The EMDR Integrative Group Treatment Protocol: Application With Child Victims of a Mass Disaster

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The EMDR Integrative Group Treatment protocol (EMDR-IGTP) has been used in different parts of the world since 1998 with both adults and children after natural or man-made disasters. This protocol combines the eight standard EMDR treatment phases with a group therapy model, thus providing more extensive reach than the individual application of EMDR. In this study the EMDR-IGTP was used with 16 bereaved children after a human provoked disaster in the Mexican State of Coahuila in 2006. Results showed a significant decrease in scores on the Child's Reaction to Traumatic Events Scale that was maintained at 3-month follow-up. Although controlled research is needed to establish the efficacy of this intervention, preliminary results suggest that EMDR-IGTP may be an effective means of providing treatment to large groups of people impacted by large-scale critical incidents (e.g., human-provoked disasters, terrorism, natural disasters).

Keywords: EMDR; group treatment; Latin America; human-provoked disaster; posttraumatic stress; children

At 2:35 a.m. on February 19, 2006, there was an explosion in the Pasta de Concho mine, trapping 65 miners. The Nueva Rosita region became the international media center of attention when rescue efforts were broadcast worldwide from this carbon mine in the Mexican State of Coahuila. Unfortunately after several days all hope was lost, the rescue failed, and the miners were officially declared dead. Media attention then shifted to related political issues, because the disaster had been caused by negligence in mine security. Although the explosion remained in the political spotlight for weeks, the families of the dead miners—their parents, wives, and children—and the members of the rescue team—received no mental health support to alleviate their deep grief, anguish, and distress.

In May, when political conditions had become favorable, a member of the Asociacion Mexicana para Ayuda Mental en Crisis (AMAMECRISIS) flew to the region to plan the provision of services. AMAMECRISIS is a nonprofit nongovernmental organization (NGO) whose mission is to prevent or alleviate the human suffering provoked by psychological trauma. This NGO has more experience working in situ with survivors of natural or human-provoked disasters than any other agency in Latin America.

AMAMECRISIS provided the following services:

- In May, psychoeducation for 50 social workers who gave support to the families of the dead miners. The social workers were taught strategies to cope with compassion fatigue.
- In May, meeting with the local mental health professionals who were working with the children on a daily basis in the schools to plan this field research study.
- In June, training eight mental health professionals in the Nueva Rosita region. The therapists received full scholarships for EMDR basic training and two advanced trainings with EMDRIA credits: EMDR integrative group treatment protocol and resources for more debilitated clients.

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- In June, implementing this field research study with provision of the EMDR Integrative Group Treatment protocol to 16 bereaved children. Treatment was provided by the eight local therapists in collaboration with the AMAMECRISIS team.
- In September, follow-up with children, parents, and teachers.

The Treatment of Trauma

Eye movement desensitization and reprocessing (EMDR; Shapiro, 2001) is a psychotherapeutic approach proven to be efficacious in the treatment of posttraumatic stress disorder (PTSD; American Psychiatric Association, 2004; Bisson & Andrew, 2007; Bleich, Kotler, Kutz, & Shalev, 2002; Chemtob, Tolin, van der Kolk, & Pitman, 2000). Published studies have investigated the effects of EMDR following man-made and natural disasters (Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997). EMDR has been reported effective in treating children following a hurricane in Hawaii (Chemtob, Nakashima, Hamada, & Carlson, 2002), with victims of the 9/11 terrorist attacks in New York City (Silver, Rogers, Knipe, & Colelli, 2005), and with victims of earthquakes in Turkey (Korkmazlar-Oral & Pamuk, 2002).

A separate body of literature also describes the effectiveness of non-EMDR group therapy approaches for disaster intervention. Following the 1988 earthquake in Turkey, Goenjian et al. (2005) provided four 30-minute cognitive behavioral (CBT) group sessions and an average of two individual sessions to children in a school-based intervention. They found that the grief-focused treatment was effective in reducing PTSD symptoms and halting the progression of depression. In another study in Athens, Giannopoulou, Dikaiakou, and Yule (2006) provided a 7-week group CBT treatment to children traumatized by an earthquake. Results showed improvement in symptoms of PTSD and depression that continued at follow-up. These studies suggest that the postdisaster implementation of mental health intervention programs to children can reduce trauma-related psychopathology. However, all of these treatments required the children's attendance over a period of several weeks, a requirement that may be hard to implement in some disaster or refugee settings.

The EMDR Integrative Group Treatment Protocol

The EMDR Integrative Group Treatment protocol (EMDR-IGTP) was developed by members of AMAMECRISIS when they were overwhelmed by the extensive need for mental health services after Hurricane Pauline ravaged the western coast of Mexico in 1997. The team arrived expecting to provide one-on-one EMDR to just a few individuals but were greeted by more than 200 distressed children and adults who had lost families and homes. The challenge was how to treat so many people simultaneously with a powerful trauma therapy (EMDR) that was originally intended for use with only one patient at a time (Jarero, Artigas, & Hartung, 2006). The result was the EMDR-IGTP, a protocol that combines the eight standard EMDR treatment phases with a group therapy model (Artigas, Jarero, Mauer, López Cano, & Alcalá, 2000; Jarero, Artigas, López Cano, Mauer, & Alcalá, 1999). It is hypothesized that the resulting format offers more extensive reach than individual EMDR applications and that the treatment may produce a more effective outcome than that expected from traditional group therapy.

We recommend that the EMDR-IGTP be part of comprehensive programs for trauma treatment with victims of disasters. Because of its utility, it has been used in multiple settings around the world. For example, Fernandez, Gallinari, and Lorenzetti (2004) reported that the group intervention appeared to successfully alleviate symptoms for all but 2 of the 236 students who witnessed an airplane crash in Italy. Adúriz and colleagues (in press) used the EMDR-IGTP with 220 child victims of a flood in Santa Fe, Argentina, in 2003 and reported significant improvement that was maintained at 3-month follow-up. Similarly, results with 44 children following the Piedras Negras flood in Mexico in 2004 (Jarero et al., 2006) showed the efficacy of the approach. Scores on the Subjective Units of Disturbance Scale (SUDS) and the Child's Reaction to Traumatic Events Scale (CRTES) showed large changes from pretreatment to posttreatment and at follow-up (see Table 1).

Anecdotal reports in other situations are consistent with these results. Gelbach and Davis (2007) stated that the EMDR Humanitarian Assistance Program (HAP) regularly teaches this approach to local clinicians.

> It . . . seems to be equally effective cross-culturally, and it has the advantage of reaching more people more quickly, involving larger segments of the community. Paraprofessionals can be taught to lead the groups under supervision of a clinician, which allows wide application in societies that have a few clinicians. For instance, in Guajarat, India, after a major earthquake, newly trained clinicians conducted group sessions that reached thousands of symptomatic children. In Chennai,

TABLE 1. Results From the EMDR-IGTP Studies in Mexico and Argentina

Study	Number of Participants	SUD Scores		CRTES Scores		
		Pretreatment	Immediate Posttreatment	Pretreatment	1-Month Follow-Up	3-Month Follow-Up
Piedras Negras, Mexico	44	9.2	1.3	32.8	8.3	
Santa Fe, Argentina	220	7.3	2.2	26.4		10.8

Source. Adúriz et al., in press; Jarero et al., 2006

> India, after the tsunami, HAP-trained clinicians treated 5,000 children in these groups in 1 year. (p. 399)

EMDR-IGTP has also been used in its original format or with adaptations to meet the circumstances to assist victims of flooding in Acapulco, México, 1997, Posoltega, Nicaragua, 1998, Caracas, Venezuela, 1999, Santa Fé, Argentina, 2003, and Piedras Negras, México, 2004; earthquake survivors in Pereira and Armenia in Colombia, 1999, Adapazari, Turkey, 1999, and San Salvador, El Salvador, 2001; child refugees of the Albania and Kosovo War, in Germany, 1999; and survivors of the tsunami (Adúriz et al., in press; Artigas et al., 2000; Gelbach & Davis, 2007; Jarero et al., 2006; Jarero et al., 1999; Korkmazlar-Oral & Pamuk, 2002; Wilson, Tinker, Hofmann, Becker, & Marshall, 2000).

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 SUD numbers.

The protocol application takes 50 to 60 minutes. 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 Emotional Protection Team work) can treat 40–50 children, a total of 160–200 children in 4 hours of work.

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 affected by the traumatic event. Team members have to be aware of the needs of the clients within their extended family, community, and culture.

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). Once appropriate rapport is established, the children are guided through a safe/secure place exercise, which provides them with a coping skill. The children are repeatedly validated regarding their feelings and other posttraumatic symptoms.

Phase 3—Assessment

Instead of being asked to visualize the target incident, as in traditional EMDR, the children are instructed to think about the aspects of the event that made them now feel most frightened, angry, or sad, and then to draw that image on the paper provided (see Figure 1, drawing A). 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 subjective disturbance (SUD).

Phase 4—Desensitization

The children are asked to look at their picture (e.g., Figure 1, drawing A) and to provide their own alternating bilateral stimulation with the Butterfly Hug (Artigas et al., 2000) by crossing their arms and tapping

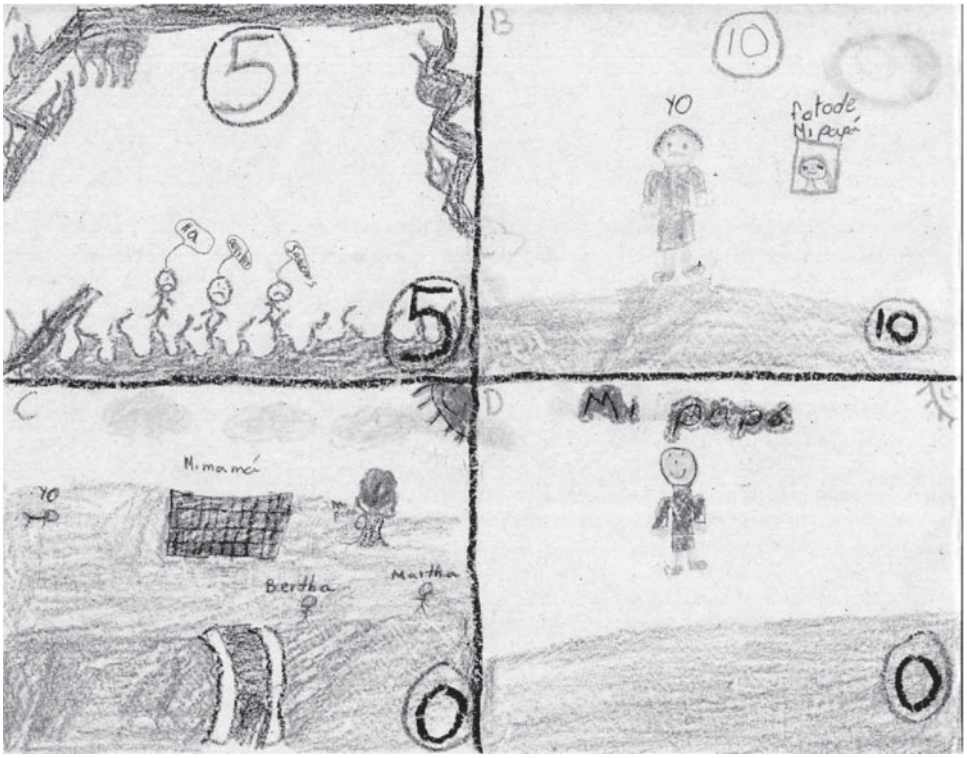


FIGURE 1. Example of a child's drawings before and during EMDR-IGTP treatment.

Note. The numbers represent the child's self-reported SUD scores.
A) Drawing A: The figures trapped inside the mine (his father one of them) are saying: "Ha," "Help," "Help us" (SUDS = 5).
B) Drawing B: "Me" and "Picture of my Dad" (SUDS = 10).
C) Drawing C: "My mother," "me," "Bertha," "Martha" (his sisters) (SUDS = 0).
D) Drawing D: "My Dad" (SUDS = 0).

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 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 (Figure 1). The level of distress associated with the incident is then assessed by asking the child to focus on the drawing that is most disturbing and to identify the current SUD level. This number is then written on the back of the paper (see Figure 2, upper left corner).

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 utilizes the future vision to identify adaptive or nonadaptive cognitions (e.g., I want to die and be with my dad in heaven) that are helpful in evaluating 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 (see Figure 2). The drawing and the phrase are then paired with the Butterfly Hug.

Phase 6—Body Scan and Phase 7—Closure

In Phase 6, 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.

Phase 8—Re-Evaluation

Phase 8 takes place immediately after the group intervention: The team leader and the Emotional Protection Team members have a debriefing about which identified children may need individual attention and which may need thorough evaluation to identify the

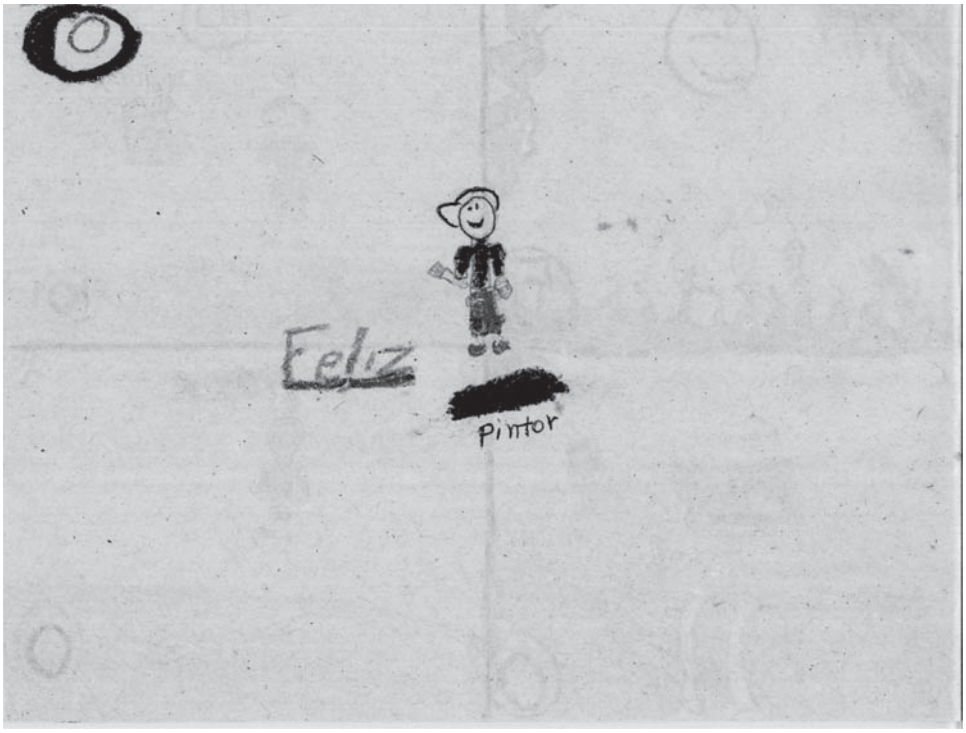


FIGURE 2. Example of the same child's drawing of his imagined future.

Note. The Spanish statement reads "Feliz = Happy. Pintor = Painter." The zero represents the child's self-reported SUD score at the end of Phase 4 for the most disturbing drawing.

nature and extent of their symptoms and any comorbid or preexisting mental health problems. Determination is made by considering the reports of their teachers and relatives, the CRTES results, the entire sequence of pictures and SUD ratings, body scan, the future vision cognition, and the Emotional Protection Team 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.

Method

Procedure

In June 2006 the treatment team provided the above-described protocol with children whose fathers had died in the mine explosion. Measurements were taken at pretreatment, posttreatment, after 1 week, and at 3 months.

Treatment Team

The team consisted of four professionals from AMAMECRISIS and eight local mental health professionals who had received training in EMDR and EMDR-IGTP from AMAMECRISIS.

Participants

Sixteen children whose fathers had died in the mine participated in the field study. They ranged in age from 6 to 12 years; 11 were male, 5 female. All of their mothers and teachers participated in the Phase 1 procedure and provided information about the children's difficulties.

Measures

The Child's Reaction to Traumatic Events Scale (CRTES; Jones, Fletcher, & Ribbe, 2002) was derived from the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979). It is a 15-item self-report measure designed to assess psychological responses to stressful life events. Responses are scored according to a Likert scale, where 0 = not at all, 1 = rarely, 3 = sometimes, and 5 = often. In addition to a total score, the CRTES provides scores for two subscales: intrusion and avoidance. Scores less than 9 are considered low distress, between 9–18 moderate distress, 19 and over high distress. Although it is a self-report measure, the questions were read aloud to the younger children by the EPT members. Their responses were recorded by the EPT. This measure was administered to the children at pretreatment, at 1-week posttreatment, and at 3-month follow-up.

A modification of the Subjective Units of Disturbance Scale (SUD; Shapiro, 2001; Wolpe, 1958) was used. Instead of asking the children to simply rate the level of their disturbance, they were 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 represented their emotion and to write the corresponding number on their picture. Children were assisted in this process by members of the EPT. SUD ratings were taken for each of the four pictures, and at the end of Phase 4 for the most disturbing drawing.

Results

Sixteen bereaved children participated in the study. All of the children completed the EMDR-IGTP and two required individual therapy. There were no differences in response between the girls ($n = 5$) and ($n = 11$) boys.

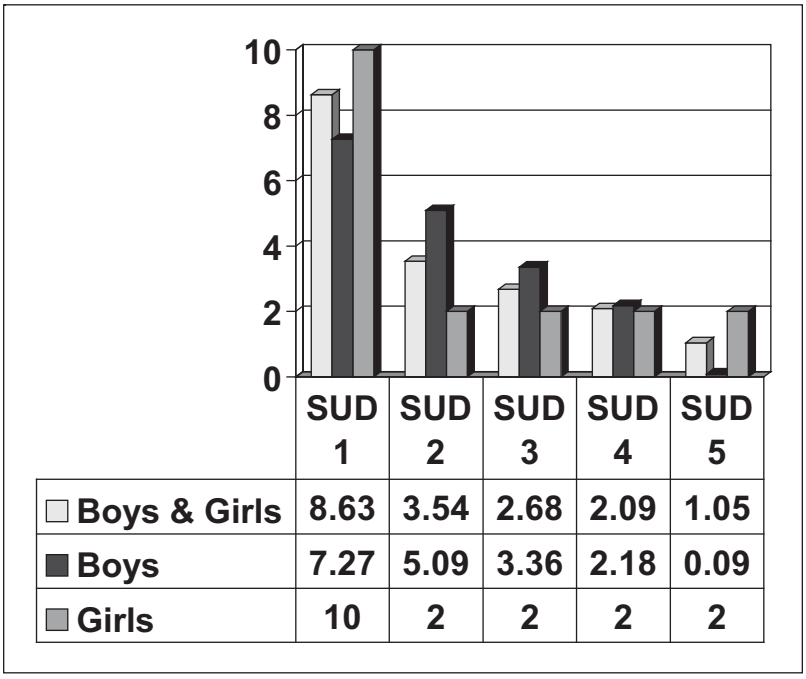
The changes during the treatment process are evident in the content of the children's drawings (see Figure 1) and are reflected in their SUD scores. As shown in Figure 3, the SUD scores decreased for each subsequent picture. The final score was reported for the "most disturbing" picture. There was a decrease in SUD ratings from a mean of 8.6 before processing to 1.0 at the end of Phase 4.

At pretreatment, the children's scores on the CRTES measure placed them in the high distress range, indicating a high level of psychological response to a stressful life event. The posttreatment CRTES scores were obtained after 1 week. They indicated a low level of distress and showed a significant decrease ($t = 8.09$, $p \leq .001$) from the pretreatment scores. Follow-up scores taken at 3 months showed a maintenance of treatment effect and a significant difference from the pretreatment scores ($t = 8.30$, $p \leq .001$; see Tables 2 and 3 and Figure 4).

Discussion

The present study was an uncontrolled field study, with treatment provided in a natural setting to a group of traumatized and bereaved children following a man-made disaster. The results indicated significant improvement on measures of self-reported distress and posttraumatic stress. The low scores on the CRTES measure at 3-month follow-up (Figure 4) suggested that the treatment benefits were maintained for that period of time. Also of clinical interest was the progressive drop in distress measured by SUD scores.

It should be noted that these results are based on an uncontrolled field study and that the conclusions are limited by this methodology. One cannot state with certainty that the results can be fully attributed to the treatment. However, the rapid shift in SUD ratings



	SUD 1	SUD 2	SUD 3	SUD 4	SUD 5
Boys & Girls	8.63	3.54	2.68	2.09	1.05
Boys	7.27	5.09	3.36	2.18	0.09
Girls	10	2	2	2	2

FIGURE 3. Treatment process changes as measured by mean SUD scores for the four pictures and for the most disturbing picture at the end of Phase 4.

TABLE 2. Scores on the CRTES Measure

	Pre	Post (1 Week)	Follow-Up (3 Months)
Boys	39.00 (12.46)	14.36 (2.73)	12.91 (3.36)
Girls	37.20 (12.26)	14.80 (3.42)	12.60 (3.13)
Boys & Girls	38.44 (12.00)	14.50 (2.85)	12.81 (3.19)

Note. Mean and standard deviations for the pre and post and follow-up scores on the Child's Reaction to Traumatic Events Scale.

TABLE 3. Comparison of Pretreatment Scores With Posttreatment and Follow-Up Scores on the CRTES Measure

	Pre-Post (1 Week)	Pre-Follow-Up (3 Months)
Boys	$t = 7.30$ (df, 10) $p \leq .000$	$t = 6.77$ (df, 10) $p \leq .000$
Girls	$t = 3.48$ (df, 4) $p \leq .025$	$t = 3.34$ (df, 4) $p \leq .012$
Boys & Girls	$t = 8.09$ (df, 15) $p \leq .000$	$t = 8.30$ (df, 15) $p \leq .000$

during the session and corresponding changes in CRTES scores suggest that the treatment was a causal factor. Although controlled research is needed to establish the efficacy of this intervention, preliminary results from this field study suggest that early intervention following man-provoked disaster may produce significant reductions in children's symptoms of posttraumatic stress. A further limitation of this study is the lack of formal diagnosis. However, diagnosis and formal assessment are time-consuming and may not be readily available in rural settings, third-world countries, or communities devastated by disaster. Consequently the application of this simple group procedure to alleviate distress and to identify individuals requiring more extensive treatment has great utility. Further assessment can then be conducted for those individuals identified in the group protocol, and individual treatment can subsequently be provided.

EMDR-IGTP has been used in its original format or with adaptations to meet the circumstances in multiple settings around the world after natural or human-provoked disasters. The protocol offers an extensive outreach, with a team of five clinicians able to treat 160–200 children in a 4-hour period. The preliminary results suggest that the EMDR-IGTP could be an effective means of providing treatment to large groups of people

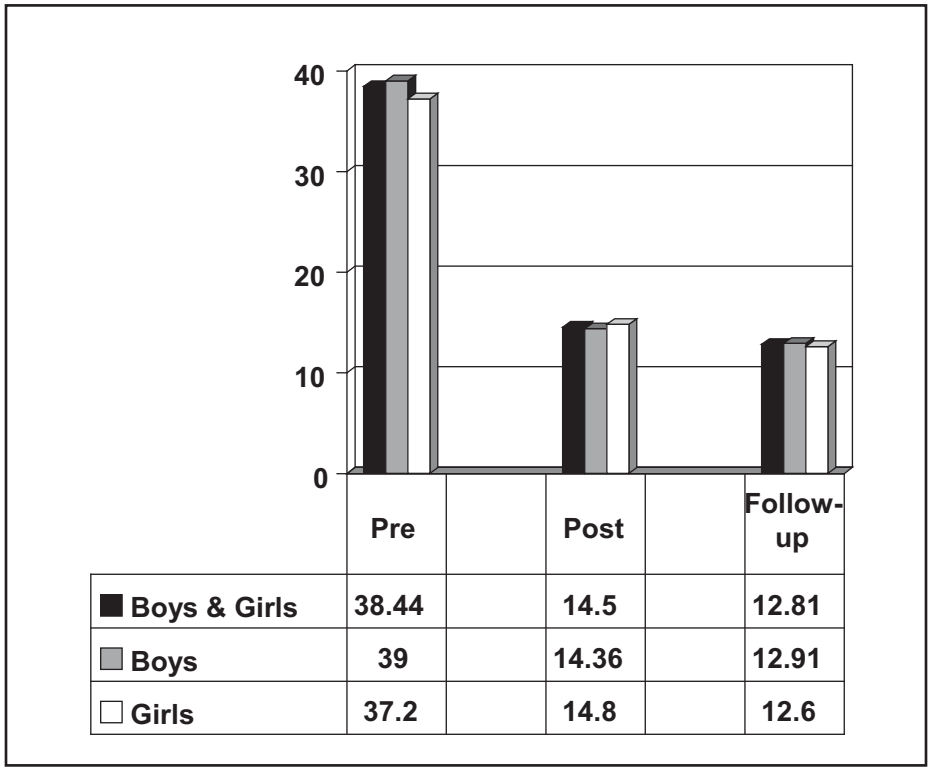


FIGURE 4. Mean scores on the CRTES measure.

Note. Scores on the Child's Reaction to Traumatic Events Scale taken at pretreatment, 1-week posttreatment, and 3-month follow-up.

impacted by large-scale critical incidents (e.g., human-provoked disasters, terrorism, natural disasters).

This is consistent with the findings of other studies that have investigated the application of EMDR-IGTP with groups of children subsequent to man-made and natural disasters. In Italy, Fernandez et al. (2004) described sustained reduction of symptoms for over 95% of 244 children. In Colombia, Adúriz and colleagues (in press) reported significant improvement for children that was maintained at 3-month follow-up. Similarly in Mexico, Jarero et al. (2006) described positive results with the treatment of 44 children (see Table 1). Anecdotal reports in other situations have included the application of the protocol with traumatized adults and are consistent with these results (Gelbach & Davis, 2007).

We are in agreement with Norris and colleagues (2002, 2004), who called for early and ongoing interventions with disaster victims. More research is needed to investigate this protocol and to evaluate its efficacy. This protocol should be applied only to a group of persons who have experienced the same critical incident. The use of this protocol is not recommended, for example, for a group of children who have had different childhood traumatic experiences. The IGTP is a modification of standard EMDR protocols and allows the treatment to be provided simultaneously to a large number of traumatized individuals who have survived a community disaster. The results of the current study suggest that the therapy effectively decreases the distress related to the critical incident.

Some of the benefits of EMDR-IGTP are its transportability; it can be easily implemented in most communities, and few supplies are needed. It is very brief, requiring only 2 hours. Distressed children are identified through this process so that they can be provided with further treatment. In addition, based on our experience in other studies using the protocol and from anecdotal reports, it appears that the model can be applied in ways that respect cultural values of victims. Given the multiple large-scale critical incidents that occur frequently on our planet and the resultant suffering and posttraumatic distress, the potential for offering hope and healing is encouraging. The preliminary and promising results of this study strongly suggest the importance of future controlled research to evaluate this protocol.

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