

# The EMDR Integrative Group Treatment Protocol for Patients With Cancer

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Experiencing cancer is a peculiar stressor within the infrastructure of posttraumatic stress disorder (PTSD) because this debilitating disease involves ongoing stressors and is both acute and potentially chronic. The experience can include a wide range of associated adverse events, such as tumor detection, diagnosis, severity of disease, and prognosis; aggressive treatment; disfigurement and bodily dysfunction; side effects of treatment; impaired physical, social, and occupational functioning; and sometimes, recurrence and diagnosis of terminal illness. This article provides a detailed description of the clinical application of the Eye Movement Desensitization and Reprocessing (EMDR) Integrative Group Treatment Protocol (EMDR-IGTP) Adapted for Adolescents and Adults Living with Ongoing Traumatic Stress for the patients with cancer. This protocol administers the eight phases of EMDR individual treatment to a group of patients using an art therapy format (i.e., drawings) and the butterfly hug (a self-administered bilateral stimulation method to process traumatic material). A previous study (Jarero et al., 2015) showed that after 6 sessions of EMDR-IGTP, there was a significant decrease in PTSD symptoms related to the diagnosis and treatment of different types of cancer in adult women. Effects were maintained at 90-day follow-up. In this article, we discuss how this protocol can be used to effectively provide intensive EMDR treatment to large groups of patients, and we provide detailed instructions for its provision to address one of the major psychological dimensions of cancer: the ongoing traumatic stress responses experienced by patients with cancer. A clinical example illustrates the treatment process.

**Keywords:** eye movement desensitization and reprocessing (EMDR); EMDR Integrative Group Treatment Protocol (EMDR-IGTP); patients with cancer; psychotherapy; posttraumatic stress disorder (PTSD); intensive EMDR therapy

Cancer is potentially both an acute and chronic debilitating disease. The diagnosis of cancer is a unique traumatic stressor (Andrykowski & Kangas, 2010). The individual's experience can be accompanied by a wide range of associated adverse events, such as tumor detection, diagnosis, severity of disease, and prognosis; aggressive treatment; disfigurement and bodily dysfunction; side effects of treatment; impaired physical, social, and occupational functioning; and sometimes, recurrence and diagnosis of terminal illness (Jarero et al., 2015).

Diagnoses of both posttraumatic stress disorder (PTSD), acute stress disorder (ASD), and adjustment disorder are not uncommon. Kangas, Henry, and Bryant (2002) reviewed 13 studies regarding PTSD

following cancer and reported that 5%–19% of patients with cancer met the full criteria for PTSD. This variance involves several factors, including the type, course, and severity of illness. In another study (Kangas, Henry, & Bryant, 2007), the same researchers investigated the correlates of ASD following a diagnosis of different types of cancer (head, neck, or lung). ASD was diagnosed in 28% of the 82 participants. About 21% of patients with cancer develop adjustment disorders (Muszbek, 2010), which are intermediary psychological states between normal response and signs of a major mental disorder (American Psychiatric Association, 2013). Some patients with cancer may have chronic adjustment disorder because they have many causes of distress, one right after another (National Cancer Institute, 2015).

## Treatment Conceptualization

We use Shapiro's (2001) adaptive information processing model in our conceptualization of the effects of trauma and the role of eye movement desensitization and reprocessing (EMDR) therapy in resolving unprocessed memories thought to cause pathological symptoms. We have previously discussed the nature of ongoing acute traumatic events, in which there is no posttrauma safety period (Jarero, Artigas, & Luber, 2011; Jarero & Uribe, 2011, 2012). For example, the case of a patient who received a cancer diagnosis 20 months ago could be conceptualized as an acute trauma situation because after hearing the cancer diagnosis, the client experienced a continuum of stressful events such as physically grueling investigations and aggressive treatments, side effects of treatments, surgery and organ mutilation, bodily dysfunction, and so forth. This type of ongoing acute traumatic stress requires a different kind of EMDR treatment approach than that typically provided for PTSD or ASD. The consolidation of the traumatic memories is prevented. Instead, the patient's memory network remains in a permanent excitatory state, expanding with each subsequent stressful event in this continuum (analogous to the ripple effect of a pebble thrown into a pond), creating a cumulative trauma exposure memory network (Jarero, Amaya, Givaudan, & Miranda, 2013) that extends into the present moment, and often producing maladaptive/catastrophic concerns about the future or flash-forwards (Logie & de Jongh, 2014). It is essential that the treatment process identifies and targets each related incident in this continuum.

## EMDR Therapy

According to the World Health Organization (WHO, 2013), trauma-focused cognitive behavioral therapy (CBT) and EMDR therapy are the only psychotherapies recommended for children, adolescents, and adults with PTSD. EMDR therapy is an inherently client-centered approach that emphasizes the client's innate capacity to heal through, what is assumed to be the activation of a physiological adaptive information processing mechanism that requires "minimal clinician intrusion" (Shapiro, 2001, p. 18). EMDR is an eight-phased standardized procedure developed to address past, current, and future aspects of traumatic events (Shapiro, 2001). During EMDR sessions, patients focus on a disturbing memory while simultaneously engaging in bilateral stimulation. Individual EMDR therapy has been found efficacious for PTSD treatment with significant reduction of symptoms in more than a dozen randomized controlled trials and

numerous meta-analyses (e.g., Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Watts et al., 2013). See EMDR Humanitarian Assistance Programs (2016) for a summary of research findings.

EMDR therapy can also be provided in a group setting to patients who have been through the same type of trauma (e.g., sexual abuse, severe interpersonal violence), experience (e.g., disaster, refugees, ongoing war), or diverse trauma histories with unifying circumstance (e.g., chronic or severe illness, domestic violence) in common. The EMDR Integrative Group Treatment Protocol (EMDR-IGTP; Artigas, Jarero, Alcalá, & López Cano, 2014) administers the eight phases of EMDR individual treatment (Shapiro, 2001) to a group of patients, using an art therapy format (i.e., drawings) and the Butterfly Hug (BH; Artigas & Jarero, 2014). The BH is a self-administered bilateral stimulation method to process traumatic material. EMDR-IGTP contains all the components of individual EMDR therapy except for the cognitive elements in Phases 3 and 5 because these are too difficult to manage within a group setting. The Phase 5 cognitive installation in individual EMDR is replaced in EMDR-IGTP with the future vision procedure (described in the following text). The effectiveness of the EMDR-IGTP has been documented for large and small groups of adult and child participants, with multiple case reports and field studies and nine randomized trials. See Jarero, Artigas, Uribe, and Miranda (2014) for a review of related research. This article discusses the adaptation of the protocol for adults experiencing the ongoing stressor of cancer diagnosis and treatment (see Table 1).

## EMDR Therapy Administered to Patients With Cancer

**Individual Format.** Results in a pilot study conducted by Capezzani et al. (2013) for patients with cancer and PTSD provided individual EMDR therapy to patients in the active phase of cancer treatment ( $n = 10$ ) and randomly assigned patients in the follow-up phase of cancer treatment to EMDR therapy ( $n = 11$ ) and CBT ( $n = 10$ ). The effectiveness of individual EMDR was observed in significant reductions in scores on the Impact of Event Scale—Revised and on the Clinician-Administered PTSD Scale for EMDR patients in both the active and follow-up phases of cancer treatment. The CBT treatment provided in this study had limited effectiveness, and EMDR produced significantly lower scores than CBT on the two measures. Ten of the 11 patients treated with EMDR therapy lost their PTSD diagnosis compared to only 1 of the CBT patients.

**TABLE 1. EMDR-IGTP Adapted for Adolescents and Adults Living With Ongoing Traumatic Stress**

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**Phase 1: Patient History and Assessment**

An individual session is provided to conduct history taking and client assessment as per standard EMDR procedures (Shapiro, 2001) to determine suitability and readiness for treatment.

Note that the following sequence of Phases 2 through 8 is provided in each session.

**Phase 2: Preparation**

In the first group session, patients are taught the butterfly hug (BH) method for self-administered bilateral stimulation (Artigas & Jarero, 2014). Patients are also familiarized with the Subjective Units of Disturbance Scale (SUDS) where 0 represents no disturbance and 10 maximum disturbance (Shapiro, 2001) and instructed in how to divide their page into four quadrants and to label them A, B, C, and D. All subsequent group sessions start with instruction in a self-soothing technique. See Jarero and Artigas (2016) for detailed instructions for some self-soothing exercises.

**Phase 3: Assessment**

**Mental Movie.** In the first group session, the team leader asks the patients to close their eyes and “run a mental movie of everything that happened just before the original incident (e.g., cancer or other chronic or prolonged illness diagnosis) until now” and then to identify “the hardest, most painful, or distressing moment” and associated emotions and body sensations. In all subsequent group sessions, the group leader asks patients to run the mental movie and then to choose for reprocessing any memory that is disturbing at that moment.

**Phase 4: Desensitization**

**Picture A.** Patients are asked to draw that experience in Square A and then to provide a SUDS score for that picture. The leader directs patients to perform the BH, stopping when ready (about 2–3 minutes).

**Picture B.** The team leader asks patients to draw how they are now feeling in Square B and then to provide a SUDS score that for picture. The leader directs patients to perform the BH, stopping when ready (about 2–3 minutes).

**Pictures C and D.** The Picture B procedure is repeated for each of Pictures C and D.

**End-of-Session SUDS Score.** The leader tells patients to observe carefully all the drawings and then choose the drawing that disturbed the most, turn their pages over, and to write a new SUDS score that represents how disturbed they feel in this moment.

**Phase 5: Future Vision**

**Picture for Future Vision.** The leader asks patients to draw how they see themselves in the future and to write a word, phrase, or a sentence as a title for the drawing. Patients then conduct the BH.

**Phase 6: Body Scan**

The team leader tells patients to recall the most disturbing drawing, and to notice any pleasant or unpleasant body sensations, and then to do the BH.

**Phase 7: Closure**

Patients perform their favorite self-soothing exercise and then are given an opportunity to share their reprocessing experiences. The emotional protection team (EPT) members normalize the reprocessing experiences, explaining these are normal and answer questions.

**Phase 8: Reevaluation and Follow-Up Recommendations**

After completion of each group session, the EPT team reviews each patient’s material to identify anyone requiring additional assistance (see following clinical example). At the end of all group sessions, any patients requiring more treatment are identified by the team.

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*Note.* The text has been modified from Jarero and Artigas (2016).

**Group Format.** Jarero et al. (2015) conducted a pilot study to evaluate the effectiveness of EMDR-IGTP Adapted for Adolescents and Adults Living With Ongoing Traumatic Stress in reducing cancer-related PTSD for adult women. EMDR-IGTP intensive therapy was administered for three consecutive

days, twice daily, to 24 adult women diagnosed with different types of cancer (cervical, breast, colon, bladder, and skin) who had PTSD symptoms related to their diagnosis and treatment. Treatment outcomes were compared between patients in the active phase of cancer treatment and those in the follow-up phase,

with scores on the Short PTSD Rating Interview (SPRINT; Connor & Davidson, 2001) at pre- and post-EMDR treatment and at 30- and 90-day follow-up. Results showed no difference between groups, with significant improvement in both groups for PTSD symptoms and overall subjective well-being.

## **The EMDR Integrative Group Treatment Protocol Adapted for Adolescents and Adults Living With Ongoing Traumatic Stress**

### **Overview**

An individual history taking and assessment session is conducted for each potential group members to determine their suitability and readiness for EMDR treatment, following standard procedures (Shapiro, 2001). Six group sessions are then provided, on three consecutive days, with sessions in both mornings and afternoons. Phases 2–7 are conducted during each highly structured group session. During this process, the patients follow directions from the team leader and work quietly and independently on their own traumatic memories, using the Adapted EMDR-IGTP (Jarero et al., 2015), as described in Table 1. If in Phase 8 and follow-up recommendations it is determined that an individual patient or patients are still distressed after completion of all group sessions, several individual EMDR sessions or more small (i.e., three to eight participants) group sessions may be administered.

Treatment is provided in an intensive format (twice daily for three consecutive days) because many patients travel to the cancer hospital from long distances and only stay there for a limited time. The intensive format allows patients to complete the full course of treatment in a short period. Treatment can be provided to a large number of patients simultaneously because there is no interaction between group members except for the (rarely used) opportunity for brief dialogue during closure in the last minutes of the session. In EMDR-IGTP, the group setting allows for a group administration of individual treatment, ensuring that many individuals can be treated simultaneously. This is highly valuable in settings where resources are limited.

EMDR-IGTP therapy is very different from traditional group therapy (e.g., Yalom, 1970) which fosters interaction between group members, who provide each other with mutual support and validation, and in which group process is considered a primary mechanism of change. It is also very different from Group Trauma-Focused CBT (TF-CBT) in that TF-CBT practice components include developing a trauma

narrative and engaging in vivo gradual exposure (Deblinger & Pollio, 2013). In EMDR-IGTP treatment, the individual initial intake interview is the only occasion during which patients briefly tell their story and verbally express their distress. Another important difference is confidentiality. While in EMDR-IGTP treatment, there is strict confidentiality. As noted by Deblinger, Pollio, and Dorsey (2016) in reference to Group TF-CBT, “Confidentiality issues are handled in a similar manner as individual therapy; however, although group members are encouraged to maintain confidentiality, it is important to note that strict confidentiality by others in the group cannot be guaranteed” (p. 62).

EMDR-IGTP therapists include the team leader and the emotional protection team (EPT) members. A ratio of one EPT member for every 8 to 10 patients is recommended. EPT members are walking among the patients so that they are accessible to them before, during, and after the group procedure. If a patient becomes distressed during the procedure, an EPT member will move to approach quietly beside the patient to show support, and if needed, the member may provide the patient with tissues. This is all done silently, and there is no interaction between patient and the EPT member, so as not to disturb the other patients who are working on their own material. Patients may also share information or ask questions of the EPT member before and after the procedure.

### **Modification of the EMDR-IGTP**

In the standard EMDR-IGTP, the team leader asks patients to “remember what happened during the event” (e.g., hurricane, earthquake). Instead, in this adaptation for ongoing traumatic stress, the team leader asks patients to “run a mental movie of everything that happened just before the original incident (e.g., cancer or other chronic or prolonged illness diagnosis) until now.” The initial treatment target is the most disturbing moment in the mental movie. In subsequent sessions, the team leader asks patients to again run the mental movie and then to target any memory that it is currently disturbing, noticing associated emotions and body sensations (see Table 1 for detailed instructions).

This adaptation to the standard EMDR-IGTP has been made because, in our understanding, the traumatic experience of cancer is not a single event with a posttrauma safety period but an experience marked by repeated traumas and indeterminate length. Therefore, identifying a discrete stressor within the multiple crises that constitute a cancer experience is



more difficult than it is for other traumas. The modification to the protocol allows for the targeting and reprocessing of all related incidents.

## Clinical Example

### The Patient

Eva was a divorced 32-year-old woman with two children, aged 7 and 9 years. She lived in a small town about 1 day's travel from the hospital, and at the time of this intervention, she was staying in the Pink Cross shelter. She was being treated for nonmetastatic breast cancer. She had previously had a mastectomy and was now receiving chemotherapy.

### Assessment

Eva presented severe PTSD symptoms. In her individual assessment, she described the following symptoms. Her negative cognitions were "I'm different," "I'm ugly because my body is disgusting," and "I'm insignificant," with repetitive thoughts such as "I'm disfigured" and "I have little time to live." She reported many flashbacks and intrusive images: (a) after the mastectomy, seeing her mutilated body in the mirror, realizing she did not have a breast; (b) the first time she received chemotherapy; and (c) the face of her friends feeling pity for her. She also had a distressing flashback, imagining herself dying alone, "Nobody will take care of me." Eva was troubled by nightmares in which cancer returns and she receive chemotherapy again and again. She reported experiencing a lot of sadness, despair, anguish, and helplessness, with uncontrollable crying. She avoided people, feeling like an object of morbid curiosity, and had isolated herself from everyone, even from those she loved. She believed that her illness was "a punishment from God because of my sins" and "I'm not going to heaven."

Eva's pretreatment score of 18 on the SPRINT (Connor & Davidson, 2001) was above the clinical cutoff of 14 and reflected her distress. The SPRINT is an eight-item interview or self-rating questionnaire with solid psychometric properties. Scores between 18 and 32 correspond to marked or severe PTSD symptoms, between 11 and 17 to moderate symptoms, between 7 and 10 to mild symptoms, and 6 or less to either minimal or no symptoms.

### Treatment Response

**Session 1 (First Day Morning).** During the first trauma processing session, Eva drew the following sequence of pictures: (a) a face in black crying (Subjective Units of Disturbance Scale [SUDS] = 10), (b) a

sad face in blue (SUDS = 8), (c) a happy face in green (SUDS = 5), and (d) a face in black (SUDS = 6). On the back of the paper, an end-of-session SUDS score of 7 and for the future vision: a black hole and the title of the drawing was "There is not hope for us" (see Figure 1).

Part of the EPT member's tasks during the group protocol is to be alert to the patient's reactions (basically to provide tissues but not to interact with them by talking), drawings, SUDS scores, and titles of the future vision drawings. In this particular case, Eva was not crying; therefore, the EPT member just made a mental note about Eva and her future vision page. During the Phase 8 reevaluation procedure, held by the EPT team immediately after each session when the patients leave the room, the team members look carefully at each drawing, SUDS scores, and titles of the future vision drawing and also listen to each EPT member's reports. In this particular case, the EPT member mentioned Eva. The EPT team decided that before the next group reprocessing, that EPT member should instruct Eva in private to make a minor modification when the leader gave the group the mental movie directions (Phase 3). Eva was told to instead, "Please run a mental movie from today to the future . . . and when you have finished, choose to reprocess anything disturbing at this moment."

**On Session 2 (First Day Afternoon).** During the second trauma processing session, Eva drew the following sequence of pictures: (a) a black spiral (SUDS = 8), (b) a sad green face (SUDS = 5), (c) a pleasant blue face (SUDS = 3), and (d) a happy purple face (SUDS = 2). On the back of the paper, an end-of-session SUDS score of 4 and the future vision was a Christian fish. The title of the drawing was "I have faith in Jesus" (see Figure 2).

**On Session 6 (Third Day Afternoon).** During the final session, Eva drew the following sequence of pictures: (a) green happy face (SUDS = 3), (b) happy orange face (SUDS = 4), (c) happy blue face (SUDS = 2), and (d) happy red face (SUDS = 1). On the back of the paper, an end-of-session SUDS score of 1. The future vision was a sun and the drawing title, "I desire to share my happiness" (see Figure 2).

### Posttreatment and Follow-Up

Eva's pretreatment score of 18 on the SPRINT (Connor & Davidson, 2001) was in the severe range and above the clinical cutoff of 14. At posttreatment, her score was reduced to 9, in the mild symptom range. At 30-day follow-up, it was 5, and at 90-day



**FIGURE 1.** Eva's drawing, Session 1. Top is four images processed in session. Bottom is future vision; a black hole, with title "There is not hope for us" (SUDS = 7).



**FIGURE 2.** Eva's drawing, Session 6. Top is four images processed in session. Bottom is future vision; a sun, with title "I desire to share my happiness" (SUDS = 1).

follow-up, 4, both indicating minimal or no symptoms. It is important to note that the reduction in scores was maintained even though Eva continued in active treatment for her breast cancer, continuing to receive chemotherapy and various follow-up scans and assessments.

## Discussion

This article provides a detailed description of the EMDR-IGTP Adapted for Adolescents (13–17 years) and Adults Living with Ongoing Traumatic Stress. As noted previously, this procedure was found effective in a pilot study with patients with cancer (Jarero et al., 2015). This protocol is a modification of the EMDR-IGTP, a procedure which has been used successfully around the world to provide rapid response to large groups of participants after disasters (Jarero & Artigas, 2016). The adaptation changes the way that the targeted memory is selected, and it was made to allow for the processing of the continuum of multiple traumatic incidents faced by clients who have ongoing traumatic stress.

It is important to mention that the EMDR-IGTP do not rule out the EMDR individual treatment because it is a therapy protocol and also a screening tool. Therefore, EMDR clinicians do not have to choose between group or individual administration when facing a large amount of people needing treatment. We recommend to first use the EMDR-IGTP and administer individual EMDR treatment only to those who require additional support based on the protocol's Phase 8 (reevaluation and follow-up) recommendations.

## Indications and Contraindications for Treatment

We use the selection criteria described in Shapiro (2001). In addition, we have flagged the importance of social support. One of the most important lessons during our research with patients with cancer was that the main difference between the two patients who needed individual therapy after the IGTP and the rest of the group was that the two patients had a complete lack of structural (social) and functional (family) support. We have now added “complete lack of structural (social) and functional (family) support” to our exclusion criteria.

## Treatment Tolerance

During our 18 years of experience working in the field with EMDR-IGTP, we have never had a patient leave the group room because they were overly distressed.

This may be because we are very careful to apply our selection criteria. However, we also hypothesize that the BH method for bilateral stimulation (Artigas & Jarero, 2014) keeps the patients in their window of tolerance and allow appropriate reprocessing. It may also be that the control obtained by clients over their bilateral stimulation using the BH may be an empowering factor that aids their retention of a sense of safety while processing traumatic memories.

## Recommendations

In support of psycho-oncology practice, the first principle of the WHO (2006) constitution prioritizes the contribution of total well-being to the happiness, harmonious relations, and security of all people, stating that “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” That is, there can be no health without mental health (Prince et al., 2007). The American College of Surgeons Commission on Cancer has set psychosocial distress screening as a new patient care standard for 2015. The standard requires accredited programs to implement a systematic distress screening protocol for all patients with cancer and provide appropriate follow-up and referral to appropriate professionals when indicated (Kendall, 2015).

Psycho-oncology research and practice has played a key role in reducing cancer risk, improving cancer survivorship, and influencing social and cultural change to eliminate disease-related stigma (Dunn, Adams, Holland, & Watson, 2015). Therefore, we recommend further research on the EMDR-IGTP adapted protocol with randomized controlled studies following the Maxfield and Hyer (2002) methodological recommendations.

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