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The Journey of EMDR

EMDR group intervention in an outpatient randomized and hospital setting: implementation and effects of "G-TEP"

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BACKGROUND

Reality of Psychotherapeutic Care

- High need for psychological help vs. insufficient treatment offers
- long waiting times until treatment
- high risk to further psychological and social impairments
- increasing need for psychotherapy due to natural and man-made disasters

! Limited therapeutic resources should be made available to many people !
! Preventive work is needed !

G-TEP - BACKGROUND

G-TEP = Group Traumatic Episode Protocol by Elan Shapiro
offers some solutions

- Group intervention
- short and intensive intervention
- complete implementation in a few days
- acute intervention (EEI Method = Early EMDR Intervention)
- as upstreamed offer to further therapy

G-TEP – BACKGROUND 1

G-TEP

Offers stabilization, stress regulation and reprocessing

- Adaptation of individual R-TEP, includes EMD and Recent Event Protocols: works on a focus issue and several closely associated PoDs from this memory network
- Breaking the association chains, often
- Limited working timeline*: Unconcluded trauma episode:* from the beginning of the stressing issue until now
- Focus on safety and containment
- Hypothesis: it activates the AIP (Adaptive Information Processing) as in classical EMDR application
- low-threshold: - no sharing of negative contents,
  - speech-reduced: write or draw contents (therapist works blinder than usual)
- manifold positive quantitative and qualitative results

G-TEP Treatment 1

Objective:

- Reduction of the initial, generel SUD of the focus topic
- enable patients better cope with their distress
- prevent negative consequences of staying untreated

Target Group

adults, adolescents and older children who

- have recently suffered traumatic or life-changing events
- are still suffering from ongoing consequences of serious, life-changing experiences that occurred some time ago

G-TEP Treatment 2

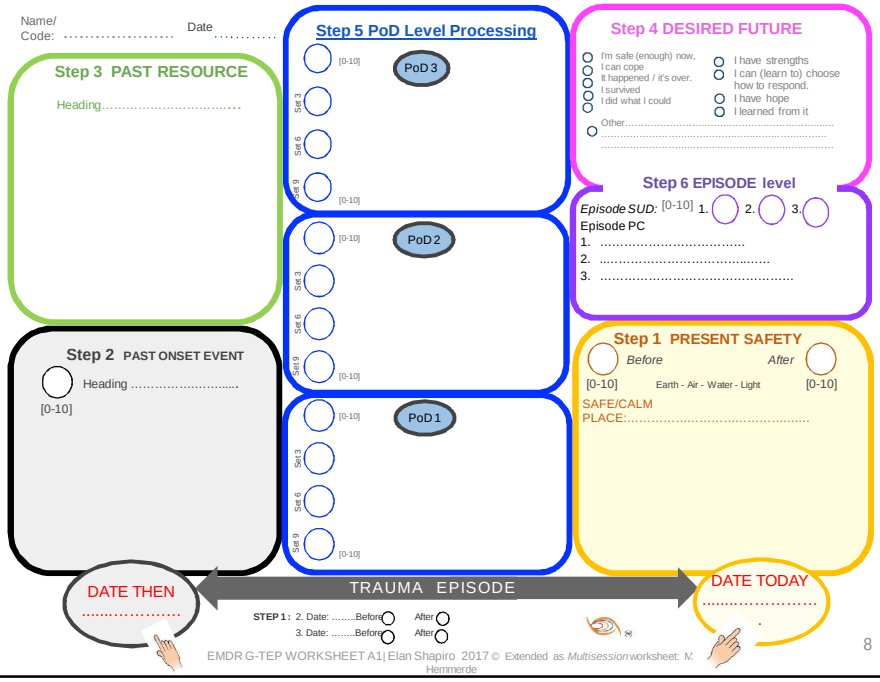
Group Treatment Procedure:

8 Steps of the EMDR protocol

- Information and Psycho-Education
- Ressource part (ensure safety!)
- EMDR-G-TEP part: Reprocessing of 9 PoDs

–Using a high structured G-TEP-worksheet

– Patients conduct bilateral stimulation themselve while re-processing their target



G-TEP Treatment - Worksheet 1

All participants have their worksheet in front of them on a table

- Step 1 works out the *current resources* with "4-Elements-Exercise", including Inner Safe Place (Shapiro, E., 2009)
- Step 2 names the initial event.
- Step 3 asks for a *past resource*, a good memory
- Step 4 elaborates the Positive Cognitions, the goal of the therapy
- Step 5 searches for stressfull aspects closely associated with the main topic, with self conducted BLS (bilateral stimulations) on limited timeline between onset and today ("mental Google search": tapping alternating on step 1-today and step 2-onset while following left-right with their eyes.
- First bad memory is written/drawn in PoD field 1 and currently experienced SUD-pre

  Reprocessing of the PoD with self conducted BLS by tapping between step 1 (present safty) and PoD field 1

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G-TEP Treatment - Worksheet 2

- After three sets, *break* of *association chains* and refocus *consciously* the original PoD1 subject; record of the now experienced SUD
- Repeated 2 times, ending with SUD post
- Procedure of step 5 is conducted for all PoDs
- Step 6: integration of this therapy part. Patients think back to the *entire episode,* record level of stress SUD and the now coherent positive thought
- Step 7 concludes the session: 4-elements exercise is repeated; if necessary further containing exercises, e.g. "inner safe"
- Step 8 checks whether further sessions are indicated.
- After the resource parts participants can share about their experiences with the 4-elements-excercise, their good memories, images, body sensations and desired future. Anchoring with butterfly hugs.

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G-TEP: EVIDENCE

- meta-analysis of 22 studies (Kaptan et al., 2021):
  → PTSD ↓, depression ↓, anxiety symptoms ↓
- in refugee samples (Lehnung et al., 2017; Yurtsever et al., 2018)
  → PTSD ↓, depression ↓
- in in/outpatient samples (Miller et al., 2021)
  → PTSD ↓, depression ↓, anxiety symptoms ↓
- in cancer patients (Roberts, 2018)
  → depression ↓, anxiety symptoms ↓
- in non-clinical workspace (Tsouvelas et al., 2019)
  → work-related distress ↓, negative job-related affect ↓

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AIMS

Investigating the efficacy and applicability of G-TEP ...

- as an offer in different settings in standard care:
  Study 1: outpatients
  Study 2: inpatients
- to determine the general effectiveness of G-TEP on the reduction of symptoms of and beyond PTSD
- in patients suffering from a variety of symptoms due to distressing memories beyond trauma-related mental disorders (AIP!)

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Additional Background – Study 1 - Madeleine Hemmerde - Outpatient Setting -

- In addition to PTSD, the rates for *various mental illnesses* are high
- persistent and/or untreated/underrated mental diseases can develop severe courses – independent of PTSD. PTSD can hide behind other diagnosis
- EMDR can help to process pathogenic memories and reduce various symptoms, not only narrowly defined to PTSD
- Striving for treatment methods with a minimum of interventions and a maximum of possible effects is limited

Aim and Target Group of this Study

In contrast to the original G-TEP approach

Offer G-TEP treatment to as many patients as possible

➢ Expanding the target group to patients suffering from *various symptoms*, not restricted to PTSD

➢ Investigate the efficacy on the reduction of *various symptoms* independent of specific diagnosis (of PTSD)

➢ Observation of further subjective positive/negative effects

Sample & Method - 1 - Study 1 outpatients

Study-design:

- randomized single blind research:
  treatment group vs. delayed treatment control group
- unrestricted sample: population in search of a therapy place
- 2-3 face-to-face interviews by the psychologist:
  - medical history
  - in-depth exploration: working out the
    - focus issue for the G-TEP treatment
    - beginning of the distressing episode
- Group Treatment:
  1. session: information, psycho-education & *resources*

  3 G-TEP-Sessions with EMDR self conducted BLS, 5 consecutive days, one day of break in between

Sample

- 45 startet
- 1 drop-out
- 26 females
- 18 males

Total: 44 pat.

Group Size

6, 7, 8 and 10 persons

ca. 120 min./session

SAMPLE & METHOD - 2 - STUDY 1 OUTPATIENTS

Integration in outpat. setting: Number of participants is limited to lead it with one therapist. Usually outpatient-therapists are working alone.

In contrast to those G-TEP- studies which usually are carried out: Adding of ...

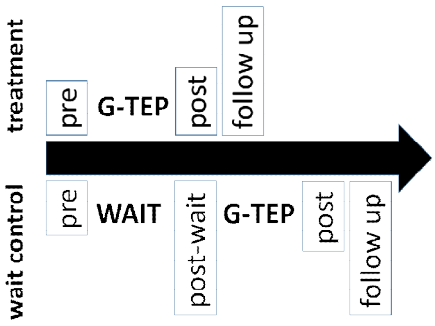
Individual Sessions - Integration Process

- 2 – 3 Sessions: e. g.
  - exploration of the subjective benefits
  - Analysis of the psychotherapeutical process
  - review on the SUDs of each of the 9 PoDs
  - Desired/undesired changes in everyday life
  - cognitive changes (PC/NC) and insights
  - notes on G-TEP- treatment

SAMPLE & METHOD - 3 - STUDY 1 OUTPATIENTS

Measure Points

(1) Pre treatment
(2) 2 weeks after treatment
(3) 3 months after treatment
(4) Afterwards individual qualitative exploration of changes, check of SUDs



RESULTS - 1 - STUDY 1 OUTPATIENTS
QUALITATIVE RESULTS FROM THE FOLLOW-UP INTERVIEWS

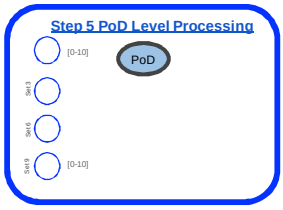
We have some impressiv qualitativ results, beyond the positiv quantitativ results:

1. Repeated instruction of the 4-Elements exercise (2 times in each session): most patients gained more access, success and motivation to use it on their own.
2. Their sense of self-efficacy and self-regulation increased; more stable in confrontation with stresses.
3. Improved self-perception e.g. feelings, physical symptoms under stressful and relieved situations.
4. Confidence in future and hope increased, for positive changes and reduction of suffering.
5. Emotionally more differentiated.
6. They perceived more consciously and in a more distanced way *their own contributions* to causing and maintaining of their suffering.
7. Strengthened ability to act: some patients had gained inner clarity and have already initiated positive changes in their life conditions.
8. Positive feedback from family/friends/colleagues about changes, e.g. clearer, more balanced and more open in social context.

RESULTS - 1 - STUDY 1 OUTPATIENTS
QUALITATIVE RESULTS FROM THE FOLLOW-UP INTERVIEWS

SUD pre

SUD post



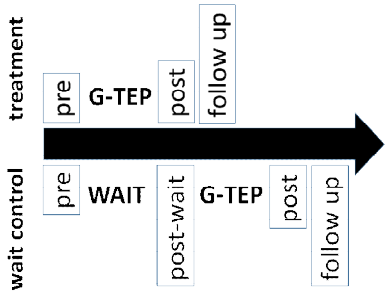
Patients compared their emotion at SUD pre with that of SUD post.

9) At least one channel of the PoDs was worked through; the original emotion of distress (SUD-pre) was processed and disappeared. The SUD-post usually refers to another disturbing aspect/channel and has a different emotional quality.

10) Even if the levels of the SUD-post or the follow-up-scores in the questionnaires remain high, many patients still felt more distanced from their PoDs and *generally* relieved.

11) Some patients went free of symptoms only with this short G-TEP treatment.

RESULTS - 2 - STUDY 1 OUTPATIENTS
QUANTITATIVE RESULTS – STUDY DESIGN

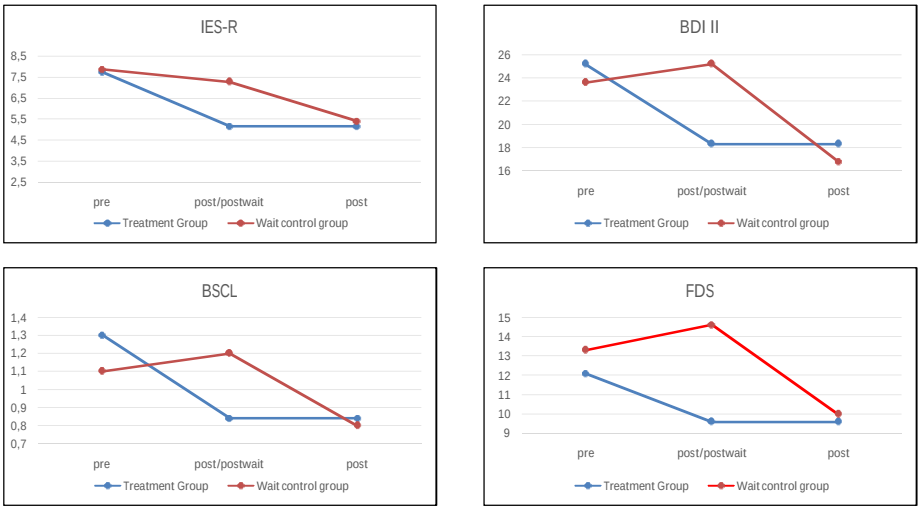


Treatment group TG n=21;
Wait Control group WCG n=23

Self-Report Questionnaires

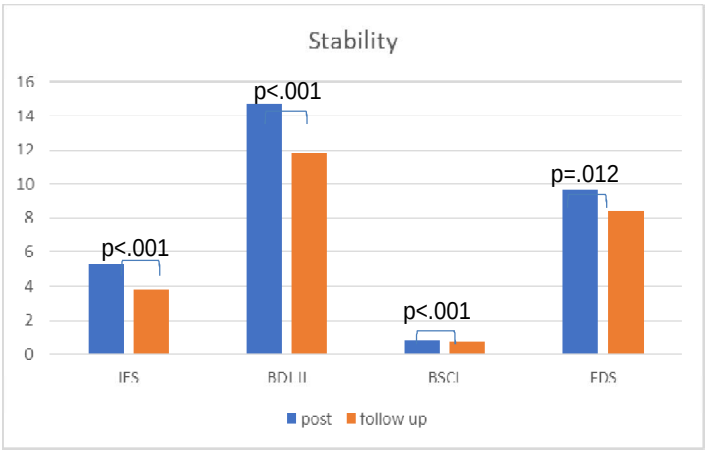
- BDI II *(Beck Depression Inventory)*
- FDS 28 *(german vers. of Dissociative experience Scale DES28)*
- IES-R *(Impact of Event Scale)*
- SCL 90-S *(Symptom check list)*
- SUD *(Subjective Units of Distress)*

RESULTS - 2 - STUDY 1 OUTPATIENTS
QUANTITATIVE RESULTS – SELF QUESTIONNAIRES



TG vs. WCG: the improvements can be causally attributed to the G-TEP intervention!

RESULTS - 2 - STUDY 1 OUTPATIENTS
QUANTITATIVE RESULTS – SELF QUESTIONNAIRES



Effects are stable, additional improvement in all measures at follow up

RESULTS - 2 - STUDY 1 OUTPATIENTS
QUANTITATIVE RESULTS – SELF QUESTIONNAIRES

Means and Standard Deviations on Dependent Measures *:*

Pre- and Posttreatment values for the G-TEP treatment group (TG), n=21
and Pre- and Postwait for the delayed treatment group (Wait Control Group WCG), n=23

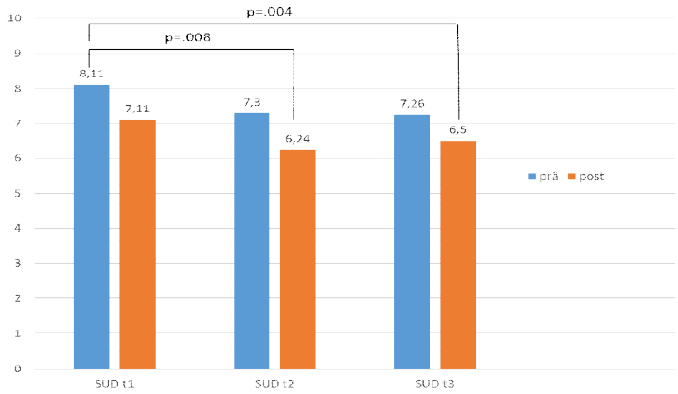
Measure	Group	Pre M (SD)	Post/Post-wait M (SD)	F (Group x Time)	Effect size (Cohen´s d)
IES-R	TG	7.74 (2.5)	5.16 (3.5)	F= 10.41	0,8 (CI: 0.22-1.48)
	WCG	7.86 (3.8)	7.27 (3.4)	p< .01	0,3 (CI: -0.43-0.76)
FDS	TG	12.1 (8.6)	9.6 (8.1)	F=4.1	0,3 (CI: -0.31-0.91)
	WCG	13.3 (8.6)	14.6 (11.8)	p< .05	0,1 (CI: -0.72-0.47)
BDI-II	TG	25.2 (14.2)	18.3 (8.1)	F=6.75	0,6 (CI: -0.01-1.22)
	WCG	23.6 (13.6)	25.2 (12.3)	p< .01	0,1 (CI:-0.71-0.47)
BSCL	TG	1.3 (0.7)	0.84 (0.6)	F=29.7	0,7 (CI: 0.08-1.33)
	WCG	1.1 (0.6)	1.2 (0.7)	p< .001	0,2 (CI: -0.75-0.44)

Note: IES-R: Impact of Event Scale revised; DES/FDS: Questionnaire on dissociative Symptoms; BDI-II: Beck Depression Inventory-II; BSCL: Brief Symptom Check List; CI: Confidence Interval

STUDY 2 - INPATIENTS

- University Clinic for Psychiatry and Psychotherapy
- Specialized multimodal inward treatment for trauma-related disorders
- G-TEP as an additional offer (introduction, 3 sessions)
- → feasability and effects of G-TEP

STUDY 2 - INPATIENTS QUANTITATIVE



- SUDs significantly decreased from t1 to t3
- no sign. changes within the single sessions
- starting the sessions t2, t3 with higher SUDs

STUDY 2 - INPATIENTS QUALITATIVE

- less inner avoidance, trauma became more ego-syntonic
  → helpful for further therapy processes
- possible and necessary to use and continue the process initiated by G-TEP in the individual setting

- Implementation:
  - the team should be confident with G-TEP
  - Selection of suitable patients
  - Feedback via the individual setting to the treatment team

G-TEP... SUMMARY

- support for the efficacy and practicability over a broad range of stress-related symptoms
- can be applied in outpatient and inward settings
- rapid reduction of intrusions, avoidance behaviors, hyperarousal, depression and global distress within the "traumatic cluster" (Stingl et al., 2021)
- important subjectiv changes, insights and experiences took place and became noticeable for patients
- can be used for stabilization and as an upstream intervention
- suitable for paving the way for further therapeutic processes

G-TEP… Advantages

- highly structured and manualized, easy to learn and to apply by therapists with sufficient trauma (EMDR) therapy expertise
- individualized trauma-/stress-focused work within a group setting
- the risk of reciprocal triggering and social anxiety is minimized as only resources and positive cognitions are discussed; low threshold method
- Use of non-/specific factors of group therapy like encouraging each other in hope, group cohesion, and universality of suffering (e.g. Yalom & Leszcz, 2005)

Implementation of G-TEP in the health care systems is recommended.

Discussion Study 1-outpatients: Implementation in a Practice of Psychotherapy – Special Features for multiple Symptoms

Most of Therapists are working alone

- Group size is limited:
  - depending of: - your clinical experience
  - individual features of patients, e.g. defense mechanism, self-consciousness, anxiety level
  - 4 to 6 persons without co-therapist
- Focus in patients with multiple symptoms is often not as clear as in ptbs patients:
  - Therapist must be able to deduce PoDs
  - even if PoDs had been subject in the pre-interviews some people don't remember them (the therapist should document the PoDs appearing in the pre-interviews)
- EMDR works a) *below* the defence level, but b) *with* the defence mechanism that can block the inner process
  - some patients deviate on dysfunctional topics: their reinforcement is not allowed
- The process always goes on after treatment: Integration in added follow-up sessions
  - Occasion to share patients' insights, changes since end of treatment until now
  - Making aware subconscious insights/changes with therapeutical help & psycho-education improve their sustainability and the benefits of the treatment

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Links: RTEP/GTEP
EEI – Early EMDR Intervention: https://www.earlyemdrintervention.org

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