EMDR

Edited by: Marilyn Luber, PhD

Eye Movement Desensitization & Reprocessing

EMDR RESOURCES IN THE ERA OF COVID-19

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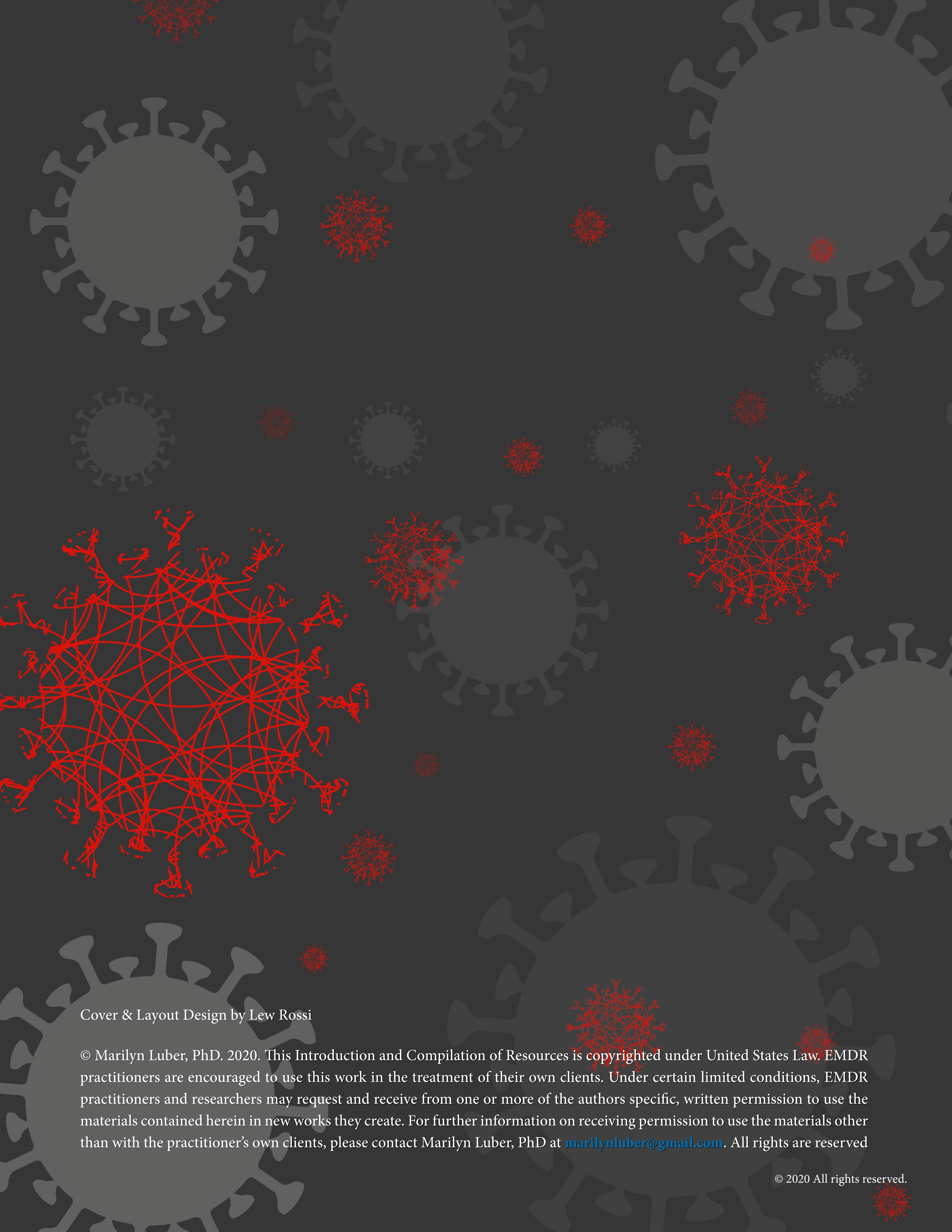

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Eye Movement Desensitization & Reprocessing

EMDR
RESOURCES IN THE ERA OF COVID-19

Edited by:

Marilyn Luber, PhD

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an inspiration at all times, but
especially in times of crises

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Marilyn Luber, PhD, is a licensed clinical psychologist and has a general private practice in Center City, Philadelphia, Pennsylvania, working with adolescents, adults, and couples, especially with complex posttraumatic stress disorder (C-PTSD), trauma and related issues, and dissociative disorders. She has worked as a Primary Consultant for the FBI field division in Philadelphia. In 1992, Dr. Francine Shapiro trained her in Eye Movement Desensitization and Reprocessing (EMDR). She was on the Founding Board of Directors of the EMDR International Association (EMDRIA) and served as the Chairman of the International Committee until June 1999. Also, she was a member of the EMDR Task Force for Dissociative Disorders. She conducts facilitator and consultation trainings and teaches other EMDR-related subjects both nationally and internationally. Since 1997, she has coordinated trainings in EMDR-related fields in the greater Philadelphia area. In 2014, she was a member of the Scientific Committee for the EMDR Europe Edinburgh Conference. Currently, she is a facilitator for the EMDR Global Alliance to support upholding the standard of EMDR Therapy worldwide. She is also a member of the Steering Committee for the Future of EMDR Therapy Project and on the Council of Scholars. In 1997, Dr. Luber was given a Humanitarian Services Award by the EMDR Humanitarian Association. Later, in 2003, she was presented with the EMDR International Association's award "For Outstanding Contribution and Service to EMDRIA" and in 2005, she was awarded "The Francine Shapiro Award for Outstanding Contribution and Service to EMDR." In 2001, through EMDR HAP (Humanitarian Assistance Programs), she published, *Handbook for EMDR Clients*, which has been translated into eight languages; the proceeds from sales of the handbook go to EMDR HAP organizations worldwide. She has written the "Around the World" and "In the Spotlight" articles for the EMDRIA Newsletter, four times a year since 1997. In 2009, she edited *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and special situations* (Springer) and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special populations* (Springer). She interviewed Francine Shapiro and co-authored the interview with Dr. Shapiro for the Journal Of EMDR Practice and Research (Luber & Shapiro, 2009) and later wrote the entry about Dr. Shapiro for E.S. Neukrug's, *The SAGE Encyclopedia of Theory in Counseling and Psychotherapy* (2015). Several years later, in 2012, she edited Springer's first CD-ROM books: *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols with Summary Sheets CD-ROM Version: Basics and Special Situations* and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols with Summary Sheets CD-ROM Version: Special Populations*. In 2014, she edited, *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets.* In 2015, three ebooks were published that supplied protocols taken from *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*: *EMDR Therapy With First Responders* (ebook only), *EMDR Therapy and Emergency Response* (ebook only), and *EMDR Therapy for Clinician Self-Care* (ebook only). The text, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-compulsive and Mood-Related Conditions* and *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating trauma-and stressor-related conditions* were released in 2015. In 2019, Springer published Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: *Treating medical-related issues* and Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: *Treating eating disorders, chronic pain, and maladaptive self-care behaviors.* In 2020, Luber compiled resources for and from the worldwide EMDR community and put online, *EMDR Resources in the Era of Covid-19.*

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{ Everything will be fine }

Italian Slogan during the Coronavirus

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Contributors

Catherine M. Butler, EdD, MFT, is a clinician in private practice in San Diego, CA. Her practice focuses on the impact of PTSD on first responders and veterans. The area of compassion fatigue and burnout has been an interest for several years and she trains extensively in the San Diego area for agencies, volunteer groups, and organizations that meet increasing demands for their services and dwindling resources. She is a member of the San Diego EMDR Trauma Recovery Network (TRN) and works to assist the community after critical incidents, as well as supporting the first responder network as they meet emergent needs. Promoting strength, resiliency and compassion within the treatment and first responder community is the focus of her work and passion

EMDR Europe - Standards Committee, is an EMDR European Committee chaired by Richard Mitchell and co-chair, Kerstin Bergh Johannesson. They are tasked with upholding the standards of EMDR therapy. Their committee includes the following members: Bjorn Aasen, Ludwig Cornil, Arne Hofmann, Ad de Jongh, Isabel Fernandez, Peter Liebermann, Udi Oren, Carlijn de Roos and Michel Silvestre.

EMDR Italy Association is the official professional association that establishes, maintains and promotes the highest standards of excellence and integrity in EMDR therapy practice, research and education in Italy. We have conducted approximately 700 interventions in the field of acute traumatization for individuals and communities, working on a pro-bono basis. These 7000 members of the Association are part of a great network that communicates on a regular basis, sharing results, tools, and skills. The Association provides psychological support in the aftermath of critical incidents occurring in schools (suicides, sudden death of students or teachers) and also in mass disasters like earthquakes, floods (such as the Genoa bridge collapse, Coronavirus pandemic). EMDR Italy has intervened in the last 4 major earthquakes in Italy, providing support to the greater population, children, emergency workers, decision makers and schools. There is ongoing collaboration with the police, the military, with the Ministries of Education, Internal Affairs and Defense, providing training, psychoeducation and interventions with their personnel exposed to traumatic events. We are a scientific society endorsed by the Ministry of Health. We have been given an award by the President of the Italian Republic for our contribution to society and to public mental health and for helping communities to recover and promoting resilience. During the COVID-19 pandemic, we are conducting almost 200 interventions. Our support is addressed to the population, to the health workers, to the families and to schools (teachers and students). We are doing all these interventions in agreement and requested by the Institutions, hospitals, the National Health service, schools, senior citizens homes, town halls, Civil Defense.

Derek Farrell, PhD is a Principal Lecturer in Psychology, an EMDR Therapy Europe Accredited Trainer and Consultant, a Chartered Psychologist, Scientist and Associate Fellow of the British Psychological Society, and an Accredited Psychotherapist with the British Association of Cognitive & Behavioral Psychotherapies (BABCP). He is past President of the EMDR UK & Ireland Board, President of Trauma Aid Europe, Past Vice President of EMDR Europe Board, Chair of the EMDR Europe Practice Committee and a participating member of the Council of Scholars Future of EMDR Project. He is involved in Humanitarian Trauma Capacity Building programs in Pakistan, Turkey, India, Cambodia, Myanmar, Thailand, Indonesia, Lebanon, Poland, Philippines, Palestine and Iraq. His PhD in Psychology was researching survivor's experiences of sexual abuse perpetrated by clergy and he has written several related publications. Derek was the recipient of the 'David Servan-Schreiber Award (2013) for Outstanding Contribution to EMDR Therapy, shortlisted for the prestigious Times Higher Education Supplement (TES) Awards (2017) for 'International Impact' for his Humanitarian Trauma Capacity Building work in Iraq with the Free Yezidi Foundation and Jiyan Foundation for Torture and Human Rights, and awarded the Trauma Aid Europe 'Humanitarian of the Year Award' (2018).

Isabel Fernández, PsyD is a clinical psychologist working in Milan. She has been trained in Cognitive Behavioral Therapy and has been on the faculty of the Italian School of Cognitive Behavior for 18 years, providing specialization training in psychotherapy. She has worked as a consultant psychologist at the psychiatric ward of Niguarda Hospital, conducting clinical research projects. Currently, she is Director of the Psychotraumatology Research Center of Milan and has published many papers, articles and books on trauma, EMDR and other topics. She is chairman of the Italian EMDR Association and President of EMDR Europe Association and a member of the Board of Directors of the Italian Federation of Scientific Psychological Societies. She has been a member of the Standing Committee Trauma and Disasters and the Board Prevention and Intervention (of the European Federation Psychological Associations) from 2005 to 2014. She has organized interventions with EMDR in mass disasters and has worked in cooperation with Civil Defense, Military and Law enforcement and firefighters to provide psychological support and trauma treatment for emergency workers. She trains graduates students and clinicians in trauma, EMDR and crisis intervention in Italy and Spain. She has done research and published on Post-traumatic stress reactions in children and adults in emergency settings and mass disasters. In 2019, she received the title of Knight Commander from the President of Italy, for the contribution given to the population and communities through the Italian EMDR Association, in the case of mass disasters.

Ana M Gómez, MC, LPC is the founder and director of the AGATE Institute. She is a psychotherapist, author, and international speaker on the treatment of complex trauma, and dissociation and the use of EMDR therapy with children and adolescents. Ana has worked extensively with families and program development to heal intergenerational trauma. She has led workshops and given keynotes in more than forty cities in the U.S. and thirty cities throughout sixteen countries. She has presented many of her online

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workshops to large audiences all over the world.Ana is the author of *EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment and Dissociation* and several book chapters and articles on the use of EMDR therapy with children and adolescents. In addition, she is the author of multiple children's books directed to increasing affect tolerance and emotional literacy as well as to prepare children for EMDR treatment. Ana has developed numerous intensive training programs and protocols that include the *EMDR-Sandtray Protocol & The Systemic, EMDR - Attachment Informed Program to Heal Intergenerational Trauma & Repair the Parent-Child Attachment Bond*. www.AnaGomez.org

Ignacio (Nacho) Jarero, PhD, EdD, is the world pioneer in the provision of EMDR therapy in a group format, AIP-informed Advance Psychosocial Interventions for trauma-exposed populations, and AIP-informed Remote Assistance. For his humanitarian services around the world with near 200 deployments since 1998, he has received the Francine Shapiro Award, the International Crisis Response Leadership Award, and the Psychotrauma Trajectory Award. For his research work with EMDR therapy, he received the EMDRIA Outstanding Research Award. Dr. Jarero is EMDR Institute Senior Trainer of Trainers and Advance Specialty Trainer and has conducted seminars and workshops around the world with participants of 67 different countries. He is a co-author of the EMDR Protocol for Recent Critical Incidents and Ongoing Traumatic Stress © (EMDR-PRECI), the Protocol for Paraprofessionals use (EMDR-PROPARA), the Acute Stress Syndrome Stabilization (ASSYST) AIP-informed procedures in group, individual and remote formats, and the EMDR Integrative Group Treatment Protocol© (EMDR-IGTP) that has been applied worldwide with natural or human provoked disaster survivors. He is also the author of the AIP-informed Advance Psychosocial Interventions for Trauma-exposed Populations Training Program.

Şenel Karaman, BA is a Psychologist, EMDR Europe Accredited Consultant and President, of EMDR Trauma Recovery, Turkey. He specializes in Family Therapy, Brief Therapy and EMDR therapy. His adult patients suffer from complex trauma, recent trauma and crisis situations. For 20 years, he has provided psychological support to clients dealing with natural disasters, terrorist attacks, plane crashes, traffic accidents, and harassment, as a therapist and manager of intervention teams. He also assisted in the development of the following books, "The Art of Being a Parent," "Tool Bag for the Psychological Counselor," "Every Child Can Trust Him," and psychological board games.

Sefa Kaya, BA is a Family and EMDR Therapist from Turkey. Currently, he is studying Counseling Psychology. He works with children, adolescents and children addressing their recent and old trauma as well as anxiety, neglect and abuse. He is assistant to the President of the EMDR Trauma Recovery Group during the Elazig earthquake 2020 project. He is working in the project helping health workers, patients with COVID-19 and their families.

Lorraine Knibbs, MSc, is an EMDR Europe Accredited Consultant, EMDR Trainer in Training and University Lecturer, teaching Masters' Programs in EMDR therapy and also Counselling and Psychotherapy Practice. She has taught and trained nationally in the UK and Ireland and more widely internationally on EMDR humanitarian projects in Poland, Greece, and the Middle East. Lorraine is Past President of EMDR UK: Vice President of Trauma Aid Europe. She is a member of the Council of Scholars and its working committees of training and credentialing and training and accreditation. She is published in the field.

Emre Konuk, MA, is a Clinical Psychologist. He received his undergraduate degree at Istanbul University, followed by a graduate degree in Clinical Psychology at Bogazici University. He received his Family Therapy Training at the Mental Research Institute (MRI), Brief Therapy Center, Palo Alto. He became a pioneer in Turkey establishing psychotherapy as a profession by founding the Institute for Behavioral Studies (DBE Davranış Bilimleri Enstitüsü) in 1985, with the vision of providing psychological services to individuals, couples and families. In 1998, he established the Organizational Development Center in order to contribute to the improvement and growth of organizations and Human Resources. He is an EMDR Institute and EMDR Europe Trainer, President of The Institute for Behavioral Studies-Istanbul, President of EMDR Association and EMDR-HAP-Turkey and General Secretary of Couples and Family Therapy Association-Turkey. He was a Board Member for the Turkish Psychologists Association, Istanbul Branch between 1990-2002, and President and Projects Coordinator between 1998-2002. At present, he is a member of the Ethics Committee for the Turkish Psychologists Association. From the 1999 Marmara Earthquake, he has been responsible for EMDR-HAP and EMDR Basic Trainings in Turkey. More than 600 professionals have been trained during EMDR and several HAP projects. He has participated in EMDR-HAP projects in Thailand, Palestine, Kenya, Lebanon and Iraq. His major concern is to establish EMDR as a major therapy approach in Turkey.

Deany Laliotis, LICSW, is the Director of Training for EMDR Institute, Inc., and has been part of Francine Shapiro's teaching faculty since 1993. An international trainer, clinical consultant, and practitioner of EMDR therapy, Deany specializes in the psychotherapy of EMDR with a particular emphasis on using the therapeutic relationship as an integral part of treating attachment trauma. Deany was awarded the Francine Shapiro Award for Outstanding Service and Clinical Excellence by the EMDR International Association in 2015. She has authored and co-authored several articles and book chapters and currently maintains a private clinical and consultation practice in Washington, DC.

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Brurit Laub, PhD, is a senior Clinical Psychologist, with over 30 years of experience working in community mental health in Israel. She was also a teacher and supervisor at the Machon Magid School of Psychotherapy at Hebrew University in Jerusalem and at different marriage and family counseling centers. She is an accredited hypnotherapist, and a supervisor in psychotherapy and family therapy. She presents workshops concerning models developed independently and together with colleagues on narrative therapy, script changing therapy, coping with monsters, dialectical cotherapy, a trans-generational tool. and work with subpersonalities nationally and internationally. She has published 15 articles on the above topics in International and Israeli journals. n 1994, she coauthored, with S. Hoffman and S. Gafni, "Co-therapy With Individuals, Families." In 2006, she collaborated again with S. Hoffman on "Innovative Interventions in Psychotherapy." She lives in Rehovot and is in private practice. In 1998, she became an EMDR Facilitator and she is an EMDR-Europe Accredited Consultant. She has been involved with HAP trainings in Turkey and Sri-Lanka. She developed a Resource Connection Envelope (RCE) for the Standard EMDR Protocol and presented it in workshops and for EMDR conferences in Tel-Aviv, London, Vancouver, Denver, Istanbul, and Norway. With Esti Bar-Sade, she developed the Imma EMDR Group Protocol, which is an adaptation of Artigas, Jarero, Alcalá, and López's IGTP. Together with Elan Shapiro, she presented their Recent Traumatic Episode Protocol (R-TEP) in Israel, Europe and the USA. She coauthored two publications about the R-TEP protocol in the *Journal of EMDR Practice & Research with Elan Shapiro and Nomi Weiner*. She lives in Rehovot and is in private practice.

Keren Mintz Malchi, PhD, is a clinical Social Worker, psychodynamic psychotherapist and a certified Marital and Family Therapist and supervisor. She is a faculty member at the School of Social Work- University of Ariel, Israel, and reaches numerous traumas and family-oriented courses. With over twenty years of clinical experience, she is an expert on complex trauma, dissociation and body-oriented psychotherapy who is trained as a Somatic Experiencing Practitioner (SEP). As a certified EMDR consultant, facilitator and trainer in trainer, she is highly involved in the EMDR Israel community, devoted to the development of EMDR therapists in Israel, supervising and teaching implementation of EMDR psychotherapy with complex clients. She supervises the sexual trauma clinic at Poleg public mental health clinic, Lev Hasharon Mental Health Center. Keren has published a number of articles and a book chapter in recent years, and has presented at over 10 conferences and learning seminars in Europe and Israel. Keren is co-chair of the EMDR research committee in Israel and dedicated to the development of EMDR research in Israel. She is in private practice in Israel, as a therapist and consultant.

Paul W. Miller, MD, DMH, MRCPsych, is a psychiatrist; accredited EMDR Trainer within EMDR Europe and an EMDR institute facilitator. He has 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. Professor Miller is a popular international speaker on topics including EMDR therapy for psychosis. He is involved in the School of Nursing at UU, providing training at an introductory skill level for EMDR therapy to every Mental Health Nurse. These are practical steps towards the pragmatic translation of trauma-sensitive research, demonstrating the validity of the traumagenic model for mental disorders and which acknowledges the efficacy of Eye Movement Desensitization & Reprocessing therapy. He is currently Visiting Professor, Faculty of Life and Health Sciences, School of Nursing and is exploring the use of Low-Intensity EMDR and EMDR therapy within The Centre for Maternal, Fetal and Infant Research (MFIR) and supervises PhD candidates exploring this application of EMDR therapy. He has been a part of an informal Technical Review with Global Initiative for Stress and Trauma Treatment (GIST-T), as one of the expert reviewers, because of the innovative work in developing a training scheme for midwives. Member of the Council of Scholars; he is part of the Future of EMDR Therapy Project (FOET). The Council is an intellectual community of 35 EMDR international thought-leaders, working together within the Project parameters to produce material that will advance the field, establish the parameters of EMDR efficacy, and identify areas for future research. The Project will determine EMDR therapy's core elements and define what constitutes a treatment modification. It will also work on developing global standards for training and competency which are objective and evidence informed. He Chairs the Training and Credentialing Workgroup.

Judy Moench, PhD, RPsych is the former President of EMDR Canada and works as a Registered Psychologist in a Private practice in Edmonton, Alberta, Canada. She is an Adjunct Professor at the University of Alberta, an EMDRIA approved consultant, and an EMDR R-TEP / G-TEP trainer. Judy assisted in compiling the initial G-TEP manual for working with groups who have been involved in a recent traumatic event. The manual has been translated into many languages and is being used in different parts of the world. She has had the opportunity to speak locally, nationally, and internationally. Judy has served as Executive Director in a not-for-profit counselling agency and worked extensively with schools. She is the coordinator of the Disaster Response Network for the Psychologists Association of Alberta and has consulted in the development of post-incident treatment for first responders. Judy has recently enjoyed adding her Therapy Dog into the private practice.

Regina Morrow Robinson EdS, LMFT, LMHC, Reg is an EMDR trainer for the EMDR Institute and Connect EMDR, Sr executive R-TEP/G-TEP Trainer, EMDRIA Consultant. She has served as Orlando, FL EMDRIA regional coordinator and TRN coordinator, EMDRIA committees focused on defining competency in EMDR therapy. She has presented at the EEI Summit on Community Response Networks. Reg has more recently provided consultation to organizations seeking to incorporate EMDR therapy into their systems of care for staff, patients and clients. She has been practicing for 32 years in both agency and private practice and now has a virtual private practice.

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Gary Quinn, MD, is a psychiatrist and Director of The Jerusalem EMDR Institute. He specializes in Crisis Intervention, the treatment of Anxiety and Depressive Disorders, and the treatment of Post-Traumatic Stress Disorder following military trauma, terrorist attacks and motor vehicle accidents. He is the Co-Founder, former Co-Chairman and current Vice Chairman of EMDR-Israel. He has conducted numerous trainings in Israel and runs supervision groups. He is the Trainer of Trainers in Asia for the EMDR Institute Inc. and is a Senior Trainer in Asia and the United States. He participated as a trainer for HAP (Humanitarian Assistance Programs) in Turkey following the earthquake of 1999, in Thailand, after the tsunami in 2004, as well in Romania and Cambodia. He has volunteered in medical hospitals after terrorist attacks and treated patients with ASD and PTSD in bomb shelters using EMDR, EMD and the group disaster protocol. He developed the Emergency Response Protocol (ERP) to treat victims of trauma with EMDR within hours of the incident, when patients are suffering from speechless terror with multiple rapid flashbacks. He has presented this work at a conference in trauma (United Kingdom and Ireland), the EMDR Society (Glasgow, Scotland), to the World Psychiatric Association Regional (Seoul, South Korea) and the EMDR European Conferences (Paris, London, Amsterdam and Vienna). He was invited to Singapore as a PTSD expert to address the Psychiatric, Psychological and Medical staff as well as policy makers from the Department of Mental Health. He was the keynote speaker at the Singapore International Conference on treatment of Acute Stress Disorder. He served as a consultant in the Ohio State University Stress, Trauma and Resilience (STAR) Program and has presented at Grand Rounds on, "EMDR, PTSD and Medical Systems Trauma" at Ohio State University Department of Psychiatry.

Elan Shapiro, MA, The 2016 David Servan-Schreiber Award went to Elan Shapiro for his outstanding contribution to EMDR therapy, in the development (with Brurit Laub) of the Recent Traumatic Episode Protocol (R-TEP), with its variation of the Group Traumatic Episode Protocol (G-TEP). R-TEP is an integrative protocol that incorporates and extends existing EMDR protocols within a new conceptual framework, together with additional measures for containment and safety. EMDR Europe has recognized the vision and achievement of Elan Shapiro, who has helped draw attention to the neglected subject of Early EMDR Intervention and the need for developing and researching specialized EMDR protocols for therapeutic interventions in the wake of catastrophes such as natural and man-made disasters. This has resulted in signifi antly boosting research and innovation in the field over the last 14 years, as demonstrated by the increasing publications in scientific papers and books sections. He has given over 100 presentations and seminars held worldwide. His work has contributed in the establishment of extending EMDR's therapeutic potential in recent trauma to a borderless audience, as well as increasing the visibility of EMDR, by bringing the EMDR R-TEP worldwide, promoting EMDR's global role. Elan Shapiro brings years of mental health care expertise in the treatment of recent trauma to his role and a strong passion for nurturing and training EMDR psychotherapists from all corners of the world. He became active in EMDR very early in his career in 1989 and served as an EMDR Institute Facilitator and was a founding member of EMDR Europe. In 2003, he was elected Secretary of the EMDR Europe Executive Committee and Board, serving two terms until 2011, is an EMDR Europe Accredited Consultant, and currently Chair of the EMDR Europe Website Committee. He has written and co-written over 20 articles on Early EMDR Intervention topics, including book sections and conference presentation and continues to write, teach and present extensively on the most recent innovations and refinements of the protocols in the treatment of recent trauma.

Roger Solomon, PhD is a Psychologist and Psychotherapist specializing in the areas of trauma and grief. He is Program Director and Senior Faculty for the EMDR (Eye Movement Desensitization and Reprocessing) Institute and provides basic and advanced EMDR training internationally. He also provides advanced specialty trainings in the areas of grief, emergency psychology, and complex trauma. Currently a consultant with the US Senate (through their in-house employee assistance program) Dr. Solomon has provided direct services, training, and program consultation to many government agencies including the FBI, Secret Service, NASA, U.S. State Department Diplomatic Security, Bureau of Alcohol, Tobacco, and Firearms; U.S. Attorneys, and numerous state and local law enforcement organizations. Dr. Solomon has planned critical incident programs, provided training for peer support teams and has provided direct services following such tragedies as Hurricane Katrina, September 11 terrorist attacks, the loss of the Shuttle Columbia, and the Oklahoma City Bombing. Internationally, he is a Visiting Professor with Salesiana University in Rome, Italy and consults with University of Rome (La Sapienza) and Polizia di Stato in Italy. He has authored or coauthored 41 articles and book chapters pertaining to EMDR, trauma, grief, and law enforcement stress.

Asena Yurtsever, MA is a Clinical Psychologist, EMDR Europe Accredited Consultant and Trainer, EMDR R-TEP/G-TEP Trainer, Family Therapist, Psychodramatist and Vice President of the EMDR Association Turkey. She supports the EMDR Trauma Recovery Group locally and internationally. She worked with the Marmara Earthquake victims (1999), survivors of a mall fire (2013), Syrian refugees (2014), families of victims of the Soma mine disaster (2015), survivors of the Atatürk Airport explosion(2016), victims' families of the Beşiktaş stadium bombing(2016), coup attempt survivors (2016), family and friends of plane crash victims (2018), Elazig earthquake victims (2020), health workers, people who have Covid-19 and their families (2020) in Turkey. She took part in EMDR trainings in Northern Iraq with EMDR Trauma Aid Europe and does consultancy in Lebanon within EMDR Trauma Aid Europe. Asena wrote, Art Psychodrama (2013) and Liyo and the Deer who Looks for Courage (2019). Also, she has co-written chapters on migraine treatment, disaster response during the 1999 Marmara earthquake, and G-TEP with Syrian refugees.

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Foreward

17th May 2020

Currently, we are living through the most extraordinary of times. Covid-19, known as the Coronavirus, has created a global crisis the likes of which have not been seen in over 100 years. It has changed our present world – how we emerge, as indeed emerge we will, this narrative is still to be written.

The Spanish flu pandemic of 1918 is estimated to have infected about one-third of the planet's population. As this virus spread there were no effective drugs or vaccines to treat this killer flu strain. Citizens at the time were ordered to wear masks, close schools, shops and movie theatres, and businesses were shuttered – a similar approach adopted in response to Covid-19.

This time of anxiety and uncertainty appears on many levels: prognosis, bereavement, testing, shortages of personal protective equipment (PPE), effective treatment interventions, managing existing resources, and how best to protect our vital first responders, keyworkers, health and social care providers, and shield populations from infection. Although Covid-19 creates large numbers of asymptomatic cases, about 20% develop more severe symptoms. However, for some, it is proving deadly. The loss of loved ones wrecks the world as we know it: trauma and grief go hand-in-hand.

Protection involves living with unfamiliar public health measures, infringement of our personal freedoms, financial hardship, and protracted periods of social isolation and distancing.

On the political stage, a compound effect relates to often conflicting messages from our Governments and International Organizations Rumour and speculation can fuel anxiety. Having access to good quality information becomes essential. But while it is important to stay informed, there are also many things we can do to support and manage our well-being during such times.

Even though we can have "no health without mental health," people are resilient and do not succumb to psychopathology. Nonetheless, self-care is essential. An inspirational writer, Eleanor Brownn (2014), acknowledges: "Rest and care are so important. When you take time to replenish your spirit, it allows you to serve others from the overflow. You cannot serve from an empty vessel." Self-care is not selfish; it is imperative in the assistance of others.

EMDR therapy is an empirically supported, internationally-recognized psychological trauma treatment. Its theoretical orientation -that of Adaptive Information Processing- offers an explanation as to how trauma memories, stored differently in the brain, lead to maladaptive responses. Therefore, these memories require processing to a more adaptive resolution. The AIP model is bigger than the Covid-19 pandemic in that it explains trauma symptoms and provides us with a means as to how best to intervene in alleviating trauma suffering.

EMDR Resources in the Era of Covid-19, edited by Marilyn Luber, is therefore most timely and welcome. There is no one more appropriate than Marilyn to encourage, collect, edit, and bring these resources to us. In her seven prior volumes, she edited a compendium of EMDR protocols, resources and procedures to support and enrich the EMDR community. This one is frontloaded by powerful narratives from one of the countries which experienced first-hand the devastating impact of this deadly virus: Italy. Isabel Fernandez provides a poignant, and indeed moving, account as to how the Corona Virus came to Italy in all its traumatic might. However, Isabel's account also provides insight, guidance, leadership, and a strategy for moving forward.

A second narrative highlights the transition to remote working and how this impacts EMDR therapy clinical practice. For some, this has been a monumental change –for others, less so. Nonetheless, the *Recommendations for the Use of Online EMDR Therapy During the COVID 19 Pandemic*" are outlined by the EMDR Europe Standards Committee in a way that offers good sense, and rich experience.

The core element of this resource is that of self-care of therapists, that has long been one of Marilyn's passions. If EMDR therapy is to contribute as a trauma response to Covid-19, then the strength, skill, resilience, and resourcefulness of our EMDR therapists are essential. Without this, the tree will fade away. Marilyn presents resources for our clients, for ourselves, and for other practitioners to use as a source of healing.

These are challenging times. We will come through this, not as we did before, but hopefully, stronger, kinder, and more resilient. Let us follow Marilyn's lead and write this next chapter together. This, for sure, is what Francine would have wanted from us. We've got this.

Take care, stay safe & make good choices

Derek Farrell

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Preface

What a difference a pandemic makes! This time last year, most of us could not have considered what we have been experiencing in the winter and spring of 2020. We would have thought it a bad TV drama and turned away. However, we are now living in an unprecedented time. Not one of us has been in a situation remotely like this where almost the whole world has shut down. Travel is at a standstill. Streets are empty. Most shops are closed and often boarded up. The stores that are open are only for essential services: pharmacies, groceries, liquor, hospitals and veterinarians for emergency situations. We are not able to see our loved ones and we must stay six feet away from each other wearing masks. How strange that a small, spikey virus called SARS CoV-2 has brought our vibrant world to a stop.

What does it mean? What can we do? When presented with a new situation, we have to adapt or perish. Are we up to the task? The uncertainty of this disease's trajectory is chilling. It is a virus that has come upon us and, as yet, we have no vaccine, with nothing in sight for quite a while. The virus is all around us unconstrained and unstoppable. Our hope has been "to flatten the curve" – so that we do not overwhelm our healthcare systems-by self-isolating or by staying in quarantine. Most predictions say that without a vaccine, we will all be infected with the disease – some mildly, some more severely and many will die. The impact on us economically is staggering, and governments and world health organizations are having to weigh the collapse of our financial systems vs. the risk of death to our citizens.

The physical effect on our bodies is only rivaled by the psychological tsunami we are feeling, and will only increase as this silent horror continues. The whole range of negative affect is amongst us: from the *fear* of getting the virus to the terror of testing positive for the SARS CoV-2 diagnosis and facing our own mortality; from the *distress* of not seeing our loved ones to the *anguish* of not being with the ones we treasure while they are sick and dying; from the *anger* of having to self-isolate day after day to the *rage* at the lack of planning and execution on the part of the governments worldwide. In addition, there is the dissmell and disgust at people who are not doing the bare minimum of wearing a mask to protect themselves and others, to our collective shame when not washing our hands as many times as we need to 24/7. As surely as we are surrounded by the virus, we are filled with this multitude of feelings without our usual outlets and coping mechanisms to release them and move forward. How do we address these needs while we are sequestered in our homes and the mental health workers amongst us have to move to the new platform of Telehealth or use the telephone to respond to this loud cry for help?

Another part of our psychological response is that those who have the virus are in a life-death struggle literally, while everyone else who has yet to be infected is in fear of that life-death struggle with the virus. This is how trauma is born. When we feel we are in a battle for our own mortality, we can become traumatized, or when we watch people with whom we are connected go through that struggle, we can be traumatized vicariously. Symptoms can include signs such as *intrusive memories* of the traumatic events, recurrent dreams, flashbacks to the event, and/or feeling the intense or prolonged psychological stress or physiological reactions that happened at the time of the exposure. Other indicators are when we *avoid* the distressing memories, thoughts and/or feelings, and try to stay away from external reminders that arouse these feelings. Our *cognitive processes* can be affected and create difficulties when trying to remember parts of the event, while, at other times, there are persistent and exaggerated negative beliefs or expectations about ourselves, others or the world. We can think that it is our fault and this thought is accompanied by a *persistent negative emotional state* that can include fear, horror, anger, guilt, and/or shame. Our interest in things that used to engage us might decrease as we grow increasingly *detached* and find it difficult to experience positive emotion. We may become more irritable and have angry outbursts or engage in reckless or *self-destructive behavior*. We might easily startle and become *hypervigilant* and be unable to concentrate or sleep well. We can have many of these symptoms or just a few but they are enough to cause great difficulties in our daily lives.

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Most traumas happen as an incident, so we can deal with it and put it in the past. However, there are other traumas that are ongoing and are not going away. That is the case with COVID-19. This situation is an ongoing trauma and we will have to prepare to deal with it over the long-term. We need to find ways to cope and get strong that will last us through time and build up our resilience.

The seed for *EMDR Resources in the Era of COVID-19* grew out of hearing how Isabel Fernandez and her colleagues were responding to the pandemic that was sweeping the world. In the US, the pandemic began to get air-time in March 2020. Places like Wuhan, China, Iran and Italy were in the news as the first places of the outbreak. It was still far away from us in the US. I was already struggling with a death in my family in January and was only paying a bit of attention to what was happening. Isabel was sequestered with her family at home, leading the charge of EMDR practitioners in Italy and charting a way forward. I later heard that Jinsong Zhang and her team in China were working to support her country men and women.

I helped Isabel with the English translation of EMDR Italy and her work, and my colleague, Gary Quinn, with his Self-Care Procedure for the Coronavirus (SPC-C). However, my husband and I were literally flattened by the virus for three weeks and I was unable to continue. I vaguely thought about this project but truly COVID had taken over and I was not able to think much. As I began to get better, personally informed by the devastating psychological and physical effects that the virus could have, I reached out to my colleagues who were helping their patients, friends and family in this battle. I knew from first-hand experience how I needed help during those dark days and my EMDR colleagues came through. My experience informed my editorial touch, and my passion to publish these resources promptly and without fee for the benefit of my colleagues and all of our patients. Many of our EMDR experts have provided their knowledge, their wisdom, and their experiences to *EMDR Resources in the Era of COVID-19*.

These resources are here for you to review and use as needed. Not every resource works in every setting or with every patient. Look through them, try them out, and then select whatever you find valuable. Please distribute them to others who would find them helpful.

In Part I, there are nine resources with the focus on *EMDR Responses to COVID-19 Around the World*. The first chapter, by Regina Morrow, is an excellent resource concerning how to understand EMDR therapy interventions in the framework of level of care. Isabel Fernandez and EMDR Italy wrote guidelines for Italy's response to the Coronavirus to help their fellow practitioners in Italy and around the world. Isabel also wrote two chapters on Phases 1 and 2 of dealing with the pandemic and what to expect. The Standards Committee from EMDR Europe shared its recommendations on how to use Online EMDR therapy. Paul Miller, Derek Farrell and Lorraine Knibbs discussed important questions concerning EMDR early interventions and scaling up our work with EMDR to address the huge need in the world for trauma treatment. They did this by considering that an EMDR-informed response with non-mental health, frontline staff and non-mental health professionals could be effective with supervision. Emre Konuk and his team discussed how EMDR practitioners are structuring their response to the pandemic in Turkey and what they do to choose and work with their population; they have even included preliminary statistical results from their study using this method. Ana Gomez and EMDR child and adolescent clinicians from 30 countries created "The Global Child-EMDR Alliance." This chapter showcases the richness of their collaboration by way of songs, books, dances and webinars in many languages. They will be available for free through their YouTube channel and their website **www.globalchildemdralliance.com** when they raise enough funds to launch it. The section ends with a transcription of Deany Laliotis' reflections on the challenges to ourselves and our patients during this perilous time.

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Part II includes four resources addressing *EMDR-Related Stabilization Techniques*. Gary Quinn's *The Self-Care Procedure for Coronavirus (SCP-C)* is a very helpful way to work with patients and colleagues concerning the range of their feelings during the pandemic. The next chapter is a worksheet that goes with the SCP-C. The Butterfly Hug (BH) – created by Lucy Artigas – is well-represented by her husband, Ignacio Jarero. There is a link to a YouTube video of Nacho doing the BH concerning the Coronavirus, as well as a transcription of the script used. The last chapter is Judy Moench's transformation of Elan Shapiro's *Four Elements for Stress Management Exercis*e into a colorful way for parents to teach their children to calm their mind and bodies.

There is one resource in Part III concerning *Early EMDR Interventions*. Brurit Laub and Keren Mintz Malchi use their expertise in EEI to create an abbreviated version of the Recent-Traumatic Episode Protocol, alternately called "The Sandwich Technique," to fill a niche for a relatively concise intervention that helps clients focus their process. The sandwich effect comes from the dialectical movement occurring when there is first an opening resource-then the trauma intervention-finishing with the closing resource; this ends with the client feeling more integrated with a sense of well-being.

Part IV is focused on *Early Self-Care Suggestions and Interventions*. This section is vital to our own and our clients' well-being. Chapters by Catherine Butler and Roger Solomon highlight the types of behaviors to cope during these tempestuous times and how to support resilience and our own strengths. The last two chapters are offshoots of Elan Shapiro's Group-Traumatic Episode Protocol. The chapter by Elan highlights how to work remotely in a group to promote self-care in a structured manner. The Self-Care Traumatic Episode Protocol by Judy Moench is to help clinicians who are feeling overloaded develop resources in a short period of time. Both chapters explore the different protocols and point clinicians in a direction to get further training concerning these useful tools.

In accordance with Dr. Francine Shapiro's motto, "Research, Research, Research," we invite you to do your own research on the effectiveness of each resource. Research will move forward the work we are needing and supporting as an EMDR community. Any of the authors, as well as our regional associations, such as EMDR-Europe, EMDRIA, EMDR Canada and EMDR-Asia, will be happy to assist you.

EMDR Resources for the Era of COVID-19 is available in an electronic format.

Experts in our field have come together during this pandemic to inform and support us as we work on the frontlines and on Telehealth to respond to the needs of those who need us. This book is not a comprehensive look at all the resources available but was put together to aid practitioners in their search to address this difficult time and to point them in directions that will support and enhance their skills. As always, the goal is to assist us in using what we know and what we learn to enrich our effectiveness as EMDR therapy practitioners.

In closing, I would like to ask you to consider taking 15 minutes a day – anyone can do something for 15 minutes – for self-care to support your staying safe in body, mind and spirit. My wish is that all of us worldwide emerge from this time more hopeful, stronger, resilient and even more committed to healing the world's traumas and discord, and supporting humanity in its journey into health and cooperation.

Marilyn Luber

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Acknowledgements

I am accustomed to dealing with challenges in my life by isolating and immersing myself in my books, writing and/or editing them. It is how I cope with difficulty. The year 2020 was no different. Having been through a grueling last 8 months with my mother as she travelled the last days of her own 94-year personal journey fighting Lung Cancer that had metastasized to her brain in April 2019 and ended on January 19, 2020, I was numb. My husband and I were spent. My mother was gone. It was such a relief because she had suffered so much. The relief took over and it anesthetized me to the finality of this moment and took over my recollections of her. The main memory was of her last hours. I was glad to push it away and not focus on it too much. I was just doing what I had to do and January gave way to February, and then, it was March 2020.

It started with my husband's exhaustion, followed by my own severe headache, pain in my jaw, and overwhelming fatigue. My primary physician, Vicki Bralow, thought it was the flu, at first. I did what I usually do – immersed myself in doing something outside myself. The pandemic was upon us. I was marveling at Isabel Fernandez, and my colleagues in Italy, and what they were doing to cope. They put together guidelines to help with ways for practitioners to respond to the pandemic, and I offered to work on their English translation. As I was doing this, it occurred to me that we were all in need of these so I decided to create a resource toolkit to assist my EMDR colleagues. My Israeli colleague, Gary Quinn, was working on his update to his Immediate Stabilization Procedure to address the coronavirus pandemic. With Brurit Laub, we contributed to Gary's work as he began to do webinars to support other practitioners and first responders across the globe. Eventually, he called it the "Self-Care Procedure for Coronavirus (SPC-C)."

But, something was happening to me. My next symptom was a sore throat. Having had strep in the past and being afraid of letting it go untreated, I asked my physician for a referral to get tested. By then, her office was closed by order of the Governor of Pennsylvania. Although I knew that we were in an unprecedented time, it really hit home when I went to UrgentCare and was told that they were not allowed to test for strep because of the risk of infection by COVID-19. I will never forget the physician standing in the doorway fully masked and gowned, not coming into the room, and just pointing in the direction of Thomas Jefferson University Hospital's testing site up the street. She told me I had to get tested. I had forgotten my cell phone -a rare occurrence- so I had them call my husband to tell him what was going on. In retrospect, I should have had him come to UrgentCare so that he could get tested as well. In the cold and rainy weather, I walked up to the testing site under a tent with space heaters. There was so much rain in this parking lot-turned-testing-site that they were sweeping the water out with brooms. After a while, sitting in this wet and cold space, the nurse came over, she told me to open my mouth. I did, I got swabbed, and was told I would get a call about the results. They did not say how long it would be.

On late Tuesday night March 24th, the day after I got tested, I noticed that there was an email to get my test results from the Jefferson portal. I remember just staring at the screen, not understanding what it said. I took a screenshot and sent it to my physician. It said, "Testing was performed using the cobas(R) SARS-CoV-2 test – Detected." Until I spoke to her directly at about 10:30pm at night, I didn't realize I had tested positive for COVID-19. Bob and I just thought we had the flu. I was scared. I had already been doing Telehealth and self – isolating at home with my husband since the 15th of March. I had also worked the day I got the diagnosis, and started my Telehealth day that Wednesday despite not feeling well. My husband was unable to get out of bed.

I push through when faced with adversity. By noon, I could barely hold my head up and had to admit defeat; there was no way I could go on speaking to my patients. I called each one, cancelled that afternoon and the rest of the week. What surprised me was that I was not putting my patients first; the virus was leaving me no choice. I crawled into bed and barely lifted my head for 3 weeks. I had made a big pot of chicken soup – that and toast with jelly saw us through several weeks of illness. We could barely move. My husband lost 11 pounds and I lost 9;

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we could barely get anything down. Thank heavens we could let Henry, our miniature schnauzer, out into our garden because our dog walker, understandably, did not want to come to our house. We could not walk him. We were barely moving. By this time, I was not even listening to TV or the radio. I just wanted quiet. Truthfully, it was a blur except for the sheer terror of waiting for my husband and me to have the "cytokine storm" I kept reading about. He was too sick, so I worried for both of us. For the most part, I stayed in bed, watched "Anne with an E" and kept my head down. At the worst moments of terror, I reached out to Gary who did his SPC-C procedure with me several times. That helped to calm me down. I also reached out to two friends/physicians, Stuart Wolfe and Steve Diamond, and my own physician, and they were supportive. My wonderful friends and family were calling, wanting so much for us to be feeling better – but we weren't and I hated disappointing them. This virus just was moving at its own rate and it was tenacious. After week three, I began to lift my head and weakly look around.

I remembered how my friend and colleague, Nacho Jarero, had me and other friends keep in daily contact with him while he was in the midst of the devastation of the Haitian Earthquake when he went to assist. I asked my friends and family to do the same, and appreciated the messages on email, texts and phone calls we received, even when I couldn't always respond. They helped buoy us up. By week four, I was getting better enough to take some air. However, that was when I began to un-numb from the death of my mother. My friend, Brurit, was there and worked with me with her "Abbreviated Recent-Traumatic Episode Protocol/Sandwich Protocol." Until then, I had been emotionally drained and was so pessimistic! It helped me to get present and start dealing with life around me. I got back to working on this ebook.

We are now 53 days after our first symptoms. I have been working with colleagues from all over the world to bring this ebook to you. I want to acknowledge and thank Regina Morrow, Isabel Fernandez, Paul Miller, Derek Farrell, Lorraine Knibbs, Emre Konuk, Senel Karama, Asena Yurtsever, Sefa Kaya, Ana Gomez, Deany Laliotis, Gary Quinn, Nacho Jarero, Judy Moench, Brurit Laub, Keren Mintz Malchi, Catherine Butler, Roger Solomon, and Elan Shapiro for the resources you have contributed to this book.

I would like to acknowledge the extraordinary work of Lew Rossi for creating the cover and layout design for this work. Lew, I don't know what I would have done without you during the publishing of this book and the other editions you have helped me see to fruition. Thank you.

I would also like to thank our friends, family and patients who were so concerned about our wellbeing and let us know through their emails, texts and phone calls of their love, support and prayers (in no particular order): Herb, Steve, Diane, Bob H., Isabel, Robbie, Arlene G, Phyllis K., Margie, Bob G., Mona, Liz, Amy, Marlena, Uri, Shelley, Ron, Jim, Dan, Doreen, Dirk, Sushma, Deany, Arlene S., Jodi, Larry, Joann, Lew, Eran, Udi, Elan, Isabelle, Sheila, Harry, Miguel, Steve H., Irene F-H., Nacho, Lucy, Emre, Zeynep, Louise, Jay, Betty Lou, Bennet, Zona, Barb, Irene, Aliki, Jack, Sheri Y., Maggie, Jim, Michael B., Siobhan, Annie T., Paul, Robert, Steve R., Debby, Rosalie, Andre, Reyhana, Roger, Queenie, Catherine, Ana Lucia, Olivier, Ad, Renee, Rob, Andrea, Susan, Jorge, Evelyn, Cinnie, Michael, Aaron, Abby, Maddie, Emmie, Scott B., Victoria, Sheila, Meryl L., Sheri S., Phyllis G., Jim, Bill, Joci, Louise, Susie, Jay, Robert, Les, Cathy, Karen, Anz, Steve H., Brad, Juliet, Jen, Lisa, Rosie, Joel, Bobby, Bob R., Bob W., Jeff, Susan, Kazumi, Dennis, Marybeth, Donny, Diane, Carol, Hank, Bill, Victor, AJ, Arne, Michael H., Richard, Emily, Judi, David, Roz, Hillary, Lindy, Virginia, Cory, Victor, Rise, and Matt. Thank you, it is only through the bright light that you offered during this dark time that we found our way back.

To Henry Raymar Luber, our sweet miniature schnauzer, who endured the disruption of his routine with some confusion but inevitably adapted in his usual endearing and intrepid style.

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To Wanda Hammoud whose insistence on antibiotics for Bob may well have saved his life.

To Bob Herbst who texted or called me every day through this dark time.

To Stuart Wolfe and Steve Diamond who shepherded me through my worst days.

To Gary Quinn and Brurit Laub who understood what I needed when I didn't and helped me through this difficult time.

To my stepdaughter, Meryl Raymar Harrell, not a day went by that Meryl was not FaceTiming me (sometimes her dad was too sick to get on) to check on us and find out what we needed. I am sorry for the times that we couldn't even manage the phone. She sent us all manner of comfort and toys for Henry; however, the most important was interacting with her, Sam, Faith and Peter and seeing them in real time.

To Vickie Bralow, our physician, who could not have been more there for us then and now. Thank you, thank you, thank you. I don't know what we would have done without you.

I would also like to thank our friends, family and patients who were so concerned about our wellbeing.

To my partner in life and in COVID, Bob Raymar. Our journey through the virus was in tandem. Often when one of us could not get out of bed, the other would step in and help out, and vice versa. We survived and are both so grateful to be here today and for each other.

In the end, I want to acknowledge my mother, Shirley Luber, who had a glorious and well-lived life; she is now at peace.

I also want to remember my friend, my family, Francine Shapiro who gave us EMDR therapy and a way to bring light where there is darkness. Thank you, Francine.

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PART I

EMDR Responses to COVID-19 Around the World

In Part I, there are nine resources with the focus on EMDR Responses to COVID-19 Around the World. The first chapter, by Regina Morrow, is an excellent resource concerning how to understand EMDR therapy interventions in the framework of level of care. Isabel Fernandez and EMDR Italy wrote guidelines for Italy's response to the Coronavirus to help their fellow practitioners in Italy and around the world. Isabel also wrote two chapters on Phases 1 and 2 of dealing with the pandemic and what to expect. The Standards Committee from EMDR Europe shared its recommendations on how to use Online EMDR therapy. Paul Miller, Derek Farrell and Lorraine Knibbs discussed important questions concerning EMDR early interventions and scaling up our work with EMDR to address the huge need in the world for trauma treatment. They did this by considering that an EMDR-informed response with non-mental health, frontline staff and non-mental health professionals could do under supervision. Emre Konuk and his team discussed how EMDR practitioners are structuring their response to the pandemic in Turkey and what they do to choose and work with their population; they have even included preliminary statistical results they have from their study using this method. Ana Gomez and EMDR child and adolescent clinicians from 30 countries created "The Global Child-EMDR Alliance." This chapter showcases the richness of their collaboration by way of songs, books, dances and webinars in many languages. They will be available for free through their YouTube channel and their website www.globalchildemdralliance.com when they raise enough funds to launch it. The section ends with a transcription of Deany Laliotis' reflections on the challenges to ourselves and our patients during this perilous time.

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Level of Care Considerations for EMDR Therapists in the Time of COVID-19

Regina Morrow Robinson

Introduction

The EMDR therapy model is rapidly evolving. The idea that EMDR therapy can offer a full range of response when it comes to mental health needs is new. There are commonly-known crisis response models that -even if outdated or have demonstrated lack of empirical support-continue to be used because they are well known. While EMDR therapy to date must be delivered by a trained therapist to be EMDR therapy, there is a new push to broaden the scope of EMDR by finding ways for it to be used with paraprofessionals under the supervision of an EMDR trained and licensed clinician. Also, it is helpful to ask questions such as how do EMDR therapy and Adaptive Information Processing fit within the continuum of care? How do EMDR therapists compare and contrast our resources with other interventions and models already in existence? **The Global Initiative for Stress and Trauma Treatment (GIST-T)** and **EMDRIA.org** have been advocating for EMDR therapy placement in the continuum of care around the world. This article is another step in that direction. I welcome your thoughts on it.

We practice in all parts of the world, in all sorts of settings, with high levels of resources and low levels of resources. Our clients, as well, have great diversity of resources available. The mental health community and EMDR community have hundreds of interventions to select from. How do

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we navigate selecting the most efficient and effective level of care for those impacted by COVID-19 when we are possibly stretched thin or on the opposite end, twiddling our thumbs hoping to help!

Each individual lives in a unique environment, country, political climate, exposure to ongoing, reoccurring, and distinct events of stress and access to resources such as readily available health and mental health care. Each therapist has a wide range of skills, experience, and risk tolerance available. Conceptualizing levels of care within diverse conditions is no small feat!

The purposes of exploring levels of care concerning EMDR are the following during the COVID-19 Pandemic and beyond.

- *Psychoeducation:* Creation of a relatable way to talk about mental health services (non-drug focused) to Stakeholders (medical care providers, others directing care to those who need it, clients and payors).
- *Pandemic Response*: Placement of EMDR products in the delivery of care in COVID-19 times among other non EMDR models and products of care.
- *Guide for New Therapists*: Guiding newly trained therapists when to use each protocol or procedure.
- *Guide for Organizations:* Guiding discussions with organizations (such as hospitals, first responders, schools, and other stakeholders) needing to determine how to integrate EMDR into their response for staff and patients.
- *EMDR Early Intervention*: Advancing the concept of EMDR early intervention can in many cases, prevent the progression of after effects of exposure to high stress and trauma.
- *Effect of Social Distancing on Care Delivery*: Looking into how social distancing impacts and even drives changes to our capacity to deliver care?

Understanding Triage for EMDR Practitioners

Triaging and allocating resources efficiently are challenges facing mental health providers amid COVID-19. Medical systems around the world practice triage. Can EMDR therapists learn to communicate within the conceptualization of triage?

Definitions of Triage

- 1 : the sorting of and allocation of treatment to patients and especially battle and disaster victims according to a system of priorities designed to maximize the number of survivors.
- 2 : the sorting of patients (as in an emergency room) according to the urgency of their need for care. Merriam-Webster, Definition of Triage. **Triage | Definition of Triage by Merriam-Webster**
- "**Triage** is the term applied to the process of classifying patients at the scene according to the severity of their injuries to determine how quickly they need care. Careful **triage** is needed to ensure that resources available in a community are properly matched to each victim's needs."

Should our community become swamped with demand for services, here are some of the questions to think about:

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- How do we triage and pair best fit levels of care with which client?
- How do we begin to change the mindset of the larger community that mental health treatment is reserved for high levels of dysfunction when we are increasingly aware that early intervention *prevents* high levels of dysfunction?
- What are the levels of care for mental health?
- How do we move from least restrictive to most restrictive?
- How do we move from the fewest resources to the greatest amount of resources utilized by providers and clients?
- How do we move from client self-delivered to therapist-delivered to intensive therapist- delivered to inpatient? The level of maladaptive verses adaptive responses does suggest a process to sort by.

These are points to continue to develop and expand upon within the EMDR community.

A Design for Creating Levels of Care

Here are some variables to consider for creating levels of care design:

- *Intensity of Need*: Intensity of need of client based on pre-existing resources within the client and level of exposure to stress or trauma.
- *Responses to Stressor*: The client's adaptive and maladaptive responses to the stressor.
- *Time Since Exposure*: The client's time since exposure to stressor; minutes to decades.
- *Time Frame of the Distress*: One-time exposure to ongoing exposure with limited sense of safety.
- *Time and Expense Cost to Client*: Minimal cost of time and expense to the client. Least to greatest amount of resources (time, expense) for the client to achieve results.
- *Time and Expense Cost to Therapist*: Least to greatest amount of resources (time, expense,) from the therapist
- *Providers' Resources*: Pre-existing resources within the provider of care (competency, knowledge, experience, skills, risk tolerance).
- *Evidence-Based*: Evidence-based models, protocols, procedures and international guidelines.

Other things to consider are the following:

- How to move a client from one level of care to another when the previous one is determined to be insufficient?
- How do we quickly assess need for greater level of care?
- How do we minimize barriers to care?

Prior to Stressor - What Resources Were Available?

Prior to stressor or trauma exposure, preventive resources and variables to consider -that may impact a client, community, or therapist's capacity to respond- might be:

- Adequate resources for safety

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- Secure food supply
- Safe connection with others (in home, community, region, country, world)
- Adequate sleep hygiene
- Physical health exercise
- Readily available health and mental health care
- Reasonable stressors
- No recent trauma exposure, if history of trauma; it has been effectively addressed.

Post Stressor or Trauma Exposure

Early intervention is suggested to best prevent acute stress disorder, PTSD, delayed onset PTSD, and secondary disorders to exposure. What are the best fit resources available to the EMDR therapist designed to respond to the stressor?

A Proposed Format of Levels of Care for Efficient and Effective Use of Resources

LEVEL 1: Self-Administered:

Steps a person takes on a daily or weekly basis to maintain wellness. It is recommended that for some individuals, a consultation with a physician or therapist are needed before initiation. Examples of self-administered self-care are the following:

- *Daily Self-Care Routines*: Sleep, nutrition, exercise, meditation, connection with stable healthy others, goal setting, daily purpose or work, spiritual practices, and others.
- *Apps*: Use of applications on phone, tablet or computer for education and commitment to a wellness process. Often, apps invite connection with safe others and a larger community. Built in accountability is often an integral component for apps.
- *Stabilization Exercises*: Books, video/you-tube, guided stabilization exercises are abundant.
- *EMDR Therapy Related Resources:*
    - **The 4 Elements Exercise** developed by Elan Shapiro, is a simple 4-step exercise designed to create a sense of calm and control. It is an integral part of the EMDR Recent Traumatic Episode Protocol (R-TEP) and the Group Traumatic Episode Protocol (G-TEP). You can access a video recorded version of the 4 Elements created by United Kingdom National Health Care System (NHS) 1stcontact.net: **Present Safety and Four Elements Exercises**. Also, see Judy Moench's Four Elements Parent Activities (Resource 13).
    - **The Butterfly Hug** developed by Lucina Artigas is a gentle way to self-administered bilateral stimulation by simply and elegantly wrapping one's arms around oneself and alternatingly tapping. Additional ways to access versions of the Butterfly hug created by United Kingdom National Health Care System (NHS) 1stcontact.net: **Using the Butterfly Hug to help with acute ongoing distress, Grounding and Stabilization using the Butterfly Hug.**

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- Developed by Ana Gomez for children is a free downloadable book for everyone to share. It has been translated into 18 languages.
- **Self administered (G-TEP-STEP)**, developed by Judy Moench is a web-based version of the contained structured G-TEP RISC (Remote Individual & Self Care) protocol which can be self-delivered. STEP is not recommended for anyone who is suicidal or has a diagnosis of dissociative or psychotic disorder. It is in 2 languages French and English. It is newly developed to address COVID-19 and currently undergoing a feasibility study to ensure it is a safe and effective resource to offer to clinicians, medical personnel and first responders. This is a treat to look forward to once the research is complete.
- **Everyoneok.be** developed by Professor Elke van Hoof from Belgium is also a web-based contained structured version of the G-TEP protocol embedded inside Dr Hoof's stress management system. Participants complete a prescreening and are not permitted to advance in the process if there are exclusion indicators of suicidality, substance abuse, dissociative process or psychotic qualities. If the participant has been personally affected by the coronavirus, seriously unwell or has lost someone to the coronavirus, the participant is encouraged not to move forward but instead seek professional mental health treatment. It is provided in 3 languages. It is newly developed to address COVID-19.

LEVEL 2 Paraprofessional-Guided:

These approaches can be delivered one to one or as group-guided experiences that cover Level 1 self-administered material and additional psychoeducation (see above section). Education topics may include: What is stress or trauma? And/or, what are normal reactions to abnormal situations? There are no discussions of stress or trauma, or talk about the disturbance. The purpose is the teaching of stabilization and calming skills.

Non-Bilateral Approaches

- **Critical Incident Stress Debriefing (CISD):** Critical Incident Stress Management (CISM) originally developed by Dr. George S. Everly and Dr. Jeffery Mitchell. Although still widely used, it is no longer recommended by international guidelines due to questions about safety. CISM indicates it is not therapy. The 7 core components of CISM are:

  1. *Pre-Crisis Preparation*: This includes stress management education, stress resistance, and crisis mitigation training for both individuals and organizations.
  2. *Briefings*: Disaster or large-scale incident, as well as, school and community support programs including demobilizations, informational briefings, "town meetings" and staff advisement.
  3. *Defusing:* This is a 3-phase, structured small group discussion provided within hours of a crisis for purposes of assessment, triaging, and acute symptom mitigation.
  4. *Critical Incident Stress Debriefing*: This (CISD) refers to the "Mitchell Model" (Mitchell and Everly, 1996), a 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if

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possible provide a sense of post-crisis psychological closure. The **Mitchell Model 7 Phase Discussion:** Introductions, Fact Phase, Thought Phase, Reaction Phase, Symptom Phase, Teaching Phase, & Re-entry.

5. *Support*: One-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum.
6. *Interventions*: Family crisis intervention, as well as, organizational consultation.
7. *Follow-up & Referral*: Follow-up and referral mechanisms for assessment and treatment, if necessary.

- **Psychological First Aid (PFA):** Developed in 2006 jointly by the U.S. Department of Veterans Affairs with the National Child Traumatic Stress Network, PFA is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism: to reduce initial distress, and to foster short- and long-term adaptive functioning. PFA indicates it is not therapy. These resources provide education for providers, parents, children and a mobile app.

Bilateral Approaches

- Acute Stress Syndrome Stabilization (**ASSYST-I, ASSYST-G, ASSYST-R**): Developed by Dr. Ignacio Jarero "I" for individual "G" for group and "R" for remote are designed to be implemented shortly after exposure to facilitate client's AIP system spontaneous processing of information within their window of tolerance.

- **Self-Care Procedure for Coronavirus (SCP-P):** Developed by Dr. Gary Quinn, M.D. He modified the Immediate Stabilization Procedure (ISP) procedure to fit better the demands of COVID-19. It is first delivered by a therapist and then taught to the client for self-administration in an ongoing manner.

- **Acute Traumatic Incident Processing (A-TIP):** Developed by Roy Kiessling, (A-TIP) utilizes bilateral eye movements to help desensitize the survivor to the traumatic event to the point where talking about it may be of help. It has recently been updated and is now to include Critical Incident Desensitization (CID).

Levels 3-8 are provided by trained Mental Health Professionals utilizing a variety of psychotherapy models and interventions. There is a current group of EMDR experts forming the Future of EMDR Therapy (FOET) working on many EMDR-related issues and "What is EMDR?" is one of them. Look forward to further advancements defining the parameters of EMDR therapy.

Note: In 2019, **EMDRIA** changed the definition of EMDR therapy to include administered by a trained-EMDR therapist. The above levels of care, therefore, cannot be called EMDR therapy according to EMDRIA. This may be different in other parts of the world. Some of the procedures listed utilize bilateral stimulation but do not meet the full definition of EMDR therapy, according to EMDRIA, as it currently stands, on one or more criteria. Some protocols listed below may not have sufficient research to prove their effectiveness.

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LEVEL 3: Stabilization

The goal of immediate stabilization is to assist the client to regulate affect utilizing a small amount of the therapist's time when the client is hyper or hypo aroused, often immediately after the exposure while avoiding activation of the trauma material.

- **Self-Care Procedure for Coronavirus (SCP-P):** Dr. Gary Quinn M.D. modified the Immediate Stabilization Procedure (ISP) procedure to better fit the demands of COVID-19. It is first delivered by a therapist and then taught to the client for self-administration in an ongoing manner.
- **Flash Technique (FT):** According to Dr. Phillip Mansfield (20?), "FT is a minimally intrusive option that does not require the client to consciously engage with the traumatic memory. This allows the client to process traumatic memories without feeling distress."
- **ASSYST-I**, **ASSYST-G**, **ASSYST-R**: Developed by Dr. Ignacio Jarero "I" for individual, "G" for group and R for remote are designed to be implemented shortly after exposure to facilitate the client's AIP system spontaneous processing of information within their window of tolerance. Focus is placed on acute intrusive somatic and sensory components of the experience.

LEVEL 4a Group Formats:

Activation and processing of trauma material occurs in this level. Therefore, guided supervised training is highly recommended for the models listed below. This level requires that the therapist and assistant be well trained and technologically equipped to provide the protocol in a group either face-to-face or remotely. In addition, adequate resources are planned for and are available to manage clients unable to continue with the group process or who find the group process does not provide sufficient results.

- **EMDR Group Traumatic Episode (EMDR G-TEP)** : Developed by Elan Shapiro, the EMDR G-TEP is highly structured and contained. It addresses the demands of an ongoing early intervention situation such as COVID-19, utilizes a highly structured worksheet allowing participants to draw components of their experience. Drawing can be highly effective for clients who, for many reasons, are unable to talk their experience out loud. There is no talk of disturbance and this prevents cross contamination of disturbance in the group. It is designed for group sizes of up to 12.
- **EMDR Group-Traumatic Episode Remote and Individual Self Care (G-TEP RISC)** : Developed by Elan Shapiro in response to COVID-19. It is a modified version of G-TEP. It can be used for therapist self-care, 1:1 applications and remote applications. In the future after accumulating experience working individually with G-TEP RISC, including supervision/consultation, therapists will be encouraged to utilize it in remote group delivery.
- **EMDR Integrative Group Treatment (EMDR IGTP)** : Developed by Ignacio Jarero, Lucina Artigas, Teresa Lopez Cano, M. Mauer, & Nicte Alcala, EMDR-IGTP is also designed to meet the demands of an on-going early intervention situation such as COVID-19. It was originally designed for face-to-face delivery to group sizes of up to 150 people, utilizing art and bilateral stimulation. Adults, adolescents and older children can benefit from this model. It requires minimal materials and a trained support team in addition to the leader.

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Both EMDR G-TEP and EMDR IGTP have good research and active ongoing research studies now.

LEVEL 4b: One to One Format

Activation and processing of trauma material is required. Delivered in a one-to-one format soon after exposure.

- **Recent Event Protocol (REP)**: Developed by Dr. Francine Shapiro, REP was designed to respond to a single recent event that had not yet consolidated into long term memory. It was not designed to focus on an ongoing event such as COVID-19. In the US, REP is required by EMDRIA to be a component of EMDR therapy trainings. EMDR and EMDR REP are an integral foundation of the following two EMDR protocols and procedures.
- **EMDR Recent Traumatic Episode (R-TEP)**: Developed by Elan Shapiro and Bruit Laub (2008). It is designed to meet the demands of an ongoing, early intervention response that includes focus on the episode, screening and extra built-in containment, due to the intensity of the event. It utilizes EMD and EMDr processing strategies. Therapists assess each individual report from the client between sets to ensure the client remains focused on the episode and is within their window of tolerance. Should larger themes beyond the episode block progress, the therapist is advised to expand to the Standard EMDR Protocol until the block is resolved then return to R-TEP.
- **EMDR Group Traumatic Episode Remote and Individual Self-Care (G-TEP RISC)**: See above.
- **EMDR Protocol for Recent Critical Incidents and Ongoing Traumatic Stress (EMDR PRECI)**: Developed by Ignacio Jarero and Lucina Artigas, it was designed to address critical incidents that continue over a long period of time and where there is no post-trauma period of safety for memory consolidation. As a result, there is an ongoing lack of safety, and the consolidation in memory of the original critical incident is prevented. In this way, the memory network remains in a permanent excitatory state, expanding with each subsequent stressful event in this continuum, with the risk of PTSD and comorbid disorders growing with the number of exposures. Adjusting the eye movements length and speed to the clients' needs helped the processing of the material. It is transportable, ease to use, time-effective, has no homework and works cross-culturally.

To compare the above models further, refer to Jarero, I., Artigas, L., & Luber, M. (2011).

- **The Coronavirus Helping Box (EMDR version)**: Developed by Ana Gomez, this is a therapist-guided resource for walking a child through working with EMDR. Parents can be invited to participate. This is a free resource for therapists and in 3 languages.
- **Acute Traumatic Incident Processing (A-TIP)**: Developed by Roy Kiessling, (A-TIP) utilizes bilateral eye movements to help desensitize the survivor to the traumatic event to the point where talking about it may be of help. It has recently been updated and now includes Critical Incident Desensitization (CID).

Non EMDR/AIP-Informed Models that Fit into this Level of Care:

- **Trauma Focused Cognitive Behavioral Therapy (TF-CBT)** and **CBT for Trauma** evolved from CBT and focuses on children, adolescents and their families. Thoughts, emotions, and behaviors are explored. The research indicates it is effective. The requirements of homework can create compliance difficulties for some clients. It is sometimes challenging for a client to verbalize to another their internal experience. This procedure can be delivered 1:1 or within a family.

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LEVEL 5: One to One Format

An episode-focused approach is aimed at just prior to the start of the stressor to the point the client is sitting with the therapist for treatment. This allows the opportunity to address the ongoing nature of the event.

- EMDR Recent Traumatic Episode Protocol (R-TEP) *(see above)*
- **EMDR Protocol for Recent Critical Incidents and Ongoing Traumatic Stress** (EMDR PRECI) *(see above)*

LEVEL 6: One to One Format

There is a broader life focus to include events outside of the current episode.

- **EMDR Therapy** (EMDR) developed by Dr. Francine Shapiro (1995, 2001, 2018) is a 3-pronged model that incorporates life experiences from birth to death. During an early intervention response provided by a therapist, it may become apparent that untreated difunctionally-stored life experiences are blocking the resolution of the current experience. The therapist, with client consent, expands the scope of the therapy contract to include addressing the earlier dysfunctionally-stored material utilizing the full 8 phases and 3-prong model.
- EMDR 2.0: Developed by Ad de Jongh and Suzy Matthijssen. EMDR 2.0 is an adjusted version of EMDR therapy based on Francine Shapiro's earlier work, and follows the Standard EMDR protocol. These include adjustments with more emphasis on the components that have been found to be effective based upon laboratory research, particularly with regard to motivating and activating the client and then desensitizing the activated material. It follows the practice based upon the following research findings that: i. a memory must be fully activated, to maximize the effect of EMDR therapy, ii, more arousal, both in relation to the memory, and in general, is associated with a stronger desensitizing effect on the memory, iii, the greater the working memory load, the greater the desensitizing effect that occurs, iv, modality-specific taxation can provide an additional effect, and iv, unexpected *surprise* effects can interrupt the reconsolidation of the memory. The underlying studies can be found at **https://psycho-trauma.nl/emdr-2-0**. The direct link to register for the workshop ≈ **https://beacon360.content.online/xbcs/S1524/catalog/product.xhtml?eid=17547** or **www.enhancingtraumatreatment.co**

LEVEL 7: One to One Format

Intensive outpatient EMDR therapy is provided in extended sessions of 3 + hours in a day or multiple days in a row in an outpatient setting.

LEVEL 8: One to One Format & Group

Inpatient due to self-harm or other factors suggesting unable to keep oneself safe. A client may voluntarily decide to attend an intensive residential program to be free of their daily commitments to focus on their own care. EMDR therapy is incorporated into inpatient programs from once a week, once daily or several hours a day. Both individual and group protocols are utilized.

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In Summary

Items to explore further:

- Where can we place the additional EMDR-inspired interventions within levels of care?
- How do we expand the research capacities of our community to address effectiveness of prevention and reduction of distress?
- How do we prove it is cost effective?
- What are the most efficient and valid methods of assessment? Keep in mind Francine Shapiro's motto: "Research, Research, Research."
- How to we upscale our capacity to both provide care and provide trainings to therapists and paraprofessionals?

This is a conversation for all EMDR therapists and other mental health professionals to become engaged in. Together, we see a much broader perspective across countries, economies, health care systems, cultures, struggles and capacities. There are many more procedures and protocols to add to the Levels of Care, both from within and outside the EMDR community. By building a far more comprehensive list, we can pursue a greater effort to compare and contrast the continuum of care and language to discuss it with people outside the mental health community. Together we can build the architecture of an EMDR response to stress and trauma. EMDRIA's Council of Scholars is hard at work trying to answer these questions and more. What is your opinion?

Please share your thoughts with Reg at **rdmorrow17@gmail.com**

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2

Italy and the Coronavirus: Suggestions for Clinicians During the Pandemic

EMDR Italy

The following series of guidelines, suggestions and tips grew out of the work that we/EMDR Italy have been doing with clients and groups during the outbreak of the Coronavirus pandemic in the earliest days of the pandemic. These are based on our collective experience and our work in the field with a large number of responses to disasters all over Italy and the world.

Guidelines for Adults: Self-Protection for Adults

When a catastrophic event occurs, it has a strong impact on individuals and their community. When there is an ongoing situation like the Coronavirus pandemic or a critical event, people often respond with a great deal of emotion. As a result, it is possible that people will not function at their best during their exposure to the event and afterwards. Here are some suggestions to help us during these times.

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What to Expect

Phases that can occur from the time you are exposed to the present:

- *Acute Phase:* You may feel the following during this phase: unimportant, a sense of derealization (feeling your surroundings are not real), not like yourself, numb, confused, space and temporal disorientation. Shock is a normal mechanism allowing us to maintain a certain distance from the event; this can help us absorb the impact and attend to the immediate needs of the situation.
- *Emotional Impact Phase*: This phase includes a variety of emotions such as sadness, guilt, rage, fear, confusion and anxiety. Somatic reactions can also develop, like physical disorders such as headaches, gastrointestinal issues, etc., and difficulties finding a state of calm.
- *Coping Phase:* During this phase, we try to cope by finding a way to understand what happened and using all our resources. We ask questions such as: "*Why did it happen?" What can I do?" "Why now?"* etc.

Most common reactions that might occur over the course of several days or weeks:

- *Intrusive Thoughts*: Recurring images; involuntary and intrusive memories (*flashbacks*).
- *Avoidance:* Wanting to avoid related thoughts or feelings; avoiding anything to do with the event/the situation.
- *Depressed Mood and/or Persistent Negative Thoughts*: Negative beliefs and expectations about ourselves or the world such as thinking: *"The world is totally dangerous."*
- *Self-blame*: Persistent and irrational feelings of guilt about self or others for having caused the traumatic event or its consequences, especially if having had contact with those infected.
- *Guilt:* Feelings of guilt for having survived/not been infected.
- *Negative Emotion*: Persistent negative emotions related to the trauma/threatening situation such as feeling fear, horror, rage, guilt, persistent shame even after the situation is getting better.
- *Sleeping and/or Eating Dysregulation*: Difficulties falling asleep, frequent awakenings and nightmares, or hypersomnia (sleeping for long periods of time). Eating too much or too little.
- *Anhedonia*: Strong loss of interest in pleasant activities.
- *Overwhelm*: Being overwhelmed by daily tasks and having to restructure daily activities; feeling paralyzed.

Note: There are marked individual differences in the appearance, duration and intensity of these reactions.

What We Can Do

- Recognize our own emotional reactions and the difficulties that we might have.
- Do not deny feelings. Remember, it is normal for everyone to have emotional reactions when an unexpected, unforeseeable and threatening event/situation occurs.
- Monitor our physical and emotional reactions.

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- Remember, we are not alone. Even when we are not in contact physically, we are part of a larger system. This organization can support and help us emotionally and psychologically.
- Talk about the critical event/situation to others. This helps us to release emotional tension.
- Respect that others' may have different emotional reactions and action/behaviour that may be difficult to understand from our point of view.
- Keep in touch with others. Establish a new, predictable daily routine during this time.
- Ask for help from people we trust and with whom we feel safe.
- Take some time to recover. It is not necessary to focus on what is happening 24/7. Pay attention to our needs. Distance ourselves from the event/the situation by sleeping, resting, thinking, crying, being with our loved ones, etc.
- Protect our emotional health by accessing support services as needed.
- Obtain psychological support focused on reprocessing traumatic memories and reactions resulting from the event/the situation, as needed.
- Limit access to media to once or twice a day. Often, when a critical incident is occurring, our response is to find meaning through spending a lot of time reading the commentary and watching the news. It is important to protect and limit ourselves from excessive exposure.
- Use official channels as our sources of information, such as the World Health Organisation website: **https://www.who.int** and follow its guidelines on hygiene practices.
- Remember that a positive attitude and avoiding catastrophic thoughts help us and our community.

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Guidelines for Children: Children Need to Understand What is Happening: Tips for Parents, Caregivers, Teachers and Grandparents: What to Say and How to Say It

In “emergency” situations, when a serious critical event affects us, there is a highly emotional impact on the individual and the community. Victims of a traumatic event experience a disruption in their mental and emotional balance; they are on a constant alert that compromises the feeling of safety. Children and adults are well equipped to face difficult situations as long as they are appropriately supported.

Reactions to traumatic events can be numerous. There is not a right or wrong way of feeling and expressing sorrow and concern. In moments of danger, children need to refer to their caregivers; however, when the caregivers are exposed to the same event, children might notice and react to the arousal in adults, who should reassure them. It is very important for adults to find psychological support and help in order to deal with their normal stress reactions and provide their children with the necessary emotional safety. When exposed to a dramatic event, children express their feelings in a different way from adults and according to the children’s age and development stage.

After being exposed to a chronic situation like the Coronavirus threat, children might feel different emotions: sadness, guilt, rage, fear, confusion and anxiety, also as a consequence of the prolonged isolation and the upset daily routine. They can also develop somatic reactions with physical symptoms (headache, stomach-ache, etc.). There are strong individual differences in the manifestation, duration and intensity of these reactions. The processing process is subjective: it is possible that some children experience only one of these reactions, while others experience many of them at the same time, for one day or for a longer period.

Here are the Most Common Reactions:

- *Stress often arises in the form of rage and irritability*. Children might address their rage and irritability to the people closest to them (parents, friends). Keep in mind that rage is a healthy feeling and can be expressed in an acceptable way.
- *Boredom can be linked to the effort of keeping up with the different pace of distance education activities*. Because of the pandemic, some countries had to close schools, children have to stay home and education activities have to take place online. Keep in mind that a radical change of environment can generate confusion and lead to struggling in following instructions. Reassure the children and explain to them that these measures were suggested by experts in order to protect them.
- *Pain is expressed through behaviour*. According to the age, it is possible that children do not express their worries verbally. They can become irritable, have concentration problems, re-enact moments of the event they witnessed, draw images that recall what they heard about the infection. They can be afraid of things that did not scare them before or show behaviours

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that are typical of previous development stages: they go back to doing things they did in the past or play games they played when they were younger.

- *Difficulty in sleeping and/or eating*. Trouble falling asleep, frequent awakenings and nightmares, or hypersomnia, which means sleeping for many more hours).
- *Lack of energy*. Fatigue, difficulties in social interaction and tendency to self-isolation.
- *Need for more attention from parents or caregivers*. Children can struggle more to separate from caregivers because they are afraid something bad can happen to them or their relatives or that they might die.

These reactions are normal, especially when there are important changes in the everyday life and in the daily routine of a child

What You Can Do with Children

- *Let children know that it is normal to be overwhelmed, scared or worried*. Explain that all the feelings are fine (normalize and validate reactions).
- *Do not deny what you are feeling, explain that it is normal*. Acknowledge that adults have emotional reactions too after such an unexpected event and that all reactions are normal and manageable. Discomfort is created when suppressing emotions, not when they are expressed. This way, children will have a role model and will learn that they can trust you and tell you about their emotional states.
- *Hear what your child is saying*. Don't say: *"I know how you feel"; "It could be worse"; "Don't think about it"; "You will be stronger thanks to this"*. These expressions that the adults use to reassure each other can interfere with showing emotions and painful feelings that are a consequence of the catastrophic event.
- *Tell the truth and stick to the facts*. Do not pretend that nothing is happening or try to minimize it. Children are great observers and they will worry more if they notice inconsistencies. Do not dwell on the magnitude of the consequences of the Coronavirus situation, especially with little children.
- *Use simple words, appropriate to the children's age*. Do not over-expose them to traumatic details and leave a lot of room for questions. If you struggle with a question, take time by saying: *"Mum doesn't know, she will look for more information and when she has it, she will tell you, ok?"*
- *Show children that they are safe now*. Also, other important adults in their life are too. Always give information sticking to reality and facts.
- *Remind them that there are trustworthy people who are taking care of fixing the consequences of the event*. Tell them that people are working to make sure we do not have any more problems like this (*"Did you see how many doctors are working? They are all very good people that know how to help adults and children that are in trouble*.")

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- *Be open and try to talk with a reassuring voice.*
- *Let children talk about their feelings*. Reassure them that even if the situation is bad, together you can deal with it. This way, it will be easier for you to check the emotional state they are in and help them in the most appropriate manner.
- *Children can have angry outbursts*. Help them talk about the reasons that they are angry with words. This can help them to gain more control to learn how to regulate it (*"Are you angry? Do you know that I am angry too?)"*
- *Children can show feelings of guilt*. If so, it is important to reassure them that they are by no means involved in the events (*"It is not your fault if…"*).
- *Restrict exposure to the media*. People affected by the Coronavirus threat need to find a meaning for what is happening and therefore spend a lot of time checking the news on TV, radio and the internet. It is important that children are never left alone while there are programs related to the event. Do not forbid checking the news but choose a moment during the day or 10 minutes to do that together (selecting the news beforehand) and to explain to children what exactly is being said. Focus the attention on the most reassuring details (for instance, the doctors that are helping) and give children all the time they need to ask questions.
- *Keep the family routine as much as possible*. This is important because it is reassuring. Do not give too many presents or organize extra activities. Keeping the routine is the most natural and healthy thing you can do.

If you do not see any improvement in your children's reactions, it is useful to address the problem to trained professionals who can help.

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Coronavirus: How to Deal with It: Suggestions for Managing Fear in Children and Adults

For Everyone:

- *Media*: Our warning and fear systems are constantly activated when we overexpose ourselves to news from the internet, radio and television. Check the news, twice a day: but, not before going to sleep.
- *Hygiene:* Follow the best hygiene practices indicated by our country's institutions and health system.
- *Official Media Resources*: Information is important. Best to use official sources of information such as WHO, ECDC, local institutions.
- *Strong Emotion*: Strong emotions such as fear or agitation are normal reactions. We know that talking about emotions can help us to feel better.
- *Routine:* Follow your usual routine as much as possible, while respecting community regulations.
- *Sleep:* Keep a regular sleeping routine, as much as possible.
- *Positive Attitude*: Remember that a positive attitude helps ourselves and our community.
- *Decision-Making*: When we are stressed we can have difficulties concentrating and making decisions. This is a normal consequence of stress. We need to be easy on ourselves.
- *Positive Influences*: Get in touch with people who make us feel good: this helps us to clear our minds and calm our fears.

With Children:

- *Truth-telling*: Tell the truth about what is happening with simple words.
- *Show Suitable Images and Information*: Dedicate one time during the day to look at information together to explain what is happening and make the content reassuring and easy to understand.
- *Love and Attention*: It is crucial to our children's wellbeing to give them love and attention at all times, but especially when there is an ongoing crisis situation.
- *Retain Routine Positive Habits*: Let children keep their routine and positive habits like playing or studying.
- *Reinforce Positive Resources*: Emphasize to our children that many experts such as researchers, doctors, nurses, the police, etc. are working to re-establish a safe environment and to help people who are ill. Highlight the positive aspects of the intervention.

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Suggestions & Guidelines for Senior Citizens

Listen to This!

It is normal to be afraid. Fear that makes us follow our doctor's instructions is a protective kind of fear. Listen when doctors tell us to not go out and "shelter in place."

In these days of the Coronavirus, we might feel isolated, abandoned, lonely, anxious, irritable or confused. Often, we have intrusive thoughts that keep coming back. These reactions often can occur when our minds are reacting to stressful situations. Staying at home is a way for us to help ourselves and others. When we all follow the instructions precisely, we help our friends, relatives and also first responders, who are working to assist those most in need.

- *Keep Informed*: Use only reliable institutional sources like the *World Health Organization*.
- *Follow Hygiene Practices*: Adhere to suggestions by your country's institutions and health system.
- *Normal Feelings During This Stressful Time of the Coronavirus*: We may feel the following:
    - Isolated or abandoned
    - Lonely
    - Irritable
    - Confused
    - Anxious
- *Intrusive Thoughts*: We may have thoughts about the situation that won't go away.
- *Restrict Media Use*: Turn off the TV, the radio and the internet. Choose only one or two moments during the day to check the news, however, not before you are going to sleep.
- *Keep a Routine*: Keeping busy decreases tension. Do the things you like to do -as much as you can- such as cooking, knitting, reading books and magazines, cleaning the house or washing a car, etc.
- *Physical Activity*: Simple exercises can help you relax and fall asleep.
- *Eat Regularly*: Make sure to eat meals as regularly as possible.
- *Communicate:* Talk and spend time with family and friends. We all communicate in different ways! Ask how to make a video call or how to use "WhatsApp" to keep in regular contact.
- *Share Concerns*: Talk to someone trustworthy about concerns, problems and feelings. Communicate with people who are more positive in their thinking. Positive emotions help.
- *Share Your Life Experiences*: Tell your children, grandchildren and friends about your childhood, for example, how you used to spend time.

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Guidelines for First Responders: Self-Protection for First Responders and Health Professionals

When a serious critical event -like the Coronavirus pandemic- affects the whole world, the emotional impact on individuals, first responders, medical staff and communities is profound. When the first responders are also victims of the same incident, their emotional reactions can be so intense that they can interfere with their functioning during and after the crisis.

These are some of the types of normal reactions that occur:

During Work Hours

During working hours, you can experience some of these reactions:

- Disorientation from the chaos in front of you.
- Stress due to over-exposure to requests such as victims' calls for help, and so many needs to be addressed at once, etc.
- Helplessness or inadequacy.
- Omnipotence and inability to perceive your own limits.
- Identification with victims and/or relatives.
- Frustration and rage for not being recognized and/or for the institutional disorganization.

After Work & At Home

At the end of your shift and/or at home you may experience the following:

- Emotions such as sadness, guilt, rage, fear, confusion and anxiety.
- No emotion/or feeling numb.
- Somatic reactions with physical symptoms such as headaches, gastrointestinal disorders, etc.
- Difficulty in calming down and relaxing.

Note: There are significant, individual differences in how these reactions show up and how long and intense they are. Some may have only one of these reactions while others have many of them at the same time. The reactions can last for one day or for a longer period.

Four Phases of Response

There are four different phases and each one of them is associated with specific reactions:

1. *Alarm:*

   Alarm is when you first feel the impact of the critical event, such as when you found out how catastrophic the Coronavirus really is.

   These are the types of reactions that can occur:

   - *Physical*: Accelerated heart rate, increased blood pressure, breathing problems.

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- *Cognitive:* Disorientation, difficulty in understanding the information received and the seriousness of the event.
- *Emotional*: Anxiety, dizziness, shock, inhibition.
- *Behavioural:* Reduction in efficiency, increased activation level, communication problems.

2. *Mobilization*:

   In the Mobilization Phase, first responders and medical staff start moving onto the scene. The previous phase's experiences and reactions are present in a smaller way. However, these responders are now mobilizing to do their job which gives them purpose to plan a focused and coordinated action. This phase means long working hours under excessive pressure.

3. *Action*:

   The focus of the Action Phase is when the first responder starts his/her work helping the victims. During this time, emotions are high and sometimes confusing.

   These are the types of reactions that can occur:

   - *Physical*: Accelerated heart rate, increased blood pressure, rapid breathing, nausea, sweating and shaking.
   - *Cognitive*: Memory problems, disorientation, confusion, loss of objectivity, difficulty in understanding.
   - *Emotional:* Feeling of invulnerability, euphoria, anxiety, rage, sadness, numbness.
   - *Behavioural*: Hyperactivity, increase in the use of alcohol, tobacco and drugs, tendency to argue, loss of efficiency and efficacy in the first aid actions.

4. *Letting Go:*

   The Letting Go Phase marks the end of the intervention and when everyone comes back to their work and social routine.

   These reactions can occur in this phase:

   - *Return of Unwanted Emotions*: Emotions that were forgotten or repressed during the heat of the action come back and need to be processed.
   - *Missing the Team*: The intense connection of the team has ended and the team member may have many feelings about the loss of these connections.

In conclusion, according to the phase and the characteristics of each individual involved in the operation, there are many different physical, cognitive, emotional and behavioural reactions.

The most common reactions that can last for some days or weeks after the intervention are the following:

- *Intrusive Images/Thoughts*: Recurring images of the scene/aspects of the scene and disturbing thoughts associated with the event that intrude into your mind.

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- *Feeling of Excessive Anxiety/Fear*: Increased sense of agitation, and fears that were not there before.
- *Avoidance*: Procrastination, lack of interest in going to the scene, thoughts about leaving the job, etc.
- *Excessive Reactions to Ordinary Stress*: Inability of modulating reactions to external requests, loss of temper on a more frequent basis.
- *Increased Irritability*: Presence of unmotivated rage.
- *Sense of Isolation*: Feeling of abandonment and loneliness, need to be by self, not wanting to talk to anyone, feeling of "being different."
- *Mental Confusion*: Concentration problems and/or incapability of making decisions, alteration of normal capacity for judgement.
- *Relational Problems*: Difficulties in the relationship with colleagues, relatives and friends.

What Can You Do?

These are the types of helpful actions you can take:

- *Identify your Emotions*: Know how to recognize your own emotional reactions and the difficulties that you might have during the exposure and after it, so you can decompress as soon as possible from the effects of stress.
- *Acknowledge Your Emotions*: Do not deny your feelings but remember that it is normal for everyone to have emotional reactions because of such tragic events.
- *Monitor Physical and Emotional Reactions*: Be able to monitor your physical and emotional reactions, recognizing your own activation systems.
- *Take Time-off*: Plan some time off to recover your physical and mental energy.
- *You Are Part of a Team*: Remember that you are not alone, but you are part of a system and an organization that can support and help first responders themselves.
- *Be Compassionate*: Look at your emotional state without judging yourself.
- *Speak About What Happened*: Talk about the critical events that happened while on duty, helping to release emotional tension.
- *Respect Others' Reactions*: Respect others' emotional reactions, even when they are completely different and difficult to understand from our point of view.
- *Use Supportive Services*: Protect your emotional health by accessing the supportive services offered to first responders. Talk to an expert that has specific information about post-traumatic reactions and who can facilitate and accelerate the resolution of the reactions themselves.
- *Debriefing*: Access, when and if possible, debriefing services that includes the decrease of emotions and defusing of the experience offered to first responders' teams. There are specific tools for supporting and preventing post-traumatic stress reactions, which can be used effectively in the few hours right after the first responder's intervention.

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Protecting Yourself Allows You to Protect Your Population

Emergency-trained mental health professionals can provide help and emotional support to you. It is important for you to learn how to recognize and manage your own reactions in different emergency situations. However, sometimes you may feel overwhelmed by a feeling of impotence and lack of control or other issues that might get triggered. *If your reactions persist and you do not see any improvement, it can be useful to address the problem with trained professionals. In a short series of individual or group sessions, they can help you to deal with your reaction. EMDR therapy is a psychotherapy for recent event trauma that can be helpful as you deal with the Coronavirus pandemic and the stressful circumstances related to it.*

EMDR

According to the World Health Organization (WHO), EMDR (Eye Movement Desensitization and Reprocessing is one of the main tools for treating Post-Traumatic Stress Disorder. EMDR Therapy is used to prevent the development of psychological issues that can arise after a critical or potentially traumatic event. In 1987, EMDR was developed by Francine Shapiro using the theoretical model, the Adaptive Information Processing (AIP) system. The aim of EMDR Therapy is to re-activate the brain's self-healing process and to reprocess the most disturbing moments connected with the critical event or period that was experienced. Over the years, several recent event protocols were developed. The main protocols used during EMDR interventions in the aftermath of a recent traumatic event are the following: the Protocol for Recent Traumatic Events (2018); The Recent Traumatic Episode Protocol (R-TEP) (Shapiro & Laub, 2008); The EMDR Protocol for Recent Critical Events (EMDR-PRECIS) (Jarero, Artigas & Luber, 2011), the EMDR Integrative Group Treatment Protocol (IGTP) (Jarero & Artigas, 2009) and the Group Traumatic Episode Protocol for EMDR (G-TEP) (Shapiro, 2017). In conclusion, EMDR can represent a useful tool to turn a negative life event into a constructive event that can be an opportunity for learning, for personal development and for psychological growth.

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Telephone Support: Guide for Counseling

This is a guide for mental health practitioners who offer telephone support to medical staff or personnel or groups from institutions or agencies. Healthcare professionals often experience secondary trauma during/after major disasters and catastrophes such as the coronavirus outbreak.

Guidelines

Gather Personal Information: Ask for personal information such as name, telephone number, place of work, job, etc. Keep in mind any privacy policies at the service/institution concerning the gathering of personal information.

Introduce Yourself and the Intervention Structure: Introduce yourself and how the intervention will be structured. Clarify that this is a specific and specialized intervention aimed at reducing stress.

- *Self-Introduction*: For example: *"I am___________________, I work in the emergency field and I am a member of ___________ Association"*
- *Introduction of Goals*: "*The aim of this telephone support today is to reduce your stress and the emotional impact you have been experiencing during the Coronavirus outbreak. I want to help you recover and come back to feeling safe in your daily life. Your employer/institution wants you to have whatever psychological support that you need. The purpose is to support you and not to judge what happened or look for whom is responsible. I want to have the opportunity to talk about your experience with you and have a place for you to give voice to your reactions to this critical situation.*

  Ultimately, I will talk to all involved in this emergency situation. The call will not be recorded, and no notes will be taken during the conversation. I am hoping that you will talk with me now. Is that ok with you?"

Questions to ask Mental Healthcare Workers:

- *"Would you like to tell me how this has been for you?"*
- *"How are you coping?"*
- *"What were your reactions after you realized what was going on?"*
- *"During these days/weeks, did you experience problems in sleeping, eating, concentrating?*
- *"Did you feel more irritable? Or did you have other reactions?"*

Explanation for Reactions/Psychoeducation Phase:

> " *All the reactions you described are normal reactions that normal people have when faced with an abnormal situation. These reactions are known as stress reactions and can last for a few days or go on for several weeks. You have already mentioned some of them. Other symptoms that people might have after a critical event are the following:*

- *Cognitive Symptoms:* They include memory and concentration problems, difficulty in problem solving, denial, and/or sense of unreality.

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- *Emotional Symptoms:* These symptoms include feeling vulnerable, rage, sadness, anxiety, depression, irritability, and/or numbness.
- *Behavioural Symptoms:* This is when you find yourself doing the following: isolating, avoiding, acting with hostility, changing your eating habits by eating too much or too little, self-medicating, and/or sleeping dysregulation.

Coping Questions:

- *"What helped you in facing the event?"*
- *"Were there moments of strength?"*
- *"In the following hours and days, what gave you some relief and help?"*
- *"Every one of us has developed personal strategies to reduce stress in critical moments of our life. What strategies helped you during difficult moments in the past?"*

Other Strategies Helpful to Reduce Stress:

- *Self-Knowledge:* Understanding the psychological and physical effects of stress and strong emotions, and recognizing the way you react when you are alarmed.
- *Remember Achievements*: Keeping a mental record of your past achievements.
- *Mental Rehearsal:* Use mental rehearsal to help plan how to react in difficult situations.
- *Words to Avoid:* Avoid saying "Why?" or "If only…"
- *Regulate Basic Functions:* Eat and sleep well.
- *Share Feelings:* Write / Talk about how you feel with friends, colleagues, etc.
- *Take Space for Yourself:* Give yourself enough time to breathe and come back to normal functioning.
- *Physical Activity:* Exercise and relax to decrease physical stress. Alternating physical exercise and deep relaxation can decrease chemicals released by stress and can help you to sleep better.
- *Encourage Routines:* Go back to some routine if possible such as your daily tasks, and plan to do activities you enjoy.

Further Questions: Ask, "*Is there anything you would like to add or ask?"*

Closing Thoughts: Say, "*Thank you for having shared such private and painful moments in your life. I am at your disposal and, if you agree, we can talk again next week about how you feel and how your reactions are evolving. I would like to say one last thing: we said that your reactions are normal, but if they persist, they do not go away or they worsen, I am available to help you recover. You can contact me directly at this number…*"

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COVID-19 Emergency: Guidelines on How to Communicate Bad News Over the Telephone

COVID-19 emergency is changing our way of communicating with patients' families. Often, a phone call is the only way to talk to family members. Increasingly, medical staff have to give clinical information -and often bad news- over the phone. It is normal to feel uncomfortable, nervous and worried about making a phone call to families, especially if we know that we have to communicate bad news like a diagnosis, deterioration in a loved one's condition or his/her death. It is also different than how medical staff usually handle these situations and may cause concern for the staff as well.

We can divide the phone call into 3 stages: 1. Opening; 2. Communication; 3. Closure

1. Opening

Goal: To make a phone call to a patient's family in a calm and empathic manner.

- *Grounding:* Before making the phone call, give yourself a moment (only a few seconds or minutes are necessary) to focus your attention on your body, where you are and what is surrounding you. In this way, you can compose yourself and be calm.
- *Pay Attention to Your Voice and Modulate its Tone*: Remember that your voice is the only cue that a family member has to help him/her prepare emotionally for what you will say next.
- *Always Greet the Family Member Calmly:* When you are calm, it helps the family member to remain calm. Remember, if you are in a hurry and anxious in your approach when speaking, it increases the alarm in the family member.
- *Introduce Yourself:* Make sure to say your full name and from where you are calling, even if you have talked to the family member other times. Introducing yourself, or reminding the family member who you are, helps the other person reduce their alarm or apprehension.

2. Communication

Goal: To communicate information about a loved one to a family member with compassion and understanding.

- *Communicate Clearly and Briefly*: Use simple words. Avoid medical terminology when possible. If you have to use medical language, be sure to explain what the terms mean.
- *Choose Words Accurately*: Before the phone call, prepare what you want to say and how to say it, in order to be empathic and supportive.
- *Give Warning that Bad News is About to Follow*: Find out if the family member is alone or with someone. Either way, invite the person to sit down: "*Please sit down on a chair or on the sofa, I am afraid I have got some bad news, 2 hours ago your father, Charles…*" When we have to communicate a death or a deterioration in conditions, it is essential to find a phrase to prepare the person to the fact that he/she is going to hear bad news. Use expressions like: "*Unfortunately*" or (only if you have to communicate the death) "*I am very sorry to have to tell you that…*". Use the persons' first name and the degree of relationship: "*I am very sorry to tell you that your husband John…*"

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- *Be Direct and To the Point*: Being direct is less stressful than saying too much. Share what happened, if it is appropriate, such as how their loved one was sedated and did not suffer during the process.
- *Leave Space for Silence and Grief*: After communicating the bad news, leave time for the news to be digested and for the person to react. Keeping quiet while someone is crying (especially over the phone) is difficult. It is easy to feel helpless, but silence is a way to communicate that we are there, and we are not leaving the person alone. Every now and then, if appropriate, you can break the silence by saying some simple words like "*I am sorry.*"
- *Leave Time for Questions*: Listen, without interrupting. If the family member is not asking questions, say something like: *"Are there any questions you would like to ask?"* Give all the information you can, but not so much to be traumatic and overwhelming. When communicating the death of a loved one, be informed about what, when and how the death happened. It is most important to know and communicate if the person expressed a wish or said something for his/her loved ones before passing away. The family will often ask questions about that.

3. Closure

Goal: To tell the family member/s what will happen next.

- *Give Practical and Technical Information*: Tell the family member/s the practical and technical information that they need to know. Explain what will happen next, who and when the family will be contacted, and where they will move the person, if relevant.
- *Psychological Services*: Inform the family member/s that there are psychological services dedicated to helping them. Psychological service members will call, if they request it, and help them address their grief or stress, depending on what the family member/s need/s.
- *Inquire What Support Family Member/s Have After the Call:* It is important to ask what the person will do right after the phone call and if he/she has thought about which friends or relatives to contact to have support. Help them if they have no plan.
- *Take Time for Yourself*: Give yourself time to go back to a state of calm. The continuous requests for assistance are a burden that wears medical personnel out. Look at your emotional state without judging yourself.
- *Safeguard Your Emotional Health*: Take advantage of the support systems offered to medical staff.

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A Picture of Italy Affected and Striving to Cope with the Coronavirus: Phase 1

Isabel Fernandez

The coronavirus or COVID-19 is a reality that is affecting European countries in different ways. The purpose of this text is to share the reflections of what we have experienced, observed and done in dealing with the Coronavirus emergency. By writing down our reflections and the lessons that we have learned in Italy, we hope that they may be of use to those in other countries.

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Psychological Issues, Challenges and the Coronavirus

There are a number of issues to be considered while working with people who have been affected by the Coronavirus pandemic:

- *Complexity*: The Coronavirus emergency has added even more *complexity* to our complex world. Even though people had been dealing with their usual difficulties in the financial, work, family dynamics and relational field that often cause them anxiety and suffering, on top of that they are facing the threat of the Coronavirus that has changed the basic ways they conduct and organize their lives.
- *Vulnerability:* The virus activated a feeling of *vulnerability,* where people feel exposed to an invisible "threat or enemy" that is difficult to fight. There are no arms, vaccines or tools to deal with it, only isolation.
- *Isolation:* Isolation means putting a whole organized life "on hold." This means that it is no longer possible to do the normal things: connect with friends and family, travel (even within the city), go to work, and/or have a social life.
- *Overwhelm:* Because we are a social species, having to isolate is overwhelming and difficult to tolerate over a long period of time.
- *Too Fast:* This complex change happened almost overnight and it was *too fast,* for us to process.
- *Adaptation*: We had to help our minds to adapt to this emergency. We had to adapt our mental and cognitive schemas so that we would behave differently in a week. We had to learn that the normal ways that filled our lives were no longer available. We are having to put up with the fact that we have to live without all these things and put our daily life on pause.
- *Connection:* Keeping connection with our friends and loved ones has been partially resolved by using technology such as Skype, WhatsApp, FaceTime, Zoom and many other channels and devices. If this would have happened before this technology, our sense of isolation and overwhelm would have been much worse.

Exposure

We first learned about this virus when we heard about what was going on in China. In these early days, China seemed very far away. The threat approached with the diagnosis of the first Italian patient and we began to feel that the virus was drawing closer, but since it was only one person, we were not really worried. Patient No. 1 had had dinner with a friend who had just returned from China. He was 38 years old, healthy and was living in a normal, small town in the North of Italy. He could have been any of us. Within 3 days, we were in a state of emergency. People rushed to the supermarkets to buy food, leaving the shelves empty. We know this is a very ancient and reptilian brain reaction for ***survival***. Once people were reassured that food was not a problem, the situation changed completely and we could see people entering supermarkets and grocery stores, one at a time, which was an unusual behavior as well.

In the past weeks, psychological reactions have had different phases. We know that in the following weeks, we will see other reactions that we cannot even begin to imagine.

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One issue that we have to keep in mind is that even though these restrictions are imposed on everybody at the same level, people will be processing what is happening differently.

Restrictions & Provisions

Restrictions and provisions from the Government were concrete proof of what was happening. We were told to stay at home, close our shops, only go to shops that were fundamental to our lives. There were penalties for shops, bars or restaurants that were still open after the new rules and what was difficult to accept was that penalties were applied to people for just walking on the street.

We were being asked to trust completely what the government and politicians said and this was also unusual. However, when it became clear that the Prime Minister and the government were relying on scientists, researchers, virologists and infection virolgists, people did exactly what they were told to do.

Emotions Related to the Coronavirus Pandemic

- *Fear of Getting Infected*: The fear of getting infected is one of the most common emotions. This fear is *adaptive and normal*. It is functional in order to encourage people to behave in a way that prevents infection. It will be a challenge after the risk is over to neutralize this fear, since the activation of the fear and the exposure to the threat is going on for a long period of time.

- *Anger:* Anger is connected to fear and also to the restrictions and to the lack of freedom to do activities that are normally important for people. It is a special kind of anger, since there is no one to blame for what is happening. There might be a search for the one who is responsible for this, like the government, the Chinese people or China as a country. This kind of behaviour although dysfunctional, can also be functional because it gives a meaning to what is happening. For example: If I find the one who is at fault, it is easier to understand from a cognitive perspective. I can label it and this is comforting sometimes, even if it is simplistic. In fact, what is happening is much more complex than this.

- *Panicking:* As numbers go up and the situation seems out of control, panicking is occurring. The peak here is coming, it is getting worse every day, even if we are all doing the necessary things. The feeling is that we could be completely at the mercy of this virus. This situation will have long lasting effects on our psyche and will be a risk factor for future situations that might be associated to the Coronavirus emergency.

- *Suffering:* People that got infected feel rejected, furthermore the heavy isolation that they have to go through because of the risk of infecting others, while needing support, is creating a lot of suffering. This is a situation when you are sick and needy and nobody can be of support and people have to stay away from you, except for the medical staff.

- *Blame*: People also *blame* themselves for having infected other people who may be seriously ill. This is going to have an impact on beliefs about themselves, *being rejected and feeling at fault* are strong emotional and cognitive mechanisms.

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- *Rejection*: Some *rituals, social rules and codes* started to change. We had to change our behaviors to include: not shaking hands, staying one meter (6 feet away) away from your friends, not getting close to talk to people. The old social rules disappeared more and more as the numbers of infected people and those who died increased. It was hard not to take it personally, as we were all now doing this with each other. The first reaction was to feel rejected and not important.
- *Depression:* As days went by, people started to feel the lack of so many of their day to day experiences: contact with others, meaningful activities that used to make them feel good and give value to their lives. This can drive some people to depression because of the deprivation that they are feeling and the isolation that they are experiencing.
- *Threat:* Daily, we are feeling the *threat* that keeps increasing and spreading. We are exposed to the daily statistics that tell us that the risk is not going down and that the pandemic is reaching all the countries. These numbers are updated constantly are very disturbing.

Reality of the Coronavirus Spreading

Statistics from the first week of the Coronavirus in Italy:

- 1000 infected
- 30 died (per day)
- 35 recovered (per day)

Statistics after 3 weeks for the Coronavirus in Italy:

- 47.860 infected
- 793 died (per day)
- 689 recovered (per day)

Because our ***safety depended*** *on* others' behaviors to follow the directives of the government, if people were not following them, people would get angry and feel helpless.

One of the most difficult parts of this emergency is that we are not able **to plan and do projects**. We are left unable to plan any kind of activity and we end up feeling that the emergency will last forever; we have lost our perspective.

As clinicians, we have to be aware that there will be major psychological risk factors as a result of the ***quarantine or lockdown***.

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Concerns About Coping Mechanisms During the Pandemic

These are the concerns about coping mechanisms during the pandemic:

- *Avoidance*: The lock down can have long lasting effects, since it is an ***"avoidance"*** response. At this time, we are avoiding people, physical contacts, places, crowds, etc. It is possible that going back to normal might not be easy for everyone.
- *Catastrophic Thoughts*: During lockdown it is easy to develop *catastrophic thoughts and interpretations of what is happening.* It is suggested that people listen to the official sources of information. Often, people tend to look for answers and solutions through other channels to give them a sense of control. For instance, there is no basis that if we eat spicy food our immune system becomes stronger. However, people want to believe this so that they have a sense of more control. It is important to fight this by highlighting only the information that we need: Stay at home, wash your hands, etc.
- *Unresolved and Complex Grief*: Seriously infected people who need hospitalization, especially seniors but not only seniors, are dying. The most difficult is that in these conditions their relatives cannot take care of them and cannot accompany them as they pass away. Relatives cannot say good bye and cannot grieve them with the usual cultural rituals that normally help and give relief (like having a funeral where family and friends can comfort each other). ***Unresolved and complex grief*** will be a significant scenario that clinicians will have to deal with in the near future.
- *Sanitary Measures:* Because of the prolonged situation, it has been hard to keep up with normal sanitary conditions, not to mention the more recent need for many more burials. We are not used to these kinds of conditions especially when we seem to have no real control of the pandemic.

Important Ways to Cope

Several factors are involved in the way the situation will evolve:

- *Individual level*: The importance of individual's compliance with the official guidelines.
- *Group Level*: It is important that smaller and larger groups monitor their behavior to limit the spread of the virus.
- *National Level*: It is critical to provide information on a national level concerning how the affected populations will be managed.
- *International Level:* We know that countries did not start with prevention regulations at the same time and many countries lost a lot of time. Many countries have not been coordinated in their efforts concerning the pandemic. We do not know how the effects of the strategies used by other countries will impact our own. This is especially of concern, regarding the policies for traveling and for facing new challenges that will come up.

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EMDR Italy

The Italian EMDR Association in the last 20 years has done around 700 interventions in emergency situations and mass disasters. All the experience and expertise we have gathered through these years had to be adapted to this new emergency related to Coronavirus. We know every critical event is different from the others that we might have dealt with, but this emergency is very special, because of its unique characteristics.

Since the beginning, on February 21st, the Italian National Association and all its members have been trying to make a difference concerning psychological support and prevention for the wellbeing of all those who have been strongly affected by the pandemic: medical staff (doctors and nurses), people infected, families of those infected, and the population in general.

We really felt that we could make a difference since as clinicians, our priority is to use our psychological expertise to help and communicate the necessary information accurately to reduce anxiety and panic and to support all the people who have been in close contact with the disease (patients, relatives and health workers). The Italian EMDR Association received many requests from institutions, hospitals, local health units, Health Protection Agencies and municipalities. We have been active on the field, providing psychological support to the population, to the people who have lost a loved one to the disease, to the health workers and the people who work long hours in this emergency every day and who are exposed to patients and to new stressing situations.

In these weeks, EMDR Italy have been sharing their experience and material with other European countries, so they could have a base that could be useful and concrete.

The Role of Our Membership

The contribution our Association members have given has been exceptional. They have responded to support requests from all over our country and members in all regions have been helping.

Activating EMDR Italy

In many mental health services, our members spoke to their directors, to their administration and suggested that these services create an official partnership with the National EMDR Association. It is in this way that EMDR Italy partnered with other institutions to manage the psychological support for the population and the medical staff. In many towns and cities, members contacted the different levels of administrations to help link these services with EMDR Italy. When the number of requests was too high, other members were available from other cities to reply to the phone. People in need were able to connect to volunteer EMDR clinicians who were available for that kind of support through calling a special toll number.

In some areas of the National Service, there was only one practitioner trained in EMDR. We offered to train the rest of their staff in Early intervention and Psychological Support that was not

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EMDR therapy but general psychological support. This was an excellent way to give them concrete tools and to introduce them to EMDR therapy. A team of experienced clinicians from the Association was created to coordinate the high numbers of requests and interventions that were developing every day. These expert teams of 5 people were giving support and guidance to membership as they were activated.

Medical Practitioners

We are aware that our medical practitioners were being exposed to great risk and concerns:

- Dealing with many patients at the same time
- Not having sufficient resources for the pandemic emergency
- Exposed to the infection
- Many becoming sick with the virus and/or dying
- Fear of infecting their families to the point of deciding to live and sleep elsewhere in order not to infect their children and relatives.

They are one of the most important populations in need of psychological support during the emergency, but their need will be even greater in the future when they go back to their day to day routine after this unparalleled emergency.

Directors of medical staff in hospitals, mostly working in resuscitation and ICU, are aware that their personnel needs and they have requested specific psychological support such as EMDR. They are advising their personnel to call the Association and to get assigned to a clinician. Most of the work will be done probably at the end of the emergency, since medical staff are focused on taking care of the current needs of their patients and are not paying attention to their own emotional response, except for some of them who are devastated.

Many doctors and nurses are getting infected and some are dying. For their colleagues this is not only traumatizing, but they do not have the time and space to grieve their colleagues and friends. Every doctor or nurse that gets infected is a reminder to the others that they could be the next one. This experience and also the fact that they have to deal with many patients at the same time with the added anxiety of not having enough respirators or life support for so many patients is very traumatizing to healthcare personnel.

Videos

We produced videos on stress reactions, stress management, EMDR. Also, we made videos to help jail directors and their personnel, the National Health Service for medical teams and for the population, in general. These videos are 5 minutes long and are very practical, especially for doctors and nurses who do not have the time to call or have psychological support right now. We have had good feedback. They are watching them and following the suggestions that were tailored for this Coronavirus emergency, for instance, what to do at the end of the shift, etc.

In emergencies, things change quickly, information may often be conflicting, and it can confuse the population – both health workers and common citizens. This is the reason why we created

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specific texts for different targets (children, elders, medical staff). We made these texts available to all the Association members so they could distribute them in their community, schools, drugstores, etc. We sent them also to the national health structures and facilities and they put them on their websites and sent it to their personnel. The Association website, the discussion list and Facebook were also important channels to disseminate information and to send useful news, practical tools and protocols for this emergency.

EMDR Italy Support

We were surprised and pleased that so many stakeholders in our country were asking the EMDR Association for help such as hospitals, citizens, medical teams, Town Halls, the National Health System, the psychological associations, the jails (there were riots inside the jails since visitors were not allowed, so the staff was greatly traumatized from the riots, as well as the coronavirus), etc.

After 8 weeks of the Coronavirus emergency, through its members, EMDR Italy through its members is offering support to the following:

- 26 Hospitals
- 46 Municipalities (big cities and towns)
- 13 National Health Service Centers
- 5 Regional/State Health Services (covering around 15,000,000 inhabitants) of Northern Italy
- 11 different associations and NGOs
- 4 Regional/State Psychological Associations
- The National Psychological Association
- Network of jails' administrators in Northern Italy
- Costa Cruises (where guests and crew members were infected during the Cruise)
- Ministry of Education (programs for teachers and students of all ages regarding the Coronavirus emergency)
- 7 Local Health Authorities (ASL)
- 17 Senior citizens home
- 1 Midwives Association
- 9 independent groups of EMDR clinicians

We organized a free seminar focused on EMDR protocols and tools applied to the Coronavirus emergency. Through streaming, this seminar helped our members (5300 members out of 7100 attended) in the following ways:

- Understand their stress reactions
- Feel part of a professional community in this time of isolation
- Learn to use the same tools to work with EMDR from the same perspective
- Increase their level of competency

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As a result, we are able to connect as a professional community, while being asked to isolate ourselves and remain alone. In this way, we could remind our membership that a concrete organization exists even though there is great uncertainty and unpredictability at this time. As one of our members wrote to us:

> *Dear colleagues,*
>
> *I attended with a lot of interest the seminar regarding the emergency that we are going through in this time of our lives.*
>
> *The seminar has been very useful from a professional point of view, since you gave us concrete tools to deal with what is going on and it has been important also from a psychological point of view. Again, I felt the enthusiasm for our work and it confirmed our role as EMDR clinicians. The seminar was useful also for my family, and clients, since I felt more confident and they could feel it.*
>
> *The dedication that you showed to us was amazing. I appreciated the way you do this, not only with expertise but also with humanity and strong values.*
>
> *I live and work in Palermo and I am part of the EMDR group that is giving tele psychological assistance.*
>
> *I have been working with EMDR for many years with good results and I am proud of being part of this Association. Thanks again for everything!*
>
> Lucrezia

Media & Connections

We have been interviewed everyday by radio, TV and newspapers. At the same time, we had to produce a lot of material for those who we are helping, for our members and psychoeducational materials for the population, in order to allow them to work in the same way.

The Ministry for Education asked us for material for children, adolescents, teachers and parents to distribute in partnership with the EMDR Association.

Our members are creating a lot of initiatives in their communities with the support of the EMDR National Association. They are all working pro bono and are coordinated by the team of experienced members of the Association.

Members who are living abroad, like in London or Spain, are organizing support for Italians that live in those places. Our support has been to help them to implement services and find colleagues in Italy who could help them with the calls that they were receiving, using WhatsApp, Skype, etc. We are doing all this by phone, Skype, Zoom, etc. We were surprised that our work could be done remotely and be so effective, even with groups of doctors and nurses.

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Conclusion

- *Emergency Concerns*: During an emergency, people respond according to their own personality, characteristics and the abilities they have learned in life. Many will develop anxiety or fear; others will become depressed, etc. It is important to know that these effects will not stop with the end of the emergency but they might persist in the medium-long term or they might even grow and generalize to a number of situations that used to generate no disturbance before.

- *Providing an Environment of Safety:* During an emergency, and particularly in this case when we are fighting against an "invisible" enemy, the people might feel in constant danger and they might feel constant fear. This feeling of threat has the priority over the cognitive-rational structures because this is a question of survival and hence it is innate and irrational. In this first phase, it will be important to provide the people with a sense of safety and remind them that there are things that we can do, so we are not so helpless. When providing support even in this situation, we noticed that it is possible to find resources, positive aspects or situations, where the client was able to feel safe. It has been fundamental in order to promote safety, to provide information and psychoeducation on what is happening and how and why we are reacting in the way we are.

- *Support Official Channels of Information*: In situations of emergency, people feel the irrational need to be reassured and to have control over what is happening. Hence, many will feel the need to follow the online news constantly. Quite often, however, they will get fake news: since it is written to stir an emotional impact, it will become viral and difficult to manage. It has been necessary to repeat how important it is to follow the official channels, like the website of the Ministry of Health, or other official websites managed by health organizations, to reassure the population and not to disseminate panic as fake news often does.

- *Legitimize Emotional Responses*: Explain the coronavirus as if it were an "invisible enemy" difficult to control and to predict. This emergency has been challenging our normal emotional responses those we are used to as human beings. This is the reason why strong anxiety and concern may arise. Trying to normalize and legitimate all these emotions can be helpful to calm down the client and to explain what is happening inside them.

- *Support Resilience*: Just as our body is equipped with an immune system, our brain is able to adapt psychologically to adverse situations, thanks to its resilience. It is important to extend the perspective of what is happening: we are not helpless even if we cannot change things. We can change our reactions and perspectives, the way we see what we are experiencing.

- *Constructive Viewpoints*: Provide a constructive view of what we are experiencing: It is possible to find resources in each situation, which can be used. This is an opportunity to devote time to a slower life, to our family and ourselves. In this moment, we can do things that have never been a priority for us. Now we can do them and use technology – streaming and platforms – we are all isolated but we are all connected as a community at the same time.

- *Support What We Can Do*: Because of all these factors, it is not possible to predict results. Many people may feel difficulties due to this unpredictability. Providing simple and clear instructions on

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what to do allows people to feel safer and lessens the unpredictability of the situation. For instance, washing your hands, cleaning all home surfaces, paying attention if you sneeze or cough, etc., but also emotional and psychological strategies to feel grounded and safe.

- *Focus on the Here and Now*: The fact that we cannot make plans at this moment may create new challenges and feelings, since we are not used to not making plans. However, it is important to state that we must focus on the here and now. This is a great opportunity to simplify our lives that are generally very complex and fast. We have the possibility to explore this simpler and easier life that the Coronavirus emergency is compelling us to conduct, changing our hierarchy of priorities.
- *Community*: Throughout the whole country *a new sense of community* has developed. People have found ways of sharing nice and pleasant moments, in creative ways, like opening their windows, or going out on their balconies or terraces and singing together or playing. Through the Internet, WhatsApp, etc. many things can be shared like having a virtual drink together or celebrating events. People that lived in the same building and had never met, now have a WhatsApp chat sharing information on grocery stores or to help if someone is in great need in the building… So, it is very positive to see that when individuals cannot make it alone, the group comes up in a natural way to help and support each other.
- *The Contribution of EMDR Therapy:* From a health perspective, specific scientific protocols have been pursued, following medical protocols, knowledge and expertise. From the psychological point of view, we must also address the needs and dynamics that are being triggered in the people, through the research-based protocols of ***EMDR therapy*** considered effective, according to the International guidelines.
- *Generosity:* The last thought is about the generosity of the members of our National EMDR Association. They are not only clinicians but they are aware of EMDR Therapy and how this can make the difference in emergencies. Despite the fact that our whole country is going through a very stressful and traumatic situations, our members exhibit the spirit of EMDR when they reach out and help those populations in need.

Isabel Fernandez is the Chairman of EMDR Italy Association and President of the EMDR Europe Association.

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4

A Picture of Italy Affected and Striving to Cope with the Coronavirus: Phase 2

Isabel Fernandez

Introduction

The Coronavirus threat has had a deep impact on our emotions, cognitive schemas, as well as on our sense of control and safety, generating new anxieties and worries and suddenly changing our lives and habits. As many countries have started to ease the lockdown measures and we are entering a new phase, it is extremely important to consider that the psychological impact of the pandemic might not be over and the population might still be at risk for developing symptoms of psychological distress. According to very important and well-known researchers in the field of stress and traumatic stress such as Van der Kolk (2015) and McFarlane (2009), a significant number of individuals, despite having initially been able to cope with a traumatic event, over time begin to present symptoms of discomfort. For example, after mass disasters like the one connected to the

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COVID-19 pandemic, symptoms often increase during the first 6 months and have a key role in the late onset of psychopathological disorders. Therefore, it is essential to intervene as soon as possible.

EMDR therapy protocols for early intervention can have a major role protecting people's psychological health, giving immediate relief and providing them with tools to prevent the future onset of psychiatric disorders or other stress reactions. At the same time, EMDR therapy can be very effective in accompanying the next phases that will be coming in the next months as we address the opening up of our countries.

In the coronavirus pandemic context, people who are particularly at risk of developing PTSD are COVID-19 patients who have perceived their life in danger, their families and health-care staff. Others at risk are relatives and friends of victims of COVID-19 who are grieving because they could not take care of their loved ones while they were dying and were not able to hold funeral services, due to social distancing measures. This critical and unexpected situation has certainly caused discomfort, also, to the people that have not been infected or that have not suffered any severe trauma. The risk of catching the virus and the compulsory measures of social distancing might themselves cause symptoms like fear, anxiety, depression, irritability and insomnia. Therefore, there are many psychological consequences that will manifest over time related not only to COVID-19 threat and its aftermath but to the greater population's experience of being in social isolation as well.

Research

Effects of Quarantine

Articles published in scientific journals confirm that quarantine, if prolonged and not voluntary, can have short- and long-term effects at a physical and psychological level, causing an increase in anxiety, mood disorders and addictions. We are a social species and isolation entails a sense of deprivation and a loss of social contact that make us suffer, since being part of a group and social closeness are linked to our ancient sense of survival. For instance, the National Institute for Health Research's (NIHR) Health Protection Research Unit (HPRU) in Emergency Preparedness and Response funded an important review (Brooks et al, 2020) of articles published on MEDLINE, PsycINFO and Web of Science about the psychological impact of quarantine. This research has analysed previous disease outbreaks: researchers have examined 24 studies that were done across 10 countries and included people with SARS, Ebola, H1N1 influenza pandemic, Middle East Respiratory Syndrome (MERS), and equine influenza. The review has shown a wide range of negative psychological effects of quarantine, including post-traumatic stress symptoms, depression, confusion, anger, fear, and substance abuse. The study, published in The *Lancet*, has found that these psychological effects can be long-lasting and they have a stronger impact on people that have a history of mental illness and on health-care workers. In particular, according to this research, hospital staff showed:

- Detachment
- Anxiety
- Irritation

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- Sleep disorders
- Concentration difficulties
- Deterioration of performance
- Reluctance going to work or considering resignation

Some studies found that after 3 years, the population had a high level of post-traumatic symptoms and 9% had depression symptomatology.

The main author, Dr Samantha K Brooks of the Department of Psychological Medicine, King's College London, has stated:

> *This Review suggests that quarantine is often associated with a negative psychological effect. The evidence that a psychological effect of quarantine can still be detected months or years later – albeit from a small number of studies – is troubling and suggests the need to ensure that effective mitigation measures are put in place as part of the quarantine planning process. Our review suggests that health-care workers deserve special attention from their managers and colleagues, and that those with vulnerable mental health would need more support during the quarantine.*

Another systematic review published in *Brain Science* (Vlachos et al., 2020) shows how isolation can have a severe impact on physical and mental health, due to the neuroendocrine and immune response. The research, done with a group of parents and children, showed that quarantined children developed post-traumatic symptoms four times higher than the control group.

Other studies of this review reported other reactions in the population, like confusion, fear, difficulty in managing anger, numbness and sleep disorders, panic attacks, deterioration of couple or family relationships and difficulties related to cohabitation. These studies highlight the possibility of developing general psychological symptoms like depression, problems of anger management, sleep disorders, fear, problems of fear extinction, and anxiety, as well.

Suicide

In addition, we have to consider another important set of adverse effects that the pandemic might have on the population, which impacts on quality of life and increases the risk of suicide.

Population's vulnerability to suicidal behaviour during a pandemic has been analysed in a study published in *The Lancet* (Gunnel et al., 2020). According to this research, a sense of loss is an important factor affecting mental health and could precipitate suicide. People realize how much they have lost during 2 months of lockdown: not only social relationships, but also job opportunities and financial resources. The Inter-Agency Standing Committee (IASC) on Mental Health and Psychosocial Support -initiated by the World Health Organization (WHO) – has guidelines that highlight the effect of the prolonged exposure to stressors during the pandemic, that can lead to long-term consequences within communities, families and vulnerable individuals. This can include deterioration of social networks, local and national economy, and stigma towards

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survivors of COVID-19. This has a very negative psychological impact, so it is necessary to undertake actions that can reduce stigma and discrimination.

Domestic Violence

Another important consequence of the pandemic is the likely increase of domestic violence, due to the lockdown and the lack of services and external support. People with important previous risk factors are also likely to develop mental health problems or exacerbate existing ones, experiencing relapses and other negative outcomes.

Post-Lockdown

It is essential not to take for granted that once lockdown will finish, everything will go back to normal without consequences for the general public health. Mental health consequences are likely to be present for longer and develop much later after the pandemic. Even when we will no longer have to stay at home and we will be allowed to go back to our routines, our minds might not always be able to turn off the switch and return to life as it was before. We need to decrease the accumulated stress that we have been exposed to during the last months and let it drain away; this takes time and it can be different for each of us.

Role of EMDR Therapy

Preventive interventions for resilience building and follow-up is essential. Psychological interventions must be meaningful and take-into-account all the phenomena and mechanisms mentioned above because they will play an important role in people's health in the coming months and years. It is important to intervene during quarantine in order to minimize these risks, and EMDR can have a fundamental role to prevent PTSD and other psychological disorders from developing. EMDR can be effective in reducing the stress caused by social isolation, working in the most distressful moments of the isolation period, especially by using EMDR Early Intervention strategies and strategies.

According to the October 2018 guidelines published by the International Society for Traumatic Stress Studies (ISTSS), psychological interventions such as EMDR not only result in a clinically significant reduction of symptoms and in improved functioning / quality of life, but are also considered interventions "with evidence in adults as early treatment in the acute phase.”

In the case of EMDR, a single session within the first 3 months of a traumatic event has already shown effectiveness for the prevention and treatment of PTSD. EMDR also had a standard recommendation for interventions performed within the first 3 months in multiple sessions. It is considered equal to CBT-T, a cognitive behavioral therapy focused on trauma. This shows how costs in terms of duration of the psychological interventions are very low and at the same time can be effective. The costs of a non-intervention in the acute phase are very significant both in terms of suffering and discomfort, but also in terms of medium and long-term services and pharmacological treatment.

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How to Prepare for the New Post-Lockdown Phase

Compulsory vs Voluntary Quarantine

No previous research has made a comparison between the psychological effects of compulsory and voluntary quarantine. However, studies indicate that reinforcing the altruistic aspect of quarantine as a way of protecting the others could make it easier to bear the stress and frustration of the situation.

Everyone is now conscious of the potential social and economic consequences of COVID-19, which is why we must be aware of these risks and implement measures to reduce their impacts. Communication and transparency are crucial. Voluntary quarantine, carried out as an altruistic act to protect others, will always be associated with less serious consequences than the compulsory quarantine. Quarantine was compulsory during the COVID-19 outbreak in Italy, but it has been beneficial to present it as an altruistic act towards the others anyway. It can be useful to make a plea for altruism, reminding people the benefits that quarantine has for the society.

Adjust Gradually

Once quarantine ends and the lockdown measures are lifted, it is essential to adjust gradually to the change. Just as life in the cities does not immediately return as it was before, we too have to get used to going back to normal a step at a time. However, just like the body, the mind has its own immune system that naturally tends to heal. We adapted to the lockdown very fast and we used all our resources to adjust to it, in the same way we will acclimate to the new phase that will be coming in the next months.

We are aware that the capacity to process this difficult experience is in our power, but it all depends on our personal history and the resources that we have or we can put in place. A useful coping strategy is to look for incidents from our past when we were put under strain and identify them: "*What helped to me the most at that time? What was the vision, the thought, the message that allowed me to overcome that moment?"* It may have been sheer determination and/or the belief in a project. We can use the resources that are already present and that proved to be effective in other situations or periods of our lives.

Health-care workers (nurses, doctors, ambulance drivers, lab technicians, etc.) are among the most exposed people and are subject to extreme stress and risk of burnout. Without a specific and focused professional support, they risk psychological distress that can lead to full-blown psychological disorders.

The Role of Thoughts & Emotions

Thoughts and emotions are very important. Another essential strategy to overcome this moment is to get in touch with our emotions: sense of loneliness, discouragement, anger, frustration. Let's ask ourselves what thoughts are associated with these emotions: "*I will never make it," "What have they done to me?"* etc. These negative thoughts that leave no escape and are catastrophic must be changed since they have a strong impact on emotions. What we say to ourselves, our

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self-talk, especially if negative, also prevails over the reassurance from others. Being told: *"It will be all right, don't worry"* is useless if I keep having the same thoughts. The concept is that we are in a situation where we are not in control of what is happening, we cannot change the external conditions but we can instead change our self-talk. It's important to understand the situation for what it is. In the meantime, take the time to process it and accept the feelings of frustration, but without continuously ruminating over the situation.

The Floatback is always an important way of identifying and resolving negative feelings and states of mind. Trying to concentrate on the disturbing feelings, thoughts and sensations and floating back to see when we have experienced the same things before can be useful in order to unhook the connection between the past and the present. The coronavirus lockdown can trigger earlier experiences when needing to stay at home during a long illness, or isolation in childhood. In the years to come, clinicians – especially EMDR clinicians- will find when they do case conceptualization with their clients that there are targets and experiences from this pandemic that will be contributing to their difficulties. Very likely, memories of this pandemic will be included in therapeutic treatment plans of many clients. Those who do not develop symptoms or reactions now, might be triggered in the future and the experience of this pandemic could be reactivated, precipitating disorders like anxiety, mood disorders, etc.

Some Practical Recommendations to the Post-Lockdown Phase

- *First Recommendation*: It is important to prioritize. Some activities will open soon, not all of them. Therefore, we should start choosing the things we would like to do, but gradually. We will not be able to see all our friends, let's decide who we would like to meet first.
- *Second Recommendation*: It is important to acknowledge the inevitable feelings of anger that are related to fear and to the sense of constraint. Usually, in these situations, we try to make sense of this anger by finding a culprit: China, WHO, etc. become targets of our frustration. It would be more adaptive to see what happened as an event bigger than us and anyone else. Be aware that everyone has done their best and that sometimes there are situations that are beyond anyone's control. It is important to always keep in mind that instead of looking for culprits, we need to focus on practical things that can be done and are being done to solve what depends on us.
- *Third Recommendation*: Isolation can cause phobias, related to the long exposure to avoidance. Having been isolated for a long time, we may find it difficult to go out, to the point we do not want to go out anymore or do not go out without anxiety. The solution is to gradually start going out again, wearing masks and/or taking other necessary precautions without developing obsessive behaviour. We could also go to the opposite extreme, where we try to do everything we have been forbidden to do. This can put us in danger again and expose us to the risk of being infected. It is important to remember that the easing of lockdown does not mean that the risk is over. If we do not follow the instructions and the rules, we could be even more exposed to infection.

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5

Recommendations for the Use of Online EMDR Therapy During the COVID-19 Pandemic

The EMDR Europe Standards Committee

Introduction

As the Covid-19 continues to develop rapidly and more of our member countries are in lockdown, it is necessary to update the previously issued guidelines for online EMDR therapy. We will continually review and update this information as needed in light of future developments.

As EMDR therapists, we are facing a new challenge which we have not encountered before. It will not be possible for many of us to offer face-to-face consultation or therapy to clients in need. However, there is a substantial amount of existing information from practitioners who have used online EMDR therapy for many years. During the present circumstances in which it is impossible to work face-to-face, these experiences need to be acknowledged.

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Use of EMDR Online Therapy

Research

There is no existing evidence to show whether there is a difference between online and face-to-face EMDR therapy. There are some small, uncontrolled studies not using EMDR which indicate there is no difference. For statistical reasons, undertaking controlled research on the difference between face-to-face and online EMDR therapy would be a vast undertaking, requiring a considerable number of participants. Such research is unlikely to happen soon.

- **It is therefore impossible to conclude from existing research whether or not there are any differences between face to face and online EMDR therapy.**

Anecdotal Evidence

There is a substantial body of anecdotal information from experienced EMDR practitioners throughout Europe which appears to show online EMDR treatment to be as effective as face-to-face EMDR therapy. The anecdotal evidence seems to be just as strong for online EMDR treatment with children as it seems to be with adults. Given the lack of available research and the fact that the crisis will continue for some time, it is reasonable to rely more heavily on the anecdotal information and to recommend the use of EMDR online therapy for any **appropriately assessed client**, both ongoing clients and new clients. Indeed, there is a distinct advantage in using online EMDR therapy in the present crisis because it will allow EMDR therapy to be offered to many clients who would otherwise not be able to receive it.

- **During the present coronavirus crisis, online EMDR therapy – that follows the Standard EMDR therapy Protocol – is therefore recommended for all clients who are appropriately assessed.**

- In addition, we want to stress the following:
  - We support the use of EMD, EMDr, and Recent Events Protocols, as well as stabilization and grounding, psychoeducation, Safe Place and Resource Installation and enhancement.
  - There is a need for caution when working with complex clients.
  - There is a need for therapists to follow their national regulations and insurance policies regarding online therapy.
  - The importance of adhering to the base of our practice, which is our EMDR Europe Code of Ethics, especially when we lack experience and knowledge.

Treatment Skills & Risks

Are special treatment skills required in applying the EMDR protocol online? Again, research cannot help us. We must still rely on the anecdotal evidence and practical experiences, and this appears to show that the Standard EMDR Protocol works well; there is no need to alter it. The most critical issues are that clinicians should only work with clients who are within their present level of competence, and that they are appropriately supervised, as would be standard practice with face-to-face clients.

- **Any risks from online EMDR therapy appear to be similar to those experienced by clinicians working face-to-face. Nevertheless, the actions that a therapist can undertake in online therapy to adjust to several risks are limited.**

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Technical & Practical Skills Involved in Running an Online Session

There is a range of technical and practical skills that a therapist will require to run a productive online EMDR session. Most EMDR clinicians are unlikely to have worked online and will need help. There is a substantial amount of existing information from practitioners who have used this method for many years. Some national associations are already collecting this information to share with their members and are running skill-sharing webinars on how to operate an online session.

The EMDR Europe Standards Committee

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6

EMDR Early Interventions in the Current COVID-19 Pandemic

Paul Miller, Derek Farrell & Lorraine Knibbs

Introduction

EMDR therapy is one of the empirically-supported treatments for the psychological effects of trauma, that is endorsed by the World Health Organization (WHO, 2013), United Nations High Commission for Refugees ((UNHCR, 2015) and the International Society for Traumatic Stress Studies (ISTSS, 2019). As examined in the ISTSS guidelines, the majority of the current research demonstrates its effectiveness with Post-Traumatic Stress Disorder (PTSD) and Complex PTSD. Additionally, EMDR has been a component in multiple trauma capacity building projects throughout the world including Syria (Acarturk et al., 2016), Pakistan (Farrell et al., 2013), Myanmar (Mehrotra, 2014) and Northern Iraq (Farrell et al., 2020), it has also been widely deployed as an early intervention (See Appendix 1 & 2). There is strong consistent evidence that EMDR Early Intervention (EEI) significantly reduces symptoms of PTSD, with effects maintained at follow-up (Shapiro and Maxfield, 2019).

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Eye Movement Desensitization and Reprocessing (EMDR) therapy was introduced in 1989 and has evolved to become a comprehensive psychotherapy, guided by Shapiro's Adaptive Information Processing (AIP) model. This model equips clinicians with a means to understand cases in a trauma-focused manner, assisting with treatment planning and delivery (Shapiro, 2007). This model views most mental health disorders as stemming from unprocessed earlier disturbing events and has opened the door for EMDR treatment of multiple disorders. There are more than 44 randomized controlled trials that have investigated EMDR treatment of posttraumatic stress disorder (PTSD), early traumatic stress, and traumatized children (Maxfield, 2019). In addition, 28 randomized controlled trials have assessed its utility in major depressive disorder, bipolar disorder, psychosis, anxiety disorders, obsessive compulsive disorder, substance use disorder and pain (Maxfield, 2019).

EMDR therapy skills are traditionally provided as an additional training for mental health professionals. In this context, it is meaningfully-structured in terms of its training curriculum, supervision provision and accreditation requirements. In Northern Ireland, a Department of Health commissioned a course that runs through Queen's University Belfast, training experienced mental health nurses in EMDR therapy: the program takes nurses through to Accredited Practitioner level. A second Masters Degree level course for Advanced Nurse Practitioners is going live in the next academic year at Ulster University with EMDR therapy and the AIP model as core elements. Pedagogically, it provides trauma-focused skills to those with pre-existing mental health professional skills, allowing for the addition of trauma-focused psychotherapy to established mental health settings. The EMDR All-Ireland Association was launched in 2020, having previously been a part of EMDR UK & Ireland. In the coming months, fifteen additional, experienced, EMDR Consultants will be accredited for Ulster (Northern Ireland, plus Donegal, Cavan & Monaghan), having completed a two-year trauma capacity building project led on the Island of Ireland. This greatly enhances the capacity to supervise and encourage clinicians towards accreditation; increasing trauma treatment capacity.

The Need for Stress & Trauma Treatment

The various international initiatives of Humanitarian/ Trauma Capacity Building projects, led by colleagues' from within the EMDR therapy community, highlight the major discrepancies between demand and supply in relation to addressing the global burden of psychological trauma. This endeavor needs to explore how EMDR-focused trauma interventions can be adapted for non-mental health workers so as to bridge the gap created by lack of capacity (Blenkinsop et al., 2018). To date, there are three models currently being trialed in Low-and middle-income countries (LMIC's), each of which are both Adaptive Information Processing (AIP) and EMDR therapy informed. They are the following:

- *Trauma Counselling Curriculum*: This arose from the Mekong Trauma Capacity Building projects for Cambodia, Thailand, Indonesia, Vietnam, and Myanmar.
- *Trauma Psycho-Social Support (TPSS+):* Developed by Trauma Aid Germany, it is being tested in the Middle East.
- *Global Initiative on Stress & Trauma Treatment (GIST-T*): This project is located in Geneva and is targeting more within the High and Middle-Income Countries.

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This shortage of mental health personnel is particularly apparent following large-scale crises in low- and middle-income countries (LMICs), but in all reasonable likelihood, we are likely to face similar challenges in the aftermath of the current Pandemic. Non-mental-health professionals could create additional capacity; extending mental health capacity, not to replace or compete with licensed mental health professionals. Currently PhD students at Ulster University are exploring such applications and international examples already exist in LMICs. This includes exploring how EMDR therapy techniques can be taught to specialist, non-mental health professionals such as Midwives so that these skills can be deployed quickly at point of need. There are already endeavors that have identified mental health champions amongst midwifery services; we can build on these specialist nurses' skills with additional EMDR therapy-based skills. For example, a midwife can be taught to use EMDR-based stabilization procedures to calm a state of panic, following an unexpected instrumented birth or birth complication. Ostensibly, this focuses on creating 'state' change, rather than trait change, thus reducing presently held levels of distress and anxiety, without processing the traumatic elements of the situation.

As part of Humanitarian/ Trauma Capacity building training curricula, both the EMDR Group-Traumatic Episode Protocol (GTEP) and EMDR Protocol for Recent Critical Incidents (PRECI) are taught to both mental health, and non-mental health participants. Admittedly, the non-mental health workers are taught a slightly diluted version of both protocols. It is important to highlight that both of these EMDR Group Protocols are effective, but at the same time, there are important distinctions between the two.

- EMDR-PRECI is a blunter instrument but is more effective in dealing with large populations.
- GTEP is more precise, allowing more time to process trauma memories than PRECI.

Both use the support of Emotional Protection Teams who are from within the local community. In addition, both PRECI and GTEP are meant to be early interventions effectively used within the first 3-months post trauma.

Given that the psychological impact of trauma is recognized as having distinct phases: immediate, acute and chronic; it is not unusual that the trauma-focused treatments have developed with a similar focus. EMDR Early Interventions (EEI) are those that are implemented within 3-months of the trauma exposure; they are observed to significantly reduce PTSD symptoms acutely and these effects have been shown to be maintained at follow-up (Shapiro and Maxfield, 2019). In the present pandemic, we are mindful of the dual function of EEI's: they reduce and resolve immediate distress and they also act as a triage, identifying those individuals who are unable to benefit from them and require higher levels of specialist input. Both are desirable in the present context of Covid-19.

The Group-Traumatic Episode Protocol (G-TEP) has been chosen in the All-Ireland context as many clinicians are familiar with it having been trained via Dr. Derek Farrell in Worcester University and local trainings through its creator, Elan Shapiro. Additionally, the methodology provides a practicum sheet, which acts as a guide to the people engaging in G-TEP online. This is widely believed to be beneficial for implementation in the current context where online delivery is an apparent necessity, due to social distancing constrictions applied by both Governments on the Island of Ireland.

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EMDR Therapy's Response to the Pandemic

In terms of training delivery, in the context of the pandemic, training has already been successfully delivered with social distancing in place within facilities such as Soldier Centre in the USA **http://www.soldier-center.org** developed and operated by retired Colonel EC Hurley [*Personal communication*] and it has also been employed as online trainings by international colleagues including Mara Tesler Stein (USA/Israel); Jamie Marich (USA) and Esly Carvalho (Brazil). These colleagues have also collaborated with the authors in regards to the delivery of online EMDR therapy, utilizing online training to assist EMDR trained therapists to continue EMDR therapy provision using online platforms such as Zoom, SKYPE, and Microsoft Teams amongst others. The EEI, G-TEP protocol has been successfully implemented online for this purpose. G-TEP serves four purposes:

1. Trauma symptom reduction
2. Prevention of deterioration of symptoms
3. Triage risk assessment
4. Community empowerment
5. Stabilization

The primary focus of GTEP is trauma memories, that drive traumatic stress responses. In accordance with Social Distancing, it would not be appropriate to offer individual face-to-face sessions and internet-based G-TEP (iGTEP) is being utilized as an efficient manner of implementing EEI in an online environment. iGTEP is currently being used to support EMDR therapists through online groups (Farrell, 2020). This support with EEI aims to ameliorate the toxic stress that frontline staff are exposed to, rendering it tolerable (Shapiro and Maxfield, 2019).

Working with Frontline Healthcare and Workers

Lai (Lai et al., 2020), explored the mental health of frontline health care and emergency workers, reporting depression, anxiety, insomnia and psychological distress. Presently, frontline workers are experiencing high levels of emotional strain, physical and mental exhaustion, distress about co-workers' health, intense fears about shortages of essential equipment, concerns about infecting family, anxiety around unfamiliar roles and expanded workloads (Ayanian, 2020): compounded by limited access to meaningful mental health services. As the pandemic progresses, mental disorders may subside naturally for some; others will experience persistent symptoms impacting on all areas of functioning.

Psychological Trauma Lens

The psychological trauma lens is a very useful way to view the current pandemic. We may consider trauma as being an experience for which a person is not adequately prepared, resulting in an overwhelming of the normal coping strategies; leading to the generation of dysfunctional memory networks: AIP postulates that these result in later psychological disorder and related behavioral issues such as addiction and mood disorders (Shapiro, 2007, Gauhar, 2016).

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Risk Factors

In regards to the mental health risks posed to front line staff by the current pandemic, a number of key risk factors related to the later development of trauma have been identified in first responders. Research shows that an effective workplace, with clear support and governance is vital in decreasing the risk of later psychological trauma (Maguen et al., 2009). In a model that included gender, ethnicity, traumatic exposure prior to training, current negative life events, and critical incident exposure over the last year, routine work environment stress was most strongly associated with PTSD symptoms. Routine work environment stress mediated the relationship between critical incident exposure and severe affective symptoms and between current negative life events and PTSD symptoms. Therefore, ensuring that the work environment is functioning optimally protects against the effects of work-related critical incidents and negative life events outside of the workplace (Maguen et al., 2009). Research has shown that PTSD *severity* is related to factors that included "dissatisfaction with organizational support" and "insecure job future." The research notes that when there is a perceived lack of support, and insecurity in respect to the job, an increased severity in PTSD is manifest (Maia et al., 2011). Effective mental health support is a vital asset in helping staff feel valued and supported and EMDR therapy as an EEI allows for early effective interventions that can reduce later suffering and at the same time acts as an effective triage, indicating those cases who require one to one trauma-focused psychotherapy (Saltini et al., 2018).

Conclusion

In summary, access to EEI can be deployed relatively rapidly through the current EMDR therapists with recent increases in supervisory capacity allowing for upskilling of those who require it. EMDR-based techniques that can be employed as EEI can also be taught to non-mental health professionals such as non-mental health frontline staff. Lessons learned from other international trauma capacity building projects that use EMDR inform our choices and a Department of Health commissioned course exists, which can identify trained experienced mental health nurses for deployment now and provide a pathway for more to be trained through to accredited practitioner status.

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Appendix 1

Dr. Ignacio Jarero's Publications as Leader / Co-author

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Appendix 2

Published Research on EMDR Early Interventions: Protocol for Recent Traumatic Events, Recent Traumatic Episode Protocol (R-TEP) and Group-Traumatic Episode Protocol (G-TEP)

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G-TEP Research planned, conducted & published Jan 2020

Elan Shapiro (Group-Traumatic Episode Protocol – group version of Recent-Traumatic Episode Protocol)

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7

A Turkish Response to Dealing with a Catastrophic Event: The COVID-19 Pandemic

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Asena Yurtsever
Sefa Kaya &
Emre Konuk

Introduction

The Turkey **EMDR Trauma Recovery Group** consists of 500 psychotherapists who received EMDR training and are carrying out the EMDR, Humanitarian Assistance Programs of the EMDR Association Turkey. They are volunteers.

When any massive traumatic event occurs in Turkey, the Turkey EMDR Trauma Recovery Group immediately take action, gets organized and gives therapy for free. The group decides how and by which methods to respond to each event, teams are formed, its budget is prepared

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and the response begins. It is a quite experienced, dynamic and active group who have responded to almost all of our country's traumatic events, beginning with the 1999 Marmara earthquake, including other natural disasters, terror attacks and mining accidents.

From the first days when the Coronavirus Pandemic started, The Turkey EMDR Trauma Recovery Group engaged its members to deal with this event. As of March 2020, 450 volunteer EMDR Therapists, have been carrying out Online EMDR and psychological support work for those affected by the virus. In this article, a summary of the work done follows, including the research documentation concerning the Coronavirus Pandemic in Turkey.

Structural Basis of the Organization

Teams

The work done for those affected by the Coronavirus (Covid-19) Pandemic, consists of 29 teams giving Online EMDR Therapy with 10 sub-units, providing support service to the organization as follows. Each team has a leader who assumes the role of a facilitator and approximately 15 EMDR Therapy volunteers are involved in each team. The EMDR Trauma Recovery Group volunteers carry out all the work.

Supervisors Team

The EMDR Trainer leads the Supervisors team and they carry out the work and interventions needed online with the general principals and rules of EMDR. Each supervisor has his/her own team. At least once a week, they have supervision meetings with the team. By discussing the treatment of each client, clinicians begin to notice common problems in the sessions and have the opportunity to come up with alternatives and other solutions. They determine what trainings are needed and set them up.

Coordination Team

The Coordination Team carries out all the operations that are needed within the EMDR Trauma Recovery Group. They help structure the operation of the whole system online, while adding volunteers to teams, structuring the members of the team, supporting the coordination between the teams, and helping volunteers come up with solutions to the problems occurring in teams and emergency cases.

Social Media Team

This team determines all the social media announcements, visuals, slogans and hashtags. They create live broadcasts about the organization for social media.

Bureaucracy & Communication Team

The Bureaucracy and Communication Team carries out the correspondence and negotiations with all public institutions, and prepare press releases.

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WhatsApp & E-mail Application Teams

Clients may reach the **EMDR Trauma Recovery Group** in two ways:

- WhatsApp
- Sending requests for help through a web address or email

The members of these two teams control the messages received and decide whether the people sending the messages meet the criteria for inclusion. If clients meet the criteria, they are sent a form to fill out. If they do not meet the criteria, they refuse the application. The people who are selected meet the following criteria:

- COVID-19 diagnosis
- Relative/s diagnosed with COVID-19
- Relative/s who died from COVID-19
- Daily contact working with COVID-19 patients such as hospital health care workers and those in government departments

Translation Team

This team translates the materials that are written in different languages and necessary for the organization into Turkish and, if needed, to English.

Morale Team

It is important to support the volunteers of the organization who are giving help to victims of a mass event. The Morale Ream responds to any difficulty the volunteers may encounter. This team consists of experienced EMDR therapists who treat volunteers and their families with EMDR, as needed.

Psychiatric Counseling Team

The Psychiatric Counseling Team makes the medical assessment of the problems that the clients bring, when needed.

Project Team

This team is responsible for writing up projects and funding applications.

Team Leaders

Each team has a leader who assumes the role of a facilitator. Leaders both direct the clients to the volunteers in their teams and solve the problems that occur. They support how the team relates to other systems of the organization.

Functioning

The system for the EMDR Trauma Recovery Groups is set up to be online. At no time is there face-to-face contact. All the documents are created and signed by using Googles' documents, sheets and forms.

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A. *General Principles***:** The Board of Directors creates bylaws for the EMDR Trauma Recovery Group:

1. *Serious Work*: The work of the EMDR Trauma Recovery Group is taken very seriously.
2. *Teamwor*k: Establish the Organization Team. Our motto is, "Good things are done together."
3. *Planning*: Plan for methods to be applied, the budget and trainings.
4. *Use a Manual*: Prepare manual for each event/project.
5. *Invitation*: EMDR Trauma Recovery Group volunteers get calls from people wanting to be part of this project.
6. *Open Communication*: Always establish open communication. Create a WhatsApp group for those who want to help with social media
7. *Team Building*: Always work in teams. Build teams according to the event type; each team is provided with a supervisor and an experienced leader.
8. *Recovery*: Another motto is, "Ready to help, trained to assist recovery." Support workshops specific to the event and distribute manuals.

B. COVID-19 Online Psychological Support and EMDR Study

1. COVID-19 Target Audience

a. Who Becomes a Client? /Client Selection Criteria

1. Relatives of people who lost their lives due to the coronavirus.
2. Diagnosed persons and their relatives.
3. Health care personnel, law enforcement officers who serve civilians directly, municipal officers, the crisis management concerning the epidemic and the people working in support services.
4. Families of #3

2. First Steps: How it Starts?

a. Infrastructure for the online system is established.

b. The Supervisors Team was created to make decisions about how to proceed concerning supervision and the needs of the EMDR Trauma Recovery Team:

- The Supervision Team gives a workshop to all the volunteer EMDR Therapists on doing Online EMDR R-TEP Therapy.
- The Supervision Team prepares the manual for the event including the following:
  1. The Coordination Team creates a structure, functioning, policies and rules for the EMDR Trauma Recovery Group.
  2. The Coordination Team creates a video on how Online EMDR Therapy is done.

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3. The Coordination Team creates stabilization techniques for online platforms.
4. The Coordination Team creates a video on how to do Online R-TEP.

c. The Social Media Team creates social media strategic planning and the writes an application (for what?).
d. The Social Media Team puts out a call for volunteers.
e. The Social Media Team announces to the public that there is an online EMDR and Psychological support for people feeling fear and anxiety, Regarding the Covid-19 Pandemic.

3. Volunteer Application:

a. To be a volunteer in the organization, fill out the "Volunteer Application Form." This includes pertinent personal information, educational background, Level 1 and Level 2 EMDR training, number of years practicing EMDR therapy and a consent form for the EMDR Trauma Recovery Group and accepting the rules of the organization.
b. Assess the application and include applicants who have had an accredited EMDR Basic training, are volunteers for the EMDR Trauma Recovery Group and accept the rules of the organization.
c. Add to the WhatsApp groups of the EMDR Trauma Recovery Group volunteers.
d. The President of the EMDR Trauma Recovery Group and Consultants and Trainers choose team leaders and supervisors based on applicant's experience, performance and EMDR training level.
e. Create a WhatsApp group for each team. All information and correspondence is through WhatsApp.

4. Planning with the Supervisor Group

a. Determine client selection criteria.
b. Decide the interventions, protocols and stabilization techniques to be used.
c. Determine who gives what trainings for the professional development of the volunteers. For the COVID-19 pandemic, EMDR R-TEP (Shapiro & Laub, 2008) was chosen to help deal with the acute stress period.
d. Determine supervision times, frequency, length and settings.
e. Determine number of sessions for each client.

   Note: In the two studies with Syrian migrants and EMDR R-TEP, the average number of sessions was 4.13 and 4.16 (Acarturk et al. 2015, 2016). For the 1999 Marmara Earthquake, the average number of sessions was 5.2. Increase number of sessions when necessary.
f. Check in to see if difficulties are arising with clients and help to generate problem solving.

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g. Determine distribution of clients to therapists.
h. The Supervisors Group focuses on managing the most useful service for the public based on the circumstances and organizing learning and development opportunities for the EMDR therapists.
i. Supervisors of volunteer teams hold weekly online meetings to assess client progress.

C. Professional Development and Trainings

1. The Supervisors Group reviewed the literature and information on applications of online trainings/telehealth and prepared a manual distilling the best information on how to do online EMDR Therapy.
2. The training for online therapy was based on *The Manual for Online EMDR Therapy*. EMDR Recent Traumatic Episode Protocol (R-TEP) training was included in the manual.
3. Teach the EMDR Recent Traumatic Episode Protocol (R-TEP) training to volunteers.
4. A series of online seminars were given to explain this project to the volunteers. The importance of following every step accurately concerning using the forms, applications and criteria for clinical judgements was emphasized.
5. Offer seminars to increase the morale and motivation of the group by telling the story of how EMDR has assisted healing world-wide. This is supported by the recollections of the more experienced volunteers.
6. Support therapists working to help people affected by the pandemic through national and international webinars and YouTube channels. The channel name is "EMDR Travma Iyilestirme Grubu." Webinars and YouTube videos are private and can only be watched by the volunteer therapists. If you are interested, contact EMDR Turkey and become a volunteer.

D. Social Media and Press Release Announcements

1. The Social Media Team chooses the platforms, languages and promotion strategies to support EMDR therapy, the work of the EMDR Association and EMDR Trauma Recovery Group.
2. Provide updates by making online live broadcasts for the public, besides the social media posts.
3. During the live broadcasts, introduce the EMDR Trauma Recovery Group's work and purpose, explain EMDR Therapy and its effectiveness, teach the public about the symptoms they might be experiencing (psycho-education) during the pandemic.
4. Continue to inform all news agencies of the current work and create opportunities to participate in programs on television and radios.

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E. Triage: After the announcement of the study to the public, client applications arrive. These are the next steps:

1. Requests come through WhatsApp or e-mail, they are evaluated and if they meet the client criteria, the "Client Information Form" (Appendix 1) is sent. While the Trauma Recovery Group can intervene in any situation, primarily, it gets involved in projects for those directly affected by the event. Those affected directly by COVID-19 were selected as the target group.
2. If clients do not meet the criteria, they are not accepted for treatment. They are referred to other professionals and organizations where they can get free treatment.
3. Clients who exhibit psychotic or serious dissociative symptoms in the application or first session are referred to their psychiatrists.

F. Forms/Scales

1. There are three different forms within the Client Information Form (see Appendix 1). These are the following:
   a. Personal Information Form
   b. The Impact of Event Scale (IES-R)
   c. Consent Form
2. Clients acknowledge that the process will be online and the Impact of Event Scale (IES-R) is be filled out, after a week, and after a month, following the completion of the process. Clients are accepted into the study and into the system once they check all the boxes in the Consent Form.

G. Client Guidance

1. Therapists select the times and days they can work on the project. Each team consists of the therapists who have selected the same times and days of the week.
2. The Information Form is sent to the leader of the team that is working on the time and day selected by the client for the initial interview on the form.
3. For the first weeks, leaders will refer clients to the most experienced EMDR therapists. This way, less experienced therapists will have the opportunity to monitor and learn about the process once more via supervision. Cases will be given to less experienced therapists in the following weeks, once they are considered ready.
4. Therapists call the clients and make an appointment for an interview. Clients and therapists together determine the day, time and frequency of their sessions.

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H. Sessions – Framework

1. Sessions are online using applications such as Skype or Zoom. Clients are encouraged to use a wide-screened monitor, if possible.
2. Sessions are limited to 5 sessions. Additional sessions can be made if necessary.
3. Therapists will – under no circumstances – ask for payment, accept a fee for the session – even if clients offer – or direct clients to any organization or service that gets money for the service.
4. Explain that these 5 sessions will only be about the symptoms related to the pandemic and Covid-19 and other subjects will be excluded from the sessions.
5. Clients who drop-out or are having problems with their therapists will be contacted by the team leader and can be referred to another therapist.
6. Methods used:
   a. Therapists will apply EMDR R-TEP Protocol.
   b. During sessions, therapists will only use EMDR therapy.

I. Supervision

1. Each team has a supervisor. They meet online at least once a week. Therapists present their cases, explain roadblocks, describe the course of the sessions and receive feedback. Supervision meetings are 90 minutes.
2. The Supervisors change teams, once a month, to supervise other teams. In this way, therapists will be able to see different points of views.
3. The Supervisors make sure each case is on the right track (the best possible track), while also supporting inexperienced therapists to learn.

J. Closure Criteria

1. According to the EMDR R-TEP process, interviews are ended once all PODs are worked on and the Traumatic Episode is completed.

K. Monitoring/Follow-up

1. *The Impact of Event Scale* is submitted at least one week after the completion of the interviews.
2. *The Impact of Event Scale* is sent once more, at least one month, after the completion of the interviews.
3. Clients whose results have not improved and continue to experience symptoms are called back for further assessment.

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Statistics

Statistical results given below are the initial data obtained between March 26 and May 4, 2020. Obtained data are collected in a research format. Required permission is obtained with the Consent Form. Findings obtained after the program will be written in a scientific format and submitted to a vetted journal.

Note: There is a N = 426. The results below show only a fraction of clients as many have not yet finished the intervention. The rest of the data will be forthcoming and analyzed after the clients' completion of their interventions.

These are the tables with the data that has been analyzed so far.

1. Gender & Occupational Group Distribution of All Applicants

Table 1. *Gender Distribution of All Applicants*

Gender	**Frequency** (n)	**Percentage** (%)
Female	334	78.40
Male	92	21.60

Table 2. *Occupational Group Distribution of the Total Applicants*

Occupational Group	**Frequency** (n)	**Percentage** (%)
Health & Related Occupations (Police forces, Municipality, the Red Crescent, etc.)	219	51.40
Coronavirus Carriers	78	18.30
Relatives of Coronavirus Carriers	70	16.43
Relatives of Coronavirus Victims	59	13.84

2. Gender & Occupational Group Distribution of the Clients with Completed Treatments

Table 1. *Gender Distribution of Clients with Completed Treatments*

Gender	**Frequency** (n)	**Percentage** (%)
Female	79	79.8
Male	20	20.2

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Table 2. *Occupational Group Distribution of Clients with Completed Treatments*

Occupational Group	**Frequency** (n)	**Percentage** (%)
Health and related occupations (Police forces, Municipality, the Red Crescent, etc.)	68	68.7
Coronavirus Carriers	13	13.1
Relatives of Coronavirus Carriers	13	13.1
Relatives of Coronavirus Victims	5	5.1

3. Impact of Completed Treatments on the Results of IES-R Scale Levels of Clients

Histogram graphs were used for the two variables and score distributions were determined as normal. "T" Test was applied for the paired samples to determine the impact of the experimental process that was applied. "T" Test results are given in Table 3.

Table 3. *"T" Test Results of the scores obtained from the pretest and final rest for impact of event scale*

	N	**X**	**Ss**	**t**	**p**
Pretest	99	46.22	11.45	13.09	.00
Post Test	99	26.28	11.85		

According to the results -obtained from the "T" Test- that were applied to determine the impact of EMDR Therapy, post test scores are significantly different from the pretest scores ($t=13.09$, $p<.01$). The results show that the pretest arithmetic mean of the citizens effected by the Coronavirus is X = 46.22 while the post-test arithmetic mean is X = 26.28.

Preliminarily, it is possible to say that the EMDR Online Therapy is efficient in lowering PTSD symptoms.

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Appendix 1: “Client Information Form”

Personal Information Form

The Personal Information Form includes the following:

1. Name, Surname ____
2. Gender ____
3. Age ____
4. Telephone ____
5. Contact in case of emergency ______________________________
6. Email __________________________
7. Check the criteria that applies to you:
   a. ❑ Relatives of the persons who lost their lives due to the coronavirus.
   b. ❑ Diagnosed persons and their relatives.
   c. ❑ All the health care personnel, law enforcement officers who give service to these persons directly, municipal officers, the crisis management concerning the epidemic and the people working in support services.
   d. ❑ Families of all the health care personnel, law enforcement officers who give service to these persons directly, municipal officers, the crisis management concerning the epidemic and the people working in support services.
8. Job ____
9. City ____
10. For health and similar employees, have you made close contact with someone diagnosed with coronavirus (COVID-19)?
11. For health and similar employees, are you in a team directly in contact with coronavirus (COVID-19)?
12. Preferable times and days for treatment

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The Impact of Event Scale (IES-R)

Administer the IES-R pre and post treatment.

Online Consultancy Consent Form

The example below shows the type of consent form we have used for this study:

Dear Client,

This is the Online Consultancy Consent Form we are using for our study. Please read the information carefully concerning your rights and our responsibilities. This information is important for us to serve you better and to support the online consultancy process more effectively:

1. For many years, online therapy has been used all over the world as a practice proven to be effective in terms of psychological health when face-to-face interviews are restricted or inappropriate.
2. The success of our study depends on the cooperation and open communication between client and therapist.
3. What is spoken during the session will remain between you and your therapist, unless you give your consent for the therapist to consult with someone else. However, in cases such as abuse, suicide risk, or threat to yourself or your relatives, we may share information about you with the legal authorities, in accordance with our professional ethical principles and laws without your permission.
4. We believe the data collected is scientifically valuable and can be used for academic purposes. However, all information concerning your identity will be encrypted.
5. Sessions take 50 minutes. However, the meeting period may exceed 50 minutes or may take a shorter amount of time, if deemed necessary by both parties.
6. You can ask your therapist about the therapy process, and his or her training and experience.
7. If your therapist arrives late for the session, your session time will still last 50 minutes. When you arrive late for the session, your therapist does not add to the interview time, the session ends at the normal time. It is your responsibility to be on time.
8. We will do everything to ensure that you will not be disturbed during the session, The door of the room will be closed. You are also responsible for ensuring that these sessions are not disturbed as well: please turn off any screens that you bring into the session. Do not use alcohol or drugs before the session, as they may interfere with your therapeutic experience. Your therapist may suggest that you contact a psychiatrist to assess your condition, if necessary.
9. The sessions will **not** be recorded digitally. Clients' privacy will be protected by encrypting the personal data you provided. If you approve the informed consent form, you undertake to protect the privacy of the therapist under the law of personal data protection. In other words, you agree to not make any type of recording of the session.
10. By accepting the above conditions for online therapy, you are saying that you understand these conditions and agree to each of them. You also agree not to record any part of the sessions or allow others to listen to the sessions by phone or other devices without prior agreement.

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11. If you behave in a disrespectful manner such as engaging in verbal insults, long speeches or unsuitable behaviors for the situation, your practitioner may end the conversation.
12. Once you have filled in the Application Form, all data but especially the question asking you "the reason of your application," is protected by our center under the law of personal data protection of Turkish law.

*I accept the online sessions. Also, I agree that I have read and understood this Statement of Consent.**

* I approve as the legal guardian of those under 18 years of age.

If you fill in and confirm the information below, you agree to continue your online sessions with our therapist.

Date: ____

Name (printed): ____________________________________

Signature:____

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8

The Global Child-EMDR Alliance

Ana M. Gomez

When the Coronavirus crisis became a reality for all of us, initial despair and fear took over. Clients of all ages were reporting increased anxiety, stress and fear. Uncertainty was free-floating amongst all of us. However, I was reminded of the incredible resiliency and strength that we all possess, especially when we work together. At this point, I knew this was much bigger than anticipated and required a much greater response. I remembered the story of the Tabonuco trees that had survived for many years in very rough terrains and strong hurricanes, in addition to structural instability. These trees survived through collaboration as they hold each other's roots to exchange nutrient and provide support to sustain the strong winds.

This is when the idea of creating a global alliance came. Immediately, I started to call child and adolescent EMDR trainers and experts around the world. When I mentioned the idea of organizing a global group that could help our children and youth, it was received with incredible passion and excitement.

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Quickly, trainers and consultants from the UK, Ireland, Turkey, Holland, Germany, Japan, Australia, Ecuador, Brazil, Argentina, Canada, Colombia, Puerto Rico, Ireland, Italy, Spain, the USA and Israel joined initially. Now, we have child EMDR leaders, trainers and consultants from over 30 countries in our Global Alliance.

The resources I am presenting here have been created by an incredibly dedicated group of people. This group has worked diligently and tirelessly to create webinars at no cost for EMDR clinicians. Story books, songs, guidelines and resources for emotional regulation and much more for children, adolescents, parents and EMDR clinicians have been created in a short period of time. We have followed the teaching of the Tabonuco trees and are holding each other as we get through this difficult time.

The Global Child-EMDR Alliance has formed four basic groups and added different task forces to divide the work load:

1. Children
2. Adolescents
3. Parents
4. EMDR Clinicians (Social media)

Each task force has been responsible for developing resources for that specific group as well as supporting each other's efforts. Resources developed have been quickly translated into multiple languages.

Below, is a summary of some of the current resources being distributed to all EMDR clinicians as well as children, adolescents and parents. It is important to highlight that we have done all this work with very little financial support and we have all donated our time, our resources and in some cases our own money.

In the future, when we have the resources to put our website online: **www.globalchildemdralliance.com**. All of our material will be available there.

In addition, there are three YouTube channels:

1. Spanish/Portuguese:
   https://www.youtube.com/channel/UCh36gfueRMq9zTiYqiRG4wA?view_as=subscriber
2. English and multiple languages:
   https://www.youtube.com/channel/UC1RyVUunlxD-7G1cTn7ymIA
3. Turkish & English:
   https://www.youtube.com/channel/UCQs45EkJvyRmwnQt6bCeNg?view_as=subscriber

In the meantime, please download what is available on my website's COVID-19 resources page and contact me with your information if you would like to be informed when the Global Child-EMDR Alliance is up and running: **https://www.anagomez.org/covid-19-resources/**

Also, there are other websites available below for your immediate use.

Note: If you see a resource without a website or contact information, it will be available on the website or the YouTube channel at a later date.

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Global Child-EMDR Alliance Resources

Free Webinars for EMDR Clinicians

Close to 15,000 clinicians from all over the world have registered to attend our past free webinars. These webinars remain open and available for viewing and new ones will be offered in the future. We also have our own YouTube channel where you can continue to access our free resources.

1. **Recording of *EMDR Child Therapy During the COVID-19 Crisis Webinar***: Organized by the "EMDR Clinicians Task Force" (presenters in alphabetical order: Amy Terrell (USA), Ana M Gomez (USA), Ann Beckly-Forest (USA) & Susan Darker-Smith (UK)) **https://youtu.be/55tVV9RzRr8**

2. **Recording of *EMDR Adult Psychotherapy During Corona Crisis Webinar***: Invited presenters in alphabetical order: Dolores Mosquera (Spain), Isabel Fernandez (Italy), Kathy Steele (USA), Tamra Hughes (USA). These presenters also donated their time.

   Adult Covid**: https://youtu.be/yQMhZ39ktnI**

   https://www.youtube.com/watch?v=yQMhZ39ktnI&feature=youtu.be

3. **En Español Grabaciones: Terapia EMDR con Niños en Tiempos del COVID-19**: Presenters in alphabetical order: Ana M Gomez (USA/Colombia) & Glenda Villamarin (Ecuador). **https://www.youtube.com/watch?v=xQuiZBs1OvA**

4. **Recording of "*The Corona Times: Navigating the Challenges & Building Bridges with our Teenage Clients***: Organized by the "Adolescent Task Force."

   Presenters in alphabetical order: Alexia Tsilimpokou (Greece), Annie Monaco (USA), Eva Malte (Denmark), Jillian Hosey (Canada), Joel Manzano Mojica and Maria Lopez (Puerto Rico) **https://youtu.be/Yug9eh0N_Ws**

5. **Recordings: Parenting Times in Coronavirus Era**: Organized by the "Parent's Task Force"

   Presenters in alphabetical order: Cathy Schweitzer (USA), Debra Wesselmann (USA), Maria Zaccagnino (Italy), & Stefanie Armstrong (USA)

   https://vimeo.com/409766915

6. Free Webinar, sponsored by the Children's Task Force. This presentation will be available in our YouTube channel: Presenters in alphabetical order: Ana M Gomez (USA/Colombia), Daniela Lempertz (Germany), Derya AltinaY (Turkey), Esty Bar-Sade (Israel) Linda McGuire (Ireland), Michel Silvestre (France), Susan Darker-Smith (UK).

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Books & Workbooks for Children

1. ***Hili and the Coronavirus***
   Esty Bar-Sade (Israel)
   Available in the following languages: English, Arabic, Hebrew, Japanese

2. ***Little Zebra's Lovey Dance***
   Derya Altinay (Turkey)
   Available in the following languages: English & Turkish
   https://www.youtube.com/channel/UCQs45EkJvyRmwn-Qt6bCeNg?view_as=subscriber

3. **Journey to Atlantis: Reaching the Resources During Coronavirus Times**
   Derya Altinay (Turkey)
   Available in the following languages: English & Turkish

4. ***Beating the Virus and Winning the World***
   Linda McGuire (Ireland)
   Available in the following languages**:** German, Hebrew, Turkish, Japanese.
   https://youtu.be/btevHHzMoUQ

5. **Corona de Invisible**
   Linda McGuire (Ireland)
   Available in the following languages: English, Turkish
   https://youtu.be/9ciy87C1xt8

6. **The Seashell**
   Susan Darker-Smith (UK)
   Available in the following languages: English, Polish

7. **Max and the Virus, Max and His Sister & Max Going Back to School**
   Michel Silvestre (France)
   Created in Doodle by: Susan Darker-Smith (UK)

8. **How to Talk About Coronavirus to Children**
   Anna Rita Verardo (Italy)
   Available in the following language: Italian, English & Japanese
   https://www.facebook.com/AssociazioneEMDRItalia/videos/496523731025383/UzpfSTE0ODc5NDE0NDY6MTAyMjIzNDc3NTU5NTEyNTY

9. **The Story of the Oyster and the Butterfly: The Coronavirus and Me**
   Ana M Gomez (USA/Colombia)
   Available in the following languages: English, Spanish, French, German, Hebrew, Portuguese, Japanese, Serbian, Chinese, Hungarian, Creole, Greek, Albanian, Romanian, Italian, Turkish, Polish, French, Tamil, Finnish, Afrikaans, Albanian, Estonian
   https://www.anagomez.org/covid-19-resources

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10. **The Coronavirus Helping Box (EMDR version)**
    Ana M Gomez (USA/Colombia)
    Available in the following languages: English, Spanish, Portuguese.
    https://www.anagomez.org/covid-19-resources

11. **The Story of the Global Child-EMDR Alliance**
    Susan Darker-Smith (UK)

12. **My Book of Resources**
    Alexandra Kerasioti & Alexia Tsilimpokou (Greece)
    Available in the following languages:
    English ≈ **http://online.fliphtml5.com/zdfdw/hvuv**
    Greek ≈ **http://online.fliphtml5.com/zdfdw/yemx**

13. **Just Like the Cactus**
    Alexandra Kerasioti & Alexia Tsilimpokou (Greece)
    Available in the following languages:
    English ≈ **http://online.fliphtml5.com/zdfdw/ochb**
    Greek ≈ **http://online.fliphtml5.com/zdfdw/ikiy**

Songs for Children During Corona Times

1. **The Lovey Dance**
   Derya Altinay (Turkey)
   Available in the following languages: English, Turkish

2. **The Oyster Dance**
   Derya Altinay (Turkey)
   Available in the following languages: English, Turkish

3. **Oh Corona**
   Linda McGuire (Ireland)
   Available in the following languages: German, Hebrew, Turkish, Japanese.
   https://www.youtube.com/watch?v=0DPTKXRTCf0

4. **D-Do the Dance!**
   Susan Darker-Smith (UK)

5. **Rainbows follow Rain / Love is the Connection**
   Susan Darker-Smith (UK)

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Additional Resources for Children

1. A video showing children how to use strategies for self- regulation is now available. This video was recorded by the "Children's Task Force." In alphabetical order: Ana M Gomez (USA/Colombia), Daniela Lempertz (Germany), Derya AltinaY (Turkey), Esty Bar-Sade (Israel) Linda McGuire (Ireland), Susan Darker-Smith (UK)

   https://www.youtube.com/watch?v=wirIpC6T3fo

2. The "Children's Task Force" has created a survey using Survey Monkey which is being distributed now seeking to investigate the main issues children are still struggling with and the resources that they are utilizing to help themselves that have been effective. Developed by: Linda McGuire (Ireland), Susan Darker-Smith (UK)

   https://www.surveymonkey.co.uk/r/WLBRGCS

   We will utilize the information from this survey to better serve our children and create additional EMDR resources.

3. The Butterfly Heart Hug
   Linda McGuire (Ireland)
   https://www.youtube.com/watch?v=9LhJXFC3UOU

Books & Stories for Adolescents

1. Noi, adolescentiiin vremea coronavirus ului INSTRUCTIUNI PENTRU SUPRAVIETUIREA EMOTIONALA
   Anna Rita Verardo (Italy)
   Available in the following language: Italian

2. The Corona Times
   Jillian Hosey (Canada)
   Available in the following languages: English, Finnish, Greek, Spanish, Romanian, Danish, Hebrew

3. The Teen Mandala Book: My Guide to Coping with Coronavirus
   Joel Manzano & Maria Lopez (Puerto Rico)
   Available in the following languages: Danish, Spanish, Arabic, English, German, Greek, Hebrew, Italian, Japanese, Portuguese

Resources for Parents

1. Help for Parents and Caregivers During the Time of the Coronavirus
   Available in the following languages: Danish, English, German, Italian
   https://www.youtube.com/watch?v=hFfwK40Oodc (English version recording: "Help for Parents During COVID-19" created by the Parent's Task Force).

2. Italian version recording: "Help for Parent During COVID-19" created by the Parent's Task Force and Presented by: Maria Zaccagnino (Italy).
   https://www.youtube.com/watch?v=mNgk96G06Uo

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3. German version recording: “Help for Parent During COVID-19” created by the Parent’s Task Force and translated by Daniela Lempertz (Germany).
   https://youtu.be/jvFwQzak4XA

4. Japanese version recording: “Help for Parent During COVID-19” created by the Parent’s Task Force and translated by Miyako Nishi Shirakawa and Japanese team (Japan).
   https://youtu.be/-ceGN6_QN1Y

5. Spanish version recording presented by Glenda Villamarin (Ecuador) from the Parent’s Task Force: “Help for Parent During COVID-19”
   https://vimeo.com/409796553?fbclid=IwAR1UG2telp688J1ITasCJ8rQ7rbwiXyeJv5lpPRUk3W5T-puPX78K_BXjQg

Social Media

1. The “Clinicians Task Force and Social Media” has created a Facebook page for the Global Child EMDR Alliance and a Facebook group:
   https://m.facebook.com/pages/category/Mental-Health-Service/Global-Child-EMDR-Alliance-110539197240016
   This is where resources created by the Global Child EMDR Alliance are shared with clinicians and the public. Amy Terrell (USA) & Ann Beckly Forest (USA) have worked diligently to maintain these groups.

2. “La Alianza Global Infanto-juvenil de Iberoamérica” has a Facebook page and the group has a YouTube channel, also:
   YouTube ≈ **https://www.youtube.com/channel/UCh36gfueRMq9zTiYqiRG4wA?view_as=subscriber**
   Facebook ≈ **https://www.earlyemdrintervention.org**
   https://www.facebook.com/alianzaglobalemdrinfantojuvenil/photos/p.102040911500381/102040911500381/?type=1&theater

3. The “Adolescents Task Force” has created an Instagram account for teens
   https://www.instagram.com/globalchildemdralliancetr

4. We have three YouTube channels:
   a. One developed by the Spanish speaking countries members of the alliance:
      https://www.youtube.com/channel/UCh36gfueRMq9zTiYqiRG4wA?view_as=subscriber
   b. The YouTube channel for resources in English and multiple languages
      https://www.youtube.com/channel/UC1RyVUunlxD-7G1cTn7ymIA
   c. Turkish & English created by Derya Altinay (Turkey) and her Turkish team:
      https://www.youtube.com/channel/UCQs45EkJvyRmwnQt6bCeNg?view_as=subscriber

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Translation

Multiple translators around the world have supported our efforts. Many of them are our own Global Alliance members. We are incredibly grateful for their help and support.

Logistics

I want to recognize the work of all the people that have done significant logistics work and donated their time to support the Global Alliance's efforts such as Jim Mason and many of the Global Alliance members' partners, family and friends.

This is truly an inspiring group of people -from around the world- who came together and created massive amounts of resources, in just five weeks. This group is showing the power that we have when we work together and in collaboration. This pandemic has brought pain and grief but has also brought out the best in all of us and this group is a testimony to this. I am honored to be among such a compassionate, wise and remarkable clinicians and human beings!!
I want to recognize the work of all the people that have done significant logistics work and donated their time to support the Global Alliance's efforts such as Jim Mason and many of the Global Alliance members' partners, family and friends.

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Therapy in a Time of Turmoil
Transcription from Livestream Webinar

Deany Laliotis

Introduction

I am grateful that we can all gather together during this very uncertain time. I am truly moved by the extraordinary response to this seminar, as it speaks to the level of commitment we have as a community to healing and helping people during this time of crisis and turmoil. I am also honored to be part of your journey to become a better therapist in the face of these new set of challenges.

Our lives and our work are not the same as they once were. I hardly recognize it. For me, it's been three weeks since I've seen my family, my friends, my colleagues and my clients. For some of you, it's just starting to happen now, and for others, it's been this way for months already.

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Nervous System When Under Threat

However long it's been, our nervous systems are all getting the message that we are under threat. Our sense of safety has been ruptured, our sense of continuity all but gone, and we're deluged with stories about life and death while we deal with the inherent uncertainty of our times.

So, how is your system responding? Are you plowing through as if everything is under control? Are you over functioning, particularly with clients who are really struggling? Are you numbing out, minimizing what's going on; perhaps avoidant, or getting too much into the weeds with the details? Are you eating a little too much chocolate drinking too much alcohol, or staying up watching the news and not getting enough sleep because you're so agitated by the time you go to bed?

Herd Mammals & Connection

You've probably experienced most of the above responses, as you, too, are struggling with the uncertainty and unpredictability of what's happening. We are all experiencing some level of fear. As herd mammals, we are wired to feel it together, as if we're being chased by a predator in the wild. That's the good news and the bad news. The good news is that we can come together as we have here today to stay connected to one another…to be in our herd. The downside is that fear is contagious. We can fuel one another's fears, too. Our client's fears can easily touch into our own… and then what? Well, of course that will happen. It's inevitable as we go through this together.

Resourcing vs. Reprocessing

One of my consultees was describing working with an Infectious Disease doctor as her client. He is working on the front lines of this pandemic and is anxious and exhausted. He shares with his therapist that they tried a viral remedy at the hospital that made the COVID patients worse. He is fearful that they will not be able to help them get better. Meanwhile, the therapist is asking questions in consultation about how to best proceed with this client, feeling like he was too overwhelmed to proceed with memory processing. What became clear as we continued to talk about it, was that SHE, TOO, was feeling fearful about whether or not she could help HIM! Once she was able to make the connection, (that is, that his fear became hers), she got really clear that the client was resourced enough to tolerate the processing and that would be far more effective than resourcing strategies.

That's actually been one of the big questions in every consultation group I've done in the last three weeks. Therapists were saying that because there is so much stress that we should just be focusing on stabilizing our clients…well, maybe that's true, but maybe, that depends.

Transitioning to a New Way of Doing EMDR Therapy

Questions like this one among many, many other concerns, is what prompted me to offer this seminar. My email has been blowing up with questions about how to transition to an online format; how you actually administer the processing, and, oh, by the way, what should we be focusing on when our clients are presenting with a crisis of one kind or another?

By now, many of you have figured out the technical aspects of administering EMDR processing procedures online, and there's a lot out there about it, so we won't be focusing so much on that

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today. Implicit in these queries, however, is the recognition that we are all in unchartered territory. *My goal for us today is for you to walk away feeling like you're not going at this alone; but instead, you are a part of the herd of EMDR therapists all over the world, and that you're walking away with a deeper appreciation of the inherent challenges of being a healer during a time of crisis*. Some of you might remember Fracnine teaching about issues of safety and talked about the "fear of being cut out of the herd." We're in that fear. For us as a community, this is a time for social cohesion and mutual support. We need our community to remain resilient if we are going to continue to bring our best selves to this work in this time of turmoil.

Switching to a Virtual Platform

I recently came home from a ski vacation on March 14th just as the crisis was escalating in this country. I was concerned about my exposure after being in crowded areas such as passenger vans, buses, trams, and of course, airplanes, with people from all over the world. My husband, Dan, and I made the decision that switching to a virtual platform was the only socially responsible thing to do. So, I contacted all my clients and consultees via email of this decision with detailed instructions on how to access the platform. One client, who has severe attachment issues, reacted with anger, feeling alone and abandoned. I shared my concerns with her, but it didn't help. Reluctantly, I agreed to meet with her in person, observing the social distancing guidelines, to see what we could figure out.

So, clearly, she was being triggered, but there is also a truth to her experience. She may not actually see me in person for a long time. For someone who was abandoned as a child, that's a major crisis. In our in-person session the next day, I shared with her my concerns about being exposed and exposing others, and, in addition to not seeing my clients, I also was not seeing my aging mother, who lives alone, or my kids or grandkids. I didn't want to take the chance that I could get someone sick.

My willingness to be open and transparent with her, to share my fears and my own personal sense of vulnerability helped us turn the corner together. She discovered that she was not alone in her experience. We were actually going through it together. Yes, this is our *collective trauma.*

What I learned from her early on in this crisis was that being more transparent, or HUMAN, was necessary. Rather than concealing my fear, I shared my personal experience in a way that offset her feeling alone. I used a most valuable and real resource…our connection.

How Do We Stay Grounded in this New Normal?

Now, is every client going to welcome our self-disclosures? Probably not. Some of our clients will find it more anxiety-provoking to bring them into a shared reality. That said, *how do we keep ourselves grounded in our own experience while, at the same time, navigating the needs of our clients?*

Offering Hope with Stories of Triumph

I think there are a number of dimensions we are all managing as part of this situation. The first one is about life and death, as I indicated earlier. We ARE under threat. People are dying and going to continue to die, some, needlessly. Some of us will lose someone we love. Some of you

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may have already lost someone you love. You may or may not have been able to see them before they died. That makes me think about what I have to say to people I really care about like my mother, for example, who is 85 and lives alone. What if I don't see her again in person? What do I want her to know? In addition to talking to her every day, I am writing her letters and putting them in the mail so she receives them in hand (after wiping, of course) and can read them the old-fashioned way…sometimes over and over again. With each letter, I share my appreciation for her and my father, particularly, what is helping me get through this. As a first-generation immigrant from Greece who came to America after the second world war, she had the experience of coming to this country experiencing a very different life…suddenly. She had no extended family, no friends, no language, no sense of place, no sense of belonging. Yet, I grew up in community, feeling safe and nurtured. My parents came with nothing and made a life for us. That is a story of triumph over adversity. It's important that we look for these kinds of stories, for ourselves, and for our clients. It keeps us hopeful that we, too, can get through this.

Another client of mine has a brother who is currently in the hospital because of a sudden diagnosis of late-stage colon cancer. She received a call from him last week just before our session that this may be the last time they speak to each other. She was devastated. He is alone in the hospital and he may die alone. She is bereft. They only recently reconnected after years of being estranged…so, the impending loss created an opportunity for conversations they might not have had otherwise.

Along the lines of life and death, our friends with whom we went on vacation with, tested positive for the virus. While they were experiencing symptoms the week before, I am meeting with my clients and consultees, while quietly managing this pit in my stomach. "*Are they going to be okay???" "Are we going to be okay?" "How am I going to handle it if they get really sick...if I get sick?*" Good question, when you have people who are depending on you as a source of support. So, I ask you, have you thought about how you're going to handle it with your clients if you get sick???

So, with the same client I shared with you earlier who felt alone and abandoned, I brought it up with her in our next session (which was virtual). I really wasn't sure how to handle this probability, or what the best course of action would be. Of course, not everyone is the same. But some clients are more vulnerable than others, so, this time, I decided to enlist her in the conversation. So, I asked her, "*How are WE going to handle it should I get sick*?" We discussed how she wanted to be informed; if she wanted the option to meet with someone else if it was a prolonged illness, etc. Ironically, she was actually relieved and reassured by the conversation. You can be sure all of our clients are all wondering about that same thing. Again, being more transparent and relational helped. There was no magic bullet.

There Are No "Right" Answers

I think the other part of it for me was that I truly didn't know what the "right" answer was. That needed to be okay, too. If I could give myself permission not to have the "right" answer, and allow myself and her to struggle with it, maybe that's as good as it gets some of the time. That has been another important lesson.

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Staying Present

Also inherent in that lesson is the importance of staying present in a moment to moment way. As EMDR therapists, we're good at that. We track the unfolding of experience in real time helping our clients tolerate NOW what they couldn't tolerate at the time. So, when our clients are coming into session struggling with the uncertainty and discontinuity of their lives, the challenge is to bring it into the moment. So, when my client was saying, "*I feel soooooo alone*," she needs me to help her discover that she can tolerate her fear now in a way she couldn't before, AND she is not alone in it. That's one way we help co-regulate our clients' experience. That, however, requires US to be grounded in the present moment, feeling into the familiarity of the connection, while at the same time, managing our own sense of loss and disruption. It's easy to get swept into the *contagion* of the moment, and before you know it, you've spent the better part of the session listening to their anxiety and fear rather than helping them with it.

The Importance of How We Listen

So, while we do need to listen to our client's stories, HOW we listen is more important. As I say to my students, "*Our clients will do in EMDR processing what they do in their lives*." And, in this time of crisis and turmoil, that is even more so the case, both for us as well as for our clients. How we do what we do, or don't do, for that matter, is amplified. So, if you're more on the avoidant side, it's easy to listen to the crisis of the day, and get seduced into the details of the pandemic, rather than to *also* listen with that third ear. Third ear listening goes something like, "*How is my client's reaction to shifting to a virtual platform, for example, indicative of the issues we're working on in therapy*? So, for my client who was really angry about having to make this shift, it wasn't just about her abandonment issues, it was also about her inflexibility, which is a habituated pattern of response for her. It was an opportunity to talk about how her upset about the change she had no control over was self-inflicted, and that it was her reaction that was the source of her suffering. So, we were able to talk about how she learned that that's what there was to do; to get angry (rather than scared or sad, or hurt) and agreed to work on it as a Target Memory (TM). In this case, the Floatback took us to a TM of watching her parents have a violent fight after her mother had done something her father disapproved of. Not surprisingly, the memory was about witnessing this pattern of behavior in others, rather than something that had happened to her. The other issue here is that the unpredictability of her childhood situation makes change REALLY hard for this client because change is experienced as a threat; that something bad is inevitably going to happen.

We Can Help Clients Change in This Time of Rapid Change and Uncertainty?

But you know what? Change **is** hard and these are HARD TIMES. So, how do we help our clients in this time of rapid change and uncertainty? In this example, I took it as an opportunity to make a past-present connection, work on the memory network of threatening experiences in her childhood in the service of helping her respond more adaptively to the changes in the near future. So, how do we decide whether to, 1) continue with our EMDR work using the standard protocol with the current context; or 2) when do we pivot away from what we've been working on and narrow the focus, using recent events protocols, stabilization interventions, crisis intervention strategies, or targeting current triggers with EMD?

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QUESTION #1 – **From the Audience**: This question is from California: *"I've been social distancing since March 12th, offering virtual EMDR sessions using bilateral audio where I'm able to control the length of the BLS passes. I'm only seeing my EMDR clients that have excellent ego strength, low dissociation, low-stress conditions and healthy supports at home. The sessions are going very well, and clients are expressing relief that it feels equivalent to being in my office. I've stopped doing EMDR with my C-PTSD clients, though. I'm hoping you can give some guidance on working with people at a distance that might need EMDR processing but are more challenging to work with. I fear not being able to sense their needs in the room or to intervene in a crisis. My instinct is to continue but would appreciate any guidance you could offer for working with dysregulated and challenging clients via telehealth."*

Wow, what a great question! I'm sure everyone is struggling with this right now. There isn't **an** answer to your question, but I do think there are guidelines. First of all, I'm glad your instinct is to continue. That's really great! I understand your reasoning that, for clients whose level of psychosocial functioning is not as high, you want to be more conservative. However, we need to task ourselves around what is factoring into our clinical decisions?

We want to be careful about withholding treatment or making an arbitrary shift away from trauma work to resourcing and stabilization just because there's a lot going on right now AND your client has C-PTSD. Yes, there's a lot going on right now. And yes, many of our more complex clients are really struggling. And yes, if they are getting further destabilized by their circumstances in a way that threatens their safety, then stabilizing them is absolutely what there is to do. And, part of the work also involves tasking your clients around what they need to be doing for themselves in between sessions. This needs to be a *team effort*. From our end, we need to offer what we can to keep them from having to be psychiatrically hospitalized, especially right now, because there's a really good chance they will be further traumatized, if they can even get in at all.

Even with clients who are not as debilitated but are easily challenged and dysregulated by these circumstances, doing some EMD to desensitize the trigger, and rehearsing the use of an established resource to help them cope with their anticipatory fears in the near future using future rehearsal is a good idea, as you suggested. That's what the *recent event protocols* are about: focusing on the most disturbing part, then the next most disturbing part, etc., without opening up the memory network. Again, we want to be mindful of what is informing our choices. The client I referred to earlier who was triggered by the change to an online format has complex PTSD. She has a disorganized attachment, a personality disorder, she doesn't work, her husband died, and she lives alone. I made the decision to meet with her in person when I did because I knew she was in real trouble. So, I made the adjustment. She's stable again, so we can continue with the work. AND, what stabilized her was that I met her in her distress, but also asked her to step up to meet me in making the adjustment.

Pros & Cons of Working Virtually

That said, a question I have is this: If you could continue to see your clients in the office while we were going through this pandemic, would you still change course? In other words, how much of your reluctance is informed by the inherent stressors of the circumstances and your clients'

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reactions to it, versus doing the work on a virtual platform that is both new for you as well as your clients? If it's more about THAT, then let's talk about the pros and cons of working virtually and how making some adjustments in HOW we work online can make it work!

Here's what I know and have heard from colleagues about their experiences with virtual EMDR therapy:

- *It's more challenging for us as well as for our clients.*
- *It's exhausting. It does gets better with time.*
- *It can be more difficult to track the client's experience virtually. Yes, but we can learn.*
- *It's more demanding for us because we can't see the client's entire body to track the subtle non-verbal cues or shifts in the client's experience. Yes, that's true, so develop your virtual felt sense. Not everything needs to be tracked visually.*

It can be more difficult to maintain contact online versus in person, especially during reprocessing. In fact, you will be oscillating between connection and disconnection.

Think of it through an attachment lens: How is a client who has an anxious attachment likely to respond to EMDR processing online? You can you can help them adjust by inviting them to FEEL into the familiarity of their connection with you. How about an avoidant? Actually, avoidants do quite well online. Now if you, the therapist, are also more avoidant, that may not work out as well as a combination. How about the client who has a disorganized attachment and is easily dysregulated? You're going to have to work harder to keep them present. You punctuate the work with more time in between for grounding and reorienting. These are topics for another time, but for now, it's one of the lenses you can look through.

While these are all variables, if not demand characteristics of working online, we ALL need to make the adjustment if we are going to maintain the continuity of care for our clients. It's not a matter of whether or not to continue with EMDR therapy virtually. It's a question of how? Everyone I have done memory reprocessing with who made the transition from in person to online unilaterally were surprised that it worked as well as it did. They report that it's not the same as being in person. That's true. But it works, and, it works well. You have to establish how the BLS is going to be administered. My suggestion is that you try to mimic what you've used in the office. With one woman, who uses multiple modalities because, she purchased an inexpensive app that has audio, too. And, from time to time, she is also tapping herself.

More importantly, here's what I've learned from my clients:

- In the first couple of meetings, I've *asked more often* throughout the session *how they're doing,* both in and out of processing.
- I ask *what helps in the processing/what doesn't*. I acknowledge that we're both on a learning curve and appreciate their patience.
- *Using my voice during sets helps keep them connected* to me and helps with dual awareness for the client; sometimes, I *shorten the sets* and *take more time in between sets.*
- With clients who are *good at self-regulation*, I let them start and stop the set.

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- *I use my nonverbals* more.
- *I ask about the body* more often.
- *Check in with the client more frequently* (sometimes because I'm not sure; other times because I want to cross-check my assessment of what is happening to make sure I'm on track). Yes, I'm learning, too.

How Are We Doing?

Another factor that we need to talk more about isn't about our clients. It's about us. We're going through a lot, too. If you're feeling overwhelmed right now because of what is going on; your situation at home is stressful; your clients are struggling; or someone you love is sick; in the hospital or worst case, has died, you should be thinking seriously about your ability to stay present to the client's experience and keeping them safe. This is not the time to push through. This is the time to reach out for support. We're in this for the long haul, so we need to be thinking more about how we're going to be taking care of ourselves so we can continue to be available to the people who are counting on us. So, if that's the case, then YES, it is a REALLY good idea to slow things down.

Starting with New Patients Virtually

QUESTION #2 – From the Audience: *"Should we take on clients we've not met in person and go beyond stabilization with EMDR?"* I hate to say this, but *it depends*. As Francine always said, "this is not a cookie cutter." Our job is to figure out how to best meet the needs of our clients given both the external as well as internal resources and variables. That includes in person versus virtual. Another important factor is *timing*.

What is the *level of urgency* to help this person? Is it imminent, as it is with these front-line health-care workers? In times like these, resourcing may end up feeling like plugging up a hole that spouts up somewhere else. At other times, it may be more prudent to wait.

While I have taken on clients virtually that I have never met in person, there is a woman that I met with recently (virtually), that, after three sessions, we mutually agreed that it would be best to wait until we could meet in person. The decision was based on the fact that there was no longer the urgency to address the issue as it had subsided; and, there were extended family staying at her house right now that would make it more challenging to carve out the time and the privacy she would need. We left it open that, if she changed her mind, she could contact me. Otherwise, she will check back in once we can resume in person meetings.

In the first vignette, I referred to a case where the therapist was struggling with her client who is an Infectious Disease doctor and was struggling with whether to stabilize only or proceed with processing? This patient is someone she has never met with in person, and because of his home situation is meeting with her in his car. They used the current stressors in the hospital and his NC which is, "*I'm not enough*," and it readily linked to specific childhood experiences. She enlisted him in the decision about whether to proceed with processing or not, and his response was

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overwhelmingly, YES. So, their plan is to target the recent trigger(s) in the hospital ER using the Full standard protocol, allowing it to go back to the past, but not to "*just let whatever happens, happen.*" We discussed the urgency of getting symptom relief in the present in order to optimize his current level of functioning, in part by taking some of the pressure off from the earlier memories and taking it back to target more frequently. IF, the client was to start getting overwhelmed, the therapist knows to close down the channels of association and shift to EMD on the current trigger.

In a situation like this, you can argue for using a recent events protocol, which also makes sense. However, in this case, his trauma is ongoing, and taking the pressure off from the earlier memories, as long as he can handle it, will yield far better treatment effects.

Now, having said all this, I have to circle back to the therapist. In this example, I know this therapist is very capable of managing uncertainty in memory processing and is very good at making on the spot adjustments to help keep her clients emotionally safe. If this were a more novice therapist, or a therapist who is particularly risk-averse, we would be having a different conversation.

Loss of Continuity

I'd like to talk about what else we're all going through. We've *lost our sense of continuity*. There's not as much we can count on right now in the same way we could before. Change is one thing; disruption is another. We can get so over focused on this situation that we lose sight of what we can do for ourselves and our clients to help maintain a sense of continuity.

One of my consultees was expressing frustration that she is finding herself functioning more as a crisis counselor than a trauma therapist. She went on to describe working with a client online who is home with her family and who was frequently being interrupted by family members coming into her room during the session. I asked the therapist how she responded to the situation. She went on to describe her frustration because the family was being disruptive, and she couldn't control for it. She went on to describe that an additional frustration what that she was finding herself putting out more fires for her clients rather than doing trauma work. So, I asked her, "*By the way, what are you working on in therapy with this client that you're having such a hard time getting to*?" She replied, "*We're working on helping her have better boundaries."* Of course, as soon as she said that, we all laughed, as she realized what had happened. Instead of harnessing the opportunity to help her client "in vivo" with the issue they had been working on, she instead, went into problem-solving mode, which for her, was her reaction to her anxiety and frustration due to the lack of control she is experiencing having to conduct therapy out of her office.

Does this story resonate with you? I hope so. We are all out of our familiar routines, our spaces, our comfort zones; we've lost our sense of being in control of our physical environments and our proximity to the people and things we love and are familiar to us. So, what is your response when your routines are disrupted? Is that your cue to go into management mode in the service of getting things "back to normal?" In these times, it's actually more about trying to establish a

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"new normal." While there is a real disruption to our lives, our challenge, both for ourselves as well as for our clients, is to *establish SOME continuity*. Do your clients have routines? Do you have routines, or are you putting out fires? Yes, we've all had to scramble to make these adjustments. For me, maintaining my exercise program because the gym is closed meant that I had to make an appointment with myself in the mornings and to keep it in the same way I keep my appointments with others. It took me a couple of weeks, but I feel so much better now that I have more continuity in my day. That helps ground me and prepare me for my day's work, not to mention that I feel better! Part of being a therapist during these times, is to help our clients with healthy routines and self-care strategies. So, think about adopting some of those self-care strategies you are espousing for your clients! As Carl Rogers said, "*I have always been better at caring for others than I have been at caring for myself. But in these later years, I have made progress!"* We don't have the luxury of waiting until we're old and wise. The time is now.

QUESTION #3 – From the Audience: This is from Donna who is working with a nurse. "*For several weeks now, I have been working with a client who is a registered nurse anesthetist. She has recently been transferred out of her specialty to provide support in the ICU at the hospital where she works, taking care of COVID patients. Parts of her are feeling exhausted, fearful, sad, and resentful. At the same time, she is feeling grief and compassion for humanity. I sometimes feel at a loss as to what to say as I try to provide the best support for her. I am interested in any feedback and suggestions you might have."*

That's a great question! And, thank you for working with our healthcare workers who are on the front lines. It sounds like she has been a client of yours before the pandemic broke out. A couple of thoughts: 1). Normalize her experience. Acknowledge the disruption. This is not the work she signed up for and, at the same time, she signed up to be a nurse that helps people who are sick. 2). What part of her experience is what ANY reasonable person would feel in this situation, and what part(s) is more about HER and what she brings to it? What grabs my attention is her feeling resentful. What is it about her history that would explain that reaction? That is *the AIP-informed question*. For the sake of example, I will make up a story that feeling resentful for doing something she doesn't want to do to help someone may have a childhood connection that could even be related to her becoming a nurse. So, I would invite her to be curious about her feelings of resentment and explore what might be driving it? I'm guessing she also feels bad about feeling resentful, which isn't helping her.

Dealing with Loss

Lastly, and perhaps most importantly, I think the biggest challenge for all of us right now and for the foreseeable future is about dealing with loss. Loss has been a thread throughout this talk. We have anticipatory losses, and we have real losses.

I have a client right now who is in the middle of chemotherapy treatments for cancer that was discovered in January. Her life has been completely turned upside down. She's a therapist, who is not only having to deal with her own mortality and vulnerability in an acute way, but she is also trying to continue to see her clients while she is losing her hair and has "chemo brain." Her response is to plow through it. "I can do this," "I'm okay," etc. Well, meanwhile, she has elected NOT to tell her patients that she is ill. While that is a very personal decision, my job as HER therapist is to gently point out to her that, while it is COMPLETELY understandable that she wants to push through this and maintain

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some level of control and normalcy over her life, at the same time, I am asking her to consider that how she's managing her sense of loss may not be the best course of action for her or her patients. Helping her acknowledge her adaptation gave us the necessary opening to approach her sense of loss in the moment so she could make contact with it in a way that allowed her to be more present to herself as well as to her clients.

In terms of the EMDR piece of her work, we targeted the trauma of her diagnosis with success. The recent triggers came up after we shifted to a virtual platform when the pandemic broke and, of course, feeling even more vulnerable than before. We targeted a recent trip on public transportation where she became really frightened of catching the virus and dying from it.

We are Going Through a Collective Trauma

QUESTION #4 – From the Audience: *"As an EMDR therapist and Consultant from a European country I get a lot of questions about how to use EMDR online with the heightened anxiety and stress of everyone, therapists and patients alike. Many of us have endured traumatic losses. The specificity of the loss, not being allowed to say goodbye, and knowing that, in their last hours they spent most of it alone, as the medical team comes in fully submerged in hazard clothing and get in and out as quickly as they can (kind of like a pitstop), and then they're left alone for hours…. How do we manage our own losses, while, at the same time helping our clients with theirs?"*

Healing Versus a Cure

This question really speaks to the fact that we are going through a collective trauma. No one is untouched by what is happening now. When that is what our patients bring to us and we are either going through it at the same time or have been through it, how do we provide a container for the human suffering that is universal to all of us? I don't claim to have an answer for you, because to offer one would be to trivialize the breadth and depth of human loss, especially when the parallels are so close to home. My counsel to you is to *use your own humanness* and to *be transparent* (in an appropriate way, of course), and to *be a mirror for your patient's pain*, in part, by sharing that you understand their pain all too well. As you described in your question, the only thing worse than the loss itself is going through it alone. Perhaps there isn't a cure, but there is healing when we can open our hearts and nurture a wounded soul.

Tara Brach, a friend and colleague, who is now a renowned meditation teacher says, "*We're not survivors of the fittest. We are survivors of the nurtured*." I think that applies all too well in this context.

In Tara's new book, "*Radical Compassion*," she offers a mindfulness practice that I think could be a great resource for us as well as for our clients. She refers to *RAIN* as a spiritual reparenting practice. The acronym is as follows:

- The **R**, is to Recognize (our experience and bring our attention to it);
- The **A**, is for Allowing (ourselves to make contact with our experience);
- The **I**, is to Investigate (more deeply into what we're experiencing);
- The **N**, is for Nurturing (to help dissolve the sense of a separate self);

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Then, as EMDR therapists, we can install that positive feeling state so it becomes a frame of reference as well as a new memory.

Existential Times

Socio-political and Cultural Context

So, I think in closing, this is an *existential time*. We must now more than ever, address our clients' clinical issues in the larger socio-political and cultural context in which we are all in together. Just as landlords are reducing or delaying rent payments, we, too, have to be flexible in our fee policies. If a client can't afford to continue their therapy, how do you plan to address it? Just like the probability of some of us getting sick with COVID; we have to be prepared for these eventualities. Get together with your peers and talk about your cases. We should ALL be talking about our cases. As a Consultant, review some of the specialized protocols such as the recent events protocol or the enhanced EMD (the 2.0) with your consultees. You can combine EMD with an EMDR-related intervention such as RDI or other resourcing strategies with clients who are more easily dysregulated. We have so many ways of using this methodology with our clients now. As a fellow health-care provider, offer your services to the local hospitals. You can become a community organizer and start making a list of EMDR therapists who are willing to work with these front-line workers who are risking their lives to save others.

Assigning Meaning

This is also a time to help our clients assign meaning to their experiences, especially loss. This is way beyond a reset. The social order as we know it is changing. How it changes depends in part on how we relate to it. Are you going to be a passenger on this train, hoping for the best or expecting the worse, or are you going to *be an active participant* that will help shape the future? As my students have heard me say a million times, "*It's not just about what happened. It's also about what happened next.*" So, in this context, it's not just about what's happening, it's also about what we do in response to what's happening.

Stay Connected

Every day we ask our clients to be brave and to venture into the unknown. Now more than ever, we, too, need to be brave. We're all in response to one another, so when you have a good experience in virtual EMDR therapy, share it! It's another story of triumph in the face of adversity. If you have a failure experience, or EMDR processing didn't work, or you encountered some other challenge experience with virtual EMDR therapy, talk to someone about it. Try to understand what happened so you can learn from it. Share what you learned so we can learn from it. We're in this for a bigger cause. Francine left us with her legacy of EMDR as her offering to alleviate suffering and promote world peace. Let's not squander it. *We have to look for these moments of opportunity to be the change we are seeking, not only to transform trauma but to transform the world.* As Heraclitus said, "*The only thing that is constant is change*."

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In honor of Francine, I would like to close with one of her favorite poems that she would recite at the end of a training. Many of you have heard this story. It seems appropriate to read it to you in closing:

A HOPI ELDER SPEAKS

" *You have been telling the people that this is the Eleventh Hour.*
Now you must go back and tell the people that is The Hour.
And there are things to be considered….

Where are you living?

What are you doing?

What are your relationships?

Where is your water?

Know your garden.

It is time to speak your truth!

Create your community.

Be good to one another.

And do not look outside yourself for the leader."

Then he clasped his hands together, smiled, and said, "This could be a good time!
There is a river that is flowing very fast. It is so great and swift that there
will be those who are afraid. They will try to hold on to the shore.
They will feel that they are being torn apart. They will suffer greatly.

Know the river has its destination. The elders say we must let go of the shore, push
off into the middle of the river, keep our eyes open, and our heads above the water.

And I say, see who is in there with you and celebrate! At this time in history,
we are to take nothing personally, least of all, ourselves. For the moment
that we do, our spiritual growth and journey comes to a halt.

The time of the lone wolf is over. Gather yourselves! Banish the word
struggle from your attitude and your vocabulary. All that we do now
must be done in a sacred manner and in celebration.

"We are the ones we've been waiting for!"

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PART II

EMDR-Related Stabilization Techniques

Part II includes 4 resources addressing EMDR-Related Stabilization Techniques. Gary Quinn's The Self-Care Procedure for Coronavirus (SCP-C) is a very helpful way to work with patients and colleagues concerning the range of their feelings during the pandemic. The next chapter is a worksheet that goes with the SCP-C. The Butterfly Hug – created by Lucy Artigas – is well represented by her husband, Ignacio Jarero. There is a link to a YouTube video of Nacho doing the BH concerning the Coronavirus, as well as a transcription of the script used. The last chapter is Judy Moench's transformation of Elan Shapiro's Four Elements for Stress Management Exercise into a colorful way for parents to teach their children to calm their mind and bodies.

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10

Self-Care Procedure for Coronavirus (SCP-C) for Mental Health Practitioners

Gary Quinn

Edited by Marilyn Luber & Brurit Laub

The coronavirus pandemic is challenging for mental health practitioners. Stabilization relating to temporary disasters, whether man-made or natural, is done by recognizing that the past danger is over. The ongoing nature of the coronavirus crisis mainly raises concerns about dangers in the present and future. Therefore, it requires a new way of stabilization than the ISP® (Immediate Stabilization Procedure). The Self Care Procedure for Coronavirus (SCP-C) for Mental Health Practitioners attempts to achieve this goal by dynamically adapting to this specific global situation.

This procedure can be used once by a mental health practitioner and then becomes a self-care procedure to be used as needed.

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The SCP-C for Coronavirus can be used with concerns such as:

- "I AM AFRAID I MIGHT GET THE VIRUS"
- "I AM AFRAID I HAVE THE CORONAVIRUS"
- "IT IS MY FAULT THAT I INFECTED OTHERS"
- "I AM ALONE OR ISOLATED"
- "I WILL HAVE NO MONEY"

SCP-C Basic Concepts

1. **Negative Thoughts**: these thoughts lead to negative, strong, exaggerated, emotional states.

   Type I Negative Thoughts are associated with feelings of anxiety, helplessness, panic, fear, loneliness, depression and anger, such as:

   - *"I cannot handle this."*
   - *"I am not in control."*
   - *"I am helpless"*

   Examples of client's statements:

   - "I am worried that I (my family and/or friends) will become ill." - Anxiety
   - "I feel sick" and/or "I have fever. - Anxiety
   - "I am going to die." Fear, Anxiety, Panic
   - "I am afraid my parents, grandparents, spouse, children are going to die." Anxiety, Fear, Panic
   - "It is overwhelming." "I cannot stand it." - Anxiety
   - "The government and health department are at fault for not doing enough." - Anger
   - "The government and health department are at fault for doing too much (ordering isolation/quarantine)." - Anger
   - "I will have no money." - Anxiety
   - "I cannot handle being in isolation/quarantine." - Helplessness, Anxiety, Anger
   - "It is not fair." – Anger, Helplessness

   Type II Negative Thoughts are associated with feelings of guilt, inadequacy, regret such as:

   - *"It is my fault that my family/ friends got coronavirus."*
   - *"I did something wrong."*
   - *"I should have known better."*

   Examples of client's statements:

   - "It is my fault I got (could have gotten) coronavirus." - Guilt
   - "It is my fault my family and friends got (could have gotten) coronavirus." - Guilt
   - "It is my fault that I did not buy enough antiviral spray, toilet paper, etc." - Inadequacy, guilt
   - "I sold and lost significant money when the stock market started to fall." - Regret

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2. **Positive Thoughts**: These thoughts do not feel true at first. After SCP-C, they feel true and are associated with positive feelings.

Tapping in SCP-C refers to Rapid Alternating Bilateral Tactile Stimulation and can calm a person with its use.

Because the Coronavirus is contagious, we do not want mental health practitioners touching clients.

Tap rapidly 1-2 passes per second or 60-120 passes per minute.

One pass = left tap, then right tap.

If the client is on a telephone, without being able to see you visually, tap your phone rapidly so the client hears the tapping.

Note:

1. **Please note that the SPC guidelines have not undergone formal clinical trials to date, and current data regarding its success, while encouraging, is still only anecdotal. There is no data yet that using SPC will be successful in treating stress symptoms related to the particular concerns of the COVID-19 virus. Your use of this procedure is up to you solely.**
2. **The SCP-C is to be used only for situations related to the coronavirus. If other past illness/es or memories come up direct clients back to their coronavirus issue. If they keep returning to past traumas, then stop SCP-C and refer to another mental health practitioner.**

SCP-C Script

Step 1: Introduction

Goal: To introduce yourself to the client.

Say, "***My name is*** ________________ (state your name)."

Say, "***I'm here to help you***."

Say, "***What is your name?"***

Say, **"*Can you tell me in a few sentences what is your concern?"***

Write the client's concern in the initial contact form.

Step 2: Preparation

Goal: To introduce the SCP-C to the client.

Say, "***There is a procedure that uses tapping that has helped other people and I think will be helpful for you. You can do it, by tapping with your hands on your knees or with the big Butterfly Hug"***

Say, ***"Place the heels of your hands on your thighs so the tips of your fingers are on the top of your knees and then lightly tap with your fingers, first one hand, then the other."***

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Say, ***"Another way of tapping is the big Butterfly Hug. Cross your arms and put your right hand on your left arm, and your left hand on your right arm.***

Say, ***I will demonstrate and tap along with you."***

Say***, "Which way of tapping suits you best?"***

After the client choses the way to tap, say the following:

Say, "***Tap with me, alternating left to right.***

The tapping will help you feel calmer. Is this ok with you? I will continue, unless you tell me to stop.

At any time during our work, you can tell me to stop or raise your hand to indicate you want to stop."

Say, ***"Stop tapping."***

Step 3: Assessment

Goal: To clarify and specify the client's negative thoughts and feelings

Say, "***While thinking of your concern ____________*** (stated during introduction***) with the coronavirus, what are your negative thoughts? Here are some typical negative thoughts:***

Say, ***"Is it?"***

Type I Negative Thought

- ***"I cannot handle this."***
- ***"I am not in control."***
- ***"I am helpless."***

Say, ***"Or is it?"***

Type II Negative Thought

- ***"It is my fault that family/ friends got coronavirus."***
- ***"I did something wrong."***
- ***"I should have known better."***

Say, **"*What are you thinking?"***

Write the client's negative thought in the initial contact form.

Type I

Say**, "*When you say this negative thought _______*** (state Type 1 negative thought***) what feelings come up now?***

Say***, "Typical feelings can be anxiety, helplessness, panic, fear, loneliness, sadness or anger."***

Say, ***"Or is it?"***

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Type II

Say**, "*When you say this negative thought* _______(**state Type 1I negative thought*) what feelings come up now?*

Say, ***"Typical feelings can be guilt, inadequacy regret.***

Say***, "Or is it both?"***

If it is both, first complete Step, 4, Type 1 Negative Thought, then go back to Step 4, Type 2 Negative Thought.

Write the client's feelings in the initial contact form.

SUDs (Subjective Units of Disturbance Scale)

Say, "***Please tell me how disturbed you are feeling now. On a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*** ______/10

Step 4: Stabilization

Goal: To recognize and communicate the client's ability to learn to handle anything that may happen.

Stabilization is done by tapping rapidly while hearing/saying a positive thought.

Type I Positive Thoughts

These positive thoughts reduce feelings of anxiety, helplessness, panic, fear, loneliness, depression, anger, and increase a sense of control and calmness.

Say***, "Start tapping****."*

While client is tapping for about one minute say these sentences often:

Say**, "*You can learn to be in reasonable control of what you can be in control of."***

Say***, "You can learn to deal with this."***

Say**, "*You can learn to have options within the framework you are now living."***

After about one minute,

Say, **"*Stop tapping. Take a breath. Let it go.***"

Continue saying the 3 phrases in one-minute segments over 5 minutes.

Say, *"**Please tell me how disturbed you are feeling now. On a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"___/10***

If SUDs are 3 or less with no Type II Negative Thoughts, go to Step 5: Closure.

If the SUDs = greater than 3, continue with supportive phrases.

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While tapping for a minute, use the phrases from the list below. Notice the ones that most apply to you.

Say, ***"Start tapping***."

Say, ***"The alternating tapping will help reduce your distress."***

Say, ***"When you are calm, as you are becoming, it strengthens your immune system to prevent illness and helps you recover."***

Say, ***"Being in isolation (alone) is a way to be in control of what you can be in control of, by preventing you from becoming infected or infecting others."***

Say, ***"You can learn to be in reasonable control of what you can, you cannot be in control of what someone else thinks, feels, says or does."***

Say, ***"This pandemic is temporary and will end."***

Say, ***"The vast majority of people recover from this virus."***

If people are symptomatic:

Say, "***The fever you have shows that your body is fighting the virus."***

Say, "***Stop tapping. Take a breath. Let it go."***

Say, "***Please tell me how disturbed you are feeling now. On a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now***?" ___/10

If SUDs are 3 or less with no Type II Negative Thoughts, go to Step 5: Closure.

If the SUDS = greater than 3, continue with supportive phrases.

Say, "***Start tapping***".

While client is tapping for about one minute say these sentences often:

Say, **"*You can learn to be in reasonable control of what you can be in control of."***

Say, **"*You can learn to deal with this."***

Say, **"*You can learn to have options within the framework you are now living."***

After about one minute,

Say, "***Stop tapping. Take a breath. Let it go***."

Continue saying the 3 phrases in one-minute segments over 5 minutes.

Say, "***Please tell me how disturbed you are feeling now. On a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"___/10***

If SUDs are 3 or less with no Type II Negative Thoughts, go to Step 5: Closure.

If client uses Type II Negative Thoughts come up at any time during Steps 1 through 4, continue below.

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Type II Positive Thoughts

These positive thoughts reduce feelings of guilt, inadequacy, and/or regret and increase a sense of self-acceptance.

Say *"**Start tapping**"*.

While client is tapping for about one minute say these sentences often:

Say, "***You did the best you could with the information you had at the time."***

Say, ***"Whatever happened, happened and you can deal with this from this moment on."***

Say, "***Stop tapping. Take a breath. Let it go."***

Continue saying the 3 phrases in one-minute segments over 5 minutes. Then check the SUD's.

Say, *"**Please tell me how disturbed you are feeling now. On a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"___/10***

If SUDs are 3 or less go to Step 5: Closure.

If the SUDs = greater than 3, continue with supportive phrases.

While tapping for a minute say the following phrases from the list below. Notice the ones that most apply to you.

Say, *"**Start tapping**"*.

Say, "***You did the best you could with the information you had at the time."***

Say, ***"We now know that people who have no symptoms can be infectious, so you may not have been able to prevent this. You did the best you could with the information you had at the time.***

Say, ***"It takes time to learn and follow all the instructions of social distancing and special hygiene measures".***

Say, ***"Whatever happened, happened and you can deal with this from this moment on."***

Say, ***"Please tell me how disturbed you are feeling now on a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?" ___/10***

If the SUDs = 3 or less, go to Step 5: Closure.

If the SUDS = greater than 3, continue with supportive phrases.

Say, *"**Start tapping."***

While client is tapping for about one minute say the following sentences often:

Say, ***"You did the best you could with the information you had at the time in the past."***

Say, ***"Whatever happened, happened and you can deal with this from this moment on."***

After about one minute,

Say, ***"Stop tapping. Take a breath. Let it go."***

Continue this for about 5 minutes

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Say, “***Please tell me how disturbed you are feeling now. On a scale of 0 to 10 where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?” ___/10***

No matter what the SUDs, go to Step 5: Closure.

Step 5: Closure

Goal: To identify useful Positive Thoughts. To give information about follow-up.

Self-Care

Give the client the Self-Care Procedure (SCP-C) Worksheet for clients.

Say, ***“Please take a look at the Positive Thoughts that were helpful and underline or circle them. If other Positive Thoughts came up during stabilization, please write them down now on the worksheet. You can use these Positive Thoughts with rapid tapping any time you need.”***

Say, ***“Would it be OK if we contact you to find out how are you?***

If the client agrees, take down his/her information:

Name: ______________________________

Telephone: ______________________________

If the mental health practitioner has a legal issue concern about using this with someone new, have the client sign and date the Disclaimer below:

DISCLAIMER: This document is intended for the use of trained professional healthcare practitioners only. Following a session with a trained healthcare practitioner, clients may use this procedure which is being provided as a service in light of the global CORONAVIRUS health crisis to potentially assist in the decrease of stress related to the Coronavirus only. Please note that the SPC-C guidelines have not undergone formal clinical trials to date, and current data regarding its success, while encouraging, is still only anecdotal. There is no data yet that using SPC-C will be successful in treating stress symptoms related to the particular concerns of the COVID-19 virus. Your use of this procedure is solely up to you.

In the event that a client using this procedure does not feel a sufficient reduction in stress or any other psychological issues, it is strongly recommended that the client contact a mental healthcare practitioner immediately. The author makes no guarantees, either expressed or implied, regarding the efficacy of the treatment procedures contained herein and makes no guarantee that following the guidelines herein will provide effective treatment for symptoms of stress or any condition related thereto. This procedure relates solely to situations related to the current Coronavirus crisis and should not be used to deal with any other types of psychological trauma.

____

Client’s signature **Date**

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Self-Care Procedure for Coronavirus (SCP-C)

Initial Contact Form

Date: __________ Time begins:______________________

Client Name: ____Age: _______

City __________________ State _____________ Country ______________________

Mental Health Practitioner's Name: ____

Telephone: ____

Coronavirus Concern: ____

Negative Thought/s: ❑ Type 1 ❑ Type II ❑ Both______________________________

Negative Feelings: ____

Pre-Intervention SUDs: ___/10

Post-Intervention SUDs: ___/10

Time Ended: ____

Agree to follow-up phone call: ❑ Yes ❑ No

Client signature: (if possible) otherwise verbal agreement____________________________

Telephone Number: ____

Follow-Up Contact: _________________________ Date of Follow-Up: __________

Current SUDs: ___/10

Additional Services Needed: ❑ Yes ❑ No

If yes, provide details: ____

Go to the website at **EMDR-Israel.org** for updates and information about doing research.
Please send the initial contact form information (no name) to **SPC.C.COVID19@gmail.com**
Please describe and send any adverse effects that might have occurred when administrating SCP-C.

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11

Self-Care Procedure for Coronavirus (SCP-C) Worksheet for Mental Health Practitioners

Gary Quinn

Edited by Marilyn Luber & Brurit Laub

The concerns about the coronavirus are mostly about possible ongoing dangers in the present and future. SCP-C can help reduce negative feelings and increase calmness and sense of control.

Instructions for Using SCP-C on your own:

Tapping in SCP-C refers to Rapid Alternating Bilateral Tactile Stimulation and can calm a person with its use.

Tap rapidly 1-2 passes per second, or 60-120 passes per minute. One pass = right tap then left tap.

Say, ***"Place the heel of your hand on your thigh so the tips of your fingers are on the top of your knees and then lightly tap with your fingers. Or you can tap the big Butterfly Hug. Cross your arms and put your right hand on your left arm, and your left hand on your right arm."***

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You can choose which type of thoughts are most helpful for you to use while tapping:

1. **Type I Positive Thoughts** to reduce feelings of anxiety, helplessness, panic, fear, loneliness, sadness, anger, and increase a sense of control and calmness.

   If you feel these feelings, start tapping and combine the tapping with the positive thoughts below:

   - ***"I can learn to be in reasonable control of what I can be in control of."***
   - ***"I can learn to deal with this."***
   - ***"I can learn to have options within the framework I am now living."***

   Add any new, Type I Positive Thoughts that you have had:

   - ____
   - ____

   "Stop tapping. Take a breath. Let it go."

Often repeating the above 3 sentences for about 5 or 10 minutes are enough to achieve calmness.
If you need more positive thoughts continue:

- ***"The alternating tapping will help reduce my distress."***
- ***"When I am calm, it strengthens my immune system and helps me prevent illness and can heal me."***
- ***"Being in isolation (alone) is being in control of what I can be in control of by preventing me from being infected or infecting others."***
- ***"I can be in reasonable control of what I can, I cannot be in control of what someone else thinks, feels, says or does."***
- ***"This pandemic is temporary and will end."***
- ***"The vast majority of people recover from the coronavirus."***

If you have coronavirus symptoms you can say:

- *"**The fever I have indicates that my body is fighting the virus.***

"Stop tapping. Take a breath. Let it go."

Continue, until you become calmer.

If the distress continues, please contact an EMDR Therapist, or other mental health professional for further assistance.

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2. **Type II Positive Thoughts** to reduce feelings of guilt, inadequacy, and/or regret and increase a sense of self-acceptance.

If you feel these feelings, start tapping and combine the tapping with the positive thoughts below:

Tap for about one minute saying or thinking the sentences that are helpful to you often:

- *"I did the best I could with the information I had then."*
- ***"Whatever happened, happened and I can learn to deal with this from this moment onward."***

Add any new, Type II Positive Thoughts that you have had:

- ____
- ____

"Stop tapping. Take a breath. Let it go."

Often repeating the above 2 sentences for about 5 or 10 minutes are enough to achieve calmness.

If you need more positive thoughts continue:

- ***"I did the best I could with the information I had then."***
- ***"I now know that clients who have no symptoms can be infectious, so there was no way I could have prevented this."***
- ***"It takes time to internalize all the instructions of social distancing and special hygiene measures".***
- ***"Whatever happened, happened and I can learn to deal with this from this moment onward."***

"Stop tapping. Take a breath. Let it go."

Continue until calmer.

If the distress continues, please contact an EMDR Therapist or other mental health professional for further assistance.

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12

The Butterfly Hug for the Coronavirus

Ignacio Jarero

Ignacio Jarero has used YouTube to show how to do “The Butterfly Hug for the Coronavirus Pandemic.” Here is the link:

https://www.youtube.com/watch?v=BGl5QOFHtbE&feature=youtu.be

This is the transcription of his YouTube video:

Hello, I am Dr. Ignacio Jarero, also known as Dr. Nacho. I am a field worker, mental health professional with almost 200 deployments around the world, working in worst case scenarios after natural or human disasters. I would like to share with you what I have been using over the past 23 years for my emotional self-care during deployment. The name of this is “The Butterfly Hug.” The Butterfly Hug was developed by the Mexican clinician named Lucina or Lucy Artigas, following Hurricane Paulina in 1998 in Mexico. Since that time, it has been used around the world in many settings, with thousands of children, adolescents and adults who have experienced adverse life experiences.

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This is a self-administered bilateral stimulation method to process distressing or adverse life experiences and the person using this method has total control.

The Butterfly Hug helps in the processing of unpleasant or annoying emotions and/or physical sensations produced by the distressing or adverse experiences.

At this moment, I am going to show you how to do the Butterfly Hug. Please, follow my instructions. One hand like this (right hand held straight up), the other hand like this (left hand held straight up) interlock your thumbs, place your hands on your chest, middle fingers below the clavicle and do this. Alternate movement (tapping using the right hand and then the left hand). At your own pace, very good. Very good.

Step 1: Right before dinner or after a distressing event, do the following: with eyes open or partially closed, not totally closed, run a mental movie of the whole distressing event or the whole day, if you are doing this on a daily basis. For example, if you are a front liner in a hospital or in another setting helping people with the coronavirus issue, start from right before the beginning, until today, or even looking into the future for any distressing scenario that you have imagined. Once you finished running the movie, go to *Step 2*:

Step 2: Observe your body, not just notice, scan your body and assess your level of disturbance from 0 which is no disturbance to 10 which is the maximum disturbance that you can feel. From 0 to 10, the maximum disturbance you can feel.

Step 3: Do the Butterfly Hug while walking or sitting in a chair pretending you are marching at your own pace. Like this (he demonstrates tapping and marching). Now, with your eyes open or partially closed, run a mental movie of the whole distressing event or the whole day if you are doing this on a daily basis, I recommend it, from right before the beginning until today or even looking into the future to any distressing scenario you have imagined. At the end of the mental movie, stop the Butterfly Hug and the walking or marching in your own seat. Now, breathe deeply (takes a breath) twice. Again, breathe deeply twice.

Step 4: Observe and notice your body. Scan your whole body. Then assess your level of disturbance now from 0 which is no disturbance to 10 which is the maximum disturbance you can feel. Now, if your disturbance is 4, 5, 6 up to 10, repeat steps 3 and 4 until your disturbance reaches levels between 0, 1, 2, or 3. Again, if your disturbance is 4 or more, repeat steps 3 and 4 until your disturbance reaches levels between 0, 1, 2, or 3.

Important note. If your distressing symptoms do not decrease or increase, contact immediately a mental health professional expert in trauma treatment.

Thank you very much for your attention and Butterfly Hugs for each one of you.

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Four Elements Parent Activities

Judy Moench

The 4 Elements was developed by Elan Shapiro in 2007 to use as a stress reduction technique. It has been modified here for use with children. In this chapter, you will see the 4 Elements slides along with a poster that parents can use with children. An e-book and additional posters are also available for free at **prepped4learning.com**. The e-book is essentially designed as a guide for parents to help teach children how to calm their mind and body while using the slides and doing other activities. It provides discussion topics, activities, posters to print or download, tips and hints, along with suggested scripts.

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CHILL WITH THE FOUR ELEMENTS

4 Elements by E. Shapiro, 2007
Adapted for Prepped 4 Learning, Moench, 2013
Parent Edition, Moench, 2020

Let's take a measure!

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How **STRESSED** are you?

0

Not stressed at all

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10

THE MOST STRESSED YOU CAN IMAGINE!

Now rate your stress level.

0-10

Remember that number.

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EARTH

Feel both of your feet on the ground.

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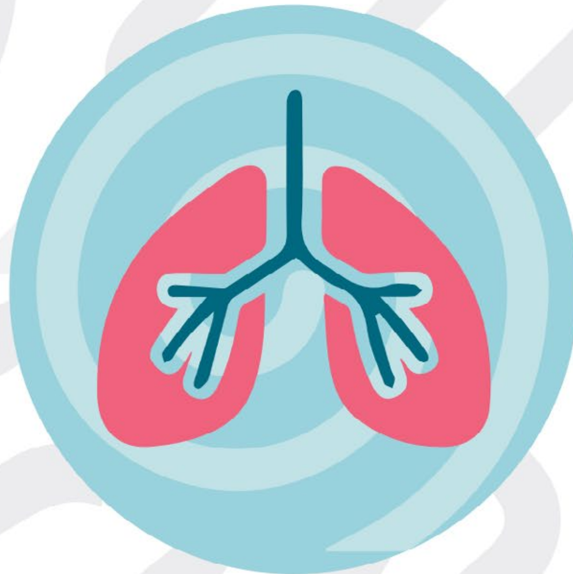
Notice 3 things you can see, hear, or touch.

AIR



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As you continue to notice your feet on the ground,

breathe 3 or 4 deep, slow belly breaths.

In through your nose. Out through your mouth.

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WATER

Continue to feel your feet on the ground,

and the air that your breathe.

Produce some saliva in your mouth.
Think about sucking a

LEMON.

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FIRE/ LIGHT

Now think about your relaxed or calm word or imagine a special calming place.

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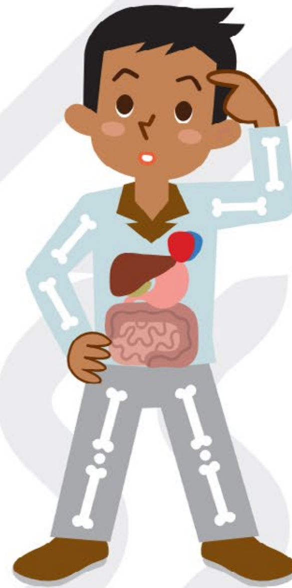
Notice where you feel calm in your body.



Let's help our brains remember what calm feels like in our bodies. Relaxed and ready to learn.

Give yourself BUTTERFLY HUGS.

Butterfly Hugs, L. Artiqas, 1998

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Notice your quiet mind.

BUTTERFLY HUGS

Butterfly Hugs, L. Artigas, 1998

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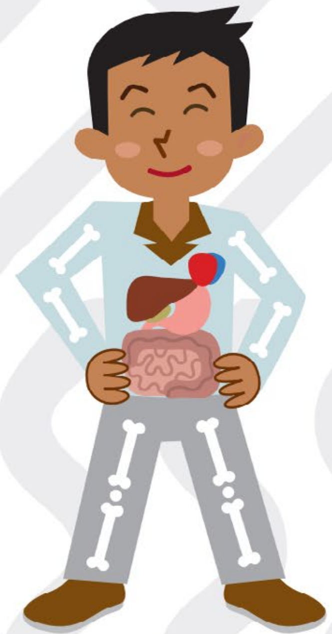
Notice the calm feelings in your body.



BUTTERFLY HUGS

Butterfly Hugs, L. Artigas, 1998

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Let's help our brain and body remember.

BUTTERFLY HUGS

Butterfly Hugs, L. Artigas, 1998

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Let's take a measure!

How STRESSED do you feel now?

0-10

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THEN?

now...

Has your rating changed?

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CHILL WITH THE FOUR ELEMENTS

PRACTICE makes PERMANENT

4 Elements by E. Shapiro, 2007
Adapted for Prepped 4 Learning, Moench, 2013
Parent Edition, Moench, 2020

Elan Shapiro created *The Four Elements Exercise for Stress Management* which has been an exciting part of a school program currently being developed.

Lucy Artigas developed the Butterfly Hug, another form of bilateral stimulation, which is an important component of this program.

Francine Shapiro created the ground-breaking methodology EMDR therapy.

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PART III

EMDR Early Interventions

There is one resource in Part III concerning Early EMDR Interventions. Brurit Laub and Keren Mintz Malchi use their expertise in EEI to create an abbreviated version of the Recent-Traumatic Episode Protocol, alternately called, "The Sandwich Technique," to fill a niche for a relatively concise intervention that helped clients focus their process. The sandwich effect comes from the dialectical movement that occurs when there is first an opening resource-then the trauma intervention-finishing with the closing intervention; this ends with the client feeling more integrated and having a sense of well-being.

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The EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP (The "Sandwich" Protocol

Brurit Laub &
Keren Mintz Malchi

The EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) Protocol is an adaptation of the EMDR R-TEP protocol and is intended for use as a short, episode/time-framed focused intervention (such as for the coronavirus outbreak), and takes approximately 40-60 minutes to complete. It can also be referred to as the "The Sandwich Protocol" because it is made up of three parts: an opening resource, a Point of Disturbance (PoD), and a closing resource. The protocol may be used a number of times, as needed. A self-help protocol is currently being drafted as well.

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There are three kinds of Early EMDR Interventions:

- *Procedures for Stabilization and Containment:* In the first group of interventions, bilateral stimulation (BLS) is used to install a resource. For instance, in the 4 elements (E. Shapiro, 2007) the BLS is used to install a safe place, together with three stabilizing somatic exercises. In the Emergency Response Procedure (ERP; Quinn, 2009) or in the Self Care Procedure for the Coronavirus (SCP-C, see Resources 7&8), rapid BLS is used to install positive thoughts.
- *Focused Processing with One Target*: A second group of interventions, utilizes either limited or focused processing with one target. For instance, the EMDR Integrative Group Treatment Protocol (IGTP; Jarero, Artigas, & Hartung, 2006) or the Imma Group Protocol (Laub & Bar-Sade, 2014) use very brief associative processing with resource installation at the beginning and end. The EMD protocol (F. Shapiro, 2004) which was reintroduced for use in emergency situations, is also a focused protocol, with a restricted range of associations due to frequent returns to the target. It does not include specific resources.
- *Focused Processing with Several Targets*: The third group of interventions includes protocols for focused processing with several targets or points of disturbance (PoDs) like the Protocol for Recent Traumatic Events (RE, REP; F. Shapiro, 1995), the EMDR Protocol for Recent Critical Incidents (EMDR-PRECI; Jarero, Artigas & Luber., 2011) , the EMDR Recent-Traumatic Episode Protocol (R-TEP; E. Shapiro & Laub, 2009), the Group-Traumatic Episode Protocol (G-TEP; E. Shapiro, 2014), Self-Care and Individual Traumatic Episode Protocol (SCI-TEP: E. Shapiro, see Resource 18 and the Self-Care Traumatic Episode Protocol (STEP; Moench, see Resource 19).

The EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) belongs to the second group of protocols, however, the authors believed there was a need for a relatively brief intervention with an increased level of resource focused processing. The two resources come before and after the processing of one Point of Disturbance (PoD) -forming a “sandwich” to facilitate a dialectical movement between trauma memory networks and adaptive ones (Laub, Weiner, & Bender, 2017). This is expected to facilitate integration and restore a sense of mental and physical equilibrium. The intervention may be helpful when there are time constraints. The protocol may be used a number of times, as needed.

In summary, The EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) provides a short, resourced processing of one point of disturbance, by a present and active therapist who makes use of four focused strategies and various interweaves to facilitate integrative processing. It also provides “a sandwich effect,” activating resources at the beginning and at the end of processing to contain and facilitate adaptive processing. The intervention may be helpful especially when there is high emotional arousal, limited access to resources in the present and/or when there are time constraints. For clients who need a lengthier intervention, the R-TEP/G-TEP, or, at times, the Standard EMDR Protocol, will be more appropriate. Since this protocol is new and research is beginning, it is recommended that the protocol be studied further to determine its efficacy. Early work with the EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) anecdotally suggests it can be helpful in the situations described above.

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The EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) Notes

Stage 1:

The therapist inquires briefly if the client is relatively stable; this means that the client is able to stay within the window of tolerance, and if not, is responsive to the therapist's attempts at assistance. The therapist also inquires if clients have sufficient support and asks clients for consent to do this EMDR episode/time-frame focused intervention.

Stage 2:

Bilateral Stimulation

If clients find the eye movements difficult during the processing, they can tap without moving their eyes. Otherwise, all BLS will be carried out with open eyes.

Stage 3:

It is important for the processing to be focused and resourced, in order to stay "on track," to keep clients in their window of tolerance, and to facilitate adaptive processing in a limited time.

Focusing is achieved through four strategies that go back-to-target (PoD): EMD, EMDr, Containing and Pairing. Resourcing is obtained through a supportive presence and continual therapeutic interweaves. A supportive presence means therapists actively use their physical body to create an atmosphere of mutuality and safety. Relational interweaves, accentuate therapists' presence and client-therapist connection, with somatic interweaves facilitating integrative processing.

EMDr Strategy

Most of the processing will be carried out with the EMDr strategy, using the range of associations limited to the episode/time-frame alone (such as the coronavirus outbreak time-frame). If associations outside of this range come up, such as childhood experiences, the therapist will validate the association, and then return to the target (the PoD).

> Say, *"What you just said is really significant, and let's go back from here to where we started from ________(*state the PoD*). What do you notice? Has anything changed?"*

Following the client's response, ask for the level of disturbance (SUD), now. If the SUD is not ecological (0-3), continue with processing.

EMD Strategy

If the point of disturbance (PoD) is intrusive (recurs repeatedly) or if an intrusive experience comes up during processing, make use of the EMD strategy, with the range of associations

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limited to the PoD only. If an association comes up that is related to the episode/time-frame, or outside of that, gently ask the client to return to the target (PoD).

> Say, "*Let's go back to the point where we started, so that your system can focus again, process the PoD and let it go. What do you notice now? Has anything changed?*"

Following the client's response, ask for the level of disturbance (SUD). If the SUD is not ecological (0-3), continue processing. Keep sets short (approximately 10 passes). After 7 sets of EMD processing, if there is no change in the SUD level, continue processing with the EMDr strategy.

Containing Strategy

Containing is achieved by going back to the target (PoD). Use sound clinical judgment to reorient, refocus or to keep clients in their window of tolerance. It is applied even when the associations are in the appropriate domains of EMD or EMDr. The containing strategy can be effective, for instance, when grounding is needed or there is looping. Then use appropriate interweaves and relatively short BLS sets. This strategy contributes to containment, as it requires an internal process of reorganization on the part of the client. It also accentuates therapists' engaged presence.

Pairing Strategy

If a client has made an adaptive association (any positive thought, emotion or sensation, or a combination of these), it is important to emphasize the association and pave the way for further change in the point of disturbance through pairing. To do this, validate the resource and ask the client to go back to target (PoD).

If an adaptive association comes up towards the end of processing, allow for an additional set of BLS to further strengthen the association, listen to what comes up and then continue with Pairing by returning to the PoD.

> Say, *"What you just said is a really valuable resource. Let's take that back with us to where we started from. When you go back to the target with the resource close at hand, what do you notice? Has anything changed?"*

In summary, return to the PoD in the following circumstances:

- When the associations have gone out of range (according to the two strategies, EMD and EMDr).
- In order to provide greater containment when deemed necessary.
- Following an adaptive association (any positive thought, emotion or sensation, or a combination of these).
- If an adaptive association comes up towards the end of processing, return to target after allowing for an additional set of BLS to strengthen the association.

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Marking Resources

During processing, write down the letter "R" next to each positive association that comes up (any positive thought, emotion or sensation, or a combination of these). This allows easy tracking of the resources at the end. Please write down the resources so that you can use them later. If you don't usually take notes during processing, you may write down the resource on the tracking sheet.

Note: In light of the fact that processing is short, it is vital that it be as resourced as possible. Therefore, it is important to bring an active and supportive presence to the work, applying several therapeutic interweaves to help the process move towards integration. After each interweave, ask the client to proceed with BLS. Somatic interweaves are especially helpful for letting go of negative body sensations, as are relational interweaves of presence, support and attunement. Mark down any interweaves that were used during processing in the tracking sheet.

Somatic Interweaves

Below is a list of somatic interweaves that can be helpful to facilitate processing (See Levine, 2010, 2012; Shapiro, 2018(, and may be used following your clinical judgement.

- When there is an association to an image, a thought or an emotion comes up, say the following:

  Say, *"Notice your body. You know, your body is always talking. When you notice that* _____________ (repeat the image, thought or emotion), *what happens in your body? Your body is letting go now of some of those difficult sensations."*

- Following a body sensation that has come up, or that may feel "stuck," say the following:

  Say, *"If that sensation could speak, what would it say?" (*For instance, if your chest could speak, what would it say?")

- If the client makes a body movement during processing, or during the sharing of associations, ask the following:

  Say, *"I would like for us to notice that movement that you just made, and repeat it, really, really slowly, from the beginning of the motion until its very end. Let's do that.*

Give the client time to repeat the motion.

  Say, *"What did you notice as you repeated that motion?"*

- If the client feels a sensation ask the following:

  Say, *"Place your hand where you feel the sensation -whether it is pleasant or unpleasant- and notice what comes up."*

- Pendulation. Use pendulation following an unpleasant body sensation that has come up, does not stop, or feels "stuck." Please have clients connect to a pleasant or neutral place in their bodies:

  Say, *"I will ask you to search for a pleasant or neutral place in your body."*

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Wait for clients' response.

Say, *"Great, now we will move back and forth, a few seconds each time, between the unpleasant sensation, and then the pleasant one. Let's try that, just move back and forth, resting at each spot for a few seconds, back and forth, back and forth, until the unpleasant sensation lessens or melts away. Great."*

- If the client cannot find a pleasant or neutral sensation, you may direct him to a place of neutrality in the body, such as the earlobe or the tip of the nose.

Say, *"Please focus on ___ (*your earlobe/tip of your nose*) and then the unpleasant sensation. Just move back and forth, resting at each spot for a few seconds, back and forth, back and forth, until the unpleasant sensation lessens or melts away. Great."*

- Use the "Voo" Exercise (Levine, 2010) to balance arousal levels.

Say, *"Now we will do a breathing exercise together that will help to pick up your energy level and let go of unpleasant sensations. We will be making a Voo sound together that will cause vibrations that will affect the longest nerve in your body, the Vagus, which comes out of our brainstem all the way down through all of our vital organs, like the heart, lungs, and gut. The 'Voo' sound is made by taking in a deep breath, and then, on the out breath, gently making the sound 'Voooooo," sustaining it through the full exhalation; vibrating the sound from the belly. At the end of the breath, we will briefly pause, allowing the next breath to fill our belly and chest. Then we will make the sound again, until it feels complete. The important thing is to let both sound and breath expire fully, pausing and waiting for the next breath to come on its own, when it is ready. Let me show you."*

Demonstrate once for the client, on your own. Then, do it twice with the client.

Say, *"Now let's do two "Voo's" together. Ready? Let's take a deep breath in, and Voooooo…"*

Relational Interweaves

It is also important to use relational interweaves throughout the process:

Say, *"You're working beautifully," "Great, just continue," "Just let yourself ride the wave a bit…. I'm with you, you're not alone."*

Relational Somatic Interweaves

Remember, your own body is a significant potential resource. Use non-verbal attuned gestures to help the client rebalance within the connection. For instance, nod, smile, make use of facial expressivity, vocal tone, mirroring, and/or use cadence sounds, such as "*Yes, yes."*

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The EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) Script

Stage 1: History Taking – Brief Intake and Building a Therapeutic Alliance

Therapeutic Alliance

Start by introducing yourself, including your professional background, and then ask clients to introduce themselves as well.

Say, ***"Hello, I am ____(**state name). **I am _______(**state profession). **Please tell me something about yourself."***

If the intervention is part of a coronavirus research project:

Say, "***We are going to do this EMDR intervention as part of the research project. You will receive some self-report questionnaires afterwards to fill out."***

Ask clients how they are doing, if they have enough support, and to sign the consent form for the intervention in the tracking sheet (see below).

Say, "***How are you doing during these difficult times. Are you getting enough support? I would appreciate if you could read over the consent form for this intervention and sign it."***

The Problem

Inquire about the problem that clients would like to work on.

Say, "***Tell me briefly, in one or two sentences about what is bothering you. What you would like to work on? If we were to do a good job together, what would you like to see happen?***"

Stage 2: Preparation - Explanation, Bilateral Stimulation, and an Opening Resource

General Explanation

The explanation will include psychoeducational information on stressful situations and on EMDR.

Say, "***Today we will be doing the EMDR Abbreviated Recent-Traumatic Episode Protocol (R-TEP) which is made up of three parts, like a sandwich: a resource, a disturbance and a resource. When we experience events that are "too much, too fast, too soon," or when we must face stressful situations for a prolonged period of time, our nervous system gets "overloaded" with threat reactions such as fight, flight, freeze. Over time, this translates into an accumulation of negative images, sounds, emotions, thoughts, body sensations and behavioral patterns. These experiences get stuck in the brain, and the purpose of the present intervention is to release some of that "charge" through resourced and focused processing, aimed at personal well-being and balance. Many times, such processing leads to a sense of resiliency and personal growth, as well.***"

Bilateral Stimulation

Say: "***Bilateral stimulation, or side-to-side stimulation, of eye movements or tapping, that we will shortly try out together, accelerates processing in EMDR. I will demonstrate some different types of bilateral stimulation, or BLS, so that you can choose the one that is right for you***."

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Demonstrate the different types of BLS with clients and practice them together.

- *Butterfly Hug*

  Say, *"**For the Butterfly Hug, cross your hands over your chest and begin tapping on your chest from one side to the other. In addition, move your eyes from side to side as fast as you can.**"*

- *Tapping*

  Say, "***For tapping, place your palms on the outer part of your thighs, close to the knee, and tap, alternating near the right knee, and then near the left one. Or, place your hands, shoulder width apart, on a table, and tap the tabletop with your palms, alternating from side to side. For both options, move your eyes from side to side, as fast as you can***."

- *Eye Movement Side to Side*

  Say, ***"For eye movements, move your eyes between two fixed dots in the room, or if the intervention is being carried out via teletherapy, between the two edges of your computer screen.***

  Say, *"**During processing, it's important to do eye movements. At first, it may be a bit difficult, but most people usually get used to it. You can do the eye movements with or without tapping as well. Let me know which type of BLS you prefer. You can also change the BLS any time**."*

  Say and demonstrate with your hand, *"**If you would like to stop at any time, just give me the stop sign, by raising your hand like this**."*

Opening Resource (Laub, 2001):

Say: *"**Before we start to work on the problem that you shared _______________** (state problem)**, I would like you to recall a moment when you felt good about yourself. You felt whole. What is the first thing that comes up for you?**"*

CONNECTING WITH THE RESOURCE

After clients share what came up, ask about the emotions and body sensations that go with the memory.

Say, *"**What emotions come up for you when you focus on that memory? What body sensations come up?**"*

Say, *"**Now, let's strengthen the connection to your resource. Try to focus on one image of the resource, and we'll slowly tap with the Butterfly Hug.**"*

Do the Butterfly Hug, tapping slowly. Gesture for the client to join you.

Say: "***Notice what you see…. hear…. smell…. notice the emotions that are coming up…. your body sensations. When you're done, give me a signal.***"

After a set of 6-10 slow passes (one pass = two taps, one on the right and one on the left), signal for clients to end.

Say, *"**What came up? What emotions and body sensations came up?**"*

Ask clients to carry out another set of tapping to strengthen the connection to the resource.

Say, "*Go with that.*"

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NAMING THE RESOURCE

Say, *"**Now I will ask you to give a name, a word or a sentence, to your resource. Notice, where in your body the positive sensation that goes with the memory is located. Let's strengthen the connection between the resource, the name and the positive sensation one more time."***

Direct clients to do one more set of Butterfly Hugs tapping to install the connection

Say, "***Continue to do the Butterfly Hug as you think of the resource and the name of your resource."***

Say, *"**What we just did is create an entrance to your resource. Now, you can reconnect with your resource whenever you would like to.**"*

Write down the resource on the tracking sheet provided.

Say, *"**In times of stress, sometimes, our positive memories aren't accessible, even though they are still inside of us. So, I suggest that we do a short exercise*** (the Voo or a breathing exercise)***, which will help you feel more stabilized."*** See below for scripts.

Stage 3: Assessment - Identification of the Point of Disturbance (PoD(and its Assessment

Google Search for Identifying the Point of Disturbance (PoD)

Say: "***Now I will ask you to scan the Coronavirus outbreak, from the time everything started and up until today, including any worries that you may have regarding the future. Please do the scan, not in any particular order, like in a Google Search. When any disturbance comes up, let me know what it is. We'll do this search with the bilateral stimulation that you chose.***"

Assessing the Point of Disturbance (PoD)

Assessment will be carried out as in the Standard EMDR Protocol, without using the Validity of Cognition (VoC) scale. Provide active assistance in finding the negative and the positive cognitions.

Image

Say, *"**When you focus on the PoD that you brought up, what image comes to mind?**"*

Negative Cognition

Say, *"**When you focus on the PoD, what is the negative belief you have about yourself, now?**"*

Positive Cognition

Say, *"**When you focus on the PoD, what positive belief do you have about yourself, now?**"*

Emotions

Say, *"**When you focus on the PoD, and say to yourself ___________*** (repeat the negative cognition)***, what emotions do you feel, now?***"

Subjective Units of Distress (SUD)

Say, ***"How disturbing is it for you, on a scale of 0 to 10, where 0 is no disturbance or neutral, and 10 is the highest disturbance imaginable?"***

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Body Sensations

Say, *"**Where do you feel it in your body?**"*

Write down the point of disturbance (PoD) and its components on the tracking sheet.

Stage 4: Desensitization – Focused Processing

Instructions for Processing

Say, *"**Now, let's start with the point of disturbance (**PoD**) that you have chosen. During the processing, I'll ask you to let whatever comes up, come up. Anything that comes up is OK. We're just noticing, without judgement. It's just like riding a train, with the scenery changing- moment by moment. From time to time, I will ask you to go back to a certain point in the memory so that your system can have a chance to refocus and reprocess it. It'll be just like "Zooming In" or "Zooming Out**"*.

Say, *"**Please bring up the PoD, with the negative belief____________** (*repeat the NC)***, and notice where you feel it in your body. And, let's start the bilateral stimulation** (*or BLS*)**. When something comes up for you and you want to share, please stop and do so."***

If clients do not stop to share their associations on their own, stop them after about 15 seconds of processing.

After each set of BLS, ask for clients' responses.

Say: *"**Take a deep breath**. **What came up?**"* Continue with processing until the SUD is ecological (0-3).

When going back to the target (PoD), ask for the SUD, according to clinical judgment.

Use "Back To Target" strategies as needed:

- *EMDr Strategy*

  If associations outside of this range come up, such as childhood experiences, the therapist will validate the association, and then return to the target (the disturbance).

  Say, *"**What you just said is really significant… and let's go back from here to where we started from** ______________________* (state the disturbance). ***What do you notice? Has anything changed?"***

Following the clients' response, ask for the level of disturbance (SUD), now. If the SUD is not ecological (0-3), continue with processing.

- *EMD Strategy*

  If the point of disturbance is intrusive (recurs repeatedly) or if an intrusive experience comes up during processing, make use of the EMD strategy, with the range of associations limited to the point of disturbance only. Keep sets short (approximately 10 passes). If an association comes up that is related to the episode/time-frame, or outside of that, gently ask clients to return to the target (disturbance/PoD).

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Say, "***Let's go back to the point where we started, so that your system can focus again, process the disturbance and let it go. What do you notice now? Has anything changed?"***

Following the clients' response, ask for the level of disturbance (SUD). If the SUD is not ecological (0-3), continue processing. After 6-7 sets, if there is no change in the SUD level, continue processing with the EMDr strategy.

- *Containing Strategy*

  Use the containing strategy, where you ask clients to go Back-To-Target /(PoD) in order to reorient, refocus or keep clients in their window of tolerance, such as when grounding is needed or there is looping. Use appropriate interweaves and provide relatively short BLS sets.

  Say, *"**I think it may be helpful, at this time, to go back to the point where we started*** ________(state PoD). ***Can you go back to where we started and take a look? What do you notice? Has anything changed?"***

- *Pairing Strategy*

  If a client has made an adaptive association, validate the resource and ask the client to go Back To Target (the disturbance/PoD).

  Say: *"**What you just said is a really valuable resource… let's take that back with us to where we started. When you go back to the target with the resource close at hand, what do you notice? Has anything changed?**"*

  If an adaptive association comes up towards the end of processing, allow for an additional set of BLS to further strengthen the association, listen to what comes up and then continue with Pairing by returning to the to target.

  Processing the point of disturbance will continue for approximately 20-30 minutes. If the client's SUD level is ecological, you may proceed to installation of the positive cognition.

  Say, "***"How disturbing is it for you, on a scale of 0 to 10, where 0 is no disturbance or neutral, and 10 is the highest disturbance imaginable?***"

  If the SUD is not ecological, offer to do the Voo exercise, or a different breathing exercise, with the client.

  Say: *"**You've done a good job. Our time is up now, and we have to finish. We can do a somatic exercise together, called "the Voo," or a different breathing exercise, in order to regulate your body and reach stabilization.**"*

The "Voo" Exercise (Levine, 2010)

Say***, "Now we will do a breathing exercise together that will help to balance your energy level and let go of unpleasant sensations. We will be making a Voo sound together that will cause vibrations that will affect the longest nerve in your body, the Vagus, which comes out of our brainstem all the way down through all of our vital organs,***

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like the heart, lungs, and gut. The 'Voo' sound is made by taking in a deep breath, and then, on the out breath, gently making the sound 'Voooooo", sustaining it through the full exhalation; vibrating the sound from the belly. At the end of the breath, we will briefly pause, allowing the next breath to fill our belly and chest. Then we will make the sound again, until it feels complete. The important thing is to let both sound and breath expire fully, pausing and waiting for the next breath to come on its own, when it is ready. Let me show you."

Demonstrate once for the client, on your own. Then, do it twice with the client.

Say, ***"Now let's do two "Voo's" together. Ready? Let's take a deep breath in, and Voooooo…"***

Another option for stabilizing is a breathing exercise.

The Breathing Exercise *(*from the 4 Elements for Stress Management, Shapiro, 2007*)*

Say*,* ***"Simply noticing the breath helps us feel centered and supported. Now breath in through your nose, letting the air go all the way to your stomach as you count 4 seconds (1..2..3..4)…. then gently hold for 2 seconds (1…2) and then breath out for 4 seconds (1..2..3..4). Let's take a minute for about 6 deeper slower breaths like this. [Pause]. Repeat this six times."***

At the end of the breathing exercise, for clients with an incomplete session, skip stages 5 and 6 and proceed to stage 7 (Closure).

Stage 5: Installation

Install the positive cognition (PC) if the SUD level is ecological (realistic), between 0-3.

New PC

Say: *"**We are nearing the end, does _______________ (**repeat the original PC**) still fit, or would you like to choose a different statement instead?**"*

Checking the VoC

Say*, "**How true does the positive belief __________________ (**repeat the PC**) feel to you on a scale of 1 to 7, where 1 means that it doesn't feel true at all, and 7 means that it feels the truest?"***

Listen to the client's answer.

Say***, "Can you hold the PoD that we worked on, in your mind, together with the words ____________________ (***repeat the PC***), and let's do another set of BLS**."*

Direct the client to perform two sets of BLS, ask what comes up and check the VoC level each time.

Say*, "**Go with that**."*

Say***, "What comes up?"***

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Say*, **"How true does the positive belief ___________________*** (repeat the PC) ***feel to you on a scale of 1 to 7, where 1 means that it doesn't feel true at all, and 7 means that it feels the truest?***

Stage 6: Body Scan

The Body Scan is carried out according to the Standard EMDR Protocol.

Say, ***"When you bring up the PoD that you had with the words ____________*** (repeat the PC***), notice what happens in all the different areas of your body -from the top of your head all the way down to your feet. What sensations do you feel?"***

Direct the client to perform BLS in order to enhance the positive sensations, or to release unpleasant ones.

Say, "***Continue to do BLS as you release the unpleasant sensations and enhance the positive ones."***

Say, "***What came up now?"***

Direct the client to perform an additional set of BLS on the body sensations.

Say, "***Notice your body sensations and go with that***."

Stage 7: Closure – Validating Resources and the Closing Resource

Validating Resources

Repeat all of the resources, or adaptive associations, that came up during processing, starting with the opening resource.

Say, ***"We are coming to an end point, you did a great job. Some important resources came up during our work together, and I'd like to remind you of them."***

Share significant resources with the client.

The Closing Resource

Say: ***"And now, as we end, I would like to ask you if there's any story that you can tell me, about you and your life experiences, from the time that you were born, until today. A story that could help teach me why you are capable of dealing with the disturbance we worked on? A story that would reflect actions that you have taken in the past, challenges that you overcame, your values or beliefs, and/or things you hold dear to your heart?***

Connecting to the Closing Resource

After clients share their stories (or a group of stories), ask what emotions, body sensations and thoughts came up.

Say, ***"What emotions come up when you focus on that memory, or on that group of your memories? Does any positive belief go with them?"***

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Say, *"**Now, let's hold the connection to your story, which is your closing resource- with the Butterfly Hug. Focus on one memory, or on the whole group*** (if more than one has come up), ***and start tapping slowly. Notice what thoughts, emotions and body sensations come up.***"

Start tapping with the Butterfly Hug, asking the client join you. After approximately 6-10 slow sets, gesture for the client to finish tapping.

Say, *"**What came up? Did you notice any emotions, any body sensations, or thoughts that came up?**"*

Ask the client to perform an additional set of Butterfly Hugs to install the resource.

Say, "***Now I will ask you to give a name, a word or a sentence to your resource. Notice, where in your body, the positive sensation that goes with the memory, is situated. Let's strengthen the connection between the resource, the name and the positive sensation one last time.***"

Direct the client to do one more set of tapping to strengthen the connection.

Say, "***Let's do one more set to strengthen the connection."***

Say, *"**What we just did is create an entrance to your resource. Now, you can reconnect with your resource whenever you would like to.**"*

Write down the closing resource with its components on the tracking sheet.

Note: If clients do not connect to the closing resource, ask them to choose one of the resources that was validated at the end of processing, or any other resource. The resource will be installed like the Opening Resource.

Words When Parting

Say, ***"I really appreciate the good work you've done, and the fact that you took the time to give you and your experiences some space. If you feel the need for any further intervention, please speak with*** **_________** (identify contact for client).**"**

Stage 8- Reevaluation - Follow Up

Begin the next session-if there is one-with reevaluation. Make sure the tracking sheet was filled out. If you do any symptom questionnaire before the intervention, do a follow-up one week after it, and three months later.

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The EMDR Abbreviated Recent-Episode Protocol (R-TEP) Tracking Sheet

Brurit Laub & Keren Mintz Malchi

Tracking sheet (May, 2020)

Date__________ Start Time:__________ End Time___________

Session Number 1____ 2____ 3____

Client's Name: (May also be written as an abbreviation) __________________ Age: _________

Location: ____

Clinician's Name: ____________________________ Phone Number: ________________________

Agreement for Follow-up: ❑ Yes ❑ No

Client Signature: ____

Phone Number: ____

Intervention Summary:

Opening Resource (Summary of resource, emotions, body sensations and name):

____

Point of Disturbance (PoD): ____

Picture: ____

Negative Thought: ____

Positive Thought: ____

Emotions: ____

Body Sensations: ____

SUD Level at the beginning of the intervention: ____/10

SUD Level at the end of the intervention: ____/10

Positive Thought (If different at end of processing): __________________________________

VoC:__/7

Resources in the Processing: ____

____

Closing Resource (Add thoughts, emotions, sensations and name):_______________________

____

____

Follow-up: Reevaluation as done in the Standard EMDR Protocol and symptom questionnaire before the intervention, one week after, and 3 months later.

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The EMDR Abbreviated Recent-Traumatic Episode Protocol – Summary

Therapeutic Alliance	• Building rapport, ascertaining stability and client support system.
The Problem	• "*Tell me briefly about what is bothering you…. What you would like to work on? If we were to do a good job together, what would you like to see happen?*"
Explanation	• Psychoeducation- Explanation about stressful situations and EMDR therapy.
Demonstrating BLS	• "*The bilateral stimulation, or side-to-side stimulation, of eye movements or tapping, that we will try out together shortly, accelerates processing in EMDR. I will demonstrate some different types of bilateral stimulation, or BLS, so that you can choose the one that is right for you.*" • BLS options: BH, tapping, EM.
Opening Resource (OR)	• "*Before we start to work on the problem that you shared _____ (*state problem*), I would like you to recall a moment when you felt good about yourself…. You felt whole…. What is the first thing that comes up for you?*" • Connecting with the resource (Emotions, Body Sensations) • BLS + Cueing • (If the client did not connect to the OR, proceed with a somatic exercise for stabilization).
Assessment: **Google Search +** **Assessment of PoD**	• Google Search: "*Now I will ask you to scan the period of the <u>Coronavirus outbreak</u>, from the time everything started and up until today, including any worries that you may have regarding the future. Please do the scan, not in any particular order, like in a Google Search… When any disturbance comes up, let me know what it is. We'll do this search with the bilateral stimulation that you chose.*" --- • As in the Standard EMDR Protocol (without VoC).
Desensitization	• Focused Processing of the PoD, using: ○ 4 "Back to Target" strategies: EMDr, EMD, Containing., Pairing, ○ 3 groups of interweaves: Somatic, Relational, Somatic/Relational ○ Marking Resources
Installation	• As in the Standard EMDR Protocol (but only if the SUD is ecological, (0-3).
Body Scan	• As in the Standard EMDR Protocol.
Closing: **Validating Resources + Closing Resource**:	• Validating Resources: "*We are coming to an end… you did a great job. Some important resources came up during our work together, and I'd like to remind you of them.*" --- • Closing Resource: "*And now, as we end, I would like to ask you – If there's any story that you can tell me, about you and your life experiences, from the time that you were born, until today…..A story that could help teach me why you are capable of dealing with the difficulty we worked on? A story that would reflect…. actions that you have taken in the past…. challenges that you overcame… your values or beliefs… and/or things you hold dear to your heart?* • Connecting with the resource (Emotions, Body Sensations) • BLS + Cueing • (If the client did not connect to the CR, you may install one of the resources that came up during reprocessing
Reevaluation	• Begin next session with reevaluation as in the Standard EMDR Protocol. • Provide research questionnaires when relevant.

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PART IV

Early Self-Care Suggestions & Interventions

Part IV is focused on Early Self-Care Suggestions and Interventions. This section is vital to our own and our clients' well-being. Chapters by Catherine Butler and Roger Solomon highlight the types of behaviors to cope during these tempestuous times and how to support resilience and our own strengths. The last two chapters are offshoots of Elan Shapiro's Group-Traumatic Episode Protocol. The chapter by Elan highlights how to work remotely in a group to promote self-care in a structured manner. The Self-Care Traumatic Episode Protocol by Judy Moench is to help clinicians who are feeling overloaded to develop resources in a short period of time. Both chapters explore the different protocols and point clinicians in a direction to get further training concerning these useful tools.

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Healer, Heal Thyself: Self-Care in the Time of COVID-19

Catherine M. Butler

As the world watches the dominos fall in increasingly complex patterns, with layer upon layer of concerns, risks, and fear, no one on the planet is currently living with any kind of physical or emotional immunity. Not even 9/11 brokered the kind of diverse needs that we see today and will continue to see in the days and weeks to come.

Those who have worked in disaster scenarios over their careers know that often what is offered at the time is psychological first aid at best, and that the survivors are then referred to higher levels of care ***outside*** of the scene. But, this time, we are all impacted by the fragility of our biome and have personal implications on top of our professional opportunities and obligations.

We are not outside the scene.

We are living in it, too.

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Everyone needs something from us, and now more than ever, the challenge must be to keep your emotional bucket as full as it can be.

No matter how you feel, you are a beacon to others: sharing your light, support and hope that cuts through the panic, despair and overwhelm. We join all the other “necessary” professions who are going to work on the physical front lines of this war, but our realm is the emotional front line. Therapists are consciously aware of what living with the handiwork of fear looks like in the present day but our challenges will surely be more significant in the long term.

Our intake questions of the future will undoubtedly ask about what resources the client had during the season of COVID-19 and what happened.

For now, in the interest of brevity, and in the spirit of promoting self-care in a time of chaos, I’d like to share this little anecdote with you that, if applied conscientiously, can fit in with the practical things we all know to do.

A colleague of mine came to the counseling profession from a career as a police officer. He faced it all, stood on the line of life and death, and had to go from one crisis to another every shift for 30 years. Upon retirement, he became a psychologist, focused on the impact of post-traumatic stress injuries for first responders.

He seemed to move with grace through all kinds of situations and always knew what to do.

I commented on that Yoda-like quality and asked him how he did that.

He said: **When I don’t know what to do, I just show up and do my next right thing.**

Think about that for a moment. Really think about it.

We don’t know what the next news report will say, or the next step that forces the community into deeper personal isolation will be, or when we can give someone we love a hug.

But, in the present moment, ask yourself what the next right thing is for you….**and do that.**

The next right thing isn’t big. It’s not about waiting in line at Costco. That might come later in the day but for your first step, bring it down to a place of power that puts yourself first. We get so busy we overlook the basics.

Take the pain reliever you need because you woke up with a headache three hours ago.

- Go get some water, and actually drink it.
- Go to the bathroom.
- Have you eaten? When?
- What will help you sleep better tonight?
- Take 3-5 deep breaths and give your brain 10 percent more clarity.
- Ask for help.
- Get some gum or hard candy going, to trick your parasympathetic nervous system into thinking you are not so stressed. If you can generate saliva, your body calms down.

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When you work in the realm of what is possible versus what is impossible, the success of that step will inform the ***next*** thing you need to do. In this fashion, you can take care of the many demands and needs that surround you personally and professionally right now. Just that small step. Then the next.

Reducing exposure to the constant flow of information is necessary. I treat media exposure almost like a food sensitivity: I can eat it but I won't feel good! Limit the saturation by agreeing to check in to a reputable local and national news source at the end of the day, when all the significant stories of the day have been synthesized down and crystallized. This way you avoid the "breaking news" that may not be news at all eventually.

When you have done **your** next right thing, it gives you the confidence to speak to your clients with confidence that they, too, have the resources they need to do **their** next right thing. Bring the meta-concerns down into a place of personal power that is manageable, supportive and most of all, empowering and kind.

Put the air mask on yourself and set yourself up for the physical and emotional marathon ahead. Use the tools that work for you, and put a note on your computer monitor that says "What's my next right thing?"

Go with that.

With respect and appreciation for you all, be well and stay well!

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Letter from Roger Solomon

Roger Solomon

Hello My Dear Colleagues,

I am passing on to you a brief, modified version of an outline I have used for resilience. May some of it be helpful to your clients, and you. As I send this off to Marilyn Luber (thanks Marilyn for coordinating this), I have some personal thoughts I want to pass on. I am reflecting on lessons learned from dealing with past tragedies that may be helpful now, and for future tragedy.

I am writing this and hearing on the news how more people are testing positive for COVID-19 and dying. (So now it's time to turn off the news - a truly great coping strategy - don't inundate yourself with the media.) Many of us and our clients are getting triggered because the present has dangers and the future is unknown. Now we have to martial our personal resources and those of our clients. We need to have a resilient attitude. Resilience is much more than, as one soldier put it, "Suck it up and move on." It is a mindset that fosters a survival attitude, a commitment to deal with adverse

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situations in an adaptive way. I believe Salvatore Maddi (2013) got it right in his concept of *hardiness*, which includes the concepts of *commitment, control,* and *challenge.*

- *Commitment:* We count, and are important; our family is important, our life is important, and our work with our clients is important, therefore let's make a commitment to deal with this situation. This is an important quote that has inspired me:

  W.H. Murray: *Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness. Concerning all acts of initiative (and creation), there is one elementary truth the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself, then providence moves too. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents, meetings and material assistance, which no man could have dreamt would have come his way. Boldness has generous, power, and magic in it. Begin it now."*

The bottom line: **MAKE A COMMITMENT TO DEAL HEAD ON AND DIRECTLY WITH THIS CRISIS**

- *Control:* We are not in control of what we are confronted with, but we can control our response to it. Vulnerability is part of the human condition, and we have to accept this. But, we are not helpless, we have control over how we deal with it.

  How do policemen get back on the street after a line of duty shooting? They focus on their tactics, their training, their ability to respond, and of course, their trust in their fellow officers. You may be able to relate to this -some of you have had an auto accident- how did you get back to driving? You perhaps realized that yes, an accident can happen again, but it does not mean it's going to. Further, you probably had a sense of control, "I can drive defensively," or "I can keep aware of my surroundings," and so on. In other words, you knew you had some control and knowing there is some control is enough for people get back into life.

The bottom line: **WE ARE NOT HELPLESS, WE HAVE CONTROL OVER HOW WE DEAL WITH IT**

- *Challenge:* There is much to be gained from getting through this crisis. We will grow, gain wisdom, become stronger and this makes it worthwhile to deal constructively with this situation. If it seems too much, break it down into smaller, doable steps. Identify family, friends, and community resources that you can rely on for help and reach out. These are challenging times and getting through this makes us stronger. So, renew your commitment to deal with this crisis.

  All around me I see people rising to the challenge, helping one another, our country and other countries responding with numerous programs, and we can help our clients keep going.

The bottom line: **CHALLENGES HELP US GROW, GAIN WISDOM AND BECOME STRONGER**

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Coping with Fear

In my many years of working with law enforcement and military personnel involved in traumatic incidents I have learned that following moments of "Oh Shit," where we are focused (even overwhelmed) by our sense of vulnerability and powerlessness, we can focus on our resolve to survive and "pump up" tremendous strength. Fear can be very useful. Critical incidents can potentially mobilize the tremendous strength of the survival instinct. Under adverse conditions, our response can come from a frame of mind of strength, control over this strength, clarity of mind, and increased alertness: *the survival resource* (Solomon, 1991).

As I might say to a first responder: "*Can you recall a time when your back was against the wall, its 'do or die,' and you had to do something? Remember the moment you knew what you had to do, and started to do it - that moment of commitment?"*

When the client can acknowledge such a moment say, "*Focus on your ability and capability to respond.*" *How does that feel, strong or weak?* (usually strong). *Controlled strength or wild* (usually controlled)? *Clear thoughts or jumbled* (usually clear)."

If the client feels agitated or is experiencing fear, I ask them to move further into their response and feel their "*ability and capability to respond*," while doing slow, deep breathing to relax and focus on their ability to respond.

I have used this in many contexts with many people who have experienced many different kinds of adversity. When talking to the widow of a police officer about this model and asking her if she could relate to the moment of positive response after her tragedy. She replied, "*Oh yes, you mean my first moment of empowerment*." That says it exactly.

Caution: Some people may become very triggered when entering the moment of vulnerability awareness. Instead, focus on being safe in the here and now, it's over, and even though I was scared - maybe even thinking that life may end- it did not, and at this moment "I am alive."

One Day at a Time

Lessons from September 11, 2001 and Hurricane Katrina

I learned many things from dealing with tragedy, but to be brief, I will describe a couple of the more important lessons.

In the immediate aftermath of September 11, people were scared. In trying to do a calm/safe place exercise, I found many people no longer had a safe place. What I found useful was asking the person to come up with a "*power stance"* where the person felt grounded, strong, capable, and then I enhanced the stance with bilateral stimulation. This was also helpful during Hurricane Katrina. In Hurricane Katrina, I worked with many people who were living in temporary shelters, had lost their safe place, and did not know when things would get better. As one client put it, "*I know I can focus on getting through today – plan for tomorrow – but ground myself in getting through today."*

The cliché, "*one day at a time,*" was very helpful. One person was very scared after September 11, and very afraid of the future. The planes continually circling overhead were a trigger. This person watched what had happened from a nearby office building and currently was involved in the immediate government investigation and response (a trigger in itself). We targeted the worst image (the second plane

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hitting the tower), using the Recent Event Protocol. As processing proceeded, the client connected the fear to childhood circumstances, and said (I kid you not): "I *am feeling what my therapist calls my 'kid shit.'"* Then the client was able to put things in perspective, and said, "*I have to take one day at a time."* This was said with such conviction and sincerity, that the true wisdom of these words struck me. This person knew he could cope with today. (This also points out the importance of identifying past memories that are "feeding" the current level of disturbance. Protocols that focus on recent events are indeed important and helpful, but at some point, past underlying memories need to be identified and processed.)

It is also important to remember this crisis will end, it is not forever and we will adapt.

Group Cohesion

Lessons from the Shuttle Columbia tragedy (disintegrated on reentry February 1, 2002).

I provided support through NASA's Employee Assistance Program, an outstanding group of competent, dedicated mental health professionals. A year later an informal outcome study on level of stress and ability to cope showed that those centers that provided interventions fostering group cohesion and support were functioning and coping better than centers that did not provide these interventions.

Similarly, my experience in working with law enforcement agencies and military strongly points to the importance of group cohesion. Those military units and law enforcement teams experienced interventions that fostered group support and cohesion experienced less trauma and higher morale than units and teams that received no intervention.

In times of distress, we are wired to reach out to others for safety. It is time now for our community of therapists to not only support our clients-our main mission-but ourselves. We need to lock arms (virtually, of course) and go forward, fostering resilience with ourselves as well as our clients. Stay in touch with each other, be there, reach out.

Roger M. Solomon, Ph.D.
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Strengthen Resilience: Promote Recovery

Roger Solomon

Understanding and promoting resilience during this COVID-19 pandemic can help our clients and augment what we do with EMDR therapy. This is part of a program I do for emergency personnel and first responders on resilience, and hopefully is applicable not only to clients, but to clinicians as well.

EMDR Therapy: A Paradigm of Resilience

EMDR therapy is an approach that is applicable to crisis intervention (within the first few days of a critical incident), for symptom relief, as well as comprehensive treatment. EMDR is a paradigm of resilience. With successful processing of a negative experience, adaptive, self-enhancing perspectives emerge. This guides future behavior. As Solomon and Shapiro (2013, p. 286-287) said:

> *In terms of the Adaptive Information Processing model, resilience, coherence and resourcefulness are responses based upon the affects and perspectives that characterize the memories that are stimulated by the current experience. When people are confronted*

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by adversity, adaptive information stored in their memory networks is available for coping with the challenge. A high level of resilience, sense of coherence, and learned resourcefulness results from the person's ability to make full use of functionally stored information and abilities acquired in his or her life.

Below, various perspectives on resilience and coping will be presented to enhance the mindset and provide the adaptive information needed when clients or practitioners are coping with this new challenge. Let's start with the concept of resilience.

Resilience

Resilience can be described in many ways:

- Positive capacity people have to cope with stress; a dynamic process where people exhibit positive behavioral adaptation when they encounter significant adversity or trauma (Luthar, Cicchetti, and Becker, 2000).
- Developed ability to be flexible and adapt rapidly to changing circumstances, acknowledging there is a stressful situation and being able to focus on one's ability to react and respond with mental and emotional strength.
- Ability to regain balance after adverse circumstances by learning from it and utilizing lessons learned to deal with present and future life.
- Life may never go back to the way it was. Therefore, we have to move through and integrate adverse circumstances and create a new normal. "What happens to us becomes part of us. Resilient people do not bounce back from hard experiences; they find healthy ways to integrate them into their lives." (Greitens, 2015, p.23)
- "Sense of coherence" (SOC). SOC is an orientation to life pertaining to the ability to comprehend a stressful situation and to use available resources for movement in a health-promoting direction with a feeling of confidence. Resilience is promoted when a stressful event is experienced as ***comprehensible, manageable,*** *and* ***meaningful*** *(*Antonovsky,1987*).*

Note: It is not that resilient individuals never experience negative affect, but rather the negative affect does not persist. Resilient individuals are able to profit from the information provided by the negative affect. It is finding meaning and learning that enriches the present and informs the future.

Let's look further at Antonovsky's SOC in light of the three important qualities of resilience as he described it to support your clients:

- *Comprehension of an Event*: We can understand what happened and how it happened, even if we may never know why something happened. Importantly, we can comprehend the implications of the event on health and wellbeing, and face it. With COVID-19, some clients may need help understanding what has happened and what is happening now, and what the implications are.

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- *Manageability*: There are constructive strategies to cope with an event, circumstance and consequences. What is happening is difficult, but can be managed. We are in control of our response to the situation. Provide clients with problem solving, affect regulation, and grounding strategies, with focus on their ability and capacity to respond.
- *Positive Meaning*: Understand the impact of an event, its significance in your life, and what can be done to make it a positive experience. There is the opportunity to know friends and family at a different level through continued positive and supportive contact, to learn new coping skills and enhance existing ones, creative ways to be with oneself, and come out stronger by coping with adversity.

Antonovsky went on to create "Salutogenesis:" this is a medical approach focusing on factors that support human health and well-being, rather than on factors that cause disease. More specifically, the "salutogenic model" is concerned with the relationship between health, stress, and coping. We can use it to address the positive growth factors that can occur as a result of a traumatic event or situation.

Salutogenic Effects Possible When Dealing with Trauma and Adversity

Trauma can have salutogenic effects. Here are some ways to think about trauma and adversity that can increase resilience and Sense of Coherence:

Positive Aspects of Trauma Experience

- Leads to *positive growth* (Tedeschi & Calhoun, 2004).
- Reinforces person's ability to *deal with adversity*. As one policeman involved in a line-of-duty shooting put it: "Surviving my incident and facing my worst fear has taught me a lot. I can use the wisdom and strength gained to deal with other life challenges."
- Clarifies values and puts *life in perspective*. A fireman responding to the Oklahoma City bombing learned: "I have always stopped to smell the roses, now I linger a little longer." After the September 11 attacks, a medic noted: "Now I know what is really important to me."
- Promotes *closer interactions* with others.
- Supports an *appreciation of life.*
- Engenders a sense of *competence and resilience* as a result of the experience.

Salutogenic Effects

People directly involved in an incident can experience coping/survival resources, moments of strength, and adaptive coping response that enhance self-efficacy. To elicit these positive moments, ask:

- *Were there any moments in dealing with this (*situation, incident, crisis or in the aftermath*), where you felt competent, effective, strong, or good about what you did?*

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- *Did you do something that helped mitigate the impact of* the (situation, incident, crisis*) either during or after the incident?*
- *Did you learn anything new or different about yourself after experiencing this event?*
- *Did you do something to help others? (*Helping others helps oneself.)
- *What have you already done* (or been doing*) to deal with this situation?*
- *The positive coping measures that you took ___________(*state what the client did*) were really helpful and supports your moving forward.*

Resourcing

Create a Resource: Create a resource by guiding a client to focus on the positive actions that were taken (mental and physical) to deal with a stressful situation. Focusing on a moment of adaptive action, and the feeling that goes with the ability and capability to respond, evokes a resourceful frame of mind that balances out the moments of vulnerability. (See Dynamics of Fear model below)

Bilateral Stimulation: Reinforce and enhance these moments of strength, positive coping and forward direction with bilateral stimulation.

Cue Word: The client can come up with a cue word or phrase associated with this resourceful state of mind (with the connection being enhanced with sets of bilateral stimulation).

Future Rehearsal: Do future rehearsal by guiding the client to imagine coping with an anticipated stressful situation, while experiencing this positive, strong frame of mind (using the cue word). If positive, enhance with bilateral stimulation. If negative associations arise, stop bilateral stimulation, explore and address the issue according to the needs of the client.

Resilient Attitudes

Reinforce the resilient attitudes below verbally and by using bilateral stimulation.

- *I am vulnerable, but not helpless.*
- *I can focus on my ability (*skill*s) and capability* (resolve, focus, and skills*) to respond.*
- *I have strengths to see me through, and vulnerabilities that can be managed.*
- *After coming to grips with my sense of vulnerability, I can emerge stronger and utilize this strength to deal with other life challenges.*

Hardiness (Maddi, 2013)

The idea of hardiness has to do with the following:

- *Commitment: I am important enough to fully involve myself in dealing with the problem. I can face it.*

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- *Control: I have the ability to influence the outcome of a problematic situation, either positively or negatively.*
- *Challenge: In dealing with this problem. I can learn and grow from it so it is worth dealing with the situation fully, with commitment.*

What prevents Hardiness?

- *Low self-esteem: I am not important. I am not worthy.*
- *Lack of self-efficacy: I'm not capable/I'm powerless.*
- *External locus of control: I am powerless/no control.*
- *Fear/avoidance of dealing with situation: I'm not safe.*
- *Lack internal resources*: The client does not have sufficient adaptive information, positive experiences, or skills.

Note: Memories underlying the above factors can be identified and processed, along with processing present triggers and applying future template for each trigger.

Broadening Your Perspective

Help clients see the bigger picture or look at the situation from different perspectives:

Finding Alternatives

- *What is your best description of the stressful circumstance. Reflect on it fully.*
    - *Who are the people involved?*
    - *What are the likely implications or effects of this situation?*
    - *What is troublesome to you about all this?*
    - *How does it make you feel/impact on you?*
- *Think of what you could do to make the circumstances worse than they are.*
- *Think of what you could do to make the circumstances better than they are.*
- *To make things better.*
    - *What would have to change?*
    - *Would you or others have to act differently?*

Changing Perspective

- *Commonplace Perspective*: This happens to many people, not just you.
- *Manageability Perspective*: Realizing it could be worse makes the situation more tolerable, enabling you to approach it long enough to solve it.

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- *Improvability Perspective*: Imagine ways to improve the circumstance rather than to just have passive optimism that does little to change it.

Becoming More Optimistic (Seligman, 1998):

- *Time limited vs. Forever*: Present circumstances will not last forever.
- *Specific to Situation vs. Generalized:* When it is specific, it does not take over one's whole life. When it is generalized, it feels all encompassing.
- *Internalizing vs. Externalizing*: Internalizing -such as: "It's all my fault"- prevents seeing the external factors and circumstances contributing to the situation that need to be dealt with.
- *Circumstance Defines Me vs. Circumstances are What Happened to Me*: Circumstances are what happened to me, they do not define me.
- *Powerless over Situation vs. Control over One's Reaction to the Situation:* A person may have no control over a situation, but can control their response to it.

One Day at a Time

- The cliché, "One day at a time," really can be helpful.
- Help the client realize things will continue to evolve, and even though we don't know the future, we can focus on getting through this day.
- The client's challenge is to get through the day in an adaptive manner.
- The client can help others get through the day (helping others helps oneself).

Dealing with Fear & Vulnerability

(adapted from Dynamics of Fear, Solomon, 1991)

- *The Importance of Fear*: You may have experienced (still are?) tremendous fear and been confronted your sense of vulnerability.
- *Automatic Response*: Realize fear is an automatic response to the perception of danger and is not a sign of weakness.
- *Use of Fear*: Fear can be utilized to exercise caution, increase alertness, and mobilize great strength.
- *Using Fear to Mobilize Survival*: Critical incidents and crises can potentially mobilize the tremendous strength of the survival instinct.
- *The Survival Resource*: Under adverse conditions, our response can come from a frame of mind of strength, control over this strength, clarity of mind, and increased alertness-the *survival resource*.
- *Transform Fear to Strength*: Policemen involved in line of duty shootings have taught me how in milliseconds fear can be transformed to strength.

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The following model – Dynamics of a Critical Incident – is an attempt to put in words something that takes place beyond words – beyond thought – but hopefully illustrates how adversity can harness and focus the strength that comes with our instinct to survive.

Dynamics of a Critical Incident

***Here Comes Trouble*:** You become aware of a threatening situation.

***Oh Shit*!**: You become aware that you *are* in trouble, and may feel weak, vulnerable, or not in control. This is the moment of vulnerability awareness.

I've got to do something: You acknowledge the danger is real and you must act to survive or gain control over the situation.

Some people think: *NO WAY, I am not going to let this happen to me (or you).*

Transition from Internal Focus to External: Now you make the transition from an internal focus on vulnerability to an external focus on the danger.

***Survival/Coping** (“I will survive”):* You focus on the danger in terms of your ability to respond to it. Maybe you start responding automatically as your previous training and experience comes forward. Consciously or instinctively you come up with a plan, start to react, and feel more balanced and in control.

Here Goes: Here goes is the moment of *commitment*. There is the resolve to act, whether instinctual or planned, which mobilizes tremendous strength. Your frame of mind is focused: characterized by strength, control over this strength, clarity of mind, and increased awareness. This is *the survival resource*.

***Response**:* You go for it, with your response fueled by the survival resource.

Lessons Learned: If we focus solely on the danger, we tend to feel weak, vulnerable and out of control. If we focus on our ability and capability to respond to the situation, we feel more balanced and in control, and strong. That's why it's important not to dwell just on the danger, but to focus on our ability to respond.

Life after “Oh Shit!”: After a critical incident, it is natural that one may dwell on the moments of "Oh Shit". But you can get stuck here. While it is important to face feelings of vulnerability (“Bad things can happen to me”) you must also give yourself credit for what you did to respond. One policeman put it this way, “There is life after ‘Oh Shit.’” Remember, sometimes doing “nothing” is the best “something” you could have done!

The moment of “HERE GOES” can be used as a resource (see above).

Commit: Acknowledge the danger and vulnerability, and then focus on your ability and capability to respond. You may not be able to control the situation, but you can control your response to it. Take a step forward, plan, think of your choices, and ***commit***:

> *Concerning all acts of initiative and creation there is one elementary truth — that the moment one definitely* **commits** *oneself then divine providence moves too. All sorts of things occur to help one that would never otherwise have occurred and which no man could have dreamed would have come their way.* (Johann Wolfgang von Goethe)

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Stress Reduction Strategies

- **Talk it Out**: Talk to friends, family, clergy, medical personnel, therapists, etc.
- **Write it Out**: Journal.
- **Work it Out**: Exercise.
- **Relax it Out**: Do deep relaxation, visualization, autogenic training, and/or meditation.
- **Self–Care**: Eat healthy, avoid substances that reduce functioning, and get proper sleep.
- **Create a Structure / Routine**: make a daily schedule for yourself that includes ***healthy rituals***. Having a structure provides predictability and sense of control.
- **Engage**: Engage in activities that affirm your identity.
- **Think Positively**: *I can't control what is going on around me, but I can control my response to it.*
- **Maintain Life Balance**: Maintain balance with yourself, work, intimacy, social, and spiritually. If one area of your life goes down, rely on other areas of your life for support and balance.
- **Actively Seek & Utilize Support***:* Reach out to others.

We Are All in This Together – Let's Lock Arms *(Virtually)* **& Go Forward!**

In Closing

EMDR therapy can be utilized to enhance resilience. As Solomon and Shapiro (2013) state:

> *EMDR therapy is designed to identify and process the past memories that underlie difficulties in coping, to address present situations that trigger disturbance, and to enable the development of a positive memory template for future adaptive behavior. The processing of pivotal memories facilitates a rapid learning experience that transforms the negative perspective and affects into more neutral or even positive ones. These then become the basis of resilience by enhancing one's ability to cope effectively with subsequent related stressors. Processing the dysfunctionally-stored memories that underlie current maladaptive behaviors enables a person to bring to bear on future adverse circumstances the full potential of his or her functional capacity and available personal resources.* (p. 287).

The overall goal of coping with resilience, going for it, is encapsulated in one of my favorite quotes by W.H. Murray (1951) who elaborated on Goethe's quote:

> *Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness. Concerning all acts of initiative (and creation), there is one elementary truth the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself, then providence moves too. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents, meetings and material assistance, which no man could have dreamt would have come his way. Boldness has generous, power, and magic in it. Begin it now."*

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Group-Traumatic Episode Protocol Remote Individual & Self-Care Protocol (G-TEP RISC)

Elan Shapiro

Description of the Group Traumatic Episode Protocol Remote Individual & Self Care Protocol (G-TEP RISC)

An adapted Group-Traumatic Episode Protocol (G-TEP) training has been developed for the "Age of Corona" that trains EMDR clinicians in the use of the G-TEP worksheet for remote individual application. The G-TEP Remote Individual & Self Care (RISC) Protocol has a number of advantages for keeping the client safe and contained. The step-by-step structured worksheet establishes a concrete representation of present, past and future resources that

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envelope the *Trauma Episode*. The form of self-BLS employed engages eye movements and focused processing procedures to ensure short chains of association. *Step 1* of the worksheet teaches stress management and has a screening function for readiness, as well as being an extended preparation. The new composite worksheet can be simply printed out on home printers or hand drawn.

The training has three parts that permit flexibility for remote delivery since they can be done separately or together:

- *Part 1*: This is a one-hour video sent to the EMDR clinician participant that serves as an introduction, overview and preparation for Parts 2 and 3 of G-TEP RISC.
- *Part 2*: This is done several days later online, after participants have watched the video and prepared the worksheets and materials needed. It takes an hour and a half and consists of questions and answers following Part 1, reviewing basic concepts of EMDR Early Intervention and a guided role play practice with a trainer who will demonstrate the procedures of the protocol script. This would enable clinicians to use the worksheet for Self-Care, until they do Part 3.
- *Part 3*: This is a three-hour experiential practice delivering the protocol as a group leader and receiving it as a group member. The practice is conducted in groups of four closely supervised by the trainers. It is recommended when possible to do parts 2 and 3 together.

After completing all 3 parts of the remote G-TEP-RISC training, although this is equivalent to the usual full G-TEP training, participants are advised to work only individually when working remotely with clients. They work with groups face-to-face. Supervision is recommended.

For further information: **EarlyEMDRintervention.org**

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The Self-Care Traumatic Episode Protocol (STEP)

Judy Moench

The Self-Care Traumatic Episode Protocol evolved following a conversation between Elan Shapiro and Judy Moench. STEP is a video series that was developed using the concepts of earlier work of Elan Shapiro and Bruit Laub. It is based on the principles of the Adaptive Information Processing Model (AIP). The Group Traumatic Episode Protocol (G-TEP) was created for groups after the Recent Traumatic Episode Protocol (R-TEP) was found successful with individuals.

STEP was initiated during the Covid-19 crisis to assist Mental Health clinicians and medical staff to decrease stress and increase coping during this difficult time. Due to the inability to meet in person, this computer adapted AIP informed protocol was born. The idea was initiated in order that clinicians -who are feeling overwhelmed by current events can- within a typical 1.5 hour-session, combine stabilization activities to ensure a present focus, have the ability to process the on-going overwhelming event(s), and develop containment strategies to allow them to continue to work effectively on the front lines.

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STEP includes initial screening to ensure suitability for moving forward with the protocol as well as a short psycho-educational component. Those who are suitable, move forward to do stabilization and further screening. The worksheet-based protocol follows for those who meet the criteria. Following the protocol, a containment video is recommended. For some, further referrals are suggested if needed.

The videos have an easy to follow format. They will be available on the EMDR Canada website initially for EMDR Canada members to use as a self-care tool and to complete initial research on efficacy of the protocol. Following the initial study, the protocol will be more widely available if efficacy is determined. Check the Prepped 4 Learning website for updates on availability **https://prepped4learning.com**. We would like to thank EMDR Canada for their support of this program. If you would like to gain access to STEP following the study, please email Judy Moench **prepped4learning@gmail.com** and we will add your name to our list for additional information.

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Appendix A ~ Global Resources

In the Beginning

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Austria
Association: EMDR-Netzwerk Osterreich ≈ **http://www.emdr-netzwerk.at**
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Azerbaijan
Facebook ≈ **https://www.facebook.com/emdra.az**
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Belgium
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Association ≈ **www.emdr.ba**
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Association: EMDR Danmark ≈ **http://www.emdr.dk**
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Association: Suomen EMDR-Yhdistys ≈ **http://www.emdr.fi**
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Ireland
Association: EMDR-All Ireland ≈ website-under construction
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Israel
Association: EMDR-IS ≈ **http://www.emdr.org.il**
Facebook ≈ **https://www.facebook.com/EMDR.IS?fref=ts&ref=br_tf**
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Lithuania
Facebook ≈ **https://www.facebook.com/EmdrEuropeAssociation/posts/lithuania-the-first-group-that-completed-the-basic-standard-training-in-vilnius-/1718255038213810**
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Poland
Association: PTT EMDR ≈ **http://www.emdr.org.pl**
Facebook ≈ **https://www.facebook.com/groups/391190417630323/?ref=br_tfemdr.org.pl**
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Association: EMDR Serbia ≈ **http://www.emdr-se-europe.org**
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IBEROMÉRICA

EMDR Iberoamérica
An association of South & Central America National EMDR Associations ≈ **www.emdriberoamerica.org**

Argentina
Association: EMDR Iberoamérica Argentina ≈ **http://www.emdribargentina.org.ar**
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Brazil
Association: EMDR Brasil ≈ **http://www.emdr.org.br**
Contact: Ana Lúcia Gomes Castello ~ **presidencia@emdr.org.br**

Chile
Association: EMDR Chile ≈ **http://www.emdrchile.cl**

Columbia
Association: EMDR-IBA Colombia ≈ **http://emdrcolombia.com**
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Costa Rica
Association: EMDR Costa Rica ≈ **http://emdrcostarica.wordpress.com**

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NORTH AMERICA

Canada
Association: EMDR Canada ≈ **http://www.emdrcanada.org**
President: Dell Cucharme ~ **info@emdrcanada.org**

United States
Association: EMDR International Association ≈ **http://emdria.org**
Executive Director: Michael Bowers ~ **exec@edmria.com**

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Related EMDR Trauma Aid/Humanitarian Assistance Programs

A S I A

Japan ~ Association: JEMDRA-HAP ≈ **http://hap.emdr.jp**

E U R O P E

Trauma Aid Europe – Association: Trauma Aid Europe ≈ **http://www.emdr-europe.org**

France – Association: Trauma Aid France ≈ **https://www.trauma-aid-france.org/page/866956-l-association**

Germany – Association: Trauma Aid ≈ **http://www.trauma-aid.org**

Spain – Association: HAP-España ≈ **http://www.emdr-es.org**

Switzerland – Association: Trauma Aid/HAP Switzerland ≈ **http://www.hap-schweiz.ch**

Turkey – Association: EMDR-HAP Turkey ≈ **www.emdr-tr.org**
Contact: Senel Karaman ~ **senelkaraman@gmail.com**

United Kingdom – Association: HAP UK ≈ **https://www.traumaaiduk.org**
Facebook: Trauma Aid UK ~ **facebook.com@tramaaiduk**
Twitter: Trauma Aid UK ~ **traumaaiduk@twitter.com**

I B E R O M É R I C A

Iberoamerica – EMDR Iberoamerica ≈ **http://emdriberoamerica.org/progamaayudahumanitaria.html**

Argentina
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Contact: Jimena Cavarra ~ **pah@emdribargentina.org.ar**

Mexico
Asociacion Mexicana para Ayuda Mental en Crisis A.C. ≈ **http://www.amamecrisis.com.mx/emdr-mexico**

N O R T H A M E R I C A

United States
Trauma Recovery's EMDR Humanitarian Assistance Program [EMDR-HAP] ≈ **http://www.emdrhap.org**

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Other Related Humanitarian Response Groups

NORTH AMERICA

United States
Association: EMDR Community Response Networks
Contact: CRN Leadership Team ~ **CRN.emdr.us@gmail.com**

Association: EMDR Disaster Network of Therapists ≈ **https://emdrdisaster.net**
Contacts: Deany Laliotis ~ **info@deanylaliotis.com** | Dan Merlis ~ **emdrdisaster@gmail.com**

Association: Trauma Recovery network/Trauma Recovery: EMDR Humanitarian Assistance Programs
≈ **https://www.emdrhap.org/content/trauma-recovery-network**
Contact: Trauma Recovery/HAP (203) 288-4450

The Francine Shapiro Library
Francine Shapiro Library's EMDR Bibliography ≈ **https://emdria.omeka.net**

EMDR Journals and E-Journals
The Journal of EMDR Practice and Research – The official publication of the EMDR International Association ≈ **http://www.springerpub.com/emdr**
EMDR-IS Electronic Journal ≈ **http://www.emdr.org.il**

EMDR Research Foundation ≈ **www.emdrresearchfoundation.org**

Related Traumatology Information

American Red Cross ≈ **www.redcross.org**

The Institute of Family Studies ≈ **https://aifs.gov.au/cfca/topics/web-resources-trauma-grief-and-loss**

David Baldwin's Trauma Pages ≈ **http://www.trauma-pages.com**

Children and War ≈ **http://www.childrenandwar.org**

European Federation of Psychologists Associations Task Force on Disaster Psychology [EFPA] ≈ **http://www.disaster.efpa.eu**

European Society for Traumatic Stress Studies ≈ **http://www.estss.org**

Give an Hour ≈ **www.giveanhour.org**

International Society for the Study of Trauma and Dissociation ≈ **https://www.isst-d.org**

The International Critical Incident Stress Foundation ≈ **http://www.icisf.org**

National Center for PTSD ≈ **http://www.ptsd.va.gov**

National Institute of Mental Health ≈ **http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml**

Wounded Warrior Project ≈ **www.woundedwarriorproject.org**

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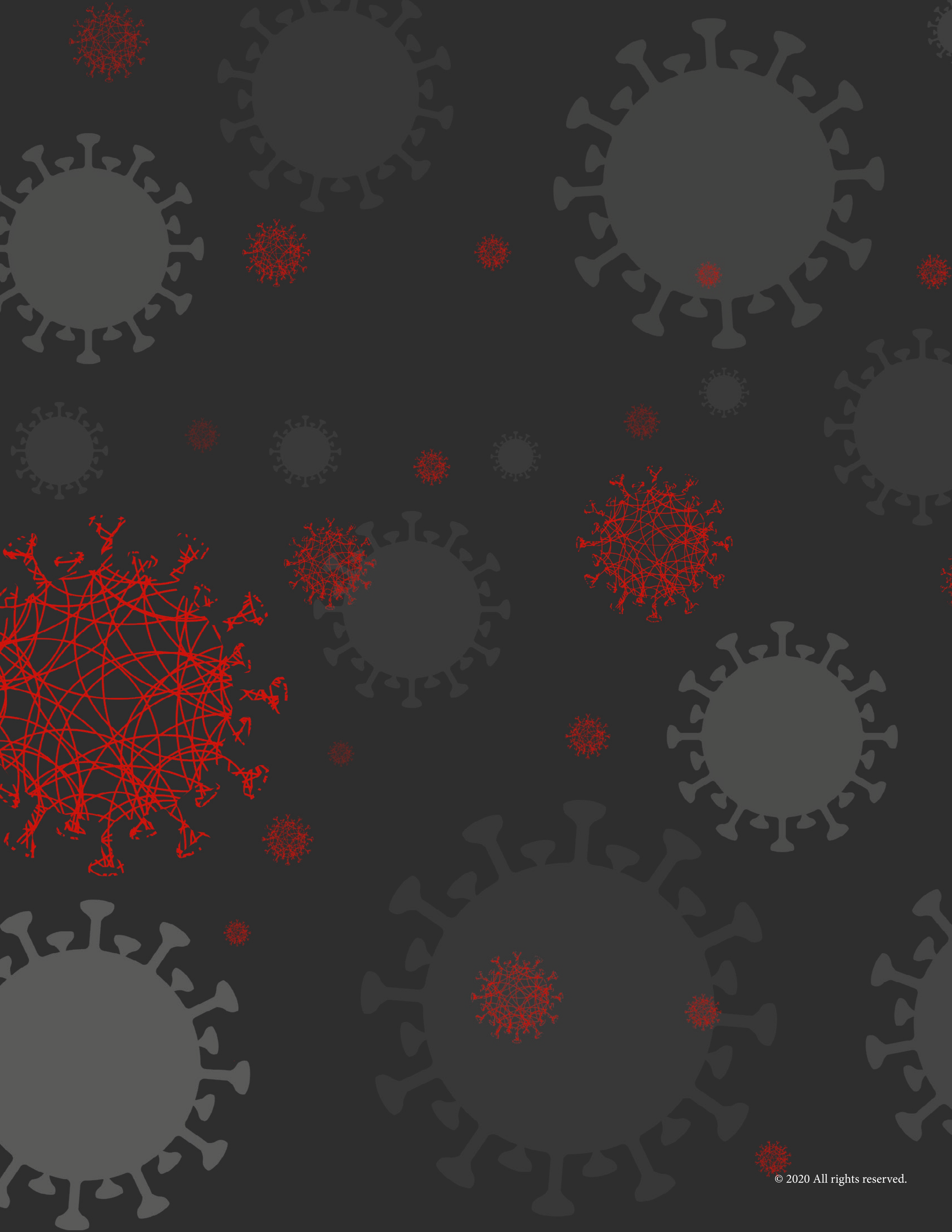

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