ARTICLES

EMDR Therapy Program for Advanced Psychosocial Interventions Provided by Paraprofessionals

Ignacio Jarero
Gregory Rake
Martha Givaudan
Latin American and Caribbean Foundation for Psychological Trauma Research, Mexico

The aim of this preliminary study was to evaluate the effectiveness of specially trained and supervised paraprofessionals in administering the eye movement desensitization and reprocessing Integrative Group Treatment Protocol (EMDR-IGTP) to reduce work-related posttraumatic stress disorder (PTSD) symptoms. The 2 paraprofessionals in this study were specially selected and trained in the application of the EMDR-IGTP and then provided treatment in an uncontrolled clinical trial to 37 clients from 3 non-governmental organizations in Bolivia. The participants were adult staff members (protective services workers, caregivers, psychologist, lawyers, and social workers) who provided care to children and adolescents with severe interpersonal trauma. Four EMDR-IGTP sessions within a parallel 2-week period were administered for each randomly assigned group. The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) was administered at pretreatment and 30 and 90 days' posttreatment. A repeated measures analysis of variance (ANOVA) determined that PCL-5 score means differed statistically significantly between time points $F(2, 72) = 574.53$, $p < .001$, $\eta_p^2 = .94$. The study presents preliminary evidence scaling up EMDR therapy in a low- and middle-income country, making it possible to reach larger numbers of people in a shorter time, thereby offering an operational advantage. The study has limitations specially related to the size of the sample, the use of only one measure, and the lack of comparison with a control group or treatment. Further studies are required to present large samples with more measures and comparison of results with another therapy or control group.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; advanced psychosocial interventions; paraprofessionals; Integrative Group Treatment Protocol (IGTP); posttraumatic stress disorder (PTSD) symptoms

All over the world, the global burden of trauma grows daily with devastating consequences for individuals, families, communities, and societies (Carriere, 2014). Low- and middle-income countries (LMIC) often lack professional resources. These limited resources can be overwhelmed by the need to respond to large traumatic events, with the result that many survivors receive no or minimal professional psychological trauma care.

The World Health Organization (WHO) Mental Health Gap Action Programme was launched in 2008, to address the lack of care and to expand service provisions for people suffering from mental, neurological, and substance use disorders (e.g., depression, psychosis, bipolar disorder, dementia, epilepsy, developmental and behavioral disorders, self-harm/suicide, alcohol and drug use disorders), especially in LMIC. This program directs its capacity building toward nonspecialized health care providers in an integrated approach that promotes mental health at all levels of care (WHO, 2010). This action program calls for the development of specific protocols and training manuals for implementing psychotherapies or psychological treatments in nonspecialized health care settings offered by trained and supervised nonspecialized health workers.

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There are precedents of cognitive-behavioral therapy (CBT) effectively delivered by paraprofessionals (nonmental health practitioners) with outcomes comparable to that of professionals (e.g., Hepner et al., 2012; Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010). There are also randomized clinical trials on mental health counseling interventions provided by local lay counselors with little to no previous mental health training or experience, which demonstrated positive findings in the area of mental health, health, and functioning outcomes (Patel, 2009; Patel et al., 2010; Patel, Chowdhary, Rahman, & Verdeli, 2011).

Carriere (2014) asserted that the world faces a mental health crisis and that eye movement desensitization and reprocessing (EMDR) therapy has three special characteristics that allow it to scale up to help confront the world's burden of traumatic stress: (a) treatment effectiveness and rapid positive results; (b) its acceptability, because it is minimally intrusive and not dependent on verbalization of the trauma; and (c) its potential as both a primary and secondary (psychological first and second aid) care intervention provided by specially trained and supervised paraprofessionals.

EMDR Therapy and EMDR Integrative Group Treatment Protocol

According to the WHO (2013) *Guidelines for the Management of Conditions Specifically Related to Stress*, trauma-focused CBT (TF-CBT) and EMDR therapy are the only psychotherapies recommended for children, adolescents, and adults with posttraumatic stress disorder (PTSD). EMDR therapy is a structured eight-phase procedure that addresses the past, present, and future aspects of distressing memories of adverse life experiences (Shapiro, 2001). Processing occurs as patients focus on the memory while engaging in bilateral stimulation. EMDR therapy has been validated by 38 randomized controlled trials and 8 meta-analyses. See EMDR Humanitarian Assistance Programs (2016) for a summary of research findings.

EMDR therapy can also be provided in a group setting to small (3–15) or large (16–50) groups of patients who have been through the same type of traumatic event (e.g., sexual abuse, severe interpersonal violence), life experience (e.g., disaster, refugees, ongoing war, terrorist attack), or distressing circumstance (e.g., chronic or severe illness, domestic violence). This is highly valuable in settings where resources are limited (Jarero, Artigas, Uribe, & García, 2016).

The EMDR Integrative Group Treatment Protocol (EMDR-IGTP; Artigas, Jarero, Alcalá, & López Cano, 2014) administers the eight phases of EMDR individual treatment (Shapiro, 2001) to a group of patients, using an art therapy format (i.e., drawings) and the butterfly hug (BH; Artigas & Jarero, 2014) as a self-administered bilateral stimulation method. In the session, following directions from the therapist, each client draws an image related to the traumatic event, and then looks at his or her drawing while doing the BH; after this, a subsequent picture is drawn and the BH self-administered. The process is repeated for each of four drawings, after which the client completes a picture of a future imagining. There is no interaction between group members and no discussion.

EMDR-IGTP provides individual EMDR therapy in a group setting. It differs from Group TF-CBT in that TF-CBT practice components include developing a trauma narrative and engaging in vivo gradual exposure (Deblinger & Pollio, 2013) and from traditional group therapy (e.g., Yalom, 1970) which fosters interaction between group members and in which group process is considered a primary mechanism of change. The effectiveness of the EMDR-IGTP has been documented for large and small groups of adult and child participants, with multiple case reports and field studies and nine randomized trials. See Jarero, Artigas, Uribe, and Miranda (2014) for a review of related research.

EMDR Therapy Program for Advanced Psychosocial Interventions Provided by Paraprofessionals

In June 2012, Dr. Francine Shapiro invited the first author (IJ) to develop a special training program to teach appropriately selected, trained, and supervised paraprofessionals (frontline workers with no previous clinical training or experience in counseling, clinical psychology, or psychiatry) how to safely provide group and individual EMDR therapy in acute trauma situations, with emphasis on building sustainable mental health treatment resources with local agencies. From 2012 to 2015, the EMDR Therapy Program for Advanced Psychosocial Interventions Provided by Paraprofessionals (EPAPI) was developed and piloted in the field within three institutions: the Mexican Department of Defense and Air Force, Mexican Navy, and World Vision International with staff from Latin American, European, Middle Eastern, African, and Asian countries. During this time, the program's cross-cultural and ecological validity (acceptability in the real world; Brewer, 2000) was established.

The EPAPI is a structured theoretical–practicum training program with a background in psychological first aid (PFA; WHO, 2011) and advanced psychosocial interventions (interventions that take more than a few hours of a health care provider's time to

learn, and typically more than a few hours to implement; WHO, 2010, p. 4). The goal of this program is to train nonspecialist mental health care providers in resource-poor settings to safely deliver high-quality care on PFA and advanced psychosocial interventions (as a form of psychological second aid) and to conduct proper referral to mental health professionals at the tertiary level when higher skills are required.

This specially designed training program is not a "train and hope approach" (one time-training with limited posttraining support). The EPAPI is based on the EMDR Institute apprenticeship model for building local capacity for mental health services delivery by local providers across cultures. Our apprenticeship model uses three main groups: (a) expert trainers; (b) facilitators, who are local individuals who have been chosen for a more advanced role based on their skills during the training; and (c) paraprofessionals, who provide the services. Also, our program places special emphasis on *training*, *supervision*, *monitoring*, *feedback and support/coaching* to help achieve adherence to the interventions.

Method

The research protocol was reviewed and approved by the Latin American and Caribbean Foundation for Psychological Trauma Research review board to ensure that the research quality of this study partially fulfilled the Revised Gold Standard Scale (Maxfield & Hyer, 2002) items. The Gold Standard criteria are 1: clearly defined target symptoms, 2: reliable and valid measures, 3: use of blind independent evaluators, 4: assessor reliability, 5: manualized treatment, 6: random assignment, 7: treatment fidelity, 8: no confounded conditions, 9: use of multimodal measures, and 10: Length of treatment for participants with single trauma (civilians). The study fully met criteria 1, 2, 4, 5, 6, 7, and 8; partially met criteria 3 and 10; and did not meet criterion 9. Participation was voluntary and there were no dropouts throughout the study period.

Purpose

The specific purpose of the study was to evaluate the effectiveness of the two paraprofessional trainees in administering the EMDR-IGTP. The purpose of the intervention was to treat 37 group members' PTSD symptoms.

Facilitators

The two male IGTP facilitators were part of a group of 12 paraprofessionals specially selected and trained by the first author (IJ) in the EPAPI in Cochabamba, Bolivia, in February 2016. This intervention was the first EMDR-IGTP intervention that either had provided.

Participants

This study was conducted in 2016 in the city of Cochabamba, Bolivia, in the offices of two different non-governmental organizations (NGOs). The sample comprised 37 staff members (protective services workers, caregivers, psychologists, lawyers, social workers) from three NGOs who provide care for extremely vulnerable populations. All 37 staff members had PTSD symptoms related to their exposure during their professional duties to the aversive details of their clients' reported traumatic events. Repeated exposure to the aversive details of a traumatic event during the course of one's professional duties qualifies as a PTSD Criterion A stressor (*DSM-5*; American Psychiatric Association [APA], 2013). Participants' age ranged from 22 to 63 years old ($M = 35.26$); there were 29 women and 8 men.

Because there were only two group facilitators (the two paraprofessionals) to conduct treatment, participants were divided into two groups to ensure sufficient staffing for the EMDR-IGTP, which requires one facilitator for each group of 10 members. There were 19 participants (16 women and 3 men) randomly assigned in Group A and 18 participants (13 women and 5 men) randomly assigned in Group B.

Inclusion criteria were (a) 18 years old or older, (b) working on a direct basis with the vulnerable population, (c) with PTSD symptoms related to their work, (d) not receiving concurrent psychotherapy, and (e) not receiving drug therapy for the PTSD. Exclusion criteria were (a) ongoing self-harm/suicidal or homicidal ideation, (b) diagnosis of psychotic or bipolar disorder, (c) diagnosis of dissociative disorder, (d) organic mental disorder, (e) substance abuse, (f) significant cognitive impairment (e.g., severe intellectual disability, dementia). All 37 participants met inclusion criteria and participated in the study. Participation was voluntary and there were no dropouts throughout the study period.

Measures

For this study, we used the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers et al., 2013). The Posttraumatic Stress Disorder Checklist (PCL; Weathers, 2008) is one of the most widely used *Diagnostic and Statistical Manual of Mental Disorders* (DSM)—correspondent self-report measure of PTSD symptoms. The PCL was revised to reflect *DSM-5*

(APA, 2013) changes to the PTSD criteria. It contains 20 items, with the added three new PTSD symptoms: blame, negative emotions, and reckless or self-destructive behavior. Respondents indicate how much they have been bothered by each PTSD symptom over the past month, using a 5-point scale ranging from 0 = *not at all*, 1 = *a little bit*, 2 = *moderately*, 3 = *quite a bit*, to 4 = *extremely*. Item scores are summed to yield a continuous measure of PTSD symptom severity for symptom clusters and for the whole disorder. A provisional PTSD diagnosis can be made by treating each item rated as 2 = *moderately* or higher as a symptom endorsed, then following the *DSM-5* diagnostic rule which requires at least 1 B item (questions 1–5), 1 C item (questions 6–7), 2 D items (questions 8–14), and 2 E items (questions 15–20). According to the National Center for PTSD (2016), a PCL-5 cut point of 33 appears to be a reasonable value to propose until further psychometric work is available. PCL-5 has a variety of purposes, including monitoring symptom change during and after treatment, screening individuals for PTSD, and making a provisional PTSD diagnosis. For the Spanish version, PCL-5 was translated and back-translated by two specialized professionals and tested for cross-cultural wording understanding in nine Spanish-speaking Latin American and Caribbean countries.

Procedure

The research was conducted in 3 stages.

Stage 1. Recruitment of Participants and Interview. During this time, a not blind research protocol assistant, previously trained in the instrument administration, general interview techniques, and ethical research conduct, explained to participants the purpose of the research, the inclusion and exclusion criteria, the request for their volunteer participation, and an informed consent letter explaining the ethical considerations. Volunteer participants were interviewed individually to collect their clinical history; to provide psycho-education related to trauma, PTSD, and EMDR therapy to decrease any possible prejudice against the treatment; and to administer the PCL-5 as a pretreatment assessment. Once the individual interview was finished, each participant was randomly assigned to Group A or B using a computer-generated random number list. Group A included 19 participants (16 women and 3 men) and Group B included 18 participants (13 women and 5 men).

Stage 2. Treatment. The EMDR-IGTP was administered by two of the specially selected and trained Bolivian paraprofessionals on four occasions to each group's (A and B) participants, in two different settings, within the same 2-week period. Treatment fidelity was fulfilled by strict observance to all steps of the scripted EMDR-IGTP.

Stage 3. Posttreatment Follow-Up Assessments: Supervision, Monitoring, Feedback, and Support/Coaching. Posttreatment follow-up assessments were conducted for Groups A and B's participants at 30 and 90 days, respectively. An independent research assistant, blind to the treatment conditions and trained in the instrument administration, and ethical research conduct, administered the PCL-5 by means of a face-to-face interview. The article's first author (IJ) provided online (Zoom & Whatsapp) video conference supervision, monitoring, feedback, and support/coaching during all three stages. During each stage, all participants were reminded that they could contact one of the two specially trained paraprofessionals to discuss any concerns or posttreatment symptoms.

Results

A repeated measures ANOVA determined that PCL-5 score means differed statistically significantly between time points, $F(2, 72) = 574.53$, $p < .001$, $\eta_p^2 = .94$. Results indicated that the EMDR-IGTP administered by paraprofessionals produced significant improvement for the participants' PTSD symptoms, reflected by the large effect size. A post hoc test using the Bonferroni correction revealed that there were significant differences between all means comparisons, from pretest to posttest (38.56 ± 1.03 vs. 19.13 ± 1.14, $p < .001$), from posttest to follow-up (19.13 ± 1.14 vs. $11.16 \pm .57$, $p < .001$), and from pretest to follow-up (38.56 ± 1.03 vs. $11.16 \pm .57$, $p < .001$; Figure 1).

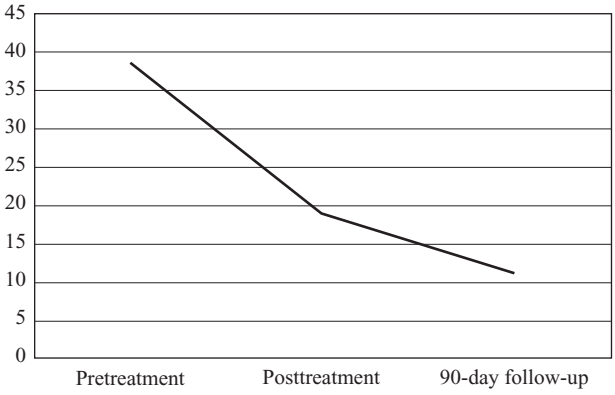

FIGURE 1. PCL-5 scores means pretreatment, posttreatment, and 90-day follow-up.

Discussion

In this study, two trained and supervised paraprofessionals provided EMDR-IGTP treatment to 37 adult staff members (protective services workers, caregivers, psychologists, lawyers, and social workers) from 3 NGOs who reported PTSD symptoms related to their work with child and adolescent survivors of severe interpersonal trauma. The two paraprofessionals were part of a group of 12 Bolivian paraprofessionals specially selected and trained by the first author (IJ) in EPAPI in Cochabamba, Bolivia, in 2016. They provided four EMDR-IGTP sessions to participants who had been randomly allocated to two different groups.

The specific purpose of the study was to investigate the effectiveness of the EMDR-IGTP treatment applied by specially selected, trained, and supervised paraprofessionals. Statistical results indicate that the EMDR-IGTP administered by paraprofessionals had a significant effect reflected on the PCL-5 scores used to assess PTSD symptoms. Results show a significant decrease from pretest to posttest, as well as from posttest to follow-up. It is interesting to note that results were maintained at 90-day follow-up, even though participants continued working in the same environment exposed to the aversive details of their clients' reported traumatic events.

Safety

In this study, no participant showed worsening in PTSD symptoms, self/harm suicidal or homicidal ideation, severe depression, or substance abuse at 90-day follow-up. Paraprofessionals complied with the self-care standards and do not report secondary traumatization at 90-day follow-up monitoring.

The principle of "do no harm" is a very important topic in our training program. The EPAPI safety working definition is *minimize the risk of harm for patients and paraprofessionals*. To comply with it, we established the following measures in selecting and training our paraprofessionals: (a) We only work with NGOs/institutions that agree, on paper, to full cooperation with us and that assume responsibility for their staff's compliance with our apprenticeship model and safety measures. (b) We select potential candidates for our training program from the NGO's local staff based on a specially designed profile. We developed this profile through a careful analysis of the characteristics of individuals that can be selected for this task. (c) We maintain a support network for trainees' supervision, monitoring, feedback, and support/coaching integrated by EMDR Institute senior trainers, trainers, approved consultants, and experts on trauma and dissociation. (d) We carefully assess all patients' pretreatment interview with special emphasis on recent history of usage of self-regulation skills and "red flags" detection (e.g., ongoing self-harm/suicidal or homicidal ideation; substance abuse or significant cognitive impairment; or diagnosis of psychosis, bipolar disorder, dissociative disorder, or organic mental disorder) that may complicate treatment of the distressing event(s) that will be addressed during the IGTP. In such cases, patients are immediately referred to a mental health professional at the tertiary level and not treated by the paraprofessional.

Paraprofessionals learn how to ensure safety during the EMDR-IGTP process. To create a safe and secure-holding environment for patients and to provide coregulation of emotional responses during the trauma work, paraprofessionals are taught to maintain a physical presence of attuned compassion. They are instructed in the close monitoring of severe abreactions and the use of effective regulation interventions. They learn how to identify, manage, and properly refer patients for any negative effects. Paraprofessionals are also taught self-care as a standard practice and are regularly monitored for secondary traumatization.

Use of Paraprofessionals

Dr. Francine Shapiro (2014) mentioned, ". . . effective mental health treatment should be available to all and not merely those in the more affluent regions of developed countries" (p. 184). The study results suggest that the widely shared concept that improvements in mental health require sophisticated and expensive technologies and highly specialized staff may be mistaken. They provide support for the assertion by Dr. Margaret Chan, director-general of WHO, that

> the reality is that most of the mental, neurological, and substance use conditions that result in high morbidity and mortality can be managed by nonspecialist health care providers. What is required is increasing the capacity of the primary health care system for delivery of an integrated package of care by training, support, and supervision. (WHO, 2010)

Carriere (2014, p. 191) proposed a three-tiered intervention pyramid, in which psychological first aid is the bottom tier. It can be provided by community volunteers, who refer clients needing more specific intervention to "second aid treatment." Second aid treatment (such as EMDR-IGTP) can be provided by paraprofessionals, who then refer any individuals requiring further intervention to the mental health

professionals in the top tier. He recommended that EMDR therapy be incorporated into community-based psychological first and second aid (the two bottom tiers in the pyramid). He also suggested that specially trained and supervised paraprofessionals could provide EMDR treatment for mild to moderate disorders (the third tier in the pyramid), helping to rationalize the use of scarce professionals' resources through timely and proper referral when higher skills are needed.

Limitations

The study has limitations specially related to the size of the sample, the use of only one measure, and the lack of comparison with a control group or treatment. Further studies are required using larger samples with more measures, and comparison of results with another therapy or control group.

Recommendations

The study presents preliminary evidence for scaling up EMDR therapy (Carriere, 2014) in an LMIC. Scaling up makes it possible to reach larger numbers of people in a shorter time thereby offering an operational advantage; this is highly valuable in settings where resources are limited (Jarero et al., 2016). In our opinion, the EMDR-IGTP is ideal to scale up EMDR therapy because it requires only two specially trained paraprofessionals on the EPAPI to deliver the protocol to 20 participants. It is totally confidential and enables each person to individualize the focus of their therapy within the group setting; requires minimal contact time to be effective, measured in hours and consecutive days, not weeks or months; reduces cultural resistance to treatment because it is minimally intrusive and relies less on language than TF-CBT; it does not require creating a narrative of the traumatic experience, verbal disclosure of details, or prolonged reliving traumatic experiences, or homework.

We believe that well-selected, trained, and supervised paraprofessionals may constitute a strong workforce in underserviced areas, moving some of the burden of mental health care provision from highly specialized professionals (e.g., psychiatrists, psychologist) to specially selected, trained, and supervised paraprofessionals working in the referral system as a link between psychological first and second aid and mental health professionals at the tertiary level. It is our hope that the EPAPI could contribute to address the world mental health service gap and "change the face of trauma" (Carriere, 2014, p. 193).

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Correspondence regarding this article should be directed to Ignacio Jarero, PhD, EdD, Boulevard de la Luz 771, Jardines del Pedregal, Álvaro Obregón, México City, Mexico 01900. E-mail: nacho@amamecrisis.com.mx