

The EMDR Integrative Group Treatment Protocol: Application With Adults During Ongoing Geopolitical Crisis

Ignacio Jarero

Lucina Artigas

AMAMECRISIS, México City, México

The eye movement desensitization and reprocessing Integrative Group Treatment Protocol (EMDR-IGTP) has been used in its original format or with adaptations to meet the circumstances in numerous settings around the world for thousands of disaster survivors after natural or man-made incidents. In this study, the EMDR-IGTP was applied during three consecutive days to a group of 20 adults during ongoing geopolitical crisis in a Central American country in 2009. Results in this uncontrolled study showed significant decreases in scores on the Subjective Unit of Disturbance Scale and the Impact of Event Scale (IES). Changes on the IES were maintained at 14 weeks follow-up even though participants were still exposed to ongoing crisis. Controlled research is recommended to further evaluate the efficacy of this intervention.

Keywords: EMDR group treatment; human provoked disaster; geopolitical crisis; posttraumatic stress

The psychological impact of natural and man-made disasters can be overwhelming for individuals, their families, and communities. Research has shown that deleterious effects can include the development of mental health problems such as symptoms of posttraumatic stress disorder (PTSD) and depression (Norris et al., 2002), with natural recovery often requiring up to 18 months. Shalev, Tuval-Mashiach, and Hadar (2004), stated that “mass violence caused by malicious human intent may be a more virulent precursor to PTSD than other types of mass trauma, such as natural disasters” (p. 4). 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). An important aspect of immediate treatment, identified by Shapiro, is helping to restore family function so that “the proper bonding and connections are able to take place with others in the subsequent years” (Luber & Shapiro, 2009, p. 226).

Clinical observations and field studies indicate that eye movement desensitization and reprocessing (EMDR) can be beneficial for alleviating excessive distress and preventing complications in the weeks and months following critical events (Silver,

Rogers, Knipe, & Colelli, 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, 2009).

EMDR has established efficacy in the treatment of PTSD (for a review see Schubert & Lee, 2009) and is also applicable to a wide range of other experientially based clinical complaints. The Adaptive Information Processing (AIP) model guides EMDR practice and conceptualizes the effects of traumatic experiences in terms of dysfunctional memory networks in a physiologically based information processing system (Shapiro, 2001). The AIP model posits that memory networks are the basis of perceptions, attitudes, and behaviors and predicts that dysfunctionally stored memories underlie many current psychological disorders. Processing the memory of disturbing events is a function of EMDR that allows appropriate connections to be made to adaptive networks. With the integration of the memory of the disturbing event into the full range of memory, there are associated

shifts in symptoms, personal characteristics, and the sense of self (Shapiro, 2001; Solomon & Shapiro, 2008).

The EMDR IGTP

The EMDR Integrative Group Treatment Protocol (IGTP) was developed by members of AMAMECRISIS (Mexican Association for Mental Health Support in Crisis) when they were overwhelmed by the extensive need for mental health services after Hurricane Pauline ravaged the western coast of Mexico in 1997 (Artigas, Jarero, Mauer, López Cano, & Alcalá, 2000; Jarero & Artigas, 2009; Jarero, Artigas, & Hartung, 2006; Jarero, Artigas, Mauer, López Cano, & Alcalá, 1999; Jarero, Artigas, & Montero, 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 utilizes the Butterfly Hug originated by Artigas as a form of a self-administered bilateral stimulation (Artigas et al., 2000; Boel, 1999). During the desensitization phase, each individual draws a personal picture of the traumatic event and rates his or her level of Subjective Units of Disturbance (SUD). The participants then look at the picture while doing the butterfly hug (crossing their arms and tapping themselves on the chest in a bilateral alternating fashion). After this, they draw another picture, rate its level of disturbance, and then look at that picture while doing the butterfly hug. The sequence is repeated several times. (For the Butterfly Hug scripted protocol, see Artigas & Jarero, 2009; for the EMDR-IGTP scripted protocol, see Artigas, Jarero, Alcalá, & López Cano, 2009.)

The protocol was originally designed for working with children and was later modified for use with adults. It is hypothesized that the resulting format offers more extensive reach than individual EMDR applications. This protocol compares favorably with group treatment of other models in terms of time, resources, and results (Adúriz, Knopfler, & Bluthgen, 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 care 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).

Effectiveness of the EMDR-IGTP

Because of its utility, this protocol has been used in its original format or with adaptations to meet the circumstances in numerous settings around the world (Gelbach & Davis, 2007; Maxfield, 2008). Anecdotal reports (Gelbach & Davis, 2007; Luber, 2009), pilot field studies (Artigas et al., 2000; Jarero et al., 1999; Jarero et al., 2006), and case reports (Birnbaum, 2007; Errebo, Knipe, Forte, Karlin, & Altayli, 2008; Fernandez, Gallinari, & Lorenzetti, 2004; Gelbach & Davis, 2007; Korkmazlar-Oral & Pamuk, 2002; Wilson, Tinker, Hofmann, Becker, & Marshall, 2000; Zaghrou-Hodali, Alissa, & Dodgson, 2008) document its effectiveness.

Three field study reports used the Child's Reaction to Traumatic Events Scale (CRTES; Jones, 1997) to collect pre- and posttreatment scores. The studies provide preliminary evidence for the protocol's efficacy and utility, showing significant alleviation of posttraumatic symptoms as measured on the CRTES. They also reported significant decreases of participants' SUD ratings, indicating immediate large decreases in emotional distress at the end of the treatment session. A study with 124 child victims of a flood in Santa Fe, Argentina, reported significant within-session SUD score reductions and significant improvement on the CRTES 3 months after administration of the IGTP (Adúriz et al., 2009). In Mexico, Jarero et al. (2006) provided the IGTP to 44 children affected by the Piedras Negras flood with a significant decrease of within-session SUD scores and significant improvement on the CRTES at 1 month posttreatment. Similarly, Jarero et al. (2008) provided IGTP to 16 children whose fathers had died in a mine collapse in Coahuila, Mexico, with significant within-session SUD reductions and significant decreases in CRTES scores measured 1 week posttreatment. Treatment effects were maintained at 3-month follow-up (Jarero & Artigas, 2009).

The Current Study

In 2009, there was a geopolitical crisis in Honduras, in which the president was removed during a military coup on June 28. This was followed with riots, murders, and widespread instability. During the middle of these events, the second author of this article arrived in Honduras in September to provide 3 days of Critical Incident Stress Management Training (Everly & Mitchell, 2008) to 20 staff care personnel. The crisis escalated during the training causing severe distress to all participants. Because of the nature of the events, the author provided EMDR-IGTP,

with the administration of pre-post and following measures.

The participants and the EMDR-IGTP leader were away from home, staying in a hotel without air conditioning, and with rationed food and water; they felt trapped and isolated because of the curfew, unable to exit the building. Although communication with the outside world was limited, they were exposed to stressful rumors, news, and situations concerning civil war, human rights abuses, and a possible invasion of Venezuelan troops. The participants were all very anxious about the safety of their families and economic future. The curfew prevented them from returning home for several days. The crisis continued for several months following the training until December 2009.

Method

In September 21 to 23, 2009, the second author of this article provided the EMDR-IGTP on three consecutive days to 20 adults ($N = 20$, 12 females and 8 males). SUD measurements were taken during the three consecutive days of the protocol application. Impact of Event Scale (IES) measurements were taken at pre-treatment, prior to the initiation of the protocol, at posttreatment, and following the final application of the protocol. At 14 weeks follow-up, the participants were contacted and all completed the IES again, reporting their distress related to the original incidents. It should be noted that at the time of follow-up, the participants were still exposed to ongoing stressors in the 2009 Honduran geopolitical crisis.

Treatment

After the 20 participants were guided through a safe/secure place exercise, the EMDR-IGTP leader asked them to think about the worst part of the event (the current crisis) and then to draw that image on the paper provided. They were then asked for the related SUD rating and told to write the corresponding number on their picture. After that they were asked to look at their picture and to provide their own alternating bilateral stimulation with the Butterfly Hug. The participants were then instructed to draw another picture of their own choice related to the event and rate it according to its level of distress. Processing continued with the adults looking at the second picture and using the Butterfly Hug. The process was repeated twice more so that each participant drew four pictures, and provided a SUD rating for each. The final level of distress associated with the current crisis was then assessed by asking to focus on the drawing

that was most disturbing and to identify the current SUD level. This number was then written on the back of the paper and was the 5th SUD rating for the session. The participants then drew a final picture that represented their future vision of themselves, along with a word or a phrase that described that picture. No SUD rating was provided for this picture. The drawing and the phrase were then paired with the Butterfly Hug. The clients were instructed to close their eyes, scan their body, and do the Butterfly Hug. Finally the participants were instructed to return to their safe/secure place.

Measures

The IES (Horowitz, Wilner, & Alvarez, 1979) is a 15-item self-rating questionnaire designed to measure subjective posttraumatic stress. Responses are scored according to a Likert scale, where 0 = not at all, 1 = rarely, 3 = sometimes, and 5 = often. Scores between 0 and 8 are considered subclinical; scores between 9 and 25 are considered low distress; scores between 26 and 43 are considered moderate distress; scores between 44 and 75 are considered high distress. The IES is considered to have good psychometric properties (Horowitz et al., 1979).

The SUD Scale (SUDS; Shapiro, 2001; Wolpe, 1958) is designed to provide a measure of the distress as subjectively experienced by the client, who is asked to indicate the level of disturbance associated with the target event by choosing a number on a 0 (no disturbance) to 10 (highest possible disturbance) scale. This scale was the measure of process changes over the course of the protocol application. Kim, Bae, and Park (2008) confirmed that the SUDS scores obtained in EMDR sessions have good psychometric properties, with evidence of convergent and discriminant validity, concurrent validity, and predictive validity.

Results

Twenty adults participated in this study. All completed the EMDR-IGTP during three consecutive days. There were no differences in response between females ($n = 12$) and males ($n = 8$). SUD ratings were made following the completion of each of four trauma-related drawings, before the application of the Butterfly Hug, and are labeled as Draws 1–4 in Table 1 and Figure 1. At the end of each session, the participant gave a final score for the most disturbing drawing; this final score is labeled as Draw 5 in Table 1 and Figure 1. The significant change in mean SUD scores during the three consecutive days of treatment process is evident in Figure 1. On the first

TABLE 1. Scores on the SUDS Measure

	Means (<i>SD</i>)		Means (<i>SD</i>)		Means (<i>SD</i>)		Comparison of		Comparison of	
	Day 1-Draw 1	Day 1-Draw 5	Day 2-Draw 5	Day 3-Draw 5	Day 1-Draw 1 versus Day 1-Draw 5	Day 1-Draw 1 versus Day 2-Draw 5	Day 1-Draw 1 versus Day 3-Draw 5			
Males <i>N</i> = 8	8.75 (0.886)	0.88 (0.641)	2.25 (1.282)	0.75 (0.463)	<i>t</i> (7) = 15.280, <i>p</i> < .001	<i>t</i> (7) = 17.197, <i>p</i> < .001	<i>t</i> (7) = 24.440, <i>p</i> < .001			
Females <i>N</i> = 12	9.00 (1.044)	1.58 (0.900)	2.42 (1.379)	0.92 (0.793)	<i>t</i> (11) = 17.071, <i>p</i> < .001	<i>t</i> (11) = 15.153, <i>p</i> < .001	<i>t</i> (11) = 21.353, <i>p</i> < .001			
Males and females <i>N</i> = 20	8.90 (0.968)	1.30 (0.865)	2.35 (1.309)	0.85 (0.671)	<i>t</i> (19) = 23.194, <i>p</i> < .001	<i>t</i> (19) = 22.244, <i>p</i> < .001	<i>t</i> (19) = 31.416, <i>p</i> < .001			

Note. Means, standard deviations (*SD*), and statistical comparisons. Draw 1 is first score of the day; Draw 5 is final score of the day.

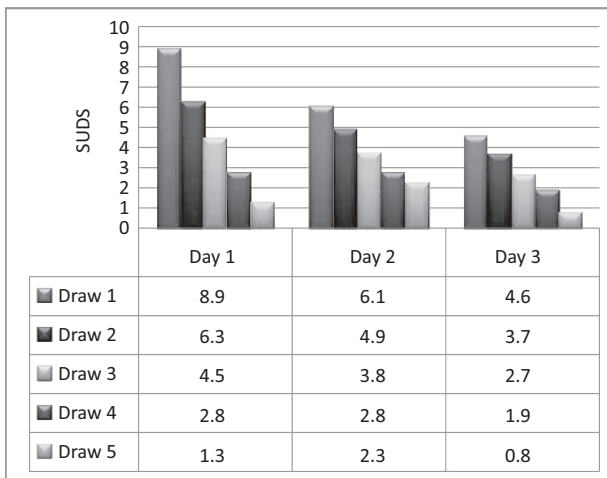


FIGURE 1. Treatment process changes during three consecutive days' application as measured by average Subjective Units of Disturbance Scale (SUDS) scores. Draw 1 is first score of the day; Draw 5 is final score for the day.

day, SUD ratings decreased from an initial mean of 8.8–1.3. At the beginning of the next day, the SUD score showed an increase to 6.1. Following the application of the protocol on that day, the SUD score decreased to 2.3. At the beginning of the third day, the score had again increased to 4.6. Following the application of the protocol on that day, the final SUD score (Draw 5) was 0.8. Statistical analysis shows a highly significant change in the SUD scores. *t*-test comparisons were made with the disturbance elicited by the initial drawing (Day 1-Draw 1) to the disturbance at the end of each day (Draw 5), with statistical significance for each comparison at $p < .001$ (see Table 1).

At pretreatment, the IES average score (mean = 49.25) placed the participants in the high distress range, indicating a high level of psychological response to a stressful life event. The posttreatment IES scores were obtained at the end of the third day and last group protocol application. They indicated a low level of distress (mean = 22.25) and showed a significant decrease from the pretreatment scores, $t(19) = 7.629$, $p < .001$. Follow-up IES ratings taken at 14 weeks under ongoing crisis showed maintenance of treatment effect (mean = 22.55), and a significant difference from the pretreatment scores, $t(19) = 8.283$, $p < .001$ (see Table 2 and Figure 2).

Discussion

The results indicated significant improvement on measures of posttraumatic stress and self-reported distress. The rapid shift in SUD ratings during the three sessions (Figure 1) is consistent with the EMDR-

IGTP pilot field studies for adult men and women treated at different natural disaster sites in Latin America (Jarero et al., 2006).

An unusual observation in this study is that the initial SUD ratings on the second and third days were somewhat elevated, rather than showing a maintenance of the previous days' final low SUD score. The higher SUD scores at the beginning of the subsequent days may be an effect of the ongoing stress and situations that the participants had to face each day in the hotel. They were constantly exposed to changing distressful news and rumors about the 2009 Honduran geopolitical crisis (e.g., civil war, human rights abuses, and foreign troops entering the country). It is apparent that despite the ongoing crisis and difficult conditions, the SUD scores decreased each day.

The posttreatment IES scores were taken at the end of the third session. The significant change in the pre-post IES scores parallels the changes in the SUD scores, and thus suggests that the group EMDR treatment was a causal factor. However it was not possible to determine this directly, as ethical considerations in this field study did not allow for an untreated comparison control group. It seems likely, however, given the ongoing stress (reflected in the daily increases in SUD ratings) that there would not have been a significant decrease in the IES scores without the provision of the group treatment.

The low scores on the IES measure were maintained at 14 weeks follow-up (Table 2, Figure 2) suggesting that the treatment benefits were maintained for that period of time. This maintenance of effects indicates that the treated event was no longer disturbing to the participants, even though the geopolitical crisis was still ongoing and the participants were often exposed to similar incidents. This is consistent with the hypothesis that follows from Shapiro's (2001) AIP model: Thoroughly processing a disturbing memory changes the way that the experience is stored in memory, so that distress is no longer triggered by similar events.

Shapiro's (2001) model also suggests that the processed memory can then become available to guide adaptive future behavior and enhance resilience. The development of resilience was not evaluated in the current study, as we did not assess whether subsequent similar incidents created less distress for the participants. It is possible that resolving initial distress might have increased resilience so that the participants would have been less disturbed by subsequent similar events. A case study that looked at the possibility that subsequent events cause less disturbance for treated clients was conducted by Zaghrout-Hodali et al. (2008). They found that provision of

TABLE 2. Scores on the IES Measure

	Means (SD) at Pre	Means (SD) at Post	Means (SD) Follow-up	Comparison of Pre and Post	Comparison of Pre and Follow-up
Males <i>N</i> = 8	49.50 (11.976)	20.63 (9.211)	18.63 (8.331)	<i>t</i> (7) = 4.099, <i>p</i> ≤ .005	<i>t</i> (7) = 4.539, <i>p</i> ≤ .003
Females <i>N</i> = 12	49.08 (10.757)	23.33 (9.218)	21.83 (8.354)	<i>t</i> (11) = 6.727, <i>p</i> ≤ .000	<i>t</i> (11) = 7.167, <i>p</i> ≤ .000
Males & females <i>N</i> = 20	49.25 (10.949)	22.25 (9.072)	20.55 (8.281)	<i>t</i> (19) = 7.629, <i>p</i> ≤ .000	<i>t</i> (19) = 8.283, <i>p</i> ≤ .000

Note. Means, standard deviations, and statistical comparisons.

EMDR group protocol helped a group of children to be less reactive when they were exposed to a subsequent traumatic event so that fewer posttraumatic stress symptoms were observed. The children’s maintenance of improvement in a situation of ongoing trauma suggests that the children may have developed some psychological and emotional resilience, coping strategies, and some sense of inoculation against the impact of further trauma. Research is needed to evaluate whether EMDR may be effective in developing adults’ resilience to ongoing crisis by enhancing the ability to cope effectively with subsequent related stressors.

The present study was an uncontrolled field study, with treatment provided in a natural setting to a group of adults exposed to ongoing geopolitical 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 posttraumatic response by reducing symptoms of posttraumatic 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. 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 EMDR as one component of a comprehensive system of interventions that promote healing and enhance resilience post disaster has important global implications (Shapiro, 2009).

There are number of advantages to using the EMDR-IGTP approach. 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 old adults. It is cost efficient, as it requires just a place on which to write, as well as paper and crayons or pencil. It can be used in a nonprivate setting such as a shelter, an open-air clinic, or even under a mango tree, like happened in Acapulco, México. 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 stress. 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 appears to be effective across cultures and can be applied in a manner that is respectful of the community’s cultural values. A single clinician can administer it with the assistance of paraprofessionals, teachers, or family members, which allows wide application of this protocol in societies with few mental health professionals (Adúriz et al., 2009; Gelbach & Davis, 2007; Jarero & Artigas, 2009).

When faced with the challenge of providing trauma treatment to a large number of people the EMDR-IGTP has demonstrated that it is a highly efficient intervention in terms of time, resources, cost, and lasting results and presents an auspicious answer to mass critical incidents. We are in agreement with Luber (2009) who called for the need to conduct randomized research that will support the empirical validation needed to reach even more of the world’s victims of disasters and to help them relieve their suffering.

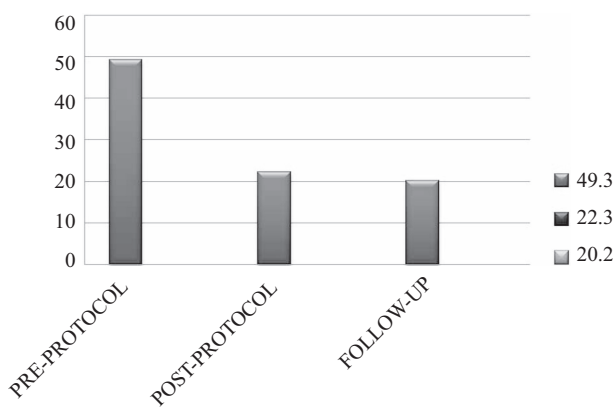


FIGURE 2. Average Impact of Event Scores. Pre-Post and Follow-up of the eye movement desensitization and reprocessing Integrative Group Treatment Protocol application.

References

- Adúriz, M. E., Knopfler, C., & Bluthgen, C., (2009). Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. *International Journal of Stress Management, 16*, 138–153.
- Artigas, L., & Jarero, I. (2009). The butterfly hug. In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Special populations* (pp. 5–7). New York: Springer Publishing.
- Artigas, L., Jarero, I., Alcalá, N., & López Cano, T. (2009). The EMDR Integrative Group Treatment Protocol (IGTP). In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basic and special situations* (pp. 279–288). New York: Springer Publishing.
- Artigas, L., Jarero, I., Mauer, M., López Cano, T., & Alcalá, N. (2000, September). *EMDR and traumatic stress after natural disasters: Integrative treatment protocol and the butterfly hug*. Poster presented at the EMDRIA Conference, Toronto, Ontario, Canada.
- Birnbaum, A. (2007). *Lessons from the Lebanon war*. Paper presented at the EMDR-Israel Conference, Tel Aviv, Israel.
- Boel, J. (1999). The butterfly hug. *EMDRIA Newsletter, 4*(4), 11–13.
- Errebo, N., Knipe, J., Forte, K., Karlin, V., & Altayli, B. (2008). EMDR-HAP training in Sri Lanka following 2004 tsunami. *Journal of EMDR Practice & Research, 2*(2), 124–139.
- Everly, G., & Mitchell, J. (2008). *Integrative crisis intervention and disaster mental health*. Ellicott City, MD: Chevron Publishing Corporation.
- Fernandez, I., Gallinari, E., & Lorenzetti, A. (2004). A school-based intervention for children who witnessed the Pirelli building airplane crash in Milan, Italy. *Journal of Brief Therapy, 2*, 129–136.
- Gelbach, R., & Davis, K. (2007). Disaster response: EMDR and family systems therapy under communitywide stress. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 387–406). New York: John Wiley.
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209–218.
- Jarero, I., & Artigas, L. (2009). EMDR Integrative Group Treatment Protocol. *Journal of EMDR Practice & Research, 3*, 287–288.
- Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR Integrative Group Treatment Protocol: A post-disaster trauma intervention for children and adults. *Traumatology, 12*, 121–129.
- Jarero, I., Artigas, L., Mauer, M., López Cano, T., & Alcalá, N. (1999, November). *Children's post traumatic stress after natural disasters: Integrative treatment protocol*. Poster presented at the annual meeting of the International Society for Traumatic Stress Studies, Miami, FL.
- Jarero, I., Artigas, L., & Montero, M. (2008). The EMDR Integrative Group Treatment Protocol: Application with child victims of mass disaster. *Journal of EMDR Practice & Research, 2*(2), 97–105.
- Jones, R. (1997). Child's reaction to traumatic events scale (CRTES). In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 291–348). New York: Guilford.
- Kim, D., Bae, H., & Park, Y. C. (2008). Validity of the Subjective Units of Disturbance Scale in EMDR. *Journal of EMDR Practice and Research, 2*(1), 57–62.
- Korkmazlar-Oral, U., & Pamuk, S. (2002). Group EMDR with child survivors of the earthquake in Turkey. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 47–50.
- Luber, M. (2009). EMDR and early interventions for groups. In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basic and special situations* (pp. 277–278). New York: Springer Publishing.
- Luber, M., & Shapiro, F. (2009). Interview with Francine Shapiro: Historical overview, present issues, and future directions of EMDR. In M. Luber (Ed.), *Eye Movement desensitization and reprocessing (EMDR) scripted protocols: Basic and special situations* (pp. 217–231). New York: Springer Publishing.
- Macy, R., Behart, L., Paulson, R., Delman, J., Schmid, L., & Smith, S. F. (2004). Community-based, acute posttraumatic stress management: A description and evaluation of a psychosocial-intervention continuum. *Harvard Rev Psychiatry, 12*, 217–218.
- Maxfield, L. (2008). EMDR treatment of recent events and community disasters. *Journal of EMDR Practice & Research, 2*(2), 74–78.
- Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part 1. An empirical review of the empirical literature, 1981–2001. *Psychiatry, 65*, 207–239.
- Schubert, S., & Lee, C. W. (2009). Adult PTSD and its treatment with EMDR: A review of controversies, evidence, and theoretical knowledge. *Journal of EMDR Practice and Research, 3*(3), 117–132.
- Shalev, A. Y., Tuval-Mashiach, R., & Hadar, H. (2004). Posttraumatic stress disorder as a result of mass trauma. *Journal of Clinical Psychiatry, 65*(Suppl. 1), 4–10.
- Shapiro, E. (2009). EMDR treatment of recent trauma. *Journal of EMDR Practice and Research, 3*, 141–151.
- Shapiro, F. (1995). *Eye movements desensitization and reprocessing. Basic principles, protocols, and procedures* (1st ed.). New York: Guilford.
- Shapiro, F. (2001). *Eye movements desensitization and reprocessing. Basic principles, protocols, and procedures* (2nd ed.). New York: Guilford.
- Shapiro, F. (2009, December). *Treating victims of trauma worldwide*. Presentation given at the Evolution of Psychotherapy Conference, Anaheim, CA.
- Silver, S. M., Rogers, S., Knipe, J., & Colelli, G. (2005). EMDR therapy following the 9/11 terrorist attacks: A community-based intervention project in New York

- City. *International Journal of Stress Management*, 12, 29–42.
- Solomon, R. M., & Shapiro, F. (2008). EMDR and the adaptive information processing model: Potential mechanism of change. *Journal of EMDR Practice and Research*, 2, 315–325.
- Wilson, S., Tinker, R., Hofmann, A., Becker, L., & Marshall, S. (2000). *A field study of EMDR with Kosovar-Albanian refugee children using a group treatment protocol*. Paper presented at the annual meeting of the International Society for the Study of Traumatic Stress, San Antonio, TX.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- Zaghrou-Hodali, M., Alissa, F., & Dodgson, P. (2008). Building resilience and dismantling fear: EMDR Group Protocol with children in an area of ongoing trauma. *Journal of EMDR Practice & Research*, 2(2), 106–113.

Correspondence regarding this article should be directed to Ignacio Jarero, Bulevar de la Luz 771, Jardines del Pedregal, Alvaro Obregón, México City, Mexico 01900. E-mail: nacho@amaecrisis.com.mx