

Evaluating the EMDR Group Traumatic Episode Protocol With Refugees: A Field Study

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In 2015, more than 1.5 million refugees arrived in Germany, many severely traumatized. Eye movement desensitization and reprocessing (EMDR) therapy has been proven to be an effective treatment for acute and chronic traumatic stress symptoms. A modification for provision in group settings was developed by E. Shapiro: the EMDR Group Traumatic Episode Protocol (G-TEP). In this field study, we investigated the effectiveness of 2 sessions of EMDR G-TEP in treating traumatized refugees. After receiving a psycho-education session, 18 Arabic-speaking refugees from Syria and Iraq who had come to Germany during the previous 5 months were assigned to treatment and/or waitlist. The Impact of Event Scale-Revised (IES-R) and Beck Depression Inventory (BDI) were administered at pre- and posttreatment. Analysis was conducted using the Mann–Whitney U test and planned Kolmogorov–Smirnov tests. Results showed significant differences between the treatment and the waitlist groups, indicating a significant decline in IES-R scores ($p < .05$). Although differences in BDI scores did not reach significance ($p = .06$), a large decline in BDI scores was seen in the treatment group. These results provide preliminary evidence that it might be effective to treat groups of traumatized refugees with EMDR G-TEP.

Keywords: eye movement desensitization and reprocessing (EMDR); Group Traumatic Episode Protocol (G-TEP); refugees; disaster mental health; posttraumatic stress; posttraumatic depression

Human migration and flight are major geopolitical issues, impacting more than 60 million people worldwide at present according to United Nations Organisation (UNO) experts (Reschke, 2015). War, hunger, and poverty are considered to be the main causes. Although this condition has been ongoing for years, it is still increasing, and some Western countries have lately been severely affected by this crisis and its accompanying problems.

In 2015, more than 1.5 million refugees arrived in Germany within a few months after a political decision to open the borders. Many of them came from war-torn Syria. Although the refugees' basic need is security, simply providing basic essentials might not be enough. Many of these refugees are severely

traumatized, and effective therapy services are very much needed. This is even more necessary in light of the integration policy in Germany, which requires refugees to integrate and learn new languages, because symptoms of posttraumatic stress disorder (PTSD) and/or depression (e.g., sleep disturbance, hyper- or hypoarousal, loss of concentration) can limit learning abilities and adaptation.

Although it might be argued that 45%–80% of those who experience traumatic events and show transient posttraumatic stress recover spontaneously (National Institute for Health and Clinical Excellence, 2005), the likelihood of developing PTSD grows with exposure to the number of traumatic events with the accumulation of dysfunctionally stored memories (McFarlane, 2009,

2010a, 2010b). It is well-known that traumatic stress is a risk factor for many psychological and somatic complaints and diseases and that PTSD with its devastating consequences can also have a late onset (Andrews, Brewin, Philpott, & Stewart, 2007).

It must be considered that in the case of refugees such as those from Syria, we are confronted with a population which has been chronically exposed to life-changing events with multiple traumatic experiences and ongoing stress. The PTSD rate in German refugees is between 16.3% and 54.9% (Bozorgmehr et al., 2016). In a review of eight studies, Slewa-Younan, Uribe Guajardo, and colleagues reported a rate of depression for refugees in Western countries between 28.3% and 75.0%, and a rate of PTSD from 8.0% to 37.2% (Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015).

Western societies aim at integrating refugees coming to their countries. Because many refugees are traumatized, it is extremely important to develop effective screening and treatment interventions for the widespread traumatic stress in this refugee population. As Carriere (2014) puts it, the benefits can be seen both at individual and community levels.

Treatment of Refugees

Care for traumatized refugees in Germany is insufficient (Bozorgmehr & Razum, 2015). In a recent report of a network of 32 German psychosocial centers that specialize in the care for traumatized refugees (Baff, 2017), the centers report that only 5% of traumatized refugees in Germany get counseling or treatment. The care in these centers—and other institutions like them—includes counseling, social work, and psychotherapy. Of the refugees seen in the centers, 36% get a psychotherapy intervention, 89% get individual psychotherapy, and 6% get group therapy (Baff, 2017).

Traditionally, it is thought that stabilization is necessary for treating trauma. Safety and containment are thought to be essential. This certainly poses a problem in the case of refugees who have just come to Germany and who are still not sure about their future. The question is whether there might be a way of introducing enough safety and containment so that treatment is possible at a rather early stage, thereby reducing posttraumatic stress and its earlier mentioned severe consequences.

EMDR

Eye movement desensitization and reprocessing (EMDR) treatment is an evidence-based therapy for PTSD that has been proven to be effective in more than 24 randomized controlled studies (EMDR Research

foundation, 2014) and therefore has been endorsed as a treatment of choice in many national and international health organizations including the World Health Organization (WHO, 2013) and also lately by the German health organization GBA (Schulz, 2015). EMDR therapy and related interventions have been shown to be effective after both natural and man-made disasters (Natha & Daiches, 2014).

In EMDR therapy, unresolved trauma memories are seen as the basis for PTSD and other related psychopathology (F. Shapiro, 1995). EMDR's structured treatment procedures use eye movements and the individual's inherent adaptive information processing system to resolve these memories, leading to an adaptive solution and remission of PTSD and other psychopathology.

Early EMDR Interventions

F. Shapiro (2001) asserted that recent traumatic memories may require a different treatment approach than that used for more historical events, conceptualizing the former as fragmented and not yet consolidated, and she proposed specialized interventions such as her Recent Event Protocol (F. Shapiro, 1995, 2001). Other early EMDR interventions (EEI) have been suggested by several authors, and several protocols are reported in the literature (e.g., Jarero, Roque-López, Gómez, & Givaudán, 2014; Jarero & Uribe, 2011, 2012; Luber, 2014; Maxfield, 2008). F. Shapiro also recommended her original EMD protocol for use in emergency situations (F. Shapiro, 2004). This approach uses a narrow focus on the disturbing target image, to which the therapist frequently returns, each time checking Subjective Unit of Disturbance (SUD) levels and limiting associative chains.

The Recent Traumatic Episode Protocol. Shapiro and Laub developed the Recent Traumatic Episode Protocol (R-TEP; Laub & Weiner, 2011; Shapiro, 2009; Shapiro & Laub, 2008, 2014). R-TEP is a structured, comprehensive, and integrative protocol for EEI, which includes and extends elements of both the EMD and the Recent Event Protocols. It is designed to address incidents that occurred over an extended time period, called the *Trauma Episode*, defined as the time from just before the onset of the traumatic event up to the present. It can be applied to life-changing traumatic events that have ongoing consequences, which are conceptualized as a trauma continuum. During R-TEP, the individual client focuses on disturbing memories or memory fragments called *Points of Disturbance* (PoDs), which are processed one at a time with EMDR strategies. This is repeated until all the disturbance has been processed to realistic levels.

Controlled studies have been published using the EMDR R-TEP in a Turkish refugee camp with Syrian refugees (Acarturk et al., 2015) and in Israel after a fatal missile attack (Shapiro & Laub, 2015). Field studies using EMDR R-TEP were conducted in Northern Italy after the earthquake in Summer 2012 (Fernandez, 2013) as well as in Istanbul in 2009 after the terrorist bombing (Kaya, 2010). In all of these studies, EMDR R-TEP was shown to be effective in reducing psychological distress. The EMDR R-TEP protocol is currently being used in controlled studies with accident trauma victims in Hungary, at three rape centers in the Netherlands and Denmark, with acute trauma in Finland, and with refugees in Italy and Jordan.

Group EMDR. R-TEP as well as almost all EMDR therapy is an individual therapy approach which limits the number of people who can be treated by a therapist. Although in most situations this might not be a problem, there are conditions in which many people must be treated at the same time, such as after natural or man-made disasters or as in the earlier described context where large numbers of refugees arrive in a community. In such cases, and with limited resources, group EEI might be an initial solution of choice.

Jarero et al. were the first to develop an EEI group intervention after hurricane Pauline devastated large parts of Mexico in 1997. Their EMDR Integrative Group Treatment Protocol (IGTP; Jarero, Artigas, & Hartung, 2006) has achieved good results and has been widely used in many countries (Jarero et al., 2014). It has been shown to be beneficial in large-scale disaster situations (Jarero et al., 2006; Jarero, Artigas, & Luber, 2011; Jarero & Uribe, 2012). This protocol is also variously known as the Group Butterfly Hug Protocol, The EMDR Group Protocol, and the Children's EMDR Group Protocol.

Originally developed for children, it employs drawings as the main form of expression. It has also been used with adults. During the desensitization phase, each individual draws a personal picture of the traumatic event and rates his or her level of SUD. The participants then look at the picture while doing the butterfly hug (crossing their arms and tapping themselves on the chest in a bilateral alternating fashion). After this, they draw another picture, rate its level of disturbance, and then look at that picture while doing the butterfly hug (BH). The sequence is repeated two more times. Then there is a positive future drawing installed with BH to finish. Disadvantages of this protocol might be that it addresses only one target per session, it relies on drawings, and it also employs very few sets of bilateral stimulation (BLS) without any eye movements.

The EMDR Group Traumatic Episode Protocol

Based on R-TEP, E. Shapiro developed the EMDR Group Traumatic Episode Protocol (G-TEP). It attempts to keep as much as possible the power of the individual EMDR R-TEP although it is in a group setting. It is a simplified adaptation of R-TEP for use with groups of adults, adolescents, and older children. It can be used for recent traumatic experiences or life-changing events with ongoing consequences that are not necessarily recent (E. Shapiro, 2012), as is the case of refugees. It incorporates the eight phases of the original EMDR protocol in a uniquely developed worksheet with a special focus on safety and containment.

Group members are led through a process where they learn stabilization and containment exercises (4 Elements; Shapiro, 2007; E. Shapiro 2012), then focus on past and future resources. A safety screening is built into the protocol to identify those not ready for the group trauma processing. After this is accomplished, they are instructed to identify PoDs by using what is called a mental "google search," just as they would do in the individual R-TEP. SUD levels of the target PoDs are checked, and the PoD is processed with self BLS that incorporates eye movements. This is done by each group member tapping with his or her own hand from one spot of the worksheet, the present safety, to another spot on the worksheet, the PoD. While tapping, they each follow their own hand with their eyes, thus assuring that BLS is done also with eye movements. After every three sets, they go back to focus on the target (the PoD), checking and recording the SUDs. After nine sets, a new "google search" is done, looking for another PoD, which then is being processed the same way. The worksheet provides for three PoDs to be processed in one G-TEP session. After processing the three PoDs, an Episode Positive Cognition (PC) is installed, and finally, the session is closed with a containment exercise.

The G-TEP has several advantages. Its structured worksheet contains all the steps needed to use the protocol, enabling rapid learning. Moreover, the worksheet format conveys a "spatial" message: the single worksheet contains a concrete spatial (interweave) setup illustrating the Trauma Episode together with present, past, and future resources. Several targets (PoDs) are being processed by a circumscribed EMD type strategy, returning back to target frequently, thus allowing for focused processing and containment. Deeper processing is facilitated with more sets of BLS. Another advantage of the G-TEP is that it uses eye movements: The self-BLS is designed to include eye movements as well as tapping. It can be applied for groups who have experienced the same or different critical incidents.

Group Traumatic Episode Protocol Research

To our knowledge, only one controlled G-TEP study exists so far. Yurtsever et al. (2014, 2017) treated a group of Syrian refugees in a Turkish refugee camp. Fifty-three adult participants with diagnosed PTSD were randomly allocated to an experimental group ($n = 21$) and a control group ($n = 32$). Assessment was conducted using IES-R, BDI-II, and Mini International Neuropsychiatric Interview (MINI) at pre-, post- and 4-week follow-up. Results showed that following the intervention, the EMDR G-TEP group had significantly lower PTSD and depression symptoms. At follow-up, 61.1% of participants in the treatment group had lost their PTSD diagnosis, compared to 6.4% in the control group. The Yurtsever et al.'s study indicates that EMDR G-TEP may be effective in reducing PTSD and depression symptoms among Syrian refugees living in a camp even after only two treatment sessions conducted over a period of 3 days. It was suggested that an increase in the number of EMDR G-TEP sessions may result in an increased therapeutic effect on PTSD.

The Current Study

The aims of this study were to explore the effectiveness of G-TEP for reducing PTSD and depression symptoms among refugees in Germany to find out whether further research might be justified.

Method

Participants

The sample comprised 18 Arabic-speaking refugees from Syria and Iraq who had come to Germany within the last 5 months via the Balkan route. The sample comprised 4 women and 14 men, mean age was 32.4 years ($SD = 5.6$). Participants had asked for psychological treatment after having received psychoeducation on trauma and PTSD following a German language lesson.

Design

The study employed a waitlist control group design (Figure 1).

Measures

The measures used were the IES-R (Weiss & Marmar, 1997) and the Beck Depression Inventory II (BDI II; Beck, Steer, & Brown, 1996; Hautzinger, Keller, & Kuehner, 2006), both in Arabic language. Both tests were administered at pre- and posttreatment. At posttreatment, participants were asked, "Since the

treatment, have you noticed any changes in the quality of your sleep? Have you noticed any changes in your stress level?"

The IES-R is commonly used clinically and in research. It is a self-report tool developed to assess posttraumatic stress, with subscales for intrusion/reexperiencing, hyperarousal, and avoidance. Item responses range from 0 (*not at all*) to 4 (*extremely*), with a maximum score of 88. It has 22 items indicating current levels of distress, derived from the *Diagnostic and Statistical Manual for Mental Disorders* (American Psychiatric Association, 2004) criteria for PTSD. Although not used for the diagnosis of PTSD, Creamer, Bell, and Failla (2003) have suggested that a cutoff score of 33 discriminates between those with and without PTSD.

The BDI-II is a 21-item self-report measure with good psychometric properties. It has a high sensitivity to changes during therapy, which was what our study was looking for. Scores range from 0 to 63, with the following cutoffs: 0–13 minimal depression, 14–19 mild depression; 20–28 moderate depression; and 29–63 severe depression.

Procedure

All participants were assessed at Time 1. Because none of them spoke German well enough, we worked with two Arab-speaking translators who had previously been provided with G-TEP treatment. The first session provided psychoeducation to the whole group about disturbing life events, trauma, PTSD, and EMDR therapy in accord with the G-TEP protocol. The group was then divided randomly in two. Because of personal reasons, three people who had first been assigned to Group 2 turned up for treatment together with Group 1, so Group 1 ($N = 12$) was larger than Group 2 ($N = 6$). At best, randomization can only be considered partial.

Group 1 consisted of eight men and three women. Mean age was 31.3 years, ranging from 20 to 45 years; Group 2 consisted of six men and one woman, mean age was 33 years, ranging from 19 to 40 years, with no statistical differences between groups.

Group 2 members were placed on a waitlist, and Group 1 received immediate treatment consisting of two sessions of EMDR G-TEP on 2 consecutive days. As required by the G-TEP protocol, the first part of each treatment session was devoted to stabilization and a short psychoeducation, following which the focus was on processing of PoDs. Each session lasted about 2 hours. After 1 week, at Time 2 (T2), participants from both groups were assessed again. The members of Group 2 then received treatment, outside

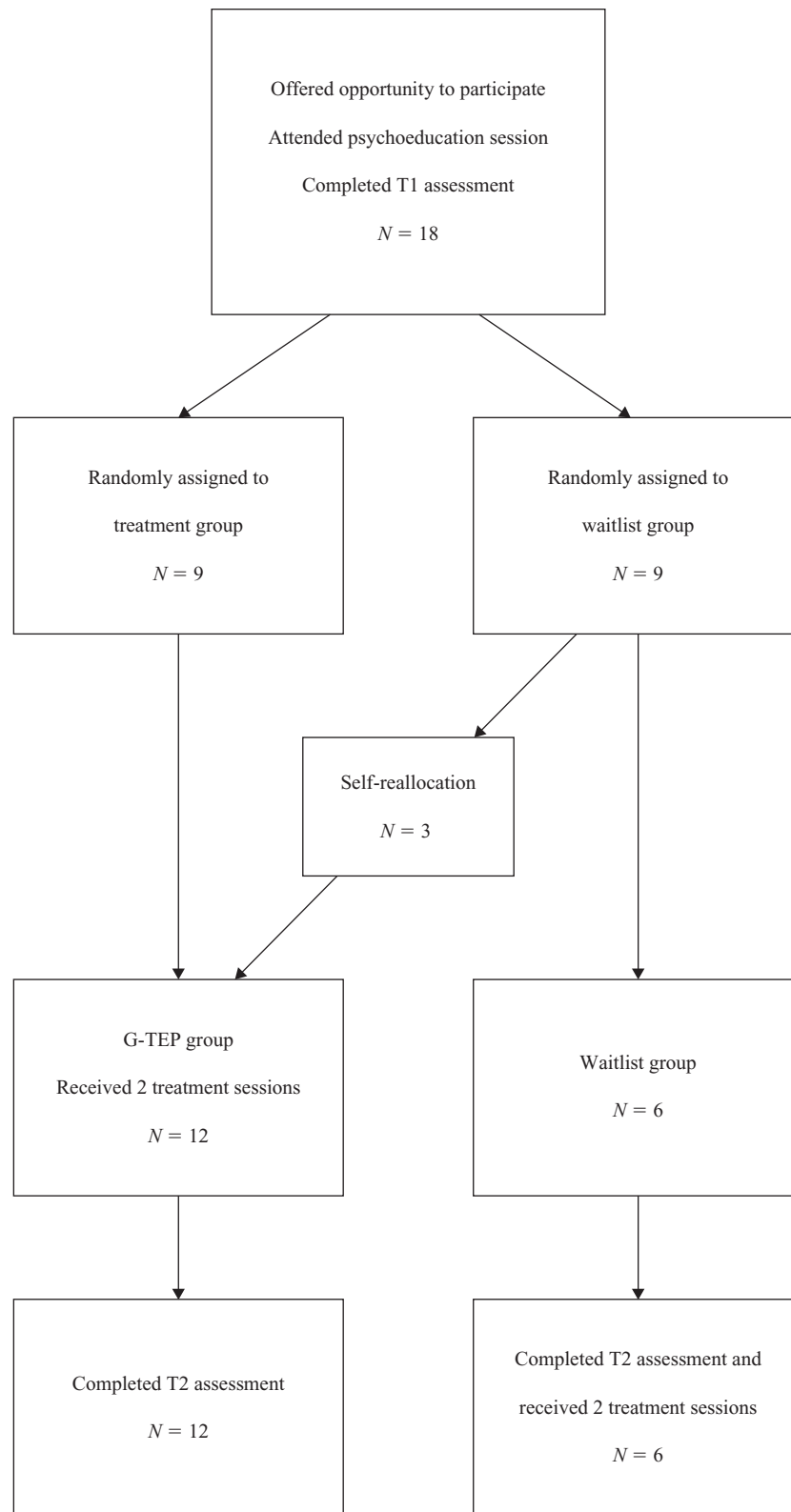


FIGURE 1. Study design.

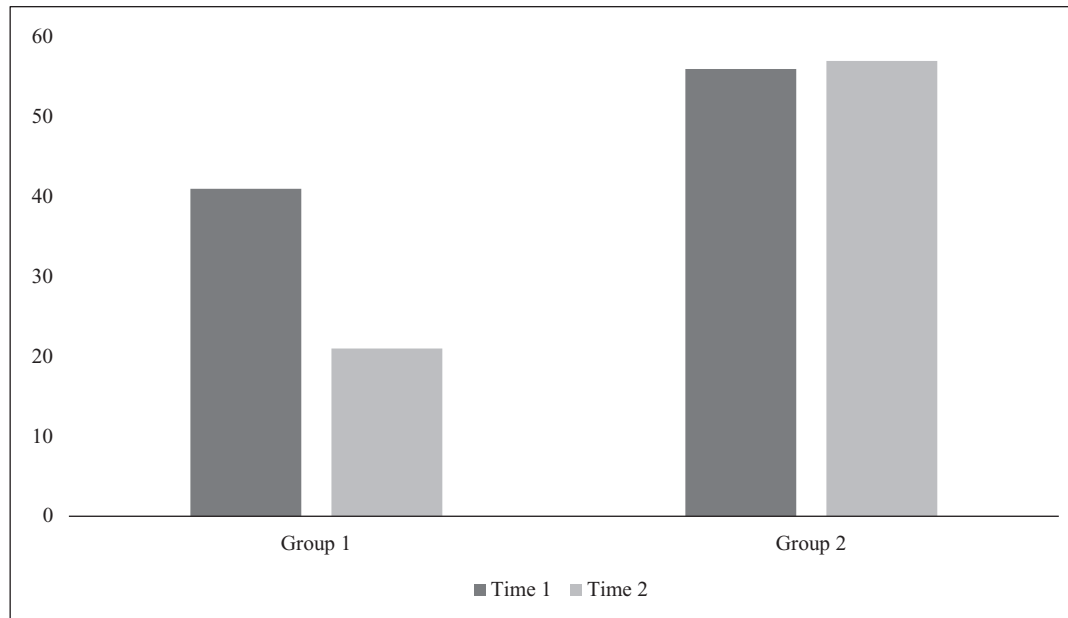


FIGURE 2. IES-R pre- and postscores of treatment and waitlist groups.
Note. Group 1 was treatment group; Group 2 was waitlist group.

the parameters of this study. Time 3 (T3) assessment was planned to be conducted at 3 months for those who could be located. Unfortunately, after 3 months, only two persons could still be traced and were still in the region; all the others had moved on. For these two, no further formal assessment was done.

Results

Data analysis

Because of very small numbers, analysis was conducted using the Mann–Whitney U test to compare the T1 and T2 means for the treatment and waitlist groups on the IES-R and BDI. Planned Kolmogorov–Smirnov tests were conducted to test distributions within groups. Data were analyzed with the SPSS version 22.0. A *p* value of .05 was considered statistically significant.

Kolmogorov–Smirnov tests revealed no differences in distribution in the two groups at pretreatment. Testing of the difference between T1 and T2 with Mann–Whitney U test revealed a significant difference in groups in the IES-R scale measures $U(16) = 31, p = .01$, indicating a significant difference in the change between T1 and T2 between the two groups. Although Group 1 showed a significant decline in the IES-R score (T1: $M = 41.8, SD = 15.6$; T2: $M = 21.6, SD = 9.9$), scores stayed almost the same in Group 2

(T1: $M = 56.2, SD = 18.3$; T2: $M = 56.6, SD = 19.7$; Figure 2).

Differences in the BDI between groups at T1 and T2 did not quite reach significance ($p = .06$), yet a large decline in BDI scores was seen in Group 1 compared to Group 2. Mean scores in Group 1 at T1 were $M = 16.9, SD = 9.9$ and dropped at T2 to $M = 7.3, SD = 4.9$, whereas mean scores in Group 2 at T1 were $M = 23.6, SD = 15.2$ and remained high at T2 with $M = 24.6, SD = 15.2$ (Figure 3).

In response to questions about observed changes, all Group 1 participants reported feeling better after treatment, less stressed, and experiencing better sleep.

Discussion

Our pilot study was conducted at a time when immediate reduction of distress was needed for refugees who had recently arrived in Germany. Its main aim was to see whether group EMDR G-TEP might be a choice in such a situation and whether further and more thorough study of this subject would be justified. Inspired by the Turkish study at a refugee camp, this pilot study was done as a preliminary investigation of the effectiveness of the EMDR G-TEP protocol in Germany.

The T1 scores for both groups showed that the refugees in our sample were experiencing substantial

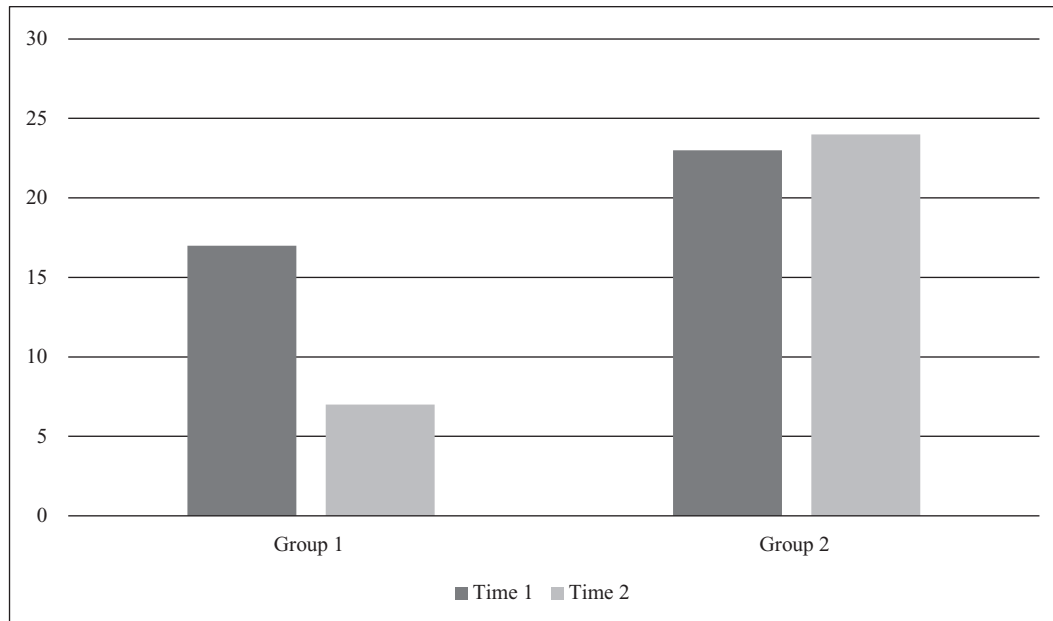


FIGURE 3. BDI: Pre- and postscores of treatment and waitlist groups.
Note. Group 1 was treatment group; Group 2 was waitlist group.

depressive and posttraumatic symptoms. The mean BDI-II scores placed Group 1 participants in the mild range and Group 2 participants in the moderate range for depressive symptoms. The mean IES-R scores for both groups were above the recommended diagnostic cutoff of 33 (Creamer et al., 2003). These findings are consistent with those of large studies, indicating significant mental health distress among refugee populations (e.g., Bozorgmehr et al., 2016; Slewa-Younan et al., 2015).

Our outcomes found that IES-R scores of the treatment group improved significantly, indicating that two sessions of group EMDR (G-TPE) following a general psychoeducation was sufficient to reduce posttraumatic stress among the refugees in our sample. The percentage of treated participants with IES-R scores above the suggested PTSD cutoff score of 33 (Creamer et al., 2003) decreased from 58% at pretreatment to 8% at posttreatment. Depression scores in the treatment group also decreased, although not statistically significant (because of the small sample). At pretreatment, the BDI mean score was 16.9, indicating mild depression, whereas at posttreatment, the mean score was 7.3, indicating that these participants no longer suffered from depression. Although the waitlist group had received some treatment in the form of psychoeducation at T1, this material appeared to have no/little impact on their scores of PTSD and depression.

The positive results of EMDR G-TPE in this study show that it may be possible to treat traumatized refugees in groups with EMDR G-TPE and efficiently reduce posttraumatic stress and perhaps depression. The treatment appeared to enable better sleep and to reduce stress, as our participants reported. In the long run, this may contribute to better integration of refugees into a new society. Refugees have the challenging task of learning a new language, accommodating to a new culture, finding employment, housing, schooling, and becoming established in new communities. Future research could examine to what extent reducing mental health challenges helps refugees with their adjustment.

Challenges of Conducting Research With Refugees

Cultural and language factors were a challenge. Having treated the two translators in advance proved to be helpful. Nonverbally, they may have communicated an atmosphere of trust because of their positive experience. Thus, we did not encounter safety issues and decompensation during the sessions. Also the translators helped us getting the group started and staying within the time constraints. As mentioned previously, we had planned a randomization of the sample, but because of personal reasons, three people who were assigned to Group 2 showed up at Group 1. In one

case, two cousins did not want to be separated. For two others, it was because of practical reasons of having been given a lift. In this situation, we decided to let them participate. We did not want to lose these participants and we wanted to ensure that they received the potential benefit of treatment. Thus, randomization was not achieved and at best can only be considered partial.

A difficulty which had not been anticipated was further migration of the refugees. Because they were allowed by the government to move to another place if they found work, all but two moved to other parts of the country within a few weeks after treatment and could not be traced by us. Because of this, the 3-month follow-up which had been planned in advance with both groups was not possible. Future studies should be aware of this difficulty. In contrast, the G-TEP study (Yurtsever et al., 2017) done before our field study was not conducted in a refugee camp but in a small town; a “real world” environment.

Nevertheless, even though we faced these various difficulties, it was possible to treat traumatized refugees with G-TEP and help them diminish PTSD and depressive symptoms. This might contribute to a better integration into our society.

Limitations

Our study is limited by small numbers, which reduced statistical power and increased the effects of individual differences within groups. Also, because of the setting, intake screening was limited and based on self-report. In this respect, the group may not have been representative. As previously mentioned, we lost randomization and we were unable to administer follow-up measures and so do not know if the results were maintained over time. The data collected by group questioning about sleep and stress was done in a group setting and so may have been influenced by social desirability factors.

Further Research

Group EMDR G-TEP may be a pragmatic and efficient way to meet the needs of traumatized refugees. Short-term group therapy allows a few therapists to provide treatment to many people, even those who are transient and only in a location for a brief period. Further research should be conducted with larger numbers of participants. A full follow-up is needed to evaluate long-term effects.

Research could investigate whether EMDR G-TEP improves other aspects of quality of life, especially concentration and learning abilities, which would be expected to facilitate refugees’ integrative abilities. It could also investigate whether refugees who have received treatment show better integration and higher levels of function within their new communities.

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