

Report of the
Psychological Assessment Mission to
Marawi, Mindanao, Philippines
7- 15 January 2018



GIST-T's Vision: A world in which the power of recovery and growth inherent in recognised trauma treatments is available to millions of traumatised people

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Appreciation: The mission was made possible through the generous contributions from Trauma Aid Germany, EMDR UK/Ireland, Dr. Amanda Roberts, Nigel Roberts and Mark Nickerson, LICSW. The mission also appreciated the tremendous support and professionalism of the staff of Nonviolent Peaceforce in Mindanao. Without their help, the mission would not have been half as productive!

Acknowledgments: All team members participated in the data collection and information gathering and contributed to the development of this final report. Data and thematic analysis was undertaken by Dr. Derek Farrell. Ms. Clare Blenkinsop edited the report. Photographs taken by GIST-T.

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Topline findings

1. Significantly high levels of trauma (PTSD), anxiety and depression
2. Paucity of specific trauma treatments available
3. High levels of exposure to Adverse Childhood Experiences (ACEs), including physical, psychological and emotional abuse and neglect
4. High levels of internalized shame responses
5. Evidence of continuation of fear, revenge and retribution
6. Multiple perspectives on the responsibility for the siege in Marawi
7. Multiple experiences of loss
8. Major concerns regarding child mental health – including trauma
9. Significant concerns about the future
10. Evidence of post-traumatic growth and resilience

Introduction

Following the recent crises of extreme violence in Marawi (the country's largest Muslim-majority city) and natural disaster in two Lanao provinces, 450,000 citizens find themselves in IDP camps or 'homestays', with no own home to return to. In addition, some 1,500 families are grieving for the loss of loved ones – many under horrifying circumstances. This will take great effort and many years to reconstruct and heal.

In response to these events, a five-member team of the Global Initiative for Stress and Trauma Treatment (GIST-T), in consultation with EMDR Philippines, Philippines Psychiatric Association, Nonviolent Peaceforce (NP) and World Bank Manila, conducted a needs assessment to understand the psychosocial impact of the recent crises in Marawi on the affected population – individuals, families, and local communities. The aim was to gather first-hand information from IDPs, review the state of current psychological services available, identify unmet mental health needs, and propose immediate and medium-term ways to strengthen capacity of mental health professionals and paraprofessionals to provide appropriate treatment.

Discussion

Origins and layers of trauma

The findings from this mission attest to the alarmingly high rates of trauma among the population. Furthermore, they highlight the substantial impact of the political, legal, and socio-cultural environment on both the prevalence of trauma, as well as processes of psychosocial rehabilitation. Indeed, trauma among this population was also shown to be experienced on a complex, collective level, related to:

- Historic trauma
- Intra-familial trauma
- Religious conflict
- Violent extremism
- Sexual and gender-based violence (SGBV)
- Natural disasters
- History of forced evacuations and displacements

Interrupting intergenerational transmission

The cycle of trauma and violence appears to have continued for generations, as indicated by the high level of adverse childhood experiences to which this adult population has been exposed. Given the significant concern raised by parents and teachers over the impact of trauma on the mental health of children in the community, the perpetuation of this cycle of trauma and violence is a significant cause for concern. The scientific literature reports that children exposed to violence and exhibiting higher levels of trauma, have an increased vulnerability towards appetitive aggression (i.e. aggressive behaviour related to actively searching violence) and engaging in acts of extremism.

Intervening with evidence-based EMDR trauma treatment, competently administered by properly trained professionals and paraprofessionals, offers an opportunity to interrupt this vicious cycle of violence. This cycle threatens to leave Mindanao politically and economically unstable for years to come with incalculable costs to the physical and mental health of its citizens, culture, society and future. Untreated trauma can infect adjacent communities and spread. Untreated trauma may leave many Mindanao children vulnerable to future recruitment efforts by Islamic extremists and other terrorist organizations. Stockholm syndrome is a condition that causes hostages and those affected by captivity to develop a psychological alliance with their captors as a survival strategy. Further fallout from these traumatic experiences may also lead to a proliferation of crime and violence. Early intervention with EMDR therapy could have a preventive effect in addition to treatment benefits.

Effect on adults and children

Serious symptoms of depression, anxiety, and trauma were clinically observed by the consultant psychologists – confirming the results of the psychometric screening. Among the most disturbing observations was the increase in physical violence and aggression reported – particularly among the youth. Children, for example, were seen to play 'ISIS-ISIS' – dressing up as fighters and 're-enacting' the traumatic events to which they had been exposed. Others were too afraid to attend school – jumping at the slightest sound of a motorcycle or a helicopter, as the noise would trigger memories of traumatic events. The emotional distress among adults was similarly observed to affect their ability to function productively.

Self-awareness of trauma

The majority of actors with whom the team engaged, including the military, teachers and humanitarian workers, spontaneously referred to themselves needing psychological assistance for their own trauma – with some becoming visibly emotionally distressed/in tears when speaking about their experiences. Despite the stigma surrounding mental health in general, many spoke directly and openly about their psychological distress and need for assistance. Quantitative results from psychometric screening, qualitative data obtained from interviews, as well as clinical observations unequivocally point to this being a traumatised population.

Current psychosocial interventions

It appears that current psychosocial interventions are inadequate to fully address this need. Interest in the mental health of this population from the international humanitarian community has recently decreased, as evidenced by the fact that the Mental Health and Psychosocial Support (MHPSS) cluster has now been deactivated. The psychosocial support offered by local organizations in the area all seem to be based on Psychological First Aid (PFA), with serious individual cases sometimes being referred to the two psychiatrists in the region. These PFA interventions are a necessary but insufficient condition to address the deeper psychological and emotional needs of this community, given that they are almost entirely 'social' and not 'psychological'. Despite the high awareness of psychological need (*invisible wounds*), responses have focused almost entirely on visible needs.

The way forward: implications for action

The findings from this mission call for urgent remedial action to treat trauma. A three-phased approach is proposed. Phase 1 is to offer emergency EMDR therapy¹ (using standard, early intervention, intensive and group protocols) to high-priority victims of the recent crises, including hostage survivors and humanitarian aid workers. Phase 2 aims to strengthen and expand capacities of local mental health personnel in the Lanao provinces, and Phase 3 would create local trauma treatment capacity through large-scale training throughout Mindanao. Further details can be found in Appendices 1 and 2.

Early EMDR interventions are ideally suited to recent trauma with ongoing consequences. New, evidence-based EMDR protocols, specifically designed to address ongoing traumatic stressors, are

¹ Eye Movement Desensitization and Reprocessing (EMDR) is one of two WHO-endorsed trauma treatments; the other one is Trauma-Focused Cognitive Behavioural Therapy (TF-CBT).

now available. Moreover, treatment will not only address current symptoms, but build resilience and a greater capacity to meet current and future challenges. Additionally, given the considerable number of IDPs in Mindanao, the use of EMDR group protocols that can treat large numbers of people simultaneously would be most appropriate. Furthermore, these group protocols are culturally portable and neutral, and can have a de-stigmatizing effect for those seeking psychological assistance. Early EMDR interventions are not only viewed as treatment but are believed to have a preventive effect, thus helping to alleviate current distress, and to avert intractable mental and physical disorders in a large segment of the population in the future. For more details, see Appendix 3.

The three-phased intervention project would aim to:

- Address and interrupt the cycle of trauma and violence affecting this population – with significant implications for peacebuilding.
- Focus on strengthening local, Mindanao-based capacity – given the importance placed on communal and religious resources for post-traumatic growth (PTG). With PTG, adversity is turned into advantage. Put differently, following effective trauma processing, positive psychological change may be experienced which rapidly moves individuals to a higher level of functioning. There is a wide understanding within clinical practice circles that EMDR therapy is uniquely capable of promoting PTG. Therefore, EMDR therapy is more than symptom reduction: it can also increase resilience and strengthen the ability to meet future life-challenges more effectively.
- Resist fly-in/fly-out routine, short-termism, mobilize/demobilize efforts, given the waxing and waning interest on the part of the international community. These trends have been observed in countries like Nepal, following the 2015 earthquake, and Haiti following the earthquake of 2010 and the subsequent cholera epidemics.
- Insist on scientific, evidence-based trauma intervention which goes beyond principles of Psychological First Aid – given the current lack thereof.

EMDR therapy is the treatment of choice. For more information, see Appendix 3. It has several advantages compared to TF-CBT: it is more quickly effective and lasting; it is less invasive as it does not require the client to explain trauma details; it can be administered on consecutive days; it requires no homework; it can be undertaken both with individuals and in groups. For more information, see Appendix 4.

Trauma relief would not only restore the health, wellbeing, educability, productivity and creativity of those now living with trauma. It **would also improve the government's image and struggle** against violent extremism – given the vulnerability towards extremist behaviour in contexts of complex trauma, and the divided loyalties and multiple perspectives on 'who is responsible' for the recent siege.

Ms. Gail Womersley (middle) going over the questionnaire with a participant with the help of an interpreter.



Dr. Derek Farrell (right) comforting a priest, returning to his parish after months of being held hostage.



Dr. Sushma Mehrotra (middle) meeting with local women.



Fr. Cornelio Jaranilla (right) conducting an interview with a participant.

Results: Quantitative and Qualitative Data Analysis

Scope of interviews

In all, some eighty participants agreed to an in-depth Trauma Assessment Interview and Psychometric Evaluation. This assessment was limited to parts of the two Lanao provinces (Mindanao), namely Marawi, Iligan, and Kauswagan. All participants resided in four evacuation centres: Pantao Ragat, Buruon, Saguiran, Baloi. All psychometrics were translated into Maranao dialect. The interviews and data collection took place within six days. Given the time restriction and geographical limitation, the results are not intended necessarily to be representative of the community as a whole. Despite this, the mission was able to access a wide range of key stakeholders thanks to the involvement of local partners in the mission. For details on the methodology used, see Appendix 5.

Section A: Quantitative Data

Demographic data was collected from all participants, as follows:

- Name
- Gender
- Age
- Educational Level
- Religion/ Ethnicity
- Marital Status
- Work Status
- Employment
- Evidence of Previous Treatment

Psychometrics used were the following instruments:

- Post-Traumatic Stress Disorder (PTSD) Checklist – 5 (PCL-5)
- Generalised Anxiety Disorder Scale (GAD-7)
- Patient Health Questionnaire – 9 (PHQ-9)
- Adverse Childhood Experiences (ACEs) Questionnaire

NB: These assessment instruments are psychometrically valid and reliable, and have been used extensively in general outpatient psychotherapy populations throughout disaster zones in Asia and the Middle East. They are also considered to be among the most robust, field tested and culturally least biased inventories appropriate for these particular cultural contexts.

1.0 Participants' Demographic Information

1.1 Gender

Figure 1 shows the gender distribution of the interview participants.

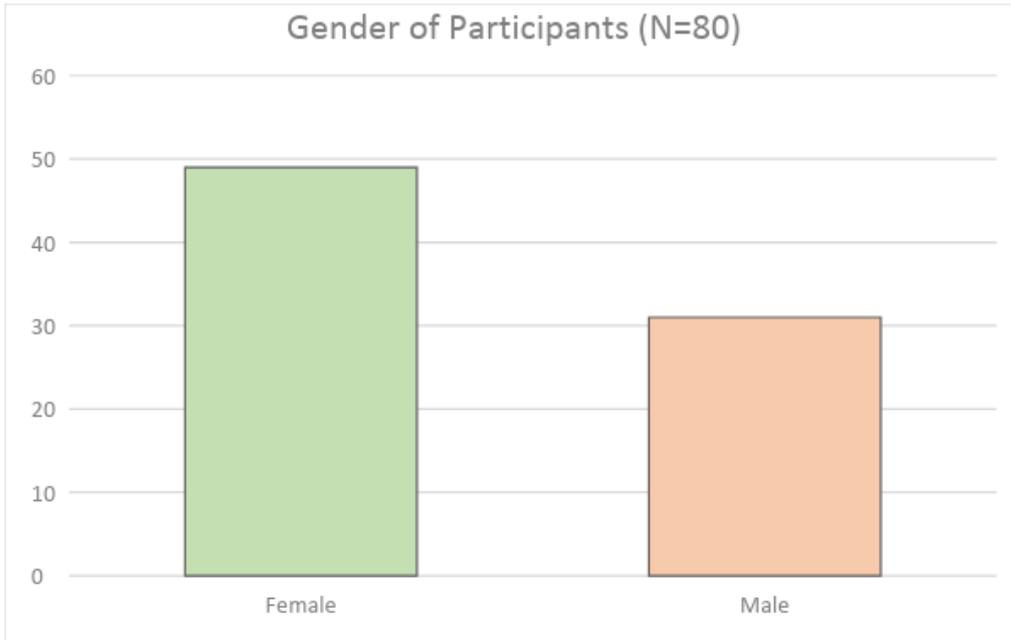


Figure 1: Gender Distribution of Participants

1.2 Age Distribution

Figure 2 shows the age distribution of the participants with a mean age of 36.9 years (μ 14.71)

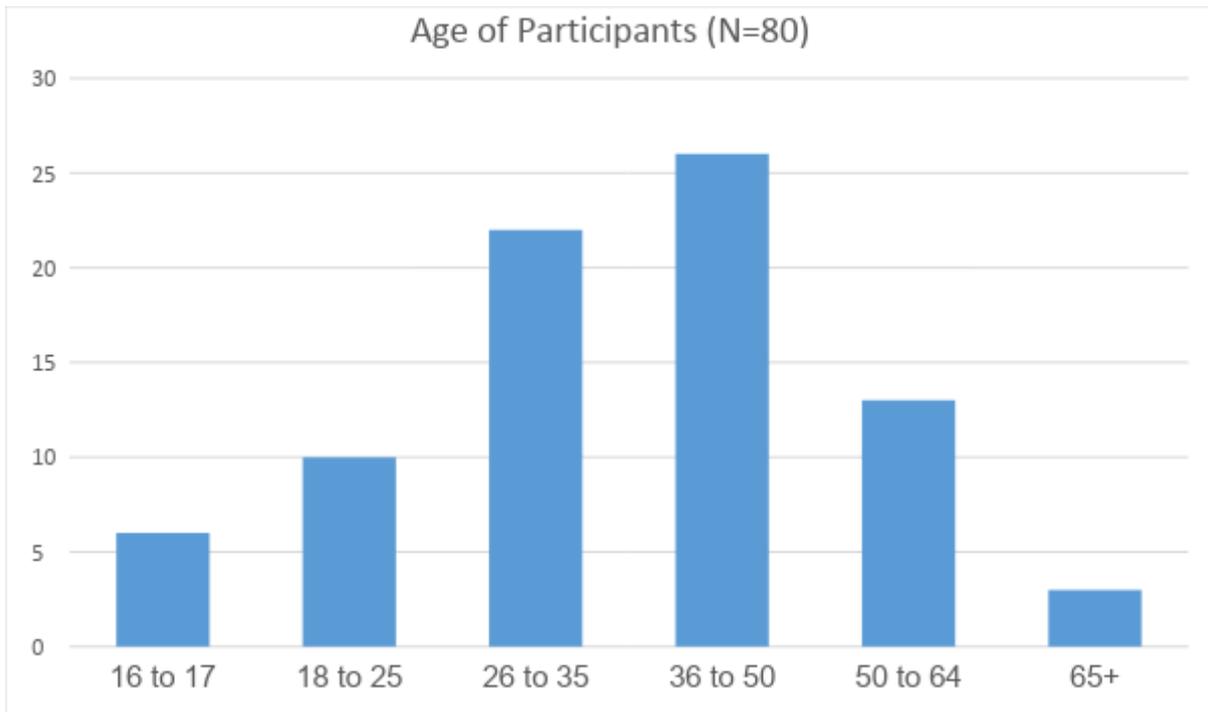


Figure 2: Age Distribution of Participants

1.3 Educational Level of Attainment

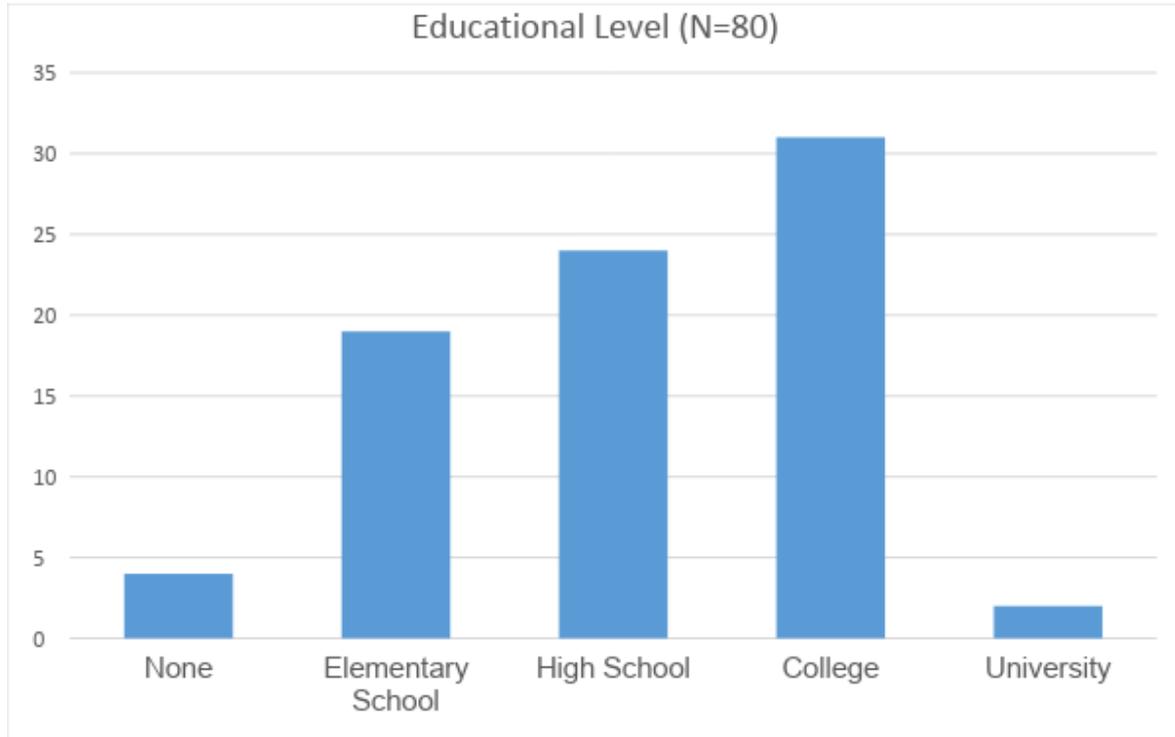


Figure 3: Educational Level of Participants

- High School Grade 7-12 (ages 13-19)
- College 1-4 (Ages 20-23)

1.4 Religion

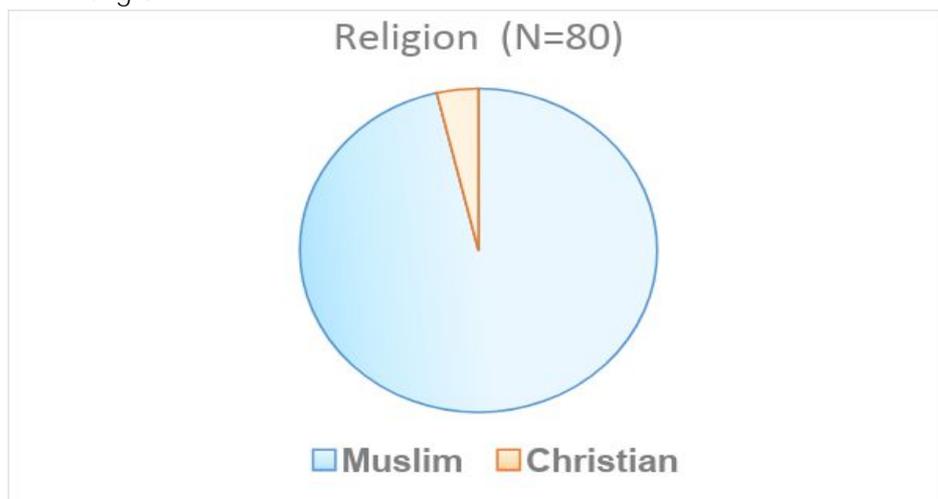


Figure 4: Religious Background of Participants

Religion	
Muslim	96.25%
Christian	3.75%

1.5 Relationship Status

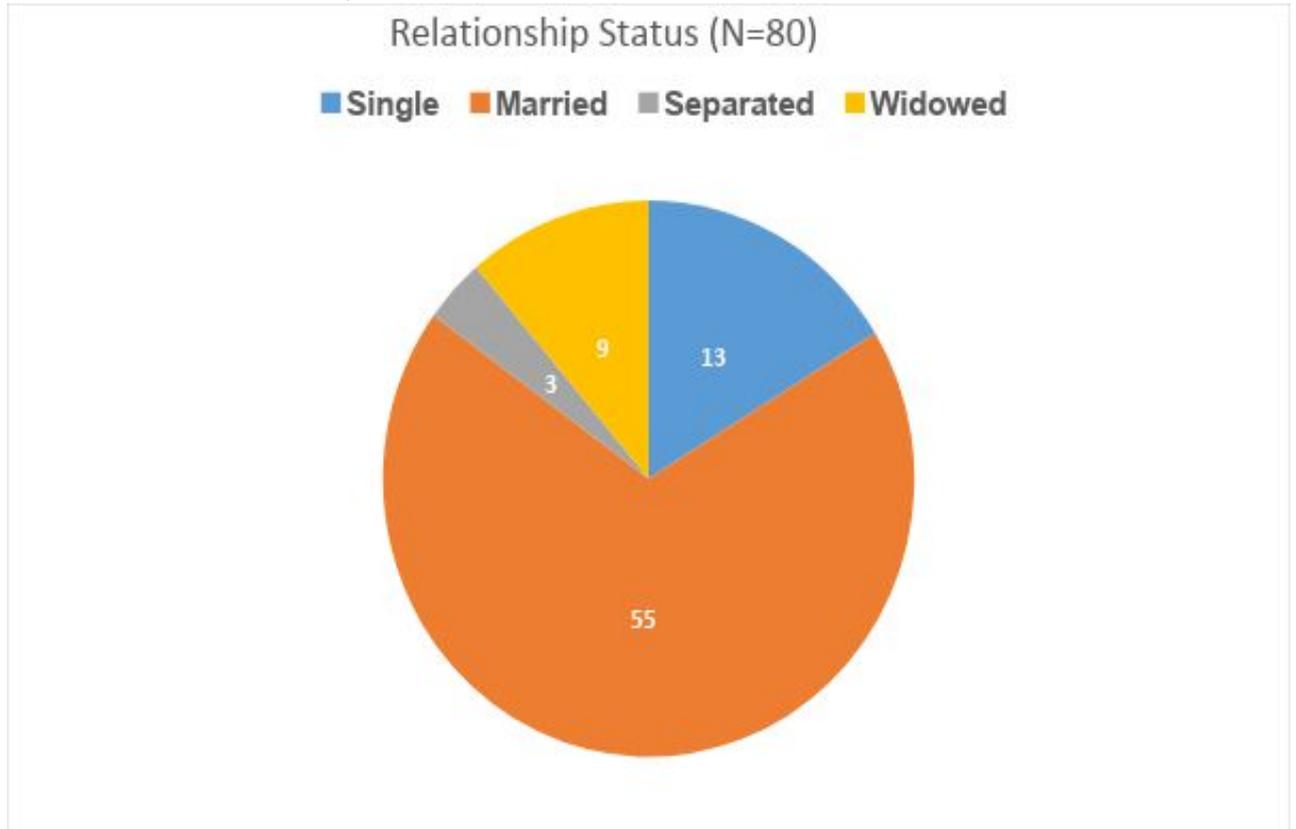


Figure 5: Relationship Status of Participants

Status	N=80
Single	13
Married	55
Separated	3
Widowed	9

1.6 Employment Status

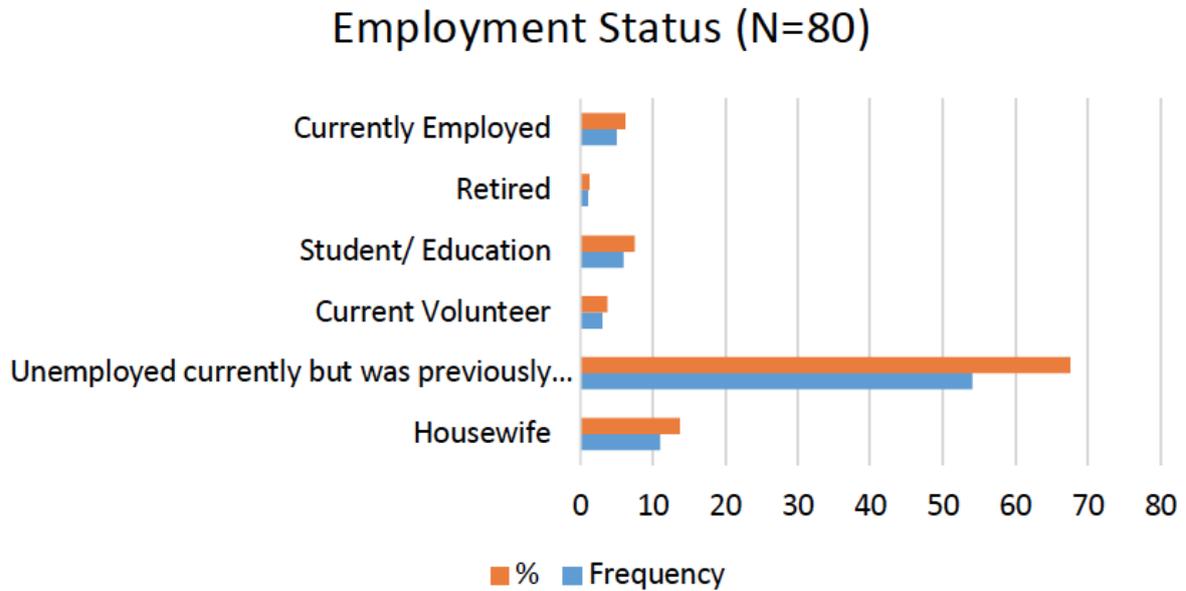
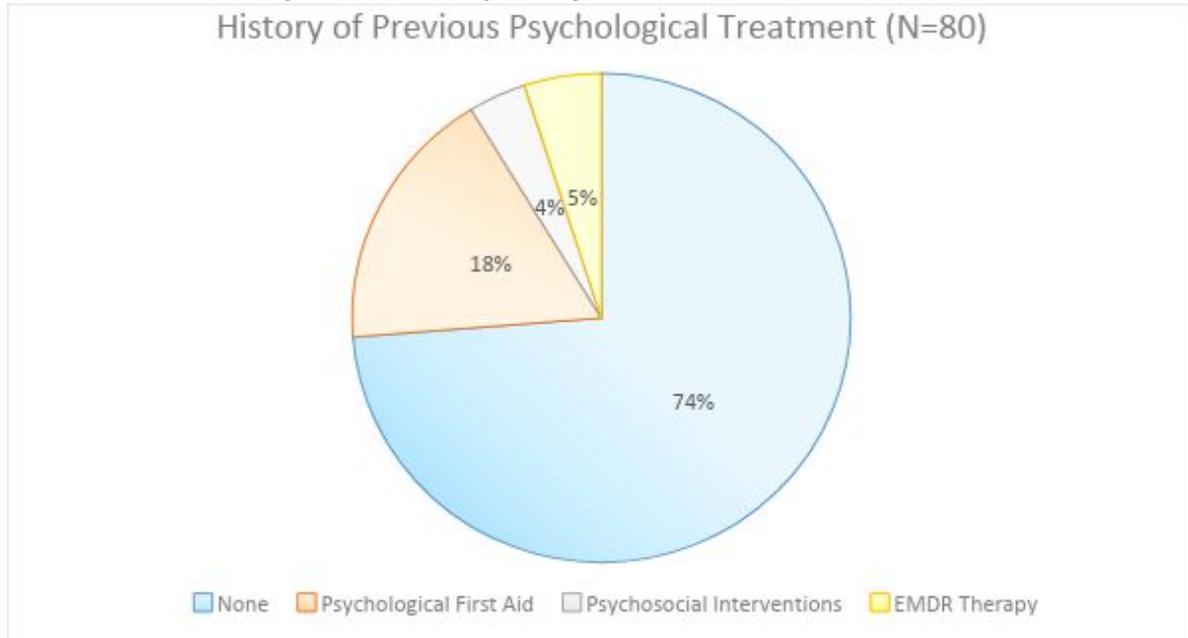


Figure 6: Current Employment Status of Participants

Employment Status	Frequency	%
Housewife	11	13.75
Unemployed currently but was previously employed before the Marawi Siege	54	67.5
Current Volunteer	3	3.75
Student/ Education	6	7.5
Retired	1	1.25
Currently Employed	5	6.25

1.7 History of Previous Psychological Treatment



Evidence of Previous Treatment	Frequency	%
None	59	73.75
Psychological First Aid	14	17.5
Psychosocial Interventions	3	3.75
EMDR Therapy	4	5

Figure 7: History of Previous Psychological Treatment

The 5% of participants who had received EMDR therapy all reported that they found the intervention helpful and beneficial. The therapy offered was a specific EMDR therapy scripted format known as the Integrative Group Therapy Protocol.² The EMDR Integrative Group Treatment protocol (EMDR-IGTP) has been used in various parts of the world since 1998, with both adults and children, after natural or man-made disasters. This protocol combines the eight standard EMDR treatment phases with a group therapy model, thus providing more extensive reach than the individual application of EMDR therapy.³

² Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative group treatment protocol: A post disaster trauma intervention for children and adults. *Traumatology, 12*(2), 121.

³ Jarero, I., Artigas, L., Montero, M., & Lena, L. (2008). The EMDR integrative group treatment protocol: Application with child victims of a mass disaster. *Journal of EMDR Practice and Research, 2*(2), 97-105.

2.0 Participant Psychometric Information

2.1 Post-Traumatic Stress Disorder (PTSD) Checklist-5 [PCL-5]

The PCL-5 is a 20-item self-report measure that assesses the 20 *DSM-5* symptoms of PTSD. The PCL-5 has a variety of purposes, including:

- Monitoring symptom change during and after treatment
- Screening individuals for PTSD
- Making a provisional PTSD diagnosis

The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS-5). However, when necessary, the PCL-5 can be used to provide a provisional PTSD diagnosis.

A diagnosis of PTSD can be made only when an individual meets a sufficient number of symptoms in each cluster of *DSM-5* criteria, with a severity of at least a 2 (moderate).⁴

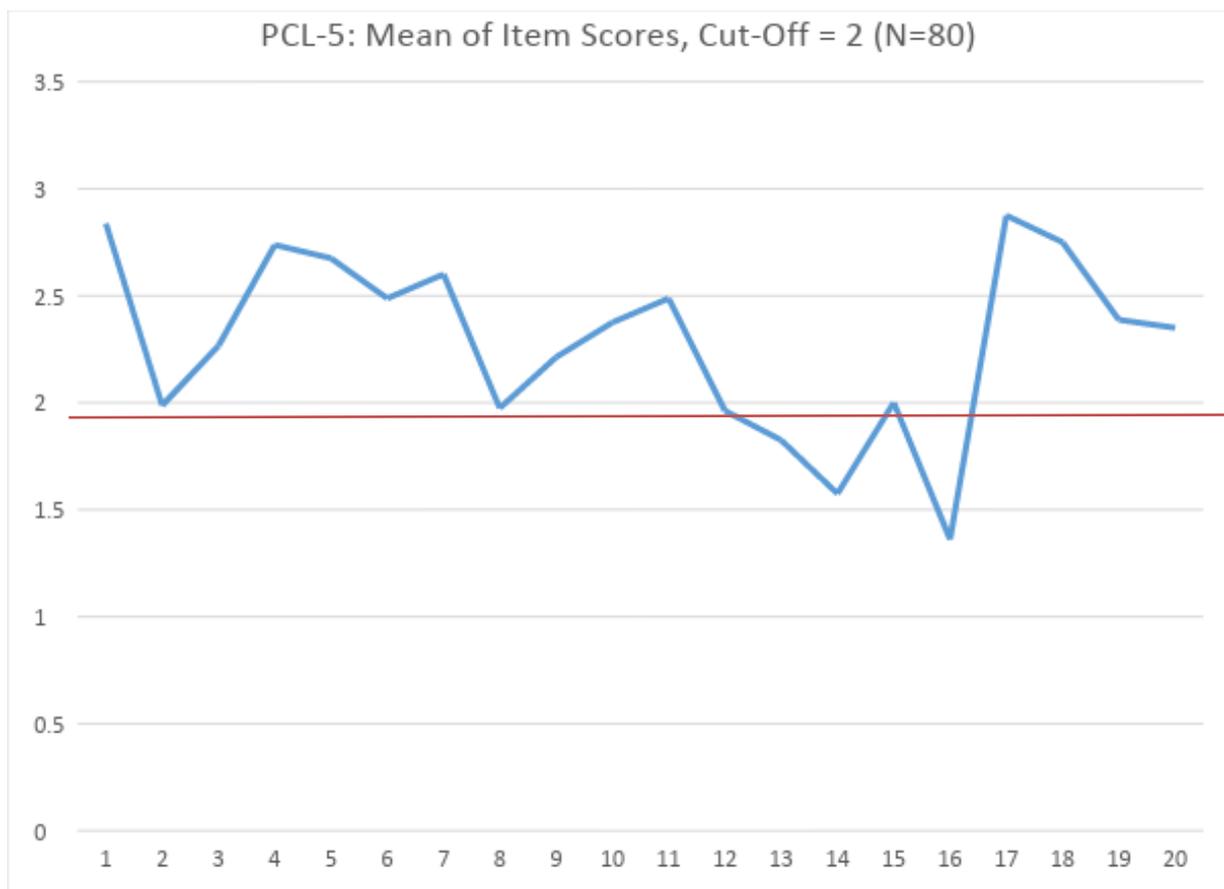


Figure 8: Mean Item Scores from the PCL-5 Checklist

⁴ Wortmann, J. H., Jordan, A. H., Weathers, F. W., Resick, P. A., Dondanville, K. A., Hall-Clark, B., ... & Mintz, J. (2016). Psychometric analysis of the PTSD Checklist-5 (PCL-5) among treatment-seeking military service members. *Psychological Assessment, 28*(11), 1392.

DSM – 5 Categories

DSM-5 Categories (N=80)			
Level	Range	Severity	Percentage
Mild	0-20	5	0.6
Moderate	20-40	20	25
Severe	40-60	40	50
Extreme	60-80	16	24.4

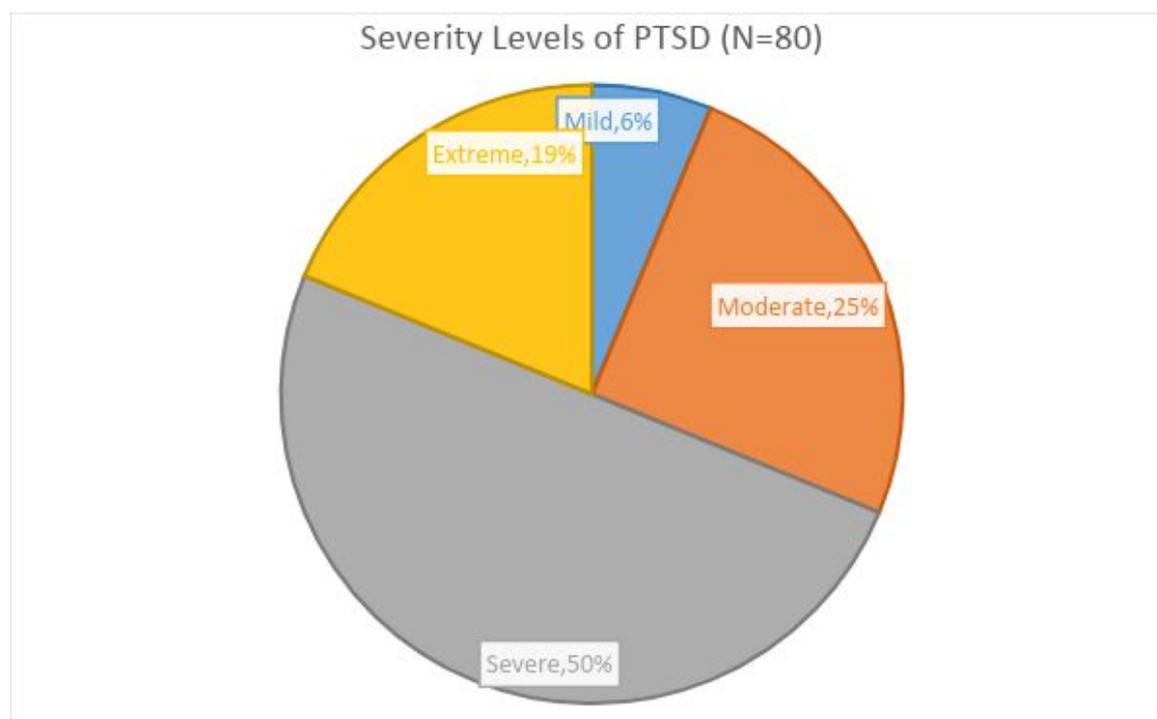


Figure 9: Severity Levels of PTSD

PCL-5	Mean
Cluster B (1)	2.5
Cluster C (1)	2.54
Cluster D (2)	2.06
Cluster E (2)	2.29
Total Mean	45.19
STD	15.66
Cut-off score	33
Mean Item	2.2875

Although the cut-off score for a provisional diagnosis of PTSD (DSM-5) is 33, the mean PCL-5 score of the participants was 45.19 (15.66) which is significantly higher.

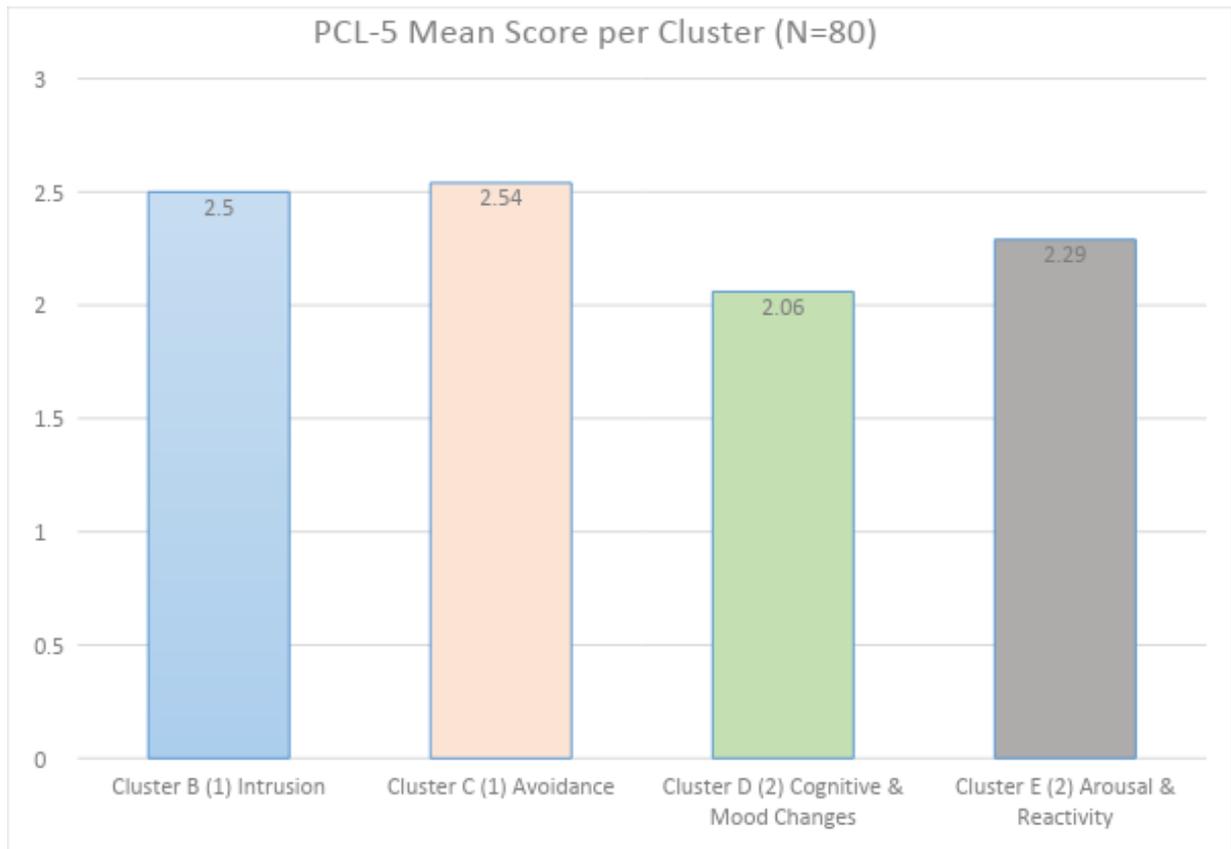


Figure 10: Mean of PCL-5 Cluster Items

Three items from the PCL-5 [13, 14 and 16] scored the lowest means:

- 13. Feeling distant or cut off from other people – Mean 1.825
- 14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you) – Mean 1.575
- 16. Taking too many risks or doing things that could cause harm – Mean 1.3625

2.2 Generalized Anxiety Disorder 7 (GAD-7)

The GAD-7⁵ is a self-reported psychometrics for measuring Generalised Anxiety. A total score of the seven items, used alongside additional clinical evaluation, indicates assessment for levels of anxiety. Severity assessed over the past two weeks.

The GAD-7 Psychometrics scores are as follows (N=80):

GAD7	Severity	Proposed Treatment	No	%
0-5	None	None	8	10
6 to 10	Mild	Watchful Waiting	8	10
11 to 15	Moderate	CBT and Pharmacotherapy	25	31.25
16 to 21	Severe	Initiation of Pharmacotherapy, CBT and Specialist Referral to Psychiatrist	39	48.75
		Mean	14.1	
		STDEV	4.86	

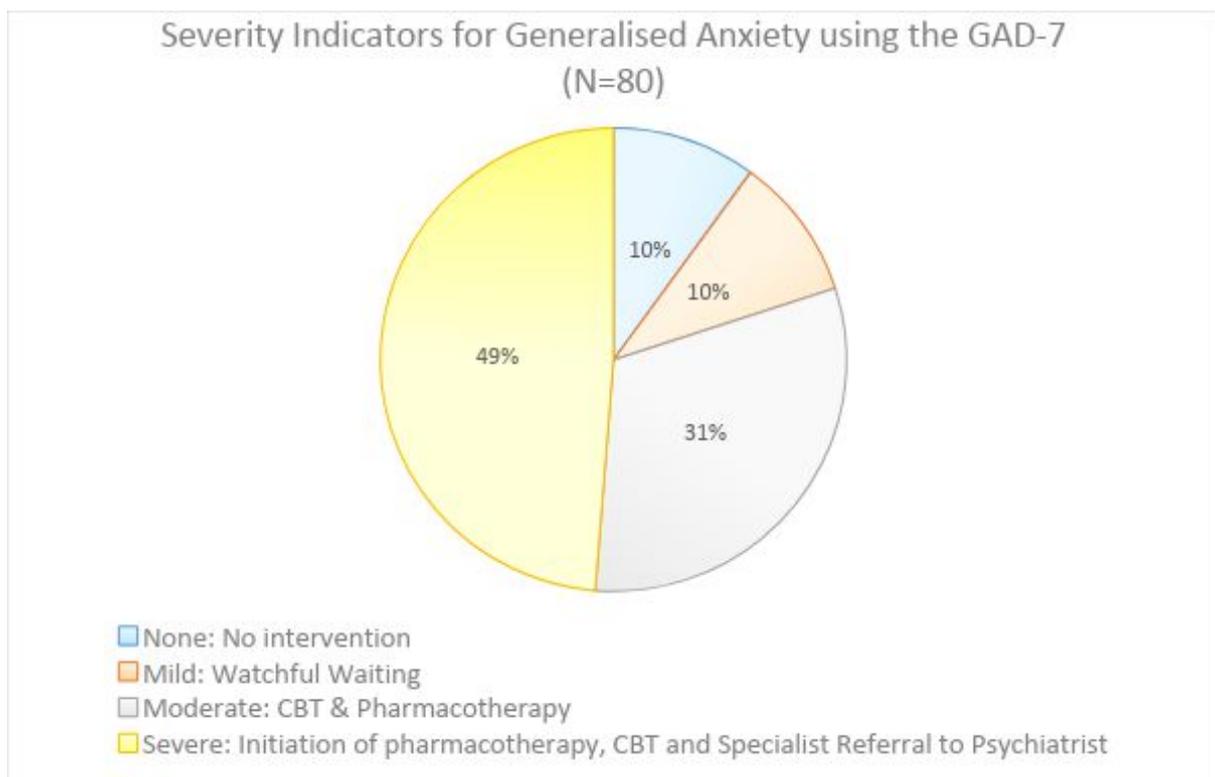


Figure 11: Severity Indicators for Generalised Anxiety using the GAD-7

⁵ Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166(10), 1092-1097.

2.3 Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9)⁶ is a self-administered version of the PRIME-MD diagnostic instrument for common mental health disorders. The PHQ-9 is the depression module from the larger psychometric. The PHQ-9 can be used to make a tentative diagnosis of depression in at risk populations alongside an additional clinical evaluation.

PHQ-9	Severity	Proposed Treatment	No.	%
0 to 4	None	None	4	5
5 to 9	Mild	Watchful waiting	19	23.75
10 to 14	Moderate	Consider CBT and pharmacotherapy	20	25
15 to 19	Moderately Severe	Immediate initiation of pharmacotherapy and CBT	23	28.75
20 to 27	Severe	Initiation of pharmacotherapy and CBT. Consider specialist referral to psychiatrist	14	17.5

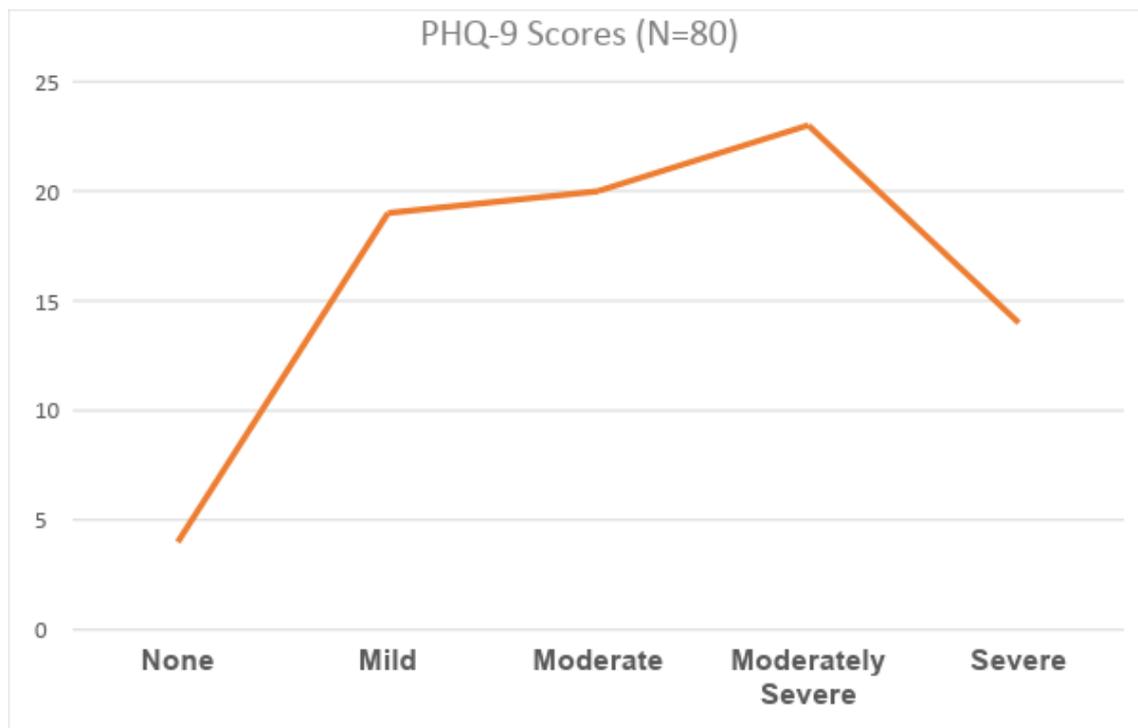


Figure 12: Severity Indicators of Depression using the PHQ-9

⁶ Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The phq-9. *Journal of General Internal Medicine*, 16(9), 606-613.

2.4 Adverse Childhood Experiences (ACEs) Scale

A few words to introduce this scale. The Adverse Childhood Experiences Scale (ACE)⁷ study was groundbreaking research conducted in the 1990s that has wide implications for medicine in general, and for mental health in particular. Its seminal finding was that, 'There is a strong graded relationship between the breadth of exposure to adverse childhood experiences and the later development of major risk factors for medical illness and premature death in adulthood' (Felitti, 1998). These results made the essential link between physical health and mental health, its resulting disability and exponential cost to society and economic productivity. Lost years of livelihood exert a toll on the overall economy. Spending money on mental health has been proven to reduce medical utilization and has a ripple effect throughout all sectors of society. Numerous references are available in the WHO literature on health economics about how untreated trauma translates into disability-adjusted life years (DALY). Spending for mental health services therefore represents an overall cost saving over time.

Adverse Childhood Experiences (ACE) refer to some of the most intense and frequently occurring sources of stress that children may suffer early in life. Such experiences include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence (WHO, 2018). Exposure to prolonged stress in childhood **can influence an individual's** health and wellbeing by compromising nervous, and immune systems. Such problems can include alcoholism, depression, eating disorders, unsafe sex, HIV/AIDS, heart disease, cancer, and other chronic diseases. The ACE Childhood Experiences Questionnaire is about assessing risk. However, it does not take into account lifestyle choices – for example, smoking, diet, exercise, alcohol intake.

Fifty-eight participants completed the ACE Questionnaire to identify evidence of child abuse, neglect and family dysfunction. The results are as follows:

⁷ Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258.

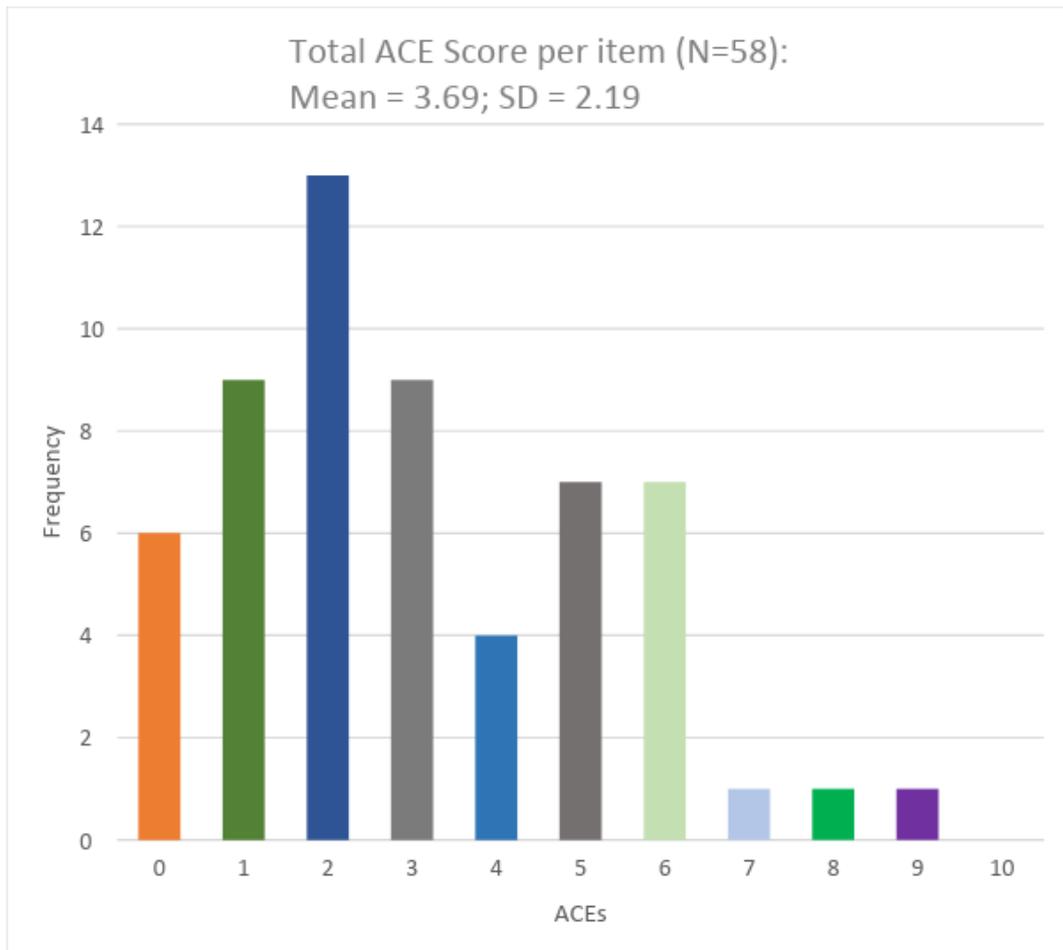


Figure 13: Total ACE Scores of Participants

The essence of each question of the ACE is as follows:

Question - While you were growing up, during your first 18 years of life:

- Q1: Psychological Abuse
- Q2: Physical Abuse
- Q3: Sexual Abuse
- Q4: Psychological/ Emotional Neglect
- Q5: Physical Neglect
- Q6: Parents Divorced/ Separated
- Q7: Physical Abuse of Mother/ Step-mother
- Q8: Exposure to Substance Misuse
- Q9: Exposure to Mental Illness or Suicide
- Q10: Incarceration

ACE results per item are as follows:

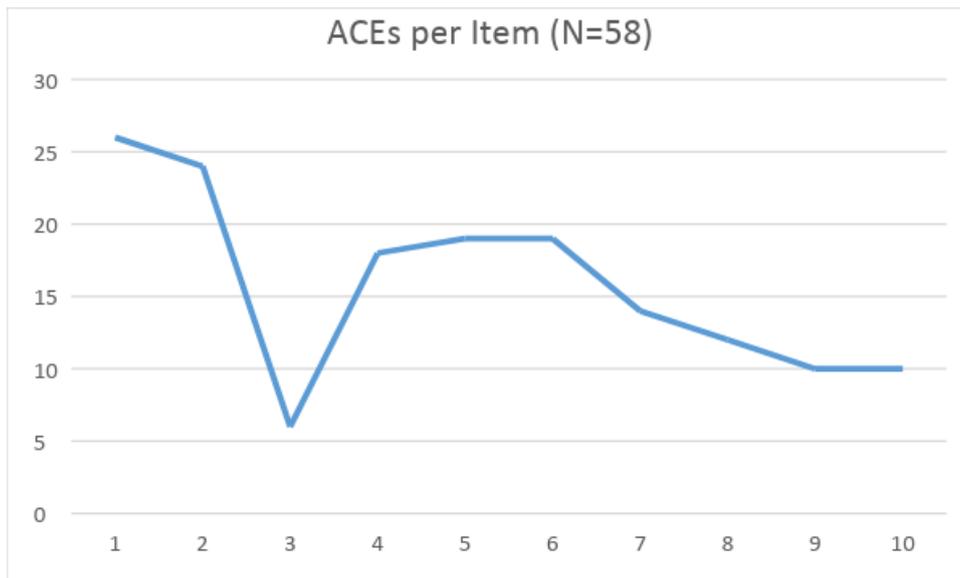


Figure 14: Adverse Childhood Experiences Item Scores

Results demonstrate that items 1, 2, 4, 5 and 6 were the highest:

- Q1: Psychological Abuse
- Q2: Physical Abuse
- Q4: Psychological/ Emotional Neglect
- Q5: Physical Neglect
- Q6: Parents Divorced/ Separated

Item Question 3: Sexual Abuse scored the lowest from the 10 items. There are two potential interpretations of this figure (10.3%) – either this is an accurate indication of potential prevalence of history of sexual abuse, or that it might be an underestimation in that cultural/ religious factors may have impacted.

Prevalence of Adverse Childhood Experiences Comparing Philippines (N=58) with the original ACE Study

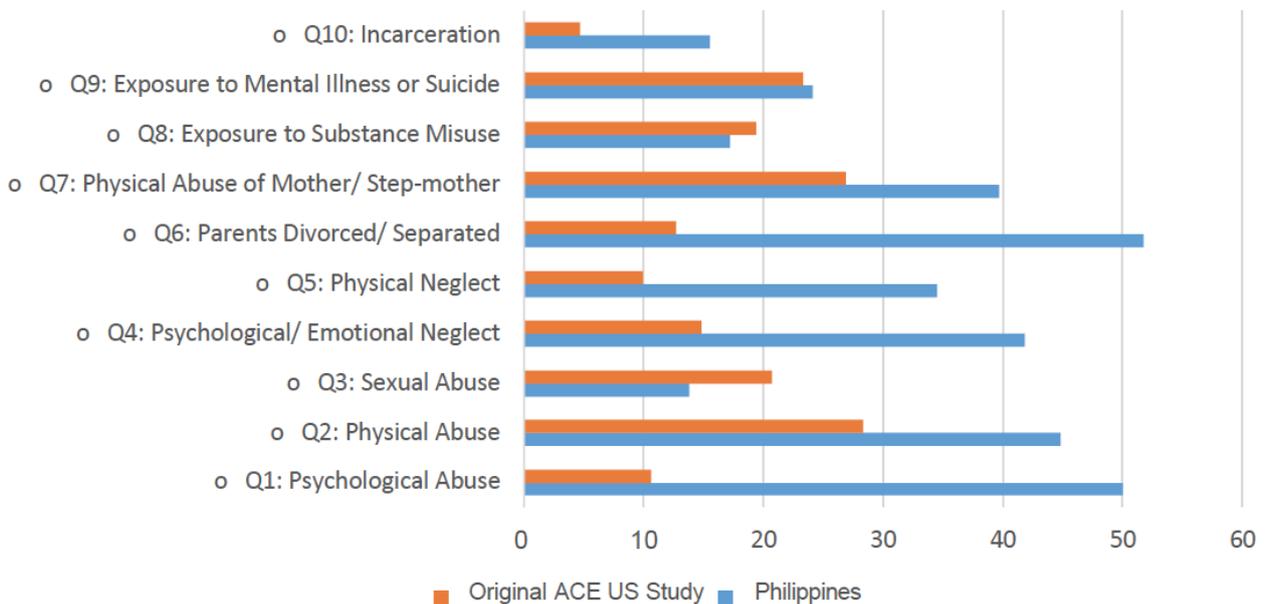


Figure 15 compares the differences in prevalence between the Philippines sample and the original ACE Study⁸

Results suggest, with the exception of Q3, concerning sexual abuse, the Philippines participants consistently score higher on each adverse childhood experience indicator. Caution needs to be exercised with these results as the Philippines data set is extremely small. Significant scaling up would be required to ascertain a more accurate picture of ACEs in the Philippines. Nonetheless the data set suggests interesting phenomenological data.

Subclinical symptoms

In addition to these obtained statistics, clinical experience has demonstrated that many people may currently carry *subclinical* symptoms of depression, trauma and anxiety that, if left untreated, can emerge as florid and treatment-resistant mental and physical disorders several years later. Therefore, it can be postulated that the statistics, presented above, do not fully reflect the depth and extent of the (currently undetectable) force of these catastrophic events in Marawi and Mindanao. EMDR early interventions can treat these sub-clinical symptoms.

⁸ Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258.

Section B: Qualitative Data

The Trauma Assessment Interview Schedule was based upon Foa (2007)⁹ and its purpose was to assess for PTSD DSM-5 Criterion A¹⁰, specified as follows:

A. The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows:

1. Direct exposure
2. Witnessing, in person
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies or pictures.

All eighty participants met the requirements for this criterion – of which only one is required.

Semi-Structured Interview Schedule

Question 1: What happened to you?

Question 2: Of all these things that happened to you, which one is currently bothering you the most? Which one causes you the most distress/ worst?

Question 3: Are you able to say who your perpetrator/ assailant was?

Question 4: Did you sustain any physical injuries?

Question 5: What impact do you think your experiences of adverse events have had on you?

Question 6: What impact do you think your experiences have had on those close to you?

Question 7: Have you been feeling guilty about the trauma or your response to it? Shamed? Angry? How much have these feelings been present for you?

Question 8: How has your mood been since the trauma?

Question 9: What behavioural changes did you notice in yourself after the trauma experience?

Question 10: What behavioural changes did you notice in significant others?

⁹ Foa, E. B., Hembree, E.A. & Rothbaum, B.O. (2007). *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist Guide*. Oxford University Press.

¹⁰ American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*. American Psychiatric Pub.

Question 11: Since the trauma, have you ever thought that life is not worth living, or thought of suicide? If yes, how often?

Question 12; What strategies/ interventions have you used in managing your trauma symptoms?

Thematic Analysis of Qualitative Data

Thematic Analysis¹¹ was used to provide a foundational understanding from the qualitative data set for identifying, analysing and reporting patterns (themes). Qualitative approaches in psychological research are incredibly diverse, complex and nuanced.

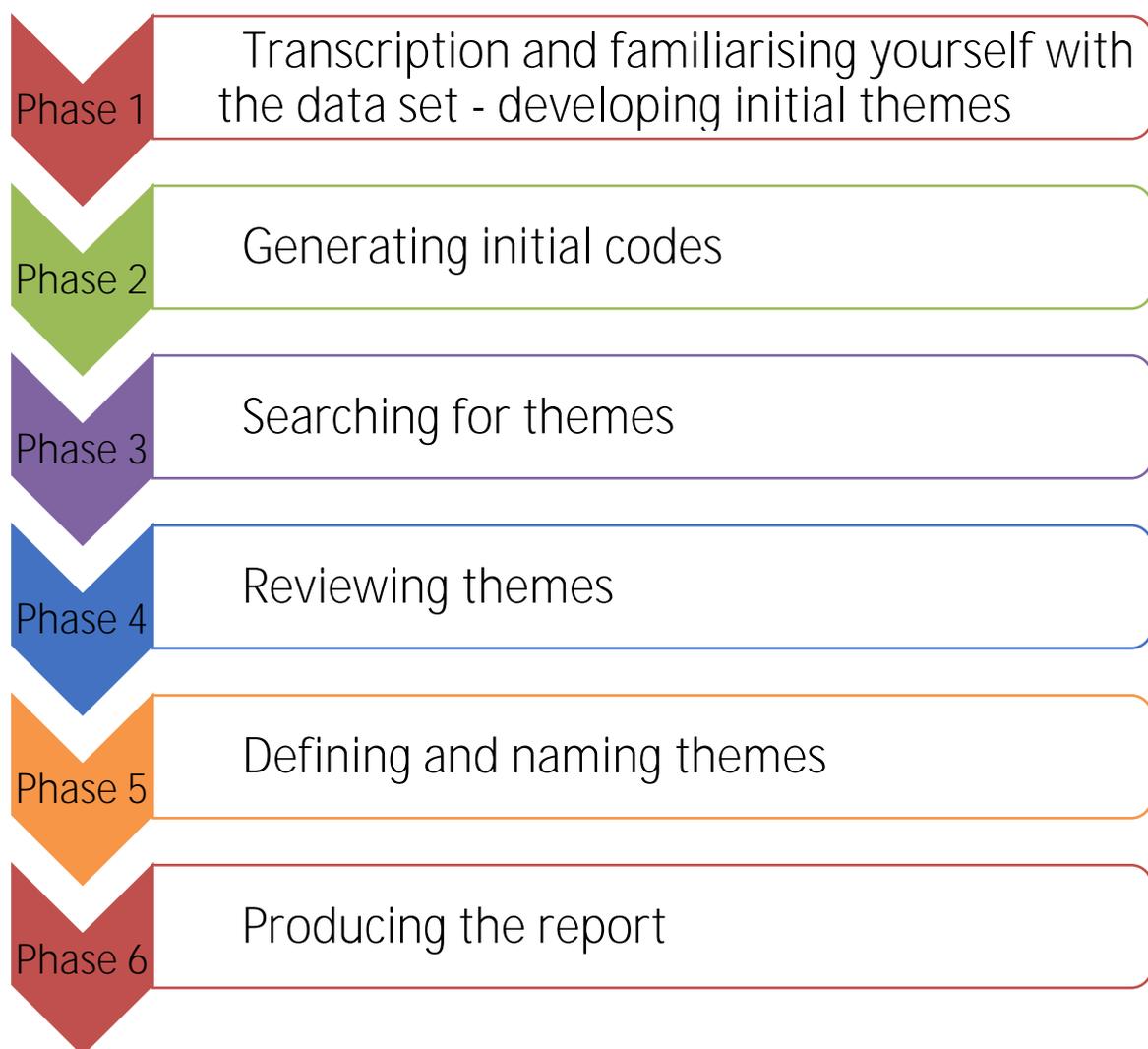


Figure 16: Stages of Thematic Analysis (Braun & Clarke, 2006)

¹¹ Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

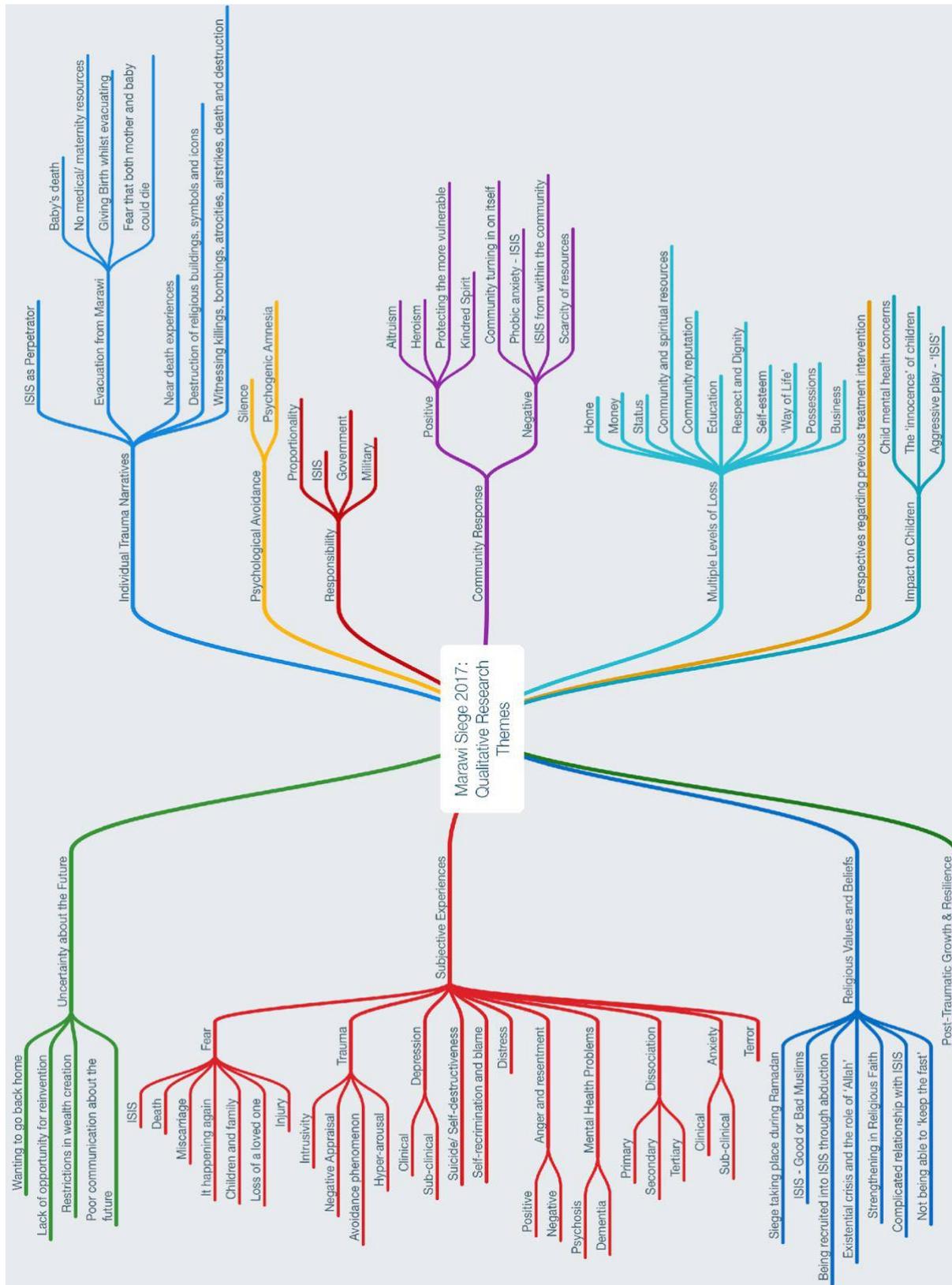


Figure 17: Qualitative Research Themes

From the data set of eighty Trauma Assessment Interviews, the following themes were identified:

- Theme 1: Subjective Experiences of the Marawi siege
- Theme 2: Individual Trauma Narratives – Specific Focus
- Theme 3: Psychological Avoidance
- Theme 4: Multiple Levels of Loss
- Theme 5: Community Response
- Theme 6: Impact on Children
- Theme 7: Religious Values and Beliefs
- Theme 8: Uncertainty about the Future
- Theme 9: Responsibility
- Theme 10: Perspectives regarding Previous Treatment Intervention
- Theme 11: Post-Traumatic Growth and Resilience

The next sections offer a selection of individual narratives, supporting the identified themes. However, to ensure the anonymity of the interviewees, no personal details of the participants are given.

Theme 1: Subjective Experiences of the Marawi Siege

Within the Trauma Interview Schedule, the first question – What happened to you? – implies no negativity, blame, proportionality or indication of responsibility or prejudice. Rather, the intention is to capture a series of subjective narratives.

Question 1: What happened to you? – brings out traumatic experiences at a subjective level. Supporting narratives are given below.

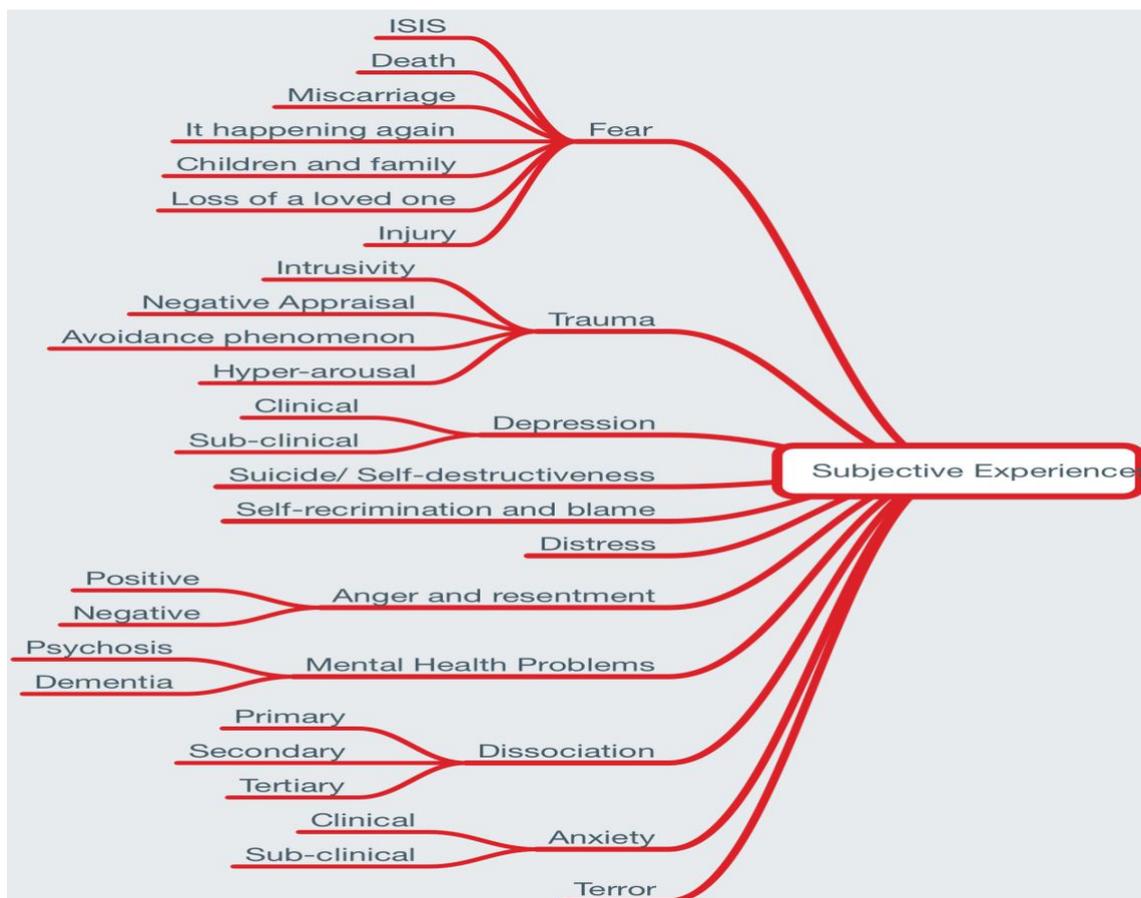


Figure 18: Sub-theme of Subjective Experience

Many of the following narratives capture subordinate themes of:

- Trauma
- Terror
- Fear
- Depression
- Suicide/ Self-destructiveness
- Self-recrimination
- Distress

- Anger and resentment
- Mental health problems
- Anxiety

“What we experienced in Marawi was terrifying. On the day we evacuated we were very frightened, we had guns pointed at us, and they threatened to fire – ISIS fighters threatened to kill us. We all thought we were going to die. It is so sad to see what has happened to Marawi. We are still troubled, but we put our faith in Allah and ask for his forgiveness. My wife and children are OK – they are strong in their faith. I feel afraid all the time, but I am frightened to show this to my family. I have to be strong for them. Before I go to sleep, my mind is racing with thoughts of Marawi, replaying the experiences repeatedly. My mind races with lots and many questions. I know this experience has changed me. I try to connect more with my faith – but I am finding this difficult. I keep asking myself, why did this happen to us. Now I am very vigilant, always anxious inside, but don't want to show it. I just want the best for my children.” P19

“I feel scared all of the time, helpless, experience flashbacks, anxious and very depressed. We were trapped for two days in our home. All of the mobile phones were down. When we escaped we were so frightened. We ran so, so fast to get away. We were terrified.” P38

“When I think about what happened to us I experience pain and rawness – and I am angry. I am constantly asking for guidance from God.” P33

“We left our home with very little, a few clothes, little money. We have lost everything. I feel stressed and anxious all the time. Even when others here in the Evacuation Centre talk about their experiences – I get agitated. It brings on bad memories. I cannot sit in any one place for any period. Sometimes I have thought that I may be better off dead. Suicide has crossed my mind.” P29

“Before I go to sleep my mind is racing with thoughts of Marawi, replaying the experiences again and again. My mind races with lots and lots of questions.” P20

Theme 2: Individual Trauma Narratives – Specific Focus

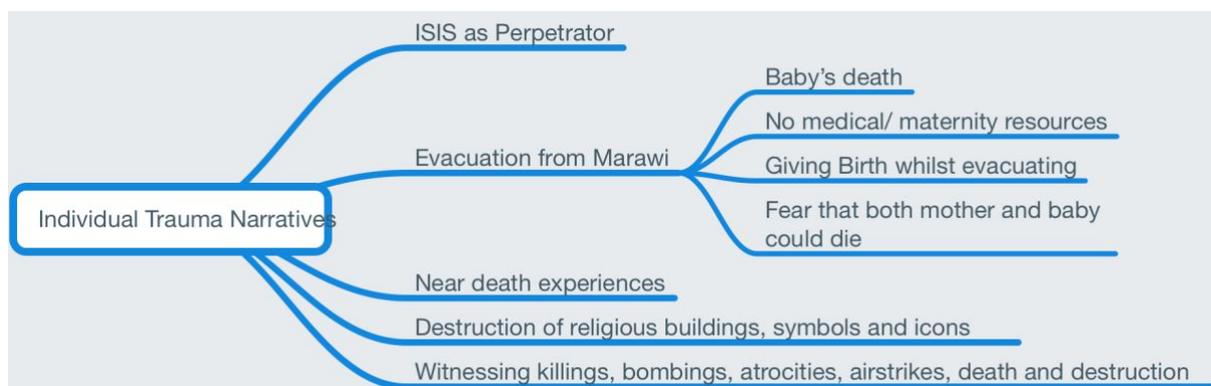


Figure 19: Sub-theme of Individual Narratives of Note

Subordinate themes:

- ISIS as perpetrator
- Evacuation from Marawi
- Near death experiences
- Destruction of buildings, symbols and icons
- Witnessing killings, bombings, atrocities, death and destruction

"I was three months pregnant when we had to escape. I was afraid for me, my husband, and my unborn child. I was petrified of losing my baby during the siege. ISIS threatened me. The worst part of the evacuation was that my father died as we were trying to escape. We could not grieve properly for the loss of our father. My baby was born here in the centre. This is no place to bring up a new baby." P9

"At first I didn't want to leave our home. I was very scared and frightened. We had to travel on foot in order to escape. We left in a hurry which meant that we could take very little – only what we could carry. I witnessed somebody being killed right in front of me. He was killed by ISIS. It was a boy, maybe nine or ten. He had stolen some food from a local market. So, they killed him, in front of everyone." P2

"I was born in Marawi. When the siege started, I was trapped for three days. I thought it would stop. I remember bullets hit our house. We had vehicles that we could use for escape, but none of us could drive. Eventually, when we did escape, it was on foot – ISIS fighters stopped us. They focussed on me, as they said my hair was too long. They reprimanded my father for allowing his son's hair to be too long. He ordered my father to cut it – and then they let us go. We were terrified that they were going to hurt us. There are times when I cry when I think of the happiness we had before." P55

"I have very painful memories of the war and the siege. I have very vivid memories of the activities of ISIS fighters. We thought we were going to die. When we were evacuating we took off our shoes so that we would not be heard. We ended up with lots of cuts and injuries to our feet. I'm very concerned about my father – he is angry all the time. I just feel lonely and sad." P46

"We were trapped in Marawi for three days during the siege (23-26 May 2017). Our house was burned and then we witnessed it being bombed. Thankfully, we were not in our house at the time. Our house was in an elevated position; we had moved to stay lower down the city. I was frightened being in Marawi as I am a Christian and this felt more scary and unsafe. We left with very little, no money – we are uncertain about the future." P50

"During the conflict, I was nine months pregnant at the time. As we were fleeing I had to give birth to my child. It didn't go OK. I was rushed to hospital where I was operated on. I survived, but my baby died. Now I'm overwhelmingly sad and fearful all of the time." P12

"We know that our home and business was destroyed by the siege. Loud noises are very distressing. We thought we would be separated from our family. Any loud noise makes my body shake and tremble, I have bad dreams and feel like I cannot control my emotions. We are afraid for our children that in the future they may join ISIS. We know of children who attended the Madrasa and were never seen again. As a parent, it is terrifying to lose one's children in this way. Why is this happening to us – have I not been a good Muslim, is Allah disappointed in us, in me?" P24

"The most terrifying part was that people thought we were part of ISIS, and there was a point when people turned on us, but we were able to reassure them that we were not ISIS. We were very afraid. The bombings and airstrikes were very frightening. We also came across ISIS fighters and they started to follow us. We were terrified. As we were fleeing, we all started reciting words from the Quran – like in unison, and eventually ISIS left us alone." P18

"23rd May 2017. I initially thought that it was a family skirmish or conflict and thought that things would settle down. Then we got the message 'ISIS' is here. I was very distressed. We started to hear gunshots, but this is not unusual for here. Then we got text messages to say that ISIS was in the Cathedral. We initially thought it would be over in a few days, but it took five months. We were very afraid. The military cordoned off the whole area. They were afraid that ISIS fighters would try to escape. We could hear the airstrikes. We could not leave as my husband was an electrician and he was told that he needed to keep the lights on for the military. Whenever the airstrikes occurred, the ground would shake. We could often see the planes as they were flying very low. Most people left – but we had to stay. We had to feed many dogs from our Catholic community for those that fled. We were afraid that our chapel would be destroyed. We feared for our children, how would we get food, we felt unsafe. It is God's will." P42

"I'm ashamed at having to give birth on the road as we were trying to evacuate." P6

"We escaped the day after the burning of the church, school and jail. We transferred from place to place along with our neighbours." P13

Theme 3: Psychological Avoidance

Subordinate themes:

- Silence
- Psychogenic amnesia

"The whole thing is too distressing. I don't want to talk about. An ISIS fighter put a gun to my head – I don't want to talk about it." P5

"I had a near death experience – but I don't want to talk about it. I thought I was going to die. The bombings were terrible. I just want to go home." P10

"I can't remember anything about the crisis – it is all just a blank. It is all a bad memory. I struggle to remember what happened. What happened in Marawi was the will of Allah." P25

"I cannot talk about it – I do not want to talk about it. What has happened has affected all of my family. I am angry with ISIS, cannot trust ISIS people, these people are from within our community. I am angry towards the bad people, I want to kill the bad people, I am full of rage. I worry for my children." P2

Theme 4: Multiple Levels of Loss

Subordinate themes:

- Home
- Money

- Status
- Community and spiritual resources
- Education
- Respect and dignity
- Self-esteem
- 'Way of life'
- Possessions
- Business

"When the siege happened, I was still at work at the university. I was about to go home when the firefight started. I called all my children and told them to go home immediately. We live close by the university. The university President asked us to stay and not leave. We witnessed the airstrikes. We did not want to show our fear and anxiety to our children. We could see the bombs exploding in the city. We were on duty day and night – we were so worried about our children. We slept in shifts to guard our children. We knew of a wife of a neighbour taken hostage by ISIS. Fr. Chito negotiated her release. When we found out that Fr. Chito had also been taken hostage – this was one of the worst parts. We prayed. However, we also know of people who lost their lives. One neighbour was hit by a stray bullet and had to have his leg amputated. Every time I see him it is a painful reminder of what happened. Now very reluctant to have conversations with Muslims – tend to stick to my own community (RC). I am afraid that they may be ISIS sympathisers and therefore our lives may be in danger." P34

"My home was not destroyed by the airstrikes – but it has been looted. I want to go back home, but I know there will be nothing there. I desperately want to go back to Marawi – but I'm being told that I cannot go there." P45

"We had a big shop in Marawi. It was a family business, very successful. But we lost everything. We used to be respected in the community. Now we have nothing." P28

"We had to leave everything behind – I miss my gadgets (electronic devices). We have nothing now really – we are surviving on my late mother's pension. P31

"We have no work, no food, and no money to start our lives again. It is just not good enough." P41

"I lived in Marawi for five years – I have very good memories of the city. My brother came and said, 'ISIS is coming'. At 3 pm, we heard gunshots. My father was not at home. We did not know what to do, or where to go. That evening we saw ISIS starting fires. My father had a second wife in another house and at the time, he was with them. We could see that ISIS were in control of the area. During the night, we escaped and headed for the mountains. We were all very afraid. Just before the siege, my mother died so we were all still grieving for her loss. It was a bad time. Leaving Marawi – leaving all my friends and our way of life. It was a place where we could practice our religion freely – I am very proud to be a Muslim." P44

"Because of what happened in Marawi it has resulted in the discontinuation of my education – this saddens me. We have also lost all our money and have no financial help. My mother is very distressed – this is heart breaking. We saw pictures on the news, which showed our house, it was still intact, but we are not allowed to go back there. I feel helpless and hopeless." P65

Theme 5: Community Response

Subordinate themes:

- Positive
 - Altruism
 - Heroism
 - Protecting the more vulnerable
 - Kindred spirit
- Negative
 - Community turning in on itself
 - Phobic anxiety
 - ISIS from within the community
 - Scarcity of resources

"We have a disabled brother and I needed to get to him to rescue him, otherwise he would have been left behind. The most terrifying part was that people thought we were part of ISIS, and there was a point when people turned on us, but we were able to reassure them that we were not ISIS. We were very afraid. The bombings and airstrikes were very frightening. We also came across ISIS fighters and they started to follow us. We were terrified. As we were fleeing, we all started reciting words from the Quran – like in unison, and eventually ISIS left us alone." P26

"I have experienced evacuating more than once before – the Marawi siege, and previously during the first martial law. Twice before I have been an IDP. For this Marawi siege we were trapped for four days. I'd recently had a stroke, so our neighbours had to help us to escape. Many of our neighbours were not from Mindanao – but still they helped us. I feel strong feelings of guilt that I cannot be more supportive to my family." P49

"Now I am very reluctant to have conversations with Muslims. I tend to stick to my own Roman Catholic community. I am afraid that there may be ISIS sympathisers living amongst us, and therefore our lives are in danger." P33

"I blame ISIS, but not just them; I blame the whole Islam community. I feel angry at the Muslims who support ISIS and the Muslims that fight." P36

Theme 6: Impact on Children

Subordinate themes:

- Child mental health concerns
- The 'innocence of children'
- Aggressive play

"When I notice the children playing, their play is more violent and aggressive, they fight all the time – they pretend to be ISIS fighters, and this is very difficult. I try to play with the children to help them not play in such aggressive ways." P17

"My children are not the same as before. They often sit and stare. They are overthinking. Their minds are distracted. I feel guilty when I see them suffering. But, I'm helpless to know what to do for them." P44

"I am afraid for my children for the future that they may join ISIS. We know of children who attended the Madrasa and were never seen again. As a parent this is terrifying to lose one's children in this way." P24

"My children have lost the desire to study. I'm afraid for their future. The children are finding it difficult to adjust to being here in the camp." P61

"When the children hear helicopters flying over they get very scared and frightened. They talk about the bombings back in Marawi." P51

"I am very concerned about my children – they are now very aggressive." P24

"My children are irritated most of the time. When they play it is more violent and aggressive, they fight all the time – they pretend to be ISIS fighters, this is very difficult for me to handle." P26

"My children are always fighting, and it is more aggressive and violent than it was before. This frightens me." P35

"The children are playing ISIS with toy guns and pretending to shoot and kill other children. They sometimes even pretend to wear the ISIS masks. They witnessed the 'Black People' during the siege." P51

Theme 7: Religious Values and Beliefs

Subordinate themes:

- Siege taking place during Ramadan
- ISIS – good or bad Muslims
- Being recruited into ISIS through abduction
- Existential crisis and the role of Allah
- Strengthening in religious faith
- Complicated relationship with ISIS
- Not being able to keep the 'fast'

"This is all God's will. What has happened has strengthened my faith, and the faith of my community. We have become more resolute." P34

"We directly witnessed the crossfire. That this was happening during Ramadan. When we evacuated I carried a 10 kg. bag of rice, which was bought to observe the fast and the prayer." P45

"I liked living in Marawi. It was a place where we could practice our religion freely – I am very proud to be a Muslim. Everybody is responsible for what has happened. Marawi was becoming not a very good place. Some people were not devout in their faith. What happened in Marawi was God's punishment. I blame ISIS and the military for what happened. I'm angry with the military as it was the military that destroyed our city." P55

"I know this experience has changed me. I try to connect more with my faith, but I am finding this difficult. I keep asking myself, why did this happen to us." P20

“Why is this happening to us – have I not been a good Muslim, is Allah disappointed in us, in me?”
P24

“I feel very, very angry. We always ensured that somebody stayed in the chapel to protect it from ISIS. When we got the text message to say that Fr. Chito had been taken hostage, we all felt a lot of pain and extremely powerless.” P34

Theme 8: Uncertainty about the future

Subordinate themes:

- Wanting to go back home
- Lack of opportunity for reinvention
- Restrictions in wealth creation
- Poor communication about the future

“My wife is very uneasy – traumatised – she is constantly angry with me. In Marawi I always knew what to do – but here in the camp nothing is certain. We have no money.” P59

“I get fever when some disturbance increases. If I have lots of worries, then I get lots of physical ailments – my BP increases. Feel very different. I'm lonelier. The food here is not good, and also not enough. We are uncertain about the future and worried **all of the time.**” P37

“A lot of worries when we think about the future, very anxious about our children, as our young children need to be fed and sent to school. I feel helpless as we have so few options.” P35

“We saw pictures on the news which showed our house, it was still intact, but we are not allowed to go back there. I feel helpless and hopeless. Nobody tells us anything.” P27

“I feel a lot of guilt since we have no source of income I feel ashamed as we have to either borrow or depend on others. This brings a lot of anger and shame to us, to me.” P36

“We are all scared and deprived of basic needs, which never happened before. We were always well provided for. Financial difficulties are the most problematic and have impacted on our lives the most. We do not know when life will become normal again.” P38

Theme 9: Responsibility

Question 3 of the Trauma Interview considered perpetrator/ assailant. Figure 13 highlights the subjective perceptions regarding responsibility for the Marawi siege:

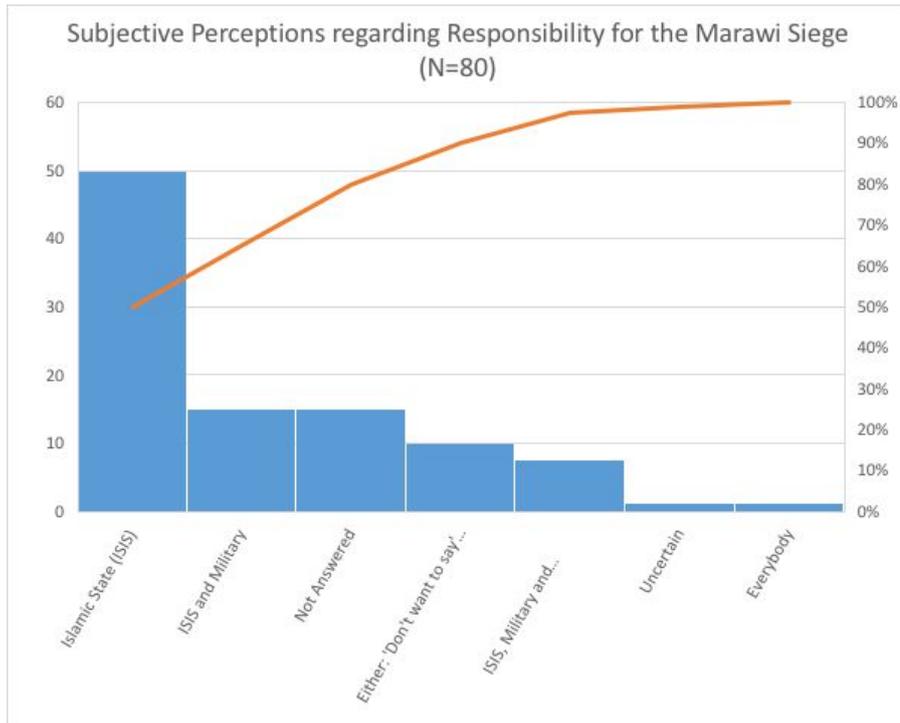


Figure: 20 Subjective Perceptions regarding Responsibility

Responsibility	No.	%
Islamic State (ISIS)	40	50
ISIS and Military	12	15
ISIS, Military and Government	6	7.5
Not Answered	12	15
Uncertain	1	1.25
Either: 'Don't want to say' or 'I'm afraid to say'	8	10
Everybody	1	1.25
Total	80	100

"I have some anger towards ISIS, but only some, as they are fighting for our religion. ISIS freed criminals from the prisons. These were the ones who killed people." P48

"The 'Black People' are responsible for what happened in Marawi." P43

Everybody is responsible for what has happened in Marawi. Marawi was becoming not a very good place. Some people were not devout in their faith. What happened in Marawi was God's punishment. I blame both ISIS and the military, but I am angrier at the military because the airstrikes destroyed our city. P74

"Angry with ISIS – can't trust ISIS people, these people are from within our community." P44

Theme 10: Perspectives regarding Previous Treatment Intervention

"Having EMDR therapy from Fr. Cornelio was very helpful. It helped me understand my feelings and explain what I was encountering and experiencing. It helped me process the traumas through the drawings and the 'Butterfly Hug'. The memories are always there – but now they are more distant and feel in the past. We did a three-day training with Fr. Cornelio, which was a good experience in sharing. I know for certain that I want to live my life by helping others." P55

"I had Psychological First Aid from an Australian Organisation. At the time it was very helpful." P3

Theme 11: Post-Traumatic Growth and Resilience

"Since the siege I have become more reflective, more devout in my faith. I want to build a stronger community for the future." P32

"Now I pray more every day. I am always reading the Quran. I have recently volunteered to work for an NGO as a facilitator." P40

"I want to become a medical doctor in the future. Marawi was not a good place. There were females not wearing their veils – and doing bad things. The markets were not clean, and the water was dirty, waste management was not good. When it rained and the sun came out, the smell was terrible. It was so bad that it affected the health of the children. Having EMDR therapy with Fr. Cornelio was very helpful. It helped me understand my feelings, what I was encountering and experiencing. It helped me process the trauma through the drawing and BLS (Butterfly Hug). The memories are always there – but now they are more distant and feel in the past. We did a three-day training with Fr. Cornelio, which was good experience in sharing. I know for certain that I want to live my life by helping others." P55

"There are times when I cry when I think of the happiness we had before. We have been taken into this Christian community – they have been very good and kind to us. I did not see good in Christian people before – I have always seen them as bad people. However, my view has changed – I see Christians differently now – I can accept help from my Christian neighbours." P56

"What has happened to us is hard, but it has brought my family closer together. We support one another. We will get through this – and be stronger again as a community. Marawi will be a stronger city in the future." P1

"My relationship with God is stronger now. Allah is the answer to all our problems." P48

Ms. Gail Womersley (middle) collaborating with interviewees with the help of Nonviolent Peaceforce.



Above: Signs marking important community needs.

A group of children passing time at one of the meeting sites.

Appendix 1: Confronting Trauma in Marawi – Outline Project Proposal Phase 1

Following the recent crises of extreme violence and natural disaster in Marawi and two surrounding provinces, 450,000 citizens found themselves in IDP camps/homestays with no home to return to. In addition, some 1,500 families are grieving for the loss of loved ones – many under horrifying circumstances. This will take great effort and many years to reconstruct and heal.

In response to these events, a five-member mission from the Global Initiative for Stress and Trauma Treatment (GIST-T), in consultation with several national and international organizations, conducted a needs assessment in January 2018, using standardized psychometric instruments and in-depth trauma interviews, to understand the psychosocial impact on the affected population. The aim was to gather information from IDPs, review the state of available psychological services, identify unmet mental health needs, and propose immediate and medium-term ways to strengthen the capacity of mental health professionals and paraprofessionals. Some 120 people were interviewed (including 80 IDPs) and several focus group discussions held with IDPs and local governmental and humanitarian actors.

The mission found a high level of psychological distress among the population studied. At least 78 percent of the IDPs screened met the criteria for Post-Traumatic Stress Disorder (PTSD) and nearly half of them could be diagnosed with severe depression, warranting initiation of specialist psychological therapy. The recent crises add to a longer history of complex trauma. Given the integral role that traumas play in the ongoing cycle of retribution, abuse, aggression and violence – quite apart from their socio-economic and health implications – the short-term and long-term adverse consequences cannot be overstated.

While there is a widespread recognition of the need for more specialist care, current interventions **do not address the population's traumas. Instead, they are primarily 'psychosocial', based on Psychological First Aid (PFA), and unable to provide adequate trauma relief.** Therefore, an urgent need exists to provide appropriate, WHO-recognized trauma therapies – primarily Eye Movement Desensitization and Reprocessing (EMDR) therapy, given its proven inherent advantages in this type of setting.

A three-phase project to address these needs is under preparation. Phase 1 is to offer emergency EMDR Therapy (using standard, intensive and group protocols) to up to 100 high-priority victims of the recent crises, including 41 hostage survivors (half are minors) and around 60 humanitarian aid workers plus another 400 priority victims to be identified (many of whom are suffering from vicarious trauma). Phase 2 aims to strengthen and expand capacities of local mental health personnel in the Lanao provinces, and Phase 3 would create local trauma treatment capacity through large-scale training throughout Mindanao.

Given the groundwork already undertaken by the January mission, Phase 1 implementation could start within two months, upon confirmation of funding, and would be completed within a year. First priority would be confirming partnership arrangements (for identification of beneficiaries and required facilities) with several local actors, including the Institute of Peace and Development Mindanao (IPDM at Mindanao State University, MSU), Nonviolent Peaceforce (NP), Department of Education, Department of Social Welfare and Development, religious organizations and several implementing civil society organizations (Médecins Sans Frontières, Balay, possibly others). An appropriate organizational structure will be negotiated and agreed at the start of the emergency Phase 1. Nonviolent Peaceforce is ready to spearhead implementation of Phase 1 emergency therapy, with GIST-T identifying and recruiting the four external therapists. Subsequent

implementation would involve the recruitment of: (i) a project coordinator (likely to be based in Mindanao State University); (ii) six therapists (two national and four international, to ensure treatment fidelity); and, (iii) at least four local translators-interpreters. In collaboration with University of Worcester, UK, evaluative research will be built in from the outset (probably one PhD candidate) to inform the development of the next two phases and to validate project impact on beneficiaries. The expected cost would be US\$200,000.

Phase 1 is built around the proposed nine-month presence of four experienced, culturally sensitive trauma psychologists to offer emergency EMDR Therapy (using standard, intensive, early intervention and group protocols) to up to 100 high-priority victims of the recent crises, including 65 known hostage survivors (half of whom are minors), plus around 40 humanitarian aid workers. An additional 400 priority victims will be identified in the course of the start-up of Phase 1. The deep trauma directly or vicariously experienced by these victims is perhaps the single biggest obstacle to their ability to function normally and participate fully in their families, communities and future.¹² Moreover, unresolved trauma from exposure to war and violence or due to any other cause may produce post-traumatic anger, fantasies of revenge and an urge to avenge. The objective is therefore to offer these trauma victims therapy in order to restore their health, wellbeing and productivity and to allow them to reintegrate and function normally in society.

Activities would be to identify, locate, contact, select and invite these trauma victims to treatment in appropriate venues and facilities while also protecting their privacy. GIST-T would identify and contract the psychologists and arrange for a special preparation training for them. Subject to further confirmation, NP has prepared an implementation plan to work with the 65 hostage survivors. Other line agencies and NGOs with access to humanitarian workers would arrange for psychological services (individual or group), most likely under the coordination of the Institute for Peace and Development Mindanao (IPDM). IPDM would also be responsible for evaluation and reporting, and for facilitating the completion of the project design work of Phase 2, which would focus on capacity strengthening.

Phases 2 and 3 would be designed in parallel, identifying implementation partners, creating coordination frameworks, budgeting implementation costs, and raising funds. Implementation could begin in 2019 and 2020, respectively.

May 2018

¹² Even long after being freed, traumatic events still cause pervasive distress. The following symptoms were observed **during the field survey and include (i) persistent 'reliving' through intrusive flashbacks, vivid memories, recurring nightmares, (ii) avoiding anything resembling, or associated with, these traumatizing events, and (iii) being unusually vigilant, with a heightened sense of current threat, often showing up as an inability to fall or stay asleep, prone to outbursts of anger, difficulty in concentrating, and an exaggerated startle response.** This textbook definition of Post-Traumatic Stress Disorder (PTSD) helps to explain how trauma adversely impacts on their daily functioning: their wellbeing, their productivity, their educability, their creativity and their inner peace. Given the extreme violence many have experienced, often over a long period of time, their trauma responses included even more serious symptoms: feelings of alienation, of mistrust, of betrayal and resentment, guilt and shame and self-blame, physical symptoms, loss of faith or purpose in life, hopelessness and depression, even suicidal thoughts. Details will be incorporated in the full mission report.

Appendix 2: Confronting Trauma in Lanao Provinces – Outline Project Proposal Phase 2

The Marawi/Vinta crises are only the most recent traumatic events in a series of man-made violence and natural disasters that have affected the population of the two Lanao provinces (pop. 1.7 million) in Mindanao for decades. The GIST-T January 2018 mission identified complex trauma as a distinct feature of the mental health condition among the population. It drew attention to the far-reaching consequences of trauma in terms of mental and physical health and longevity, productivity and educability, and the recurrence of violence. If traumatized people do not receive timely therapy, they will live the rest of their lives with PTSD. Because time does not heal their inner wounds: the chronic impact of unresolved trauma affects long-term physical and mental health. A large body of evidence and clinical experience shows that EMDR therapy is particularly effective at treating complex trauma when placed in the hands of well-trained clinicians with access to ongoing expert consultation.

Research over the past two decades has made great strides in identifying and measuring causes and consequences of unresolved trauma, as well as finding safer, more effective and efficient treatments. EMDR Therapy is one of two WHO-recognized trauma treatments. It has proven comparative advantages in humanitarian settings: for example, it can be performed on consecutive days (or even intensively – **two sessions a day**), **can be undertaken as group therapy, there's no homework, and 'early intervention' may pre-empt PTSD and other trauma disorders from 'setting in'**. Another distinct advantage of EMDR Therapy is that it does not involve **in-depth disclosure of an individual's trauma** which is of significant benefit in addressing issues such as gender-based violence, child abuse and shame-based trauma.

In contrast to Phase 1 (emergency treatment), Phase 2 aims to strengthen and expand local treatment capacity directed at a larger number of affected people, living with PTSD, in the two Lanao provinces. At the start of Phase 2, consensus building workshops will be held prior to partnership Memoranda of Understanding (MoUs) being agreed with local organizations (governmental, civil society, religious, etc.). These will build on existing relationships and local experience from Phase 1. Community trauma awareness campaigns will be organized. The first task for project management will be to identify about 100 suitable trainee-candidates (psychologists, social workers, counsellors) – people who already have access to traumatized populations. These trainee/graduates need to be available, after completing the course, for temporary or full-time assignment for at least two years on a pro bono basis or paid by their parent organization. They will initiate treatment of referred cases using appropriate facilities, with an emphasis on easy, convenient, inconspicuous access that is in no way stigmatizing, and on sensitivity to gender, language and cultural heritage. Clients will be reached through fixed services, mobile outreach, or home visits. This intervention would target IDPs in camps and homestay evacuees through parallel but coordinated services delivery.

Internationally recognized standards to qualify EMDR therapists require training in Level 1 and Level 2, followed by a period of supervised clinical practice, usually within one year. The project would adopt a recognized international training model already in use in South-East Asia, each full course comprising four distinct but connected five-day trainings followed each time by a two-month period of formal clinical supervision. Skype/Zoom connections with outside expert would be used for consultation and supervision. (For more detail, see footnote¹³). The maximum number of trainees per course would be 50

¹³ EMDR training, supervision and research approach:

1. EMDR therapy training for mental health professionals as part of a broader trauma capacity strategy
2. EMDR therapy speciality trainings:

for Year 1, and a further 50 in Year 2. Another ten local training facilitators and ten clinical supervisors will be prepared as senior staff for future EMDR training courses. This will also lay the groundwork for an expansion throughout Mindanao into Phase 3.

A strong evaluative research component would be built in with support from the Mindanao State University, plus a minimum of international assistance to ensure adherence to global standards and benchmarks. Innovations planned include the introduction of EMDR Early Intervention (EI) and other special protocols, involvement of non-specialists and paraprofessionals, establishing a local Community Trauma Response Network, rapid PTSD assessment methods using mobile phones, approaches to collective trauma healing, and online teaching-and-learning in self-care and peer-to-peer support, in local languages. A twinning arrangement between University of Worcester, UK, and Mindanao State University will also be considered with the aim of building **capacity for an EMDR Masters' Degree** program.

The provisional estimated cost is US\$1 million over a period of two years beginning in 2019. Detailed project design and implementation planning would incorporate lessons learnt during the early stages of Phase 1. Phase 2 sets the stage for scaling up throughout Mindanao under Phase 3, estimated to cost \$15 million.

May 2018

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- a. EMDR therapy with children and adolescents
 - b. EMDR therapy as an intensive treatment intervention
 - c. EMDR therapy group interventions
 3. EMDR stabilisation and resourcing – paraprofessional training
 4. EMDR-informed psychological first aid training
 5. EMDR-informed psychological second aid training
 6. Establishment of EMDR clinical supervision/ consultation network
 7. EMDR therapy Philippines research and development strategy

Appendix 3: What is EMDR therapy?

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy originally developed by Francine Shapiro (1989, 2018) for the treatment of post-traumatic stress disorder (PTSD). With more than 20 randomized clinical trials and several meta-analyses confirming its effectiveness, EMDR therapy is recognized internationally as an efficacious therapy in the PTSD practice guidelines of agencies such as the World Health Organization and U.S. Departments of Veterans Affairs and Defense. EMDR therapy is also used for a wide range of trauma-related psychological conditions – the method is now widely understood as more than a trauma treatment. It is recognised as an effective psychotherapeutic evidence-based treatment modality for a wide range of conditions, including but not limited to depression, anxiety, panic, problematic behaviours, compulsions, somatic disorders, addictions, anger and chronic pain.

Adaptive Information Processing

According to Shapiro’s Adaptive Information Processing (AIP) model, symptoms and disorders are viewed as manifestations of distressing memories which were not adequately processed. These memories, with their related emotions, thoughts, beliefs, and sensations, are understood to be stored in isolation, unable to link into the wider memory network. When triggered, symptoms flare and perceptions are skewed. When these maladaptive memories are processed with EMDR, there is a reduction or elimination of disturbing emotions, associated symptoms, and presenting problems as well as an increase in insight and a broader understanding of the memories.

EMDR therapy uses a structured eight-phase approach, and a three-pronged protocol to address past, present and future aspects of the presenting problem. During EMDR, clients briefly focus on the trauma memory and simultaneously experience bilateral stimulation (BLS), which can include the use of eye movements and/or bilateral tones or taps.

Although therapy is usually provided individually on a once-weekly basis, research has shown the effectiveness of intensive treatment – for example, with sessions twice daily for one or two weeks. EMDR therapy group protocols designed to address adverse life experiences with ongoing consequences also offer the unique clinical advantage of non-disclosure of trauma narratives, of particular relevance where there is a stigmatization of mental health services. Group protocols can neutralize this stigma by making these interventions ‘normative’. EMDR therapy clinicians would not pathologize those seeking relief; these are normal people exposed to abnormal events who have been ‘affected’. Furthermore, their cultural adaptability and economy of scale is highly relevant in Mindanao given the large number of IDPs and those living in resettlement camps. The EMDR Integrative Group Treatment Protocol, IGTP, has been widely used globally for almost 20 years in disaster zones, including human massacre situations. Similarly, the EMDR Group Traumatic Episode Protocol, G-TEP has been used extensively with Syrian refugees, in disaster zones throughout the United States and Europe and in the Middle East for close to 5 years.

As EMDR therapy has evolved, a number of specialized adaptations and variants have come to the fore, all based on the AIP model. One of these is EMDR Early Intervention, which is of particular relevance to Low- and Middle-Income Countries (LMICs).

EMDR Early Intervention (EMDR EI)

EMDR Early Intervention describes the use of several specific protocols, intended to address trauma at the earliest possible time. Sometimes administered within hours of a traumatic event, treatment is typically provided within the first three months after exposure. All EMDR EI protocols include the client focusing attention on the disturbing memory while experiencing bilateral stimulation, as well as other specific and unique procedural elements.

EMDR EI protocols include both individual and group interventions and are designed to reduce the negative impact of acute stress from recent events, or even from certain types of ongoing circumstances, by focusing on stabilization, symptom reduction, and reprocessing of trauma memories. The EMDR group protocols are embedded with psychological safety and containment procedures that keep both the provider(s) and recipient(s) grounded and sheltered from the traumatic narratives and memories thus also helping to prevent vicarious traumatization of healthcare workers.

EMDR EI procedures have been explored in many settings and locations since the early days of EMDR therapy. They have been applied with children, adolescents, and adults, after man-made and natural disasters, in refugee camps, with first responders, medical and military personnel, in schools, and in many other circumstances. EMDR EI is increasingly being offered to trauma survivors throughout the world. It is provided by independent EMDR practitioners, by agencies and organizations, and by volunteer groups of EMDR practitioners. It is also being used as part of large-scale collaborative disaster relief services.

All the published research on EMDR EI has shown positive results, with reduction in symptoms of traumatic stress. Since EMDR therapy is an evidence-based psychotherapy, and since the EMDR EI protocols are based on EMDR's AIP model, these positive results can be expected. However, as innovative EMDR EI protocols are developed and applied, attention needs to be focused on conducting systematic research. During all phases, clinicians will be instructed to take pre-intervention and post-intervention data, along with follow-up qualitative and quantitative outcome measures.

EMDR EI's advantages

Some EMDR EI procedures are known to reduce and/or eliminate symptoms of traumatic stress, depression, and anxiety, with results maintained at follow up (usually about three months post-treatment). **Adverse reactions have not been reported and EMDR EI's appear to be safe and effective**, with individuals of all ages, genders, and varied nationalities and ethnicities.

EMDR EI treatments are brief Interventions, which can be administered on consecutive days, and/or twice a day. They are easy to use, portable, accessible, and short-term treatments. They can be used in disaster zones, hospitals, emergency rooms, schools, clinics, agencies, refugee camps, and private therapy practices. They can be provided in a group format or to individuals.

EMDR EI interventions can also be viewed as efficient and inexpensive screening tools, providing a low intensity treatment that is adequate for the majority of sufferers, while simultaneously identifying individuals who require more intensive and costly treatment.

Any successful trauma treatment produces significant economic, social and cultural benefits for individuals, families and communities, although the efforts to quantify these benefits remain limited.

For more information, see:

http://emdria.site-ym.com/?page=emdr_therapy

<http://www.emdr.com/what-is-emdr/>

Appendix 4: Comparing three treatment modalities for PTSD: PET, CPT and EMDR therapy

Three treatments for PTSD that are well supported by empirical evidence are: Prolonged Exposure Therapy (PET), Cognitive Processing Therapy (CPT) and Eye Movement Desensitization and Reprocessing (EMDR) therapy.

- PET and CPT, based upon 'real world experiences', indicate substantial drop-out rates from treatment (Najavits, 2015).
- PET and CPT require very detailed narratives about the trauma experiences. This can often be extremely challenging and difficult for clients. EMDR Therapy does not require detailed narratives - it requires the memory of the trauma to be 'active' in the client's mind during trauma processing.
- EMDR therapy is more effective than PET and CPT when dealing with traumas that are **'shame-based' and/or when there is 'fear of retribution' through the disclosure of sensitive** or incriminating material. In EMDR therapy this is known as the *Blind -2-Therapist* Protocol (Farrell, 2015, 2018 a, b). This is particularly helpful when addressing trauma aspects sensitive to culture and gender, for example survivors of sexual assault, military veterans, survivors of childhood abuse.
- Numerous international trainings in EMDR therapy, as part of either humanitarian assistance interventions or trauma treatment capacity building programs (currently in operation in Pakistan, China, Palestine, Myanmar, Iraq, Lebanon, Thailand and Cambodia) demonstrate that as an experiential treatment, EMDR therapy is more culturally adaptable and sensitive than TF-CBT, PET and CPT.

Appendix 5: Methodology – a further note

During the mission, the members reviewed preliminary data obtained in June 2017, visited four IDP evacuation centres and homestays, visited the most affected area (MAA) aka 'Ground Zero', conducted interviews and psychometric screening with 80 IDPs, conducted Focus Group Discussions with 20 humanitarian workers and eight teachers.

Meetings were held with the following local actors:

- Hostages (3)
- OCHA
- Military commanders (2)
- Grievance committee (1)
- Town mayor (1)
- Camp organizers (4)
- Religious leaders
- Lay counsellors (25)
- CSWD staff (1)
- MSU professors (2)
- Institute of Peace and Development Mindanao (1)
- Medical staff (DoH) (1)
- Psychiatrists (3)
- Representatives of three NGOs (MSF, NP, Balay RC)
- Dept. of Education (9)

It must be noted that the intention of the mission was a rapid assessment, conducted over a six-day period. The assessment was limited to three places within the two Lanao provinces in Mindanao, namely Marawi, Iligan and Kauswagan.

It was conducted with the assistance of four translators/interpreters. As such, cultural and linguistic barriers may have influenced the data. This is a particularly relevant consideration, given the fact that topics raised were often controversial, culturally sensitive or taboo. This includes, for example, issues surrounding suicidality, rape and forced marriages, suspected criminality of military, sympathies with ISIS, antipathies for GOP/AFP, corruption etc. Many nuanced interpretations and understandings of the context may therefore have gone unnoticed. However, the work with interpreters/translators, and other local collaborators, did allow for a more nuanced and sensitive understanding of the context as well as a cultural proximity to the population.

This report is based on analysis of some 600 pages of data. A strength of the mission was the application of several standardized psychometric screening/assessment instruments to obtain quantitative results, and the use of Focus Group Discussions and in-depth Trauma Assessment Interviews to elicit rich qualitative data.

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**OUR AIM IS TO
REDUCE THE
GLOBAL
BURDEN OF
STRESS AND
TRAUMA, AND
IN DOING SO
PROMOTE
HEALING,
HEALTH AND
HOPE, AND
FOSTER
RESILIENCE,
PEACE AND
PRODUCTIVITY.**

”

PROBLEM

An estimated 500 million people worldwide suffer from trauma and its adverse consequences. These consequences include impaired health, relationships and productivity. Unresolved trauma can lead to violence, abuse and new trauma.

But today effective, scalable treatments exist. The duty of care requires us to make them widely available.

GOALS

To create greater awareness and understanding among key stakeholders about the far-reaching social, economic, physical and mental consequences of stress and trauma, and of the effective treatments currently available.

To increase the availability of effective services for stress and trauma in settings of violence, natural disaster and humanitarian emergency.

To enable the greater use and coverage of services related to stress and trauma reduction.

To promote research into new, appropriate methods and approaches that will facilitate scaling-up of broader stress and trauma services within existing formal systems.

