

EMDR EARLY INTERVENTION AND CRISIS RESPONSE: RESEARCHER'S TOOLKIT

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In 2013, the EMDR Research Foundation (aka the Foundation) established “Addressing the Global Burden of Trauma” as one of its research priorities. Whether natural or man-made, the Foundation supports research exploring the effectiveness of early EMDR interventions in response to trauma and disaster. The EMDR Early Intervention and Crisis Response: Researcher’s Toolkit was specifically designed to assist EMDR clinicians who provide early EMDR interventions as part of frontline trauma response and recovery. The primary goal of the Toolkit is to increase data collection and publication of studies in order to gain a better understanding of the most effective ways to intervene after a traumatic event.

The Toolkit is intended only for EMDR clinicians who have completed the standard EMDR Training and, ideally, are fully trained in the use of the selected specialty protocols. This brief introduction, the protocols, and the worksheets are not a substitute for adequate and appropriate training.

INTRODUCTION

Although there is expanding data documenting the utility of EMDR in response to trauma and crisis situations, much more is needed. Also, there is limited research comparing the effectiveness of the Early EMDR Intervention protocols (EIs) to other interventions or to the standard EMDR protocol. This includes both child and adult protocols and individual or group protocols.

For clinicians and crisis response teams, it can be difficult to collect data while, at the same time, providing services to those who are suffering. It is a vulnerable time. It is the Foundation’s hope that this Toolkit will assist EMDR clinicians to create response projects that include a solid research design and the sensitive gathering of meaningful data. In addition to disasters that impact groups or communities, it is also important to explore the impact of early treatment in individual traumas, such as rape, motor vehicle accidents, or violent death of a family member. In each instance, research is important to guide clinicians to a better understanding of how to best treat or even prevent the development of PTSD.

There are many factors to consider in the implementation of early intervention and crisis response. The initial stages of any project include careful planning and preparation. The Foundation is grateful to Marilyn Luber for her book, [*Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets*](#) (2014), Springer Publishing Company, LLC. In this major collection of Early EMDR Interventions, Dr. Luber and her contributors discuss their experiences in disaster response, elements to be considered in preparation, and the development and application of their programs and protocols. These clinicians address key aspects of planning, needs

assessment, resource development, team building, project definition, intervention, documentation, and follow-up, as well as vicarious trauma and care of the team members. These are vital components of a crisis response project, and the Foundation strongly encourages clinicians to refer to this valuable resource as well as others during the initial planning phase of any trauma or crisis response project.

Detailed scripted protocols with instructions and summary sheets may be found in *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets* (Luber, 2014). In order to maintain fidelity to these protocols, clinicians are encouraged to study this book and other resource materials.

The material included in the Toolkit have been created and designed to serve as a field guide for those already trained and familiar with these specialty trauma and crisis response protocols. This Toolkit outlines potential designs for the project and the research, selection of protocols, selection of measures, timing and collection of data, and the recording of that data. For a list of published studies on EMDR early interventions, please see Appendix E: "Research on EMDR early intervention protocols" compiled by Louise Maxfield, Ph.D. (2018)

For any intervention that includes the collection of data for research: It is necessary to inform the participant about the terms of engagement and to obtain appropriate informed consent. At the very least, the clinician should obtain a typical Informed Consent form to provide treatment. In most cases, a second form obtaining permission from the participant to be included in a research study will also be required. There are samples of clinical forms in Appendix A (pages 21-31), where you will also find a link to download an editable Word document. The specific requirements for these forms may vary by country. It is important to follow national and state professional guidelines, requirements, and/or recommendations for legal documentation.

In client information, specify if the participant is a child (17 or below) or adult (18 and over), male or female, type of trauma incurred, and length of time since the event. If possible and appropriate, get additional demographics, such as education, marital status, occupation, or other relevant demographics. In some situations, it may be possible to obtain scores on the [Adverse Childhood Experience \(ACE\) Questionnaire](#). This can be very useful in analyses of greater pools of data.

SELECTION OF DESIGN

RANDOMIZED CONTROL DESIGNS

While other less rigorous designs may be used to study treatment effects, the best way to determine the effectiveness of an intervention is to use a Randomized Controlled Trial (RCT) and to include a comparison or control group. Only then can it be claimed that the change has occurred because of the intervention and not by the passage of time or the changes in conditions (e. g., political, personal, or environmental). RCTs may be used to compare two interventions simultaneously (e. g., EEI vs. trauma-focused Cognitive Behavioral Therapy (tfCBT) or a single intervention with a control group). Perhaps the most important research

in crisis response would be using the RCT design comparing EMDR EI with a no-treatment control group. This would allow study of long term outcomes, such as the number of participants acquiring PTSD and/or major depression in the no-treatment group as compared to the treatment group. It is difficult, however, for crisis response teams to leave a group of survivors untreated. The following is an excellent guide for those working in crisis response or in low-income countries: *Design, Implementation, Monitoring, and Evaluation of Mental Health and Psychosocial Assistance Programs for Trauma Survivors in Low Resource Countries: User's Manual for Researchers and Program Implementers (Adult Version), Module 6: Using Controlled Trials to Assess Program Impacts*. This manual was developed by Johns Hopkins University Bloomberg School of Public Health, DIME Manual Module 6, September 2013. The full text link (pdf) from John Hopkins University can be found on the EMDR Research Foundation's site for download: [DIME](#).

There are additional resources available regarding Randomized Control Designs. See:

- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196997/>
- <http://himmelfarb.gwu.edu/tutorials/studydesign101/rcts.html>
- <http://www.socialresearchmethods.net/kb/destypes.php>.

Randomized Wait-List/Delayed Treatment Control Design:

In situations where a single intervention is to be delivered (e.g., Early EMDR Intervention), a randomized wait-list control design is often the design of choice. On the surface, this design may appear to be too difficult, inappropriate, or even unethical following a disaster. In these situations, however, the need often exceeds the capacity to provide services, and waiting is usually the norm. In this design, all potential participants are screened, and those selected are pre-tested and then randomly assigned to two groups. Half are treated immediately while the rest are pre/post tested after the “wait time,” and then treated as well, therefore the controlled trials can be conducted in such a way that those supplying the services can be fully utilized throughout the service delivery period and that those who wait would be no different in absence of the study. In addition, this type of design allows the service providers to identify those most in need and to help provide safety until treatment is available. If in danger, participants can be removed from the study and either be given immediate treatment or referred to emergency services.

Assignment of individuals to treatment groups should be done randomly so that there is no systematic difference between the groups (e.g., those who show up first and therefore have quicker access to services, those who appear to have the most need gain access to more rapid treatment). If treatment is to be given at the community level, then random assignment should be made at the community level.

Flow of the project is as follows:

1. Establish selection criteria
2. Screen all potential participants for selection criteria
3. Pre-test for all selected participants
4. Randomly assign those selected for intervention to Group 1 (treatment group) or Group 2 (wait-list control group)

5. Group 1
 - a. Administer intervention
 - b. Post-test

After determined waiting period (usually the length of time required to complete the process with Group 1) begin Group 2

6. Group 2
 - a. No-treatment waitlist period
 - b. Post-waitlist test (which also serves as Pre-test for the intervention)
 - c. Administer intervention (delayed treatment condition)
 - d Post-test

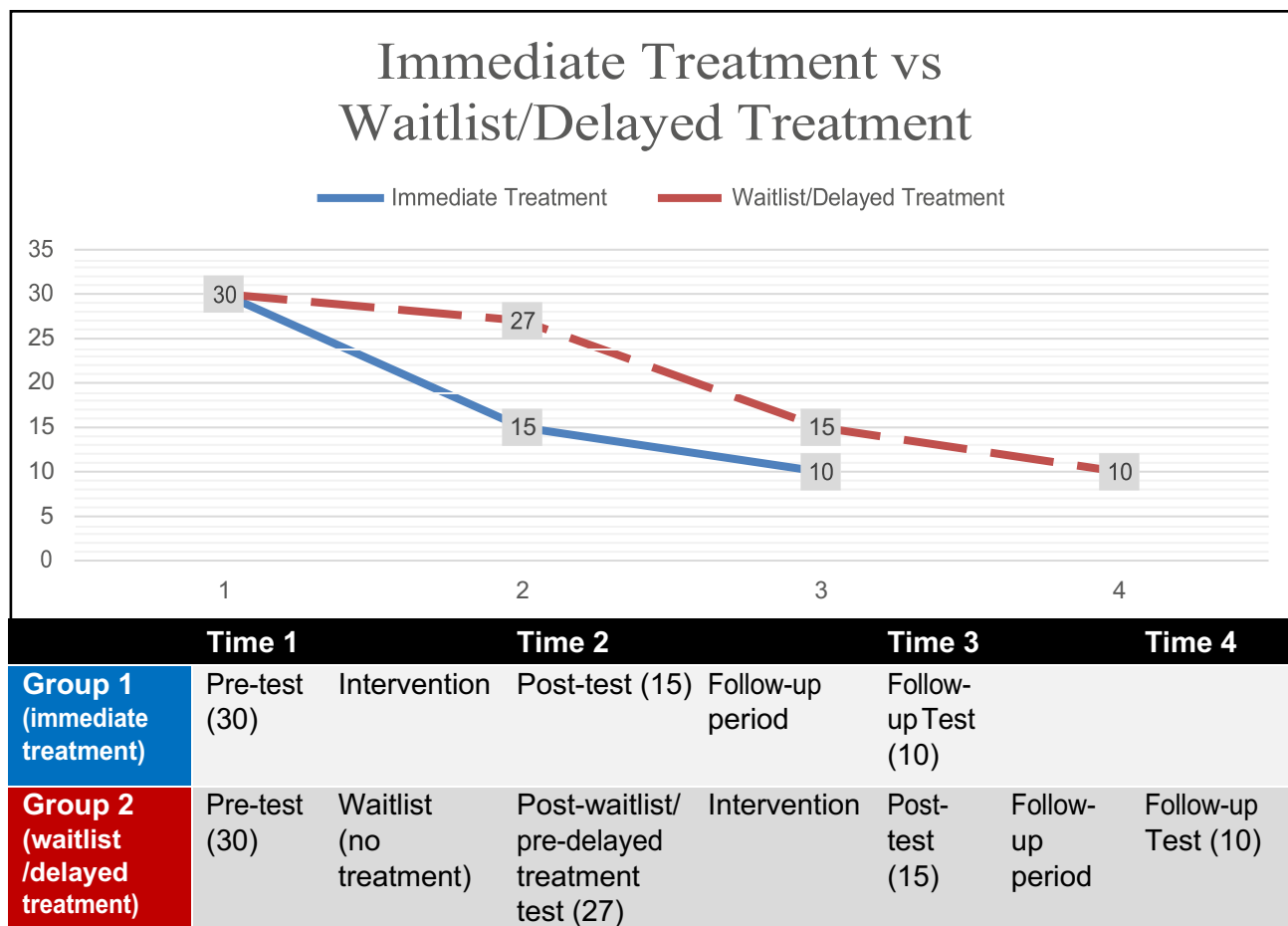
Note 1: The most important analysis in this study is the comparison of pre-post (Time 1 and Time 2) scores for the two groups. That analysis shows how much improvement there is with no-treatment and allows for the possible conclusion that treatment had an effect if time 2 treatment group score is improved compared to time 2 waitlist score.

After determined follow-up period:

7. Follow-up assessment for Group 1
8. Follow-up assessment for Group 2

Note 2: As it will increase the ability to obtain these important measures, it is often advantageous to train local staff to conduct the follow-up assessment.

Diagram of the design, with hypothetical scores in parentheses:



Randomized Wait-List Control Design with Consecutive Day Treatment (Example)

Just as outlined above, the RCT can be conducted as a wait-list control design when delivering consecutive days of treatment. After being screened for selection criteria, qualifying participants complete pre-test measures. They are then randomly assigned to Group 1 (Consecutive Day Treatment begins right away) or Group 2 (waitlist and Delayed Consecutive Day Treatment received after the specified waiting period—usually the length of time necessary to complete intervention for Group 1). Group 1 receives treatment, and post-treatment assessment. Following the wait period, Group 2 receives pre-treatment assessment, treatment, and then post treatment assessment. Both groups would receive follow-up assessment.

Randomized Comparison Group Design

Randomized Comparison Group Design is used when the researcher wants to compare two different treatments (e.g., EEI vs. trauma-focused CBT (tfCBT), or EEI vs. treatment as usual (TAU)). As outlined above, potential participants are all screened for the inclusion/exclusion criteria and then randomly assigned to treatment groups. For example, Group 1 might be receiving individual Recent Traumatic Episode Protocol (R-TEP) intervention and Group 2 might be receiving tfCBT. Both groups will be given pre-treatment measures, all participants will receive the designated treatment, and both groups will be given post-treatment measures. Then at the pre-designated follow-up, both groups will receive follow-up measures.

NON-RANDOMIZED DESIGNS

It is strongly recommended to use a randomized design rather than one of the choices below. Non-randomized field studies do not substantially add to the evidence base for EMDR and are much less likely to be published.

Non-Randomized Wait-List Control Design

While simpler to implement, Non-Randomized Wait-List Control Design introduces the likelihood of a systematic bias or confounding element that may bias the data or make it inaccurate if the treatments are applied in other situations. For example, if those who arrive at the treatment center first are in the treatment group and later arrivals are assigned to the control group, then the first group to arrive may be made up of individuals with more resources for mobility or they may be a group that was closer to the disaster and, therefore, potentially more impacted. The systematic bias may go either way but, in either case, it skews the data in one direction or another. It is strongly recommended that a randomized assignment to groups be utilized to give strength to the outcome measures.

Single Case Experimental Design:

The Single Case Experimental Design (SCED) can be used to test the effect of a treatment on a single participant where the participant acts as his or her own control. This can be useful when there are too few subjects to do a randomized controlled trial or when initially

exploring the effectiveness of an intervention. There are many variations of the SCED. For research on the effectiveness of one of the EEIs, the most likely choice would be a multiple baseline design since treatment cannot be meaningfully withdrawn. This would mean initial measures of behaviors or symptoms (the dependent variable), the introduction of the EEI (the independent variable) with continuing measurements, and then post-measures of the same behaviors or symptoms. The measurement of the behaviors or symptoms should occur early, frequently and consistently in order to most clearly demonstrate the impact of the treatment. The SCED can be repeated in any number of individuals. In multiple baseline studies, the intervention is introduced in a staggered sequence across individuals. If the change in the dependent variable repeatedly occurs after the introduction of the treatment, this can demonstrate a causal relationship between the treatment and the outcome (Hammond et al., 2014). All other aspects (e. g., selection of measures, selection of protocol, and treatment fidelity) will still apply.

Simple Data Collection:

There will be some situations (e. g., small numbers, the expense of the intervention, or if conducting a pilot study) where the best that can be done is simple data collection. In these situations, it is still important to define selection criteria, administer pre-treatment measures, provide the intervention, and administer post-treatment as well as follow-up measures. All other research aspects (e. g., selection of measures, selection of protocol, and treatment fidelity) will still apply. Be aware that this type of study is a field study and no definitive conclusions can be made with this type of design.

SELECTION OF INTERVENTION/PROTOCOL

The intervention should be carried out with fidelity to the protocol and with the same level of services, resources, and supervision as would usually be provided under the circumstances. Only then is it possible to determine the effectiveness of the intervention.

Fidelity to the selected protocol can be checked by asking a fellow clinician to observe and mark off each step of the protocol as it is being delivered by the clinician during the session. Planning and carrying out fidelity checks in randomly selected sessions ensures treatment fidelity and creates a stronger study.

Select the appropriate protocol based on the time elapsed since the event and whether it is to be an individual treatment or a group protocol. The treatment selected is often based on the numbers to be served and the capacity of the team. There are additional EMDR Early Interventions described in the literature.

For the purposes of this Toolkit, the focus will be on the following:

Stabilization protocols (Use within minutes or hours)

- **EMDR Emergency Room (EMDR-ER)** (Guedalia & Yoeli, 2003)
- **Emergency Response Procedure (ERP)** (Quinn, 2005, 2009)
- **Immediate Stabilization Procedure (ISP®)** (Quinn, 2018)

EEl protocols for individual treatment (Use from 24 hours to 78 hours)

- **URGent EMDR Treatment Protocol (URG-EMDR)** (Tarquinio, C. et al.; 2012, 2013).

EEl protocols for individual treatment (Use from two days to six months)

- **EMDR Protocol for Recent Critical Incidents (EMDR PRECI)** (Jarero & Artigas, 2011)
- **Recent Event Protocol (REP)** (F. Shapiro, 1995, 2001, 2018)
- **EMDR - Recent Traumatic Episode Protocol (EMDR R-TEP)** (E. Shapiro & Laub, 2008).

EEl protocols for group treatment (Use from two days and beyond)

- **EMDR Integrative Group Treatment Protocol (EMDR IGTP):**
 - **Adult** - (Jarero & Artigas, 2000)
 - **Adolescents (Between 14 and 17 Years) and Adults Living with Ongoing Traumatic Stress** (Artigas & Jarero, 2009)
 - **Early Intervention with Children** (Artigas, Jarero, Alcalá, et al, 2008)
- **Group Space EMDR Protocol (Formerly “IMMA Group Protocol.”)** Based on IGTP for children 5 years and older) (Laub & Bar-Sade, 2009, 2013)
- **Group Traumatic Episode Protocol (G-TEP)** (E. Shapiro, 2013).

Resources for stabilization

- **The Butterfly Hug** (Artigas et al, 2000)
- **The Four Elements Exercise for Stress Reduction/the Resource Envelope** (E. Shapiro & Laub, 2012)

ACCESS TO PROTOCOLS:

The protocols listed above, with links to additional information, resources, and related articles are available in the appendices (see Appendix C on pages 35-55.) For the most recent publications and complete information about the use of EEl protocols, please refer to these and other resources listed in the Francine Shapiro Library. Another effective way to access publications is through Google Scholar <https://scholar.google.com/>. As a reminder, these protocols are being provided for use only by graduates of an EMDR Standard Training Program that has been approved by a recognized EMDR Regional Association. Again, this Toolkit is intended only for **EMDR clinicians who have completed standard EMDR training and, ideally, are fully trained in the use of the specialty protocols referenced within it.**

An abbreviated field guide may also be found in the appendices. Special thanks to Beverlee Laidlaw-Chasse for granting permission to reproduce *The Pocket Guide to Early EMDR Interventions* (see Appendix D on pages 56-69.) In order to provide quick and easy reference to much-needed materials for clinicians in the field, the Pocket Guide was created and compiled as part of the development of the Arizona Trauma Response Network (AzTRAN). (<https://www.aetr2n.net/>). The website is a valuable resource for EMDR therapists involved with trauma and disaster response.

Abbreviated field guides for the following protocols may be found in the **Pocket Guide**:

- **REP—Recent Event Protocol** (F. Shapiro, 1995, 2001, 2011, 2018)
- **EMDR-ER—EMDR Emergency Room** (Guedalia & Yoeli, 2003)
- **ERP—Emergency Response Procedure** (Quinn, 2005, 2009)
- **EMDRR-TEP—EMDR Recent Traumatic Episode Protocol** (E. Shapiro & Laub, 2008)
- **EMDR PRECI—EMDR Protocol for Recent Critical Incidents** (Jarero & Artigas, 2011)
- **EMDR IGTP—EMDR Integrative Group Treatment Protocol – Adult** (Jarero & Artigas, 2000, 2009)
- **EMDR G-TEP—EMDR Group Traumatic Episode Protocol** (E. Shapiro, 2013)

The **Pocket Guide** also includes:

- **The Four Elements Exercise for Stress/Resource Connection Envelope - Abbreviated Version** (E. Shapiro and Laub, 2012)
- **The Trauma Response Information Sheet** (AZTrn.org, 2014)

SELECTION OF MEASURES

Screening:

All participants should be screened and selected for treatment according to the selection criteria at the beginning of participation in the study. All selection criteria should be built into the study instrument so that it can easily be determined from these records whether an individual was included or excluded correctly. The screening process should also include questions about safety and self-harm. Clients who might be in danger should be monitored for safety and referred for additional care as indicated.

Assessment:

After being screened and determined appropriate for the study, participants are (randomly) divided into groups. Each participant should be given the selected measurements before and at the completion of the intervention and at a prescribed follow-up interval. These assessments should be done by trained interviewers or persons trained in the use of the selected measures whenever possible. In order to reduce any stake in the outcome and decrease the possibility of introducing a bias to the results, the assessments should not be completed by the program implementers. So as to reduce potential bias, it is best to have assessments completed by a program implementer who is unknown to the participants. If not possible, one provider could conduct the pre-treatment assessment while another conducts the post-treatment and follow-up assessments.

Except for the Clinician-Administered PTSD Scale (CAPS), the measures listed here are self-report measures that can be administered in five to ten minutes and can be given individually or in groups. Typically, these measures are administered pre-treatment, post-treatment, and at a pre-determined follow-up. These measures are often used for disaster response research or for studies following a disturbing life event. Additional measures should be considered for specific situations or for specific populations.

In Appendix B (pages 32-34) of this document you will find a Table of Measures with information and links to the following measures:

- **Brief Resilience Coping Scale (BRCS)**
(Sinclair and Wallston, 2004)
- **The Children's Revised Impact of Event Scale (CRIES)**
(Perrin S., Meiser-Stedman R., Smith P., 2005)
- **The Clinician Administered Clinician PTSD Scale for DSM-5(CAPS-5)**
(Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M., 2013)
- **Impact of Events Scale. Revised (IES-R)**
(Weiss, D. and Marmar, C., 1977)
- **PTSD Checklist for DSM 5 (PCL-5)**
(Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. 2013)
- **The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT)**
(Connor, K., and Davidson, J., 2001)

FOLLOW UP

The follow-up interval should be determined by the amount of time contact will be maintained with the participants. Depending on circumstances, it can be difficult to maintain contact in disaster situations. Follow-up may range from one month to three or six months. It is important to be realistic in planning. Be sure to include mechanisms for continued contact to obtain follow-up measures. It is often useful to train local staff to administer the follow-up measures. This helps to obtain these measures and minimizes the amount of time that the researchers must remain in the field.

IMPLEMENTATION AND MONITORING

Note: Please see [*Design, Implementation, Monitoring, and Evaluation of Mental Health and Psychosocial Assistance Programs for Trauma Survivors in Low Resource Countries: User's Manual for Researchers and Program Implementers \(Adult Version\), Module 6: Using Controlled Trials to Assess Program Impacts \(DIME\)*](#) for additional discussion of each of these components.

The project should include plans for monitoring and documenting all aspects, including:

- Fidelity of recruitment, inclusion and exclusion criteria
- Fidelity of treatment
- Fidelity of assessment
- Monitoring participants for signs of danger (e. g., suicidality)
- Monitoring each contact, data point

COLLECTION OF DATA

In situations of recent trauma or natural disaster, it is a challenge to plan, collect, collate, and maintain sufficient data. This requires careful planning and sufficient staff. Please consider what, how, and where information will be collected and by whom, how it will be collected and stored, and who will transform the information into a useable format. It is helpful to appoint a member of the team to be responsible for all of the documentation. Excel spreadsheets designed specifically for the information to be collected work well. It is suggested that all forms be easy to understand and to complete. At a minimum, there will be records of the initial contact with demographic information, safety assessment, and inclusion/exclusion criteria. Written consent for treatment should be obtained as well as signed permission from the individual to be included in a research study and to have data collected. There will be tracking logs to document each contact point, services provided, pre, post, and follow-up measures. Examples of forms and tracking logs can be found in the DIME article.

With the exception of the CAPS-5, the measures included here are self-report measures that can be completed in five to ten minutes and can be administered individually or in groups. Sufficient copies of the assessment tools should be readily available and, if hard copies are being used, may be attached to each participant file for easy access and recording of responses. Alternately, if computers and internet access are available, it may be ideal to have raw data immediately sent electronically to a data collection point.

Measures should be administered at pre-intervention, post-intervention and follow-up, ideally at three to six months. Due to conditions in the field, the availability of personnel, and the mobility of participants, it is often difficult to get follow-up measures past 30 days. It may be useful to train local personnel in administration of the measures to assist with follow-up data.

PUBLICATION

The following is an outline of requirements for publication in the Journal of EMDR Practice and Research. Other journals may require different formatting styles, so it is important to check with each prior to submission of your manuscript. For a list of published studies on EMDR early interventions, please see Appendix E: "*Research on EMDR early intervention protocols*" compiled by Louise Maxfield, Ph.D. (2018) on pages 70-72.

General Directions

- Manuscripts must be professionally prepared in accordance with the *Publication Manual of the American Psychological Association*, 6th edition, 2010.
- Manuscripts should be double-spaced throughout, with one inch margins and size 12 Times font. They should be no more than 35 double-spaced pages in length (about 9000 words) including references, tables, and figures, etc.
- Photos and line art figures should be sent as tiff or jpg (300dpi) or eps (800ppi) files.

Authors are responsible for obtaining written permission from copyright owners for illustrations, adaptations, or quotes of more than 300 words.

Specific Directions

Title

The title should be no longer than 15 words.

Abstract

The abstract can be up to 225 words in length. It should be a single paragraph, contain a brief comprehensive summary of content, mentioning problem, participant(s), design, results, and conclusions. Include 4 to 6 keywords or terms, listed below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

Literature Review

All articles must contain a comprehensive literature review. For example, a manuscript describing EMDR treatment of a certain disorder would summarize the literature about the nature of that disorder, review research studies that investigated outcomes of other treatments, as well as studies that evaluated EMDR treatment of that disorder. With the exception of seminal sources, the reviewed literature should be current and published within the last 10 years.

Description of EMDR therapy

Because articles are available online, accessible to naïve uninformed readers, they should provide a brief adequate description of EMDR therapy, and, if appropriate, a brief description of the adaptive information processing model.

Description of comparative therapy or condition/s

If this is a study with a comparative condition, the paper should provide an adequate description of the comparative therapy or condition/s (enough so that a naïve uninformed reader can understand the paper). If a therapy is compared to EMDR, its description should be made in an unbiased manner, similar in length, style, and tone to the EMDR description. If appropriate, the description could include a brief description of the treatment's theoretical basis.

Research question/s

Studies should succinctly articulate their research question(s) and/or hypotheses. The focus and purpose of the paper should be clearly stated.

Method

Provide labelled sections for each of the following areas, as needed.

Design/Procedure

A clear description of design should be provided, including steps taken to avoid bias.

Participants

Articles must provide information about how participants were selected and inclusion/exclusion criteria. If this is a case series, it is important that the participants include ALL CONSECUTIVE clients who met inclusion criteria. This should include those who dropped out of treatment, and those who did poorly, as well as those who did well.

Measures

If possible, diagnostic assessments at pre-post are recommended. The study should provide each measure's psychometric information, and report when they were administered, and who administered them. Include descriptions of SUD and VOC scores if these are used in the study.

Treatment/s

The description of treatments should contain sufficient detail, so that they can be replicated. If deviations to standard procedures were used, include reasons for the modifications and describe any research support for the modification. Therapists' qualifications should be described. If treatment fidelity was assessed, that should also be stated.

Case Description/s

One of the advantages of case studies is that they provide rich detailed contextual information about treatment provision and response. A single case study is expected to provide more detailed information than case series, and it should include information about initial presentation, history, assessment, treatment, and results (outcome and follow-up). The course of treatment should be laid out clearly, and the therapist's decision points identified and explained. Case studies often organize treatment chronologically.

Results

Descriptive and quantitative data and participant flow should all be clearly reported. Appropriate analyses should be conducted and reported using standard conventions. Explanations and interpretations of the results should not be included in the Results section. When appropriate the use of effect sizes is recommended. The same results should not be reported in both a figure and a table.

Discussion

The Discussion should evaluate, interpret, and explain the implication of results. It should include a discussion of theoretical, clinical, and/or practical consequences, and link findings to prior publications. It should also explain limitations and make recommendations for future research.

References

The Reference section should be formatted according to APA style.

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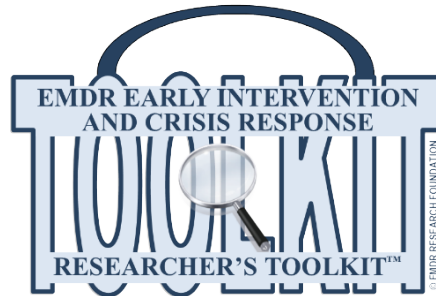
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TOOLKIT USER REGISTRATION



Please complete our online [**EMDR EARLY INTERVENTION AND CRISIS RESPONSE: RESEARCHER'S TOOLKIT USER REGISTRATION FORM**](#) so that we can send you Toolkit updates, information, and opportunities. In addition, this information will help us to know how the Toolkit is being used so that we can be aware of what is useful to those conducting EMDR early intervention and crisis response research now and in the future.



EMDR EARLY INTERVENTION AND CRISIS RESPONSE: RESEARCHER'S TOOLKIT

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For the latest Toolkit version, go to <http://www.emdrfoundation.org/resources/toolkit>

APPENDIX A: SAMPLES OF CLINICAL FORMS

On the following pages you will find examples of clinical forms to adapt for your use.

APPENDIX A: SAMPLES OF CLINICAL FORMS	
SAMPLE OF CLINICAL FORM	TOOLKIT PAGE #
Summary of Contact with Client	22
Client Information Form	23-24
Adult Consent Form	25-27
Consent for Older Child	28-29
Consent Parents for Child	30-31
<i>These forms should be adapted to the situation and particular needs of the project</i>	

You can also access these form samples to adapt to your own use in editable Word documents and the same PDF version at our website:

- [Full-text LINK to Word version of samples of clinical forms](#)
Note that when you click on this link, the editable Word document (.docx) will download to your computer or device. Please check the regular location on your computer or device for downloaded documents.
- [Full-text LINK to PDF version of samples of clinical forms](#)
This is a downloadable PDF of Appendix A.

SUMMARY OF CONTACT WITH CLIENT

[illegible]

Therapist Signature

Therapist Name Date

CLIENT INFORMATION (SAMPLE)

Please fill out the following form as completely as possible.

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male

Home Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

Home: () _____ Can we leave a message at this number? ☐ Yes ☐ No

Work: () _____ Can we leave a message at this number? ☐ Yes ☐ No

Cell: () _____ Can we leave a message at this number? ☐ Yes ☐ No

Marital Status

☐ Single ☐ Divorced (___ years) ☐ Living as Married (___ years)

☐ Married (___ years) ☐ Separated (___ years) ☐ Widowed (___ years)

Spouse's/Partner's Name: _____

If we are unable to reach you, is it OK to contact your spouse/partner? ☐ Yes ☐ No

If yes, spouse/partner's phone number: () _____

Names and ages of children (if any):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any other individuals who live in your home? ☐ Yes ☐ No

If yes, please indicate name and relationship: _____

Emergency Contact Information

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and the rules of my profession to contact someone close to you (relative, spouse, close friend).

Name: _____

Address: _____

Phone: () _____ Relationship to you: _____

Referent

By whom were you referred? _____

Other Professionals Involved in Your Treatment

Medical Provider/Clinic Name: _____

Address: _____ Phone: _____

May I have your permission to contact this person for continuity of care? ☐ Yes ☐ No

Psychiatric Provider/Clinic Name: _____

Address: _____ Phone: _____

May I have your permission to contact this person for continuity of care? ☐ Yes ☐ No

Type of trauma experienced:

Date, or length of time since it occurred _____

Education:

- | | |
|---|--|
| <input type="checkbox"/> Primary school | <input type="checkbox"/> College graduate |
| <input type="checkbox"/> High School | <input type="checkbox"/> Graduate program |
| <input type="checkbox"/> Trade School | <input type="checkbox"/> Professional Degree |

Employment Status:

Are you employed? ☐ Yes ☐ No Are you using EAP? ☐ Yes ☐ No

Employer Name: _____ - _____

Position: _____

Thank you!

SAMPLE CONSENT APPROPRIATE FOR ADULTS

NOTE: You can either modify the Consent Template for Adults or use the below sample letter to obtain written consent. The information in this letter must include all of the following elements found in the Consent Form for Adults, which contains detailed information about each element:

**TITLE OF PROJECT
RESEARCHER'S NAME(S) AND CONTACT
INFORMATION PURPOSE OF STUDY
DURATION AND LOCATION OF
STUDY PROCEDURES
POTENTIAL RISKS AND
DISCOMFORTS BENEFITS
CONFIDENTIALITY/ANONYMITY
COMPENSATION FOR
PARTICIPATION RIGHT TO
REFUSE OR WITHDRAW OFFER
TO ANSWER QUESTIONS**

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study entitled (fill in title of project) conducted by (researcher's name), and (affiliation)

WHAT THE STUDY IS ABOUT:

The purpose of this research study is to ... (Describe the purpose or objectives of the research clearly and concisely in language appropriate to the subject population).

WHAT WE WILL ASK YOU TO DO:

During this study, the following will happen.... (As clearly as possible, describe in lay language, step by step, what you will ask the participant to do or what will be done to the participant).

DURATION AND LOCATION OF THE STUDY:

Your participation in this study will involve (give expected duration, number of sessions, and time frame of the sessions, e.g., "one session that lasts one hour"; "three 30-minutes sessions once a week for three weeks"). The study will take place (give location of study).

SAMPLE CONSENT FORM APPROPRIATE FOR ADULTS, page 1 of 3

POTENTIAL RISKS AND DISCOMFORTS:

The research procedures described above may involve the following risks and/or discomforts: (Outline any foreseeable risks--physical, psychological, social, economic, legal--that might be greater than those encountered in everyday life and note any expected discomforts participants may encounter, explaining their likelihood and significance.) If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

MEDICAL CONCERNS:

If you have any medical issues that might impair your ability to take part fully in treatment, you should contact your medical provider to get clearance for participating in EMDR. If you have any legal issues that might be impacted by your treatment, you should contact your attorney to discuss this form of treatment and get clearance for participating in this study.

BENEFITS:

The possible benefits to you of participating in this study are (describe) _____.

PRIVACY/CONFIDENTIALITY:

(NOTE: Anonymity means that no identifying information such as name or student ID number is collected, so the privacy of participants is assured. Confidentiality means that the researcher (or perhaps the instructor) will have a record of who participated but the data will be kept private.)

Because you will not be providing any information that can uniquely identify you (such as your name), the data you provide will be anonymous.

OR

Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will ... [explain how you will keep their names and data secure and who will have access to the data, e.g., your research assistants, your advisor, your teacher, your classmates.]

(NOTE: If there is a master list that includes the participant's name and a code linking the name to the data, this must be made explicit to participants and the master list must be kept secure and separately from the collected data. Explain when the consent forms and any other identifiable data will be destroyed. Note: The IRB requires PIs to keep consent forms for 3 years. You do not ever have to destroy raw data but at some reasonable point, you should destroy anyone's ability to link the participants' data to identifying information.)

COMPENSATION/PAYMENT FOR PARTICIPATION:

There is no payment or other form of compensation for your participation in this study.

OR

You will receive _____ for your participation in this study. If you choose to withdraw before completing the study, you will receive _____.

SAMPLE CONSENT FORM APPROPRIATE FOR ADULTS, page 2 of 3

(NOTE: If participants are to be compensated or paid, specify compensation [e.g. research participant pool credit; extra credit for course] or dollar amount and address the matter of proration if participant withdraws or if the study is terminated by the researcher. If there is no compensation, specify that that is the case by saying that there will be no financial compensation for participation in the study.)

VOLUNTARY NATURE OF THE STUDY:

Your participation is voluntary and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty or loss of benefits [or describe how it may be prorated for early withdrawal]. In addition, the researcher has the right to withdraw you from participation in the study at any time.

(NOTE: PI may omit the phrase "loss of benefits" if it does not apply to the research. If participants are students, patients, or employees, explicitly note that nonparticipation or withdrawal from the study will not affect their grade, employment status, or treatment, as appropriate.)

OFFER TO ANSWER QUESTIONS:

Please ask any questions you have now. If you have questions later, you should contact the principal investigator: (name of PI) at (phone number) or (email address).

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

PARTICIPANT'S SIGNATURE

DATE

ADDITIONAL ITEMS TO NOTE:

EXPERIMENTAL TREATMENTS: When appropriate, be sure to explicitly identify any procedures that are experimental and disclose appropriate alternative procedures or courses of treatment, if any, which might be advantageous to the subject;

GREATER THAN MINIMAL RISK STUDIES: For research involving more than minimal risk, include an explanation as to whether any compensation or medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained. In addition, explicitly note who to contact in the event of a research-related injury to the subject.

VIDEO AND AUDIO RECORDINGS: For studies in which audio or video recording of participants are to be made, the consent form should include information as to why the recordings are needed for the research, where and how they will be stored and identified, and what will be done with them upon completion of the research (e.g., archived after transcription, kept indefinitely, destroyed after X years).

EXAMPLE: CONSENT FOR AN OLDER CHILD

(Date)

Dear _____:

Identify yourself, your position, the request and a description of the study

*My name is _____ and I am (state your position or affiliation). I am asking you to participate in a project that examines the effectiveness of an intervention for children/adolescents who have suffered a traumatic event).

Outline the procedure to screen for eligibility, the requirements of the study, rights to discontinue, risks, and confidentiality

*I am asking you to fill out 3 short questionnaires that will take less than 30 minutes. After filling out the forms, if you are eligible to participate, you will be invited to participate in a study and receive 4-6 sessions of EMDR. After you receive the therapy, you will be asked to fill out 2 questionnaires again and you will then be asked again 3 and 6 months later to fill out the same 2 forms again. Your parents or legal guardians have already given permission for you to participate in this study, but you do not have to participate if you do not want to. You may quit this study at any time by simply telling me that you do not want to continue. You can skip any questions or tasks that you do not want to complete. Your participation in this study will not affect your grades in anyway. There are no known risks involved in this study and you will receive nothing for your participation. To protect your confidentiality, your responses will not be shared with anyone unless required by law. Your teacher will not know if you chose to participate in this project and neither your parents or teacher will know any of answers to your questions which will be kept by me.

Provide your contact information

If you have any question about this study, please contact me at _____. Sincerely

yours,

Signature

Professional signature line

*Example of information to be included

EXAMPLE: CONSENT FOR AN OLDER CHILD, page 1 of 2

Agreement

I agree to participate in this research project and I have received a copy of this form.

Student's Name (Please Print) *Date*

Student's Signature

I have explained to the above named individual the nature and purpose, benefits and possible risks associated with participation in this research. I have answered all questions that have been raised and I have provided the participant with a copy of this form.

Researcher *Date*

EXAMPLE: CONSENT FOR AN OLDER CHILD, page 2 of 2

SAMPLE OF PARENT PERMISSION FOR CHILD

(Date)

Dear Parents,

My name is (research assistant's name) and I am a (give name, position, and role within the research project). We are writing this letter to explain why we would like for you and your child to participate in our research project *Group Intervention Study for Children and Adolescents and their Parents Exposed to Trauma*. We are studying the effectiveness of an intervention with children/adolescents and their parents called the Integrative Trauma Group Protocol-Eye Movement Desensitization and Reprocessing (IGTP-EMDR) on disturbing symptoms that can result from a traumatic event. There are a variety of EMDR protocols with the IGTP protocol that has been developed specifically for use in groups. When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings and body sensations. This protocol seems to stimulate the information and allows the brain to reprocess the experience to a healthy, adaptive resolution. That may be what is happening in REM or dream sleep.

If your child is eligible to participate and you and s/he agree, s/he will be in a group with 3 other children and 2 therapists for a one-day workshop that will last no longer than 6 hours. The IGTP-EMDR protocol consists of the following: your child will be asked to imagine a place that feels calm and safe and to draw a picture of that place and then to gently pat their upper chest with their opposite hand for a minute.

The IGTP-EMDR is also called the "butterfly hug". Your child can share their calm place with the group if s/he wishes but does not have to. Then your child will be asked to draw a picture of the most disturbing part about what happened to them. Your child will not be asked to share what is disturbing with anyone but to only draw the picture. Your child will repeat the butterfly hug while looking at their drawing. This will be repeated 3-4 more times as needed until it is less disturbing. The group will end with a positive picture about how your child would like to feel in the future. We would like to see if this intervention helps to decrease disturbing symptoms in the present and strengthens your child's well-being in the future. Parents will also be offered a one day workshop explaining trauma symptoms and will also participate in the same protocol as their children as described above. Parents do not have to participate in this study to attend the workshop. If you do not want your child to participate, your child can still get help through a referral to an individual therapist.

With your permission if your child participates, I will ask your child to complete 2 short questionnaires that would take less than 20 minutes and if your child is eligible to participate, then s/he will be asked to fill out 2 more forms again taking less than 20 minutes to fill out prior to the group. Your child, if eligible, will be invited to attend a one day workshop with 3 other children led by 2 licensed mental health providers. Your child's participation in this study is completely voluntary and will not affect his or her grades in any way. Your child may quit this study at any time by simply saying "Stop" or "I do not wish to participate." You will also be asked to fill out 2 forms about your child that will take about 15 minutes. If your child is eligible to participate in this project, then you will be contacted and asked to fill out 1 questionnaire again after your child the group ends and then again at 3 and 6 months later. Your child will be asked to fill out 2 questionnaires again at the end of EMDR and then again 3 and 6 months later. If you the parent wish to participate in the study, you will be asked to fill out 2 forms before and after the workshop and then again 3 and 6 months later. The forms that you and your child will be asked to fill out measure symptoms of trauma and it is hoped that this workshop will help to decrease these symptoms.

SAMPLE OF PARENT PERMISSION FOR CHILD, page 1 of 2

The study will be conducted at the therapist's office. There are no known risks involved in this study and neither you nor your child will receive any compensation for his or her participation. To protect you and your child's confidentiality, your child's name nor your name will not appear on any record sheets. The information obtained will not be shared with anyone, unless required by law. The records will be maintained by me. If you have any questions, please contact **(Give name and contact information for the person who is in charge of the study)**. If you or your child does not want to participate, your child will be referred to a therapist for individual psychotherapy.

It is hoped that disturbing symptoms will be decreased and there is some preliminary research that shows that the IGTP-EMDR protocol does decrease disturbing symptoms caused by an adverse experience. If there is any discomfort experienced by your child in the group, s/he will be receive stabilization if in the clinical judgment of the therapists this is warranted and the referred for individual therapy. This letter will serve as a consent form for your child's and your participation and will be kept **(state where the records will be maintained)**. If you have any questions about you or your child's rights as a participant, please contact **(Give name and contact information of person who can give further information about the study)**.

Sincerely yours,

Signature

Professional signature line

APPENDIX B: TABLE OF MEASURES – PAGE 1

Measure and link	Citation/Versions	Description	Additional Resources/Discussion
Brief Resilience and Coping Scale (BRCS) TOOLKIT LINK: <u>BRCS</u>	<p>Sinclair, V. G., & Wallston, K.A. (2004). The development and psychometric evaluation of the Brief Resilient Coping Scale. <i>Assessment</i>, 11 (1), 94-101. https://www.ncbi.nlm.nih.gov/pubmed/14994958</p> <p>From the abstract: "(T)he Brief Resilient Coping Scale (BRCS) is a 4-item measure designed to capture tendencies to cope with stress in a highly adaptive manner. The BRCS has adequate internal consistency and test-retest reliability. Convergent validity of the scale is demonstrated by predictable correlations with measures of personal coping resources (e.g., optimism, helplessness, self-efficacy), pain coping behaviors, and psychological well-being. ... The sensitivity of the BRCS to changes associated with a cognitive-behavioral intervention is also demonstrated. The BRCS may be useful for identifying individuals in need of interventions designed to enhance resilient coping skills."</p>	<p>Description: The BRCS is in the public domain and can be used for research and education as long as it is properly cited and as long as the authors are acknowledged (Sinclair & Wallston, 2004) It consists of 4 items scored on Likert scale 1-5.</p> <ul style="list-style-type: none"> • Administration: Self Report • Length of Time: A couple minutes • Details: See https://www.psychtoolkit.org/survey-library/resilience-brcs.html#refs • Publicly Available: An online, self scoring version of the BRCS is available at https://www.psychtoolkit.org/survey-library/resilience-brcs.html# 	<p>The possible score range on the BRCS is from 4 (low resilience) to 20 (high resilience): <i>Low resilient copers: 4-13 points</i> <i>Medium resilient copers: 14-16 points</i> <i>High resilient copers: 17-20 points</i></p> <p>This easily administered Resiliency Scale has been added to measure personal coping resources and to help identify which individuals are more likely to engage adaptive coping mechanisms following crisis events or stressful situations. For more information, please see the 2004 article by Sinclair & Wallston and the following articles:</p> <p>Kocalevent, R.-D., Zenger, M., Hinz, A., Klapp, B., & Brähler, E. (2017). Resilient coping in the general population: standardization of the brief resilient coping scale (BRCS). <i>Health and Quality of Life Outcomes</i>, 15, 251. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5746021/</p> <p>Cosco, T. D., Kaushal, A., Richards, M., Kuh, D., & Stafford, M. (2016). Resilience measurement in later life: a systematic review and psychometric analysis. <i>Health and Quality of Life Outcomes</i>, 14, 16. http://doi.org/10.1186/s12955-016-0418-6</p> <p>Spanish Version: Tomás, J. M., Meléndez, J. C., Sancho, P., & Mayordomo, T. (2012). Adaptation and initial validation of the BRCS in an elderly Spanish sample. <i>European Journal of Psychological Assessment</i>.</p>
Children's Revised Impact of Events Scale – CRIES (13) TOOLKIT LINKS: <u>CRIES-13</u> <u>CRIES-8</u>	<p>Perrin S, Meiser-Stedman R, Smith P (2005) The Children's Revised Impact of Event Scale (CRIES): Validity as a screening instrument for PTSD. <i>Behavioural and Cognitive Psychotherapy</i> 33: 487–498. doi:10.1017/s1352465805002419</p> <p>Versions: <u>CRIES-13</u> includes arousal items; while <u>CRIES-8</u> lacks any arousal items.</p>	<p>Adapted from the IES (see above) the CRIES-13 is a brief measure designed to screen children at risk for Posttraumatic Stress Disorder (PTSD).</p> <ul style="list-style-type: none"> • Administration: Self-administered (can be used in groups) • Length of Time: 5-10 minutes • Details: 8 original items plus 5 • Publicly Available: Yes: http://www.childrenandwar.org/measures/ <p><u>-English</u> <u>-Spanish</u></p>	<p>Use and analysis regarding the revisions for children: Dyregrov, A., Kuterovac, G. & Barath, A. (1996) Factor analysis of the Impact of Event Scale with children in war. <i>Scandinavian Journal of Psychology</i>, 36, 339-350.</p> <p>Smith P, Perrin S, Dyregrov A, Yule W (2003) Principal components analysis of the impact of event scale with children in war. <i>Personality and Individual Differences</i> 34(2):315–322. doi: 10.1016/s0191-8869(02)00047-8</p> <p>Yule W, Bruggencate ST, Joseph S (1994) <u>Principal components analysis of the impact of events scale in adolescents who survived a shipping disaster. Personality and Individual Differences</u> 16(5):685–691. doi:10.1016/0191-8869(94)90210-0</p>

APPENDIX B: TABLE OF MEASURES – page 2

Measure and link	Citation/Versions	Description	Additional Resources/Discussion
Clinician Administered PTSD Scale for DSM-5 (CAPS-5) TOOLKIT LINK: CAPS-5 request form	<p>Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). <i>The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)</i>.</p> <p>Versions: CAPS for DSM-IV: Blake, D.D., Weathers, F.W., Nagy, L.M., Kaloupek, D. G., Gusman, F.D., Charney, D.S., & Keane, T.M. (1995). The development of a clinician-administered PTSD scale. (PDF) Journal of Traumatic Stress, 8, 75-90. Doi: 10.1002/jts.2490080106</p> <p>Three versions of the CAPS-5 correspond to different time periods: past week, past month, and worst month (lifetime). A version for children and adolescents (CAPS-CA for DSM-IV) is available, with a version currently being revised to correspond to DSM-5.</p>	<p>Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is a 30-item structured interview that corresponds to the DSM-5 criteria for PTSD. It is the gold standard in PTSD assessment.</p> <ul style="list-style-type: none"> • Administration: A CAPS trained clinician • Length of Time: 45-60 minutes (decreases with repeated administrations) • Details: 30-item, frequency and intensity of symptoms in past week Companion administration manual covers scoring; workshops are also offered <p>Publicly Available: Yes, request through Department of Veteran Affairs</p>	<p>CAPS Training: To learn about training to give a CAPS assessment, see CAPS Training Information.</p> <p>Interview available from the National Center for PTSD at www.ptsd.va.gov.</p>
Impact of Events Scale. Revised (IES-R) TOOLKIT LINKS: IES IES scoring	<p>Impact of Events Scale. Revised (IES-R) Weiss, D and Marmar, C. (1977) in J. Wilson and T. Keane, Assessing Psychological Trauma and PTSD. New York. Guilford.</p> <p>Versions: Original 15 item Impact of Events Scale: Horowitz, M. J., Wilner, N., and Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. Psychosom. Med., 41, 209-218.</p>	<p>Widely used 22 item self-report measure designed to assess current subject distress for any specific life event. Available in English, Spanish, and other languages.</p> <ul style="list-style-type: none"> • Administration: Self report • Length of Time: 5-10 minutes • Details: 22 items • Publicly Available: Yes. Contact Daniel Weiss, PhD. Department of Psychiatry, University of California. San Francisco, PO Box F-0984, San Francisco, CA 94143-0984, Phone: (415) 476-7557 Email: daniel.weiss@ucsf.edu or hugos@lppi.ucsf.edu 	<p>Impact of Event Scale - Revised (IES-R). (Weiss & Marmar, 1997)</p> <p>Christianson, S, and Marren, J., (2013) <i>The Impact of Events Scale-Revised (IES-R)</i>. From the Hartford Institute for Geriatric Nursing, New York University, College of Nursing. Issue 19. IES-R</p>

APPENDIX B: TABLE OF MEASURES - page 3

Measure and link	Citation/Versions	Description	Additional Resources/Discussion
PTSD Checklist for DSM 5 (PCL-5) TOOLKIT LINK: PCL-5 PCL-5 with criterion A	<p>Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5).</p> <p>The previous version: PCL for DSM-IV has three versions, PCL-M (military), PCL-C (civilian), and PCL-S (specific), which varies slightly in the instructions and wording of the phrase referring to the index event. PCL-5 is most similar to the PCL-S (specific) version. There are no corresponding PCL-M or PCL-C versions of PCL-5. Although there is only one version of the PCL-5 items, there are three formats of the PCL-5 measure, including one without a Criterion A component, one with a Criterion A component, and one with the LEC-5 and extended Criterion A component.</p>	<p>The PCL-5 is a 20 item self-report measure that assesses the 20 DSM 5 symptoms of PTSD. The wording of PCL-5 items reflects both changes to existing symptoms and the addition of new symptoms in DSM-5.</p> <p>The PCL-5 has a variety of purposes, including monitoring symptom change during and after treatment, screening individuals for PTSD, and making a provisional PTSD diagnosis.</p> <ul style="list-style-type: none"> • Administration: Self-report • Length of Time: 5-10 minutes • Details: Interpretation should be made by a clinician. There are several options for scoring. <p>Publicly Available: Yes, request through Department of Veteran Affairs: http://www.ptsd.va.gov/professional/assessment/ncptsd-instrument-request-form.asp</p>	<p>The self-report rating scale is 0-4 for each symptom, reflecting a change from 1-5 in the DSM-IV version. Rating scale descriptors are the same: "Not at all," "A little bit," "Moderately," "Quite a bit," and "Extremely."</p> <p>The change in the rating scale combined with the increase from 17 to 20 items means that PCL-5 scores are not compatible with PCL for DSM-IV scores and cannot be used interchangeably.</p> <p>PCL for DSM-IV:</p> <p>Bliese, P. D., Wright, K. M., Adler, A. B., Cabrera, O., Castrol, C. A., & Hoge, C. W. (2008). Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. <i>Journal of Consulting and Clinical Psychology</i>, 76, 272-281. doi: 10.1037/0022-006X.76.2.272</p> <p>Monson, C. M., Gradus, J. L., Young-Xu, Y., Schnurr, P. P., Price, J. L., & Schumm, J. A. (2008). Change in posttraumatic stress disorder symptoms: Do clinicians and patients agree? (PDF) <i>Psychological Assessment</i>, 20, 131-138. doi: 10.1037/1040-3590.20.2.131</p>
Short PTSD Rating Interview (SPRINT): TOOLKIT LINK: SPRINT	<p>Connor, K., and Davidson, J. (2001). SPRINT: A brief global assessment of post-traumatic stress disorder. <i>International Clinical Psychopharmacology</i>, 16, 279-284.</p>	<p>The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) is an eight-item self-report measure that assesses the core symptoms of PTSD (intrusion, avoidance, numbing, arousal), somatic malaise, stress vulnerability, and role and social functional impairment. Symptoms are rated on five point scales from 0 (not at all) to 4 (very much).</p> <ul style="list-style-type: none"> • Administration: Self-report • Length of Time: 5-10 minutes • Details: 8-item, Likert-type scale assesses symptoms and functional impairment in past week • Publicly Available: Yes, email: jonathan.davidson@duke.edu http://www.ptsd.va.gov/professional/assessment/screens/sprint.asp 	<p>From Jonathan Davidson: "The SPRINT can serve as a measure of the severity of PTSD symptoms in people who have survived a serious trauma. Even if they do not meet the diagnostic criteria of PTSD, the scale can provide an indication of how severe of a problem these symptoms might be. The scale can be given at any time after the event, and the items are usually rated for the previous week.</p> <p>Davidson, J.R.T., Colket, J.T. (1997). The eight-item treatment-outcome post-traumatic stress disorder scale: a brief measure to assess treatment outcome in post-traumatic stress disorder. <i>International Clinical Psychopharmacology</i>, 12, 41-45.</p>

APPENDIX C: EMDR EARLY INTERVENTION AND CRISIS RESPONSE RESEARCHER'S PROTOCOLS, RESOURCES AND REFERENCES

Author and Publisher Acknowledgements			
The EMDR Research Foundation wishes to thank Springer Publishing for permission to reproduce two of the scripted protocols from Marilyn Luber’s book (2014) and the individual authors who have given permission for online access to the protocols included in the EMDR Early Intervention and Crisis Response: Researcher's Toolkit . Other protocols are accessible directly from the authors, and many are included in open-access journal articles. In addition, all of the scripted protocols are available in Luber’s, <i>Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters; Models, Scripted Protocols and Summary Sheets</i> , (2014). The book is also available in CD-ROM format which includes writable and printable forms.			
Luber, M (ed.) 2014. Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters; Models, Scripted Protocols and Summary Sheets. Springer Publishing Company. ISBN: 978-0-8261-9921-8			
FORMAT		URL INK	
CD-ROM from Springer Publishing Company		http://www.springerpub.com/implementing-emdr-early-mental-health-interventions-for-man-made-and-natural-disasters-cd-rom.html	
Book and CD-ROM from Amazon		http://a.co/btY89pM	
EMDR EARLY INTERVENTION AND CRISIS RESPONSE RESEARCH PROTOCOLS			
TYPE OF PROTOCOL	TIME	PROTOCOL NAME AND AUTHOR(S)	PAGE/LINK
Stabilization Protocols	For use within minutes or hours	ERP--Emergency Room Procedure (Quinn; 2005)	36
		EMDR-ER—EMDR Emergency Room [Guedalia and Yoeli; 2000]	37
		ISP® – Immediate Stabilization Procedure (Quinn; 2018)	38
EEI protocols for individual treatment	For use from 24 to 78 hours	URG-EMDR - URGent EMDR treatment protocol (Tarquinio, C. et al.; 2012, 2013)	39
	For use from two days to six months	EMDR PRECI—Protocol for Recent Critical Incidents (Jarero and Artigas; 2011)	40-42
		REP—Recent Event Protocol (Francine Shapiro; 1995, 2001, 2018)	43
		EMDR R-TEP—Recent Traumatic Episode Protocol (Elan Shapiro and Brurit Laub; 2008)	44-47
EEI protocols for group treatment	For use from two days and beyond	Group Space EMDR Protocol (Formerly “IMMA”) (Laub and Bar Sade; 2009, 2013)	48
		EMDR G-TEP – Group Traumatic Episode Protocol (Elan Shapiro; 2013)	49
		EMDR IGTP—EMDR Integrative Group Treatment Protocol–Adult (Jarero and Artigas; 2000)	50-53
		EMDR IGTP—EMDR Integrative Group Treatment Protocol for Adolescents (Between 14 and 17 Years) and Adults Living with Ongoing Traumatic Stress (Jarero and Artigas; 2000)	
		EMDR IGTP—EMDR Integrative Group Treatment Protocol for Early Intervention with Children (Jarero and Artigas; 2000)	
Resources for Stabilization	Anytime	The Butterfly Hug (Artigas and Jarero; 2000)	54
		The Four Elements Exercise for Stress Reduction (Elan Shapiro, 2007)	55

ERP—Emergency Response Procedure	
Authors	<i>Quinn (2005)</i>
Type	<i>Stabilization Protocol</i>
Time	<i>For use within minutes or hours</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ ERP Field Manual available at the EMDR Research Foundation site: ERPLINK ✓ ERP contact form available at the EMDR Research Foundation site: ERP Contact LINK ✓ Available from the author. Contact Gary Quinn by email: Gary.Quinn.MD.EMDR@gmail.com ✓ Also in Luber, M. (2014). Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters: Models, Scripted Protocols and Summary Sheets (pp. 143-155). New York, NY: Springer Publishing Co.
Publications	Quinn, G., Elkins, Y., Zucker, D., & Smith, M. (submitted). Emergency Response Procedure: Immediate stabilization following trauma and disaster—case studies.
Comments	<i>The Emergency Response Procedure is for use by EMDR-trained clinicians and can be utilized before or during reprocessing to assist a client with stabilization or to regain a sense of presence and safety.</i>

EMDR-ER—EMDR Emergency Room	
Authors	<i>Guedalia and Yoeli (2000)</i>
Type	<i>EEL protocols for individual treatment</i>
Time	<i>For use within minutes or hours</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ Available from the author. Contact Judith Guedalia by email at drjudith2006@gmail.com ✓ Also in Luber, M. (2014) <i>Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters: Models, Scripted Protocols and Summary Sheets</i> (pp. 157-170). New York, NY: Springer Publishing Co.
Comments	<i>No additional comments provided.</i>
Recent Publications	<p>Guedalia, J. B., & Yoeli, F. (2009). EMDR emergency room and wards protocol (EMDR-ER). In M. Luber (Ed.), <i>Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations</i> (pp. 241-250). New York, NY: Springer Publishing Co.</p> <p>Guedalia, J. S. B., & Yoeli, F. R. (2014). EMDR emergency room and wards protocol (EMDR-ER). In M. Luber (Ed.), <i>Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets</i> (pp. 157-165). New York, NY: Springer Publishing Co.</p> <p>Luber, M. (2014). Summary Sheet: EMDR emergency room and wards protocol (EMDR-ER). In M. Luber (Ed.), <i>Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets</i> (pp. 167-174). New York, NY: Springer Publishing Co.</p>

Immediate Stabilization Procedure (ISP ®)	
Authors	Quinn (© 2018)
Type	<i>Stabilization Protocol</i>
Time	<i>For use within minutes or hours</i>
Access to Protocol	<ul style="list-style-type: none"> <input type="checkbox"/> ISP Field Manual available at the EMDR Research Foundation website [ISP LINK] <input type="checkbox"/> ISP contact form at the EMDR Research Foundation website [ISP Contact LINK] <input type="checkbox"/> Also available from the author. Contact Dr. Gary Quinn by email: EMDR.Institute.of.Israel@gmail.com
Publications	Quinn, G., Elkins, Y., Zucker, D., & Smith, M. (submitted). Emergency Response Procedure: Immediate stabilization following trauma and disaster—case studies.
Comments	<i>Immediate Stabilization Procedure (ISP®) has been manualized so it can be taught to first responders or other non-mental health emergency personnel working within a structured response team and in a setting that includes supervision/consultation. Please contact Dr. Gary Quinn for further information, and to participate in the continuing collection of data. EMDR.Institute.of.Israel@gmail.com</i>

URGent EMDR treatment protocol (URG-EMDR)	
Authors	Tarquinio, C. et al. (2012, 2013)
Type	<i>Individual intervention—early emergency treatment</i>
Time	<i>For use within 24 to 78 hours</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ General description of the protocol at the EMDR Research Foundation website: [URG LINK] ✓ Also available from the author. Contact Professor Cyril Tarquinio by email: cyril.tarquinio@univ-lorraine.fr
Publications	<p>Brennstuhl, M.J., Tarquinio, C., Strub, L., Montel, M., Rydberg, J.A., & Kapuola, Z. (2013) Benefits of Immediate EMDR vs. Eclectic Therapy Intervention for Victims of Physical Violence and Accidents at the Workplace: A Pilot Study. <i>Issues in Mental Health Nursing</i>, 34:425–434, DOI: 10.3109/01612840.2012.759633</p> <p>Tarquinio, C., Brennstuhl, M.J., Reichenbach, S., Rydberg, J.A., & Tarquinio, P. (2012) Early treatment of rape victims: Presentation of an emergency EMDR protocol. <i>Sexologies</i>. doi:10.1016/j.sexol.2011.11.012</p>
Comments	<p><i>“The URGent EMDR treatment protocol (URG-EMDR) was developed after experimenting with several protocols for several months. It cannot be considered as an original contribution, but rather an integrative approach which combines the key points of the basic protocol of Francine Shapiro (2001), of the Recent Event Protocol of Francine Shapiro (2001), of the R-TEP protocol of Shapiro and Laub (2008, 2009), of the Modified Abridged EMDR protocol of Kutz (Kutz et al., 2008) and the Emergency Response Procedure of Quinn (2009), as well as some principles related to psychological debriefing.” (Tarquinio, 2012)</i></p> <p><i>“The protocol was developed because of difficulties encountered in applying other approaches in the context of early treatment. Being too unwieldy, too complex, and requiring an overly canonical approach, other models did not always fit our purposes. We developed the URG-EMDR protocol in order to have a tool that would be more flexible and more suited to the situations we encounter.” (Brennstuhl et al., 2013)</i></p>

EMDR PRECI—Protocol for Recent Critical Incidents	
Authors	<i>Jarero and Artigas (2011)</i>
Type	<i>EEL protocols for individual treatment</i>
Time	<i>Two days to six months</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ Full-text protocol at the EMDR Research Foundation website: [PRECILINK] ✓ Also available from the author. Contact by Dr. Nacho Jarero by emailat: nacho@amamecrisis.com.mx ✓ Also in Lubet, M. (2014). Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters: Models, Scripted Protocols and Summary Sheets (pp. 217-232.) New York, NY: Springer Publishing Co.
Comments	<i>Additional comments by Dr. Jarero follow the recent publications section</i>
Recent Publications	<p>Jarero, I., Artigas, L., & Lubet, M. (2011). The EMDR protocol for recent critical incidents: Application in a disaster mental health continuum of care context. Journal of EMDR Practice and Research, 5(3), 82-94. doi:10.1891/1933-3196.5.3.82.</p> <p>Jarero, I., & Uribe, S. (2011). The EMDR protocol for recent critical incidents: Brief report of an application in a human massacre situation. Journal of EMDR Practice and Research, 5(4), 156-165. doi:10.1891/1933-3196.5.4.156.</p> <p>Jarero, I., & Uribe, S. (2012). The EMDR protocol for recent critical incidents: Follow-up report of an application in a human massacre situation. Journal of EMDR Practice and Research, 6(2), 50-61. doi:10.1891/1933-3196.6.2.50.</p> <p>Jarero, I., & Artigas, L. (2014). The EMDR protocol for recent critical incidents (EMDR-PRECI). In M. Lubet (Ed.), <i>Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets</i> (pp. 217-228). New York, NY: Springer Publishing Co</p> <p>Jarero, I., Uribe, S., Artigas, L., & Givudan, M. EMDR-PRECI: An RCT After a Technological Disaster. Journal of EMDR Practice and Research, 9(4), 2015. https://doi.org/10.1891/1933-3196.9.4.166 .</p> <p>Jarero, I., & Artigas, L. (2015). The EMDR Protocol for Recent Critical Incidents (EMDR-PRECI) and Ongoing Traumatic Stress © Scripted Protocol, updated.</p> <p>Lubet, M. (2014). Summary sheet: The EMDR protocol for recent critical incidents (EMDR-PRECI). In M. Lubet (Ed.), <i>Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets</i> (pp. 229-232). New York, NY: Springer Publishing Co.</p>

EMDR PRECI—Protocol for Recent Critical Incidents

Additional Comments by Dr. Jarero

Dr. Jarero has generously offered his personal contact information to consult with those doing Early EMDR Intervention and using EMDR-PRECI in the field : NACHO JARERO nacho@amamecrisis.com.mx

QUESTION	ANSWER BY DR. JARERO
<p>1.a. OPTIMAL USE</p> <p><i>What population(s) do you consider appropriate for use of this protocol? (Adults, children, specific symptoms, situations, or populations).</i></p>	<p>Adolescents (13 to 18) and adults (over 18). It can be used with acute stress symptoms, Acute Stress Disorder (ASD), or PTSD, whether sub-threshold or threshold symptoms, recent or ongoing trauma, or in a disaster mental health continuum of care context.</p>
<p>1.b OPTIMAL USE</p> <p><i>What is the optimal or intended timing for use of this protocol?</i></p>	<p>It was developed in the field to treat critical incidents where related stressful events continue for an extended time and where there is no post-trauma period of safety for memory consolidation.</p> <p>In some critical incidents (e.g., earthquake, flooding, landslides, tsunamis), related stressful events continue for an extended time (often more than 6 months). We have argued that this lack of a post-trauma period of safety prevents the consolidation in memory of the original critical incident. (See our articles which are available via the Francine Shapiro Library.)</p> <p>The optimal timing is as soon as you arrive in the disaster area. Sometimes it could take months because of security reasons.</p>
<p>1.c. OPTIMAL USE</p> <p><i>If the intervention follows the Scripted Protocol as described in Marilyn Luber's 2014 publication, would that be sufficient to maintain fidelity?</i></p>	<p>Yes.</p> <p>Luber, Marilyn (Ed.), 2014. <i>Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets</i>. New York: Springer Publishing Company</p>
<p>2. Is there anything else you want us to be aware of regarding the protocol or the project?</p>	<p>Yes, the EMDR-PRECI, if possible, should be administered on consecutive days, once or twice a day (morning and afternoon) and at least 4 times to get optimal results.</p>
<p>3. If you have conducted research on the effectiveness of this protocol, a. what research designs have you used?</p>	<p>i. Randomized Controlled Trial/ Randomized Wait-List Control ii. Non-Randomized with control group</p>
<p>3.b. Which research measures would you recommend that yield sufficient data and are easy to use for those unaccustomed to collecting data as a part of their intervention?</p>	<p>The Impact of Events Scale (IES-R) and the Short PTSD Rating Interview (SPRINT).</p>

**Additional Comments by Dr. Jarero regarding EMDR PRECI – Protocol for Recent Critical Incidents
(Continued)**

<i>3.c. In addition to pre and post treatment measures, what is the ideal interval for follow-up measures?</i>	In a disaster mental health continuum of care context, we would be lucky if we were able to have follow-up measures at 30 days because of the mobility of the survivors.
<i>3.d. What issues or concerns have you encountered in collecting data and conducting research in disaster situations?</i>	The great mobility of the survivors and the difficulty for survivors to understand the questions on the measures, even if the questions are very simple. In third-world countries, many survivors have no schooling.
<i>4. What would you suggest as part of a research toolkit for the disaster response HAP programs worldwide so that they can include data collection as part of their routine process?</i>	Instruments that can be administered in a very short period of time (up to 10 minutes) and easy to understand. The best examples are the IES-R and the SPRINT.
<i>5. In your opinion, what type of study is really most crucial as THE breakthrough in the field?</i>	Randomized Control Trials comparing EMDR Therapy and trauma focused CBT. I strongly believe that the comparison between EMDR and tfCBT is much more important and with capability for world-wide impact than the comparison between the various EMDR early intervention protocols.

REP—Recent Event Protocol	
Authors	<i>Francine Shapiro (1995, 2001, 2018)</i>
Type	<i>EEL protocols for individual treatment</i>
Time	<i>For use from two days to six months</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ Full-text protocol at the EMDR Research Foundation website: [REPLINK] ✓ Also in Luber, M. (2014) Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters: Models, Scripted Protocols and Summary Sheets (pp. 175-191). New York, NY: Springer Publishing Co. ✓ <i>Shapiro, F. (2018) Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures</i> (3rd Ed.) (pp. 223-225). New York, NY: Guilford Press.
Comments	<i>No additional comments provided.</i>
Recent Publications	<p>Buydens, S. L., Wilensky, M., & Hensley, B. J. (2014). Effects of the EMDR protocol for recent traumatic events on acute stress disorder: A case series. <i>Journal of EMDR Practice and Research</i>, 8(1), 2-12. https://doi.org/10.1891/1933-3196.8.1.2</p> <p>Tarquino, C., Rotonda, C., Houllé, W., Montel S., Rydberg, J.A., Minary, L., Dellucci, H., Tarquino, P., Fayard, A., & Alla F. (2016): Early Psychological Preventive Intervention For Workplace Violence: A Randomized Controlled Explorative and Comparative Study Between EMDR-Recent Event and Critical Incident Stress Debriefing, Issues. in Mental Health Nursing, http://dx.doi.org/10.1080/01612840.2016.1224282</p>

EMDR R-TEP—Recent Traumatic Episode Protocol	
Authors	<i>Elan Shapiro and Brurit Laub (2008)</i>
Type	<i>EEL protocols for individual treatment</i>
Time	<i>Two days to six months</i>
Access to Protocol	<p>✓ From: IMPLEMENTING EMDR EARLY MENTAL HEALTH INTERVENTIONS FOR MAN-MADE AND NATURAL DISASTERS. Marilyn Luber, PhD. Copyright 2014, Reproduced with the permission of Springer Publishing Company, LLC. ISBN: 978-0-8261-9921-8.</p> <p>Chapter 12: The Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI), Elan Shapiro and Brurit Laub [RTEP-Chapter 12 LINK]</p> <p>Chapter 12a: Summary Sheet: The Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI), Elan Shapiro and Brurit Laub. Summary Sheet by Marilyn Luber [RTEP-Chapter 12a LINK]</p> <hr/> <p>✓ The EMDR Recent Traumatic Episode Protocol (EMDR R-TEP) for Early EMDR Intervention (EEI.) Overview & protocol instructions Elan Shapiro & Brurit Laub (revised Sept. 2014) [RTEP Manual LINK]</p> <p>✓ Fidelity Checklist: [RTEP Fidelity Checklist LINK]</p>
Comments	<i>Additional comments by Elan Shapiro follow the recent publications sections.</i>
Recent Publications	<p>Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. <i>European Journal of Psychotraumatology</i> Vol. 6: 27414 - http://dx.doi.org/10.3402/ejpt.v6.27414</p> <p>Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Gulen, B., & Cuijpers, P. (2016). The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: results of a randomized controlled trial. <i>Psychological Medicine</i>, Cambridge University Press. doi:10.1017/S0033291716001070</p> <p>Konuk, E. & Zat, Z. (2015). Humanitarian Programs and Interventions in Turkey. <i>Journal of EMDR Practice and Research</i>, 9(2): 106-113. http://dx.doi.org/10.1891/1933-3196.9.2.106</p> <p>Laub, B., & Weiner, N. (2011). A developmental/integrative perspective of the recent traumatic episode protocol. <i>Journal of EMDR Practice and Research</i>, 5(2), 57-72. doi:10.1891/1933-3196.5.2.57.</p>

EMDR R-TEP—Recent Traumatic Episode Protocol, (continued)

- Shapiro, E. & Laub, B. (2015). Early EMDR Intervention Following a Community Critical Incident: A Randomized Clinical Trial. *Journal of EMDR Practice and Research*, Vol 9 (1). pp.17-27. <http://dx.doi.org/10.1891/1933-3196.9.1.17>
- Shapiro, E., & Laub, B. (2014). The recent traumatic episode protocol (R-TEP): An integrative protocol for early EMDR intervention (EEI). In M. Luber (Ed.), *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets* (pp. 193-207). New York, NY: Springer Publishing Co.
- Shapiro, E., & Laub, B. (2008). [Early EMDR intervention \(EEI\): A summary, a theoretical model, and the recent traumatic episode protocol \(R-TEP\)](#). *Journal of EMDR Practice and Research*, 2(2), 79-96. doi:10.1891/1933-3196.2.2.79.
- Tofani, L & Wheeler, K. (2011). The recent traumatic episode protocol: Outcome evaluation and analysis of three case studies. *Journal of EMDR Practice and Research*, 5(3), 95-110.

EMDR R-TEP—Recent Traumatic Episode Protocol Additional Comments by Elan Shapiro

QUESTION	ANSWER BY ELAN SHAPIRO
1.a. OPTIMAL USE <i>What population(s) do you consider appropriate for use of this protocol? (Adults, children, specific symptoms, situations, or populations).</i>	Adults, older children, traumatic stress, recent trauma, prevention
1.b OPTIMAL USE <i>What is the optimal or intended timing for use of this protocol?</i>	To be researched but I would say from several days after the critical event
1.c. OPTIMAL USE <i>If the intervention follows the Scripted Protocol as described in Marilyn Luber's 2014 publication, would that be sufficient to maintain fidelity?</i>	Yes, although we have a Fidelity Checklist (FIDELITY CHECKLIST LINK.) Luber, Marilyn (Ed.), 2014. <i>Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets</i> . New York: Springer Publishing Company
2. If you have conducted research on the effectiveness of this protocol, what research designs have you used?	i. Randomized wait-list/delayed treatment control ii. Case studies

EMDR R-TEP—Recent Traumatic Episode Protocol

Additional Comments by Elan Shapiro (continued)

<p>3. Which research measures would you recommend that yield sufficient data and are easy to use for those unaccustomed to collecting data as a part of their intervention?</p>	<p>The Impact of Events Scale (IES-R), IES/R, PHQ9 (depression), PRS (Problem Rating Scale, Greenwald,)</p>
<p>4. In addition to pre and post treatment measures, what is the ideal interval for follow-up measures?</p>	<p>3 months, if possible</p>
<p>5. What issues or concerns have you encountered in collecting data and conducting research in disaster situations?</p>	<p>a. We have included with our EMDRR-TEP handout a data intake sheet (see below) and 3X IES-R forms labeled pre- post- & follow-up for basic data collection</p> <p>b. Danger of pathologizing (meta-communication of the presence of mental health practitioners when working with normal people who have been exposed to abnormal situations).</p> <p>c. The risk of opening clinical issues that were not anticipated.</p> <p>d. Maintaining safety of client AND therapist in emergency situations.</p> <p>e. Good practice guidelines are needed in all areas, such as: How to present the intervention without disempowering or pathologizing, research formalities and procedures, client consent, not cutting corners, reaching out to potential participants, and dealing with avoidance. Another important area is helping the helpers, especially in areas of compassion fatigue and the danger of vicarious traumatization.</p>
<p>6. In your opinion, what type of study is really most crucial as THE breakthrough in the field?</p>	<p>It's most important to conduct studies that would meet the criteria for inclusion in the Cochrane reviews. See the criteria in the Appendix.</p> <p>1- Delayed treatment controlled designs or comparison treatments for people with Traumatic Stress Symptoms seem pragmatic, but need to be done with larger numbers</p> <p>2- Another challenge is to demonstrate effectiveness of preventive intervention even in the absence of clinically significant symptoms. If we only treat those with clinical symptoms, we miss many who could have benefitted (2/3 of those who develop PTSD did NOT have ASD, so delayed onset PTSD is overlooked). Since about 2/3 will also recover spontaneously it is difficult to demonstrate the prevention of pathology unless large-scale longitudinal follow-up studies are conducted.</p>

EMDR R-TEP—EMDR Recent Traumatic Episode Protocol
DATA COLLECTION
Phase I: History (INTAKE)

A. Date today: _____ Date of trauma: _____ Times since trauma: _____

Clinician: _____ Client's name / initials / no: _____ 1. M / 2. F

Contact Phone no: _____ email: _____

Age: _____ Family status: _____ Education (no. of years): _____

Employment: 1. working 2. not working _____

B. Type of intervention: 1. R-TEP _____ 2. Other (specify) _____

Recent Traumatic incident or incidents _____

Medication: 1. No 2. Yes (specify + when started) _____

Physical injury: 1. No 2. Yes (specify type + severity) _____

Level of Functioning (compared to usual) [LO] 1.....2.....3.....4 [HI]

Previous psychological treatment: 1. No 2. Yes (specify) _____

C. Previous trauma history

Event _____ date (year) _____

Event _____ date (year) _____

Event _____ date (year) _____

D. Preparation: (Poor) 1.....5 (Excellent)

E. "SMS" evaluations: [LO] 1.....5 [HI]: Severity.....Motivation.....Strengths.....

COMMENTS (continue on other side of page)

Please scan & send completed INTAKE & IES data forms
to: elanshapiro@gmail.com ; bruritlaub7@gmail.com Fax: 00 972 4 9530048

The Group Space EMDR Protocol (formerly “Imma Group Protocol”)	
Authors	<i>Brurit Laub and Esti Bar-Sade (2009)</i>
Type	<i>EEL protocols for group treatment</i>
Time	<i>Two days to six months</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ Full-text protocol of the Group Space EMDR Protocol (formerly “IMMA”) at the EMDR Research Foundation website: [IMMALINK] ✓ Laub, B., & Bar-Sade, E. (2014). <i>The Imma EMDR group protocol</i>. In M. Luber (Ed.), Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets (pp. 267-273). New York, NY: Springer Publishing Co. ✓ Laub, B., & Bar-Sade, E. (2009). <i>The IMMA EMDR group protocol</i>. In M. Luber (Ed.), Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basics and special situations (pp. 289-296). New York, NY: Springer Publishing Co...
Comments	<i>Based on the EMDR Integrative Group Treatment Protocol (IGTP) by Jarero, Artigas, Alcalá, and López, the Four Elements Exercise by Elan Shapiro, and the principles of group therapy work. This protocol is designed for small groups of children from the age of 5 upward.</i>

EMDR G-TEP—Group Traumatic Episode Protocol

Authors	<i>Elan Shapiro (2013)</i>
Type	<i>EEL protocols for group treatment</i>
Time	<i>Two days to six months</i>
Access to Protocol	The EMDR Group-Traumatic Episode Protocol (EMDR G-TEP) for Early EMDR Intervention (EEL) Manual, 7 th Edition. Overview & protocol instructions Elan Shapiro & Judy Moench (revised March 2018). [G-TEP LINK]
Comments	<i>No additional comments provided.</i>
Recent Publications	<p>Konuk, E., Yurtsever, A., Tükel, F., Konuk, E. K., Çetinkaya, M., Zat, Z., & Shapiro, E. D. (2018). An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees with Post Traumatic Stress Symptoms: Results of a Randomized Controlled Trial. <i>Frontiers in Psychology</i>, 9, 493.</p> <p>Lehnung, M., Shapiro, E., Schreiber, M., & Hofmann, A. (2017). Evaluating the EMDR Group Traumatic Episode Protocol With Refugees: A Field Study. <i>Journal of EMDR Practice and Research</i>, Volume 11, Number 3, 2017, pp. 129-138(10). https://doi.org/10.1891/1933-3196.11.3.129</p> <p>Shapiro, E. (2013, November). <i>The group traumatic episode protocol (G-TEP) for early EMDR intervention (EEL)</i>. Paper presented at the EMDR Symposium, Istanbul, Turkey.</p> <p>Yurtsever, A., Konuk, E., Akyuz, T., Tükel, F., Zat, Z., Acarturk, C. & Cetinkaya, M. (In press). <i>An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees with Post Traumatic Stress Symptoms: Results of a Controlled Trial</i>. Paper presented at EMDR Europe Conference, Edinburgh, June 2014.</p>

EMDRIGTP—EMDR Integrative Group Treatment Protocol
Adult
Adolescents and Adults Living with Ongoing Traumatic Stress
Children

Authors	<i>Jarero and Artigas (2000)</i>
Type	<i>EI protocols for group treatment</i>
Time	<i>Two days to six months</i>
Access to Protocol	<p>IGTP for Adults</p> <p>From: IMPLEMENTING EMDR EARLY MENTAL HEALTH INTERVENTIONS FOR MAN-MADE AND NATURAL DISASTERS. Marilyn Luber, PhD Copyright 2014, Reproduced with the permission of Springer Publishing Co., LLC ISBN: 978-0-8261-9921-8</p> <ul style="list-style-type: none"> ✓ Chapter 15: The EMDR Integrative Group Treatment Protocol (IGTP) for Adults, Ignacio Jarero & Lucina Artigas [IGTP Chapter 15 LINK] ✓ Chapter 15a: Summary Sheet for Each Participant: The EMDR Integrative Group Treatment Protocol (IGTP) for Adults, Ignacio Jarero and Lucina Artigas. Summary Sheet by Marilyn Luber [IGTP Chapter 15a LINK] ✓ Chapter 15b: Summary Sheet for Clinicians: The EMDR Integrative Group Treatment Protocol (IGTP) for Adults, Ignacio Jarero & Lucina Artigas. Summary Sheet by Marilyn Luber [IGTP Chapter 15b LINK] <hr/> <p>IGTP for Adolescents and Adults</p> <ul style="list-style-type: none"> ✓ Jarero, I, Artigas, L, (2015). The EMDR Integrative Group Treatment Protocol (IGTP) for Early Intervention with Adolescents (between 14 and 17 years) and Adults. ©EMDR-IGTP Script Notes. February 2015. [IGTP Adults LINK] <p>IGTP for Adolescents and Adults Living with Ongoing Traumatic Stress</p> <ul style="list-style-type: none"> ✓ Jarero, I, Artigas, L, (2017) EMDR Integrative Group Treatment Protocol (IGTP) Adapted for Ongoing Traumatic Stress © EMDR-IGTP-OTS. November 2017. [IGTP Ongoing LINK] <p>IGTP for Children</p> <ul style="list-style-type: none"> ✓ Artigas, L., Jarero, I., Alcala, N., & Cano, T.L. (2015). The EMDR Integrative Group Treatment Protocol (IGTP) for Early Intervention with Children. February 2015 © [IGTP Children LINK]

EMDR IGTP – Integrative Group Treatment Protocol (continued)

Comments	<i>Additional comments by Dr. Jarero are on the next page.</i>
Recent Publications	<p>Adúriz, M. E., Bluthgen, C., Knopfler, C. (2009). Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. International Journal of Stress Management, Vol 16(2), May 2009, 138-153. http://dx.doi.org/10.1037/a0014719</p> <p>Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative group treatment protocol: A post disaster trauma intervention for children and adults. Traumatology, 12(2), 121-129. doi:10.1177/1534765606294561.</p> <p>Jarero, I., Artigas, L., Montero, M., & Lopez-Lena, L.. (2008). The EMDR integrative group treatment protocol: Application with child victims of a mass disaster. Journal of EMDR Practice and Research, 2(2), 97-105.</p> <p>Jarero, I., Artigas, L., Uribe, S., Garcia, L., Cavazos, M., & Givaudan, M. (2014). Pilot Research Study on the Provision of the EMDR Integrative Group Treatment Protocol with Female Cancer Patients. Revista Iberoamericana de Psicopatología y Disociación. Vol. 6. Num. 3, 2014. ISSN: 2007-8544.</p> <p>Jarero, I., Roque-López, S., & Gomez, J. (2013). The provision of an EMDR-based multicomponent trauma treatment with child victims of severe interpersonal trauma. Journal of EMDR Practice and Research, 7(1), 17-28. doi:10.1891/1933-3196.7.1.17.</p> <p>Jarero, I., Roque-López, S., Gómez, J., & Givaudan, M. (2014). Third research study on the provision of the EMDR integrative group treatment protocol with child victims of severe interpersonal violence. Revista Iberoamericana de Psicopatología y Disociación, 6(2).</p> <p>Jarero, I., & Artigas, L. (2010). The EMDR integrative group treatment protocol: Application with adults during ongoing geopolitical crisis. Journal of EMDR Practice and Research, 4(4), 148-155. doi:10.1891/1933-3196.4.4.148.</p> <p>Jarero, I., & Artigas, L. (2012). The EMDR integrative group treatment protocol: EMDR group treatment for early intervention following critical incidents. Revue Européenne De Psychologie Appliquée/European Review of Applied Psychology, 62(4), 219-222. doi:10.1016/j.erap.2012.04.004.</p> <p>Jarero, I., Artigas, L., Uribe, S., Garcia, L.E., Cavazos, M.A., & Givaudan, M. (2015). Pilot Research Study on the Provision of the Eye Movement Desensitization and Reprocessing Integrative Group Treatment Protocol With Female Cancer Patients. EMDR Journal of Practice and Research, 9 (2) 2015, (98-105) https://doi.org/10.1891/1933-3196.9.2.98</p>

EMDR IGTP—Integrative Group Treatment Protocol

Additional Comments by Dr. Jarero

Dr. Jarero has generously offered his personal contact information to consult with those doing Early EMDR Intervention and using EMDR-PRECI in the field : NACHO JARERO nacho@amamecrisis.com.mx

QUESTION	ANSWER BY DR. JARERO
<p>1.a. OPTIMAL USE</p> <p><i>What population(s) do you consider appropriate for use of this protocol? (Adults, children, specific symptoms, situations, or populations).</i></p>	<p>Children (7-12) Adolescents (13 to 18) and Adults (over 18)</p> <p>It can be used with acute stress symptoms, Acute Stress Disorder (ASD), or PTSD, whether sub-threshold or threshold symptoms, recent or ongoing trauma, or in a disaster mental health continuum of care context.</p>
<p>1.b OPTIMAL USE</p> <p><i>What is the optimal or intended timing for use of this protocol?</i></p>	<p>The optimal timing is as soon as you arrive in the disaster area. Sometimes it could take months because of security reasons.</p>
<p>1.c. OPTIMAL USE</p> <p><i>If the intervention follows the Scripted Protocol as described in Marilyn Luber's 2014 publication, would that be sufficient to maintain fidelity?</i></p>	<p>Yes.</p> <p>Luber, Marilyn (Ed.), 2014. <i>Implementing EMDR Early Mental Health Interventions for Man-made and Natural Disasters: Models, Scripted Protocols and Summary Sheets</i>. New York: Springer Publishing Company</p>
<p>2. Is there anything else you want us to be aware of regarding the protocol or the project?</p>	<p>Yes, the EMDR-IGTP, if possible, should be administered on consecutive days, once or twice a day (morning and afternoon) and at least 4 times to get optimal results.</p>
<p>3. If you have conducted research on the effectiveness of this protocol:</p> <p>3.a. What research designs have you used?</p>	<p>Single group with pre and post treatment measures</p>
<p>3.b. Which research measures would you recommend that yield sufficient data and are easy to use for those unaccustomed to collecting data as a part of their intervention?</p>	<p>The Impact of Events Scale (IES-R) and the Short PTSD Rating Interview (SPRINT).</p>
<p>3.c. In addition to pre and post treatment measures, what is the ideal interval for follow-up measures?</p>	<p>In a disaster mental health continuum of care context, we would be lucky if we were able to have follow-up measures at 30 days because of the mobility of the survivors.</p>

**Additional Comments by Dr. Jarero regarding EMDR IGTP – Integrative Group Treatment
(continued)**

<p><i>3.d. What issues or concerns have you encountered in collecting data and conducting research in disaster situations?</i></p>	<p>The great mobility of the survivors and the difficulty for survivors to understand the questions on the measures, even if the questions are very simple. In third-world countries, many survivors have no schooling.</p>
<p><i>4. What would you suggest as part of a research toolkit for the disaster response HAP programs worldwide so that they can include data collection as part of their routine process?</i></p>	<p>Instruments that can be administered in a very short period of time (up to 10 minutes) and easy to understand. The best examples are the IES-R and the SPRINT.</p>
<p><i>5. In your opinion, what type of study is really most crucial as THE breakthrough in the field?</i></p>	<p>Randomized Control Trials comparing EMDR Therapy and trauma focused CBT. I strongly believe that the comparison between EMDR and tfCBT is much more important and with capability for world-wide impact than the comparison between the various EMDR Early Intervention protocols.</p>

The Butterfly Hug	
Authors	<i>Artigas and Jarero (2000)</i>
Type	<i>Resources for stabilization</i>
Time	<i>Anytime</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ Full-text protocol at the EMDR Research Foundation: [BUTTERFLY HUG LINK] ✓ Also in Luber, M. (2014). Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters: Models, Scripted Protocols and Summary Sheets (pp. 127-131). New York, NY: Springer Publishing Co.
Comments	<i>No additional comments provided.</i>
Recent Publications	<p>Adler-Tapia, R., & Settle, C. (2008). EMDR butterfly hug/group protocol: Fidelity research manual. Hamden, CT: EMDR Humanitarian Assistance Programs.</p> <p>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.</p> <p>Artigas, L., & Jarero, I. (2014). The butterfly hug. In M. Luber (Ed.), <i>Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets</i> (pp. 127-130). New York, NY: Springer Publishing Co.</p> <p>Fernandez, I., Gallinari, E., & Lorenzetti, A. (2004, Spring-Summer). A school-based EMDR intervention for children who witnessed the Pirelli Building airplane crash in Milan, Italy. <i>Journal of Brief Therapy</i>, 2(2), 129-136.</p> <p>Luber, M. (2014). Summary sheet: The butterfly hug. In M. Luber (Ed.), <i>Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets</i> (p. 131). New York, NY: Springer Publishing Co.</p>

The Four Elements Exercise for Stress Management

Authors	<i>Elan Shapiro (2007)</i>
Type	<i>Resources for stabilization</i>
Time	<i>Anytime</i>
Access to Protocol	<ul style="list-style-type: none"> ✓ Full-text protocol at the EMDR Research Foundation: [FOUR ELEMENTS LINK] ✓ Also in Luber, M. (2014). Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters; Models, Scripted Protocols and Summary Sheets (pp. 133-138). New York, NY: Springer Publishing Co.
Comments	<i>No additional comments provided.</i>
Recent Publications	<p>Lobenstine, F., & Shapiro, E. (2007). What is an effective self-soothing technique that I can teach my client to use at home when stressed? Journal of EMDR Practice and Research, 1(2), 122-124. doi:10.1891/1933-3196.1.2.122.</p> <p>Shapiro, E. (2009). Four elements exercise for stress management. In M. Luber (Ed.), Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basics and special situations (pp. 73-79). New York, NY: Springer Publishing Co.</p> <p>Shapiro, E. (2014). Four elements exercise for stress management. In M. Luber (Ed.), Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets (pp. 133-138). New York, NY: Springer Publishing Co.</p>

POCKET GUIDE

To Early EMDR Intervention Protocols

Compiled by **Beverlee Laidlaw Chasse, MC, LPC**

with formatting and design by Katy Murray, MSW, LICSW, BCD

Contents

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○ EMDR-ER—Emergency Room and Wards Protocol	3
○ EMDR-PRECI—Protocol for Recent Critical Incidents	4
○ REP—Recent Event Protocol	5
○ EMDR R-TEP—Recent Traumatic Episode Protocol	6
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This Pocket Guide is included in the EMDR Research Foundation's **EMDR Early Intervention and Crisis Response: Researcher's Toolkit**.
To access the entire Toolkit, [go to www.emdrresearchfoundation.org/toolkit/](http://www.emdrresearchfoundation.org/toolkit/)



4-2018

ERP—Emergency Response Procedure [Quinn; 2004]	
For Use With	Victims of trauma within hours of incident. Patients that present with “silent terror” shaking, inability to speak, or if verbal in a highly agitated state. Can also be used for acute abreactions during any phase of the EMDR process.
Phase 1 Client History	<ol style="list-style-type: none"> 1. Get brief history from ambulance, hospital staff, or whoever has information (if patient can't tell you, focus on immediate trauma only). 2. Establish present time orientation and safety. 3. If client is verbal get history on immediate trauma (right before trauma to present moment).
Phase 2 Preparation	<ol style="list-style-type: none"> 1. Normalize patient's behavior and physical reactions. 2. Explain what acute stress reactions are. 3. Give brief explanation of EMDR 4. Establish a calm and present orientation 5. Client does not have to be speaking in order to begin.
Phase 3 Assessment	<ol style="list-style-type: none"> 1. Assume that patient is in a highly agitated, acute stress reaction state. 2. Patient is already accessing image because they are already in them internally. 3. Assume NC (I am in danger). 4. Assume initial PC (I am safe now from that event). 5. Assume emotion as high fear or terror. 6. Assume a SUD close to 10. 7. Therapist notices bodysensations. 8. Do not encourage free associations.
Phase 4 Desensitization	<ol style="list-style-type: none"> 1. Utilize dual attention to help patient gain external focus (in the ER or safe area, away from event). 2. Use bilateral stimulation and use cognitive interweaves to establish current safety and present time orientation.
Phase 5 Installation	<ol style="list-style-type: none"> 1. Standard installation is not done. 2. Current safety is reinforced instead using breathing techniques. 3. Patients must say that they are safe and recognize that the event is over to move to closure. 4. Or, if client wants to give you a narrative of what is experienced, do a narrative and shift to EMD protocol or R-TEP.
Phase 6 Body Scan	<ol style="list-style-type: none"> 1. Not done formally. 2. Acknowledge cessation of shaking, calming of body, and ability to connect.
Phase 7 Closure	<ol style="list-style-type: none"> 1. Provide education script about what can happen after a trauma experience. 2. Give referrals for if symptoms continue to be acute and are not subsiding. 3. Client is given handout on common physiological and emotional symptoms that occur in the first 48-72 hours.
Phase 8 Reevaluation	<ol style="list-style-type: none"> 1. In emergency situations, reevaluation doesn't always happen. 2. Whenever possible, contact patients within a week via phone to assess situation and provide support.

Tables adapted from Marilyn Luber's Scripted Protocols (2009, 2013) and original theorists' publications. ©2013, 2018 Beverlee Laidlaw Chasse

EMDR-ER—EMDR Emergency Room [Guedalia and Yoeli; 2000]

For Use With	Used when patients are unable to move onto the ambulatory staging area. Patient is frozen, laying, unable to resume motor functioning, dazed stupor or dorsal vagal state.
Phase 1 Client History	<ol style="list-style-type: none"> 1. Medical and physical stabilization and safety <ul style="list-style-type: none"> • Basic level of physical relatedness, can respond to questions, breathing cadence slows down • Can focus eyes, looks around, shows interest at some level of surroundings 2. Mirror: Breathe in same cadence and hold patient's hand 3. You must establish trust and safety in the moment. 4. Establish present time orientation and say short comforting statements.
Phase 2 Preparation	<ol style="list-style-type: none"> 1. Make them comfortable so they can interact with environment and you. 2. Introduce yourself, make contact and ask for permission to tap; if no, go to explanation of EMDR 3. If client can't respond verbally, touch two places and stand in their line of vision as you touch them. 4. Foster sense of calm and safety; educate about normal acute stress disorder reactions.
Phase 3 Assessment	<ol style="list-style-type: none"> 1. Present affirmation of patient being alive and safe in present moment. 2. Assist client to move from internal focus to external focus. 3. Have client do a narrative of the event (note affect, NC, sensations) 4. Have client focus on IMAGE (target) of event. 5. Clinician gives PC to client; affirm safety, control, recovery; get a VOC and then an NC if prudent 6. Encourage authentic empathy, crying, and sighing—EMOTION. 7. You do not have to get a SUD, as it is probably obvious (ex 15 out of 10) 8. Do NOT ask about body if client is injured.
Phase 4 Desensitization	<ol style="list-style-type: none"> 1. Use distancing techniques, video, reversed binoculars, television. 2. Suggest tapping on hands, shoulders, and knees. 3. Have client begin narrative of target experience; Do NOT have client close their eyes. 4. Continue to infuse current safety and present orientation.
Phase 5 Installation	<ol style="list-style-type: none"> 1. Therapist repeats narrative of what happened to client, building a more rich story 2. Check patient's physical and emotional state, using BLS if possible 3. Help incorporate sequences, such as time and place, into narrative 4. Subtly use patient's own language to repeat the story to get cohesive picture/narrative 5. Goal: the world isn't such a bad place, it's worth it to continue living 6. Focus is on installation of control, self-determination, power/competence and humanity 7. Narrative created will hopefully be crystallized for future reference 8. Repeat until the patient has reprocessed the event and demonstrated that he/she is able to verbalize sensory experiences
Phase 6 Body Scan	<ol style="list-style-type: none"> 1. Acknowledge changes in patient's emotional tone and physical reactions. 2. Check for any residual, unprocessed information.
Phase 7 Closure	<ol style="list-style-type: none"> 1. Have patient repeat narrative in presence of physician. 2. Provide handout about the normalization of symptoms and what to expect in the next 48-72 hours.
Phase 8 Reevaluation	<ol style="list-style-type: none"> 1. Patient is given information for follow-up with; let patient know they are eligible for group and other therapeutic services. 2. Have patient verbally commit to follow-up with appropriate physicians and clinicians. 3. Patient is discharged.

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EMDR PRECI—Protocol for Recent Critical Incidents [Jarero and Artigas; 2011]

For Use With	Used with disaster survivors more than two days after a traumatic event up to six months post event (or as long as there is still ongoing trauma). Appropriate for events where clients are still living in areas with ongoing trauma and violence.
Phase 1 Client History	<ol style="list-style-type: none"> 1. Do not do any early history—focus only on narrative. 2. Ask client to describe the traumatic event in narrative form from right before the event occurred until the present moment. 3. If there is great distress (can't speak, crying) do not push for narrative and get a brief description of what happened. 4. Identify fragments of the event that stand out for them. 5. Do not use bilaterals. 6. Give diagnostic psychometrics of IES and SPRINT, if possible.
Phase 2 Preparation	<ol style="list-style-type: none"> 1. Screen for appropriateness for EMDR PRECI <ul style="list-style-type: none"> • Life threatening substance abuse, serious suicide attempts, self-mutilation • Serious assaultive behavior, signs of dissociative disorder 2. Educate about EMDR-AIP 3. Explain mechanics of train “stop” signal and “keep going” signal. 4. Teach butterfly hug and have them do it. 5. Teach self-soothing strategies (1) abdominal breathing (2) concentration exercise and (3) pleasant memory technique.
Phase 3 Assessment & Phase 4 Desensitization	<ol style="list-style-type: none"> 1. Have client run a movie of the event from right before the beginning until today. 2. Do not use bilaterals. 3. At the end have them tell you the worst fragment. 4. Assess fragments individually. <ul style="list-style-type: none"> • Worst fragment • Elicit other fragments • Desensitize all fragments using standard procedures until SUD at “0” or ecologically sound. 5. Processing sequence includes image, NC, emotion, SUD, location of physical sensation—no PC or VOC. 6. Only offer NC if clients are unable to come up with their own. 7. Use butterfly hug or eye movements for desensitization. 8. To elicit other fragments ask the client to visualize the entire sequence of the event again with eyes closed and reprocess only the fragments with disturbance.
Phase 5 Installation	<ol style="list-style-type: none"> 1. Develop a PC for the entire event. 2. Get a VOC. 3. Install PC using butterfly hug when client no longer identifies further disturbance when visualizing event with eyes open. 4. Shapiro suggests reviewing whole sequence holding PC.
Phase 6 Body Scan	<ol style="list-style-type: none"> 1. Run a body scan using standard procedures. 2. Reprocess any disturbance.
Phase 7 Closure	<ol style="list-style-type: none"> 1. Standard procedure. 2. Use Jarero and Artigas' self-soothing strategies learned at the beginning if necessary. 3. Remind client to use one of the self-control techniques as needed.
Phase 8 Reevaluation	<ol style="list-style-type: none"> 1. Make sure past memories are reprocessed. 2. Reprocess any present triggers. 3. A future template is done for each trigger.

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REP—Recent Event Protocol [Francine Shapiro; 1995, 2001, 2018]

For Use With	Patients who have experienced a recent trauma within the past two to three months, but past the first two days. If patients are displaying Acute Stress Reactions, additional stabilization exercises in history taking/preparation (like below) should be used.
Phase 1 Client History & Phase 2 Preparation	<ol style="list-style-type: none"> 1. Develop rapport and trust—goal is to prepare client to tell story while being calm and maintaining dual attention. 2. Educate regarding ASR symptoms; normalize physiological and psychological difficulties with regard to recent experience. 3. During narrative history taking on critical event, assess for the following to determine client readiness for trauma processing: Signs of dissociative disorders (not event-related symptoms); a danger to themselves or others; active psychosis; major vegetative depression; a history of suicide attempts; loss of consciousness during event. Loss of consciousness during event; can client maintain connection with therapist and sensation during BLS 4. Gather only essential background; medical/medications/drug/alcohol use/abuse/resources/past traumatic experiences. 5. Have client demonstrate deep breathing and other activities that activate the parasympathetic system and the relaxation response, grounding techniques. 6. Do “safe place” or resource exercise—tap into positive adaptive experiences if needed 7. Prepare client for EMDR processing of recent event—teach metaphors and techniques that foster stability and a sense of mastery and control—explain mechanics, stop signal. 8. Discuss ways to distance self during narrative, if necessary, until able to fully connect to experience. 9. Obtain a narrative of the event from what they were doing before the event until they felt safe, noting segments of disturbance for potential targets, identifying the most disturbing (first target).
Phase 3 Assessment & Phase 4 Desensitization & Phase 5 Installation	<ol style="list-style-type: none"> 1. Process the most disturbing segment “t” first (use of eye movements preferred; other methods tapping, auditory, tactile). 2. Assess: Image, NC, PC, VOC, Emotion, SUD, Location of physical sensation. 3. Can suggest a tentative NC and PC if they have difficulty. 4. Reprocess using standard EMDR protocol through to completion of installation. 5. Get SUDs down to 0 or 1, and VOC up to 6 or 7. (Ecologically sound.) 6. Repeat phases 3-5 for all other disturbing segments “t’s” of the event in chronological order. 7. Once all targets have been processed, have client visualize the entire event from start to finish with eyes closed. If disturbance is reported, process using standard EMDR protocol. 8. Continue to process until client can visualize the event from start to finish without any emotional, cognitive or somatic distress (unless ecological). 9. Develop a PC for the entire event, have client visualize entire event with that PC in mind with eyes open and adding EM’s.
Phase 6 Body Scan	<ol style="list-style-type: none"> 1. Combine original incident with PC and ask client to scan the body; process any sensations client reports. 2. If disturbing material, feelings or sensations emerge, return to processing or appropriately contain material if needed.
Phase 7 Closure	<ol style="list-style-type: none"> 1. Choose appropriate termination point and adequately debrief. 2. Provide support and normalize experience. 3. If material is not completely processed, utilize safe place, visual healing, or containment to close incomplete session. 4. Discuss possibility of continued processing between sessions; encourages client maintain a log; call if having difficulties.
Phase 8 Reevaluation	<ol style="list-style-type: none"> 1. Check to make sure all parts of the recent past event are preprocessed. 2. Target and reprocess any present triggers activated by this event. 3. Do a future template for each present trigger.

R-TEP—Recent Traumatic Episode Protocol [Elan Shapiro & Brurit Laub; 2008, 2014]

For Use With	Victims of RECENT trauma who may or may not be continuing to experience ongoing trauma in the aftermath of a crisis.
Phase 1 Client History	<ol style="list-style-type: none"> 1. Brief intake history to assess SMS (Severity/Motivation/Strengths). 2. Current trauma-focused therapy contract. 3. Psychoeducation regarding trauma episode and AIP (Adaptive Information Processing). 4. Conceptualizes traumatic episode as a trauma continuum from before the traumatic event until the present. 5. General description of trauma. AVOID GOING INTO DETAILS No BLS.
Phase 2 Preparation	1. Extended preparation uses E. Shapiro's 4-element self-soothing strategies (includes grounding, deep breathing, eliciting relaxation response, and safe place) and Laub's Resource Connection Envelope.
Phase 3 Assessment	<ol style="list-style-type: none"> 1. Obtains a narrative history of the trauma episode with BLS. 2. Uses Google search with BLS to identify the first PoD (Point of Disturbance) and then assesses the PoD with image, NC, PC, VOC, emotion, SUD, and body sensation location. 3. Waits for clients to respond with their own NC before offering one. Suggests a tentative NC and PC to the client if they have difficulty forming NC or PC. 4. After a PoD is reprocessed, repeat Google search using BLS to find the next PoD. Sequencing is not necessarily chronological. 5. Each identified PoD is assessed as a complete target with image, NC, PC, VOC, emotion, SUD, and body sensation location.
Phase 4 Desensitization	<ol style="list-style-type: none"> 1. Uses "Focused Processing" = default EMDr strategy (containing associations to current episode only.) Or EMD Strategy (containing associations relating directly to the PoD only) when it is an intrusive fragment. EMDr free associative processing is used if trauma episode-focused processing is not sufficient. 2. Uses various forms of BLS, but recommends tapping and EM and always keeping eyes open, as well for monitoring outer attention and grounding in the present safety. 3. Each subsequent PoD is processed with Focused Processing to completion of installation phase (not necessarily chronological). No body scan yet.
Phase 5 Installation	<ol style="list-style-type: none"> 1. Install PC for each target when SUD is ecological. 2. Installation of the PC uses standard EMDR procedure with frequent checking of VOC. 3. Installation for entire episode is conducted when the client identifies no further PoDs when doing a "Google search" of episode. 4. PC is developed for the whole episode. 5. Installation of the episode PC uses standard EMDR procedures, which include frequent checking of VOC.
Phase 6 Body Scan	<ol style="list-style-type: none"> 1. No body scan until all the targets of the T-episode are processed. 2. Then do body scan for whole episode.
Phase 7 Closure	1. Use E. Shapiro's 4-element self-soothing strategies (includes safe place and Laub's resource connection envelope).
Phase 8 Reevaluation	<ol style="list-style-type: none"> 1. Check for remaining PoDs using "Google Search" at next session. 2. Follow-up at the end.

***EMD strategy:** Narrow focus going only with associations relating to the PoD but returning to Target (PoD) and checking SUD when it departs from PoD. If SUD stuck (6 sets) expand naturally into EMDr strategy. Used when POD is an intrusive fragment (reoccurring image, sensation, thought, feeling.)

***EMDr strategy:** Wider focus allowing associative chains relating to the T-Episode. If SUD stuck consider narrower

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EMDRIGTP—EMDR Integrative Group Treatment Protocol—Adult [Jarero and Artigas, 2000]	
For Use With	Providing treatment to large groups of people (both children and adults) impacted by large-scale critical incidents.
Phase 1 Client History <i>For children use toys and play during phases 1 & 2.</i>	<ul style="list-style-type: none"> • Attention to basic needs (shelter, food, security) and getting permission to treat (from hosting organization). • Establish emotional protection team (and gather history through this team: symptoms, family status, infrastructure, etc.). • Organize meeting to explain trauma from adaptive information processing perspective. • Invite people to participate in a small group process (if many people, schedule multiple sessions over many days—no more than 20-30 participants in a group). Two hours are scheduled for a group session.
Phase 2 Preparation	<ol style="list-style-type: none"> 1. PART ONE: Goal of building rapport and trust (with children—use drums, puppets, toys, storytelling, etc.). 2. Emotional protection team is introduced and placed around the circle (try to have 8-10 participants per team member). Active supportive listening is the role—do not probe for emotional responses or information. 3. Explain group process, policies and procedures. Do brief introductions. Introduce AIP (adaptive information processing). 4. Ask people for symptoms they may be exhibiting (Have any of you been experiencing nightmares? Show of hands). 5. Don't force anyone to talk, and note if there is any deterioration or dysfunction—those who are unable to attend to their basic responsibilities and activities. (Triage those who may need more personal attention.) 6. Normalize symptoms. Teach self-soothing activities (abdominal breathing, concentration exercise, pleasant memory, butterfly hug)—remind that they can use these activities anytime 7. Share coping strategies to use after a trauma (i.e., drinking water, eating healthy, exercise, self-soothing techniques, etc.). 8. Prepare for trauma work by checking and validating the signs and symptoms of PTSD (can do IES or CRTES). 9. Encourage people to verbalize traumatic memories as much as they feel comfortable doing so. 10. PART TWO: Introduce and use HAP SUD scale measure (HAP faces). 11. Give out paper and crayons and write name on top left page and then turn over the paper. 12. Divide into four squares; put letters A, B, C, D on each square.
Phase 3 Assessment	<ol style="list-style-type: none"> 1. As a group, remember the event, and raise their hands to acknowledge that they are thinking about worst part of event. 2. Draw in square "A" a picture that represents this experience. Have them do SUD rating 0-10 and any NC. Write them down.
Phase 4 Desensitization	<ol style="list-style-type: none"> 1. Put crayons aside and do butterfly hug for 60 seconds while looking at picture "A." 2. Observe feelings and draw whatever you want in square B related to the event. 3. Get another SUD when you look at square "B"—write it down 4. Do butterfly hug for 60 seconds again looking at picture "B" 5. Repeat steps 1-4 for pictures "C" and "D" 6. Look at drawing that disturbs you the most, and write down the SUD about how you feel about the drawing now.

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EMDR IGTP—EMDR Integrative Group Treatment Protocol – Adult [Jarero and Artigas, 2000]	
For Use With	Providing treatment to large groups of people (both children and adults) impacted by large-scale critical incidents.
Phase 1 Client History <i>For children use toys and play during phases 1 & 2.</i>	<ul style="list-style-type: none"> • Attention to basic needs (shelter, food, security) and getting permission to treat (from hosting organization). • Establish emotional protection team (and gather history through this team: symptoms, family status, infrastructure, etc.). • Organize meeting to explain trauma from adaptive information processing perspective. • Invite people to participate in a small group process (if many people, schedule multiple sessions over many days—no more than 20-30 participants in a group). Two hours are scheduled for a group session.
Phase 2 Preparation	<ol style="list-style-type: none"> 13. PART ONE: Goal of building rapport and trust (with children—use drums, puppets, toys, storytelling, etc.). 14. Emotional protection team is introduced and placed around the circle (try to have 8-10 participants per team member). Active supportive listening is the role—do not probe for emotional responses or information. 15. Explain group process, policies and procedures. Do brief introductions. Introduce AIP (adaptive information processing). 16. Ask people for symptoms they may be exhibiting (Have any of you been experiencing nightmares? Show of hands). 17. Don't force anyone to talk, and note if there is any deterioration or dysfunction—those who are unable to attend to their basic responsibilities and activities. (Triage those who may need more personal attention.) 18. Normalize symptoms. Teach self-soothing activities (abdominal breathing, concentration exercise, pleasant memory, butterfly hug)—remind that they can use these activities anytime 19. Share coping strategies to use after a trauma (i.e., drinking water, eating healthy, exercise, self-soothing techniques, etc.). 20. Prepare for trauma work by checking and validating the signs and symptoms of PTSD (can do IES or CRTES). 21. Encourage people to verbalize traumatic memories as much as they feel comfortable doing so. 22. PART TWO: Introduce and use HAP SUD scale measure (HAP faces). 23. Give out paper and crayons and write name on top left page and then turn over the paper. 24. Divide into four squares; put letters A, B, C, D on each square.
Phase 3 Assessment	<ol style="list-style-type: none"> 3. As a group, remember the event, and raise their hands to acknowledge that they are thinking about worst part of event. 4. Draw in square “A” a picture that represents this experience. Have them do SUD rating 0-10 and any NC. Write them down.
Phase 4 Desensitization	<ol style="list-style-type: none"> 7. Put crayons aside and do butterfly hug for 60 seconds while looking at picture “A.” 8. Observe feelings and draw whatever you want in square B related to the event. 9. Get another SUD when you look at square “B”—write it down 10. Do butterfly hug for 60 seconds again looking at picture “B” 11. Repeat steps 1-4 for pictures “C” and “D” 12. Look at drawing that disturbs you the most, and write down the SUD about how you feel about the drawing now.

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EMDR G-TEP (EMDR Group Traumatic Episode Protocol - Elan Shapiro, 2015 ©)

For Use With	<ul style="list-style-type: none"> • Suitable for working with groups of people (older children and adults) impacted by large-scale critical incidents. • Also suitable for families, couples. • Offering stabilisation, stress management & an adaptive processing screening check, for all exposed. • Providing intensive current trauma episode processing when appropriate
Intake & Data Collection	<ul style="list-style-type: none"> • Obtain initial data for assessment information, screening & group selection: • Conduct brief individual interviews & joining when possible • Administer psychometric measures for PTSD, Depression & Resilience (e.g. PCL-5, MINI; PHQ-9, BDI; BRS / CD-RISC 10) • Repeat these measures POST treatment & at FOLLOW-UP • Work Seated around tables up to about 12 participants in a group. 2-3 hours are scheduled for a group session.
Materials & Setup	<ul style="list-style-type: none"> • Participants work on a G-TEP Worksheet printed on a large sheet of paper; Coloured pens or pencils; A silicon rubber wristband or a sticker; Faces scale & stickers for children or non-literate populations. • The G-TEP manual has the protocol script & all the instructions for the group leader and a worksheet with summary notes. • The setup is designed for use with this single worksheet to guide the process step by step. • The slides & worksheet of the EMDR G-TEP are colour-coded so that each step has its own colour to make it easier to follow. • The Worksheet is a meta-communication: in which the trauma event is enveloped with present/ past/& future resources graphically conveying that the event is in the past- they are safe now in the present & that there is hope for the future. • Group leaders should have additional support staff, to aid with logistics, monitor & support those who need assistance.
Step One Preparation	<ul style="list-style-type: none"> • STEP 1 Preparation & screening: This step can stand alone as it is helpful for all for stress management & for screening. • Ask to write down SUD before (0...10). • Teach the 4 Elements exercise (Includes Safe/calm place drawing or words). • Ask to write SUD after (0...10) ; Write the Date TODAY.
Step Two: Onset of Trauma	<ul style="list-style-type: none"> • Write a heading (word or words, symbol or sketch) for the Onset of Trauma Episode. • Write SUD (0.....10) now. • Write the 'Date THEN' (for when the event happened). NB: No sharing of the traumas.
Step Three: Past Resource	<ul style="list-style-type: none"> • Recall a memory where you felt good with yourself, felt whole. • Notice feelings and body sensations. • Strengthen connection with set of Butterfly Hugs. • Draw or write something to represent it. • Give it a name and strengthen with Butterfly Hugs. • Invite group sharing of good memories.

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Step Four: Future Resource	<p><i>EMDR G-TEP - CONTINUED FROM PREVIOUS PAGE</i></p> <ul style="list-style-type: none"> • Ask group members how they would like to think about themselves and the events that have happened. Show list for examples. • Draw or write any other thoughts or pictures of how you would like to see yourself in the future. • Invite group sharing of desired future.
Step Five: Pod Level Processing	<ul style="list-style-type: none"> • Scan Episode to Identify Points of Disturbance (PoDs). • Focused Processing (Desensitization) of each in turn with EMD type strategy. • Identify PoDs using 'Google Search'/Scan. • Use self-BLS by tapping in the (PRESENT) safe place <u>DATE TODAY</u> box and then the (PAST) disturbance <u>DATE THEN</u> box, i.e. with one hand. Look at your hand as you do this. • When a PoD is identified then STOP and draw/write it. Write SUD rating (0 – 10). Take some deep breaths until everyone is ready. • Focused processing. Focus on the PoD and tap on Step 1 <u>DATE TODAY</u> in the safe place box, and then the PoD in Step 5, tap back and forth together with the group leader who paces the group by counting &/or loud tapping. After each set of BLS, take a breath and pay attention to Images, Sensations, Feelings, and Thoughts or to whatever you notice. • Repeat for 9 sets (3 x 3 for each PoD). After every 3rd set re-focus on that PoD and write down SUD (0 – 10). • Repeat the same procedure three times (PoD level processing as in items 1 and 2 above for PoD1, PoD2, PoD3).
Step Six: Episode Level Processing	<ul style="list-style-type: none"> • Ask group members to think about the whole episode and check the Episode SUD (0–10) rating. If Episode SUD is above 5 consider further sessions. • Underline the sentence that feels the most true now (in box 4). How would you like to think about the whole Episode now?. What have you learned? What are you taking with you? Encourage group sharing and feedback from all participants. . • Install a PC for the Episode: Choose the words that feel the most true now. Repeat silently while using Butterfly Hugs (2 to 3 sets of about 20 seconds each).
Step 7: Closure	<ul style="list-style-type: none"> • Rehearse 4 Elements.
Step Eight: Follow Up	<ul style="list-style-type: none"> • Do additional sessions if needed. • Screen for those who need a referral for individual sessions.

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Instructions for printing: Print on minimum A3 size matt paper in color

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4 Elements Exercise for Stress Reduction

EARTH-AIR-WATER-FIRE

(Adapted from Elan Shapiro, 2012 by Beverlee Laidlaw Chasse)

Earth: GROUNDING, REALITY OF SAFETY IN THE PRESENT MOMENT

Take a minute to "land", be here, now. Feel both feet on the ground, feel the support of the chair. Look around and notice 3 things. What do you see? What do you hear? Imagine you are a tree, roots coming down through your feet connecting with the healing energy and strength of the Earth.

Air: BREATHING FOR CENTERING

Imagine you have a balloon in your belly. When you INHALE fill the balloon. When you EXHALE deflate the balloon completely and squeeze out any emotional distress you are experiencing. Option: Breathe in through your nose as you count 4 seconds, then hold for 2 sec and then breathe out for 4 sec. and hold for 2 sec. Take about a dozen deeper, slower breaths like this.

Water: CALM AND CONTROLLED. MORE IN CONTROL, SWITCHING ON THE RELAXATION RESPONSE

Make Saliva, Get moisture in your mouth. When you are anxious or in fight, flight or freeze your Sympathetic Nervous System shuts down your digestive system and your mouth goes dry. So when you start making saliva you switch on the digestive system again and the Parasympathetic Nervous System activates the relaxation response allowing you to feel calmer, focused and more in control.

Fire: LIGHT UP THE PATH OF YOUR IMAGINATION

Bring up an image of SAFE PLACE or an experience when you felt comfortable or good about yourself.

Let yourself be there. What can you see, hear, smell. What does it feel like outside your body? Inside your body. Activate this experience by doing the BUTTERFLY HUG. Cross your arms across your chest so that your thumbs are intertwined and your other fingers are spread under both collarbones. (See diagram below) Slowly tap bilaterally, on each side of your chest, to enhance the feelings of SAFETY and CALM in your body. Wear a 4 Elements Bracelet on your wrist and use it as a reminder that you now know how to immediately reduce your stress levels by performing the 4 Elements Exercise.



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Abbreviated: Resource Connection Envelope

During Preparation:

“Before we work on..... (*current traumatic experience*), we would like for you to recall a moment in time when you felt good about yourself, a time or situation in which you felt whole, or well (**Note- This does not have to be a resource directly related to the issue at hand like RDI**). You may close your eyes while beginning to tap using Butterfly Hug Bilateral (BHBs).... Allow yourself to stay with the memory, and be there; notice what you see, hear, smell, and allow your feelings and body sensations to emerge.”

Get a cue word or phrase to anchor it and provide an entrance door (Do BHB).

or

Posture Cue – Choose posture that fits their resource experience to enhance the resource (Do BHB).

During Desensitization:

Note Adaptive Responses, Positive Thoughts and Emotions, Body Sensations, and Positive Resource Experiences.

During Closing:

1) Connection to Closing Resource:

- Therapist reviews any resource noted during processing including first resource and invites the client to choose one of these; or develop another one.
- Have them connect to the resource, notice feeling, body sensations, and do BHB's.
- Get cue word or posture associated with resource (if new enhance it with BHB).

2) (*If Appropriate*) Develop a Future Resource Connection:

- How client would like to see themselves in the future. Enhance with BHB.



Adapted from: Laub, Brurit and Shapiro, Elan.
2012, May. RTEP Training. Scottsdale, AZ
©Beverlee Chasse 2013

Trauma Response Information Sheet

Adapted from Lerner, M. D. and Shelton, R. D. (2005). *Comprehensive Acute Traumatic Stress Management: CATSM*. The American Academy of Experts in Traumatic Stress: Commack, NY.

The following acute stress reactions are experienced by people during a traumatic event and are normal responses to an abnormal event. The problem is when the following reactions are experienced weeks, months and years after the event and are joined by other symptoms like recurrent disturbing dreams, flashbacks, avoidance behaviors and dissociations.

Emotional Responses

- Shock
- Highly anxious; hyper-active
- Stunned; emotionally numb
- In a fog; apathetic
- Denial, dissociation, amnesia
- Feeling of unreality
- Panic
- Fear
- Intense feeling of aloneness
- Hopelessness
- Helplessness
- Emptiness
- Uncertainty
- Horror
- Terror
- Anger
- Hostility
- Irritability
- Depression
- Grief
- Feelings of guilt

Cognitive Responses

- Impaired concentration
- Confusion
- Disorientation
- Difficulty making decisions
- Short attention span
- Suggestibility
- Vulnerability
- Forgetfulness
- Self-blame
- Blaming others
- Lowered self-efficacy
- Thoughts of losing control

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- Hyper vigilance
- Continually thinking about incident; playing tape over and over again

Physiological Responses

- Rapid heart beat
- Elevated blood pressure
- Difficulty breathing*
- Shock symptoms*
- Chest pains*
- Cardiac palpitations*
- Muscle tension and pains
- Fatigue
- Fainting
- Flushed face
- Pale appearance
- Chills
- Cold, clammy skin
- Increased sweating
- Thirst
- Dizziness
- Vertigo
- Hyperventilation
- Headaches
- Grinding teeth
- Gastrointestinal upset
- Freeze

*** Requires immediate medical attention**



Behavioral Responses

- Withdrawal, spacing out
- No communication
- Changes in speech patterns
- Regressive behaviors
- Erratic movements
- Impulsivity
- Reluctance to abandon property
- Aimlessly walking, pacing
- Inability to sit still
- Exaggerated startle response
- Anti-social behaviors
- Amnesia, partial or complete

Spiritual Responses

- Anger and distance from God
- Withdrawal from attending services; anger at clergy
- Sudden turn towards God
- Increased involvement in religious community
- Praying, saying scripture, hymns
- Praying doesn't comfort like it used to
- Life empty without meaning
- God is powerless; individual feels unprotected and abandoned
- Question beliefs previously held
- Happened to me because I'm being punished

Appendix E: EEI RESEARCH, April 2018

RESEARCH ON EMDR EARLY INTERVENTION PROTOCOLS

Louise Maxfield, Ph.D., Psychologist

Part A: Studies in which treatment was provided within 3 months post-trauma

Individual Treatment

Recent Event Protocol (EMDR-RE) Developed by Francine Shapiro	
RCT	Tarquinio, C., Rotonda, C., Houllé, W. A., Montel, S., Rydberg, J. A., Minary, L., et al. (2016). Early psychological preventive intervention for workplace violence: A randomized controlled explorative and comparative study between EMDR-Recent Event and Critical Incident Stress Debriefing. <i>Issues in Mental Health Nursing</i> , 37(11), 787-799. DOI: 10.1080/01612840.2016.1224282
Case Studies	Buydens, S. L., Wilensky, M., & Hensley, B. J. (2014). Effects of the EMDR protocol for recent traumatic events on acute stress disorder: A case series. <i>Journal of EMDR Practice and Research</i> , 8(1), 2-12. https://doi.org/10.1891/1933-3196.8.1.2
	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. <i>International Journal of Stress Management</i> , 12 (1): 29-42. 1541. DOI: 10.1037/1072-5245.12.1.29 .
	Wesson, M., & Gould, M. (2009). Intervening early with EMDR on military operations: A case study. <i>Journal of EMDR Practice and Research</i> , 3(2), 91-97. https://doi.org/10.1891/1933-3196.3.2.91
Recent Traumatic Episode Protocol (R-TEP) Developed by Elan Shapiro And Brurit Laub	
RCTs	Shapiro, E., & Laub, B. (2015). Early EMDR intervention following a community critical incident: A randomized clinical trial. <i>Journal of EMDR Practice and Research</i> , 9(1), 17-27. http://dx.doi.org/10.1891/1933-3196.9.1.17
	Shapiro, E., Laub, B., & Rosenblat, O. (2018). Early EMDR Intervention following intense rocket attacks on a town: A randomised clinical trial. <i>Clinical Neuropsychology</i> .
Controlled Study	Saltini, A., Rebecchi, D., Callera, C., Fernandez, I. Bergonzini, E., & Starace, F. (2017). Early Eye Movement Desensitisation and Reprocessing (EMDR) intervention in a disaster mental health care context. <i>Psychology, Health & Medicine</i> . http://dx.doi.org/10.1080/13548506.2017.1344255
EMDR Protocol for Recent Critical Incidents (EMDR-PRECI) Developed by Jarero et al.	
RCTs	Jarero, I., Artigas, L., & Luber, M. (2011). The EMDR protocol for recent critical incidents: Application in a disaster mental health continuum of care context. <i>Journal of EMDR Practice and Research</i> , 5(3), 82-94. https://doi.org/10.1891/1933-3196.5.3.82
	Jarero, I., Uribe, S., Artigas, M., & Givaudan, M. (2015). EMDR protocol for Recent Critical Incidents: A randomized controlled trial in a technological disaster context. <i>Journal of EMDR Practice and Research</i> , 9(4), 166-173. https://doi.org/10.1891/1933-3196.9.4.166
Controlled Studies	Jarero, I., & Uribe, S. (2011). The EMDR Protocol for recent critical incidents: Brief report of an application in a human massacre situation. <i>Journal of EMDR Practice and Research</i> , 5(4), 156-165. https://doi.org/10.1891/1933-3196.5.4.156
	Jarero, I., & Uribe, S. (2012). The EMDR protocol for recent critical incidents: Follow-up report of an application in a human massacre situation . <i>Journal of EMDR Practice and Research</i> , 6(2), 50-61. https://doi.org/10.1891/1933-3196.6.2.50

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EMDR Protocol with Paraprofessionals in Acute Trauma Situations (EMDR-PROPARG) Developed by Jarero et al.

RCT	Jarero, I., Amaya, C., Givaudan, M., & Miranda, A. (2013). EMDR individual protocol for paraprofessional use: A randomized controlled trial with first responders. <i>Journal of EMDR Practice and Research</i> , 7(2), 55-64. https://doi.org/10.1891/1933-3196.7.2.55
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Urgent EMDR Treatment Protocol (URG-EMDR) Developed by Cyril Tarquinio & Marie-Jo Brennstuhl

Controlled Study	Brennstuhl, M. J., Tarquinio, C., Strub, L., Montel, S., Rydberg, J. A., & Kapoula, Z. (2013). Benefits of Immediate EMDR vs. Eclectic Therapy intervention for victims of physical violence and accidents at the workplace: a pilot study. <i>Issues in Mental Health Nursing</i> , 34(6), 425-434, DOI: 10.3109/01612840.2012.759633
Case Study	Tarquinio, C., Brennstuhl, M. J., Reichenbach, S., Rydberg, J. A., & Tarquinio, P. (2012). Early management of rape victims and presentation of an emergency EMDR treatment protocol. <i>Sexologies</i> , 21 (3), 147-156. https://doi.org/10.1016/j.sexol.2011.11.012

Group Treatment

EMDR Integrated Group Treatment Protocol (EMDR-IGTP) Developed by Jarero et al.

Case Studies	Adúriz, M. E., Knopfler, C., & Bluthgen, C. (2009). Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. <i>International Journal of Stress Management</i> , 16(2), 138–153. http://dx.doi.org/10.1037/a0014719
	Allon, M. (2015). EMDR group therapy with women who were sexually assaulted in the Congo. <i>Journal of EMDR Practice and Research</i> , 9(1), 28-34. http://dx.doi.org/10.1891/1933-3196.9.1.28
	Fernandez, I., Gallinari, E., & Lorenzetti, A. (2003). A school-based eye movement desensitization and reprocessing intervention for children who witnessed the Pirelli building airplane crash in Milan, Italy. <i>Journal of Brief Therapy</i> , 2 (2). 129-36.
	Jarero, I., & Artigas, L. (2010). EMDR integrative group treatment protocol: Application with adults during ongoing geopolitical crisis. <i>Journal of EMDR Practice and Research</i> , 4(4), 148–155. https://doi.org/10.1891/1933-3196.4.4.148
	Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative treatment protocol: A post-disaster trauma intervention for children & adults. <i>Traumatology</i> , 12, 121–129. https://doi.org/10.1177/1534765606294561
	Jarero, I., Artigas, L., & Montero, M. (2008). The EMDR integrative group treatment protocol: Application with child victims of a mass disaster. <i>Journal of EMDR Practice and Research</i> , 2, 97–105. https://doi.org/10.1891/1933-3196.2.2.97
	Korkmazlar-Oral, U., & Pamuk, S. (2002). Group EMDR with child survivors of the earthquake in Turkey. Association of Child Psychology and Psychiatry (ACPP). Occasional Papers No. 19, 47–50
	Maslovaric, G., Zaccagnino, M., Mezzaluna, C., Perilli, S., Trivellato, D., Longo, V., & Civilotti, C. (2017). The effectiveness of Eye Movement Desensitization and Reprocessing Integrative Group Protocol with adolescent survivors of the Central Italy Earthquake. <i>Front. Psychol.</i> 8:1826. DOI: 10.3389/fpsyg.2017.01826
	Zaghrou-Hodali, M., Alissa, F., & Dodgson, P. (2008). Building resilience and dismantling fear: EMDR group protocol with children in an area of ongoing trauma. <i>Journal of EMDR Practice and Research</i> , 2(2), 106-113. doi:10.1891/1933-3196.2.2.106

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RESEARCH ON EMDR EARLY INTERVENTION PROTOCOLS

Part B: Studies providing treatment for “ongoing” or historical trauma

Individual Treatment

Recent Traumatic Episode Protocol (R-TEP) Developed by Elan Shapiro And Brurit Laub	
RCT	Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M. Gulen, B., & Cuijpers, P. (2016). The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: Results of a randomized controlled trial. <i>Psychological Medicine</i> , 46(12), 2583-2593. https://doi.org/10.1017/S0033291716001070
Case Study	Tofani, L. R., & Wheeler, K. (2011). The recent-traumatic episode protocol: Outcome evaluation and analysis of three case studies. <i>Journal of EMDR Practice and Research</i> , 5(3), 95-110. doi:10.1891/1933-3196.5.3.95.

Group Treatment

Group Traumatic Episode Protocol (G-TEP) Developed by Elan Shapiro	
RCT	Yurtsever, A., Tükel, F., Konuk, E., Çetinkaya, M., Zat, Z., & Shapiro, E.D. (in press). An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees with posttraumatic stress symptoms: Results of a randomized controlled trial. <i>Frontiers of Psychology</i> .
Pilot Study	Lehnung, M., Shapiro, E., Schreiber, M., & Hofmann, A. (2017). Evaluating the EMDR Group Traumatic Episode Protocol (EMDR G-TEP) with refugees: A field study. <i>Journal of EMDR Practice and Research</i> 11(3). https://doi.org/10.1891/1933-3196.11.3.129
Case Study	Roberts, K. A. (in press). The Effects of the EMDR Group Traumatic Episode Protocol, G-TEP with cancer survivors. <i>Journal of EMDR Practice and Research</i> , 12(3).
EMDR Integrated Group Treatment Protocol Adapted for Adolescents and Adults with Ongoing Traumatic Stress (EMDR-IGTP-OTS) Developed by Jarero et al.	
RCT	Jarero, I., Givaudan, M., & Osorio, A. (in press). Provision of the EMDR IGTPOTS to female patients with cancer-related PTSD symptoms. <i>Journal of EMDR Practice and Research</i> , 12(3).
Pilot Study	Jarero, I., Artigas, L., Uribe, S., García, L. E., Cavazos, M. A., & Givaudan, M. (2015). Pilot research study on the provision of the eye movement desensitization and reprocessing integrative group treatment protocol with female cancer patients. <i>Journal of EMDR Practice and Research</i> , 9(2), 98-105. https://dx.doi.org/10.1891/1933-3196.9.2.98
Case Studies	Jarero, I., Artigas, L., Uribe, S., & García, L. E. (2016). The EMDR integrative group treatment protocol for patients with cancer. <i>Journal of EMDR Practice and Research</i> , 10(3), 199-207. http://dx.doi.org/10.1891/1933-3196.10.3.199
	Jarero, I., Roque-López, S., & Gomez, J. (2013). The provision of an EMDR-based multicomponent trauma treatment with child victims of severe interpersonal trauma. <i>Journal of EMDR Practice and Research</i> , 7(1), 17-28. https://doi.org/10.1891/1933-3196.7.1.17

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This paper was presented at the EMDR Early Intervention and Crisis Response Summit Conference, Natick, MA, April 2018.

EMDR Early Intervention and Crisis Response: Researcher's Toolkit: Main Text
Toolkit pages 1-20 | URL with Hyperlink

Toolkit Webpage URL to be cited in all publications (electronic or printed)	EMDR Research Foundation webpage that introduces the Toolkit. Other websites, emails, posts, or any form of electronic or printed media/publications should use ONLY this URL to link to this Toolkit.	http://emdrfoundation.org/resources/toolkit/toolkit/
Toolkit User Registration (online form)	Please complete our user registration form so that we can send you Toolkit updates, information, and opportunities. In addition, this information will help us to know how the Toolkit is being used so that we can be aware of what is useful to those conducting EMDR early intervention and crisis response research now and in the future.	https://mailchi.mp/emdrresearchfoundation/researchertoolkit
ACES Questionnaire	Adverse Child Experiences Study website homepage	https://acestoohigh.com/got-your-ace-score/
DIME Manual Module 6	(DIME) Design, Implementation, Monitoring, and Evaluation of Mental Health and Psychosocial Assistance Programs for Trauma Survivors in Low Resource Countries: User's Manual for Researchers and Program Implementers (Adult Version), Module 6: Using Controlled Trials to Assess Program Impacts. Johns Hopkins University Bloomberg School of Public Health. 9/2013.	http://emdrfoundation.org/toolkit/dime.pdf
Toolkit	EMDR Early Intervention and Crisis Response Researcher's Toolkit, (2018) The EMDR Research Foundation	http://emdrresearchfoundation.org/toolkit/toolkit-with-appendices.pdf
Luber (2014). Book and CD-ROM from Amazon	Luber, M (ed.) 2014. Implementing EMDR Early Mental Health Interventions for Manmade and Natural Disasters;	http://a.co/btY89pM
Luber (2014). Book and CD-ROM from Springer	Models, Scripted Protocols and Summary Sheets. Springer Publishing Company. ISBN: 978-0-8261-9921-8.	http://www.springerpub.com/implementing-emdr-early-mental-health-interventions-for-man-made-and-natural-disasters-cd-rom.html
Appendix A: Clinical Forms Toolkit pages 21-31 URL with Hyperlink to Clinical Forms		
Clinical Forms (PDF)	EMDR Early Intervention and Crisis Response: Researcher's Toolkit Appendix A: Samples of Clinical Forms (2014) [PDF version]	http://emdrfoundation.org/toolkit/clinical-forms.pdf
Clinical Forms (Word document)	EMDR Early Intervention and Crisis Response: Researcher's Toolkit Appendix A: Samples of Clinical Forms (2014) [Word document]	http://emdrfoundation.org/toolkit/clinical-forms.docx
Appendix B: Table of Measures Toolkit pages 32-34 URL with Hyperlink to Specific Measures		
BRCS	Brief Resilience and Coping Scale (BRCS). Sinclair & Wallston, 2004.	http://emdrresearchfoundation.org/toolkit/brcs.pdf
CRIES-13	Children's Revised Impact of Events Scale –CRIES (13). Children and War Foundation, 1998.	http://emdrresearchfoundation.org/toolkit/cries-13.pdf
CRIES-8	Children's Revised Impact of Events Scale 8 –CRIES (8). Children and War Foundation, 1998.	http://emdrresearchfoundation.org/toolkit/cries-8.pdf
IES-R	IMPACT OF EVENT SCALE-REVISED, Daniel S. Weiss, PhD & Charles R. Marmar, MD	http://emdrresearchfoundation.org/toolkit/ies.pdf
IES-R Scoring	IMPACT OF EVENT SCALE-REVISED, Daniel S. Weiss, PhD & Charles R. Marmar, MD, (includes scoring page)	http://emdrresearchfoundation.org/toolkit/ies-scoring.pdf
PCL-5	PTSD Checklist for DSM 5 (PCL-5) (8/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr - National Center for PTSD	http://emdrresearchfoundation.org/toolkit/pcl-5.pdf

Appendix B, Continued

PCL-5-Criterion-a	PTSD Checklist for DSM 5 (PCL-5) Including Criterion A (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr - National Center for PTSD	http://emdrfoundation.org/toolkit/pcl-5-criterion-a.pdf
SPRINT	Short PTSD Rating Interview (SPRINT) John R.T. Davidson (2000)	http://emdrfoundation.org/toolkit/sprint.pdf
Toolkit Table of Measures	EMDR Early Intervention and Crisis Response: Researcher's Toolkit Appendix B: TABLE OF MEASURES	http://emdrresearchfoundation.org/toolkit/table-of-measures.pdf

Appendix C: Protocols, Resources and References | Toolkit pages 35-55 | URL with Hyperlink to the Protocol

Butterfly Hug	The Butterfly Hug Method for Bilateral Stimulation, Lucina Artigas and Ignacio Jarero. September, 2014	http://emdrfoundation.org/toolkit/butterfly-hug.pdf
ERP	Emergency Response Procedure. G. Quinn, 2005, 2009	http://emdrfoundation.org/toolkit/erp.pdf
EMDR-ER	EMDR Emergency Room (EMDR-ER), J. Guedalia & F. Yoeli, 2000)	http://emdrfoundation.org/toolkit/emdr-er.pdf
Four Elements	4 Elements Exercises for Stress Reduction (Earth-Air-Water - Fire), Elan Shapiro, 2012	http://emdrfoundation.org/toolkit/four-elements.pdf
G-TEP	EMDR Group Traumatic Episode Protocol. E. Shapiro (2013)	http://emdrfoundation.org/toolkit/gtep.pdf
Group Space EMDR Protocol (formerly IMMA)	Group Space EMDR Protocol (formerly "IMMA Group Protocol"), Brurit Laub and Esti Bar-Sade. 2014	http://emdrfoundation.org/toolkit/imma.pdf
IGTP Adults	The EMDR Integrative Group Treatment Protocol (IGTP) for Early Intervention with Adolescents (between 14 and 17 years) and Adults. By I. Jarero and L. Artigas 2015.	http://emdrfoundation.org/toolkit/igtp-adult.pdf
IGTP Cancer Study	Pilot Research Study on the Provision of the EMDR Integrative Group Treatment Protocol with Female Cancer Patients (2014)	http://emdrfoundation.org/toolkit/igtp-cancer-study.pdf
IGTP Children	The EMDR Integrative Group Treatment Protocol (IGTP) for Early Intervention with Children, Lucina Artigas, Ignacio Jarero, Nicté Alcalá & Teresa López Cano, 2015.	http://emdrfoundation.org/toolkit/igtp-children.pdf
IGTP-Luber-Chapter-15 (With Permission from Springer Publishing)	Chapter 15: The EMDR Integrative Group Treatment Protocol (IGTP) for Adults. By I. Jarero & Lucina Artigas (2014)	http://emdrfoundation.org/toolkit/igtp-luber-ch15.pdf
IGTP-Luber-Chapter-15a (With permission from Springer Publishing)	Chapter 15a: Summary Sheet for Each Participant: The EMDR Integrative Group Treatment Protocol (IGTP) for Adults. By Ignacio Jarero and Lucina Artigas. Summary Sheet by Marilyn Luber (2014)	http://emdrfoundation.org/toolkit/igtp-luber-ch15a.pdf
IGTP-Luber-Chapter 15b (With permission: Springer Publishing)	Chapter 15b: Summary Sheet for Clinicians: The EMDR Integrative Group Treatment Protocol (IGTP) for Adults. By I. Jarero & L. Artigas. Summary Sheet by Marilyn Luber (2014)	http://emdrfoundation.org/toolkit/igtp-luber-ch15b.pdf
IGTP-Ongoing	EMDR Integrative Group Treatment Protocol for Adolescents (Between 14 and 17 years) and Adult Living in Ongoing Traumatic Stress. I. Jarero and L. Artigas. (2017.)	http://emdrfoundation.org/toolkit/igtp-ongoing.pdf
ISP Protocol	Immediate Stabilization Procedure. G. Quinn (2018)	http://emdrfoundation.org/toolkit/isp.pdf
PRECI	The EMDR Protocol for Recent Critical Incidents (EMDR-PRECI) and Ongoing Traumatic Stress. Ignacio Jarero & Lucina Artigas. September, 2014	http://emdrfoundation.org/toolkit/preci.pdf

APPENDIX F: TOOLKIT URLSWITHHYPERLINKS		Page 3 of 3
Appendix C: Protocols, Resources and References Toolkit pages 35-55 URL with Hyperlink to the Protocol		
REP (Recent Event Protocol - F. Shapiro)	Recent Event Protocol, F. Shapiro, 1995, 2001, 2018.	http://emdrfoundation.org/toolkit/rep.pdf
R-TEP-fidelity-checklist	EMDR Recent Traumatic Episode Protocol (EMDR R-TEP) Fidelity Scale. Revised 8/2014, E. Shapiro & B. Laub	http://emdrfoundation.org/toolkit/rtep-fidelity-checklist.pdf
R-TEP-Luber-Chapter-12 (With Permission from Springer Publishing)	Chapter 12: The Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI). By Elan Shapiro and Brurit Laub (2014)	http://emdrfoundation.org/toolkit/rtep-luber-ch12.pdf
R-TEP-Luber-Chapter-12a (With Permission from Springer Publishing)	Chapter 12a: Summary Sheet: The Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI), Elan Shapiro and Brurit Laub. Summary Sheet by Marilyn Luber (2014)	http://emdrfoundation.org/toolkit/rtep-luber-ch12a.pdf
R-TEP-Manual (Recent Traumatic Episodes Protocol E. Shapiro)	The EMDR Recent Traumatic Episode Protocol (EMDR R-TEP) for Early EMDR Intervention (EEI.) Overview & protocol instructions Elan Shapiro & Brurit Laub (2014)	http://emdrfoundation.org/toolkit/rtep-manual.pdf
URG	URGent EMDR Treatment Protocol. C. Tarquinio, et al; 2012, 2013.	http://emdrfoundation.org/toolkit/urg.pdf
Appendix D: Pocket Guide Toolkit pages 56-69 URL with Hyperlink		
The Pocket Guide to Early EMDR Interventions. Laidlaw-Chasse, B. (2018)		http://emdrfoundation.org/toolkit/pocket-guide.pdf
Appendix E: Research on EMDR early intervention protocols Toolkit pages 70-72 URL with Hyperlink		
Maxfield, L. (2018, April). <i>Research on EMDR early intervention protocols</i> . Paper presented at the EMDR Early Intervention and Crisis Response Summit Conference, Natick, MA.		http://emdrfoundation.org/toolkit/eei-research.pdf
Appendix F: Table of URLs Toolkit pages 73-75 URL with Hyperlink		
EEIR Toolkit Table of URLs with Hyperlinks		http://emdrfoundation.org/toolkit/table-of-urls.pdf
Appendix G: About the EMDR Foundation Toolkit page 76 URL with Hyperlink		
Introduction to the EMDR Foundation		http://emdrfoundation.org/toolkit/about-emdr-research-foundation.pdf
Toolkit Version 03.2018 Release Notes Toolkit page 77 URL with Hyperlink		
Toolkit Version 03.2018 Release Notes		http://emdrfoundation.org/toolkit/version-release-notes

ABOUT THE EMDR FOUNDATION

Founded, in 2006, the Foundation is a registered 501c3 dedicated to the promotion of quality, unbiased research in EMDR therapy. Since its inception, the Foundation has funded over \$330,000 in grants and awards for EMDR therapy research. By expanding the understanding and effective use of EMDR, ultimately the Foundation enhances the quality of life for people everywhere by facilitating healing, health, and wellbeing.

Our research funding priorities apply to research across the lifespan:

- **1st Priority - Advancing Evidence Based Practice:** Increase quality EMDR research in areas where we already have a foot-hold in the literature but where more evidence is needed. Specifically, the use of EMDR therapy to treat anxiety, depression, military PTSD, phantom limb pain, and recovery from the impact of cardiac events or cancer.
- **2nd Priority - Addressing the Global Burden of Trauma:** Investigate the use of EMDR in natural or man-made disaster responses by determining the effectiveness of the EMDR standard, early intervention, or group protocols.
- **3rd Priority - Building Clinical Evidence:** There are a number of areas where EMDR therapy is being used and shows promise with some research indicators of success. However, more research is needed to build a body of literature in these populations or diagnostic categories; for example, addictive and compulsive disorders, other medical/somatic conditions, dissociative disorders, and suicide prevention or its impact.

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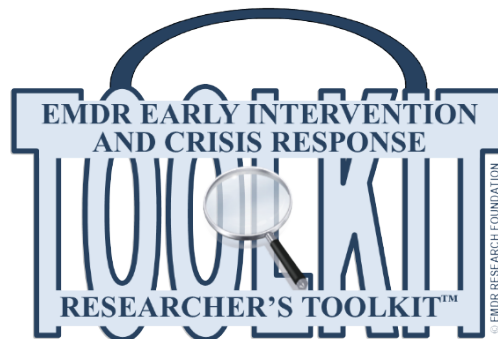
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