Humanitarian Projects and Growth of EMDR Therapy in Asia

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

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

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

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

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

EMDR and Humanitarian Interventions

Many studies (Shapiro, 2014) have evaluated the effectiveness of EMDR interventions when use to treat

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the psychological consequences of humanitarian disasters. EMDR can be applied by a team of clinicians working in the disaster site and even under unstable conditions. It can be used as an early intervention, after some weeks and months, and even after some years, with an untreated population.

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

The Development of EMDR in Asia

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

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

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

EMDR Humanitarian Projects in Bangladesh

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

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

EMDR Humanitarian Projects in India

The 2001 Earthquake in India. On January 26, 2001, as the entire nation was celebrating Republic day, the western part of the state of Gujarat experienced one of the most intense earthquakes in Indian history. Within a span of a few seconds, entire villages and

towns were flattened. The government responded immediately in terms of relief and rescue. The entire world shared the grief of the people of Gujarat, and massive aid was given in terms of rescue, makeshift shelters, medical help, clothing, food, and so forth. However, mental health was not a priority then.

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

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

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

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

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

EMDR Humanitarian Projects in China

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

After the devastating earthquake in Sichuan province on May 12, 2008, many children lost their parents. Two weeks after the earthquake, more than 500 children who lost one or both parents were temporarily moved to Rizhao, Shandong province. Child psychiatrists and postgraduates from the Institute of Mental Health of Beijing University and Xinhua Hospital of Shanghai Jiao Tong University provided psychological intervention for several months. After the interview and standardized assessments, approximately

8% were diagnosed with PTSD or posttraumatic stress syndrome (Zhang, 2010). Twenty-six children completed at least three EMDR therapy sessions as individuals or in groups. The scores of PTSD symptoms were significantly decreased. In the follow-up assessment, some children could do the safe place exercise and butterfly hugs by themselves, and said the skills were very useful.

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

EMDR Humanitarian Projects in Indonesia, Cambodia, and Thailand

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

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

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

EMDR Humanitarian Projects in Hong Kong

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

EMDR Humanitarian Projects in Sri Lanka

It was after the catastrophic tsunami of 2004, EMDR was introduced to Sri Lanka. Around 35,000 people were killed and many were injured, and others were

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

EMDR Humanitarian Projects in Pakistan

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

EMDR Humanitarian Projects in South Korea

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

EMDR Humanitarian Projects in Japan

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

The Development of EMDR Therapy in Asia

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

Although most training, capacity building, and mentoring were initially done by members of the American and European EMDR humanitarian associations, gradual transfer of learning and teaching has been simultaneously taking place. Asian trainers and facilitators are being trained along with technical support of training material for the new trainers. The continuing seminars and supervision with an interchange of EMDR team members from Indonesia, Thailand, China, and later Cambodia and Myanmar has helped to build a network of support that naturally flowed into the creation of EMDR Asia. Asian therapists have also worked together to respond to humanitarian crises. For example, based on experience and lessons learned post-tsunami in Thailand, a team of psychologists was trained in Cambodia and worked for 4 months to respond to the devastation from Typhoon Ketsana in 2009 (Lopacka, Ean, & Phoeun, 2010). Some Asian trainers jointly conducted a Part 1 EMDR training in the Philippines in early 2014, after Super Typhoon Haiyan in November 2013, with the support of HAP United States, 80 mental health workers were trained and provided supervision.

As we look to the future, most EMDR psychotherapists from Asia have voiced their desire to further strengthen EMDR and resources within Asia. Growing popularity and widespread use of EMDR psychotherapy has led to coordinated efforts for consolidating and establishing formal bodies in many Asian countries to oversee training, establish standards of practice, and coordinate various projects.

Formation of National Associations and EMDR Asia

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

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

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

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

Future Plans and Challenges

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

Humanitarian efforts are hampered by the fact that there are insufficient mental health professionals in many Asian countries. Often, those practitioners are concentrated in metropolises, as are private practitioners who are not available for community-based outreach for trauma-related work. There are success stories of professionals coming together for trauma relief after the floods, earthquakes, and tsunamis in Bangladesh, China, India, Indonesia, Japan, Pakistan, and Sri Lanka. Although some of these efforts were responses to the emergencies by individuals or group of practitioners, others were organized by national or regional initiatives.

Although there are some important exceptions, a common problem faced in Asia is the lack of institutional support to promote mental health and related interventions. For example, after natural disasters, leading national and international health organizations focus on physical and social rehabilitation. The supply of food, clothes, medicines, and the restructuring of the destroyed area is thought to complete the requirements of basic needs. Acknowledging the importance of emotional and psychological well-being takes a backseat, and the possibility that untreated acute stress can lead to PTSD and other mental health problems is not understood.

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

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

References

Bhadlikar, D. (2014, January). *EMDR with obsessive compulsive disorder—An Indian experience*. Paper presented at the 2nd EMDR Asia Conference, Manila, Philippines.

Bumke, P. J., & Sodemann, U. (2010, July). *The efficacy of EMDR in a new cultural context: Some findings from the ACEH survey*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Chung, Y. C., Kim, D., Kim, S., Bae, H., Lee, K., & Go, B. (2014). Treatment response of affect regulation group therapy for recently traumatized school children. *Journal of Korean Neuropsychiatric Association*, *53*(3), 171–177. http://dx.doi.org/10.4306/jknpa.2014.53.3.171

Direzkia, Y., & Syahriati, E. (2010, July). *Safe place: An ambivalence*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Errebo, N. (2010, July). *A decade of EMDR humanitarian trainings in Asia*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Errebo, N., Knipe, J., Forte, K., Karlin, V., & Altayli, B. (2008). EMDR-HAP training in Sri Lanka following 2004 tsunami. *Journal of EMDR Practice & Research*, *2*(2), 124–139.

Farrell, D. (2014). Developing EMDR therapy in Pakistan as part of a humanitarian endeavor. *Journal of EMDR Practice and Research*, *8*(4), 233–239.

Jarero, I., Artigas, L, & Montero, M. (2008). The EMDR integrative group treatment protocol: Application with child victims of mass disaster. *Journal of EMDR Practice & Research*, *2*(2), 97–105.

Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative group treatment protocol: A post-disaster trauma intervention for children and adults. *Traumatology*, 12, 121–129.

Jayatunge, R. M. (2008). Combating tsunami disaster through EMDR. *Journal of EMDR Practice and Research*, *2*(2), 140–145.

Kannan, L., & Mehrotra, S. (2010, July). *Effectiveness of EMDR with those undergoing traumatic divorce*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Kim, D., Choi, J., Kim, S. H., Oh, D. H., Park, S. C., & Lee, S. H. (2010). A pilot study of brief eye movement desensitization and reprocessing (EMDR) for treatment of acute phase schizophrenia. *Korean Journal of Biological Psychiatry*, *17*(2), 94–102.

Kusumowardhani, R. (2010, July). *Safe place and light stream stabilization technique on EMDR preparation phase are effective for coping insomnia on women patient that are newly diagnosed HIV infected*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Kusumowardhani, R. (2014, January). *Absorption technique and EMDR to enhance the motivation, reduce anxiety and increase confidence of athletes for preparing the province competition*. Paper presented at the 2nd EMDR Asia Conference, Manila, Philippines.

Liow, J. (2014, January). *Utilization of EMDR in complicated grief resulting from disenfranchised losses*. Paper presented at the 2nd EMDR Asia Conference, Manila, Philippines.

Lopacka, J., & Phoeum, B. (2010, July). *Building on experience: Post-typhoon trauma EMDR work in Cambodia utilising the lessons learned from Thailand's post-tsunami program*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Lv, Q. (2010, July). *Crisis intervention and trauma therapy in China*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Mattheß, H., & Sodermann, U. (2014). Trauma-Aid, Humanitarian Assistance Programme Germany. *Journal of EMDR Practice and Research*, *8*(4), .

Mehrotra, S. (2008, October). *The efficacy of using EMDR in the aftermath of an earthquake in India.* Keynote presented at the 9th EMDR Europe Association Conference, London, England.

Mehrotra, S., Purandare, M., Tank, P., & Bhagwagar, H. (2013). Establishing EMDR connections with earthquake survivors of Gujarat, Western India (2001). In M. Luber (Ed.), *Implementing EMDR early mental health interventions for man-made and natural disasters: Models, scripted protocols, and summary sheets* (pp. 107–120). New York, NY: Springer Publishing.

Mehrotra, S., Raja, T., Samant, B., & Tank, P. (2001). *Impact and expression of trauma in children exposed to the earthquake*. Paper presented at South Asia Regional Conference, Mumbai, India.

Munshi, C., & Mehrotra, S. (2014, January). *A study on eye movement desensitization and reprocessing (EMDR) as a strategy for reducing high test anxiety in students of 12th grade*. Paper presented at the 2nd EMDR Asia Conference, Manila, Philippines.

Purandare, M., Bhagwagar, H., & Tank, P. (2010, July). *EMDR on children affected by earthquake.* Paper presented at the First EMDR Asia Conference, Bali, Indonesia.

Qian, M. (2010, July). *Posttraumatic growth and its impact factors among earthquake victims in Sichuan*. Presentation at the 1st EMDR Asia Conference, Bali, Indonesia.

Rana, M. (2010, July). *Dealing with psycho trauma in war against terror*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Shapiro, F., (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York, NY: Guilford Press.

Shapiro, F. (2014). EMDR therapy humanitarian assistance programs: Treating the psychological, physical and societal effects of adverse experiences worldwide. *Journal of EMDR Practice and Research*, *8*(4), .

Tahir, K. (2010, July). *Role of EMDR in the rehabilitation of acid burn survivors*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

Woo, M. (2014). Eye movement desensitization treatment of nightmares: A case report. *Journal of EMDR Practice and Research*, *8*(3), 129–134.

World Health Organization. (2013). *Guidelines for the managements of conditions specifically related to stress*. Geneva, Switzerland: Author.

Zhang, J. (2010, July). *The effect of EMDR for children with PTSD/PTSS after Sichuan earthquake*. Paper presented at the 1st EMDR Asia Conference, Bali, Indonesia.

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