

White Paper

Eye Movement Desensitization and Reprocessing Early Intervention (EMDR EI)

Developed by members of the 2018 EMDR Early Intervention and Crisis Response Summit
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Introduction

The purpose of this White Paper is to encourage the further development of EMDR Early Intervention (EMDR EI), to describe its uses and advantages, to identify questions and topics for priority research, and to identify strategies to expand its use in low-and middle-income countries (LMICs). These topics will be discussed and explored in depth during the Global Summit Conference *EMDR Early Intervention and Crisis Response: Current Practices, Research Findings, Global Needs and Future Directions*, to be held in Boston, 20-22 April 2018. The White Paper will remain a work-in-progress before, during and after the Summit Conference, and will serve as the basis of a subsequent overview journal article.

Problem statement

Exposure to traumatic events and circumstances has a devastating impact on the lives of tens of millions of people around the world each year. The twin crises caused by man-made and natural disasters mean that the incidence of trauma is on the rise. Research has shown that the adverse effects of such events and circumstances go well beyond mental and physical health problems. Trauma also takes its toll on communities and nations, for example by reducing productivity, compromised educability, and an increased probability of violence, abuse and renewed trauma.

The treatment gap (defined as the difference between need for, and availability of/access to professional services) is almost certainly widening, especially in situations of violent conflict and natural disasters in economically under-resourced locations. The shortage of mental health professionals worldwide, that has severe negative impacts on communities already facing overwhelming challenges, is a major concern.

A substantial portion of Individuals experiencing recent traumatic events suffer from acute traumatic distress, with symptoms of intrusion, avoidance and hyperarousal, associated with significant impairment in daily functioning. Many will recover spontaneously, but some will go on

to develop posttraumatic stress disorder (PTSD), a mood disorder, or other psychological and physical disorders, with associated functional impairments. Research suggests the possibility that early intervention, which reduces or eliminates acute distress, may prevent the development of subsequent disorders.

Many EMDR-based psychological approaches and protocols have been developed, with the goal of addressing acute distress and preventing the development of PTSD, other disorders, and future complications. Positive results have been reported with several EMDR-based interventions. However, many of these innovative approaches have yet to be adequately tested and supported by research.

Many questions remain unanswered and there is an urgent need to investigate how effective and efficient these protocols are, and how they compare to other early interventions. Further questions relate to conceptual and scientific issues, and still others focus on operational and organizational issues. See Appendices 4 and 5 for lists of published EMDR EI research studies.

EMDR therapy

EMDR therapy, originally developed for the treatment of PTSD, has evolved into a comprehensive psychotherapy approach to a variety of mental health and physical difficulties. It includes a standardized three-pronged protocol that should only be administered by licensed mental health professionals. It is based on the Adaptive Information Processing (AIP) model.¹ As EMDR therapy has evolved, a number of specialized adaptations and variants have come to the fore, all based on the AIP model. One of these is EMDR EI.

Definition of EMDR EI

The term EMDR EI is currently used in various ways. For the purpose of this White Paper, EMDR Early Intervention (EMDR EI)² describes the use of several specific protocols³, intended to address trauma at the earliest possible time. Sometimes administered within hours of a traumatic event, treatment is typically provided within the first three months after exposure. Some writers have suggested that EI need not arbitrarily be limited to that three-month period, but for the purpose of this White Paper we will use the three-month definition to focus our discussions. All EMDR EI protocols include the client focusing attention on the disturbing memory while experiencing bilateral stimulation, as well as other specific and unique procedural elements. See Appendix 3 for a list of EMDR EI protocols.

Use of EMDR EI

¹ Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures (3rd edition)*. New York: Guilford Press.

² Different presenters often use different terms to describe their own adaptations or variants of EMDR EI: EMDR-based EI, EMDR-EI, EEI, EI, Early Psychological Intervention or EPI, Early Psychological Preventive Intervention, Immediate EMDR Intervention, Early EMDR Intervention and early intervention(s), Low-intensity EMDR, and Restricted Processing Interventions. For the purpose of this White Paper, the term used is EMDR Early Intervention, EMDR EI, or simply EI.

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EMDR EI protocols include both individual and group interventions and are designed to reduce the negative impact of acute stress from recent events, or even from certain types of ongoing circumstances, by focusing on stabilization, symptom reduction, and reprocessing of trauma memories.

EMDR EI procedures have been explored in many settings and locations since the early days of EMDR therapy. They have been applied with children, adolescents, and adults, after man-made and natural disasters, in refugee camps, with first responders, medical and military personnel, in schools, and in many other circumstances. EMDR EI is increasingly being offered to trauma survivors throughout the world. It is provided by independent EMDR practitioners, by agencies and organizations, and by volunteer groups of EMDR practitioners. It is also being used as part of large-scale collaborative disaster relief services.

EMDR EI Research

There are at least 23 published research studies that have investigated the use of EMDR EI procedures in the treatment of posttraumatic stress, within 3 months following the traumatic episode. (See Appendix 4). These studies consistently showed a significant decrease in posttraumatic symptoms with results being maintained at follow-up. Fourteen studies were uncontrolled, three were non-randomized controlled studies, and six were randomized controlled trials (RCTs). All nine controlled studies evaluated the effectiveness of individual EMDR EI. Most used a waitlist control and all found a significant difference between the improvement noted for EMDR EI participants compared to those waiting for treatment.

Three of the controlled studies compared an EMDR EI intervention to another therapy. An RCT⁴ comparing one session of Francine Shapiro's Recent Event Protocol (REP) with Critical Incident Stress Debriefing (CISD) and another RCT⁵ comparing three sessions of EMDR PROPARA with supportive counseling found the EMDR EI interventions to produce significantly reduced symptoms of PTSD, compared to the treatment control. Similarly, a matched control study⁶ compared one session of URG-EMDR and eclectic therapy, reporting significantly superior results for URG-EMDR, compared to eclectic therapy. All results were maintained at 3-month follow-up. The effect of R-TEP on symptoms of depression was studied in two RCTs^{7,8}, finding a significant decrease in depressive symptoms, and, in one study, a significant difference between treated and waitlist participants. That study is also the only study to examine whether EMDR-EI increased resilience, but the results showed no significant effect.

⁴ 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. *Issues in Mental Health Nursing, 37*(11),787-799.

⁵ Jarero, I., Amaya, C., Givaudan, M., & Miranda, A. (2013). EMDR individual protocol for paraprofessional use: A randomized controlled trial with first responders. *Journal of EMDR Practice and Research, 7*(2), 55-64.

⁶ 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. *Issues in Mental Health Nursing, 34*(6), 425-434.

⁷ Shapiro, E., & Laub, B. (2015). Early EMDR intervention following a community critical incident: A randomized clinical trial. *Journal of EMDR Practice and Research, 9*(1), 17-27.

⁸ Shapiro, E., Laub, B., & Rosenblat, O. (2018). Early EMDR Intervention following intense rocket attacks on a town: A randomised clinical trial. *Clinical Neuropsychology*.

These positive results are promising, and there is strong consistent evidence that EMDR EI reduces distress, with effects maintained at follow-up. However, no study has yet examined whether EMDR EI prevents the development of, or results in the remission of diagnosed PTSD or any other mental health disorder. No study has shown whether EMDR EI increases resilience. No study has compared EMDR EI to a trauma-focused CBT intervention. Future research is needed to investigate these and other critical questions. In addition, as innovative EMDR EI protocols are developed and applied, attention needs to be focused on conducting systematic research.

EMDR EI's advantages

Some EMDR EI procedures are known to reduce and/or eliminate symptoms of traumatic stress, depression, and anxiety, with results maintained at follow-up (usually about three months post-treatment). Adverse reactions have not been reported and EMDR EI's appear to be safe and effective, with individuals of all ages, genders, and varied nationalities and ethnicities.

EMDR EI treatments are brief Interventions, which can be administered on consecutive days, and/or twice a day. They are easy to use, portable, accessible, and short-term treatments. They can be used in disaster zones, hospitals, emergency rooms, schools, clinics, agencies, refugee camps, and private therapy practices. They can be provided in a group format or to individuals.

EMDR EI interventions can also be viewed as efficient and inexpensive screening tools, providing a low intensity treatment that is adequate for the majority of sufferers, while simultaneously identifying individuals who require more intensive and costly treatment.

Any successful trauma treatment produces significant economic, social and cultural benefits for individuals, families and communities, although the efforts to quantify these benefits remain limited.

Possible future directions for the advancement of EMDR EI

The immense backlog of trauma, and the continuous addition of new cases, challenges the world's capacity to deal with this largely unrecognized global burden of trauma. EMDR EI holds the promise to make a significant contribution, by professionals, towards the elimination of this burden.

But bridging the treatment gap altogether requires the creation of additional capacities. There is a need for training and deploying large numbers of non-mental health professionals as well as fully trained and licensed professionals. This shortage of mental health personnel is particularly apparent following large- scale crises in low- and middle-income countries (LMICs). Non-mental-health professionals (see Appendix 1) are needed to extend mental health capacity, not to replace or compete with licensed mental health professionals.

The WHO has recently rolled out its CBT-based Low Intensity Intervention (LII) program⁹ for implementation by non-specialists, covering the whole range of mental health conditions, including depression, suicidality, epilepsy, substance abuse etc. This program, part of WHO's mental health global action plan (mhGAP), comprises a large-scale training and evaluation scheme aimed at the shifting and sharing of tasks involving mental health interventions previously reserved for professionals. While this program is still in its test stage, it is based on earlier trials that provided scientific evidence of effectiveness. WHO has already developed guidelines and packages for the training, deployment and supervision of their LII non-specialists. For more information on Low Intensity CBT, see Appendix 2.

EMDR EI guidelines and implementation standards and procedures need to be further articulated and established. This should be followed by the development of recommended intervention packages designed for specific intervention conditions. Appropriate training methods for such interventions should be developed. Maximum use should be made of the new possibilities offered by the new technologies (MOOCs, apps, social media, etc.)

Reports and research regarding the value of EMDR EI should be gathered and evaluated, including those related to medium- to large-scale intervention projects. Presentations at the Summit Conference will bring together many new studies. A series of research questions, both scientific and conceptual are listed below, together with some operational and implementation issues.

Open questions regarding EMDR EI

Research is needed to answer the following clinical questions.

- What is the potential impact of EMDR EI following a traumatic event? Does it reduce development of physical or psychological symptoms? Reduce the number of problematic behaviors, such as substance abuse? Prevent the development of PTSD? Increase resilience? Positively impact quality of life? Assist in economic recovery for individuals and communities?
- What is the optimal utilization of EMDR EI? What is the optimal timing of interventions, choice of protocol, selection of participants, length of intervention? What data can readily be collected in time of crises?
- How do the EMDR EIs compare with other early mental health interventions? Data is needed regarding safety, effectiveness, ease of delivery, and ability to utilize non-mental health professionals as part of an intervention team.

Conceptual or policy questions

- Access: How can EMDR EI services be better known and more easily accessed by agencies, organizations, first-responders, individual consumers?

⁹ WHO, mhGAP Training Manual for the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings—version 2.0 (for field testing). References on pp. 466-470.

- Disaster and crises response in low and middle-income countries (LMICs). What is the best way to identify mental health needs and gain community support for intervention?
- Can EMDR EI services extend their reach and be implemented effectively by task sharing with trained non- specialist health care providers? To build capacity in LMICs, what is needed to ensure that such services are sustainable and of sufficient quality? Is the provision of EMDR EI economically efficient? What is the benefit/cost ratio for EMDR EI when compared to other interventions, or to no mental health intervention?
- Should EMDR EIs be included in large-scale and ongoing intervention models around the globe? If so, how can EMDR EI methods be integrated with comprehensive health and mental health care services globally?

9 April 2018

Appendix 1. Categories of non-mental-health professionals

It is not easy to delineate who is included in the term non-mental-health professional, given the differences in needs, resources, settings and cultures. WHO now uses the term non-specialist health care provider. This term can be considered to cover the following three groups:

(i) allied professionals-- medical professionals, including doctors, nurses, midwives who come in frequent contact with traumatized people

(ii) first-responders-- including emergency service providers, firefighters, police and military, who have first-hand involvement with traumatic events and affected people, and who are increasingly prepared to offer early psychological treatment to their colleagues and peers, and to others

(iii) paraprofessionals-- trained, skilled and supervised caregivers (but not licensed mental health professionals), including religious counsellors, voluntary health workers, trusted community caregivers and elders, and others.

Where there are no better alternatives, all these non-mental-health professionals are the best 'mental health people' available in low-resource settings and crisis situations.

Appendix 2. Low Intensity CBT

Low-intensity CBT (LI CBT) is a relatively new, empirically-supported, cost-effective treatment intervention that aims at 'improving access' by ensuring availability, utilization, effectiveness, equity, efficiency and client-centeredness.¹⁰ It is delivered in a variety of different forms, including guided and unguided internet-based formats, CBT group interventions, and self-help strategies. In addition, it utilises several delivery formats and platforms, including telephone, email, SMS, as well as face-to-face sessions. These formats can be either personalised or automated.

Paraprofessionals trained in LI CBT are supported by licensed mental health workers to ensure treatment fidelity, provide support (particularly with difficult/challenging clients), enhance skills, and reinforce application. LI CBT paraprofessional training involves LI CBT programme delivery models; developing safe and effective working relationships; promoting self-help and providing support; developing and fostering relationships with key collaborative partners and stakeholders and conducting risk assessment, triage and referring on. The advantages of LI CBT include improving speed of access and the total number of people who can access evidence-based treatment interventions, flexibility in service delivery, capacity building, improved responsiveness, promoting client choice and informed decision making, and cost- effectiveness of services.

¹⁰ Bennett-Levy, J. et al (2010) *Oxford Guide to Low Intensity CBT Interventions*. Oxford: OUP.

Appendix 3.

EMDR EI PROTOCOLS

Rosalie Thomas, Ph.D., Psychologist

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)

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

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

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

- Recent Event Protocol (REP) F. Shapiro (1995, 2001, 2018)
- EMDR-Recent Traumatic Episode Protocol (EMDR R-TEP) E. Shapiro & Laub (2008)
- EMDR Protocol for Recent Critical Incidents (EMDR PRECI) Jarero & Artigas (2011)
- EMDR Individual Protocol for use with Paraprofessionals (EMDR – PROPARA) Jarero, Amaya, Givaudan, & Miranda (2013)

EI 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 Traumatic Episode Protocol (G-TEP) E. Shapiro (2013)
- Imma Group Protocol (Based on IGTP for children 5 years and older). Laub & Bar- Sade (2009, 2013)

Descriptions of these protocols may be available in related research studies listed in Appendix 4. For more information, please contact the developers, or see :

Thomas, R., (2014, 2018). *EMDR Early Intervention and Crisis Response: Researcher's Toolkit*. Retrieved from www.emdrresearchfoundation.org/toolkit

Luber, M. (2014). *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets*. New York, NY: Springer Publishing Co.

Appendix 4.

RESEARCH ON EMDR EARLY INTERVENTION PROTOCOLS

Louise Maxfield, Ph.D., Psychologist

April, 2018

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	Tarquino, 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., Callerame, 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., & Lubet, 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

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
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

Appendix 5.

RESEARCH ON EMDR EARLY INTERVENTION PROTOCOLS

Part B: Studies in which EMDR EI treatment was provided 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

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. (2018). 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> , https://www.frontiersin.org/articles/10.3389/fpsyg.2018.00493/full
Field 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. (2018). The Effects of the EMDR Group Traumatic Episode Protocol, G-TEP with cancer survivors. <i>Journal of EMDR Practice and Research</i> , 12(3), 105-117. DOI: 10.1891/1933-3196.12.3.105.
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. (2018). Provision of the EMDR IGTP OTS to female patients with cancer-related PTSD symptoms. <i>Journal of EMDR Practice and Research</i> , 12(3), 94-104. DOI: 10.1891/1933-3196.12.3.94
Controlled 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 Study	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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Clare Blenkinsop studied Sociology at Durham University, followed by Business Management at the London School of Management Studies. Having worked in UK theatre management for almost ten years, Clare re-trained to work in business promotion in developing countries. She lived for 25 years outside Europe, including in Indonesia, Malaysia, Bangladesh, Zambia, Myanmar, Nepal and Dominica, working with both national and international NGOs (Consumers International, Save the Children), and UN agencies, the longest period being with UNICEF for 15 years working in advocacy and communication fields. In 2016, having worked in Geneva for several years, she joined Rolf Carriere to establish and run the Global Initiative for Stress and Trauma Treatment (GIST-T).

Rolf Carriere studied development economics and philosophy at Groningen University, Netherlands. From 1971 till 2005 he worked with UNICEF and the World Bank, mostly in health and nutrition in Asia, including nine years in India. His last positions were UNICEF Country Representative in Bhutan, Myanmar, Bangladesh and Indonesia. In 1985, he co-founded the Iodine Global Network (ICCIDD). In 2002, Rolf established and managed the Global Alliance for Improved Nutrition (GAIN) in Geneva. In 2016, he founded the Global Initiative for Stress and Trauma Treatment (GIST-T). Rolf currently serves on the Boards of Nonviolent Peaceforce and the Free Yezidi Foundation.

Derek Farrell is Principal Lecturer in Psychology at the University of Worcester (UK), where he is course director of the world's first MSc EMDR Therapy programme. Derek is involved in trauma capacity building projects in Pakistan, Turkey, India, Cambodia, Myanmar, Thailand, Indonesia, Philippines, Lebanon, Poland, Palestine and Iraq. Derek is an EMDR Europe Approved Trainer and Consultant, as well as a Chartered Psychologist with the British Psychological Society, and an Accredited Psychotherapist with the British Association of Cognitive and Behavioural Psychotherapies (BABCP). He is President of EMDR Europe Trauma Aid Programme, and Vice-President of EMDR Europe. In 2013, he received the David Servan-Schreiber award.

Marilyn Luber is a licensed clinical psychologist in Philadelphia, Pennsylvania. She specializes in EMDR Therapy and has presented at national and international conferences and has undertaken workshops in the United States, Europe, Middle East and China. She edited a series of six books on different uses of EMDR protocols and procedures. She has published articles in professional journals and regularly contributes two columns to EMDRIA's newsletter. She has received the Francine Shapiro Award, the EMDRIA Award for outstanding contribution and service to EMDRIA, and the EMDR Humanitarian Services Award. Currently, she is a facilitator for the EMDR Global Alliance supporting the standards of EMDR Therapy worldwide.

Louise Maxfield is a clinical psychologist and EMDRIA consultant in Ottawa Canada. After becoming an EMDR therapist in 1993, she was an investigator in several EMDR research studies and consulted on many international research projects. She has published more than 20 scientific articles and chapters about EMDR, is the co-editor of Handbook of EMDR and Family Therapy Processes, and has presented six plenary addresses at EMDRIA and EMDR Canada conferences about EMDR research. She is the founding editor and Editor-in-Chief of the Journal of EMDR Practice and Research. Dr. Maxfield has received the Outstanding Research Award from both EMDRIA and EMDR Canada, and EMDRIA's Francine Shapiro Award.

Mark Nickerson, a psychotherapist in Amherst, MA for 30 years, is an EMDRIA approved consultant and an EMDR Institute trainer. He conducts advanced EMDR trainings nationally and internationally on topics including treatment for problem behaviors, problematic anger and violence, cultural competence, and the effective use of EMDR protocols. He has developed innovative programs designed to reduce and resolve interpersonal conflict and created the Cycle Model to assess and treat problem behaviors. He has served on the EMDRIA Board for six years and was President in 2014. He is editor/author of Cultural Competence and Healing Culturally-Based Trauma with EMDR Therapy: Insights, Strategies and Protocols (Springer, 2016) and The Wounds Within (Skyhorse, 2015), on challenges facing war veterans and their families.

Udi Oren is a clinical and medical psychologist who has been part of the EMDR community for the past 20 years. He provides EMDR trainings, as an EMDR Institute and an EMDR Europe trainer, in many countries in Asia, Europe and Africa, and has actively contributed to the growth of several EMDR national associations. Areas of greatest clinical interest include the field of combat-related PTSD (and other conditions) and stress/trauma related medical conditions. Udi has served as the Chair of the Israeli EMDR Association since its creation in 1997, and as the President of EMDR Europe between 2007 and 2015.

Rosalie Thomas is a licensed psychologist in Washington State. Now retired, she offers consultation and training in EMDR. Rosalie served as Board Member, Treasurer and President of the EMDR International Association. She is an EMDRIA Certified Clinician and Approved Consultant and currently chairs the EMDRIA conference committee. Rosalie is also a facilitator and trainer for the EMDR Humanitarian Assistance Program, and facilitator for trainings given by the EMDR Institute. She has participated in training programs throughout the United States, Japan, Bangladesh, and India. In 2006, Dr. Thomas was the recipient of an award for Special Recognition of her leadership in EMDRIA and she was the recipient of the Francine Shapiro Award in 2007.