Traumatized refugees and EMDR psychotherapy: a brief report of experience-based EMDR practices with refugees and asylum seekers in Italy

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REFUGEES: FEATURES AND SOCIAL BACKGROUND

- Europe is facing a special flow of refugees in recent times, that are escaping from war, violence, terrorism, political persecution and poverty. They risk their lives to cross the Mediterranean and other borders to reach Europe where they hope to find a solution for their situation and a safe place to live.
- Many do not survive the crossing or the exploitation by traffickers, as we have seen recently.
- While humanitarian support is improving and some EU countries take up large numbers of migrants, they generally face huge difficulties in finding a new place to live, adjusting to their new environment, building up a new life amidst prejudice and hostility, and coping with mental health problems caused by their stressful experiences.

REFUGEES

Those who, because of fears of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion, are outside their countries of nationality and are unable or unwilling to avail themselves of the protection of those countries.

Those who are legally acknowledged to meet this definition are granted the right not to be sent back to they countries of origin.

ASYLUM SEEKERS

Those who flee from their own country and seek sanctuary in another country.

They apply for asylum, the right to be recognized as a refugee and receive legal protection and assistance for their basic needs.

They must demonstrate that their fear of persecution in their home country is well-founded. Their claim to that right is still under examination.

THE IMPACT OF TRAUMATIC EVENTS

Mental health of refugees is generally acknowledged to be influenced both by traumatic and current stressors (e.g., Miller & Rasmussen, 2010). Refugees are at high risk of experiencing traumatic events before, during, and after their flight (Silove, Tarn, Bowles, & Reid, 1991).

SPECIAL POPULATION WITH SPECIAL NEEDS

Before fleeing: traumatic events may vary from imprisonment and torture in political refugees, forced witnessing and committing of atrocities in former child soldiers, and bombings and rape in civilian war survivors, to injury and witnessing the death of others in refugee military veterans.

The flight itself may be traumatizing because refugees often employ the use of smugglers to cross international borders and in the process may face serious threats including injury or death or human trafficking (e.g., Arbel & Brenner, 2013).

After the flight, refugees are at risk of being imprisoned or deported (e.g., Robjant, Hassan, & Katona, 2009), whereas women and children are at special risk of sexual abuse or exploitation (see www.unhcr.org). In addition to traumatic stressors, current stressors both in the country of refuge and the country of origin impact the mental health of both adults and children (Fazel et al., 2011; Steel et al., 2009).

- The accumulation of stressors not only leaves refugees at higher risk of developing mental health problems than general populations (Bronstein & Montgomery, 2011; Fazel et al., 2005), economic migrants (Lindert, Von Ehrenstein, Priebe, Mielck, & Brähler, 2009), and compatriots who have stayed in their countries of origin (Porter & Haslam, 2001), but may also complicate their psychosocial recovery.

- The fear, depression, anxiety, anger, and pain from unprocessed trauma experiences, in fact, have debilitating effects on the individual that can derail any hope of a happy and productive life. There is also a negative impact on families, as the individual's pain can result in domestic violence and the intergenerational effects through inadequate bonding, aggression, or withdrawal.

EMDR

Helping these people is a great clinical challenge since it has to do with transcultural psychiatric principles

According to research and International guidelines EMDR therapy can give a great contribution to refugees to prevent mental disorders, resolving risk factors and facilitating integration and adjustment to a new culture, using and transforming the critical experience that this population is exposed to in a constructive way.

EMDR does not include homework assignments, minimalizes language issues, and has been found efficacious with patients from non-Western cultural backgrounds (Jaberghaderi et al., 2004)

Western centers for refugee mental health are increasingly using EMDR with their refugee patients. Yet, meeting the needs of a growing refugee population crisis in Western countries, is a growing humanitarian emergency, and hence adjusted trauma-focused treatments are being increasingly incorporated within public mental health provision.

It is important to coordinate with institutions and local services so that EMDR therapy interventions become part of the institutionalized assistance to populations after a disaster. The processing of the traumatic experience can occur without obstacles, even under unstable chaotic conditions, which are very common in these circumstances.

EMDR in the field: Working in the hot spots of refugees arrivals

EMDR treatment can be implemented in the different phases of trauma, individually and in groups. EMDR clinicians can be involved with different purposes:

- To intervene in acute phase of traumatization related to critical incidents, reduction of arousal reactions, prevent the accumulation of traumatic stress
- To intervene with refugees to reduce risk factors for mental and emotional disorders
- To intervene with the groups in order to enhance resources and protection factors
- To intervene with personnel that has been exposed to high levels of stress related to their humanitarian work
- To prepare refugees to have further psychological support in European countries, through EMDR Europe network (15.000 EMDR clinicians in 28 European countries)

EMDR treatment is easily implemented with the help of a translator, it has been widely used already with translators in European countries in the last 15 years, without difficulties regarding different languages and cultures.

EMDR clinicians can treat groups of refugees, in order to be time effective. In this way more people can receive specialized evidence based trauma prevention and treatment, in the acute as well as in the chronic phase of trauma.

Traumatized Refugees and EMDR Psychotherapy: A Brief Report of Experience-based EMDR Practices with Refugees and Asylum Seekers in Italy

- This is a brief of gathered information pulled out from reports of 12 Italian clinicians, who are at present in the process of treating with EMDR refugees and asylum seekers within migrant centers and mental health facilities in Italy. The aim is to organize an explanatory model of successful applications of EMDR with these types of populations from diverse cultural backgrounds.
- This brief report describes EMDR interventions with heterogeneous populations of refugees and asylum seekers, coming from war torn and developing countries, mainly sub-Saharan Africa and the Middle East, who have been resettled in Italy in governmental and NGO camps, and who have sought treatment in mental health services for trauma-related disorders.

Refugees, Asylum Seekers and Psychosocial Factors

All EMDR treated individuals that we are including in this report have experienced extremely traumatic events such as torture, rape, loss, have been exploited and abandoned, and most of them have come by sea after a horrifyingly dangerous journey.

The greatest issues bearing on these populations is their role loss, as well as loss from multiple deaths.

Their belief system completely embraces fatalism and animism, to which they surrender their ability to make choices and personal strategic planning.

Also, it is necessary to point out that many refugees have a very low level of education.

SYMPTOMS

The most common psychological symptoms are complex PTSD and dissociative states.

Yet, people coming from developing countries, mainly Africa, tend to express emotional distress through their body. In fact, somatic disorders are frequently brought to the clinician's attention, and may often be a sign of unreferred post-traumatic symptomatology.

It comes with no surprise that mental health issues may be routinely misdiagnosed in transcultural medical settings (cit. Onofri et al., 2014). Frequent somatization disorders include gastritis, dermatitis, difficulties in concentrating, nightmares, difficulties in learning (e.g. Italian), and sleeping disorders.

Their core traumatic feeling is an utter sense of powerlessness they perceive as inscribed in their body: to overcome this, these individuals still need to realize that they survived.

Furthermore, social exclusion experienced in hosting countries can lead to worsening of PTSD symptomatology.

Hence, there is a need to tailor interventions as close as possible to patient's most compelling needs and objectives, as well as addressing any recent and past traumatic episodes.

Helping these displaced and highly traumatized populations need to put into words their life experiences and create a narrative, as well as help them experience their identity and human rights, is of utmost importance.

THE ISSUE OF STIGMA

Stigma is a mark of disgrace that sets a person apart. It leads to the experience of isolation, shame and hence reluctance to seek and accept help. When a person is labeled by their condition, they can be discriminated and be victim of prejudice and negative actions.

ACTIONS TO TACKLE STIGMA

- Deliver psychoeducation on trauma
- Raise awareness within the reception camps about the benefits of psychological counseling subsequent to trauma.
- Ask how would symptoms be dealt with in their country of origin and create a link with the culture of the host country.
- Invite all refugees living in the camp to participate and take part at group meetings, mainstreaming resilience and positive sharing. Groups may lead subsequently to one-to-one treatment with clinician.

- The most basic element of communication between clinician and patients must be a very simple and "unshaming" language. On a one-to-one basis, patients need to hear that what they are going through is a “normal” response to extremely adverse life events, and that they are not “crazy” or ill.

- Clinicians usually avoid introducing themselves as psychiatrists or psychotherapists, but simply explain that they are doctors who have been providing help to strong and brave people who have been able to survive extremely difficult circumstances.

- Treat refugees not as victims, but as active agents of their lives in the face of adversity. It is essential to develop a deep sense of appreciation and admiration toward these people, for having been able to endure and withstand such harsh experiences. This enables for attunement to happen and maintain a coherent verbal and nonverbal communication.

- Clinicians can explain the most frequently observed symptoms in traumatized refugees, validating their experience. This will help the person feel reassured and understood for how they are coming to terms with their extreme distress, normalizing their experience, as well as foster hope.

- However, the greatest challenges against stigma are not met with war trauma, but with people who have been traumatized by sexual and domestic violence prior to the war. These patients need to be treated in total secrecy and sessions may be labeled for the others as “relaxation”, since this term carries a non-stigmatizing connotation.

ADAPTATIONS OF EMDR PROCEDURES

The EMDR protocol can be applied as the sole therapeutic intervention or as part of a phase or multimodal approach.
Several reports have found it to be effective in stabilizing patients, as provided in emergency settings.
Specifically, clinicians reported the effectiveness of the EMDR Recent Traumatic Event Protocol (Shapiro, E. & Laub, B.; 2008) and of the EMDR Integrative Group Treatment Protocol – IGTP (Artigas, L., Jarero, I., Alcalá, N. &López Cano T.), which proved to be very flexible and useful in reprocessing the cumulative recent and fragmented highly traumatic events.

- When treating such bereaved and culturally diverse people, clinicians are required to be sensitive toward cultural privacy and modesty concerns and ask permission for touching the patient. Opposite-sex clinicians and interpreters should be avoided. It is important to maintain appropriate distance.

- This population usually experience their emotions in the heart, never in their stomach. It is essential to start with a psychoeducation on EMDR and help them develop an emotional literacy, as well as teach them breathing and relaxation techniques.

- An initial, thorough stabilization process, as well as resource installation, has proven to be crucial.

- Past and recent trauma are not easily reprocessed, due to refugees' ongoing traumatization, caused by their current living conditions. Initially, clinicians should help patient focus only on the present: it is nearly impossible for them to concentrate on the past due to cultural barriers, as well as far too painful, and can hardly envision an alternative future.

- Generally, when applying EMDR, clinicians reported the need to be very flexible, shifting constantly from past to present, reprocessing many large T traumas from the past, along with very severe ongoing current trauma.

- Once current living conditions in terms of safety and stability within the camps had been ensured, clinicians usually began with history taking which could take several days, due to the presence of many past and recent trauma.

- Refugees appear to frequently manifest somatization disorders and the therapeutic process has proved to be more effective when keeping the focus on the body (body scan, relaxation techniques), since they express their pain through their bodies rather than verbally. Hence, resolution of symptomatology is usually facilitated by reprocessing the traumatic core via the somatic experience. It is known, that a process of change in these types of populations and in individuals suffering from complex PTSD, often occurs at a somatic level (cit. Onofri *et al.*, 2014).

- Clinicians have observed little mentalizing abilities or different folk concepts, restricting the ability to create a link between their emotional and cognitive states. However, in one similar case, clinician succeeded in identifying the NC and PC, by explaining these two key concepts in a very simple language and by using drawings. Drawings of the map of their journey, pictures, songs and the use of a more simplified language were also used for effective EMDR reprocessing.

A clinician, regularly working with adults and teens of 16 years of age, reported to apply the standard EMDR protocol with minor modifications with a positive outcome:

- two sessions for history taking,
- stabilization with resource enforcement
- safe place
- targets identification
- therapeutic plan addressing initially the large T trauma (e.g. events that have forced the person to flee from their country), subsequently moving on to smaller t traumas.

Another clinician described an effective use of EMDR Standard Protocol with minor modifications with two adult refugees, by:

1. stabilizing patient
2. identifying any somatic sensation
3. subsequently frequently addressing their somatic sensations as targets, and finally identifying a negative and positive cognition

This clinician snaps her fingers after eyes movement sets and frequently touches their hands, in order to keep patients focused in the here and now. Patients are usually allowed to talk during the bilateral stimulation, as it appeared to increase reprocessing in this population.

In some of these reports, reprocessing was more difficult when dealing with feelings of unfairness and anger. However, feelings linked to pain, guilt, believing one could have done more, as well as a great sense of powerlessness, were found to be reprocessed more rapidly.

A successful team operating in South Italy adapted their therapeutic skills to an ethnopsychotherapeutic approach.
They have found that these patients are not prone to ask for help, because the concept of counseling or psychotherapy may be completely alien to them. However, when constantly plagued by recurrent nightmares and flashbacks, that is when they understand they need help.

- Their intervention plan usually begins by delivering psychoeducation on EMDR's function, in terms of taking the pain away, not the memories, since this population often fears to lose the memories of their relatives even if they are dead, since memories is all they have.
- The therapeutic intervention must be done in their native language, "the language of the heart".
- Tapping may be more advisable in most cases, than eye movements.
- Although creating a Safe Place has proven to be difficult, in some cases Muslims were able to select the conclusion of the Ramadan as a very joyous moment.
- Since reprocessing their numerous large T trauma may be far too overwhelming, these clinicians recommend to safely target the traumatic event with Jim Knipe's CIPOS method (The Method of Constant Installation of Present Orientation and Safety).

3 Case Reports of EMDR therapy with adults within a phase centered intervention plan (Onofri, A., Gattinara Castelli, P., Ciolfi, A., Lepore, M.,Ventriglia, S., 2014)

The following outlines a program with a formal structure of EMDR treatment intervention with refugees and asylum center displaced in refugee camps in Rome (Onofri *et al.*, 2014). The core team provided a one-to-one treatment to 3 Refugees. The intervention planned 15 sessions for each patient.

Priority intervention areas were:
1. Reduction of symptomatology.
2. Managing and regulating dissociative episodes and anxiety states, connected to the fear of being deported to another camp or country.
3. Rehearsing and getting prepared for the asylum interview.
4. Help build trust and hope for the future.

- Throughout the intervention, patients were more likely to feel stable, and felt they could trust the clinician, sensing that their story and most incumbent needs were taken seriously.
- The main focus was the somatic component of patients' psychological distress linked to the traumatic experience. An initial bottom-up reprocessing addressed the body, moved on to the emotional component of the distress, and finally accessed cognitions, enabling recall, reprocessing and integration of the traumatic experiences.
- Patients seemed reluctant toward reprocessing their extremely painful past, whilst struggling with their current difficult and sometimes threatening living conditions.

The intervention for treatment of trauma with EMDR included 3 modules of 5 sessions each.

Module 1:
1. Psychoeducation on the effects of psychological trauma, relaxation techniques and grounding to manage dissociative and anxiety symptomatology.
2. Mindfulness and somatic sensorial exercises to increase personal awareness and emotional management.
3. Creating the Safe Place, positive resource installation, stress management skills with the use of bilateral stimulation (Shapiro, F., 2012)

Module 2:
1. Providing help in rehearsing for the asylum interview.
2. Constructing a coherent narrative through the use of bilateral stimulation as required by the Recent Traumatic Episode Protocol (Shapiro, E.; &Brurit, 2012).

Module 3:
Current living conditions need to have been assessed as sufficiently stable.
1. Reprocessing patient's entire life history and the most challenging traumatic issues with Standard EMDR protocol.

The Role of Cultural Mediators and Language

Interestingly, although ethnic matching between patient and clinician may be preferred by patients (cit. Cabral *et al*., 2011), language matching, that is, conducting psychotherapy in the client's mother tongue, has proven to be more effective for treatment (cit. Griner& Smith, 2006).
Yet, as refugee populations within the camps are usually culturally diverse, both language and ethnic matching may not always be feasible.

Almost all of the clinicians of the present survey, reported that cultural mediators can often hamper the therapeutic process.
They require a great amount of psychoeducation on symptoms of PTSD, Dissociation and EMDR, since it is often found that they are not always successful in facilitating communication and understanding between clinician and patient: they tend to become over-involved, interfering, as well as seem not to be able to convey the meaning appropriately, engendering stuck points: a wrong tone of voice on behalf of the mediator, can be very disturbing when patient is reprocessing or may produce either an inhibiting or arousing response during patient's attempt to convey an emotion or traumatic experience.

LOW LEVEL OF EDUCATION

All clinicians found out that being uneducated can be the only real impediment to working efficiently with EMDR therapy because of the difficulty in finding the NC and the PC.

The mechanisms underlying the bilateral stimulations and the bodily focus inherent to EMDR are universal factors, as research demostrated.

Refugees from the most diverse cultural and religious background, but with a modest level of education, seem to respond well to EMDR therapy, but we need to adapt the standard protocol to this particular population.

Therefore, when having to treat uneducated refugees, the following three aspects are required:

1. Work with patients who to some degree are able to mentalize some concepts. If not, we have to help them.
2. As a clinician, being able to build an attachment bond with our patient.
3. As a clinician, having cultural sensitivity, which includes awareness and minimization of cultural biases.

Cultural sensitivity and competence is the ability of recognizing one’s own cultural standards, as well as understanding frameworks for the worldview of people from diverse cultural background.

Commitment to action

EMDR is treatment of choice for trauma and trauma related disorders. EMDR clinicians working with refugees recognize that trauma can be effectively and efficiently treated, it is important, therefore, to bringing healing to those in need. No one should be left behind, effective mental health treatment should be available to all in need, EMDR can be easily implemented, is brief and trauma centered.

Conclusions

- Empirical support for EMDR psychotherapy has few studies of actual psychotherapy with traumatized refugees and asylum seekers (ter Heide *et al.*, 2014). This encourages the need to study the implementation of EMDR as a first-line trauma-focused psychological treatment with refugees.

- High-quality research is needed to determine acceptability, safety, and efficacy of EMDR with traumatized refugees and asylum seekers. Challenges for research in this field are outlining conceptualization of key concepts, evaluate the implementation of culturally competent adaptations within the standard EMDR protocol, and eventually forming ethnically homogeneous groups for comparisons. Variables related to cultural competence of the clinician and sensitivity of cultural mediators also need to be assessed.