see a lot of gory things and the mental health professionals must be prepared to listen. There have been more than a few first responders who have told me the mental health professional they told their story to was visibly upset and this was a turn-off. The mental health professional does not have to be stone-faced and distant but can respond calmly and empathically, e.g. "That must have been tough". Further, being judgmental or second guessing the actions of the first responder will be an instant turn-off. Understanding what was happening from the responder's perspective, knowing that crucial decisions have to be made within seconds that experts have hours to investigate when it is over, is a helpful and therapeutic attitude.

In the PowerPoint presentation there is information on typical responses to a critical incident. Many normal reactions are misunderstood by those who experience them. These need to be explained (and normalized) by the mental health professionals. For example, slow motion is quite common in moments of peak stress. I have talked to many first responders who thought they were going 'nuts'. Explaining that this reaction, and similar peak stress reactions such as tunnel vision and auditory exclusion are normal and aid in survival can be helpful. Providing simple psychosocial education on coping strategies (e.g. talk it out, write it out, work it out [exercise], eat healthy, minimize alcohol and caffeine, reach out to others, keep up your daily life routine (its normalizing and enhances one's sense of control and predictability), etc.)

EMDR therapy can be quite helpful to first responders, especially with recent traumatic events. The PowerPoint presentation goes over some important points for each phase of EMDR therapy. Though EMDR results can be rapid, blocked processing can occur. The mental health professional needs to be mindful that past traumas, both professional and personal, can be triggered by a current incident, and need to be processed.

Be cognizant that everything you write down may potentially be subpoenaed. Of course, you keep records, but what you record may potentially be looked at by a judge to determine if it is confidential, and you may be subpoenaed to give a statement or a deposition.

Peer support can be helpful. Those fellow responders who have 'been there' are a credible source of support. Peers can listen in an understanding way, tell their story to normalize someone else's reactions, and explain EMDR procedures. Peer supporters can recommend the 'Jedi mind trick' (as one peer calls it) and describe how helpful it can be. Peers can facilitate referral to mental health

professionals and conduct informal follow up. **"The use of paraprofessionals is very underutilized."**

We owe our first responders a caring attitude, respect, and understanding. So, to the man I described in the opening paragraph, I say, "Yes, I proudly work with people who kill, who are willing to put their life on the line and suffer from having to make a fatal decision to defend their life or someone else's…"

Roger Solomon is a clinical psychologist specializing in trauma and grief. He is a Senior Faculty member of the EMDR Institute and teaches EMDR internationally. Formerly the police psychologist for Colorado Springs Police Department and the Washington State Patrol, he is currently a consultant with the U.S. Senate and provides direct services to the Senate community. He has consulted with the FBI, ATF, NASA, and numerous law enforcement agencies. He has provided psychological services following several traumatic events including the September 11 terrorist attack, Hurricane Katrina, and the Oklahoma City bombing.

COMMUNITY-BASED EMDR EI SERVICES: COMPREHENSIVE AGENCY RESPONSE TO THE ISTANBUL ATATURK AIRPORT BOMBING

Emre Konuk, MA

In August 1999 a damaging earthquake struck northwestern Turkey, being most severe in the industrialised area near Istanbul. Twenty thousand people died and 500,000 were left homeless, with 60,000 buildings collapsed and a further 80,000 damaged. From this grim experience there were some important results: much stricter building regulations were formulated, and many people learned how to intervene positively in relation to trauma.

By October 1999 the DBE Institute had held EMDR trainings for 110 participants, with the support of 16 trainers and facilitators. It also noted that although 500,000 people became homeless overnight, within two weeks this number reduced to 150,000. What had happened to the other 350,000? Because of the strong family ties among Turkish people, they had been absorbed back into their family

structure. The government, acknowledging the importance of family ties, particularly in times of disaster, created a Ministry of Family & Social Policies, to support family structures.

With the creation of the Ministry of Family and Social Policies, a long process of interaction and engagement between the government, institutions, communities and the DBE Institute began, much of it focused on mental health issues. The Ministry of Family and Social Policies now has a centre in each of the 81 cities of Turkey, staffed by 2,000 professionals who are being trained in EMDR. Similarly, there are now counselling centres for children and teenagers run by the Ministry of Education in cities, and mental health service centres in municipalities, with a further 35 women's health centres in Istanbul. EMDR-HAP Turkey has organised numerous trainings, so that gradually all the staff of these centres are trained in early intervention and screening techniques. More recently the Ministry of Justice has enabled 60 EMDR therapist to work in the country's 190 gaols, with such good results that a special protocol has been developed and a further 500 therapists will be trained. The agreement with the DBE Institute is that at times of national disaster these therapists may be released from their regular duties for emergency work.

For large-scale disasters the DBE Institute has a four-phase intervention programme:

- Phase I: For groups of 50-100 people who have been involved in the traumatic event,
  - Psycho-education is offered
  - Stabilisation and normalisation techniques are used
  - Assessments are made (IES-R, PCL-5, SA-45, ACE, etc)
  - Screening is undertaken to identify individuals in need of special care
- Phase II: Psycho-education is given for managers and team leaders
- Phase III: G-TEP (EMDR Group Protocol) is undertaken for screening purposes
- Phase IV: Individual sessions of EMDR R-TEP for the severely traumatised

Following the bombings in the Istanbul airport in June 2016, in which 42 people died and 230 were injured, EMDR-HAP Turkey began work within 22 hours. In total, 1,397 people received treatment, with 40 EMDR therapists working for 10 weeks. Although the programme was planned and set up also as a research project, unfortunately the workers' union refused to give permission for this aspect to go ahead,

as they were frightened that bosses might use results of the research to sack workers. However, some data was collected and, in all cases, showed positive results.

Emre Konuk is a Clinical Psychologist. He received his Master's in Clinical Psychology at Bogazici University and his Family Therapy Training at the Mental Research Institute (MRI), Brief Therapy Center, Palo Alto. A pioneer in Turkey, he established psychotherapy as a profession by founding the Institute for Behavioral Studies (DBE Davranış Bilimleri Enstitüsü). He is an EMDR Institute and EMDR Europe Trainer, President of The Institute for Behavioral Studies-Istanbul, President of EMDR Association Turkey and President of Couples and Family Therapy Association-Turkey. Since the 1999 Marmara Earthquake, he has been responsible for EMDR-HAP and EMDR Basic Trainings in Turkey. He has participated in EMDR-HAP projects in Thailand, Palestine, Kenya, Lebanon and Iraq. His wants to establish EMDR as a major therapy approach in Turkey.

CHALLENGES FOR EARLY EMDR THERAPY INTERVENTIONS: LESSONS LEARNED FROM FIELD EXPERIENCES IN INDIA AND NEPAL

Sushma Mehrotra, PhD

EMDR therapy is becoming popular among mental health professionals in Asia. The numbers of EMDR therapists are the increase and several trauma relief initiatives have been reported. There are EMDR Associations and they have volunteers eagerly waiting to respond soon after emergencies and to offer their services for the relief operations. However, we as EMDR leaders find it challenging to make an entry soon after disasters, natural or manmade.

First of all, where to go and how to begin? **"What happens after a disaster? The money is in plenty, but it is not channeled. The political will for mental health is still not optimized."** The relief services by army, police, medical assistance and other rehabilitation begin at the earliest. Donations pour in for the basic needs (food, shelter and medical services), but mental health, though considered essential, yet takes a back seat. Reviews of existing reports from Asia related to disaster response do not give adequate importance to mental health issues. Prior experience with earthquakes, floods,

tsunami and terrorism attack shows that getting quick buy-in from Government departments, police, health services, educational institutions, civil society and community is vital for the *early* interventions. Awareness of the impact of catastrophes on mental health is lacking, not only among the policy makers but also among the general population. Our approach involves awareness of PTSD and its impact on the general population, gaining government permissions, and police notifications, collaborating with health services, education departments and NGOs.

In this presentation the experience of mass-scale group intervention has been sketched from hands-on involvement of planning, commencing, observations, feedback, research, illustrations and stories of local challenges. The interventions were from India and Nepal after manmade and natural disasters. These interventions were made possible by the support of good Samaritans, NGOs, Universities and local level educational institutions and to some extent by local representatives from the World Health Organization in Nepal. **"Often they were offering psychosocial support, but actually it was more consoling than counseling."** The teamwork of EMDR Association volunteers and support from Trauma Recovery/HAP, and Dr. Ignacio Jarero, were the key drivers of the humanitarian projects which ended in several trainings for local level capacity building, as well as outreach to attend trauma victims.

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Sushma Mehrotra, having gained her MPhil and PhD in Clinical Psychology, became a faculty member at SNDT Women's University in Mumbai from 1990-2004. She is a trainer with Trauma Recovery/HAP for Asia. Her post-disaster work has included leading group interventions with EMDR practitioners among 16,000 children and adults following the earthquake in Gujarat, India, 2001, and children and teachers of Kashmir affected by floods in September 2014. In association with Trauma Recovery/HAP, WHO and local NGOs, she

initiated interventions in Nepal after the 2015 earthquake. She was the first President of EMDR Association of Asia (2008-2017).

EMDR-EI FOR FIRST-RESPONDERS

Sonny Provetto, LICSW

Core elements for using EMDR-EI and why the current interventions don't work

- Current intervention models are not effective.
- Groups tend to be too large and non-homogenous.
- Peer facilitators are not well trained.
- Little to no follow up after the initial debriefing.
- Many First Responders will not talk about feelings in an open group.
- Many times, the group cross-blends professions (e.g., Fire with Police).
- The current model just allows for an informal intervention directly after an event, where EMDR-EI can utilize grounding exercises, and EMD if necessary.

Why use EMDR-EI:

- R-TEP and G-TEP are well suited for First-Responders in both a group or individual setting.
- G-TEP can be used for blending multiple professions in processing the same traumatic event at the same time.
- Group sizes can be increased and still maintain effectiveness.
- Interventions can be used directly after the responders return to their station.
- EMDR-EI uses a subjective measure of disturbance to assess individuals and establish follow-up guidelines.
- EMDR-EI have techniques that can be deployed by peer support officers and can be trained as para-professionals.
- Peers can easily be taught EI interventions.
- R/TEP and G/TEP can be used as a screening tool in assessing an officer's overall level of disturbance.
- EMDR practitioners have more control over the integration process of trauma for each responder.

- These protocols build on the core elements of AIP model that ultimately relate to a responder's experience in seeking help using EMDR.

Sonny Provetto is an EMDR clinician and a trauma consultant for police departments and emergency responders in northern Vermont. His experiences as a police officer and emergency mental health clinician at 911 have guided his clinical practice with first responders for more than 17 years. Sonny consults on issues of stress and trauma with 10 VT police departments including the VT State Police and the VT Department of Children and Families. This past June, Sonny testified for the Vermont legislature as a subject matter expert on PTSD and influenced legislation making Vermont the first state to recognize PTSD as a compensable work-related injury for first responders. It was through his understanding of EMDR and its efficacy that the legislature saw the value of treating first responders immediately after traumatic events.

PARTNERING WITH AND SERVING FIRST RESPONDERS AND PUBLIC SAFETY PROFESSIONALS: CAUTIONS, QUESTIONS AND INTERVENTIONS WITH EMDR EIS PRACTICE-BASED EVIDENCE

Robbie Adler-Tapia, PhD

SUMMARY

When treating First Responders and Public Safety Professionals, therapists need to understand more than just EMDR Therapy. This presentation challenges therapists to consider all of the questions and legal ramifications associated with providing psychological services to First Responders and Public Safety Professionals. Providing EMDR EIs not only includes case conceptualization, but also treatment planning with a fiduciary awareness of the implications that extend beyond treatment. This summary suggests that therapists and EMDR therapy organizations consider the implications of EMDR EIs by asking questions each time treatment is provided. EMDR therapists and organizations need to ask, what do I need to know in order to proceed with an EMDR EI with First Responders and Public Safety Professionals? The following are a summary of the questions for which the presentation suggested cautions and considerations.

WHO?
First responders or Protective Service Workers who respond to manmade and natural disasters experience daily career exposure to acute stress and trauma. By working in professional positions in law enforcement, fire sciences, emergency medical services, search and rescue, 911 operators and dispatchers, emergency room staff (including doctors and nurses), child welfare workers, and even psychotherapists, these individuals experience direct or secondary trauma from the work environment.

WHAT? QUESTIONS & CAUTIONS

- When is the right time to use an EMDR EI? Under what conditions? For whom?
- And, why? Do I have the training and expertise to ethically provide an EMDR EI to First Responder/Public Safety Professionals?
- What's my ethical and fiduciary responsibility to provide treatment services in a complicated legal situation?
- According to Cornell Law School's website, "A fiduciary duty is the highest standard of care. The person who has a fiduciary duty is called the fiduciary, and the person to whom he owes the duty, is typically referred to as the principal or the beneficiary." http://www.rashmiairan.com/ ethical-standards-fiduciary-duty/

WHAT ARE THE POSSIBLE LEGAL QUAGMIRES I MIGHT ENCOUNTER?

- Will there be Worker's Compensation, Employment Law Issues, Criminal Law, and/or Civil Law legal quagmires?
- How might your treatment and documentation impact your client?
- When might telling the story of the event in a clinical setting contribute to a legal problem?

WHO IS MY CLIENT?

- Is your client a victim and/or witness to crime?
- How might your EMDR EI impact later benefits for victims of mass events?
- Are there any employment implications?

WHAT ARE THE ASSIGNMENTS?

- What's the professional's assignment?
- Will this client be a witness?
- What rights does your client have as a victim?

WHAT SHOULD I DOCUMENT WITH AN EMDR EI?

- How might my documentation be used?
- Will your client's employer ask for written documentation?

SHOULD I USE STANDARDIZED MEASURES BEFORE PROVIDING TREATMENT?

- Document Pre-treatment Symptoms with a Trauma Symptom Questionnaire and treatment progress with a Post-Traumatic Growth Inventory (PTGI) to inspire healing, document progress, and recover from the line of duty injuries.

CASE CONCEPTUALIZATION: WHY WOULD I USE AN EMDR EI WITH A FIRST RESPONDER?

- Many first responders have to prove they have line of duty PTSD and may experience Institutional Betrayal when they are challenged about the injury.
- Does the therapist also need to consider assessment and treatment of Institutional Betrayal?
- What does the therapist target first?
- When should the therapist not target the index event with an EMDR EI?
- When is EMDR EI contraindicated?
- What are potential issues in other countries?
- Concerns for witnesses – EMDR Early Intervention can contaminate the client's testimony if provided too soon. An EI Group process can cross contaminate and impact the memories of witnesses.
- A Parade of Faces (Adler-Tapia, 2013) is a metaphor for all the calls that linger and haunt first responders contributing to the onset of physical and mental health issues.

WHAT ARE THE CONSIDERATIONS FOR IMPLEMENTING THE THREE PRONGS OF EMDR THERAPY?

Questions for the First Responder client:

- What happened to me, not just my professional report?
- What triggers it now when I go on more calls?
- How does this impact my family?
- If the client is a witness, should I consider an EMDR Therapy Reverse Protocol?

WHAT I'VE LEARNED:

- The issue with EMDR EI in First Responders and Public Safety needs to be addressed, because it's not the same in the US as in other countries, and certainly different in each state of the US. The complicated forensic issues vary by incident, by country, by state, by community, employer and agency.
- Treat every case like it will end up in court.
- Informed consent, pre-treatment assessment, and treatment documentation can help your client.

WHAT'S NEXT? Advocacy for First Responders and Public Safety Professionals access to care.

ADVOCATE FOR PEDIATRIC EMDR EI (Adler-Tapia, 2017) Don't forget the youngest victims in need of developmentally grounded EMDR EIs!

Disclaimer

This document does not replace legal advice. Please seek guidance from your licensing/certification board, attorney, and professional organizations in your respective community.

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Dr. Adler-Tapia is a licensed psychologist who has worked with individuals encountering trauma, attachment and dissociation for more than 30 years. She treats children of all ages including those with intellectual and/or developmental disabilities. Her career includes counseling, consultation and psychological services for children and families referred by child welfare, Military Veterans, and Public Safety Professionals. Dr. Adler-Tapia also provides post-shooting debriefings

and treatment of acute stress and trauma with Law Enforcement Professionals, and consults with Law Enforcement Agencies. She has authored several books, chapters, and articles on treating trauma. Her volunteer work includes collaborating on the CEBC update and SAMHSA approval for EMDR therapy with children, Mental Health Consultant for PISTLE, and as a member of the Arizona State Subcommittee on PTSD in the Military and Public Safety.

FIRST RESPONDER CUMULATIVE TRAUMATIC STRESS EXPOSURE

Sara G. Gilman, PsyD

Key components in Working with First Responders – Know who you're working with!

Police Officers, Fire Fighters, 911-Dispatchers, Emergency Medical Service Personnel, Rescue Workers, Public Safety Service Workers, Counselors.

Current Research on First Responder Stress & PTSD - Prevalence

Firefighters - Cross-cultural studies: estimated prevalence of 22% U.S. firefighters.

Dispatchers –experience secondary traumatic stress 12-16%

Police Officers – 7-19% - *Hurricane Katrina* = 19%**,** *Urban LEO* = 24%

First responder professional U.S. organizations are reporting that a First Responder commits suicide every 18 Hours (SafeCallNow.org). Research done by the Badge of Life (BOL)wrote in 2016, 'The reduction of suicides in both 2012 & 2016 can likely be attributed to the increasingly **aggressive application of mental health programs**, suicide prevention training, peer support and chaplaincy programs, CISM and an increasing openness by officers to psychotherapy in a toxic career field'.

Sub-threshold Posttraumatic Stress Disorder (S-PTSD) in first responders.

Multiple studies have reported that PTSD symptoms affect first responders' mental and physical health, job performance and family life, early detection of S-PTSD is important for curbing symptom progression and improving patient outcomes, and S-PTSD has the potential to develop into full PTSD if left untreated. S-PTSD symptoms include irritability, sleep disruption, fatigue, anger, detachment, isolation, alcohol use increase, hypervigilance, startling, physical aches & pains, headaches and anxiety. Diminished qaulity of life can be ongoing in this population. If these stress symptoms are left unaddressed, they often do not imporve. Proactively addressing stress management and self care are vital compenents to the first responder understanding their normal stress responses to cumulative exposure and what they can do about it.

Protective factors have been identified that reduce the negative impact of repeated exposure.

1. Strong and consistent social support networks at work and at home.
2. The ability to bring meaning and purpose to work and to critical incidents.
3. Positive self-esteem, meaning the belief in yourself to succeed and grow through challenges.
4. Collective positive self-esteem in personal and work communities, while encouraging others self-respect!

EMDR-EI as part of improving First Responder resiliency

More clinicians in the field are conducting research with EMDR as an intervention executed sooner than later for those who are experiencing stress symptoms. This aims to be a <u>proactive</u> and <u>preventive</u> treatment package, designed to process and resolve the trauma memories before the symptoms become overwhelming. There is hope that EMDR-EI may have the potential to ward off the more significant impact of full blown PTSD. This is very exciting when we consider the health and well-being of our first responders over their careers.

What does S-PTSD look like on the first responder and on the organization?

If an employee is suffering, so is the organization. The impact includes:

more sick days due to medical problems: headaches, Irritable Bowel Syndrome, high blood pressure, lower immune system, weight gain, sleep problems, injuries, substance abuse/addiction, low morale, irritable, cynical, lack of trust, inconsistent impulse control, excessive force, marital strain, conflicts with peeers, isolation, withdrawal, lower life and job satisfaction, on-duty safety violations, increase in Workers Compensation claims.

Boots On The Ground – Lessons from the field

Access to effective Mental Health services is still limited across the U.S., therapists must step out and get involved with the agencies in your area. **Building relationships is a key to successful integration!** Mental Health Professionals who adopt a '*boots on the ground*' mindset, can begin the process of forming a collaborative alliance with Peer Support Teams and Chaplains who are already assisting first responder agencies.

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Dr. Gilman's doctoral dissertation focused on the effects of cumulative traumatic stress exposure in first responders and the use of EMDR as an early intervention. She is a former San Diego Rural Firefighter/EMT and served on the San Diego Critical Incident Stress Management

Team for over 10 years. As co-founder and President of Coherence Associates, Inc., she consults with agencies to build strong peer support teams, and trains personnel in 'Peak Performance and Mental Toughness for the First Responder'. She was awarded Fellowship status with the American Academy of Experts in Traumatic Stress for her extensive work in utilizing EMDR with first responders following critical incidents. As author, speaker, and consultant, she has impacted first responder professionals including 911-Telecommunicators, Police, Firefighters, and EMTs.

ORGANIZATIONAL ISSUES AND SCALING UP FOR EMDR EARLY INTERVENTION

Michael Bowers, MA

For the EMDR community to have measurable impact in areas of need by providing early intervention EMDR and EMDR based interventions, several areas of concern must be considered and addressed.

First, there must be an active and focused attempt to learn from and engage with the agencies who are now providing disaster and trauma relief across the globe. While there are committed and experienced EMDR practitioners engaged in this work, at least from the US perspective, we have not established formal connections or memoranda of agreement with such agencies. We also have a limited activity history of advocacy with these groups to inform/educate/persuade about the impact and effectiveness of EMDR therapy and related interventions with the target populations of these agencies and NGOs.

In the US, for example, the model that has developed in the EMDR community is focused on local networking and intervention. The principle idea under this model is that the local clinicians are best able to establish relationships with local providers and therefore will be prepared and have access to those first responders when the need arises. To use an analogy, we tend to work more as guerilla warriors than those who are part of a standing army.

The challenge with this model is that most of the local organizations are oriented toward, and take direction, from their vertically oriented system. For example, the American Red Cross utilizes a system of

local chapters that can respond directly for needs in their locales. However, in large part, these local chapters depend on their national counterparts for direction and resources when the need outstrips their ability to respond. The American Red Cross, in turn, builds its scaling capacity in a significant way by establishing formal partnerships with national professional organizations. This enables them to offer training and then to have a corps of various practitioners who can be deployed as circumstances demand to provide the necessary response. For example, both as the Executive Director of the American Association for Marriage and Family Therapy (AAMFT) and the CEO of the American Physical Therapy Association (APTA), I ensured that we had in place: 1) a formal memorandum of partnership with the American Red Cross, which articulated each parties duties and responsibilities, 2) a system of trainings in Red Cross processes and procedures that was offered at both organizational and local chapter events, and 3) sent out calls for volunteer deployment as the need was identified.

In the EMDR community, we do not have this set of formal agreements with either the American Red Cross, nor any model for formal agreements with more local organizations. Rather, we tend to run operations that are either more loosely articulated or are independent. By definition, this will limit our ability to scale, or to have a measurable impact on the way the response systems are organized and ultimately delivered (and whether or not they are relatively more or less EMDR friendly).

The second factor that is important to consider is how much we can realistically do without partnering and trying to influence these larger organizations from the inside. A review of the finances of all three US based organizations supporting EMDR therapy and interventions (EMDRIA, the EMDR Foundation, and Trauma Recovery/HAP), shows that the net assets of all three organizations combined is less than $750,000. Most of the income of these organizations is spent on programming, which is admirable. However, the fact that there is no reserve fund capability to build capacity and reach into these organizations in a strategic and focused way is somewhat problematic.

Finally, there is a third challenge for the EMDR community in scaling up. That is the fact that there is a tendency in our community to create or design a protocol or model for intervention, and then to treat that innovation as intellectual property, protecting either trademark or copyright use. While this is understandable from a creator's perspective, it is not a conducive context for wide dissemination or scaling up—whether in early intervention or normal clinical care. While I have no particular suggestions for how to manage or address this reality, the tension between protecting intellectual property and

creating models for the widest possible dissemination and public use and good, requires more consideration and discussion in our community.

None of these concerns is insurmountable. The fact is, we have meaningful interventions which, if applied appropriately and in a timely fashion, can have an outsize impact on a needy population. The challenge for us will be one of focus, priority, and will. I am confident we can make a difference, if we commit ourselves to do so.

Michael Bowers, Executive Director of EMDRIA, is an association executive with over thirty years' experience in health policy and health care delivery. He has worked on policy and law regarding health care organization, finance, and delivery since 1986. He has served as the Executive Director of the American Association for Marriage and Family Therapy (AAMFT) and the CEO of the American Physical Therapy Association (APTA). As a mental health advocate, he has provided testimony to the US Senate, the US House of Representatives, and in 22 state legislatures, and appeared on CNN and NBC Nightly News. He has also developed and maintained partnership agreements for disaster relief with the Red Cross.

INTRODUCTION OF THE TRAUMA RECOVERY NETWORK

Donald F. deGraffenried, LCSW

In the US, there are 43 national TRN associations, 159 national members, 596 individual members and a total of 755 members.

The Trauma Recovery Network is designed to mobilize a *pro bono* response of EMDR therapists in the event of a community natural or man-made disaster.

The newest TRNs are in southeast Florida in response to the Parkland mass shooting and in southern Nevada in response to the Mandalay Bay mass shooting.

The largest TRNs are in Arizona with 66 members and the heart of Texas with 45 members.

To start a TRN in your community, contact Donald deGraffenried at the number below and ask for the handout: *How to Successfully Start a TRN In Your Community in 30 Days or Less.*

Director of Program and Community Development
TR/HAP EMDR Humanitarian Assistance Programs
ddegraff@emdrhap.org
203/288-4450

Donald deGraffenried is a passionate advocate for expanding EMDR therapy into agency and community mental health settings and has started several agency-based EMDR programs. He is Senior Trainer for the Trauma Recovery EMDR Humanitarian Assistance Programs. He is also the lead consultant to all the Trauma Recovery Networks that are a part of TR/EMDR HAP. He has worked extensively using EMDR in community settings working with survivors of homicide and is the Coordinator of the Greater New Haven Recovery Network (GNH TRN). This provides up to 10 pro bono sessions to crime victims and survivors of homicide, who have been referred by the New Haven Police Department.

EMDR EARLY INTERVENTION STRATEGIES FOR MILITARY AND VETERAN-RELATED EVENTS

E. C. Hurley, PhD

MILITARY EARLY INTERVENTION: A pattern for early intervention developed on the battlefield

- Russian physicians (1902-1904) located psychiatrists both on the front and the at home station.
- British and French (1914-1918) discovered proximity as important for forward treatment.
- British and French physicians noted patients with war neurosis improved more rapidly when treated near the front lines.
- 1917 – Thomas Salmon, U.S. Army physician developed comprehensive program for the prevention and treatment of war neurosis with doctrine of early medical intervention.
- The military doctrine in treating war casualties:
    - Immediacy

    - Proximity
    - Expectancy
- All wounded are treated regardless of affiliation

MILITARY DISASTER RELIEF: National, Multi-National and International

2000 – EMDR Early Intervention (EI) strategies used after combat missions allow for immediacy, proximity, and expectancy. Humanitarian relief is increasingly a humanitarian mission using defense forces.

- Often only the military has the manpower, equipment, training and organization necessary to gather the relief effort required during catastrophic incident recovery.
- Military alliances allow for international cooperation. The international guidelines on the use of military and civil defense assets in disaster relief (Oslo guidelines), created in 1994 to provide an international normative and practical framework for disaster response, call for foreign military humanitarian aid to be used by nations as a 'last resort'.
- U.S. military combat operational stress control – EMDR EI used by some EMDR trained therapists.
- EMDR early treatment has been provided to military personnel between the battlefield and home station (Russell, 2006; Wesson & Gould, 2009).
- U.S. military disaster response medical units already have some mental health personnel trained in EMDR EI. We need EMDR EI trained in all immediate response mental health units.
- Currently: Tailoring the EI to address each traumatic situation.
- Future needs: Educate and incorporate EI into military mental health units for crisis response.

VETERAN AFFAIRS CRISIS RESPONSE

- Recent events responses to Department of Veterans Affairs (DVA) crisis response teams during times of veteran suicides on premises, as well as other disasters.
- Train DVA teams in the use of EMDR EI protocols for crisis response at local veterans' affairs centers. EMDR therapy trained therapists aware of need in response to suicides and other deaths on property.
- Veteran organizations conducting humanitarian missions need EMDR EI care for their missions (1) population served and (2) veteran staff members.

- Future needs: (1) train DVA therapists for EMDR early intervention responses; (2) integrate EI trained therapists with veteran humanitarian service missions.

APPLICATIONS

- Education and training of agencies in EMDR EI applications.
- Integration of programs into agencies.
- Research.

E.C. Hurley is a retired Colonel in the U.S. Army with 33 years military experience, many in crisis situations. He is the Founder/Director of the Soldier Center in Clarksville, TN which provides EMDR-based treatment. He is experienced in addressing early intervention responses in combat areas, natural disaster zones and local veteran crisis responses. His experience ranges from coordinating EMDR Therapy volunteer response following hurricane Katrina, to training soldiers in early intervention responses during combat, and training military medical units to provide EMDR early intervention during crisis response. Additionally, he provides training and consultation to therapists in veteran-focused agencies providing crisis response using EMDR early intervention strategies.

RESEARCH HOW-TO'S

Louise Maxfield, PhD

This presentation provided a brief overview of research methodology, with a primary focus on simple instructions for clinicians wanting to do research in their own practices/agencies, and a brief overview of recent quality standards.

Step One: Articulate the Research Question
The research question determines the research design. For example, a randomized controlled trial (RCT) is required to investigate 'Does EMDR EI prevent PTSD?' by comparing PTSD rates at follow-up for participants assigned to treatment with those assigned to no treatment. Case studies can evaluate how members of a certain population (e.g., fire fighters) respond to EMDR EI, by measuring

symptom levels at baseline, pre, post, and follow-up assessment times.

Although RCTs are essential for establishing EMDR's efficacy, case studies are valuable in providing preliminary evidence for effectiveness, suggesting that future RCTs may be of value and should be funded. Ethical research approval is needed from the researcher's institution/ agency and possibly third-party-funder.

Step Two: Select Type of Participants
Examples: first responders; victims of rape/ assault/ workplace violence; survivors of a car accident/ disaster/ mass event / shooting; and those experiencing current stressors. Informed consent from participants is essential. Choose a homogeneous population, with similar time-period post-trauma.

Step Three: Select Treatment
What treatment will you use? Will you check fidelity? How? How many therapists are needed? Who will they be?

Step Four: Select Assessment Tools
Diagnosis (strongly recommended). Inventories measuring Posttraumatic symptoms, Depressive symptoms, Substance use, Sleep problems, Somatic complaints, Quality of Life, etc. It is recommended that small studies use only two measures. In RCTs it is important that measures be administered by a blind independent and trained person. In a case study, the therapist can have clients complete inventories in the waiting room. It is recommended that measures be administered as often as possible/appropriate, e.g., weekly, biweekly, and at least at pre, post, and follow-up.

Example: Hypothetical Case study with firefighters
Research question: How do traumatized firefighters respond to R-TEP?
Method: Case study design

- Participants: 12 Firefighters seen in private practice through Employee Assistance Program
- Treatment: Intake session (preparation, history, informed consent), followed by three sessions R-TEP, within a one-week period
- Measures: Diagnosis by referring doctor, IES-R and BDI administered at intake & pre-treatment, weekly, post, and 3-months follow-up
- Collect session information – SUD, VOC scores, targets, client response, therapist decision points, interweaves, transcripts/client statements

- Diagnostic assessment conducted by referring doctor at follow-up

Step Five: Data Analysis
Data analysis calculators can be found online.

Writing up Report
Follow established publication guidelines (available online). Note that all studies must report on all participants. Case studies must report on consecutive cases. See Appelbaum et al. (2018), http://dx.doi.org/10.1037/amp0000191

Firefighter example:
Participant flow: 12 firefighters invited; 2 declined. 1 dropped out during treatment, 1 was lost to follow-up. N= 10 at pre-treatment, 9 at post-treatment, 8 at follow-up.

Methodological Standards
Standards for RCTs have become more rigorous, with new guidelines for Quality and regarding Bias. RCTs which do not meet current methodological standards, or in which bias is detected are devalued and may be dismissed in treatment guidelines. Resources:
http://training.cochrane.org/resource/assessing-risk-bias-included-studies
Consort 2010 guidelines for randomized research:
http://www.consort-statement.org/

Louise Maxfield is a clinical psychologist and EMDRIA consultant. After becoming an EMDR therapist in 1993, she was an investigator in four EMDR research studies and has consulted on many international research projects. She has published more than 20 scientific articles and chapters about EMDR, is the co-editor of Handbook of EMDR and Family Therapy Processes, and has presented six plenary addresses at EMDRIA and EMDR Canada conferences about EMDR research. She is the founding editor and Editor-in-Chief of the Journal of EMDR Practice and Research. Dr. Maxfield has received the Outstanding Research Award from both EMDRIA and EMDR Canada, and EMDRIA's Francine Shapiro Award.

CAPACITY BUILDING PROJECTS USING EARLY INTERVENTION AND LOW-INTENSITY INTERVENTIONS: INTERNATIONAL EXPERIENCES

Derek Farrell, PhD

Most of the world is unaware and insufficiently provisioned in addressing the global burden of psychological trauma. Furthermore, there is also substantive disparity in both the provision and accessibility of suitability qualified health professionals. By means of example – Norway, a population of 5 million, spends approximately $9,715 per person on health, and per 100,000 of the population has almost 30 psychiatrists and 54 psychologists. Comparing this with Iraq, a population of 35 million, spends approximately $305 per person on health, and per 100,000 has just 0.4 psychiatrists and 0.1 psychologists. The current prevalence of PTSD in Iraq is estimated to be approximately 60%. Trauma capacity building in Iraq cannot rest solely with existing resources – there is insufficient provision, and a paucity of empirically-based trauma treatment interventions. The strategy for developing EMDR Therapy in Iraq needs to be different to the approach adopted for Norway.

The World Health Organization (2013) guidelines for the treatment of PTSD provide significant endorsement for both CBT – trauma focused (TF-CBT), and EMDR therapy. It would be fair to state however, that CBT-TF has been more active in considering how principles of CBT can be carried out by paraprofessionals in environments where a paucity of appropriate resources is available. For example, the WHO developed a Psychosocial Management Programme for Perinatal Depression – based on CBT principles, which provided training in empathy, communication skills, social supports, problems solving etc., where a mental health background or experience in CBT was not considered necessary. Not only was a comprehensive training provided, but clinical supervision was seen as an essential aspect of the program.

Another example, also supported by WHO is the Problem Management Plus (PM+) Programme: A trans-diagnostic psychological intervention for common mental health problems. This program was also a paraprofessional intervention focusing upon anxiety, depression and PTSD.

The primary focus of Low-intensity CBT (LI-CBT) is to deliver interventions in a variety of different forms including both guided and unguided internet-based formats, CBT group interventions, and self-help strategies. In addition, it also utilizes several delivery

formats/platforms including telephone, email, SMS, as well as face-to-face sessions. These formats can be either personalized or automated. The broader aspiration of LI-CBT relates to the provision of cost-effective CBT interventions, service systems that are more functional and 'fit for purpose' (incorporating collaborative care), routinely measuring outcomes and providing a clear rationale regarding clinical decision-making (Levy & Farrand, 2010).

A current estimation is that EMDR therapy is approximately 10-years behind the CBT community in terms of both early interventions and low-intensity interventions. Low-

intensity CBT appears safe, effective, addresses risk, and is underpinned by robust clinical supervision. These advantages improve access, responsiveness and availability of resources

Trauma Aid Germany is one of the largest trauma-capacity building organizations within the EMDR community. A long-standing project has centered upon the Mekong region in South East Asia – primarily focused upon Cambodia, Thailand, Indonesia and Myanmar. One of the major research findings from the first project was to ascertain whether Trauma Stabilization was a treatment affect for PTSD Although a retrospective study, results indicated that Trauma Stabilization was indeed a 'treatment effect' for both adults and children who met the DSM-5 and ICD-11 PTSD criteria with remission rates of over 90% (Eichfeld et al, 2018).

A summary of the results are as follows:

- EMDR-Informed Trauma stabilization is highly effective in its own to remise PTSD clients
- Trauma stabilization is highly effective in adults as well as in children
- Also, subclinical clients (not fulfilling all necessary criteria) profit from Adaptive Information Processing (or AIP-)Informed Trauma Stabilization
- ICD-11 PTSD diagnosis is more conservative than DSM-V PTSD (Intrusions criterion)
- AIP-Informed Trauma stabilization is highly effective in reducing all criteria of PTSD
- AIP-Informed Trauma stabilization is safe, flexible, language independent and culturally sensitive

The conclusions from the Mekong Projects to date are as follows:

1. Trauma Stabilization, informed by AIP paradigm and EMDR principles, is a sufficient agent of change in trauma therapy.
2. AIP-informed Trauma Stabilization Interventions can be carried out by paraprofessionals provided that sufficient training is provided and robust clinical supervision by licensed mental health professionals is also provided.

Derek Farrell is Principal Lecturer in Psychology at the University of Worcester (UK), where he is course director of the world's first MSc EMDR Therapy programme. Derek is involved in trauma capacity building projects in Pakistan, Turkey, India, Cambodia, Myanmar, Thailand, Indonesia, Philippines, Lebanon, Poland, Palestine and Iraq. Derek is an EMDR Europe Approved Trainer and Consultant, as well as a Chartered Psychologist with the British Psychological Society, and an Accredited Psychotherapist with the British Association of Cognitive and Behavioural Psychotherapies (BABCP). He is President of EMDR Europe Trauma Aid Programme, and Vice-President of EMDR Europe. In 2013, he received the David Servan-Schreiber award.

COMMUNITY RESPONSE NETWORKS: US EXAMPLES OF EARLY INTERVENTION

Reg Morrow Robinson, Karen Alter-Reid, Beverlee Laidlaw Chasse, Terry Becker-Fritz, Rebecca Rosenblum

The panel was represented by Coordinators of five U.S. Community Response Networks (CRNs): Karen Alter-Reid, Fairfield County, CT; Terry Becker-Fritz, Central Virginia; Beverlee Laidlaw Chasse, Arizona; Regina Morrow, Orlando, Florida; and Rebecca Rosenblum, Boston Area (Eastern Massachusetts), MA. Community Response Networks (CRNs) are geographically organized groups of licensed EMDR trained therapists who provide EMDR therapy and EMDR Early Interventions. CRNs work within a continuum of care following a disaster or similar stressful event in the community. They incorporate EMDR with community and disaster response agencies to accomplish the mission

of alleviating aftereffects of disaster by applying EMDR early interventions.

Each CRN develops their own mission statement and goals; defines member qualifications and responsibilities; defines service(s) to be provided, determines whether to be a Response, Recovery or both Response/Recovery network. CRN's provide education to therapists, allied professionals and the general community.

Typically, there are four stages in the implementation of a CRN: before-going-live preparations, immediate deployment, ongoing episode efforts, and maintenance of CRN's 'in between incidents.'

Central Virginia's CRN responses to the Charlottesville Unite the Right Rally and the Richmond Confederate Monument Rally in 2017 were described. Fifty-one survivors were treated. Interventions included: grounding and present safety, Early Intervention (EI) Protocols of Psychological 1st Aid and A-TIP; and EMDR Early intervention (EI) Protocols of Recent Incident Protocol.

Arizona's statewide CRN has responded to limited, community and large-scale tragedies since 2010, i.e. shootings, rapes, veteran suicides, house fires and the Yarnell Hill Wildfire Tragedy. Volunteers have provided close to 1000 hours of pro bono individual and group EMDR EI intervention, as well as EMDR EI education and training for volunteers, first responder and disaster response and recovery organizations, and the community in general.

Fairfield County's CRN emphasizes work with first responders since responding to firefighters at a tragic fire in 2011. In 2012/2013, the team treated 250 individuals impacted by the Sandy Hook school shooting. They are advocates of a 'Therapy for Therapists' program for therapists involved in 'shared primary trauma' and/or responding to disasters.

The Boston Area TRN responded to the Boston Marathon in 2013 and was invited to work with the Boston Public Heath Commission's All-Hazard team. The CRN emphasizes ongoing response to both Big D disasters and small d disasters, including community violence, hate crimes, deportation threats, and seeks partnerships with local communities with ties to disasters elsewhere (i.e. local Puerto Rican's affected by Hurricane Maria's impact on their families and communities back home).

The Orlando CRN responded to the Pulse Night Club Shooting in 2016 and provided Basic Training and R-TEP/G-TEP trainings to their community within 24 days of the event.

The panel encouraged other communities of EMDR therapists to form local CRNs so that they could provide Early Intervention (EI) locally. Lessons learned were highlighted as well as challenges that networks may face. Handouts from each panel presenter were provided with extensive information about websites, organizational structures, achievements, how-to-roadmaps, community and disaster response organizations with whom to interface, and materials to be used in trainings.

Reg Morrow Robinson earned an M.Ed., Ed.S. from the University of Florida focusing on marriage and family therapy and mental health counseling. EMDR Therapy entered her practice in 1995 where she moved to become an EMDRIA consultant, EMDR Institute regional and EMDRHAP trainer, and R-TEP/G-TEP independent trainer. Reg launched the Greater Orlando, FL EMDRIA Regional Network in 2005. She sits on the EMDRIA Regional Coordinator's Committee and the S&T Professional Development Committee. She has presented on Consultation at EMDRIA in 2012 and 2015. Reg worked with others from across the country, to respond the Pulse Night Club incident in December 2016.

Karen Alter-Reid is a clinical psychologist and EMDR Institute regional trainer. She is Faculty, EMDR Senior Consultant and Trainer at the National Institute for the Psychotherapies' Integrative Trauma Program. As Co-Coordinator of the Fairfield County TRN, she has overseen trauma/EMDR education and treatment of first responders, and created a 'Therapy for Therapists' program. She has presented at EMDRIA conferences on her work with first responders and therapists. Currently, she is Clinical Consultant to a research project using the Reverse Protocol with court-involved youth. She co-authored with Dr. Ruth Heber, The Trans-generational Impact of Anti-Semitism: Searching for EMDR Targets to Heal Internalized Stigma and Expand Identity.

Beverlee Laidlaw Chasse is a psychotherapist in Scottsdale, AZ. She is an EMDR Institute facilitator, EMDRIA Approved Consultant and EMDR R-TEP/G-TEP Trainer for Trauma Recovery/HAP. Beverlee has presented internationally on Early EMDR Interventions: Preventing PTSD and other post-trauma injuries. She was also instrumental in forming the Arizona Trauma Recovery Network, AzTRN, a state-wide network of over 170 EMDR therapists who are ready to provide pro bono, quality, Early EMDR Intervention (EEI) after disasters or community critical incidences. Her Early EMDR Interventions Pocket

Guide, compiled in 2013, has been included in the EMDR Research Foundation's Early EMDR Intervention Toolkit.

Terry Becker-Fritz has a Master's degree from Ohio State University and has her national certification as a clinical nurse specialist through the ANCC. She is a consultant in EMDR Therapy, and an independent trainer. Her clinical expertise is working with victims of trauma of all ages. Terry helped create the Central Virginia Trauma Recovery Network and is serving as the Leadership Chair. This TRN has a response team of 29 EMDR clinicians and the team was onsite and operational at the Charlottesville event of 12 August 2017. On that day, 20 highly traumatized victims were treated and in the following two weeks another 59 people were helped.

Rebecca E. Rosenblum is a private practice clinical psychologist, with a background in behavioral medicine, hospital and nursing home settings. An EMDRIA approved consultant, she integrates EMDR Therapy and its neurologically based framework with psychodynamic, cognitive behavioral, systems, and feminist therapy perspectives. She is bilingual/binational Portuguese, and serves adults with classic as well as developmental trauma, attending to ethnic, gender, linguistic, sexual orientation and socioeconomic contexts. She volunteers her time to coordinate the Boston Area Trauma Recovery Network (TRN) – serving eastern Massachusetts – using EMDR-EI and the TRN to address trauma in marginalized communities, and recently publishing on this work.

SPECIAL INTEREST GROUP: EI AS A SPECIALTY

Reported by Reg Morrow Robinson, Ed.S.

<u>What are your key interests?</u>

- *First responders*
- *Medical teams; ER MD, nurses*
- *Direct care staff working with chronic mental health*
- *Gun violence in communities*
- *Kids*
- *HIV*
- *Kids with HIV*
- *Teens*

- *Teens with suicide contagion*
- *1st nation stressors- workers delivering care*
- *Marginalized populations (not in one area such as the LGBTQ community)*
- *Fishermen- family stress when fisherman does not return as expected, impacts from weather*
- *India clashes between the caste system*
- *Foster care kids moving into it, around inside of it, aging out*
- *Chronic health issues; CA, MS, cardiac, etc.*
- *Head injuries*
- *Pre- and post-deployment for Doctors Without Borders (MSF), Dept of Defense, MH clinicians*
- *Sexual abuse*
- *Domestic violence*
- *Undocumented immigrants, fear of deportation, DACA*
- *Chronic addiction*
- *Active care givers of ALS and other chronic conditions*
- *Corrections officers*
- *Red Cross field hospital*
- *Injured in hobby; equestrians, skiers, et*
- *Athletes with a tough competition*
- *Sex workers*
- *Teachers: loss due to suicide, teaching team member loss, acts of violence within the day, kids' responses to prevention drills*
- *TRNs and Regional networks responding to a crisis*
- *Minority Religious communities*
- *Clergy and staff*
- *Victims of resurgence of racism*
- *EAP therapists*
- *Licensed*

What are the challenges you perceive you need to overcome?

- *Lack of trauma education*
- *Emergency responders not knowing EMDR treatment, resistance, I am invincible*
- *First responders cannot show weakness due to fear of losing face, losing job, cut from the herd*
- *Funding: where to find it*
- *EMDR clinicians not informed of current research and protocols of EI*
- *Overcoming ineffective previous treatment experiences*
- *Overcoming EAP system -fear exposure if seek in house treatment*

- *Do not believe EMDR as valid*
- *Awareness of legal and witness issues - will receiving EMDR have an impact capacity to be a strong witness?*
- *Belief that PTSD is lifelong inside the military*
- *Disability benefits*
- *Insurance limits on about of time client can be seen in one visit, not more than once a week, prevents intensive treatment*
- *Tricare's limits that therapist may not seek reimbursement and provide pro bono care*
- *Political leaders do not know about EMDR and therefore unable to support it*
- *Religious leaders the same as above*
- *Scheduling time to provide immediate intensives within in already busy schedule*
- *MED codes for billing diagnosis*
- *Treatment may begin before a full diagnosis is made by MH clinician*
- *Gaining informed consent when there is silent terror or unable to talk and describe internal experiences to clinician*
- *Cultural and community beliefs that grief needs to last for a long time*

Goals

- *What is my speed for EI? Develop it*
- *How to advertise EI/ develop a description*
- *Elevator speech for another mental health professional, medical professional, lay person*
- *Simple explanation of the neurobiology of trauma*
- *Determine reasonable fees for EI services*
- *Create method process to schedule for EI and EI intensives*
- *Develop a plan to get the word out about EI to referral sources, and community*
- *Working with State Boards to redefine scope of service as some states limit how services can be provided based on licensure*
- *Work around for insurance barriers*
- *Plan to educate insurance systems about EI*
- *Mitigate suicide risk by delivering EI in schools following a completed suicide*
- *Develop a plan to get EI into the media: news, talk shows, Reddit, linked in, first responders, universities, EMDR community, EAPs*
- *Assist agencies to develop EI responses for employees following an incident (hospitals, e=mental health programs)*

- *Normalize prevention by providing EI*
- *Build an army of EI therapist*
- *Improve education of EI in basic trainings*
- *Create a system to share EI information*
- *Weave it into study groups*

Challenges to reaching goals

- *Takes time to build research*
- *Time to educate*
- *Takes money*
- *Pharmaceutical framework- meds first*
- *Creative and consistent trainings to stay fresh and alert*
- *Culture beliefs*
- *Convincing companies it could save money*
- *Helping therapists overcome fear of risk of something new*
- *Isolated therapists who aren't exposed to EI*
- *Limited method to stay connected*

Steps taken by whom?

- *Each therapist responsible to learn EI*
- *Start with your own practice adding EI*
- *EMDRIA provide materials to market and talk to insurance comprises*
- *S&T modify basic training requirements to include EI*
- *Training providers make training more affordable*
- *Clearing house of EI specialty-related information*

Reg Morrow Robinson earned an M.Ed., Ed.S. from the University of Florida focusing on marriage and family therapy and mental health counseling. EMDR Therapy entered her practice in 1995 where she moved to become an EMDRIA consultant, EMDR Institute regional and EMDRHAP trainer, and R-TEP/G-TEP independent trainer. Reg launched the Greater Orlando, FL EMDRIA Regional Network in 2005. She sits on the EMDRIA Regional Coordinator's Committee and the S&T Professional Development Committee. She has presented on Consultation at EMDRIA in 2012 and 2015. Reg worked with others from across the country, to respond the Pulse Night Club incident in December 2016.

SPECIAL INTEREST GROUP: REGIONAL COMMUNITY NETWORKS

Reported by Terry Becker-Fritz, MA

We had approximately 40 people from around the US attend this SIG. Below are the key questions & the summary of suggestions/concerns that were shared.

KEY INTERESTS:

1. Don't reinvent the wheel – Share
   - Website designs
   - Power Point presentations
   - Brochures
   - Media information
   - Handouts
   - Policies/Procedures
   - Marketing information
2. Develop partnerships between organizations-- identifying which ones
3. Create a clearinghouse for all TRN/CRNs to access
   - Videos
   - Training materials
   - Research
   - Handouts
4. There isn't one organization that meets local TRNs' immediate needs. All are important but are separate
   - EMDRIA
   - HAP
   - Regional Groups
   - Myriad of federal, state, & local organizations involved in disaster response

GOALS:

1. Easy access to already created materials – one central location
2. Slide-decks for training lay people, mental health & allied professionals
3. Standard Mission & goals – VENN diagram built from all TRNs
4. Central clearinghouse & communication system

5. Identify people/departments/agencies in local government to build relationships
6. Compile state requirements for individual licensure on disaster response
7. System to coordinate between 46 TRNs, CRNs, & Regional networks
8. Compile state requirements for individual licensure on disaster response
9. Identify strengths & challenges of being a response, recovery, or both organization
10. Determine when to refer out or within regarding an incident &/or episode
11. Introduction materials to take to potential partners

CHALLENGES:

1. Money, Money, Money – fund raising, securing funds, tax ID, checking account, etc.
2. Ways to remain active between disasters
3. Recruiting & retaining volunteers
4. Being inclusive of diversity within the team
5. Connecting with agencies
6. Getting a place at the table
7. Liabilities & protection for TRN/CRN organizations
8. Maintaining leadership team
9. Issues regarding forms to be used & decision-making responsibilities
10. Standards for being a volunteer
11. Distance between members
12. Coordination between TRN/CRN & regional networks

CREATIVE MARKETING OF TRNs:

1. Information to hospitals, agencies, 1st responders, & medical providers
2. Work with local suicide prevention coalitions
3. Need of vetted providers – law enforcement, clergy, first responders
4. University talks
5. Lifelong learning workshops
6. Add EEI as a specialty on EMDRIA website personal website, business marketing, newsletter
7. Contact 911 responder organizations
8. State association presentations

9. Constructive dialogue on list-serves
10. Publishing presentations to professional organizations within disciplines & across disciplines
11. Short newsletter publications

STEPS TO TAKE:

1. Develop coordination between TRNs & Regional Networks
2. A Demo proof of concept projects (define what is needed)
3. Define relationships (which ones?)
4. Determine which overall umbrella is home to HAP, GIT, EMDRIA, others?
5. Pull together an executive group/coalition from all 46 TRN's to examine structure options
6. Create a communication clearinghouse such as a list-serve routed through a central website
7. Create a vetted list of EEI therapists
8. EEI having a more pronounced place in basic training
9. Identify a CE clearinghouse for each license & exceptions by state
10. Clear listing of Good Samaritan Laws by area
11. Clarify options & legalities around funds, accounts, 501C3
12. Review & streamline forms
13. Create a single 501C3 managing & tracking accounts for separate 5013Cs
14. Sharing information with all clinicians at all levels
15. Create an Executive Board of CRN experienced clinicians

Terry Becker-Fritz has a Master's degree from Ohio State University and has her national certification as a clinical nurse specialist through the ANCC. She is a consultant in EMDR Therapy, and an independent trainer. Her clinical expertise is working with victims of trauma of all ages. Terry helped create the Central Virginia Trauma Recovery Network and is serving as the Leadership Chair. This TRN has a response team of 29 EMDR clinicians and the team was onsite and operational at the Charlottesville event of 12 August 2017. On that day, 20 highly traumatized victims were treated and in the following two weeks another 59 people were helped.

SPECIAL INTEREST GROUP: RESEARCH

Reported by Louise Maxfield, PhD

About 40-50 persons were in attendance. The meeting focused on finding solutions to expressed needs about conducting research. The majority of attendees were clinicians interested in doing research in their own practices, agencies, and/or organizations.

Future Connection

Attendees expressed interest in forming a support/resource group to share information and seek assistance. Possibilities included:

1. Using the EMDRIA Research SIG. However, a number of attendees were not from the USA and were not EMDRIA members
2. Using WhatsApp.
    - Louise Maxfield will email this report, and some other material to members.
    - A request will be made for someone to host the WhatsApp.

Topics

Topics addressed included:

1. Approvals
2. Trial registries
3. Finding research partners
4. Seeking research consultation
5. Outcome measures
6. Research topics
7. Funding
8. Finding information

Approvals

1. Institutional Review Boards (IRBs)
    a. Some journals require that research studies can only be considered for publication if the design was approved by an IRB. The *Journal of EMDR Practice and Research* does not have this requirement. Researchers are encouraged to investigate whether they will need IRB approval to get their research article published in the journal of their choice.

    b. The EMDR Research Foundation Toolkit ('toolkit') has a list of IRBs.
    c. All institutions such as universities and hospitals have IRBs.
    d. Some agencies and community organizations may have IRBs.
    e. There are commercial IRBs where you can pay money to have your research design evaluated. You can apply to the EMDR Research Foundation for related funding.
2. Informed consent from participants
    a. Participants in your study must receive information about the study, and must provide you with written informed consent before they can be included. This consent typically includes an agreement to participate in the experiment, and agreement to allow their data to be anonymously published.
    b. Sample informed consent forms are available in the Toolkit.
3. Approval from other partners
    a. It is possible that agreement may be needed by treatment funders (such as insurance agencies) or by employers (in the case of Employee Assistance Programs). You should make sure to contact all involved parties before starting your study to find out what requirements there may be.

Partners

Most attendees expressed interest in partnering with someone who could assist in various aspects of the research project:

1. Consultation re various aspects of the design
2. Collaborating in research project
3. Data entry
4. Data analysis
5. Writing up the study

Various potential partners were identified:

1. University professors
2. Graduate students
3. Workplace colleagues
4. Researchers who have previously published on the topic at interest

Ways to find potential partners included:

1. Reading the Faculty bios on your university's webpage to find professors with matching interests

2. Googling faculty members
3. Googling research articles in your area of interest to locate researchers
4. Becoming involved as a volunteer or by doing presentations on the topic of interest, public speaking engagements, speaking on national public radio (NPR) to connect with others
5. Talking to local experts or service providers in your area of interest (e.g., rape crisis center)

Example:

Someone was interested in studying the responses of autistic participants to EMDR treatment. It was recommended that she read the studies by Mevissen et al. for background about how other research has been done, and then that she contact Dr. Mevissen to ask for suggestions on the new proposed study.

Becoming Informed

1. Use Google scholar to search for material.
2. Google search the title of an article to access it. The literature review (and related reference list) in an article is a great source to identify other articles.
3. Reference lists contain the DOI number for each article, which is a link to the online permanent location for each article. DOI= digital object identifier.
4. Start an article reading group to learn more about research and outcome studies.

More Education and Training on How to Conduct Research

1. EMDRIA conference should host a workshop on how to get started with a research project
2. EMDRIA website could include online video presentations on how to do research
3. Workshops could also cover how to understand research results

Funding Sources

1. EMDR Research Foundation
2. EMDR Europe Research Committee

Outcome Measures

In addition to regular measures, participants expressed interest in

1. Doing neurobiological studies, using brain scans.
2. Examining pre-post changes in cognitive content in narrative accounts of the event
3. Using economic outcomes.

Trial registries

There are "increased calls, both nationally and internationally, for *clinical trial registration*. This involves providing information to a registry about the results upon its completion. Trial registration can enhance transparency by providing a complete description of the trial to both the scientific community and the general public. From an ethical perspective, the Declaration of Helsinki, which is the set of ethical principles regarding human experimentation developed by the World Medical Association (2013), stated that 'every clinical trial must be registered in a publicly accessible database before recruitment of the first subject' (p. 2193). Trial registration also helps minimize publication bias and selective reporting of results. As of January 18, 2017, all clinical trials, funded in whole or in part by the National Institutes of Health (NIH), must be registered in ClinicalTrials.gov. A *clinical trial* is defined by NIH as a 'research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes' (NIH, 2014, para. 4).

Relevant to the majority of clinical trials conducted by psychologists, this definition includes various types of psychotherapy and psychosocial interventions (e.g., cognitive therapy, diet, exercise, problem-solving training) as well as delivery systems (e.g., telemedicine, face-to-face interviews). Additional information can be found in FAQs on the NIH website (http://www.grants.nih.gov/clinicaltrials_fdaaa/faq.htm#5052).

On an international basis, the World Health Organization (WHO) manages the International Clinical Trials Registry Platform (http://www.who.int/ictrp/trial_reg/en/), which provides a way to search ClinicalTrials.gov and other registries. Information about where a trial is registered should be reported on the title page, in the abstract, and in the reporting of the experimental manipulation."

FROM: pages 10, 13. Applebaum et al., 2018. Journal article reporting standards for quantitative research in psychology: The APA Publications and Communications Board Task Force Report. *American Psychologist, 73*(1), 3-25. http://dx.doi.org/10.1037/amp0000191

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and chapters about EMDR, is the co-editor of Handbook of EMDR and Family Therapy Processes, and has presented six plenary addresses at EMDRIA and EMDR Canada conferences about EMDR research. She is the founding editor and Editor-in-Chief of the Journal of EMDR Practice and Research. Dr. Maxfield has received the Outstanding Research Award from both EMDRIA and EMDR Canada, and EMDRIA's Francine Shapiro Award.

SPECIAL INTEREST GROUP: SCALING UP

Reported by Carolina De La Torre Ugarte

1. Current issues EMDR practitioners face in the field

a. Systems such as insurance, liability, etc. often limit what clinicians can do. How fearful does the EMDR community need to be? If we get too caught up in the regulations, it may well become elitist and incapable of adapting to various other cultures— often with greater needs.

b. Issues with follow-up. Working in contexts like emergency rooms and disasters make follow-up difficult. How do we address this? EI and simplified protocols for use by non-MH-specialists and paraprofessionals (e.g., physicians, nurses, midwifes) are one answer.

c. How to avoid the EMDR community response teams going solo into crisis and disaster settings, and instead work with other teams and systems that are already in place? Collaboration with large or small organisations, including Red Cross and others, and always in coordination with government (ministries of health *and* others). Inserting EMDR training and therapy capacity into existing large health infrastructures is one way to scale up.

d. Existing price differences in supervision (CBT provides funding, while EMDR does not) should prompt EMDR professional associations to look at CBT as a model, as Derek Farrell suggested.

2. Exploring the possibility of training paraprofessionals/non-specialists.

a. What do we do in a country without any psychologists or psychiatrists? There is a need for context-specific training, and permission to use the most appropriate materials available. Standardization and certification would be welcome. Focus on the opportunities afforded by estimated 10 million doctors, 19 million nurses, and 5 million community health workers in the world! Not to speak of teachers, first-responders, mediators, religious leaders and many others.

b. Supervision and ongoing research need to be implemented.

c. Current status: EMDR training is expensive and eligible to few due to strict prerequisites.

d. Military. Many traumatized veterans are struggling to be empowered and could be an ideal group for peer support. Some training materials are already available. Not all military leadership is supportive of EMDR. If you live in a pocket that is supportive of EMDR, ask the leadership to host or co-host a workshop for other leaders to share experiences and describe benefits, thus overcoming reluctance or resistance.

e. Strongly recommended to start exploration/implementation of paraprofessionals scheme outside western world. LAMICs often have less regulations for professionals, and at the same time very high need/demand for services, especially during or following crises. But remember: RESEARCH. RESEARCH. RESEARCH!

f. Supervision is a keyword. How do we do it? And who provides it? Explore the possibility of training online, use of Skype, Zoom, etc. When internet is not an option, how can we provide face-to-face support? Jon Rohde mentioned to look for specific windows of opportunity for supportive supervision. For example, CHWs come to a main hub or center once a month to submit reports and collect supplies. What are the other windows or moments that exist in current systems to offer supportive supervision when internet is insufficient or unavailable?

g. Emre Konuk mentioned the importance of goodwill and trust when considering who qualifies for EMDR standard training. In Turkey, training was provided to non-Master's holding professionals. This boosted the country's trauma care capacity at

a time of increased need, and due to close supervision, there were no negative effects.

3. EMDR must adapt to cultural contexts in collaboration

a. EMDR *must not* become another tool for colonialism. Psychology itself does not have a good reputation in many circles due to its long history as a tool of control or oppression. Therefore, here is an opportunity to explore how the field of psychology— not just EMDR— can help others heal by collaborating within various cultural contexts. Mutual respect, collaboration and empowerment are key.

Examples mentioned:

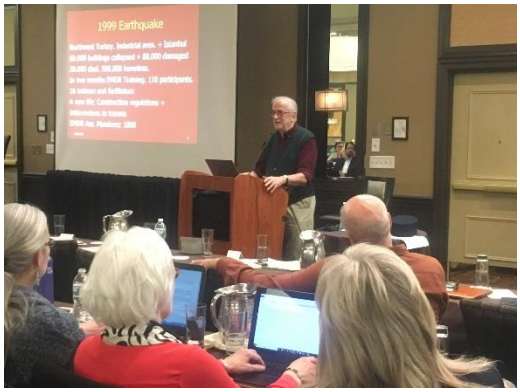
- Inquiring about hand drumming in certain African dances-- let's ask where this practice comes from and whether any similarities and differences with EMDR can be observed. It is a noteworthy cultural practice worth exploring.
- Increasing the speed of Butterfly Hug for earthquake survivors. This adjustment was made when therapist realized the group was unresponsive to the initial protocol.
- Clients being offered the option to draw in the sand instead of with pen and paper. That option was suggested as a possibility when working with women from a specific tribe in the Middle East where women educating themselves or being educated could be punishable by death. Writing with pen and paper would 1) be a sign of education and 2) be physical evidence of that transgression. By drawing in the sand, they can participate without fear of punishment.

Carolina De La Torre Ugarte studied Psychology, Sociology and Anthropology at the University of Tennessee. In her research Voices Unheard: An Exploratory Study of Families of Inmates, she conducted interviews with adult family members of people in prison to better understand the impact of incarceration on communities. As Project Director at the Global Initiative for Stress and Trauma Treatment (GIST-T), Carolina collaborates with NGOs to assess their staff needs regarding stress and trauma in humanitarian settings. She is pursuing a Master's degree in Anthropology and Sociology at the Graduate

Institute of International and Development Studies in Geneva, Switzerland. Her research interests include the role of trauma in conflict, the influence of culture and setting on coping skills, restorative justice practices, and prison reform.

PHOTOGRAPHS FROM THE EVENT

EMDR R-TEP Flow chart 2
Trauma - EPISODE
[2] Episode Narrative
Telling the story
of the Traumatic Episode
out loud with BLS
During the intake
the client is deliberately not asked
to recount the details of the trauma
to avoid triggering activation
prematurely


1999 Earthquake

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