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# The Use of the NADA Protocol for PTSD in Kenya

## Die Anwendung des NADA-Protokolls bei post-traumatischem Stresssyndrom (PTSD) in Kenia

### Abstract

**Background:** The five needle auricular acupuncture technique known as the NADA protocol was originally developed to address issues of addiction. It has since found wider applications in behavioral health, including use in the treatment of Post Traumatic Stress Disorder.

**Objective:** To optimize applications of the NADA protocol as it is used in communities affected by physical or mental trauma, particularly those residing in developing countries.

**Methods:** NADA trainings were conducted in Kenya among refugees after the 2007 post-election violence which left hundreds of thousands of persons displaced and traumatized.

**Conclusion:** Our experience shows that the NADA protocol can have a profound effect on communities experiencing hardship and transition. Elements we found to be important to the success of such trainings include sponsorship by an international agency, contacts among local service-providing organizations, inclusion of community members in decision-making, follow-up communication with all collaborators and participants, and complete flexibility around clearly defined goals.

### Zusammenfassung

**Hintergrund:** Das NADA-Protokoll mit der Nadelung von fünf Ohrpunkten war zunächst für die Therapie von Menschen mit Abhängigkeitserkrankungen entwickelt worden. Seitdem hat sich das therapeutische Spektrum erweitert, so auf dem Gebiet psychischer Störungen allgemein wie auch bei PTSD im Speziellen.

**Ziel:** Die Erprobung des NADA-Protokolls an Menschen, speziell in Entwicklungsländern, die durch umweltbedingte oder politisch-soziale Katastrophen physische oder psychische Traumata erlitten haben.

**Methoden:** Nachdem im Jahre 2007 in Kenia die Wahlen zu blutigen Aufständen mit Hunderttausenden von Flüchtlingen geführt hatten, führten wir in Flüchtlingslagern Ausbildungskurse für das NADA-Protokoll durch.

**Ergebnis:** Unsere Erfahrung zeigt, dass das NADA-Protokoll einen profunden Effekt auf traumatisierte Menschen haben kann, die eine Phase von Not und Flucht hinter sich gebracht haben. Wichtige Voraussetzungen für den Erfolg solcher Ausbildungen sind: Die Unterstützung durch eine internationale Hilfsorganisation, Kontakte zu lokalen Hilfsorganisationen, die Einbeziehung der betroffenen Gemeinschaft in die Entscheidungsschritte, ein Follow-up mit den Mitarbeitern und Beteiligten, sowie ausreichende Flexibilität in der Handhabung klar definierter Ziele.

The National Acupuncture Detoxification Association (NADA) technique is a standardized auricular acupuncture protocol used to address behavioral health including addictions, mental health, and disaster and emotional trauma. Originally developed to treat heroin addiction in an urban setting, NADA use has since expanded, now stretching across the globe into diverse cultural, economic, and social settings. Because the technique is extremely cost-effective and flexible, it is particularly valued where resources may be insufficient to meet need. The NADA protocol is of particular relevance in post-disaster settings and as a treatment tool for Post Traumatic Stress Disorder (PTSD).

The NADA technique differs from other healthcare tools in its simplicity, and the volume of patients that can receive care with limited resources. Most healthcare workers, particularly in the treatment of PTSD, are required to have significant training and education in order to be effective in the field. By contrast, the NADA technique can be learned in a week's time, and is provided in group settings in which one provider can treat dozens of patients per hour. It should be noted here that in an ideal setting, NADA is provided as part of comprehensive care which includes counseling and other therapies. In hardship areas such as developing countries or post-disaster regions, however, it may be the only form of treatment available specific to PTSD, and as such, has proven an effective treatment method.

While it is valuable to provide short-term treatments in these remote or post-disaster areas, as is performed by volunteers who travel from elsewhere to offer relief, the use of NADA for PTSD is most successful through training of persons who will have ongoing presence in the community. It is for this reason that my colleague in this work, Beth Cole (LAc, NADA RT), and I focus on training members of local communities in the NADA protocol.

## Contextual background – a need for treatment

Our initial project addressing PTSD trained local persons to provide NADA treatments to Kenyan refugees in Uganda. Beth and I had met on an international acupuncture project in East Africa, and in December of 2007 I had returned to the continent to train Kenyan healthcare workers in basic acupuncture protocols. The atmosphere in Kenya at that time was charged with anticipation of the upcoming presidential elections, which were held one week after my departure. The results of the elections were widely disputed, and erupted into extensive violence described in vivid terms in international journals such as the New York Times. [1] Reports varied, but deaths attributed to the post-election violence were generally estimated to exceed one thousand, and hundreds of thousands of persons were displaced. As relief workers with experience in the region, an understanding of the NADA protocol's potential in treatment of PTSD, and personal connections to some of those affected, Beth and I immediately began exploring the feasibility of conducting a NADA training that would benefit people affected by the violence in Kenya.

## Project Development

Because of on-going security dangers in Kenya itself, we decided to focus our efforts on the thousands of refugees pouring over the border into Uganda. We immediately contacted friends and colleagues in that country for news and suggestions of how to proceed. We were put in touch with a Franciscan nun who ran a school in the border town of Tororo, who in turn connected us with a local man who was volunteering with an organization providing support to a refugee camp set up by the United Nations High Commissioner for Refugees (UNHCR).

While establishing these contacts, we also began collecting supplies for the trip. Acupuncture needles are not available locally, and therefore it was necessary to collect sufficient needles for the training and for ongoing treatments of thousands of people. Through the generosity of several acupuncture supply companies, we were able to collect over 100,000 needles. Although we knew other supplies such as cotton and alcohol were available in Uganda, we anticipated that the influx of a traumatized population was likely to have diminished local availability of medical supplies, and so we gathered what we could of these. We also put together a manual from which to train; essentially a streamlined version of the US NADA organization's 200+ page training manual.

We arrived in Uganda in April, 2008, and made our way to the Southeastern town of Tororo. The Mulanda UNHCR camp was located on the outskirts of town. Even at that time, refugees were continuing to arrive daily, and a host of international non-governmental agencies and community based organizations were coordinating services. Our first step upon arrival at the camp was to visit the UNHCR authorities. We described our project, displayed our



Fig. 1: The UNHCR refugee camp



Fig. 2: First day of training



Fig. 3: Group treatment



Fig. 4: Teens



credentials, and received permission to proceed with the planned training. Our initial intention had been to train local volunteers of organizations like the Red Cross, who would provide treatments to the camp community, and who would then be equipped to provide treatments in the wake of other emergencies. Upon arriving at the camp, however, we were informed that the refugee camp was to close within days of completion of the training, and all refugees were to be relocated to a permanent settlement camp in another part of the country. This meant that were we to follow through with our original plan to train NGO (Non Government Organization) volunteers, the refugees for whom the treatments were intended would have no access to them. We adapted our plan accordingly and instead selected trainees from among the refugees in order that treatments would continue to be available to the displaced community. When the post-election violence had erupted, the residents at the camp had been conducting lives and professions back in Kenya, so we reasoned that among these were many with healthcare and counseling experience who would be appropriate candidates for the training.

## First encounters

In our attempt to identify suitable trainees from among the thousands of camp residents, we appealed to community leaders. The camp was divided into 6 blocks, so we called a meeting of the male and female heads of each of these. We offered a basic description of acupuncture, a more specific description of the NADA protocol we were proposing to teach, how we would like to select trainees, and asked for questions. After a lengthy polite and smiling silence, our facilitator suggested we give the leaders time to talk amongst themselves after which we would reconvene. While we waited, our facilitator explained that the social and political structure of the camp community prevented our audience from questioning our proposal or challenging its appropriateness for their community. The leaders, per-

ceiving us as part of an international organization and therefore as authority figures in their current situation, were waiting for us to tell them what they had to do, as one of their primary functions as 'community leaders' was to organize their groups to receive food aid, healthcare, or provide work parties. International aid and relief work is often applied in this hierarchical manner, whereby decisions are made and orders given by people outside the affected population, resulting in misunderstandings and misapplications.

When we reconvened, we encouraged the leaders to engage us and share reactions to our proposal. After the first tentative hand was raised, the questions came quickly. Among these:

- Were the needles pushed all the way through the ears and into the brain?
- Were there powerful chemicals on the needles that we were proposing to inject into their population?
- Were there religious implications with this treatment?
- What were Beth & my qualifications?

We answered these and other questions and made some clarifications, then provided a demonstration of the technique after which we answered more questions. We finished by offering a NADA treatment for anyone interested in the experience. When the first few brave block leaders received their needles and didn't fall over dead, others also became curious and eventually the whole group was given the protocol. By the end of the meeting the leaders enthusiastically agreed to notify appropriate persons within their groups who might qualify for trainings, and almost every one among them asked if they, too, could participate in the training.

This initial meeting was a wonderful learning experience for us. In subsequent trainings, we have given only a short introduction about the treatment, and followed this with a demonstration of the technique on one another. We encourage questions and discussions, and end with a group treatment. We have found the participatory nature of this program to be the most effective way to clearly communicate



Fig. 5: Treating a teenage girl



Fig. 6: Beads for children

the nature of the treatment. We also came to recognize that many of the communities we work with feel victimized by foreigners in the area of healthcare specifically. In East Africa and Haiti both (see article in the next issue), people made allusions to foreign companies or organizations “experimenting” on the local population with negative results, and during most of my trips to these areas there were stories circulating about suspect medical practices of local (as in the case of poisonings or witchcraft) and foreign (such as vaccinations that may be spreading disease, or unqualified persons practicing medicine) origin.

### Selecting trainees and training site

We had originally decided to train 10 people in the technique but increased our training group to 20 people when several times this number presented themselves for training. We used as our selection criteria:

- Previous experience in patient care (healthcare workers, social workers, counselors)
- Availability to attend the full training session
- Willingness to provide free treatments to the community after the training
- Ability to speak and read English

As most of the buildings within the camp were in constant use by the various organizations and their programs, we were fortunate to be provided use of a church that was in the final stages of construction. We used desks and benches from the schoolhouse, transporting these with the help of the young faculty, or with the cheering and exuberant schoolchildren themselves.

### Five or three needles?

Although the standard NADA protocol uses 5 needles, there is a trend in relief work of using only 3 needles per ear, or a total of 6 needles per treatment. This is based on

NADA founder Dr. Michael O. Smith’s experience of treatment delivery overseas, and subsequent advice to others treating in similar settings [2]. There is a clear advantage in using fewer needles, as the needle supply will treat around 40% more patients, but is this method as efficacious for the patient?

In previous projects involving the application of body acupuncture in East Africa, I had noted that many patients had striking results from treatment, far exceeding those I could expect in my US based clinic. There were numerous examples of truly dramatic improvements in patient conditions using body acupuncture, and I had often wondered about this. My speculations about why this should be range from the regularity and organic nature of our East African patients’ lives (whole organic foods, regularly spaced meals, more exercise and time outdoors, less electronic environmental ‘noise’ such as TV, computers), to the relative lack of healthcare options so that any healthcare interventions yield more spectacular results.

With this in mind, we followed Dr. Smith’s advice by training our group in the full 5 needle protocol, but explained the 3 needle strategy of using Sympathetic, Shen Men, and choosing one from among the 3 organ points, usually the Lung point. During the classroom exercises, trainees used all 5 needles on each other for practice, but when we moved into the clinical portion of the training, we advised using only 3 needles per ear. Most patients did receive only 3 needles, but occasionally in our supervisory role we would come across patients with 5 needles per ear. Usually these were friends or family of the trainee doing the needling, who was attempting to provide an extra special treatment for their loved one, with the assumption that ‘more is better.’ Curiously, almost all of the adverse treatment reactions during the clinical portion of the training were those patients who had received 5 needles. These people most commonly reported headaches, anxiety, and/or racing heart rates, which was alleviated by the removal of some of the needles. Fortunately these adverse effects were rare. The more common adverse reaction in the US is needle shock, a condition



Fig. 7: Treating the members of a family



Fig. 8: The welcome ceremony at the refugee camp – children dancing



occurring after insertion of the needles which presents as general malaise, cold perspiration, nausea, and, in extreme situations, loss of consciousness. We saw no incidents of this condition during treatments at Mulanda.

### Amending the NADA protocol for children

The refugee community included hundreds of children and they, also, came in for treatment. Children could choose whether to receive needles, or the acupressure-style application of ear beads on the points. Many parents described an increase in fear and anxiety in their children since their lives had been disrupted by violence, with experience of nightmares and a significant rise in bed-wetting. For these families living in tents with no electricity or running water, this last symptom was especially vexing, as all clothing and bedding items were hand-washed and sun-dried. All children received the Shen Men point, used to alleviate stress and anxiety, and for those exhibiting bed-wetting,

we added the Kidney point. The Kidneys as perceived in Chinese medicine relate to fear, and control of urinary discharge among other things [3]. After only one treatment, we received feedback from parents that bedwetting was reduced, with incidents decreasing with further treatment. Several people also reported a reduction in fighting among their sons. “My nephew used to fight every day” said one woman. “After the treatments, he just laughs if the other boys tease him, and finds something else to do.”

By the end of training, 21 trainees had provided over 500 treatments to their fellow refugees, and received certificates of completion. We held a public celebration for the awarding of certificates to formalize the transition of these 21 people from trainees to practitioners, and to introduce them in this new capacity as a community resource. After the ceremony, one trainee-cum-practitioner said “I am no longer just a refugee. Now I am a graduate.”

The following week, the refugees were rolled out of Mulanda in large trucks, traveling across Uganda to a settlement camp they now share with Congolese, Sudanese and Ugandan refugees. The new camp, Kiryandongo, became a permanent home for this Kenyan community, who were allotted plots of land to farm as the Ugandan government absorbed them into their education and healthcare systems. Throughout this transitional period, we maintained contact with the group through a pre-arranged communication ladder and were therefore able to answer treatment questions, clarify protocols, provide additional supplies as needed, and make suggestions to optimize treatment delivery. Permission was soon granted to begin treatment provision to other displaced persons at the camp, and soon the NADA Specialists were providing thousands of treatments per month.

### Follow-up site visit

When we returned to the community in December 2008 six months after the initial training, these NADA practitioners had delivered over 18,000 treatments. In an hours-long welcoming ceremony we were regaled with songs, dances, and several plays put on by different community groups, usually depicting lives changed, stresses relieved and general improvements to people's well-being with the application of the NADA protocol. Our trainees were the last group to perform, and their play was about a man who was always angry, and who spent his days at the bar drinking with loose women then going home to beat his wife. A new face in the bar he frequented told him about acupuncture which was happening “just down the road”, and recommended he try it. After receiving treatments, the man found a job and became a loving husband and father. I was curious whether our trainees were suggesting a correlation between NADA treatments and a reduction in domestic violence. The lead actor/trainee said that yes, this play was his own experience, and that it was common for men receiving the treatment to exhibit more peaceful demeanors.



Fig. 9: A play put on by high school students about acupuncture



Fig. 10: The author (right) together with her collaborator Beth Cole

During this play, the trainees performed an actual needling session, in the course of which one actress pretended to have needle shock, with the other actors responding appropriately. Remembering the absolute absence of needle shock during the training session in Mulanda, we asked whether they were seeing a lot of it in the new location. They reported that there had not been one incident in the 18,000 treatments provided, but they had wanted us to see that they remembered what to do if such an occasion presented itself.

We trained several different groups on that first trip in April, including staff at a school for troubled children run by the Franciscan nun who had acted as our initial contact for the Mulanda project. Children at the school were coming from backgrounds such as child soldiers, forced prostitution, and other adversity. Many of them initially reported a history of sleep trouble, including nightmares and insomnia. One child described a dream of lying in a grave watching the dirt being filled in. After several treatments, most of the children reported improvement to general well-being, and a common response was “I slept like I did when I was a small child” and “I feel happy like I did before my parents died.”

One nurse mid-wife who trained with the school staff worked in a village health clinic some distance from Tororo. After the training she provided NADA treatments to the

families coming to the clinic, and reported that in her dealings with persons expressing suicidal ideation and mental disturbances she found the NADA technique extremely effective in providing a means for the patients to rediscover hope and peace in their lives. Again, in the cases of domestic violence, the NADA technique was helpful for all family members.

Within months of that training, a disturbance arose between two clans in the nurse's region. In a dispute over land use, livestock were killed, crops and huts were set afire, and one woman lost her baby when her home was burned down. Several families were moved to a camp for internally displaced persons, and guarded by military personnel. The nurse visited the camp to provide NADA treatments, which again proved useful for those who had lost parts of their lives through violence. She also offered the NADA protocol to the soldiers guarding the camp, and these treatments became so popular that she was invited to continue her visits at the request of the soldiers who reported improved sleep, lower stress levels, and decreased cravings for cigarettes and alcohol.

## Conclusion

From these experiences, Beth and I recognize that the NADA protocol can have a profound effect on communities experiencing hardship and transition. Elements we found to be important to the success of such trainings include sponsorship by an international agency, contacts among local service-providing organizations, inclusion of community members in decision-making, follow-up communication with all collaborators and participants, and complete flexibility around clearly defined goals.

## References

1. Gettleman J. Disputed vote plunges Kenya into bloodshed. *The New York Times*. (2007, December 31). Retrieved from <http://www.nytimes.com/2007/12/31/world/africa/31kenya.html>
2. Smith MO. Story of the Development of NADA Protocol. NADA International. 2006;3:1
3. O'Connor J, Bensky D. *Acupuncture, a Comprehensive Text*. Chicago: Eastland Press, 1981

### Author information – STRICTA requirements

Megan Yarberry is the Academic Dean of an accredited graduate program of Oriental medicine in Hawaii where she also has a private practice. She holds a Master's degree in Acupuncture and Oriental Medicine and has 15 years of clinical experience. She is a NADA Registered Trainer, and has had NADA specific experience in HIV/AIDS clinics, prisons, mental health clinics, and detox facilities in Oregon and Hawaii. Since 2005 Ms. Yarberry has provided NADA and other trainings in Kenya, Uganda, and Haiti. Ms. Yarberry has been awarded by the US NADA organization for her work in East Africa.