

## THE USE OF EMDR WITH REFUGEES AND ASYLUM SEEKERS: A REVIEW OF RESEARCH STUDIES

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### Abstract

Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro 2001), is an evidence based therapy for PTSD and could be effective in the treatment of traumatized and therefore, has been endorsed as a treatment of choice in many national and international health organizations including the World Health Organisation. This article reviews the current state of knowledge regarding the use of EMDR in the refugees and asylum seekers treatment of PTSD. Recently there is a growing interest in implementing EMDR as a trauma-focused intervention. On reviewing nine studies, authors found that EMDR was more efficacious against waitlist, and was equally efficacious against stabilization.

**Key words:** EMDR, PTSD, refugees, asylum seekers, trauma

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### Introduction

Refugees and asylum seekers is a population exposed to multiple traumatic experiences and on-going stress. They are forced to leave their home countries to escape persecution and war. Most of them have suffered several traumatic events, such as the murder of family and friends, severe injury, and/or threat of death and torture, prior to their flight (de Jong et al. 2001; Mollica et al. 1999, 2001)

The likelihood of developing Post-Traumatic Stress Disorder (PTSD) grows with exposure to a number of traumatic events, with the accumulation of dysfunctional stored memories (McFarlane 2009, 2010). A recent meta-analysis of 181 studies, that have been undertaken with conflict-affected populations, reported a high prevalence of PTSD (Steel, et al. 2009). Furthermore, several studies have shown the presence of complex PTSD symptomatology in the migrant population, which has been subjected mainly to interpersonal violence, both by witnessing or by having directly suffered it (Sabin et al. 2006, Rasmussen et al. 2007, Spitzer et al. 2009).

To find a psychotherapeutic method to treat post-traumatic symptoms in refugee populations is at the present a clinical challenge, and a meaningful and necessary task. The most recent reviews on psychological treatment of refugees show the effectiveness of therapies specifically centred on trauma (Lambert and Alhassoun 2015).

Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro 2001), an evidence based therapy for PTSD, emerges as a highly recommended therapy in the treatment of traumatized refugees (Sjölund et al. 2004, ter Heide et al. 2011) and therefore, has been

confirmed as a treatment of choice in many national and international health organizations including the World Health Organisation (WHO 2013). EMDR is a therapy focused on the bodily aspects of the psychological distress that includes the treatment of the somatic component of traumatic experiences. During the therapeutic process, the clinician starts from the body, go through the emotions, and finally arrive at the cognitive level, promoting a process of access, elaboration and integration of the traumatic experiences (Solomon et al. 2008, Parnell 2007, Castelli Gattinara et al. 2017). EMDR is carried out when the patient focuses on the most distressing memory of the traumatic event besides the related negative self-cognition. At the same time, the therapist provides bilateral stimulation (like eye movements, tapping, or bilateral tones). When a patient retrieves the worse part of the traumatic memory and performs the dual task, the mental image of the trauma becomes less vivid and emotional and the patient feels less distress related to the traumatic event (Solomon et al. 2008).

There are several hypotheses to explain the mechanism of action: one is that the two tasks (retrieving the memory and performing eye movements) compete for limited working memory capacity (Van den Hout & Engelhard 2012), another is that Eye Movement produces a redirection of attention resulting in an integration of disturbing memories into semantic networks (Stickgold 2002). EMDR has been proven effective in more than 24 randomized controlled studies with patients affected by PTSD symptoms (Lee and Cuijpers 2013).

Our purpose is to analyse the efficacy of the EMDR with refugees and asylum seekers. This purpose is grounded on the characteristics of the traumatic

symptoms of refugees: high rates of somatization were found among this population, so much, so that this somatic symptomatology is considered in this particular clinical population a “primary” therapeutic target (Aragona et al. 2010). EMDR as a bottom up elaboration could be particularly useful to process these bodily symptoms. Scientific investigation of the effectiveness of EMDR to reduce psychological burden in refugees and asylum seekers is an important issue and is useful in determining whether to offer them this therapy. Other reviews deal with the different therapies used with these populations (e.g. Tribe et al. 2017), but we intend focus exclusively on the use of EMDR. Through this review, we intend answer important questions on the use of EMDR for refugees and asylum seekers who live in very difficult circumstances and had experimented very severe and continuous trauma.

## Systematic Review: Method

Published studies were searched including (1) a comprehensive search of the PsychINFO, Social Sciences Index, Medline, and Google Scholar database; (2) a search of the articles of the authors in this field of research, (3) examination of the citations from selected papers. Searches were conducted using all variations of these major keywords in the title or the abstract in a separate and/or combined search: *EMDR, Asylum Seekers, Refugees*. We included no restriction for the year of publication and collected articles from 2000 through August 2017, in English, Italian, Spanish, and French. 50 potentially relevant empirical studies, including journal articles and dissertations, were located and each was reviewed to determine eligibility for inclusion. Only nine were consistent with our purposes. A study was included if it met the following three criteria: first, there is a pre- post- evaluation; second, a diagnosis of PTSD by the criteria set out in the DSM-IV or DSM-5 with formal psychological measures or by clinical observation was formulated; third, the article was a primary research article.

## Systematic Review: Results

Few studies have investigated the efficacy of EMDR psychotherapy with traumatized refugees and asylum seekers, but recently there is a growing interest in implementing EMDR as a trauma-focused intervention. We founded 9 studies in the last 15 years (**table 1**).

The first question is if EMDR treatment could be effective even if the treatment is conducted while the subject is still in dangerous or difficult circumstances. Acaturk and his group (Acaturk et al. 2015, 2016) conducted two pioneering studies with adult Syrian refugees in a Kilis camp at the border between Turkey and Syria where the conditions are not as safe for refugees as in Western countries. The objective was to determine the effect of EMDR on PTSD and Depression symptoms. The number of participants were 29 for the first study and 90 for the second. The sample was mainly women (76% and 74% respectively) with primary or secondary education. Both the studies are culturally sensitive and adopted specific measures in order to prevent drop out: the treatment was done in their mother language, if necessary with an interpreter, the researchers tried to match the gender of the therapist with the gender of the client, the study was explained to key members of the Community. The Refugees were randomly assigned either to the EMDR group or to waitlist control group. The main outcome measures for PTSD and Depression

were the Impact of Event Scale Revised (IES R) and Beck Depression Inventory (BDI-II) in the first study, and IES-R, Harvard Trauma Questionnaire (HTQ), BDI-II, Hopkins Symptoms Checklist in the second study. Both studies compared EMDR as sole therapeutic intervention to Waitlist.

In the first study the psychotherapists used the EMDR standard protocol for 7 sessions, and in the second they used the EMDR R-Tep protocol (an adapted protocol focused on recent traumatic events with an extended time perspective) for a mean of 4,2 sessions. An expert supervisor supported treatment fidelity. In the second study, only 70 participants completed the research protocol, reasons for drop out were refusal of entering into treatment or moving out from the camp. Results of both studies indicate a significant reduction in PTSD and Depression symptoms and demonstrate the acceptability of a trauma-focused treatment. One limit was a short follow up of only 5 weeks, because people very often left the camp. For this reason is difficult to determine the long-term effect of EMDR on this population.

The second question is if EMDR treatment, which enhances traumatic memories, can be counter-productive when trauma is very severe and cumulative, or if in these cases stabilization treatment is preferable. Asylum seekers and refugees are considered a complicated population from a clinical point of view, as many of them suffer of symptoms (severe emotion dysregulation and dissociation) that are due to cumulative and usually early traumatic experiences and consequently, trauma focused therapy could be harmful for them as they can be overwhelmed by traumatic memories (Nickerson et al. 2011). It is argued, following a phase-oriented approach (Courtois et al. 2009, Herman, 1999), that this kind of population may require a long stabilization phase before trauma work. Three randomized studies have been conducted by ter Heide and her research group (2011, 2015, 2016) with the objective to determine safety and effectiveness of EMDR treatment compared to stabilization as usual intervention. All studies demonstrate the possibility to use EMDR with asylum seekers and refugees. Even if results are lower than in other clinical populations, directly targeting the traumatic memories is not harmful for them.

In the first randomized pilot study (ter Heide et al. 2011) 11 sessions of standard EMDR protocol were compared with 11 sessions of stabilization in 20 asylums seekers and refugees with chronic PTSD. Symptoms of PTSD (SCID-I, HTQ) depression and anxiety (HSCL-25) and quality of life (WHOQOL-BREF) were assessed pre- and post- treatment and 3 month follow up. Acceptability of treatment intervention was equal in both conditions, with a high level of drop out, but none of the participants dropped out from EMDR intervention because of high levels of psychological distress. In the study, no difference in efficacy was found between EMDR and Stabilization treatment.

The second study carried out by ter Heide et al. (2016), in line with the first one, engaged a larger sample: 72 refugees and asylum seekers with chronic and severe PTSD symptoms. Participants were randomly assigned to 9 Sessions of standard EMDR protocol (12 hours), or to 12 sessions of Stabilization (12 hours). PTSD diagnosis was measured by CAPS and HTQ. Among the pre-, post- and follow up assessment both groups achieved a clinically significant improvement in PTSD severity, but no significant effect on depression, anxiety and quality of life had been found. The rate of drop out was equal for both groups. Contrary to the expectation, both treatments showed the same effect. This could be due to the limited number of EMDR sessions (only 6 for

desensitization and processing) that can be not enough for patients with complex and prolonged traumatic experiences. It would be interesting for future trials to test the efficacy of EMDR in combination with stabilization.

The study conducted by ter Heide et al. (2015) is the only study that divided refugees who were already resettled and asylum seekers, whereas the control group consisted of a different clinical population: people traumatized during work. The aim of the study was to compare treatment response between these three groups after 1 year of treatment in a specialized psychotrauma institute. Outcome measure was HTQ. Treatment for PTSD consisted of a combination of supportive therapy, pharmacotherapy and an evidence based trauma-focused therapy (EMDR, or Narrative Exposure Therapy or Brief Eclectic Psychotherapy (BEPP) depending on the therapist's training). Results showed that the two groups: asylum seekers (n = 21) and resettled refugees (n = 169) had significantly lower PTSD symptom between pre- and post- assessment than did the comparison group (n = 37). Furthermore, asylum seekers showed the worst result, probably due to their uncertain condition. Limits of the study were the differences of sample sizes between the groups and the difficulty to determine the efficacy of the different trauma focused interventions: in effect, the specific contribution of EMDR treatment to the patients' improvement was not inferable.

The third question is if EMDR also helps PTDS patients with comorbid depression. One hypothesis is that many refugees experienced traumatic losses that could be in themselves the major causes of depression; researchers considered the possibility of addressing first depression and then PTSD, underlining the necessity to work through grief and loss before targeting traumatic memories. Haagen et al. (2017) collected data from a randomized controlled trial of 72 participants using CAPS and HSCL-25 as outcome measures. Lack of refugee status, comorbid depression, demographic, trauma-related and treatment-related variables were analyzed as potential predictors of PTSD treatment outcome. Haagen and his group found that patients with severe depression improved less than the others. No other variables had been found to predict treatment response.

The research carried out by Lehnung and her colleagues is the first controlled study using the EMDR Group Traumatic Episode protocol (G-Tep). This protocol is an adaptation of the Recent Event Protocol developed by Shapiro (2012) to address life-changing traumatic events that have ongoing consequences. The aim of the study was to determine the efficacy of EMDR group protocol compared with a waitlist control group. The sample (n=18) was composed mainly by men (77%) recently arrived in Western countries. Random assignment to a treatment was only partial. Pre- and post-outcome measures were performed using IES-R scale for PTSD and BDI for depression. The programmed follow up at 3 months was not possible because all participants but two had moved to another place. Results showed a significant decrease for PTSD symptoms and a non-significant but large reduction of BDI scores in the experimental compared to the control group. Limits of the study were the small size of the sample, the partial randomization and the use of only a self-report instrument to assess PTSD symptoms. These results also evidenced that patients severely depressed after EMDR treatment improve less than mildly depressed ones.

The last question is if EMDR can also be effective for children. Two studies address this topic: on the one hand, Oras et al. (2004) studied the effectiveness of EMDR for 13 refugee children in Sweden (aged 8-16

years) suffering from PTSD. Instruments used for pre- and post- assessment were the Post Traumatic Stress Symptom Scale for children and the Global Assessment and Functioning (GAF). EMDR treatment was performed together with traditional psychotherapeutic methods for children in a psychodynamic context. EMDR sessions ranged from one to six, following the EMDR standard protocol for children and adolescents. Treatment resulted in significant improvement for PTSD symptoms and for global functioning. The improvement was more in the cases where the families had stable life conditions (i.e. got a permanent residence permit). Therefore, it is possible that the improvement was influenced not only by EMDR treatment, but also by other factors. Limits of the study are a small sample size and the absence of a control group that would have been useful to evaluate the positive effect of EMDR in combination with traditional psychotherapy.

On the other hand, Zaghrou-Hodali M. et al. (2008) used the EMDR group protocol for children to study the efficacy of this treatment in an area of ongoing violence such as a Refugee Camp in Israel. The sample was composed by seven children age 8-12 residing. Assessment was done pre-post and at a 4 month follow up (through therapist's clinical observation during play and parents' reports). Results showed that the EMDR approach could be effective in a group setting, both in reducing symptoms of intrusion and avoidance. The absence of both standardized measures for PTSD and a Control group indicates the need for a more systematic research, but these results suggest the possibility of effectively using the EMDR group protocol in an area of ongoing trauma, reaching a large number of children.

## Conclusion

Some important considerations for clinical practice emerged from this Review. All the research demonstrates the possibility to use trauma focused treatment, such as EMDR, with this population, and highlight that exposure to traumatic memories carries no risk. All of them found improvement in the PTSD symptoms and demonstrate the efficacy of EMDR treatment for PTSD symptoms, even if some research underline that its effectiveness is not so high than in other clinical population.

There is a limited number of research presenting different treatment design to determine EMDR efficacy: some of them study EMDR as the sole therapeutic intervention compared to waitlist, others try to explore the size of differences in efficacy between EMDR and stabilization, none of them compare EMDR to evidence-based treatments such as NET or TFCBT. The effectiveness of EMDR has been evidenced against waiting list but not against stabilization. Furthermore, there is a great difference in the number of EMDR sessions on considering the different studies, but for the future, it would be valuable to standardize the number of sessions or make them dependent on treatment efficacy. Lack of long-term follow up is another limit of these studies.

Considering the high number and severity of traumatic experiences so common among refugees and asylum seekers, research need a better comprehension on core mechanism underlying Refugees mental health. One challenge that is coming out from these studies is the importance to understand more in depth individual differences in treatment responses in order to establish the preferable treatment for a specific patient. Refugees and Asylum seekers are often chronically traumatized patients with dissociative symptoms that may need

both stabilization and trauma processing. An optimal approach, care centered on the patients, may require to alternate continuously stabilization procedures and trauma-focused interventions along the therapeutic process, to reach a successful integration of traumatic experiences (Liotti 2017).

Interestingly, EMDR Psychotherapy is developing new adapted protocols (i.e. R-Tep and G-Tep, developed by Shapiro 2012), that include both stabilization and trauma work and can be more effective with this clinical population, but research on this is still ongoing.

In our opinion, future research studies should investigate efficacy of EMDR approach inside to a multimodal format, assessing not only the decrease of symptoms but also the improvement in social functioning. Limit of this review is the small number of studies evaluated, but, due to the growing interest in this field, a future review will contain a large amount of research.

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