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Review Article

The Experience of Disability in Cameroonian Families and the Contribution of EMDR Psychotherapy

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Abstract

In Cameroon, the number of people with disabilities is estimated at nearly two million nine hundred and ten thousand (2,910,000). Thus, a little over 5% of the population of Cameroon suffers from at least one disability [1]. These alarming figures lead us to consider the issue of children's disability and its impact on the health of their parent(s). Certain types of disability cause more suffering to caregivers and relatives than to the disabled person. Within the framework of our activities in clinical psychology with associations of parents of children living with disabilities, through clinical interviews with parents of children with Down syndrome and autism, we have observed that many of these parents present various forms of psychopathology related to the disability of their children: affective disorders, depressive anxiety disorders, acute stress, behavioral disorders, PTSD, etc. We wondered how to deal with these suffering parents. To answer this question, we administered the SPRINT (a recent traumatic event assessment scale) to parents of children with disabilities whose discourse highlighted their experience with their different child as traumatic. This evaluation allowed us to set up therapeutic projects with EMDR (Eye Movement Desensitization Reprocessing). Through a reading of seven clinical cases followed in Yaoundé, Cameroon, we were able to verify that EMDR psychotherapy is a useful care tool for the management of parents of different children in pain. For most of the cases, the first EMDR session was very satisfactory. The results obtained were astonishing: 04 parents saw their VOC (truth scale) rise to 7 and their SUD (suffering scale) drop to 2 at the end of the first EMDR session. For the 03 other parents, the VOC rose progressively over the course of the sessions to reach 7 at the sixth session with an economic SUD at 1, due to their sometimes traumatic childhood experiences.

Keywords: *Disability, Child with a disability, Psychopathology, EMDR, PTSD, SUD, VOC*

Disability and Society

Society is a group of men and women who are united by nature or by laws. These laws differ from one sphere to another. Thus, what is seen as taboo in one society may be normal in another. However, there are common features between societies with regard to the concept of norm. This norm is applied to each individual who, for the most part, is subjected to it without any choice. Those who deviate from this pre-established norm are considered a problem, a social case. It is in this logic that the person living with a disability fits in. "Disability" is used here as an umbrella term for impairments, activity limitations and participation restrictions that represent the negative aspects of the interaction between a person (with a condition) and contextual factors (personal and environmental). Disability is neither a purely biological nor a purely social phenomenon" [2]. A person with a disability is therefore a person with physical, mental, or sensory incompetencies that affect their activities of daily living and limit their actions in society. The concept of disability can be defined in several ways depending on the culture and society. In so-called Western societies, disability is seen as incapacity, a lack. However, it should be noted that the concept of disability has evolved in these societies with the scientific progress of the 19th century because it was not always so. In African society, disability is still considered by most people as a curse to be got rid of. In most regions of Cameroon, disability is seen and understood as something mystical, supernatural. With the mixing of populations, a slight evolution of mentalities, the advent of ICTs, and access to education, this conception is changing. 5.4% of the population in Cameroon suffer from at least one type of disability. Sensory impairments (3.6%) are the most frequent, due to (2.2%) for visual impairments and (1.6%) for hearing impairments, followed by motor impairments (1.2%) which are mainly deformities of the lower or upper limbs [3]. According to the same survey, "the proportion of people with disabilities is higher in rural areas (6%) than in urban areas (4%) and "this proportion increases steadily with age, from just over 1% among children aged 0-4 years to 6% among people aged 25-49 years and reaches 19% among those aged 50 years or more."

Disability and Its Manifestations

Disability is an impairment that limits the subject in the efficient performance of his or her actions. According to the WHO, "disability is universal". According to the INS and ICF International survey, it is defined as "a disadvantage resulting from an impairment or disability, which limits or prevents the individual concerned from performing a role that is normal for him or her, taking into account age, gender, and social and cultural factors". The number of people with disabilities is estimated to be over one billion people, including about 15% of the world's population in general, and in turn, one in seven people [4].

Disability generates clinical manifestations that are often poorly understood. Whether sensory, motor, mental or social, disability always poses a societal problem. The lack of expression of positive emotions by parents towards their children with disabilities is a striking modality of the functioning of families with a child with a disability in Cameroon. Today, many families or parents want to give the maximum to their disabled child. Unfortunately, they face several difficulties or sufferings that can put them at a disadvantage; among others; the gaze of the other, the mourning of the idealized child, the fear of reliving the same experience and the inadequacy of our environment in terms of infrastructure. Whether it is sensory, motor, mental or social, disability almost always poses a problem of social integration. The emotional suffering of families with regard to their children with disabilities is a striking feature of the functioning of families with a child with a disability in Cameroon. In our different actions carried out with the parents of disabled people, we noticed that several parents had psychological illnesses linked to their child's disability. We wondered if the non-acceptance of a child's disability could lead to a psychological illness? What can be done to help them? What types of psychotherapies would best respond to their suffering? From these questions arise a series of hypotheses among which the following one. Following a high SPRINT score in these parents, we can use EMDR therapy to treat them and especially to control the impact of the suffering during therapy.

The term disability has several definitions depending on the model (medical and social). Medically, it is defined as an incapacity, a deficiency, a lack, whereas socially, it is defined as an inadequacy. It is for this reason that the WHO, taking into account these two models, defines a disabled person as "any person whose physical or mental integrity is temporarily or permanently impaired, either congenitally or as a result of age or accident, so that his or her autonomy, ability to attend school or to hold a job are compromised. The French law of February 11, 2005 [5] on equal rights and opportunities, participation and citizenship of people with disabilities provides a simpler definition of disability. According to this law, disability is "any limitation of activity or restriction of participation in society suffered in his or her environment by a person due to a substantial, lasting or permanent impairment of one or more physical, sensory, mental, cognitive or psychic functions, a multiple disability or a disabling health disorder. Disability is a social notion rather than a medical one because the person living with a disability needs to move in a society to consider himself as an important being. In short, the term disability refers to the difficulty that an individual encounters in interacting with his or her environment and that is caused by an impairment that results in a permanent or non-permanent inability to access, express, understand or apprehend.

In Cameroon, the population of people living with a disability is estimated at nearly 10% of the 18 million inhabitants [6], a percentage that has doubled in four years since the INS and ICF International survey. To understand the psychological situation of this part of the population, we must invoke the psychology of disability, which condenses the entirety of the psychological needs and experiences of the person with a disability as well as those around them, without ignoring the characteristics related to their life phases. It allows for a better understanding of the needs, adaptation problems and significant interference according to the types of disability situations (motor, sensory, psychological or mental). To make this field of investigation more concrete, let's look at the role of a psychologist.

The Psychologist in Question

The psychologist is a health professional whose role is to offer the individual a place to listen, to speak, and to maintain confidentiality in order to identify conflicts. He is trained in the psychological analysis of the individual, but also in the analysis of factors internal or external to the individual that influence this psychological functioning. He is an expert in conscious and unconscious psychological functioning. His analysis allows him to understand what is going on in the individual at the cognitive, affective and behavioral levels, contextual and social. To perfect this, he has the appropriate methods, tools and techniques. His essential skills are: psychological evaluation (audits, diagnoses, counseling, training, orientation), clinical interviewing, psychological support, therapeutic management. In this panoply of skills, there is one that allows the specialist to work directly with the patient or individual with a mental health problem.

The clinical psychologist is the one who works at the bedside of the individual. He promotes mental health through prevention, care and reintegration or professional orientation. He/she assesses the people who make a request in order to determine the nature, causes and potential effects of the distress (emotional, physical, social) felt by the person or group. He intervenes in order to prevent, treat and address psychopathologies, emotional conflicts, and skill deficits at the root of the dysfunction. He therefore intervenes for the promotion of health. It is in this movement that the clinician is training in psychotherapy. One of these revolutionary therapies is called EMDR

What is EMDR?

EMDR psychotherapy is a fairly new therapeutic intervention that aims to provide relief to patients with post-traumatic stress disorder by helping them to let go of traumatic memories. EMDR (Eye Movement Desensitization and Reprocessing) is a therapy developed in the late 1980s by Francine Shapiro [7]. With the aim of reducing the emotional charge linked to traumatic events, EMDR thus becomes a powerful tool for "cognitive restructuring". It is a therapy that is currently used to effectively treat a wide variety of psychological disorders resulting from traumatic memories, including anxiety disorders, depression, stress and trauma [8]. But especially in Post-Traumatic Stress Disorder (PTSD). Shapiro's theory stipulates that the information linked to the trauma is stored in a fragmented manner (images, sounds, smells, places, events, etc.) in the brain and that these different fragments are not linked together, which prevents the integration of the trauma into the memory. It presents a specific information processing system, which deals with traumatic memories, called Adaptive Information Processing (AIT), so that during the course of our existence, certain information is not processed, and therefore not memorized, which means that it is constantly present in our memory. This dysfunctional information remains unresolved and constitutes dysfunctional memory networks; their voluntary or involuntary recall is unpleasant and painful, and the emotion can arise unexpectedly as soon as the

environment recalls the circumstances of the traumatic event. They are the source of various disorders such as intrusive thoughts and images, nightmares, fears, untimely startles, phobias... The objective of the therapy is to promote the transfer of information between the emotional and cognitive brains in order to stop the disorders.

The EMDR Procedure

EMDR combines several methods already used by other approaches. In particular: CBT (cognitive and behavioral therapies), psychodynamic therapies and Ericksonian hypnosis. It consists of eight essential phases: the patient's life history and treatment planning (collection of anamnestic data, the most distant or most recent memories), the preparation of the patient (targeting plan in agreement with the patient), the evaluation (preparation phase for cognitive associations for the TAI), thedesensitization (bilateral stimulation), settling (positive cognition reinforcement), body scanning, closing and re-evaluation.

When life episodes generate too much emotional disturbance, whether they are small traumas (being humiliated as a child, witnessing violent arguments from one's parents, etc.), or large traumas (rape, accident, attack, earthquake...), the information processing system is blocked. This leads to the following consequences: post-traumatic stress disorder, depressive, anxiety or eating disorders, drug addiction, various physical disorders... EMDR is based on a neurological model in which the alternating stimulation of the cerebral hemispheres re-establishes a process of re-connecting the elements of information processing (emotional, cognitive, physical) disconnected by the traumatic event. In other words, the adaptive process of information processing could be reactivated by the bilateral stimulations. Once reactivated, this system would process the traumatic material in an accelerated manner. Thanks to this system, negative emotions are neutralized and adaptive information arises spontaneously. EMDR makes it possible to establish a connection between the memory network that contains the traumatic memory and the memory networks that carry the adaptive, incorporated experiences that have meaning for the individual and constitute psychological resources.

The Principle of EMDR Therapy

After having had an initial clinical interview with the patient, the therapist verifies the patient's problematic using a scale of his or her choice, after which he or she must respect the above-mentioned steps. The patient identifies a representative image of the most disturbing dysfunctional target memory, gives the negative cognition of himself, finds a positive cognition of the same register with a verification scale, identifies the emotions linked to the target, the related body sensations, and above all situates the suffering, the disturbance linked to the event on a scale. The cognitive evaluation of the target dysfunctional memory is done on a subjective scale and the degree of distress in relation to the target memory is evaluated throughout the desensitization phase. During this desensitization phase, the patient returns to the image from the beginning by making a kind of cognitive association, while simultaneously making eye movements from left to right in order to follow the therapist's hand movements, which act as a dual-action stimulus (either in front of the eyes, on the knees, on the shoulders or beside the ears). After each series of SBA (bilateral stimulation) the patient is asked to report the associative information that was elicited during the EMDR session, the instruction given to the patient is either to move the eyes from left to right, to listen to the sounds produced by the hand, to listen to the vibrations produced by the tapping... at a regular rhythm, while thinking of elements of a traumatic memory.

The EMDR Session

Each classic EMDR session lasts between 45 and 90 minutes. The EMDR treatment begins with a preparation. It is important for the therapist to diagnose the type of trauma (simple, psychic poisoning or complex). The therapist also helps the patient to develop resources, not only to improve his or her relationship with himself or herself and others, but also to facilitate the treatment of the trauma. EMDR allows the brain to reprocess the emotional information in order to remove the trauma from the nervous system. Before beginning the EMDR treatment, the therapist follows the above-mentioned steps. In this way, he/she offers the patient a safe therapeutic space that will allow him/her toto confront the origin of his suffering and especially to take refuge in a comfort zone in case of abreaction.

As Martine Gercault [9] puts it so well Once the foundations of the work have been established, the practitioner will help the patient to locate and represent as accurately as possible the origin of the target event, to feel in his or her body the perceptions, emotions and sensations that are linked to it. While the thoughts and affects surface, the psychotherapist sweeps his or her hand in front of the patient's face and the patient follows rhythmically with his or her eyes". The reprocessing of a trauma can take from one to several sessions. To reprocess a traumatic episode, the psychotherapist invites the patient to focus on his or her memory, by being in contact with its sensory elements (visual, auditory, olfactory, kinesthetic, gustatory...), with the beliefs and negative emotions generated. The therapist then initiates a series of alternating bilateral left and right stimulations (30 seconds to a few minutes) of eye movements, sounds or tactile stimulations. As free associations of ideas emerge, the patients reprocess the different information linked to the memory, integrating them into their memory network in a functional, adapted manner. Between each series, the therapist asks the patient to take a deep breath and to share what came to mind during the stimuli. These successive and quite brief series of bilateral movements continue until the emotions are neutralized and the emotional scars of the past are emptied of their traumatic charge. When the traumatic memory is thought of again without emotional discomfort and associated with positive thoughts, the therapist moves on to the next phase. The traumatic memories lose their negative emotional charge, thus ending the suffering and negative reactions. It may happen that during a session, the patient experiences strong emotions; it may also happen that between sessions such emotions resurface, as well as other memories, as in any form of psychotherapy. In the end, the patient experiences an improvement in the emotional disturbance related to the memory being treated, and a calming. Through this process, images, perceptions and memories that were negatively encoded in the emotional brain are reprocessed and lose their dramatic intensity. The past adversity is replaced by the uniqueness of the event.

Procedure for the Parent Survey

The first step taken was to contact the heads of the associations we had identified for our investigation (WellbeingAfrica, an association of parents of children with disabilities that works for the rights of vulnerable people), the Little Prince and the Moabi [P²M], an association of parents of children living with disabilities whose main mission is the empowerment of people with Down's syndrome and other disabilities). Having obtained the various appointments, we organized ourselves for the meeting with the targeted parents. Once on site, after a detailed explanation of the object of our research, we were allowed to "arrange" an appointment with the parents concerned. On the day of the meeting, we first proceeded with a sort of interactive discussion with all the parents present. The purpose was to give them all the explanations related to the research and to the importance of their participation, especially for their well-being.

After this collective meeting phase, which lasted about 20 minutes, each parent was taken individually in a more private setting of the institution (consultation room or office set up on site). There, we would conduct a clinical interview with the parent to ensure that he or she met the inclusion criteria for our sample. As a reminder, these criteria were: being a parent (father or mother) since birth, having denial of their child's disability, having a psychological disorder related to their child's disability, and especially having a high SPRINT score, willingly agreeing to take an active part in therapy… Once these conditions were met, we asked the parent to ask any questions he or she might have about our study. After these preliminary steps we would then make a well-framed appointment for the preparation of the actual therapy.

Post-Traumatic Stress Disorder (PTSD) Clinic

Post-traumatic stress disorder (PTSD) affects people who have experienced trauma caused by violence, disability, accident, natural disaster or war, or degrading treatment. How society views the trauma. Lack of support or negative behaviours of those around them (criticism, blame, lack of understanding and empathy, or hostile, controlling, intrusive or stressful behaviours) aggravate the symptoms. Victims feel painfully judged by others. Support from others is very important. Trauma-related thoughts made by the victim herself.

A set of symptoms can develop in a person following a confrontation with an intense stressful event (loss of an object) that would involve serious injuries or a feeling of helplessness. Such situations sometimes trigger strong anxieties, chills, sweating, trembling; and psychic sides such as dreams, flashbacks and sometimes avoidance of similar situations. The positive symptoms are: reliving, avoidance, negative alterations, neurovegetative disorders. These symptoms cause significant suffering in the person, leading to an alteration in their social and professional functioning, and many other important areas. Thus, the patient's entire functioning may be turned towards the trauma and its memory. Victims will tend to avoid thoughts and conversations that remind them of the traumatic event, as well as places, situations and people that may remind them of the original situation. Their interests and relationships gradually diminish.

Presentation of the Cases

Case PS

PS is a young married woman of 35 years old, of Catholic religion, of Bamileke ethnicity. Her schooling level is that of the 4th grade. She carries out an informal activity that is very common among women in Cameroon, known as "bayamselam," which consists of buying food products in bulk at the end of the fields to transport them to the city markets and sell them in retail. She is the third of five siblings and her 15-year-old disabled child is schizophrenic. During the interview, she appeared very distressed. She was born in 2003 in Yaoundé, the first of five children of PS, including one girl and four boys.

Case M

M is a young Cameroonian woman, 42 years old, of Bulu ethnicity, with a BTS level of education and unemployed. She is the first of two girls. She is the mother of J who was born on May 31, 1997. He is the only child of M and suffers from an autistic spectrum disorder.

Case E

E was born 55 years ago to a Christian protestant family in the Sanaga Maritime. She has a CEPE. She is a housewife, married and mother of five children, herself the fifth of seven children. She is the mother of Y, born in 2007 in Yaoundé, the fourth of her five children. 02 girls and 03 boys, she attends a local special school, she has a mental retardation.

Case T

T is a 48 year old housewife. Of the Foulbé ethnic group, she is Muslim, without school education, she is married and mother of seven children. She is the sixth of nine children. She is the mother of J, born in 2007, who is the first of these 07 children, of which 03 are girls and 04 are boys. He has been in the special SIL for three consecutive years.

Case X

X was born 45 years ago and is of Douala ethnicity. Catholic, with a literary baccalaureate, he is a service provider. He is the first of three siblings, including two boys and a girl. X is the father of K who was born in 1998. He would suffer from an autism spectrum disorder.

Case P

P is a 30 year old Gabonese, of Fang ethnicity, catholic, he holds a BEPC, he is a military man by profession and single with two children, he is the second of three siblings. He is the father of B who was born in 2002 in Yaoundé, the first of 02 boys and he is being trained in a specialized school in the area. He has been suffering from schizophrenia for two years.

Case Z

Z is a 38 year old housewife, of Bulu ethnicity, from the evangelical church, with no school education. An only child, she is married and has three children. The disabled child is the third of 8 years old, autistic, and attends an inclusive school in the area.

Analysis of the Data Collected during EMDR Therapy

Seven parents were recruited on the basis of individualized clinical interviews among the parents of children with disabilities, including five (05) mothers and two (02) fathers from associations of parents of children with disabilities in Yaounde. Before starting the therapy, we made sure of the type of trauma that each parent might have, because the arrival of the disabled child could be just the trigger for the suffering. After each session, we administered a Stressful Event Rating Scale (SPRINT) to the parent to assess the effectiveness of EMDR therapy. By doing this, we were able to treat all seven parents according to their individual schedules, over a period of 2 months, with an average of 5 sessions of 60-90 minutes each (Table 1).

An insecure family context, a feeling of guilt related to a probable negligence during the pregnancy and the development of the disabled child, stereotypes, accusations and stigmatizations coming from the entourage, lack of projection in the future, feeling of devaluation, the look of others, the physical manifestations are the elements that emerge from the discourse of the different parents.

Clinical Case PS

For EMDR therapy, we need 08 phases: the life history of the subject, the assessment, the desensitization, the reinforcement of positive cognition, the body scan, the future scenario, the closure and the reassessment.

Clinical Aspects of the Test

The relationship with the clinician being well established, PS presents her apprehensions, suspects at the beginning of the manipulation as she declares "I trust you docta, even as I don't know what I'm getting into, this doesn't seem catholic to me, looking from left to right there scares me". In spite of this, she lends herself to the game and respects all the instructions given for the good progress of the EMDR therapy.

The encounter with the therapy device immediately provokes a movement of surprise in PS. She smiles when I explain the course of the session. Regarding the eye movements, she said to me: "Docta, excuse me, but I am going to laugh". This observation is recurrent with EMDR patients, because it is different from what they expect, not only do we not only do active listening or give them advice, but we also ask them to make eye movements, and to verbalize what comes to their mind during desensitization.

The Subject's Life Story

PS is a young woman of 35 years old, of Catholic religion, of Bamiléké ethnicity. Her school level is that of the 4th grade. She is the third of five siblings and her 15-year-old disabled child has schizophrenia. Her score on the SPRINT test by Connor & Davidson 1997, translated by F. Mousnier - Lompré 2014 is 18. We made a targeting plan and listed 02 targets: The first is a conflict with her father because she never felt loved by him. The second is her child's disability. With her permission, we started the therapy with the current situation, which is her child's disabling illness.

Assessment of the Situation

The elements of the therapy are: the image which is the haunting voice of her daughter in crisis, the negative cognition "I am a bad mother", the positive cognition "I am a good mother", the VOC equals 2, the emotions are crying and sadness, the SUD equals 9 and as body sensation the pain in the throat and the heart palpitations.

Desensitization

This phase is marked by bilateral stimulations, breathing movements and especially by adaptive information processing (AIT). PS's speech reveals an increased suffering following her daughter's diagnosis. She revisits her childhood, her friends, her family, her marriage, in short, all the important elements of her life and notes a major fact that justifies her discomfort. Her behavior when she was young, she says in these terms: "I see myself with my brother making fun of people with a physical handicap, especially the neighbor's son who had a limp", "I can't live with a handicap or put up with a person with a handicap". As the therapy progressed, she understood that she did not have the right to decide for anyone, that life had its elements that she had to accept and deal with, that she had regained her values and, above all, that she had found meaning in all the efforts she had made since her daughter's diagnosis, in all the appeals she had had to make for the child's well-being, and, above all, that she had been a good mother because she had not abandoned her child in her situation of psychological illness. When the SUD drops to 1 economic, we move on to phase 5.

Reinforcement of Positive Cognition

We just check the positive cognition that she gave at the beginning namely "I am a good mother", when the VOC goes up to 7, we go to phase 6.

Table 1: Analysis of the data collected during EMDR therapy.

	Most Disturbing Image	Negative Cognition	Emotion	Body Sensations SSC	SUD	Positive Cognition	VOC
PS	Haunting voice	I am a bad mom	Crying, sadness	Pain in throat and heart palpitations	9	I am a good mom	3
M	Vision of agressive child	I am the worst of all	Crying	Headaches	10	I am among the best	2
E	Sight of a normal child	I am sick	Sadness	Jerky breathing	8	I am a human with limits	2
T	The sight of an inhuman	I am a monster	Crying	child Pain in the lower limbs	9	I am human	1
X	A difficult delivery	I am an incompetent father	Sadness	Tachycardia	7	I am a good father	3
P	Nightmares	I suck	Crying	Sweating	9	I am capable	1
Z	A beautiful but hyperactive baby	I am a bad mother	Sadness	Sore throat	8	I am a good person	2

The elements that allowed us to start the therapy are stored.

The Body Scan

In a relaxing atmosphere, we go over all the parts of her body, always coming back to the disturbing image that we no longer name in this phase. We just say to him, thinking back to the starting image, and especially to the negative cognition that you stated at the beginning, we are going to do an examination of your whole body starting from the head, the neck… to the toes. The instruction is simple: every time she recently feels a knot, a pinch, a pain, an affect in any part of her body, she reports it to us and we desensitize. She has reported pain in her throat and neck and each time we ask her after the desensitization: "what came to mind", until we get zero pain or manifestations in the body. Once the VOC is verified, we change phase.

The Closing

After having informed Mrs. PS that we will soon stop the session, we say to her: "you have worked well today, I encourage you to note down everything that appears in the meantime, you can report them to me at our next session".

Reassessment

This session allows us to make a small evaluation of the previous one in order to desensitize the new elements if there are any. After six sessions, we have allowed Mrs. PS to have another look (admiring) on her child.

Results

The action of EMDR is based on the association of psychological and neurological processes. This technique allows the patient to revisit a traumatic event. This therapeutic action is understood as an information processing therapy during which the patient recounts the traumatic event by means of its cognitive, affective and physiological characteristics while concentrating visually, audibly on bilateral movements of an external stimulus until the psychological distress evoked by the traumatic memories diminishes or disappears (Shapiro, 2001).

We have experienced this in the seven parents who, after just two months of care, regained the smile they thought was lost forever. For most of the cases, the first EMDR session was very satisfactory for the parents because 4 of them saw their VOC rise to 7 and their SUD drop to 2. For the other 03 parents, the VOC rose progressively during the sessions to reach 7 at the sixth session with an economic SUD because of the sometimes traumatic experience of these parents.

Discussion

Contrary to other types of therapy which are all equally effective, EMDR has the particularity of not expecting patients to verbalize and perform precise tasks which will constitute the action of the treatment received. The effects of EMDR are less prolonged than cognitive and behavioral therapies, which facilitates the rapid recovery of parents who cannot feel good just by verbalizing their suffering. The main advantage of EMDR lies in the brevity of the application of this technique. Indeed, when properly indicated, it acts directly and shows positive effects in the first session. EMDR has been used in randomized controlled studies with a waiting list where placebo control groups show a definite therapeutic effect [10].

Conclusion

Our work highlights the action of EMDR therapy on the psychological problems of parents of disabled children. For these parents at the end of the therapies, each parent, who at the beginning felt a fair amount of suffering at the sight of his or her disabled child, found himself or herself satisfied with his or her life and, above all, found qualities to be amplified in order to consolidate each of his or her different child's achievements. The results are very satisfactory.

The treatment is essentially psychosomatic and global. It would be interesting to verify the stability of the results in a few years by observing the parents concerned over the years. In the field of brief and effective therapies, EMDR is one more tool that seems promising.

We did this study in 2019, to check the sustainability of the therapy, we did an evaluation three months for each one after stopping the therapy and one year after. The advantage was that we stayed in contact with the parents in question.

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