Trauma Informed Care to Revitalizing EMDR Practice in Bangladesh

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Bangladesh is a disaster prone area. The risk is increasingly high due to its geographic location, demographic nature, cultural context, religious mandate, historical heritage, political upheaval, social mobility and moral vice. Presence of visible and invisible trauma often not duly addressed oroverlooked in the management of aftermath.EMDR as a viable tool for trauma recovery was introduced to Bangladesh for nearly two decades back by UNICEF in 1998. About 200 psychiatrists, clinical psychologists and psychologists were trained in basic of EMDR.Yet only 4% of them continued to practice EMDR. The stumbling blocks to continueEMDR practice after the basic training as revealed from the interview with the key participants of the former training is presented in Box 1:

Box I: Identified blocks for EMDR practice after 1998 training

1. Time constrain: For psychiatrists, not enough time to expend on EMDR in their medical practice
2. Supremacy of CBT: Dominance of CBT overpowered the use of EMDR among clinical psychologists.
3. Insufficient scope for practice: Other than those who already had a setup for clinical practice, very few could sustain their practice in EMDR.
4. Low motivation: Academicians were skeptical and lack the internal push to pursue on EMDR.
5. Short of trauma knowhow: The budding counselors and psychotherapists felt the need of readiness to handle trauma with EMDR.
6. Fear of keeping standard: Enthusiasm among the interested was cancelled out by no further opportunity for supervised practice on EMDR protocol.
7. Limited opportunity:No scope of continuous professional development limited further scaling up of EMDR.
8. Ethical concern: Keeping boundary and acclaiming undue credential created misconception and apprehension on the use of EMDR.
9. Adverse view of EMDR community towards Bangladesh experience

Nonetheless, it paved the path for psychological treatment in response to trauma after mental health crisis andthe thirst for EMDR remained dormant for a long period among many. It was the persistent effort of one person, Professor Dr Shamim F Karim, that EMDR was revitalized with the good office of HAP/Trauma Aid Switzerland. Considering the earlier pitfalls, a long term project was conceived. Initially, Dhaka Shishu Hospital took the lead and subsequently a LOU was signed between HAP/Trauma Aid Switzerland and Educational and Counselling Psychology Department of Dhaka University to run the training program on “Psychotraumatology and EMDR in Bangladesh” to ensure accountability and sustainability.

**Trauma Informed Care Model for Bangladesh:**The multilevel program started with preparatory formation of a core group and a one day introductory seminar on trauma information and EMDR to set the ground and explore the fitness in terms of accessibility to mental health service. Intense, culturally appropriate curriculum on psychotraumatology was developed by Hanna Egli-Bernd as foundation before EMDR basic training and continuous supervision was incorporated.The multilevel trauma informed care model used in the program is presented in Figure I:

Figure I: Multilevel trauma informed care model used in Bangladesh

The curriculum includes relevant topics concerning theory and treatment approaches for psychotraumatology, including psychotherapeutic and psychodynamic techniques related to the treatment of a variety of trauma-related syndromes, with particular focus on complex trauma and attachment issues. It also covered practical knowledge, stabilization, diagnostics and treatment planning for traumatized adults, adolescents and children. 10 days spread over one year period on psychotraumatology with practicum and case supervision was subsequently followed by basic EMDR training (Level 1 and 2). Trainers from EMDR India, sourcing EMDR manual of Trauma Recovery, USA, conducted the Basic EMDR weekend workshops. Two cohortswere trained following the module. Out of 71 who received Psychotraumatology foundation training in two cohorts, 56 received EMDR basic training with 40awarded certification after meeting the criteria successfully.

Figure II: Successive participants at multilevel trauma informed care module (2 cohorts)

**Outcome and output of the Module:**  Anaction research was conducted to trail the benefits and barriers of integrating psychotraumatology and EMDR in practice as a tool for trauma recovery in Bangladesh. Firsthand experience of the group involved as actor in action was explored using multiple measures, ie. KAS questionnaire, reflective feedback, key informant interview and storytelling. Learning objectives of the action research were:

* To mark out the use of EMDR in Bangladesh
* To score the need of appropriate curriculum
* To identify gaps in EMDR practice
* To appraise effectiveness in trauma recovery

Included participants were psychologist, counselor, and university teachers, working in mental health field. All were above28 years with 83% female and majority married. 77% of the respondents were from psychology background and 67% having more than 5 years experience in counseling. One exception was made by including two other than psychologists or psychiatrists for their long experience. The respondents belong to diverse working place, hospitals, NGOs, university and schools.

**Psychotraumatology Curriculum Scored High**

Survey results shows that 100 % of the respondents incorporated EMDR in their regular practice, with application of EMDR on average 20-40% of their client. Of which 22% reached up to 8 phases, while majority of clients had positive effect after stabilization. Importantly, EMDR was applied to both adult and children with diverse issue parenting, PTSD, child abuse, sexual abuse, phobia, relationship and even drug addiction. 100 % of the respondents found curriculum of psychotraumatology extremely beneficial and helpful for laying the foundation for better understanding of EMDR, theoretical knowhow and stabilization techniques for handling complex trauma, selecting clients and identifying core issues. It certainly enhanced the skill and confidence of the practitioner. On average, the respondents took 5-6 case supervision and 67% were comfortable in using EMDR for healing and reducing discomfort. The study revealed that 127% of the respondents faced difficult at 4 stage of desensitization and reprocessing. Next important area of difficulty was assessment phase (45%); particularly at the stage of identifying NC and PC. Major difficulties from the side of client were identified as physical or emotional distress of the client (67%), reluctant to recall past (31%) or discontinuation (33%) and uneducated (28). Overall, all were amazed by the wonder and magical effect of EMDR in quick recovery and healing. Need for continuous supervision and further training for enhancing competence and skill to handling complex trauma and difficult client by using diverse protocol was emphasized. Ethical issue of maintaining boundaries and standard, adapting manual to Bangla language to make it more culturally appropriate were the primary future concerns. In conclusion, the outcome of the project was (a) replicable training module on psychotraumatology, and (b) 71.42% of the cohorts are practicing EMDR effectively to handle after effect of trauma. Success of the program twisted the demand for scaling up and continuity. This research highlights the necessity of strengthening the local body and resources to expedite and sustain the benefit that would further guarantee the forward movement of EMDR practice in Bangladesh. The goodwill and benevolence of EMDR community around the globe will help to develop EMDR as public health approach to achieve justice in trauma initiatives.

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