

# EMDR Integrative Group Treatment Protocol: A Postdisaster Trauma Intervention for Children and Adults

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Eye movement desensitization and reprocessing (EMDR) is recognized as an effective and efficient treatment for trauma-related issues. This article describes an integrated EMDR and group treatment for children and adults traumatized by natural disasters in several Latin American countries. This protocol combines the eight standard EMDR treatment phases with a group therapy model. The hypothesis is that the resulting hybrid offers more extensive reach than did the original EMDR model, which was intended for use with individuals, and takes treatment efficacy and efficiency well beyond

that expected from traditional group process. To illustrate the application of the model, one formally measured field study and nine pilot projects are described. The promising results of this intervention suggest that EMDR is an effective means of providing treatment to large groups of people impacted by large-scale traumatic events (e.g., natural disasters). Controlled research is needed to clarify this issue.

**Keywords:** EMDR; Latin America; natural disaster; posttraumatic stress; trauma; children

Although the literature on the effects of disasters has been accumulating for more than 2 decades, information on disaster-related symptomatology among victims in developing countries is proportionately sparse (Norris et al., 2002). One tentative conclusion is that natural disasters in the developing world are particularly complex. In a recent longitudinal study of the effects of floods and mudslides in Mexico, a team of international researchers found that disaster survivors reported a high prevalence of posttraumatic stress disorder (PTSD) (24% on average, ranging from 14% at one site to 47% in another) and a high incidence of major depressive disorder (Norris, Murphy, Baker, & Perilla, 2004). Interpretation of these data was complicated by the finding that residents of certain sites had experienced other potentially traumatic events during their lives and that their PTSD symptoms may have predated the disasters studied, lending support to the observation that trauma in developing

countries is unusually commonplace, challenging to treat, and difficult to study.

Postdisaster data gathered in 6-month intervals allowed the researchers in Norris et al. to observe the progress of PTSD symptoms. They noted that although the incidence of PTSD declined with time, this natural recovery continued for 18 months before leveling off, reflecting how natural healing can be painfully prolonged. Even by the 18-month leveling-off period, PTSD rates for the disaster victims remained higher than the PTSD base-rate in Mexico. These researchers concluded that their findings support a call for "early and ongoing interventions that provide mental health care to disaster victims in a way that is culturally appropriate and feasible for places . . . that have few mental health professionals to draw upon" (Norris et al., 2004, pp. 290-291).

## Eye Movement Desensitization and Reprocessing

The effectiveness of eye movement desensitization and reprocessing (EMDR) in the treatment of trauma survivors has been recognized by a variety of professional

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groups, including the American Psychological Association (Chambless et al., 1998), the American Psychiatric Association (2004), the International Society for Traumatic Stress Studies (Chemtob, Tolin, van der Kolk, & Pitman, 2000), the Israeli National Council for Mental Health (Bleich, Kotler, Kutz, & Shaley, 2002), the Northern Ireland Department of Health (Clinical Resource Efficiency Support Team, 2003), and the U.S. Departments of Defense and Veterans Affairs (2004).

Published studies have investigated the effects of EMDR following manmade and natural disasters (Fernandez, Gallinari, & Lorenzetti, 2004; Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997).

EMDR has been reported as effective in the treatment of 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 (E. Konuk, personal communication, 2005; Korkmazlar-Oral & Pamuk, 2002). In all of these studies, standard EMDR treatment was conducted, that is, each subject-patient was treated on an individual basis, one at a time.

Standard EMDR treatment is based on the adaptive information processing (AIP) model (Shapiro, 2001). An assumption of the AIP model is that the human neurobiological system inherently processes information in a manner that promotes adaptive resolution. According to this theory, a person who experiences a crisis or life-threatening event will generally work through the experience naturally. Unfortunately, some critical experiences are more powerful than is the AIP system, such that the event can overwhelm the system. These events, unprocessed and unresolved, are said to be stored as traumatic memories that can trouble the individual for years to come, affecting past, present, and future. The unresolved past is experienced as if it is reoccurring again and again, rather than as a distant memory. Present-day symptoms appear in the form of troubling thoughts, emotions, sensations, and behaviors, and otherwise innocuous stimuli (such as a car backfiring, or the grimace of a boss) can remind the person of the traumatic event and trigger inappropriate reactions. As a result, the person's sense of a future is curtailed and pessimistic.

EMDR appears to facilitate the AIP system so that the individual is able to process traumatic memories to a state of natural and appropriate resolution.

The past event becomes only a memory, without its negative emotional disturbance. Present-day symptoms are reduced or eliminated, and previous triggers become simply sounds and pictures. And the individual dares to dream about future possibilities.

There are eight phases in standard EMDR treatment. In Phase 1, a thorough history is taken to identify early traumas and present triggers, as well as to recognize client strengths and resources. In subsequent EMDR treatment, the client will be doing the work of healing by connecting adaptive information already within the AIP system with the unresolved traumatic memories. In Phase 2, the client is helped to become prepared for the unusual speed and power of EMDR, and additional attention is given to helping the client to develop internal resources that can be used during treatment. Phases 3 through 7 involve the processing of traumatic memories. In Phase 3, assessment, a specific traumatic memory is identified along with the client's thoughts and feelings about the memory. The client then rates the disturbing power of that memory with a variation of the SUD or subjective units of disturbance (Wolpe, 1958), where a zero means no disturbance whatsoever and a 10 the maximum imaginable. To stimulate healing possibilities, the client also rates the believability of a positive self-statement, this time using a scale that measures how true a given statement feels to the client.

Phase 4 is treatment proper, or desensitization. Standardized treatment procedures include having the client focus on the visual, somatic, and rational features of the traumatic event while providing bilateral stimulation in the form of alternating eye movements, taps on either side of the body (for example, on the client's hands), and/or alternating bilateral tones. It is theorized that the client is thus enabled to give dual attention both to the disturbing memory and to present-day strengths and healing resources. This is distinct from treatments that encourage a focus either on the past alone (which can quickly become overwhelming and even retraumatizing) or on the present (which can produce rational understanding without accompanying emotional change). During desensitization, the client reports that the negative emotions and sensations that previously characterized the traumatic memory are reduced (as the term implies), and the memory becomes simply a memory of a past event.

In the next two phases, the client is invited to strengthen positive ways of thinking and feeling

about the memory; a body check is done to identify any residual somatic symptoms. Additional desensitization can be provided if necessary. The seventh phase involves a special closure to the session to remind the client that he or she may continue to process other memories (the AIP is said to be functioning again) between sessions and that it is normal to experience new insights, feelings, and sensations (both pleasant and disturbing). This careful attention to the unexpected as well as the predicted is repeated in Phase 8, which is a reassessment of the client's experiences during the following session.

## AMAMECRISIS

The team of the Mexican Association for Crisis Therapy (Asociación Mexicana para Ayuda Mental en Crisis – AMAMECRISIS) provides mental health and other assistance to persons affected by natural and human-caused disasters. During the 72 hr following a disaster, the team provides on-the-scene support to child and adult victims and their families, and to frontline workers and caregivers such as emergency personnel, rescue workers, and mental health professionals. For survivors who develop PTSD or other trauma symptoms, and for service personnel suffering from compassion fatigue, innovative mental health interventions (such as the EMDR protocol to be described) are offered from 1 to 12 weeks postdisaster or longer, if necessary and feasible.

## The EMDR Integrated Group Treatment Protocol

The current article describes an EMDR integrated group treatment protocol (EMDR-IGTP) that was inspired by requests for mental health attention following a massive natural disaster. In 1997, hurricane Pauline struck the western coast of Mexico. The AMAMECRISIS team responded quickly to the need for services and was as quickly overwhelmed by the extent of the need. The team clinicians thought that they would conduct one-on-one EMDR with just a few of the children and adults, who had lost families and homes; however, on the first day, they were met by more than 200 distressed youngsters and adults. The team challenge was how to treat these many needy children and adults simultaneously with a powerful trauma treatment (EMDR) that was originally intended only for use with one patient at a time.

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, Maure, & Alcalá, 1999). The protocol was originally structured within a play therapy format and was modified later for use with adults. The hypothesis is that the resulting hybrid offers more extensive reach than did the original EMDR model, which was intended for use with individuals, and takes treatment efficacy and efficiency well beyond that expected from traditional group process.

The protocol has been designed to achieve the following main objectives:

- To identify the patients with symptoms of acute posttraumatic stress or posttraumatic stress disorder
- To confront the traumatic material
- To bring to conscience aspects of the trauma that were dissociated
- To facilitate the expression of painful emotions and/or shameful behaviors
- To offer the patient support and empathy
- To condense the different aspects of the trauma in representative and more manageable images
- To increase the patient's perception of domain over the elements of the traumatic experience
- To reprocess traumatic memories

Professionals who use EMDR will find that the protocol follows the basic EMDR pattern with several modifications: during Phase 1, the clinical history is obtained of parents and teachers and a formal evaluation with a properly validated instrument is taken. During Phase 2, children play specially designed games to promote rapport and the installation of the safe/secure place. The information of Phase 3 is obtained from the client's first drawing that draws and colors the critical event instead of visualizing it mentally. During Phase 4, the clients provide their own bilateral stimulation using the butterfly hug (Artigas et al., 2000); SUD measure is taken with pictures of faces that represent different emotions and with repeated drawings of the incident instead of numbers in a questionnaire. In Phase 5, the client makes a drawing and a word or written sentence. During Phase 6, the clients scan all their body and do the butterfly hug. In Phase 7, the clients return to the safe/secure place to close the session, and in Phase 8, the clients who show more distress are assisted using this protocol on an individual basis or in small groups. Throughout the protocol, the lead

therapist is assisted by the Emotional Protection Team (EPT). Members of the EPT provide individual help for any child who does not find the group treatment format to be sufficient or comfortable. In some cases, an individual child will relive (“abreact”) the traumatic event with such intense emotion that individual treatment is required to protect the child and to complete treatment.

The protocol is still in its experimental stages. As mentioned above, the controlled research to date that supports the efficacy of EMDR is applicable only to individual treatment. Support for the EMDR group protocol described here has so far been limited to case studies. Other field studies of the protocol have been conducted with children victims of a flood in Argentina (Adúriz et al., in press) and, with modifications, with children who witnessed an airplane crash in Italy (Fernandez et al., 2004) and Kosovar-Albanian refugee children in Germany (Wilson, Tinker, Hofmann, Becker, & Marshall, 2000). In this article, we describe additional applications of the protocol.

### **A Case Example of the EMDR-IGTP**

Piedras Negras, Mexico, lies along the Mexico-USA border. On April 2, 2004, a flood in this city killed 38 children and adults, and destroyed hundreds of homes. On April 6, the AMAMECRISIS team arrived on site with pamphlets on emotional first aid and conducted the Crisis Management Briefing Protocol (Mitchell & Everly, 2001). On May 15, members of the AMAMECRISIS team conducted EMDR with 44 children, using the EMDR Integrated Group Treatment Protocol. Twenty-two of the children were male and 22 were female, ranging in age from 8 to 15 years. All had lost their homes and, in some cases, loved ones.

During Phase 1 of the protocol, team members educated teachers, parents, and relatives about the course of trauma and enlisted these individuals to identify affected children. At the end of the group intervention, any child requiring individual attention was treated separately from the group and was further assessed for co- or preexisting mental health problems. Following treatment, all clients were taught basic affect management techniques to cope with stress and to prepare for the future. The clinical history is obtained of parents and teachers, and a formal evaluation with a properly validated instrument is taken.

Phase 2 of the protocol begins with an integration 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. Although the materials used in the interventions described here included a Mexican doll called Lupita, a drum, and a doll dolphin, other materials may be used. The dolphin is used, for example, to familiarize the children with their 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 helps them to learn coping skills. The children are repeatedly validated regarding their feelings and other symptoms related to the traumatic event. As mentioned above in the protocol description the lead therapist was assisted by the EPT throughout the intervention.

The figures that follow depict the process of change during EMDR processing. During Phase 3 of treatment, the children are instructed to think about the aspects of the event that made them feel most frightened, angry, or sad, and then to draw that image on the paper provided (see Figure 1, drawing A). After rating their level of distress using a modified version of the SUD scale (pictures of faces substitute for numbers), the children initiate Phase 4 of the protocol, focusing on the drawing while tapping themselves on the chest in bilateral and alternating fashion (a procedure called the butterfly hug). The children are then instructed to draw three more pictures of their choosing, each of which is rated according to level of distress and reprocessed using the butterfly hug (Figure 1, drawings B, C, and D). The level of distress associated with the initial target is then assessed by returning the child’s focus to the drawing that perturbs the most and identifying the current SUD level (Figure 2, upper right corner).

In Phase 5, they draw a picture that represents their future vision of themselves, along with a word or a phrase that describes that picture (Figure 2). The drawing and the phrase are also paired with the butterfly hug. After that, 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 is initiated at the end of the group intervention. The EPT has a debriefing about the identified children who need individual attention and have to be thoroughly evaluated to identify the nature and extent of their symptoms, and any co- or preexisting mental health problems. After that evaluation, the team members keep working with them using the EMDR-IGTP in small groups or on an individual basis.



**Figure 1.** Example of a child's drawings before, during, and following eye movement desensitization and reprocessing integrated group treatment protocol treatment. The numbers represent the child's self-reported Subjective Units of Disturbance Scale scores.



**Figure 2.** Example of a child's drawing of her imagined future. The Spanish statement reads, "The future will be achieved." The zero represents her self-reported Subjective Units of Disturbance Scale score.

As we explained before, the protocol follows the basic EMDR model, with several modifications:

- The client (especially in the case of children) sketches and colors the critical event instead of mentally visualizing it.
- Instead of relying on the therapist, clients provide their own alternating bilateral stimulation with the butterfly hug (Artigas et al., 2000).

- Special attention is given to establishing a safe/secure place.
- Process measures of subjective distress are conducted with faces representing different emotions, and with repeated sketches of the incident instead of with numbers on an inventory.
- Several team members work in conjunction so that any client requiring individual attention can be identified and treated separately from the group.

## Measurement and Results

Pre- and posttreatment measures were made with the Child's Reaction to Traumatic Events Scale (CRTES) (Jones, 1997) and a modified Subjective Units of Disturbance Scale (SUDS) (Wolpe, 1958). The CRTES, which was derived from the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979), is a 15-item self-report scale intended to measure the frequency of symptoms related to trauma. In addition to a total score, the CRTES provides scores for two subscales: intrusion and avoidance.

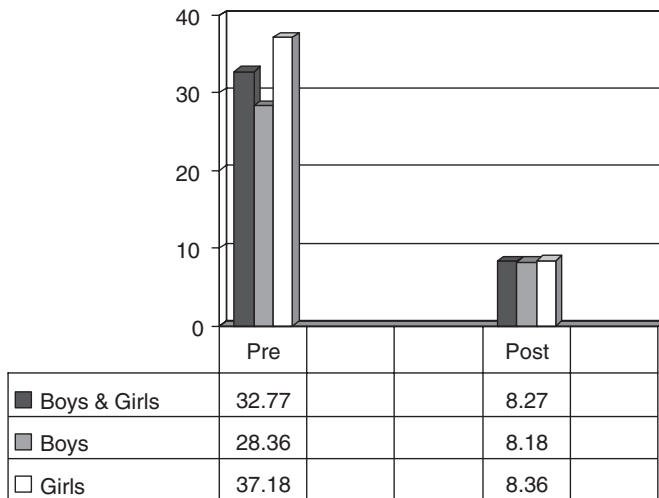
In Figures 3 and 4, we can see the correlation between CRTES and SUDS scores. On May 15, 2004, the pretreatment group average CRTES score was 32.77, indicating a high degree of distress; the pretreatment SUDS average was 9.24. Following treatment on the same date, the final SUDS had decreased to 1.29.

On Jun 12, 2004, four weeks after beginning treatment, the team returned to Piedras Negras to conduct a follow-up of the same 44 children using the CRTES. Mean CRTES scores had decreased significantly from 32.77 (pretreatment) to 8.27 (at 4-week follow-up), indicating low distress at follow-up (Figure 3).

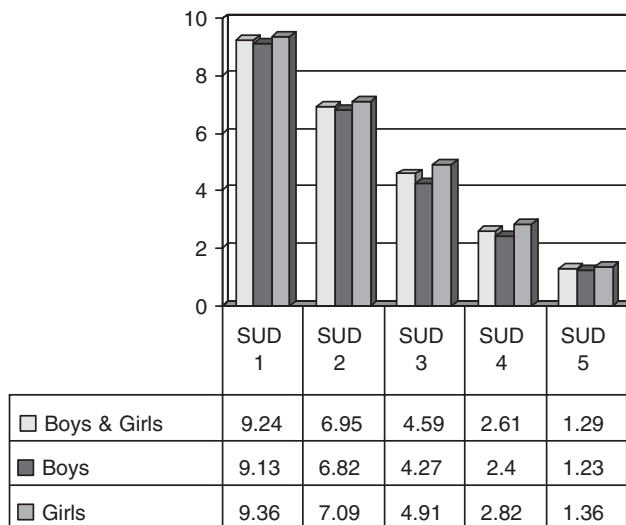
## Other Case Examples

Since 1998, the AMAMECRISIS team followed the EMDR-IGTP protocol to treat children and adults in nine pilot studies in Mexico, Nicaragua, El Salvador, Colombia, and Venezuela after natural mass disasters. Temporary shelters were used as the treatment site for a transient population, conditions that made it difficult both to gather formal measurement data and to conduct follow-up interviews.

As a pretreatment measure, a simplified version of the Impact of Events Scale (Horowitz et al., 1979) was used to identify symptoms, and the SUDS was the measure of process changes over the course of EMDR treatment.

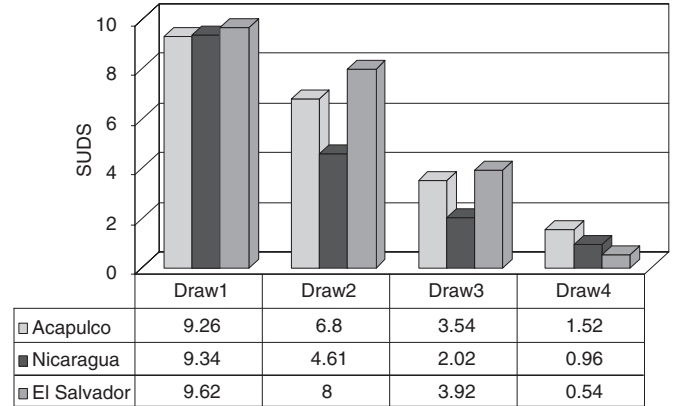


**Figure 3.** Average pre- and posttreatment Child's Reaction to Traumatic Events Scale score, Piedras Negras Study. Pre – May 15, 2004; Post – June 12, 2004.

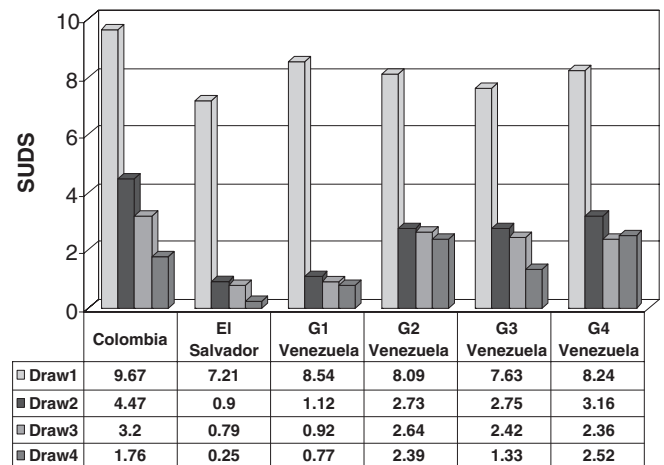


**Figure 4.** Treatment process changes as measured by average Subjective Units of Disturbance Scale (SUDS) scores. Piedras Negras Study, May 15, 2004.

The results of these studies (Figures 5 and 6) were consistent with the Piedras Negras findings. The data from these various projects lend support to the use of EMDR-IGTP in mass disaster situations.



**Figure 5.** Average Subjective Units of Disturbance Scale (SUDS) scores for children treated at different natural disaster sites, before (Draw1), during (Draw2, Draw3), and following treatment (Draw4).



**Figure 6.** Average Subjective Units of Disturbance Scale (SUDS) scores for adult men and women treated at different natural disaster sites, before (Draw1), during (Draw2, Draw3), and following treatment (Draw4).

## Discussion

Findings from a field study of the use of an EMDR-IGTP suggest early intervention following disaster can produce significant reductions in distress in children as measured by the CRTES instrument (Figure 3).

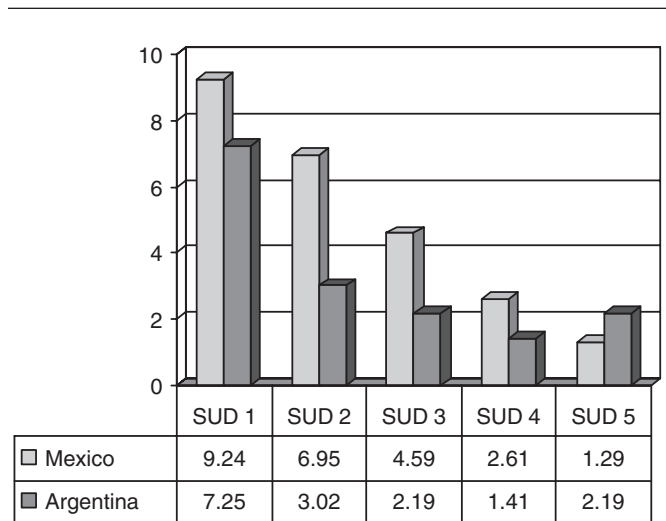
We can see a correlation between the pretreatment measures: CRTES 32.77 (Figure 3), SUD average in the first drawing is 9.24 (Figure 4), and the girl's drawing in the first SUD is 10 (Figure 1).

In Figure 4, we can see how the SUD average decreases over the course of treatment in correlation with the girl's drawing (Figures 1 and 2). The low distress scores as measured by the CRTES at follow-up 1 month later (Figure 3) indicate that treatment benefits were maintained for that period of time.

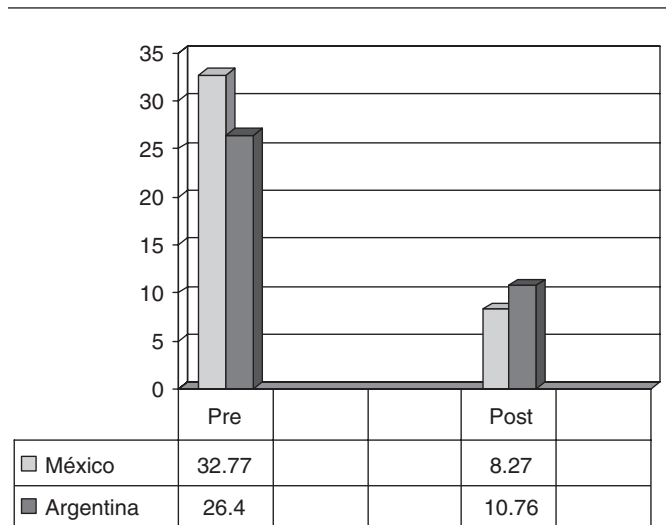
These changes are also consistent with observations from the work conducted at a disaster site in Argentina (following a flood) by Adúriz and her colleagues in 2003 (in press), using the EMDR-IGTP with child victims of the flood. They reported process changes over the course of treatment, as measured by subjective reports of distress using the SUDS and changes on CRTES measures from pre- to posttreatment that were similar to the Piedras Negras findings (see Figures 7 and 8 for comparisons of the results of these two studies). The Argentina group also reported that positive changes following treatment were further indicated by behavioral observations made by teachers before and after treatment. Positive changes were maintained at approximately the 3-month follow-up.

The pilot projects preceding the Piedras Negras study (Figures 5 and 6) are considered only to be clinically relevant case studies. They enabled our team to learn how to work under conditions of physical and social chaos, how to be inventive under overwhelming demands, and how to strategize for subsequent data gathering. Also of clinical interest was the progressive drop in distress as measured by SUDS scores, changes parallel to the decreases in CRTES, and SUDS scores observed in the Piedras Negras study. The nonexperimental design of this pilot field study has inherent limitations, and these results must be considered preliminary and heuristic. However, the results indicate that the continued use of the EMDR-IGTP warrants further and more rigorous study.

In the absence of any reports of negative impact resulting from the intervention, we tentatively conclude that EMDR intervention with children in a group format can be conducted with both safety and efficacy, and in a relatively short period of time. In our experience, the whole protocol takes 50 to 60 min. During that time, the team can work comfortably with 25 to 30 children and 40 to 50 adults. We



**Figure 7.** Average Subjective Units of Disturbance Scale (SUDS) score comparison for two eye movement desensitization and reprocessing integrated group treatment protocol projects in Mexico and Argentina.



**Figure 8.** Average pre- and posttreatment Child's Reaction to Traumatic Events Scale scores for two eye movement desensitization and reprocessing integrated group treatment protocol projects: Mexico (Piedras Negras), treatment on May 15, 2004, and posttreatment follow-up on June 12, 2004; Argentina (Santa Fe), treatment on July 28, 2003, and posttreatment follow-up on November 1, 2003.

recommend a ratio of one team member for eight clients/patients.

The protocol application takes between 50 to 60 min. During that time, a team of five clinicians

(one leading the protocol and four doing the EPT work) can treat 25 to 30 children. A total of 120 children in a day.

We recommend a ratio of 8 to 10 children for 1 mental health professional. Teachers can be of great help to the EPT, helping the children write their names, ages, and SUD numbers).

Subsequent to group treatment, the team can treat those who require individual follow-up attention, using the EMDR-IGTP in small groups or on an individual basis. Our experience in the field suggests that about 6% of those treated in a group setting require individual follow-up.

We end with a story told by one of the treated children to remind us of the individual pain and sorrow that can be overshadowed by the statistics of large-scale traumatic events. Here is how Rosa Irene described her drawings in Figures 1 and 2:

When the water came close to their home, her father helped her to climb up a tree near her house. Her mother helped Rosa Irene's siblings (9 and 7 years) to climb a tree in front of the house. The water destroyed their house and reached the top of the trees where they were. Her dad holds her very tightly and she escaped being washed away by the water. She saw how their mom could not hold her two siblings, and the smaller one was dragged away by the water, and on the following day they found him dead.

We are in agreement with Norris et al. (2004) who called for early and ongoing interventions with disaster victims, and believe the model we described can be applied in ways that respect cultural values of victims while offering hope and healing.

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