

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

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Isabel Fernandez

Chiara Callerame

Giada Maslovaric

*Psychotraumatology Research and Studies Center (C.R.S.P.)*

*Milan, Italy*

Kathleen Wheeler

*Fairfield University, Connecticut*

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

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

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

## Humanitarian Interventions

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

acute stress responses after a disaster are universal, whereas the person's culture determines the way these responses are manifest (National Institute of Mental Health [NIMH], 2014).

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

## EMDR Research

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

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

Less research has been conducted in emergency situations for acute stress responses for numerous reasons; some of which include the lack of a research infrastructure in place, the disarray of community supports and resources in times of crisis, and the fact that clinicians who are helping the victims are

naturally reluctant to collect data in disasters. The priority should be and has been to provide services and alleviate suffering as soon as possible.

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

## EMDR Therapy: A Humanitarian Intervention

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

Using recent events protocols such as Shapiro's protocol for recent traumatic events (Shapiro, 2001, 2006), the recent-traumatic episode protocol (R-TEP; Shapiro & Laub, 2008), the integrative group trauma protocol (IGTP; Artigas, Jarero, Alcalá, & Cano, 2014), or the PRECI (Jarero et al., 2011) for processing traumatic experiences have been essential in disaster situations. After processing the recent traumatic experience of the event and present triggers, future templates can then be successfully completed even if the disaster is ongoing. EMDR interventions offer

psychological and psychosocial aid in all phases in the aftermath, in the first phase of the disaster, after some weeks and months, and even after some years if the population has not been reached before.

EMDR therapy has been offered in crisis situations in schools and organized with all appropriate individuals and agencies (school personnel, parents, education department, etc.). The collaboration of different organizations and parties establishes clear roles, starting with adults (processing of their own experience, psychoeducation, information on how to handle child and adolescent victims in the aftermath of a disaster, explaining EMDR intervention and obtaining the informed consent). This outreach is important to treat the whole community.

The request for EMDR interventions after a community, a school, or a mass disaster is increasing. One reason for this growing request may be that EMDR therapy is becoming well-known among psychologists and clinicians so that when a disaster occurs, professionals ask for help from EMDR associations, EMDR teams, or EMDR clinicians. Thus, it appears that word of EMDR's efficacy is spreading and requests occur sometimes immediately after the event, on the same day, or the day after. This allows EMDR teams to organize to intervene in the very early part of the stress reaction.

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

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

Over the past few years, Italy has suffered several natural disasters as well as violent acts, forcing entire

communities to struggle to get back to their normal life. Very often, emergency situations are initially viewed from an economic and social perspective. Yet, once people are back to their normal life, many individuals suffer the long-term sequelae of trauma that includes numerous risk factors for mental and physical health. The Italian EMDR Association has been working to develop awareness in institutions and agencies involved with populations exposed to extreme stress. For more than 10 years, a network of EMDR clinicians working pro bono has been activated immediately after the catastrophic event. This has happened many times in different disasters, with different characteristics, from tremendous earthquakes to events such as those following domestic violence.

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

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

All EMDR treatment was coordinated by the national health system and the Italian EMDR

**TABLE 1. EMDR Italy Disaster Interventions**

Project	No. of Treated	EMDR Treatment	Outcomes	Follow-up
<b>Natural Disasters</b>				
Molise, Italy, earthquake 2002 (Fernandez, 2007)	32 children age 6 years	Six EMDR sessions	Children's PTSD symptoms dropped from 63.6% to 28.6%.	6 months later, maintained and improved to 9%
Capoterra (Sardinia, Italy) flood 2008	128 children with PTSD	Six EMDR sessions	94% had no PTSD 1 week after EMDR	5 months later, children who had not received treatment, had high level of PTSD symptoms.
L'Aquila, Italy, earthquake 2009	17 children with PTSD	Six EMDR sessions	After treatment, only 5% still suffered from typical posttraumatic symptoms.	
Emilia, Italy, earthquake 2012	629 adults	One to a maximum of four EMDR sessions	The group that was not presenting symptoms anymore after treatment rose from 13.3% to 57.6%.	
<b>Man-Made Disasters</b>				
Milan, Italy, airplane crash 2002 (Fernandez, Gallinari, & Lorenzetti, 2005)	236 children 6–11 years old	EMDR-IGTP (Jarero et. al., 2008)	No further posttraumatic stress responses	No dysfunctional behaviors nor any posttraumatic stress responses at the beginning of the new school year
Stroppiana, Italy, school bus accident 2007	30 children 25 adults	Three to eight EMDR sessions	One week after EMDR treatment, 81% did not present PTSD symptoms.	Three months and 1 year after treatment, results were maintained.
Viggiù, Italy, car accident 2008	16 adolescents	Three to six EMDR sessions		
Turin, Italy, schoolbus accident 2010	78	R-TEP	Children treated in acute phase had a significant difference in symptomatology compared with those with delayed treatment.	

*Note.* PTSD = posttraumatic stress disorder; EMDR-IGTP = EMDR integrative group treatment protocol; R-TEP = recent-traumatic episode protocol.

Association working closely with the local health administration. The teaching staff and other members of the school staff were supportive in every phase of the intervention. The entire staff received the opportunity for psychological support, which consisted of individual consultation, group debriefing, psychoeducational meetings on stress responses in children, lessons on handling the class, and some critical aspects that had emerged during everyday life in the aftermath as well as individual EMDR

sessions targeting their own personal experience. Parents were also given education to understand their own and their child's posttraumatic stress responses. Parents were trained how to support their children in the aftermath of the trauma. During these meetings, therapists measured stress reactions and symptoms before starting to work with the children. Parents were interviewed to assess their child symptoms, informed about the type of intervention the child was going to be provided with, provided

information concerning EMDR therapy, and informed consent was obtained.

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

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

monitoring was enabled for the first time to illustrate during the reliving of the traumatic event through the neurobiological activities of people with chronic symptomatology 10 years after a mass disaster.

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

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

## **EMDR Humanitarian Projects Within European Countries**

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

effectiveness, making it faster and cheaper than other resource intensive therapies.

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

#### Therapist Training: Humanitarian Assistance Program Projects Conducted by European National EMDR Associations

The main objective of EMDR HAP is to respond to community-wide disasters. To work toward this goal, the specific HAP focus is to help local therapists treat traumatized people by training them in

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

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

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

Country Receiving Training	European EMDR Organization Providing Training	Time Frame	Number of Therapists Trained
Africa	Switzerland, France, Norway and Sweden association		
Baltic countries	HAP Sweden		20
Bangladesh	HAP United Kingdom	2004–2014	25
China	Trauma-Aid Germany	Since 2005	161 therapists 20 supervisors
Cuba	EMDR Italy and Spain associations	2008–2014	340
Haiti	Trauma-Aid Germany	2012–2013	
Pakistan	EMDR Europe HAP		125 therapists
Rwanda	Trauma-Aid Germany	Since 2010	
Slovakia	Trauma-Aid Germany	Since 2003	More than 70 therapists
Thailand, Cambodia, and Indonesia	Trauma-Aid Germany	2010–2013	30 therapists and 15 supervisors
Ukraine	EMDR Institute Austria and Germany	Since 2006	73

Note. HAP = Humanitarian Assistance Program.

from Ukraine took part in trainings in Vienna, Austria (by invitation of EMDR Institute Austria and EMDR Institute Germany).

The projects were financed by the following means:

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

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

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

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

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

In addition to these projects, other EMDR Europe projects have been developed in many other areas of

the world, such as in Vietnam (EMDR Italy), Cuba (EMDR Italy and Spain) in Pakistan (EMDR United Kingdom and Ireland), in China (EMDR Germany), and in Kenya (EMDR Germany). There are most likely other projects that these authors are not aware of.

## Lessons Learned

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

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

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

The humanitarian projects described in this article demonstrate support for the effectiveness of EMDR treatment with children as well as with adults in the aftermath of a mass disaster. A large percentage of the population involved in these events participated in EMDR treatment. If we compare the number of people who participated in treatment with other studies published in the literature (Stallard, Salter, & Velleman, 2004), the high representativeness of the

populations described here suggests that EMDR therapy is generally accepted.

We also found pretreatment that PTSD and subclinical PTSD rate are usually higher than that reported in other studies. We consistently observed that acute posttraumatic stress symptoms do not subside 3 months from the event as described in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; APA, 2000), but lacking specialized treatment symptoms further increase in children. The results obtained after treatment have been significant and highlight the effectiveness of the EMDR approach, both immediately, mid-crisis, and post trauma. This confirms findings published in the literature especially regarding the efficacy of EMDR therapy with children (Chemtob, Nakashima, & Carlson, 2002; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2013; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009).

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

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

the strong need for a specific intervention also for the caregivers of children surviving mass disasters.

## Future Plans and Challenges

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

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

It is important that an infrastructure for research be developed to understand which protocols are best in which situations, for which population and when is the best time to intervene. Designs such as a wait-list/control may be feasible in such situations, but clear instructions need to be detailed for clinicians who are most likely not researchers to accomplish this. Instruments that are valid and reliable in chaotic situations need to be identified and made available to those providing the treatment and training. Because most clinicians are not researchers, research guidelines need to be clear, specific, and detailed enough to provide empirical results without interfering with the humanitarian aid offered. Along with these research considerations, attention and sensitivity to the victims must remain the priority. The immediacy of data collection in a chaotic situation in a timely way is challenging. A user-friendly toolkit should be made available to EMDR national and humanitarian associations so that outcome data can be collected, coded, and entered on a database that is shared globally to advance the science of EMDR therapy's efficacy for recent trauma. An international collaboration is currently underway to develop such a resource.



Securing funding for the treatment of those affected by disasters, the training of clinicians, and for conducting research is of paramount importance. The initiatives described here illustrate the generosity of clinicians and members of the EMDR community. Perhaps other EMDR associations in the world could follow EMDR Europe's lead and "adopt" a country to provide the needed resources to support training and assist in the development of the adopted country's own EMDR association. It is essential to provide the opportunity to people, groups, and nations to overcome traumatic experiences and relieve the suffering, grief, anger, and resulting psychiatric disorders. It is EMDR Europe's mission to reach more people and populations to offer the possibility to live without suffering unduly from trauma in the future and for future generations' health.

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Correspondence regarding this article should be directed to Isabel Fernandez, Center of Psychotraumatology, via Vitruvio 43, 20124, Milan, Italy. E-mail: [isabelf@tin.it](mailto:isabelf@tin.it)