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Original article

The EMDR integrative group treatment protocol: EMDR group treatment for early intervention following critical incidents

Le protocole intégratif EMDR de groupe : le traitement de groupe EMDR pour une intervention précoce après des incidents critiques

I. Jarero*, L. Artigas, AMAMECRISIS co-founders

Bulevar de la Luz 771, Jardines del Pedregal, Álvaro Obregón, 01900 Mexico, Mexico

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ABSTRACT

Introduction. – This paper presents an overview of the Eye Movement Desensitization and Reprocessing – Integrative Group Treatment Protocol (EMDR-IGTP) that has been used since 1998 with both children and adults in its original format or with adaptations to meet the circumstances in numerous settings around the world for thousands of survivors of natural or man-made disasters and during ongoing geopolitical crisis.

Method. – The author's intention is to highlight and enlighten the reader of the existence of this protocol that combines the eight standard EMDR treatment phases with a group therapy model and an art therapy format and use the Butterfly Hug as a form of a self-administered bilateral stimulation, thus providing more extensive reach than the individual EMDR application.

Conclusion. – Randomize Controlled Trial Research is suggested to establish the efficacy of this intervention.

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RÉSUMÉ

Introduction. – Cet article présente un protocole EMDR intégratif destiné à la prise en charge d'un groupe : le Eye Movement Desensitization and Reprocessing – Integrative Group Treatment Protocol (EMDR-IGTP). Ce protocole auto-administré est utilisé depuis 1998 tant avec les enfants qu'avec les adultes, soit dans sa forme originelle, soit avec des adaptations aux contextes de prise en charge des survivants. Ces événements traumatiques pouvaient selon les cas être des catastrophes naturelles ou des catastrophes d'origine humaine, en lien avec les conséquences que peuvent parfois avoir les crises géopolitiques.

Méthodologie. – L'intention des auteurs est de proposer une analyse complète de la littérature sur l'EMDR-IGTP qui combine les huit phases classiques du protocole EMDR standard. Ce protocole a été mis en œuvre dans des situations qui ont souvent impliqué un nombre important d'individus. Les résultats obtenus indiquent qu'il s'avère très efficace en termes de temps, de ressources, de coût et de maintien des effets thérapeutiques.

Conclusion. – Des recherches contrôlées randomisées restent encore nécessaires pour apporter une validation empirique à ce protocole.

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Given the pervasive negative mental health effects of natural or man-made disasters, ethnopolitical violence or geopolitical crisis, interventions are needed that can be efficiently applied. The possibility of utilizing Eye Movement Desensitization and Reprocessing

(EMDR) as one component of a comprehensive system of interventions that promote healing and enhance resilience post-disaster has important global implications (Shapiro, 2009b). The number of traumatized individuals in the world is staggering and the need for treatment to help large groups of people get back to baseline functioning as rapidly as possible is essential (Luber, 2009). Dr. Francine Shapiro mentioned: "So, whether it is having HAP projects or the individual response of clinicians who are working in environments

* Corresponding author.

E-mail address: nacho@amamecrisis.com.mx (I. Jarero).

of ethnopolitical violence or others going in and working after man-made disasters or natural disasters, you are liberating the individual adults and children who have been traumatized, and you are ensuring that the proper bonding and connections are able to take place with others in the subsequent years.” (Luber and Shapiro, 2009, p. 226).

EMDR has established efficacy in the treatment of post-traumatic stress disorder or PTSD (Schubert and Lee, 2009) and is also applicable to a wide range of other experientially based clinical complaints. Early EMDR intervention has a natural place in the Crisis Intervention and Disaster Mental Health Continuum of Care Context and EMDR may be key to early intervention as a brief treatment modality (Jarero et al., 2011). Clinical observations and field studies indicate that EMDR can be beneficial for alleviating excessive distress and preventing complications in the weeks and months following critical events (Silver et al., 2005). EMDR may offer a key prophylactic role with early interventions as a relatively brief treatment specializing in the adaptive processing of trauma memories and may prevent sensitization or accumulation of negative associated links, thus promoting mental health and resilience (especially in ongoing trauma), and reducing suffering and later complications (Shapiro, 2009a).

All theoretical explanations of psychotherapy are unconfirmed hypothesis. The theoretical model on which EMDR is based, Adaptive Information Processing (AIP), posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client’s ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers. The evolution and elucidation of both neurobiological mechanisms (unknown for any form of psychotherapy) and theoretical models are ongoing through research and theory development (EMDR, 2011).

1. The Eye Movement Desensitization and Reprocessing – Integrative Group Treatment Protocol (EMDR-IGTP)

The EMDR-IGTP was developed by members of Mexican Association for Mental Health Support in Crisis (AMAMECRISIS) when they were overwhelmed by the extensive need for mental health services, after hurricane Pauline ravaged the western coast of Mexico in 1997. This protocol has been used in its original format or with adaptations to meet the circumstances in numerous settings around the world (Gelbach and Davis, 2007; Maxfield, 2008). Case reports and field studies have documented its effectiveness with children and adults after natural or man-made disasters and during ongoing war trauma (Adúriz et al., 2009; Jarero and Artigas, 2009; Jarero et al., 1999, 2006, 2008; Zaghrou-Hodali et al., 2008). This protocol is also variously known as The Group Butterfly Hug Protocol, The EMDR Group Protocol, and the Children’s EMDR Group Protocol.

This protocol combines the eight standard EMDR treatment phases (Shapiro, 1995, 2001) with a group therapy model and an art therapy format and use the Butterfly Hug originated by Artigas as a form of a self-administered bilateral stimulation (Artigas et al., 2000; Artigas and Jarero, 2009; Boel, 1999). Because of the group format it is hypothesized by the authors that the resulting format offers more extensive reach than individual EMDR applications. The justification for modifying the EMDR protocol was to provide

mental health services in a disaster aftermath circumstances and fulfill the mental health population’s needs. The theoretical rationale for the amendments was based in the AIP model (Shapiro, 2001). This model guides clinical practice, explain EMDR’s effects, and provides a common platform for theoretical discussion. The AIP model provides the framework through which the eight phases and the three prongs (past, present, and future) of EMDR are understood and implemented (EMDR, 2011).

The protocol was originally designed for working with children and was later modified for use with adults. This protocol compares favorably with group treatment of other models in terms of time, resources, and results (Adúriz et al., 2009). The authors recommend that the EMDR-IGTP must be part of a community-based trauma response program that provides a continuum of care for the treatment and management of individual and group reactions to shared traumatic events. This continuum of care must be accessible to the community members and sensitive to each participant’s gender, developmental stage, ethnocultural background, and magnitude of trauma exposure (Macy et al., 2004).

2. Description of the procedure

EMDR-IGTP is administered by an EMDR clinician, who leads the team and who is assisted by other clinicians or paraprofessionals previously trained in this protocol. The assisting clinicians or paraprofessionals are called the “Emotional Protection Team” (EPT). Teachers can also be of great assistance, helping the children write their names, ages, and subjective disturbance (SUD) numbers.

Field experience showed that the protocol application takes an average of 50 to 60 min. A ratio of 8–10 children for each mental health professional is recommended. A team of five clinicians (one leading the protocol and four doing the EPT work) can treat 40–50 children, a total of 160–200 children in 4 h work.

2.1. Phase 1 – Client history

During phase 1 of the protocol, team members educate teachers, mothers, and relatives about the course of trauma and enlist these individuals to identify children who have been exposed to the traumatic event. Team members need to be aware of the needs of the clients within their extended family, community, and culture.

2.2. Phase 2 – Preparation

Phase 2 of the protocol begins with an exercise intended to familiarize the children with the space and objects included in the intervention, to establish rapport and trust, and to facilitate group formation. Toys such as a doll dolphin can be used to familiarize the children with the expression of emotions (e.g., they imitate the expressions of the dolphin). Using clinical judgment, once appropriate rapport is established, team members administer the Child’s Reaction to Traumatic Events Scale [CRTES] (Jones, 1997). Then children are guided through a safe/secure place exercise, which provides them with an emotion regulation skill and introduce the bilateral stimulation through the Butterfly Hug (Artigas et al., 2000). The children are repeatedly validated regarding their feelings and other post-traumatic symptoms.

2.3. Phase 3 – Assessment

Instead of being asked to visualize the target incident, as in the standard EMDR protocol, the children are instructed to think about the aspects of the event that make them feel most frightened, angry, or sad now, and to draw that image on the paper provided. They are then shown a diagram that depicts faces representing different

levels of negative emotion (from 0 to 10, where 0 shows no disturbance and 10 shows severe disturbance) and asked to select the face that best represents their emotion and to write the corresponding number on their picture, thus providing the Team with ratings of SUD.

2.4. Phase 4 – Desensitization

The children are asked to look at their picture and to provide their own alternating bilateral stimulation with the Butterfly Hug (Artigas et al., 2000), by crossing their arms and tapping themselves on the chest in a bilateral alternating fashion. The children are then instructed to draw another picture of their own choice, related to the event, and to rate it according to its level of distress. Processing continues with the child looking at the second picture and using the Butterfly Hug. The process is repeated twice more so that there are four pictures. The level of distress associated with the incident is then assessed by asking the child to focus on the drawing that is the most disturbing and to identify the current SUD level. This number is then written on the back of the paper. SUD level of subjective emotional disturbance should reach the zero or an ecological level of disturbance in order to have the memory of the incident completely desensitized. Not all the children can reach this level of disturbance during the group protocol.

2.5. Phase 5 – Future vision (replacing Installation)

Phase 5 of the standard EMDR protocol cannot be conducted in large groups since each participant may have a different SUD level. Also some children cannot progress any further in the group protocol to reach an ecological level of disturbance. This may be because they have blocking beliefs, previous problems, or trauma, and/or require additional time for processing. Consequently, the Group Protocol use the future vision to identify adaptive or non-adaptive cognitions (e.g., I want to die and be with my dad in heaven) that are helpful in the evaluation of the child at the end of the protocol. The children draw a picture that represents their future vision of themselves, along with a word or a phrase that describes that picture. The drawing and the phrase are then paired with the Butterfly Hug.

2.6. Phases 6 – Body scan and phase 7 – Closure

Phase 6 is conducted in large groups even though each participant may have a different SUD level and may not reach zero. During this phase the children are instructed to close their eyes, scan their body, and do the Butterfly Hug. Finally, in phase 7, the children are instructed to return to their safe/secure place.

2.7. Phase 8 – Reevaluation

Phase 8 takes place immediately after the group intervention: the team leader and the EPT members have a debriefing about which identified children may need individual attention and which may need thorough evaluation to identify the nature and extent of their symptoms, and any comorbid or preexisting mental health problems. This evaluation is made by considering the reports of teachers and relatives, the CRTES results administered during phase 2–Preparation, the entire sequence of pictures and SUD ratings, the body scan, the future vision cognition, and the EPT Report. After the evaluation, the team members work with the identified children by using the EMDR-IGTP in smaller groups or by providing individual treatment (Jarero et al., 2008). See Artigas et al. (2009) for the EMDR-IGTP scripted protocol.

3. Effectiveness of the EMDR Integrative Group Treatment Protocol

Anecdotal reports (Gelbach and Davis, 2007; Luber, 2009), pilot field studies (Artigas et al., 2000; Jarero et al., 1999, 2006), and case reports (Birnbaum, 2007; Errebo et al., 2008; Fernandez et al., 2004; Gelbach and Davis, 2007; Korkmazlar–Oral and Pamuk, 2002; Wilson et al., 2000; Zaghrou-Hodali et al., 2008) document its effectiveness.

Three field studies with children (Adúriz et al., 2009; Jarero et al., 2006, 2008) provide evidence for the protocol efficacy and utility, showing statistically significant reduction of posttraumatic stress symptoms immediately after the intervention that were sustained at post-treatment evaluation, as measured by psychometric scales. They also report significant decreases of participants' SUD scale ratings. SUD scale has been shown to have a good concordance with physiological autonomic measures of anxiety in EMDR studies (Wilson et al., 1996). Physiological de-arousal and relaxation are related to a decrease in the SUD score at the end of a session (Sack et al., 2008), and the SUD is significantly correlated with posttreatment therapist-rated improvement (Kim et al., 2008).

One field study with 20 adults under ongoing geopolitical crisis in a Central America country (Jarero and Artigas, 2010) showed a statistically significant decrease in the scores on the SUD scale and the Impact of Event Scale (IES) that were maintained at the fourteen weeks follow-up even though participants were still exposed to the ongoing crisis. It lends support to the view that the EMDR-IGTP can be used effectively with adults as an early intervention in the acute phase of the post-traumatic response by reducing symptoms of post-traumatic stress and self-reported distress. The findings also showed that it could be applied successfully in a situation of ongoing geopolitical crisis and violence, with the effects maintained throughout the crisis.

A field study on adult rape victims in the Democratic Republic of Congo showed that after two sessions of the EMDR group protocol the 50 women treated reported cessation of PTSD symptoms and pain in lower back since rape (Shapiro, 2011).

“Despite methodological limitations, this study supports the efficacy of the EMDR group treatment in the amelioration and prevention of posttraumatic stress disorder symptoms, providing an efficient, simple, and economic (in terms of time and resources) tool for disaster-related trauma” (Adúriz et al., 2009, p. 138).

Trauma based interventions such as EMDR has limitations. PTSD is one of the possible manifestations of trauma following collectively experienced traumatic events such as disasters whereas there is evidence to suggest that other conditions such as depression are common. More research is needed to prove the effectiveness of EMDR for such traumatic manifestations.

There are number of advantages to using this protocol. The group administration can involve large segments of an affected community, agency, or organization and reach more people in a time-efficient manner. The protocol is adaptable to a wide age range: from 7 years to the elderly. It is cost-efficient, as it requires just a place in which to write, as well as paper and crayons or pencils. It can be used in non-private settings such as a shelter, an open-air clinic, or even under a mango tree as was done in Acapulco, Mexico. Clients in the group do not have to verbalize information about the trauma and the treatment appears to be well tolerated in situations of exposure to ongoing crisis. Therapy can be done on subsequent days and there is no need for homework between sessions. The treatment identifies individuals with more severe symptoms who may require individual attention. The protocol is easily taught to both new and experienced EMDR practitioners. It respects clients' cultural values and seems to be equally effective cross-culturally. A single clinician can administer it with the assistance of paraprofessionals, teachers, or family members, thus

allowing for the wide application of this protocol in societies with few mental health professionals (Adúriz et al., 2009; Gelbach and Davis, 2007, Jarero and Artigas, 2009).

When faced with the challenge of providing trauma treatment to a large number of people, the EMDR-IGTP protocol was demonstrated to be a highly efficient intervention in terms of time, resources, cost, and lasting results; it presents an auspicious answer to mass critical incidents. We are in agreement with Dr. Luber (2009) who called for the need to conduct randomized research that will provide the empirical validation needed to reach an even larger number of the world's disaster victims and to help relieve their suffering, and with Dr. Francine Shapiro who in a statement to the EMDR-IGTP authors, when they received the Francine Shapiro Award from the EMDR Ibero America Association in 2007, wrote: "And if others will follow in their footsteps, and conduct the randomized research needed to solidify the work in the eyes of the world, to have it declared" empirically validated "by the large international organizations such as UNICEF, then thousands and thousands more will be healed in the coming years. So as you applaud the work of these wonderful people, please see what a difference can be made through a dedication to relieve suffering." (Luber, 2009, p. 278).

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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