

European Centers for  
refugee mental health  
are increasingly using  
EMDR with this  
population



## Experience-based EMDR Practices and Research (EMDR Italy Association network) with Refugees and Asylum Seekers in Italy

*Italian EMDR clinicians, treat regularly with EMDR, refugees and asylum seekers within migrant centers and mental health facilities*


Refugees and asylum seekers, coming from war torn, mainly sub-Saharan Africa and the Middle East, are resettled in Italy in governmental and NGO camps, and many seek treatment or are referred to mental health services for trauma-related disorders.



## EMDR in the field:

### Working in the hot spots of refugees arrivals

- Intervening in the acute phase of traumatization related to critical incidents, during the flight
- Reducing risk factors for mental and emotional disorders (domestic violence, intergenerational effects like inadequate bonding, withdrawal, etc.)
- Organizing group interventions in order to enhance resources and protection factors
- Intervening with personnel that has been exposed to high levels of stress related to their humanitarian work
- Providing help in rehearsing for the asylum interview. Constructing a consistent narrative through the use of bilateral stimulation with the Recent Traumatic Episode Protocol (Shapiro, E.; & Brurit, 2012).
- Preparing refugees to have further psychological support in European countries, through EMDR Europe network (17.000 EMDR clinicians in 24 European countries)



# Refugees, Asylum Seekers and Psychosocial Factors

All EMDR treated individuals 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 horrifying and dangerous journey.

The greatest issues for these populations is their role loss, identity 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.



# Symptoms

The most common psychological symptoms among all treated individuals with EMDR, are complex PTSD, dissociative states, depression and somatization. Usually 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 posttraumatic symptomatology. Mental health issues are usually misdiagnosed in transcultural medical settings (Onofri *et al.*, 2014). Frequent disorders include gastritis, dermatitis, difficulties in concentrating, nightmares, difficulties in learning (e.g. Italian), and sleeping disorders.



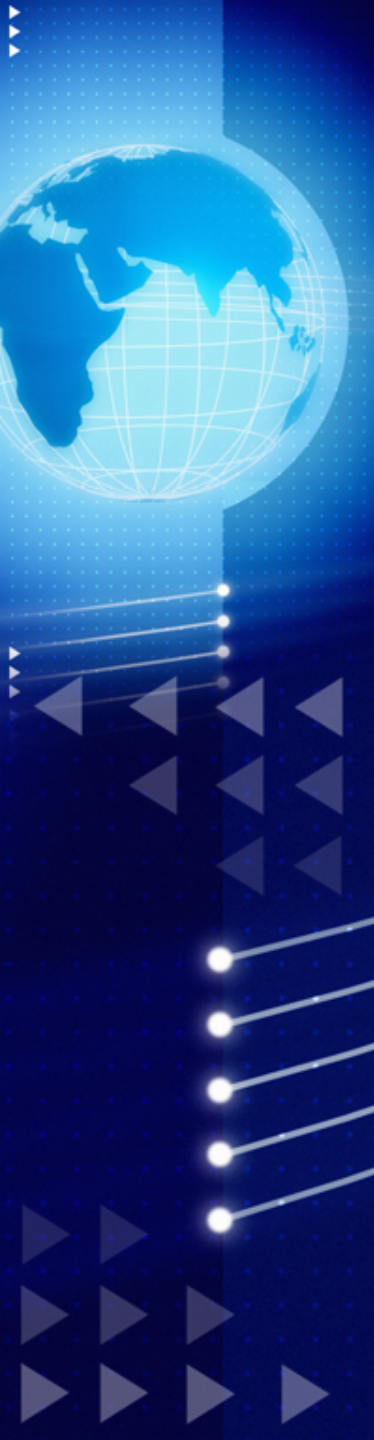
Their core traumatic feeling is an utter sense of powerlessness they perceive as inscribed in their body: to overcome this, clinicians noted that these individuals still need to realize that they've survived. Furthermore, **social exclusion experienced in hosting countries can lead to worsening of PTSD symptomatology.**

Interventions go from dealing with the most compelling needs and objectives, as well as addressing any recent and past traumatic episodes. They need to put into words their life experiences and create a



The therapeutic intervention must be done in their native language, “the language of the heart”

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 refugees in group settings, 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.



- 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.
- EMDR 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.



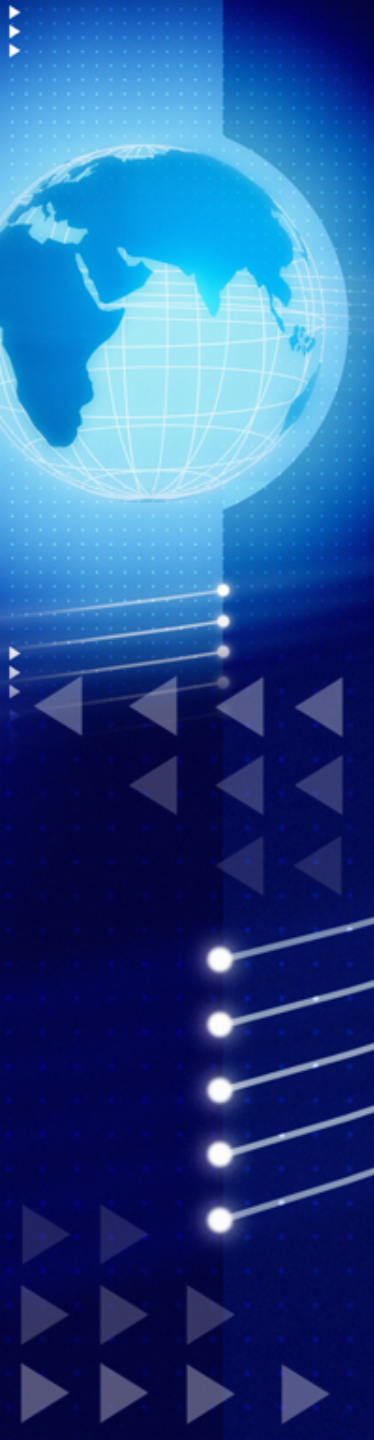
- Treating refugees not as victims, but as active agents of their lives in the face of adversity. It is essential to develop a deep sense of appreciation and admiration toward these people, for having been able to endure and withstand such harsh experiences.
- The greatest challenges against stigma are not met with war trauma, but with people who have been traumatized by sexual and domestic violence prior to the war.



# The Issue of Stigma

EMDR clinicians have listed a series of actions to tackle stigma:

- Deliver psychoeducation on trauma
- Raise awareness within the 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.



- Clinicians have to be sensitive toward cultural patterns, they have to ask permission for touching the patient. Opposite-sex clinicians and interpreters should be avoided, as well as maintaining appropriate distance.
- 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 being too painful



- 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 sessions, due to the presence of many past and recent trauma.



## SPECIAL POPULATION WITH SPECIAL NEEDS

- When constantly plagued by recurrent nightmares and flashbacks, that is when they understand they need help.
- We explain 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.
- 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, clinicians recommend to safely target the traumatic event with Jim Knipe's CIPOS method (The Method of Constant Installation of Personal Orientation and Safety).



# Adaptations of EMDR Procedures

Some reports noted that assessing or installing respectively the negative cognition (NC) and positive cognition (PC), and in some cases the Safe Place, was almost impossible, since patients did not seem to understand these concepts, but rather experienced their emotions in their body and “heart”.

This difficulty may lie in their little mentalizing abilities or different cultural concepts, not always having the ability to create a link between their emotional and cognitive states.

Drawings of the map of their journey, pictures, songs and the use of a more simplified language are also used for effective EMDR reprocessing.



# EMDR: new frontier of treatment with refugees

- Decrease in anxiety, depression, nightmares, rumination, and subjective wellbeing (SUD of traumatic memories go to zero)
- Efficacy in addressing traumatic events and building resilience and hope in situations of ongoing trauma.



### 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)

- 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.
- Results: 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 efficacy of Eye Movement Desensitization and Reprocessing for PTSD and depression among Syrian refugees: Results of a Randomized Controlled Trial  
Ceren Acarturk, Emre Konuk, Mustafa Cetinkaya, Ibrahim Senay, Marit Sijbrandij, Birg Galen, Pim Cuijpers



## GAZIANTEP ORPHANAGE FOR SYRIAN CHILDREN (June 2016-July 2016)

The Orphanage requested for these children EMDR treatment to provide relief and a therapeutic treatment for their trauma. EMDR helped to heal their war wounds, while promoting adaptation and integration process within the new society and community of their host country (Turkey).

The fear, depression, anxiety, anger, and pain from their unprocessed trauma experiences, in fact, can have debilitating effects on the individual that can *derail any hope of a happy and productive life.*



# References:

- Oras R., Cancela de Ezpeleta S., Ahmad A. (2004). Treatment of traumatized refugee children with EyeMovement Desensitization and Reprocessing in a psychodynamic context. *Nord Journal Psychiatry*. 58:199 - 203.
- *Smith*, Timothy B. and *Griner*, D. (2006). Culturally Adapted Mental Health Interventions: A Meta-Analytic Review. *All Faculty Publications*, Paper 279. Cabral R.R., Smith TB. (2011). Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, 58(4):537-54.
- Ter Heide, F., Mooren, T.M., Knipscheer, J.W., Kleber, R.J. (2014). EMDR With Traumatized Refugees: From Experience-Based to Evidence-Based Practice. *Journal of EMDR Practice and Research*. Volume 8, Number 3, 147.
- Zaghrout-Hodali, M. (2014). Humanitarian Work Using EMDR in Palestine and the Arab World. *Journal of EMDR Practice and Research*. Volume 8, Number 4.
- Onofri, A., Gattinara Castelli, P., Ciolfi, A., Lepore, M., Ventriglia, S. (2014). L'Approccio EMDR in un Servizio di Aiuto Psicologico per Rifugiati e richiedenti Asilo a Roma. *Psicobiettivo*. Vol. 24.
- The UN Refugee Agency. Retrieved January 22nd, 2016, from <http://www.unrefugees.org/what-is-a-refugee>.