

RESEARCH ARTICLE

Eye Movement Desensitization and Reprocessing Integrative Group Treatment Protocol for the Reduction of Perceived Stress in Parents with Disabled Children: A Therapeutic Approach

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Severe disabilities in children can cause high levels of stress within families, and scientific literature reports a few studies about using Eye Movement Desensitization and Reprocessing (EMDR) group therapies for reducing parents'/caregivers' stress. This research, based on a pre-post study design, aims to verify (a) if the EMDR Integrative Group Treatment Protocol is an effective therapy in reducing perceived stress and (b) if EMDR Integrative Group Treatment Protocol is effective in reducing some psychopathologic caregivers' symptoms. The participants consisted of 15 parents with severely disabled children who underwent therapy sessions of 100 to 120 min each administered by 2 trained EMDR therapists with a specific training in this protocol. At baseline, the Perceived Stress Scale and the Symptoms Checklist-90 were administered, with respect for anonymity, by the same 2 trained therapists who conducted the sessions. At the end of these sessions, a week later, the same scales were administered along with a parent's statement questionnaire. These scales and the questionnaire were administered again after 3-month posttreatment. The results demonstrated an important improvement of the caregivers' stress (Perceived Stress Scale raw score from 33.33 to 22.86 after a week [t value 9.92×10^{-9} , $P < 0.05$], and the score decreased also after 3 months posttreatment [t value 3.06×10^{-4} , $P < 0.05$]), and a substantial decrease of the parents' worries (statements reported from parents as "reduction of future worries", "more information to copy with", and "feeling less alone") emerged from the anonymous questionnaires administered a week and 3 months posttreatment.

Introduction

Eye Movement Desensitization and Reprocessing (EMDR) [1–3] is a well-known evidence-based treatment recommended by some guidelines (<https://www.apa.org/ptsd-guideline/ptsd.pdf> [4]) for the treatment of posttraumatic stress disorder (PTSD) and trauma memories [5–7]. The standard EMDR protocol consists of a structured set of procedures based on the Adaptive Information Processing (AIP) model [8]. The AIP model was developed to explain the rapid change toward positive resolution that is observed in EMDR memory reprocessing [7]. AIP assumes "an inherent system in all of us that is physiologically geared to process information to a state of mental health" [7]. The AIP system may be disrupted by trauma, severe levels of stress, or other variables like the influence of psychoactive drugs

[9]. When a negative experience overwhelms the information processing system of the brain, we are unable to process the experience to resolution, and the memory is maladaptively encoded. The pathogenic memories associated with the traumatic events generate symptoms and become the focus of treatment. The EMDR therapy is based on 8 phases that describe the procedural steps, the course of treatment from the first moment to the last session as well as evaluating the target memory itself [9]. During these phases, fast bilateral stimulation is used to activate the client's inherent information processing system for 20 to 30 s at a time with a brief check in to ensure that the process is moving. The desensitization and the reprocessing of the traumatic memory allow to integrate the trauma and to create more adaptive associations and a cognitive and emotional restructuring [10]. The assumption of EMDR therapy is that this procedure

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has the capacity to activate a neuropsychologically innate mechanism of the information processing [11]. According to some authors, “some types of stimulations produced by the therapist, with the dual attention to the external stimulus and to the flow of mental processing, activate an effective process of accelerated and ecological information processing” [10] (p. 210). It is therefore assumed that the patient has the needed resources for the emotional and cognitive processing of a traumatic memory and that the therapist has the role of facilitating this process [12].

Furthermore, many therapists use EMDR therapy not only for the treatment of PTSD but also for other clinical disorders, such as anxiety disorders, panic disorder [13–18], depressive symptoms [19,20], somatization disorders, dissociative disorders, eating disorders, and sexual disorders [21–24].

Although EMDR therapy has had great success, it still has a long way to go [25].

Following Hurricane Pauline in Mexico, which caused 230 to 500 deaths and 300,000 displaced people in 1997 (“Initial Disaster Appeal Mexico Hurricane Pauline”. Relief Web. 1997-10-24; Roth, David M. “Hurricane Pauline - October 3-10, 1997”. Tropical Cyclone Rainfall. United States Weather Prediction Center), a group of EMDR therapists, Ignacio Jarero and Lucina Artigas, started treating the traumatic event, and subsequently, the members of the Mexican Association for Mental Health Support in Crisis developed a protocol to be able to cope with such a catastrophe: Thus, EMDR-IGTP (Eye Movement Desensitization and Reprocessing-Integrative Group Treatment Protocol) was born.

The EMDR-IGTP is a group therapy that combines the EMDR therapy of 8 standard phases with a group therapy model and uses a particular form of self-administered bilateral stimulation called the Butterfly Hug [26], together with the use of drawing tasks [27]. The protocol is structured as a form of play therapy but has been successfully applied to disaster survivors with ages ranging from 7 to over 50 [28] and to support rescuers and third-type victims.

The advantages of the application of this protocol, apart from its simultaneous applicability to several subjects, are connected by the no specificity of the setting, which must no longer be necessarily a “private” space, thus difficult to find in emergency situations. In addition, the IGTP does not ask the subjects in the group to verbalize the information regarding the trauma. The therapy can be applied over several consecutive days; there are no specific tasks to carry out between sessions, and treating several subjects at the same time makes it possible to rapidly assist many parts of the affected community.

The EMDR-IGTP originally was developed to use with children [29]. The developers have adapted the EMDR-IGTP so that it can be used with adults [30]. This therapy has been used in the field of early intervention, and there are studies in the literature that demonstrate the effectiveness and usefulness of this intervention [27,31]. EMDR-IGTP was also adapted for emergency situations in Italy by Maslovic and Fernandez [32,33]. In fact, in Italy, following some disasters, EMDR group was implemented [34]. This intervention was applied to different levels of exposure to the traumatic event and to different age groups. EMDR-IGTP treatment aims to facilitate the management and processing of traumatic material present after the event, also offering support and treating the greatest number of people within the same context. EMDR-IGTP has also been adapted by Jarero et al. for the processing of ongoing trauma related to the recurring stressful situations that are still occurring in the life of the patients [30,35].

In the literature, EMDR group therapy is used with parents of children with a rare life-limiting illness and with children subjected to traumatic events or with important disabilities [36]. Some examples are the study conducted by Passoni et al. [34] on caregivers of patients with dementia and some projects involving parents with children with disabilities and autism spectrum disorders [37–39]. In Passoni’s research, 44 primary caregivers entered the study. They were randomly assigned to either the “immediate” branch, who received the treatment soon after recruitment, or to the “delayed” branch, who received it 2 months after recruitment. The treatment consisted of 8 group sessions (1 per week) spanning over 2 months. Emotional distress was measured before the treatment, immediately after the end of it, and 2 months later (follow-up), by means of several clinical scales (Impact of Event Scale-Revised, Caregiver Needs Assessment, Caregiver Burden Inventory, and Anxiety and Depression Scale-Reduced Form). The “immediate” branch improved significantly more than the “delayed” (control) branch on The Impact of Event Scale-Revised, the Anxiety, and the Depression scales; however, after treatment, such an improvement was maintained only in the first scale. The “delayed” branch took less advantage of the treatment, showing significant reduction only on the Depression scale, an effect that disappeared at follow-up. These results demonstrate that EMDR-IGTP may reduce stress-related symptoms, anxiety, and depression in caregivers of patients with dementia (as discussed by Passoni et al. [34]).

Severe disability represents a factor of high family stress [40–44] and the daily healthcare burden management risk to develop psychopathologic symptoms [45].

In scientific literature, there are a few studies on the use of EMDR group therapy to reduce parental/caregiver stress [46]. Incerti et al., in a study of 2020, reported some preliminary results of the effectiveness of an integrative group treatment protocol in reducing the posttraumatic symptoms in a group of parents with disabled children [47]. In this study, the participants were 39 parents, and the treatment consisted of 10 group sessions. Emotional distress, coping strategies, and posttraumatic growth were measured before treatment and 3 months after the project, comparing the average scores of several clinical scales. These preliminary results reveal an improvement in the Post-Traumatic Growth Scale scores after treatment.

The caregivers of children with neurodevelopmental disorders experience high levels of stress, and the daily caregiving burden increases the risk of developing psychopathologic symptoms such as PTSD (as discussed by Incerti and Cavallera [48]). The goal of Cavallera’s study is to assess the effectiveness of EMDR Integrative Group Therapy for Ongoing Traumatic Stress in reducing post-traumatic symptoms and improving psychological well-being in caregivers of children with neurodevelopmental disorders. This study was a monocentric prospective study with a process–outcome design, employing a 2-arm, single-blind protocol, and the participants will undergo 6 120-min group sessions facilitated by certified EMDR practitioners. A control group will be included for comparison. The expected results from this study were that the caregivers experienced a significant reduction in posttraumatic stress symptoms, an improvement in adaptive coping strategies and caregiving competency, and enhanced psychological well-being.

This present study research aims to verify if the EMDR-IGTP could be an effective therapeutic approach in reducing perceived stress in family members and at the same time to detect a possible reduction of some psychopathological aspects related to the daily management of the disability.

It is also a contribution for researchers and professional healthcare providers to enhance the EMDR-IGTP as a support program for caregivers especially in the public health services.

Methods

This research involved 15 parents with children supported by the Child Neuropsychiatry of Udine (Italy) with important diagnoses in the field of childhood disability. Children were not involved, and this research was a 1-arm, pre-post repeated measures design. The treatment was proposed to 20 parents selected among the current patients by 2 trained EMDR-IGTP healthcare practitioners, but only 15 of them agreed to participate in this research study. The purposes of the research, the methods of carrying out the sessions, and the pre- and post-anonymous questionnaires were explained to the participants, and they signed a written consent in which the possibility of publication was explicitly stated and that the participants' rights, their privacy, and well-being would be respected. The sessions of 100 to 120 min each were conducted by 2 qualified EMDR therapists. Before the first meeting, participants were administered the Perceived Stress Scale (PSS) and the Symptoms Checklist-90 (SCL-90) (for the evaluation of some psychopathological components) in an individual session conducted by the same therapist. During this pretreatment assessment, the EMDR group therapy was explained in detail, data were collected, and the anonymous questionnaires were administered. At the end of the sessions, a week later and 3 months posttreatment, the tests and the parent's statement questionnaire were administered again. The statistical test used to determine the significance of the scores was the Student *t* test, and the *P* was 0.05, as reported in the tables.

Questionnaires

- SCL-90 (Derogatis LR, 1973–Italian adaptation by Sarno I et al., 2011): The SCL-90 is a self-administered questionnaire that assesses a broad spectrum of psychological problems and psychopathological symptoms, measuring both internalizing symptoms (depression, somatization, and anxiety) and externalizing symptoms (aggression, hostility, and impulsivity). It is a 90-item questionnaire on a Likert scale from 0 to 4, and it is validated in a large sample aged between 13 and 70 years. Mean scores equal

to or greater than 1 for each area were of clinical interest. In this study, only the areas with a score above 1 have been considered.

- PSS (Cohen S, et al., 1983 and 1988–Italian translation by Andrea Fossati, Vita-Salute San Raffaele University of Milan, 2010): The PSS is the most widely used psychological instrument to measure the perception of stress. It consists of 10 items and is based on a Likert scale from 0 to 4. A total score greater than 27 is clinically significant and identifies an overload of stress.
- Anonymous parent's statement questionnaire and the satisfaction questionnaire: The parent's statement questionnaire was based on free impressions and considerations collected from the parents and regarding their feeling after the group treatment. The satisfaction questionnaire used was based on a Likert scale from 1 to 5 and investigated satisfaction regarding the treatments received, the location, the duration, the therapist's skills, and general satisfaction. It was settled by the 2 EMDR practitioner therapists before starting the sessions.

Results

Participants were parents who formed a homogeneous group in terms of sex, age, education, and nationality but not in occupation as reported in Table 1.

Table 2 shows the children's diagnosis mostly represented, which were autism spectrum disorder (5 children), Down syndrome (2 children), rare genetic syndrome (3 children), and mental retardation (5 children).

Table 3 reports the values obtained on the PSS and on SCL-90 at the beginning of the treatment, a week posttreatment, and at the follow-up at 3 months posttreatment. Table 4 reports the scores obtained at baseline and a week posttreatment by considering the sex variable. A score higher than 27 for the PSS is considered clinically significant, and a value higher than 1 obtained at the SCL-90 parameters is clinically significant.

Almost all the parameters considered reported a significant decrease of the scores both a week posttreatment and at the follow-up at 3 months posttreatment (*t* values below *P* < 0.05). Only the INT (Inadequacy) parameter of the SCL-90 reported a significant decrease a week posttreatment but not at the follow-up at 3 months posttreatment even if there was a slight decrease (*t* value above *P* < 0.05).

Table 1. Characteristics of the parents who participated in the study

Parent sociodemographic characteristics	Male <i>n</i> <i>M</i> (<i>SD</i>)	Female <i>n</i> <i>M</i> (<i>SD</i>)	Tot <i>n</i> <i>M</i> (<i>SD</i>)
Parents	7	8	15
Age	37.14 (3.58)	36.25 (6.29)	36.66 (5.05)
Education (years)	12.28 (3.45)	13.62 (3.21)	13 (3.27)
Italian nationality	7	8	15
Occupation			
Employed	7	3	10
Unemployed		5	5

Table 4 shows some scores slightly different from male and female especially for the following parameters of SCL-90: DEP, ANX, and SLEEP. The hypothetical reasons have been reported in Discussion.

For some additional information, the authors decided to administer 2 questionnaires at the end of the sessions (a week and 3 months posttreatment) where the participants were asked about their impressions and considerations and the level of appreciation of the sessions. All the parents fulfilled the 2 questionnaires, and the results are shown in Tables 5 and 6. All the participants reported high levels of appreciation both a week and 3 months posttreatment.

Table 2. Children's diagnosis

Child diagnosis	<i>n</i>
Autism spectrum disorder	5
Down syndrome	2
Rare genetic syndrome	3
Mental retardation	5

Discussion

The purposes of this study were to verify (a) if EMDR-IGTP is an effective therapy in reducing perceived stress and (b) if EMDR-IGTP is effective in reducing some psychopathologic caregivers' symptoms, and the data collected may confirm these 2 research hypotheses.

It was expected that the participants experienced a decrease in their stress level and in some psychopathologic symptoms along with an improvement in adaptive coping strategies as reported and compared with the recent literature in this field [36,37,45,48]. In particular, the study by Incerti et al. reports a significant improvement of the mental health of caregivers and a better quality of children's care [48].

The sample considered involved fathers and mothers equally, but the difference that is recorded concerns the occupation of mothers who are probably more involved in caring for their children, to the detriment of their working career. A piece of data that does not appear in the table concerns the general level of education, which is higher in mothers since among the participants of the group there were more mothers with a degree than fathers with a degree. In the discussions at the end of the sessions, feelings of regret often emerged from the women who declared that they had given up a working career for assisting their children.

Table 3. PSS and SCL-90 data

Parameters	Baseline <i>M (SD)</i>	A week later <i>M (SD)</i>	<i>t</i> value <i>P</i> < 0.05	3 months later <i>M (SD)</i>	<i>t</i> value <i>P</i> < 0.05
PSS	33.33 (2.41)	22.86 (1.88)	9.92×10^{-9}	21.53 (1.39)	3.06×10^{-4}
SCL-90					
GSI	1.31 (1.13)	0.72 (0.05)	8.01×10^{-12}	0.70 (0.04)	1.25×10^{-3}
SOM	1.15 (0.22)	0.54 (0.19)	2.09×10^{-5}	0.52 (0.18)	4.94×10^{-3}
INT	1.49 (0.17)	0.45 (0.21)	9.28×10^{-10}	0.44 (0.19)	$7.30 \times 10^{-2*}$
DEP	2.59 (0.31)	1.33 (0.26)	4.79×10^{-10}	0.84 (0.05)	1.095×10^{-6}
ANX	3.06 (0.39)	1.44 (0.27)	3.87×10^{-11}	0.87 (0.23)	4.45×10^{-7}
SLEEP	2.21 (0.54)	0.99 (0.32)	1.80×10^{-8}	0.79 (0.17)	3.42×10^{-4}

Table 4. Scores at PSS and SCL-90 considering sex

Parameters	Baseline		After a week posttreatment	
	Male <i>M (SD)</i>	Female <i>M (SD)</i>	Male <i>M (SD)</i>	Female <i>M (SD)</i>
PSS	34.28 (1.49)	32.5 (2.83)	23 (1.53)	22.75 (2.25)
SCL-90				
GSI	1.26 (1.13)	1.33 (0.12)	0.69 (0.05)	0.74 (0.04)
SOM	1.03 (0.23)	1.24 (0.16)	0.63 (0.19)	0.45 (0.17)
INT	1.42 (0.16)	1.56 (0.15)	0.51 (0.22)	0.38 (0.19)
DEP	2.49 (0.23)	2.69 (0.35)	1.15 (0.19)	1.49 (0.19)
ANX	3.03 (0.34)	3.08 (0.45)	1.39 (0.17)	1.47 (0.34)
SLEEP	2.19 (0.69)	2.22 (0.42)	0.78 (0.28)	1.18 (0.23)

Table 5. Statements reported by the parents (15 participants)

Considerations	Number a week later	Number 3 months later
Greater awareness	15	15
Reduction of future worries	12	15
More information to copy with	15	15
Less alone and more sharing	13	15
Mutual help	15	15
Wish to continue with self-managed group	15	15

Table 6. Level of appreciation reported by the parents. Likert scale: 1, not satisfied; 2, not very satisfied; 3, satisfied; 4, quite satisfied; 5 very satisfied.

Item	A week later	Three months later
General satisfaction	5	5
Session utility	5	5
Session time	5	5
General organization	5	5
Places	5	5
Tools used	5	5
Theme explanation	5	5
Therapists' skills	5	5
Session management	5	5
Information received	5	5
Knowledge before the start of sessions	1	1
Knowledge at the end of sessions	4	5

Considering the results reported in Table 3, the level of perceived stress appears high at baseline, while at the end of the sessions, the total score is below the critical value (cutoff 27, PSS raw score from 33.33 to 22.86 after a week [t value 9.92×10^{-9} , $P < 0.05$], and the score decreased also after 3 months posttreatment [t value 3.06×10^{-4} , $P < 0.05$]). The results of the value of perceived stress in relation to gender are interesting (Table 4). It is observed that fathers are more stressed than mothers even if the greater care burden falls on mothers, and even at the end of the treatment, there is a slight difference in the score in males compared to females, although below the threshold value (raw score 23 for fathers versus 22.75 for mothers). The reasons of this difference are not clear. The authors tried to find an explanation, but there were only some suppositions: work-related stress; thoughts of being the only income

provider; and little health care involvement with their children and consequently high level of guilt.

The global indicator of perceived discomfort (GSI) appeared clinically significant and more present in mothers (0.74 versus 0.69 in raw score), while somatization symptoms (SOM) had a lower value in mothers at the end of the course (Table 4, 0.45 versus 0.63 in raw score). The same trend was found for feelings of inadequacy (INT), which are reduced more in mothers after the sessions (Table 4, 0.38 versus 0.51 in raw score) at a week posttreatment. Globally, the same parameter (INT), at 3 months posttreatment, had a slight decrease but not too significant, and the reasons for this were not clear to the authors that supposed that, maybe, the feeling of inadequacy needs more time to change in positive terms. The parameters related to tension, irritability, anxiety (ANX), symptoms of depression (DEP), and sleep disturbances (SLEEP) presented very high scores at baseline, while they reduced at a week and 3 months posttreatment. It should be noted that some anxiety and depressive symptoms remained albeit with a significant reduction particularly in mothers at a week posttreatment (1.49 for females versus 1.15 for males in DEP raw score; 1.47 for females versus 1.39 for males in ANX raw score). The same trend at a week posttreatment had the sleep disturbances that were reduced in fathers, while they remained in mothers even if they presented a reduction (1.18 in females versus 0.78 in males). Globally, at the follow-up, at 3 months posttreatment, the 3 parameters DEP, ANX, and SLEEP had a significant decrease with a score below the cutoff (<1).

The considerations that were most reported by the parents with a questionnaire (Table 5) at the end of the treatment and regarding some thematics, such as the awareness of the care burden, the future (after us), and other feelings, testified the validity of the EMDR-IGTP sessions, and the scores obtained in the appreciation test administered at the end of the sessions (a week later and 3 months posttreatment) and reported in Table 6 confirm this assumption.

The issues raised in this discussion are relevant in the clinical setting, and our study suggests that an EMDR-IGTP therapy could be a response to the difficulties experienced by the caregivers, and it could enable them to better cope with the unavoidable sequence of stressful events. Moreover, without a specific parent group intervention, the caregivers' emotional conditions might worsen, leading to a less responsive care for their children.

This research, despite the small sample, shows that an EMDR-IGTP therapy might be an effective approach in reducing the stress perceived by caregivers of disabled people, allowing a reduction in some anxiety and depressive symptoms related to the workload and uncertainty about the future of their family members. In our sample, the best benefits are experienced by fathers compared to mothers, especially for depressive and anxious symptoms and sleep disorders. Conversely, somatization symptoms are more present in fathers.

This study could offer an important contribution for the application of EMDR-IGTP for parents' groups with disabled children. These results could encourage healthcare providers to develop specific support therapies within public healthcare programs with the aim to enhance better quality of care for disabled children and their parents. Moreover, these results might be a basis for larger, randomized controlled trials to explore the long-term effects of an EMDR-IGTP therapy.

Further experimental research designs would bring more information and data supporting the effectiveness of EMDR-IGTP, and they might consider specifically parental emotional distress and how a parent component of the family might facilitate the healthy changes.

In terms of limits, the present results need further investigation. In fact, it should be necessary to expand the sample and to collect data from follow-ups after the end of the treatment, especially regarding distress symptoms and depressive and anxiety symptoms.

Ethical Approval

An ethical approval was not applicable, but this study was approved, before its start, by the Authority Health of Azienda Sanitaria Universitaria Friuli Centrale of Udine (Italy) in respect of the principles of the Declaration of Helsinki and conducted in accordance with the EU General Data Protection Regulation (GDPR). An informed consent, in which the study was illustrated in detail, to participate and for publication (in print or online) was obtained and signed by the patients before the intervention.

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Author contributions: F.B., M.M.B., R.D., and L.B. designed the study and contributed to the acquisition of the data. F.B. and M.M.B. analyzed the data. All authors interpreted the data. F.B. drafted the manuscript. F.B. and M.M.B. performed the measurements. V.L. and D.M. critically revised the manuscript. F.B. and M.M.B. had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analyses. All authors have read the manuscript, approved the final draft of the paper, and agreed with its submission.

Competing interests: The authors declare that they have no competing interests.

Data Availability

The data and materials that support the findings of this study are available from the corresponding author upon reasonable request.

References

- Shapiro F. Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *J Trauma Stress*. 1989;2(2):199–223.
- Shapiro F. Eye movement desensitization and reprocessing (EMDR): Clinical and research implications of an integrated psychotherapy treatment. *J Anxiety Disord*. 1999;13(1-2):35–67.
- Shapiro F. L'EMDR e la concettualizzazione del caso secondo la prospettiva dell'Adaptive Information Processing. In: Shapiro F, Kaslow FW, Maxfield L, editors. *Manuale di EMDR e terapia familiare*. Milano: Ferrari Sinibaldi; 2011.
- American Psychiatric Association. *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder*. Arlington (VA): American Psychiatric Association Practice Guidelines; 2004. <https://doi.org/https://www.apa.org/ptsd-guideline/ptsd.pdf>
- Fernandez I, Gallinari E, Solomon R. *Training in integrated relational psychotherapy: an evidence-based approach*. Cham: Springer Nature Switzerland; 2024. Trauma resolution: A healing journey through EMDR therapy; p. 343–378.
- Giannantonio M. *Memorie traumatiche: EMDR e strategie avanzate in psicoterapia e psicotraumatologia*. Milano: Raffaello Cortina Editore; 2014.
- Shapiro F. *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures*. 3rd ed. New York: Guilford Press; 2018.
- Shapiro F, Laliotis D. EMDR and the adaptive information processing model: Integrative treatment and case conceptualization. *Clin Soc Work J*. 2011;39:191–200.
- Hase M. The structure of EMDR therapy: A guide for the therapist. *Front Psychol*. 2021;12:660753.
- Giannantonio M. L'approccio con l'eye movement desensitization and reprocessing (EMDR). In: Giannantonio M, Lenzi S, editors. *Il disturbo di panico. Psicoterapia cognitiva, ipnosi, EMDR*. Milano: Raffaello Cortina Editore; 2009b.
- Elofsson UOE, von Scheele B, Theorell T, Söndergaard HP. Physiological correlates of eye movement desensitization and re-processing. *J Anxiety Disord*. 2007;22(4):622–663.
- Dworkin M. *La relazione terapeutica nel trattamento EMDR, edizione italiana a cura di Barbara Gallo e Maria Silvana Patti*. Milano: Raffaello Cortina Editore; 2010.
- de Jongh A, ten Broeke E. Treatment of specific phobias with EMDR: Conceptualization and strategies for the selection of appropriate memories. *J EMDR Pract Res*. 2007;1(1):46–57.
- de Jongh A, ten Broeke E. EMDR and the anxiety disorders: Exploring the current status. *J EMDR Pract Res*. 2009;3(3):133–140.
- de Jongh A, de Ross C, El-Leithy S. State of the science: Eye movement desensitization and reprocessing (EMDR) therapy. *J Trauma Stress*. 2024;37(2):205–216.
- Fernandez I, Faretta E. Eye movement desensitization and reprocessing in the treatment of panic disorder with agoraphobia. *Clin Case Stud*. 2007;6(1):44–63.
- Goldstein AJ, de Beures E, Chambless DL, Wilson KA. EMDR for panic disorder with agoraphobia: Comparison with waiting list and credible attention-placebo control condition. *J Consult Clin Psychol*. 2001;68(6):947–956.
- Shapiro F, Forrest MS. *EMDR. Una terapia innovativa per l'ansia, lo stress e i disturbi di origine traumatica*. Roma: Astrolabio; 1998.
- Hofmann A, Hase M, Liebermann P, Ostacoli L, Lehnung M, Ebner F, Rost C, Lubner M, Tuman V. DeprEnd©—EMDR therapy protocol for the treatment of depressive disorders. In: Lubner M, editor. *Eye Movement Desensitization and Reprocessing (EMDR) therapy scripted protocols and summary sheets: Treating anxiety, obsessive-compulsive, and mood-related conditions*. New York (NY): Springer Publishing Co; 2016. p. 289–311.
- Rovaris M, Toselli E, Mendozzi L, Di Tella S, Pirastru A, Blasi V, Baglio F, Ostacoli L, D'Abramo A, Incerti A, et al. Eye movement desensitization and reprocessing for depressed individuals with multiple sclerosis: A pilot study. *Mult Scler J*. 2024;30(6):747–750.
- Fernandez I. EMDR as treatment of post-traumatic reactions: A field study on child victims of an earthquake. *Educ Child Psychol*. 2007;24(1):65–72.
- Gauvreau P, Bouchard S. Preliminary evidence for the efficacy of EMDR in treating generalized anxiety disorder. *J EMDR Pract Res*. 2008;2(1):26–40.

23. Schurmans K. A clinical vignette: EMDR treatment of choking phobia. *J EMDR Pract Res.* 2007;1(2):118–121.
24. Triscari MT, Faraci P, D'Angelo V, Urso V, Catalisano D. Two treatments for fear of flying compared: Cognitive behavioral therapy combined with systematic desensitization or eye movement desensitization and reprocessing (EMDR). *Aviat Psychol Appl Hum Factors.* 2011;1(1):9–14.
25. Maxfield L. Twenty years of EMDR. *J EMDR Pract Res.* 2009;3(3):115–116.
26. Jarero I, Artigas L, Montero M, Lena L. The EMDR integrative group treatment protocol: Application with child victims of a mass disaster. *J EMDR Pract Res.* 2008;2(2):97–105.
27. Maxfield L. EMDR treatment of recent events and community disasters. *J EMDR Pract Res.* 2008;2(2):74–78.
28. Jarero I, Artigas L. The EMDR integrative group treatment protocol: Application with adults during ongoing geopolitical crisis. *J EMDR Pract Res.* 2010;4(4):148–155.
29. Lubet M. *Implementing EMDR early mental health interventions for man made and natural disasters: Models, scripted protocols and summary sheets.* New York (NY): Springer Publishing Company; 2013.
30. Jarero I, Artigas L, AMAMECRISIS co-founders. The EMDR integrative group treatment protocol: EMDR group treatment for early intervention following critical incidents. *Eur Rev Appl Psychol.* 2012;62(4):219–222.
31. Fernandez I, Gallinari E, Lorenzetti A. A school-based intervention for children who witnessed the Pirelli building airplane crash in Milan. *J Brief Ther.* 2004;2(2):129–136.
32. Fernandez I. Terremoto e ferite dell'anima: Come affrontare le macerie emotive. *Psicologia Contemporanea.* 2017;261(3):16–21.
33. Maslovaric G, Zaccagnino M, Mezzaluna C, Perilli S, Trivellato D, Longo V, Civilotti C. The effectiveness of eye movement desensitization and reprocessing integrative group protocol with adolescent survivors of the Central Italy earthquake. *Front Psychol.* 2017;8:1826.
34. Passoni S, Curinga T, Torlodo A, Berlingeri M, Fernandez I, Bottini G. Eye movement desensitization and reprocessing integrative group treatment protocol (EMDR-IGTP) applied to caregivers of patients with dementia. *Front Psychol.* 2018;9:967.
35. Jarero I, Givaudan M, Osorio A. Randomized controlled trial on the provision of the EMDR integrative group treatment protocol adapted for ongoing traumatic stress to female patients with cancer-related posttraumatic stress disorder symptoms. *J EMDR Pract Res.* 2018;12(3):94–104.
36. Conijn T, De Roos C, Vreugdenhil HJI, Van Dijk-Lokkart EM, Wijburg FA, Haverman L. Effectiveness of time-limited eye movement desensitization reprocessing therapy for parents of children with a rare life-limiting illness: A randomized clinical trial. *Orphanet J Rare Dis.* 2022;17(1):328.
37. Encinas M, Osorio A, Jarero I, Givaudan M. Randomized controlled clinical trial on the provision of the EMDR-PRECI to family caregivers of patients with autism spectrum disorder. *Psychol Behav Sci Int J.* 2019;11(1):555802.
38. Leuning EM, van den Berk-Smeekens I, van Dongen-Boomsma M, Staal WG. Eye Movement Desensitization and Reprocessing in adolescents with autism; Efficacy on ASD symptoms and stress. *Front Psychiatry.* 2023;14:981975.
39. Lobregt-van Burren E, Mevissen L, de Jongh A. Eye movement desensitization and reprocessing (EMDR) therapy in children and adults with autism. *Encyclopedia of Autism Spectrum Disorders.* 2020. https://doi.org/10.1007/978-1-4614-6435-8_102388-1
40. Dondi A. Disabilità, trauma familiare e resilienza. Il peso della normalità per fratelli e sorelle delle persone disabili. *Quaderni di Psicologia, Analisi transazionale e Scienze Umane.* 2008;49:117–142.
41. Hadi R, Efat S, Farshid S, Leili T, Mahdih S. Eye movements desensitization and reprocessing with finger movements and elite mobile health software on guilt feeling of parents of children with autism: A randomized trial. *J Psychiatr Ment Health Nurs.* 2025;32(1):89–101.
42. Manetti M, Zanobini M, Usai MC. *La famiglia di fronte alla disabilità. Stress, risorse e sostegni.* Trento: Erikson; 2002.
43. Pavone M. (a cura di) *Famiglia e progetto di vita. Crescere un figlio disabile dalla nascita alla vita adulta.* Trento: Erikson; 2009.
44. Sorrentino AM. *Figli disabili. La famiglia di fronte all'handicap.* Milano: Raffaello Cortina Editore; 2006.
45. Terrell DE, Resnick C. Pilot Research Study: Utilizing the EMDR integrative group treatment protocol online to help parents with the stresses of having a special needs child. In: Uniyal R, Rizvi F, editors. *Understanding disability.* Singapore: Springer; 2023. https://doi.org/10.1007/978-981-99-4925-0_2
46. Rossi F, Fernandez I, Fiore F, Maslovaric G, Incerti A. Caregiving parent group: Intervento di gruppo con i genitori di bambini con disabilità basato sull'integrazione tra emdr e cbt FORUM di PSICOTERAPIA e RICERCA scuola di specializzazione Studi Cognitivi, 2017 May 5–6.
47. Incerti A, Cimorelli F, Fiore F, Maslovaric G, Rossi F, Fernandez I. Affrontare il trauma per gestire la disabilità: Risultati preliminari in un intervento di gruppo per genitori. *Quaderni di Psicoterapia Cognitiva.* 2020;46:2020.
48. Incerti A, Cavalera C. EMDR integrative group therapy for ongoing traumatic stress in caregivers of children with neurodevelopmental disorders. *PsyArxiv.* 2025. <https://doi.org/10.31234/osf.io/2rt39>

Eye Movement Desensitization and Reprocessing Integrative Group Treatment Protocol for the Reduction of Perceived Stress in Parents with Disabled Children: A Therapeutic Approach

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Severe disabilities in children can cause high levels of stress within families, and scientific literature reports a few studies about using Eye Movement Desensitization and Reprocessing (EMDR) group therapies for reducing parents'/ caregivers' stress. This research, based on a pre-post study design, aims to verify (a) if the EMDR Integrative Group Treatment Protocol is an effective therapy in reducing perceived stress and (b) if EMDR Integrative Group Treatment Protocol is effective in reducing some psychopathologic caregivers' symptoms. The participants consisted of 15 parents with severely disabled children who underwent therapy sessions of 100 to 120 min each administered by 2 trained EMDR therapists with a specific training in this protocol. At baseline, the Perceived Stress Scale and the Symptoms Checklist-90 were administered, with respect for anonymity, by the same 2 trained therapists who conducted the sessions. At the end of these sessions, a week later, the same scales were administered along with a parent's statement questionnaire. These scales and the questionnaire were administered again after 3-month posttreatment. The results demonstrated an important improvement of the caregivers' stress (Perceived Stress Scale raw score from 33.33 to 22.86 after a week [t value 9.92×10^{-9} , $P < 0.05$], and the score decreased also after 3 months posttreatment [t value 3.06×10^{-4} , $P < 0.05$]), and a substantial decrease of the parents' worries (statements reported from parents as "reduction of future worries", "more information to copy with", and "feeling less alone") emerged from the anonymous questionnaires administered a week and 3 months posttreatment.

Image

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