

Trauma Psycho Social Support Plus® and EMDR therapy for children and adolescents in a post-conflict setting: Mental health training in Kurdistan

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Key points of interest

- Trauma Psycho Social Support Plus (TPSS+®) is a stabilisation approach using EMDR therapy elements and designed for social workers. The methods taught can be used as standalone interventions as preparation for EMDR therapy interventions. The training program focuses on fostering resilience by means of resource installation and psychoeducation about trauma.

Abstract

Introduction: This paper describes the implementation of a pilot project in Kurdistan / Northern Iraq on the use of EMDR in children in post-conflict settings.

Methods: A 4-field scheme aimed at patient stabilisation was taught to social workers for

the application with children and adolescents in Northern Iraq. If possible, the stabilisation was followed by procedures aimed at memory reprocessing or modification within the eight-phase EMDR protocol and (in all cases) with further care.

Results: An initial assessment of the children and adolescents themselves revealed significant traumatic burden. The subjective distress was reduced when the rescue and the present situation were reflected age-appropriately with the help of pictures and sketches. For six children and adolescents, a post-stabilisation treatment within EMDR therapy was offered.

The first results in this very small sample were encouraging providing support for a full-scale controlled study.

Keywords: Posttraumatic stress disorder, Eye Movement Desensitization and Reprocessing, resource installation, psychological first response, intervention.

Introduction

In 2017 TraumaAid collected information and data in different Kurdish refugee camps regarding priority needs. Parents complained about problems in raising their children after the war events and their escape – problems that in a professional's view result from the traumatic quality of the incidents. In parallel,

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a questionnaire was created and later handed out to social workers and mental health professionals in two camps in Kurdistan by Terre des Hommes (TdH) Italy (personal communication, June 16, 2017) to assess the needs of the employees in better serving the refugee population. The answers from the staff (N=21) showed as top priority being trained on “case management and dealing with different types of child abuse”, followed by “psychosocial support” in general, “dealing with trauma”, “psychological first aid”, and “awareness raising in families”. This was the basis for a training program that included trauma recognition, methods of stabilisation and working with grief and loss as part of an EMDR education program. The program included a novel focus, the so-called EMDR-Plus, which prepares for EMDR psychotherapy.

EMDR therapy is a psychotherapeutic approach focusing on stressful memories that a patient has made in a traumatic or otherwise adverse event (Shapiro, 1992, 2001). The therapy features an eight-phase approach in which the earliest or most stressful event is identified and reprocessed under bilateral stimulation. Stabilisation is an essential part of the eight-phase approach (Phase 2). EMDR has proven effective for the treatment of PTSD in various studies and is accepted as a standard treatment for PTSD by the WHO (Bisson & Andrew 2007; Lee & Cuijpers, 2013, World Health Organization, 2013). EMDR therapy is currently offered by Jiyān-Foundation across six counselling centres in Kurdistan. There are few scientific research articles about refugees especially in the Eastern Mediterranean Region. One of them highlights the therapeutic work with victims of the Syrian war and describes EMDR therapy with traumatic material (Zaghrout-Hodali, 2014). As training a therapist in EMDR therapy is considered to take too much time under an emergency sit-

uation, the seminar “Trauma Psycho Social Support Plus” (TPSS+®) was supposed to widen the options of the professionals who work in this field with EMDR therapy-based methods of psychosocial support.

At the end of the seminar, social workers and other health professionals should be able to teach parents and other family members how they could use resource installation with their children. In the unlikely case of later access to EMDR therapy, this would be a helpful preparation (Gattinara and Pallini, 2017). Most likely, children will have to cope without the chance of therapy – for those, the resource installation procedure could be an important chance to gain more emotional stability. Bilateral stimulation (BLS) is for example administered by alternate tapping on the knees or shoulders, which can be offered by the therapist or as therapist guided self-stimulation. We hypothesised that this approach would support emotional balance and thus stabilisation of the person as a whole. In contrast to advanced techniques like resource development and installation for children (RDI) (Adler-Tapia et al., 2008, p. 77-79), in EMDR-Plus it is not necessary to activate negative memories. That requires advanced experience in psychotrauma therapy. After war or long-lasting crisis, instead of focusing on trauma confrontation, the way to reinforce personal resources is to focus on symptom relief (Steinert et al., 2016).

Trauma Psycho Social Support Plus: Description of its position in the support pyramid

The model of a pyramid may explain the position of TPSS+® in the system of refugee camp-based health care (see Figure 1). At the bottom of the pyramid, the work of different caretakers who provide Psychological First Aid for all refugees in the first hours and days is displayed. Later during the stay in the

camp, there is a program specifically for children: The Child Friendly Spaces (Snider & Ager, 2018). At the next level, professionals provide support for families and groups, who are able to develop a structured help for the unique situation of living in a refugee camp. The problems of families are as specific as family structures are themselves. Therefore, working with groups proves to be just as challenging: Group members can be of different ages and gender; they face different problems and strive for different goals.

At the second level, this is what TPSS+® has to offer: A complete training for psychologists, social workers and similar professionals to install a positive and solution-orientated attitude. This attitude and understanding sets the baseline for this approach completed by the training of resource installation. The top of the pyramid is reserved for the work of specialists; fully trained trauma therapists are pro-

viding EMDR therapy for individual persons (children, adolescents, adults) and groups.

Data concerning children affected by war events and suffering from psychopathological symptoms

Syria has suffered civil war since 2011. Quosh et al. (2013) summarises that “three out of four Syrian children have lost a loved one in the fighting, more than 60% experienced events where they felt their lives were in danger, and 50% had been exposed to 6 or more traumatic events. However, 71% of the girls and 61% of the boys also had strong close relationships to trusted persons for help and support. At the same time, 30% reported that they had been separated from their families. Also, around 60% of the children reported symptoms of depression (significantly higher among girls), 45% reported symptoms of PTSD, 22% aggression and 65% psychosomatic symptoms to a degree that seriously reduced the children’s level of functioning (Özer et al., 2013, 36)” (p. 287).

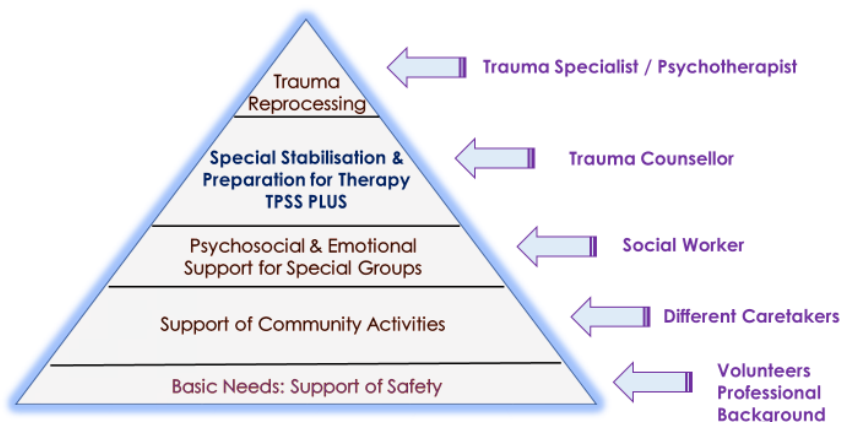


Figure 1. Graphic Description of Trauma Psycho Social Support Plus (TPSS+®)

Children are especially vulnerable as they are still in the process of developing their working model of the world and how they define human relationships, their own perspective and meaning in this world. It is essential to help them find a way to deal with their experiences.

Therapists and health workers in the Eastern Mediterranean region

The World Health Organization (2016) stated in the recently published Mental Health Atlas that “across the Eastern Mediterranean region, nurses (including both psychiatric nurses and general nurses working in mental health facilities) make up the largest professional group among the mental health workforce, followed by psychiatrists, psychologists and social workers”. (...). The average total mental health workforce in the Eastern Mediterranean Region is 14.6 per 100 000 population. This is less than half the comparable global rate of 33.8 per 100 000 population. The number of psychologists, social workers and occupational therapists per 100 000 population is less than a quarter of the global average”. In Europe, training in EMDR therapy will only be offered to therapists who have completed at least their first level psychotherapeutic education (Farrell & Keenan, 2013). Even for those therapists, it is a challenge to adopt EMDR into the daily routine depending on institutional conditions.

Trauma and resource related social support training

Based on this element, TPSS+® is a program based on a training on “Pre-therapeutic EMDR” (Phase 1 and 2 of the eight-phase EMDR therapy approach): only slow tactile bilateral stimulation and resource installation. According to available evidence, the impact of slow bilateral stimulation (therapist directed

eye movements or tactile stimulation) during presentation or activation of a resource can facilitate the access to positive memories (Amano & Toichi, 2016). The proposal was to train in a short but daily ritual that help parents and children to build positive relationships again. The intervention intends to create and install a memory network of safety in the child which will help to cope with fear responses in a long-term view. Tactile bilateral stimulation was preferred as it is considered less activating in a memory network compared to the use of eye movements. Additionally, one can also use a resource installation technique in a group setting and the overall biological principles of information processing in front of shocking and stressful events seems to be transculturally acceptable.

According to the Adaptive Information Processing (AIP) model (Shapiro, 1995, 2001), the model of pathogenesis and change in EMDR therapy, an intrinsic information processing system is responsible for the way that memories are stored in the brain (Solomon & Shapiro, 2008). If the information processing system is impaired, a stressful life event is assumed to be stored and isolated in the networks as “frozen in time”: “Attitude, emotions, and sensations are not considered simple reactions to a past event; they are seen as manifestations of the physiologically encoded perceptions in memory and the reactions to them” (Solomon & Shapiro, 2008, p. 316). Even if encoded a long time ago, this dysfunctional encoded, maladaptive memory can be triggered by similar events or similar parts of it: sounds, smells, pictures, etc. This memory will then totally or partially invade into consciousness and influence perception of the present as well as action.

Particularly children will be confused about their reactions to daily experiences: During their daily routine they might find themselves

slipping into quick and highly arousing emotions of fear or anger they cannot control. Psychoeducation is necessary to understand this inner process and can prevent children and adolescents from feeling insane. Furthermore, the intention of the training was to show and train methods to deal with those confusing reactions before they occur again.

As a first step, the lap of the parent representing a safe environment was used to install a sense of safety in the present following the TPSS+® and Resource-Oriented Trauma Therapy with Elements of EMDR (ROTATE) treatment manual (Wöller & Mattheß, 2020).

Parenting in a refugee camp

One of the most important factors of getting a positive view of the future for children and teenagers is education and that parents in general have the central desire to be able to cope with their educational tasks even under the circumstances of a refugee camp. They are motivated to understand how best to parent in this context and are keen to receive parenting advice and thought that this would improve their children's welfare" (El-Khani et al., 2018, p. 26). The importance of a good education might be an aspect which helps parents and children to accept a therapeutic approach: if a child is willing to learn but he or she is not able to focus, to concentrate and to control his or her feelings, it becomes an obstacle to education (Hase & Bublak, 2015). Children can learn better and be more successful in school if they learn to stabilise themselves by resource installation and begin to manage their emotions. This is the objective of the TPSS+® program. If trained by professionals how to use resource installation parents should be able to apply resource installation with their children on their lap like a ritual even outside a therapeutic setting. Even if there is no higher level of education or knowl-

edge about psychology it should be possible to explain to parents that this method is helpful for the children to recover from the effects of traumatic events. Of course, this applies to such a post conflict setting where trauma has hit the family and cannot be transferred to a setting where a child is victimized by parents. To assist the parents of integrating resource installation in their daily routines of raising their children the Android-App "TraumaAid" (available for Android systems in German, English and Arabic) was developed. The app provides a fixed rhythm including a sound, a point or dot that moves left- right on the screen of the mobile phone and parents only have to do the tapping on the knees of their children, sitting on their laps (Figure 2) in the same rhythm.

From a trainer's point of view, it is important to keep it simple: Parents should be instructed to find positive memories, abilities, capacities, strengths etc. Children and adolescents should draw pictures or look for symbols that represent a personal resource. This practice aims to activate positive memories. To emphasize the difference to more advanced techniques of problem-solving methods originating from EMDR therapy: It is not necessary to focus on problematic current life situations or traumatic events here. In this setting, it seemed reasonable just to focus on the positive experiences.

Figure 2 summarises the treatment for children led by their parents to develop a daily ritual. Initial practicing with the help of a health professional is recommended.

The age of children receiving resource installation in this way can range from three to eight years. Younger children may receive the tactile stimulation (taps) on their knees or shoulders but without watching the point of the mobile phone which goes left-right and back 5 times (up to 40 times in total) – the

The Way to Use the TraumaAid APP

- Sit down with your child on the ground or on a chair
- Before you should have painted a picture with a positive ability (resource)
- Alternatively you can take a symbol
- Watch your mobile phone and the picture together with your child
- Do the tapping in accordance with the left-right-rhythm (5x ... 5x ...)

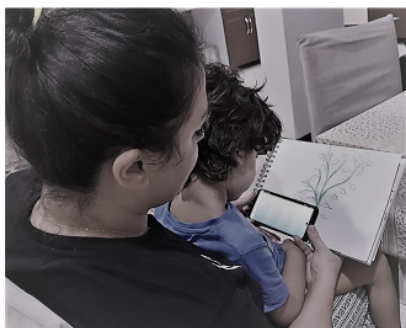


Figure 2. Resource Installation for Parents

Note. The child is watching the screen without earphones (optional) at the same time as tapping by the mother.

sound may be enough to underline the necessary rhythm of tapping. Older children may avoid sitting on the lap of an adult. A solution recommended is applying the tactile stimulation themselves, supported by a warm voice and possibly being held by parents. This was described as the butterfly hug (Jarero, 2002). Two effects are expected: Children calm down which is helpful for the widespread hyperarousal and the brain is stimulated in a special way that will not trigger traumatic material but implement feelings of safety. Research on bilateral stimulation to enhance positive elements supports this assumption (Amano & Toichi, 2016).

The present exploratory uncontrolled study.

The aim of the programme was to provide mental health staff with background knowledge of the dynamics of traumatization and to teach resource installation for mental health staff to work responsibly with chil-

dren, adolescents, and their parents. Part of the TPSS+® series of seminars was the application of 4-Field-Procedure, a procedure in EMDR therapy close to the IGTP procedure (Jarero et al., 2006) which offers a structured confrontation of traumatic memories in group and single settings. As educated EMDR therapists were not available in the refugee camp setting this procedure was adapted to the field conditions as described in the procedure section. About half a year after the training seminar, there was a post-training meeting at which two EMDR therapists would visit the refugee camp and treat sufficiently prepared children and adolescents with EMDR.

Methods

Participants

The 4-Field Procedure was conducted with 37 local children and adolescents (mean age of 11 years, approximately balanced distribu-

tion of girls and boys), who provided pictures with stress assessments or stress assessments only at a post-training meeting about half a year after the initial training seminar. No cases were excluded. Six patients were sufficiently stable to receive EMDR at the post-training meeting.

Materials

Apart from the impressions from the patients' pictures and sketches, self-report data concerning the subjective stress level were recorded in terms of subjective units of distress (SUD). The widely used SUD scale (Wolpe, 1990) asks the perceived momentary stress in a simplified form from 0 as the least distress imaginable to 10 as the most distress imaginable. SUD were gathered as a measure of the current stress level when remembering the escape compared to the stress level when remembering the rescue.

Procedure

Immediately after the first training, the social workers who were responsible for the counselling process applied a 4-field scheme to children and adolescents. As a gentle method with minimal moments of confrontation, it aims to stabilise.

The procedure only required two sheets of writing paper and pens.

1. Children were asked to paint a picture of a resource on the first paper
2. Children were asked to fold the second paper twice to get four fields
3. Four questions / topics were explained to children and in accordance with the answers four pictures or sketches should be drawn in the four squares from right to left (countries where Arabic writing is common) and from top to bottom.
 - "What happened to me?"

- "I'm in safety again."
- "It was helpful to me."
- "Getting simple but realistic help (in the future)."

4. For each picture, children should assess the distress that they felt in the moment ("now") on the SUD scale from 0 (*neutral*) and 10 (*maximum imaginable distress*). The group or child should then use tactile bilateral stimulation and a kind of ritual to deal with bad memories. This ritual was described in a standard way with the words: "Let's drum away the bad pictures together – knock on your knees as loud, fast and strong as possible".

According to clinical judgment, 3 children needed further stabilisation measures. Therefore, they could not participate in further EMDR therapy. The previous interventions of their counsellors were continued and supplemented by the external consultants. Three children had received sufficient preparation (i.e., they exhibited sufficient stability), giving reason to assume they were ready for an EMDR 8-phases approach intervention. Even though for one adolescent drawing the traumatizing events and leaving it in an imaginary container was the appropriate measure at that time. Two children could be treated successfully according to the 8-phases of EMDR therapy using the protocol adapted for children. They were prepared well (phase 1, history taking and phase 2, preparation) and could move on to phase 3, assessment of the traumatic event. Phase 3 includes figuring out the worst image as part of this event, the negative cognition about oneself associated with it, and its counterpart - the positive and desired cognition. How true this positive cognition feels is scored on a scale ("Validity of Cognition") as well as the degree of distress

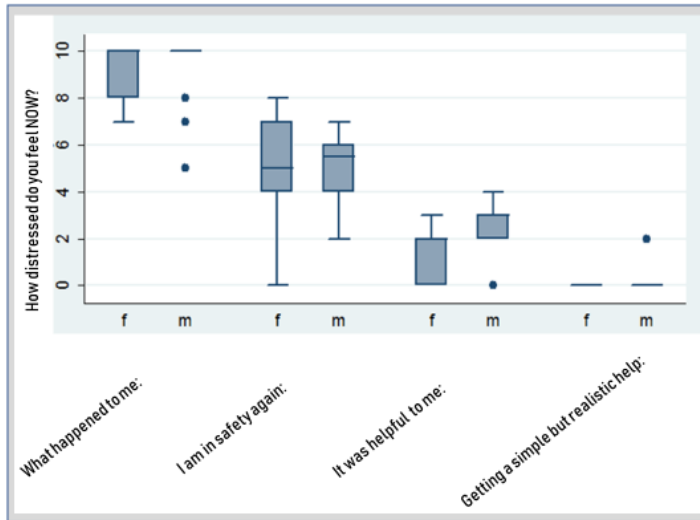


Figure 3. Boxplots of SUDs in a 4-Field-Scheme (Field-IGTP)

Note. $N = 37$. SUD = Subjective Units of Distress.

(SUD). Emerging emotions and bodily feelings during this processing work are part of the assessment. Phases 4 serves - accompanied by bilateral stimulation - for desensitization and if successful the therapist can anchor the positive cognition in phase 5 (“Installation”). A body scan - phase 6 - that assesses the tension in the body is followed by the conclusion of the session (phase 7, closure). Phase 8 reviews the previous process at the beginning of the next session.

All children received two (case 1, 2 and 3) or three (case 4, 5 and 6) sessions of 60 to 75 minutes each. Further care after the sessions by the responsible social workers was ensured.

Results

Application 4-field-scheme

The average SUD was 8.6 for the critical event, 4.6 for the moment of rescue, 1.8 for the thought about helpful things (also persons), and 0.2 for the phantasy about a simple but

realistic future help. Figure 3 graphically illustrates these developments as a function of gender. Thus, there was a near-maximal level of subjective distress when children painted their pictures and remembered the incidents. After being rescued and remembering that moment, subjective distress decreased notably but still exhibited a considerable amount of distress in the children’s memory. The subjective distress in connection with the pictures of helpful things and persons seemed to be bearable for a child in the camp situation, and the subjective distress in connection with imagining getting simple but realistic help was near-zero.

Results of EMDR therapy application

The results of the interventions with the six children served by the therapists on visit are summarised in Table 1. Safe and reliable stabilisation is a prerequisite for processing therapy such as EMDR. This could not be determined with certainty by the therapists

Table 1. The Interface Between TPSS+® and EMDR – Six Cases

Patient / Gender	Traumatic Event(s)	Main Symptoms	Intervention: Phase 1 & 2 (preparation) or 8-phase EMDR protocol	SUD 1 - SUD 2	Positive Cognition / Symptom Relief?
Case 1: Girl aged 7	Saw dead bodies and be-headed people	Flashbacks, beating siblings heavily	1 & 2– not stable enough for confrontation	Not available	Visibly better concentration, less aggressive
Case 2: Boy aged 9	Lost his father during escape	Severely confused, self-harming	1 & 2– not stable enough for confrontation. But: Sketching house and rescue, mentioning bombing	Not available	Able to pick up contact during sessions
Case 3: Boy aged 16	Captured by ISIS	Flashbacks, flooded by memories	1 & 2– not stable enough for confrontation; minimal first confrontation step: Pendulation technique, events sorted along a time-line	Not available	Relaxation during sessions
Case 4: Boy aged 17	Group rape and tortured continuously	Bed wetting every night	1 & 2– not stable enough for confrontation. But: Draw four hidden images of traumatic experiences – put them into a container made of a paper envelop	Not available	No bedwetting the next two nights. “I have achieved it and will continue to achieve it!”
Case 5: Girl aged 10	Saw the dead body of her mother killed by ISIS	Depressive, always crying, burn-out on a child level	8-phase-EMDR-protocol for children: Phase 3 - 8	10 - 0	“I always do my very best!” More open during sessions, interested in playing and dancing in therapy container
Case 6: Boy aged 7	Bomb attack, thrown behind a rock, survived together with his father	Bed wetting	8-phase-EMDR-protocol for children: Phase 3 - 8	10 - 0	“I am safe, in safety!” No bed wetting the next two nights

Note. SUD = Subjective Units of Distress.

for all participants. It was always decided towards the safe side in order not to burden anyone additionally. However, for two of the children in question, the decision for a processing session could be made safely.

Discussion

The TPSS+® training presented here aims to encourage social workers to integrate trauma-informed interventions into their daily work. The interventions should be easy to use and adaptable for children and adolescents according to their age. These are based on the EMDR trauma therapy procedures. For the individuals in the therapeutic process, a main goal is to create windows for relief. This is all the more important the more stressful the life situation is.

The results of this pilot project showed that if an adequate preparation is offered, therapy sessions with children in refugee camps can be conducted in a safe and efficient way.

Using the example of a 4-field-scheme, the first findings showed how much children and adolescents in question suffer with their memories. Their self-assessment was close to the most subjective distress possible when they were asked to outline their traumatic experiences.

After focusing on the rescue situation and on the current situation in the camp, the perceived stress level decreased. The goal of these interventions was to provide relief and help those seeking advice to perceive it accurately. Feeling this relief was seen as the basis for coping with daily life under considerable stress and threat. The answers in the last field of the scheme (step 3 / topic 4) shows that children don't know about the circumstances they would meet coming home. It seems important for social workers to inform children and youth about the reality of their home in a case of return to prevent them to live with illusions.

Additional processing

TPSS+® and EMDR have the same theoretical basis but are performed by different professionals. If a social worker is well trained in the methods of TPSS+®, it should be possible to refer traumatised children and adolescents to an EMDR therapist. Among a very small number of six individuals, the clinical judgment for four of them was that more stabilisation was needed before the next step of trauma processing could be offered. Two individuals were given a full EMDR intervention, which they seemed to benefit well from on the behavioural level. A focused approach of preparing children and adolescents for EMDR with TPSS+® might help increase the number of sufficiently stable patients in refugee camps to be treated with EMDR.

Though the results are promising, there are a few notable limitations to the present pilot uncontrolled preliminary study. The sample size was very small. The research work was difficult due to the often-pressurized working conditions in the refugee camp, in which the daily crisis management of refugees is the main priority. There was no follow-up measurement to examine how patients were doing several weeks after the initial measurement. There was no control group of patients (waiting list) or a treatment as usual intervention. Finally, the study design did not involve blinding, which could have prevented the possibility of experimenter or expectancy effects.

Conclusion

With reference to the intervention pyramid shown above, TPSS+® could fill the gap between the first respectively second level (supplying basic needs for people in the refugee camps) and the top of the pyramid (psychotrauma therapy). Resource installation and modified EMDR procedures as provided by TPSS+® can meet these demands in

a way that is culturally appropriate. The results suggest that resource installation is a feasible option according to clinical impression and staff capacity. This combination, supported by a referral system to an EMDR therapist would provide a therapeutic basis without language barriers. Larger-scale research should test this preliminary conclusion.

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