

Brief Intensive Acute Intervention.

Implementability and evaluation of the group therapeutic EMDR method G-TEP in outpatient psychotherapy - a randomized pilot study -

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This pilot study investigated the EMDR method (Eye Movement Desensitization and Reprocessing) in its group application with the Group Traumatic Episode Protocol (G-TEP) by Elan Shapiro, which was originally developed for the treatment of traumatized persons. In contrast, this Randomized Controlled Trial (RCT) examined the feasibility of implementing the G-TEP method in the outpatient setting and its efficacy on various symptoms - not on diagnoses, in comparison to those G-TEP- studies which usually are carried out. Also, it added 2-3 individual follow-up interviews. The aim is to make treatment accessible to a broader population. In a randomized "wait-list control group design", after a psycho-educational and resource session, the treatment group received three 120-minute EMDR G-TEP treatments on three consecutive days; a total of nine distressing aspects, the "Points of disturbance (PoD)", of a selected topic focus were processed with EMDR. The wait-list control group then underwent the same G-TEP treatment. Symptom intensity was recorded before, two weeks and three months after treatment.

Results: The analysis of the results shows significantly lower symptom scores in the BDI II, IES-R, and BSCL for the treatment group after the G-TEP interventions than for the control group, not so in the FDS. There was also a decrease in the level of subjectively experienced distress SUD related to the processed PoDs and the overall episode theme. Patients also reported positive subjective, qualitative changes.

Keywords: G-TEP (Group Traumatic Episode Protocol), EMDR (Eye Movement Desensitization and Reprocessing), short-term therapy, intensive therapy, brief acute intervention, feasibility, outpatient psychotherapy, group therapy.

Mental health is an indispensable prerequisite for coping with private and working life, as well as participating in social life. Mental illness that leads to restrictions in quality of life, health, and ability to work, even to the point of work inability, is on the rise (de.statista, 2018; RKI. Barmer Arztreport, 2018). In addition, people are affected by natural and man-made disasters. Many people in need of treatment are faced with too few specialists and long waiting times, so that no current treatment can take place. The new wave of refugees since 2015 has exacerbated this situation (destatis.de, 2017). The health care system is thus faced with the challenge of providing adequate and, above all, short term psychotherapeutic care to those needing therapy in order to prevent aggravation and chronification. Initial scientific studies and clinical experiences show that G-TEP is promising for treating several affected persons simultaneously in a group setting and for achieving initial relief.

The G-TEP method

EMDR has proven to be an evidence-based individual therapy method and has been officially approved by the Gemeinsamer Bundesausschuss (Federal Joint Committee, G-BA, 2014) due to its scientifically proven effectiveness. Trauma-associated disorders such as depression and anxiety respond to EMDR therapy for PTSD (e.g., Hofmann et al., 2014).

The G-TEP method is used as an Early EMDR Intervention (EEI) with some success. It has been developed for adults, adolescents, and older children who

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

It is suitable for groups as well as for families and couples and offers stabilization, stress regulation and reprocessing.

G-TEP was developed by E. Shapiro based on the individual R-TEP method (Recent Traumatic Episode Protocol, E. Shapiro & Laub, 2008), which targets recent traumatic events that have ongoing consequences. The R-TEP integrates approaches from Francine Shapiro's Recent Event Protocol and her EMD Protocol. The latter focuses on stressful memories or memory fragments (PoD - Point of Disturbance) that are directly connected to the stressful event (*episode topic*) and interrupts chains of association by frequently redirecting the concentration back to the focus and thereby raising its SUD value, which needs to be reduced (SUD = Subjective Unit of Distress, between 0 - neutral feeling/no distress - and 10 - maximum distress). According to the Adaptive Information Processing (AIP) model, blocked pathogenic memories are fed to processing (Shapiro, Francine, 2001; Solomon et al., 2008). The temporal frame for R-TEP content begins with the initial event up to the present time (*unconcluded trauma episode*). Memories closely associated with the *episode topic* are worked through with EMDR.

Inspired by e. g. the wave of refugees in 2015 the group application G-TEP should be able to treat several traumatized people at the same time. By promoting the adaptive processing their initial stress shall be reduced, so that they can better cope with their everyday lives in a more stabilized way as they wait for further therapy availability.

The patients may suffer from the same or different stressful events. During G-TEP treatment, the participants do not talk about stressful content as is usual in group therapy, but exclusively share about their positive experiences, but exchange exclusively about their positive experiences and cognitions, which can have a positive reinforcing effect. In EMDR treatments, the focus is on the *inner process*, the AIP, which supports and accelerates the healing processes, while the content fades into the background. This is accomplished in the G-TEP group setting because the interaction between patient and therapist is limited. There is no narrative about the traumatic episode and no feedback is given regarding the disturbing content that emerges during reprocessing. The therapist guides close step-by-step through the standardized therapeutic process.

G-TEP - Research

At the time of this trial in 2019, only two randomized G-TEP trials were available.

The randomized study by *Lehning* et al. (2017) included 18 refugees from Iraq and Syria living in a German refugee camp. The IES-R score was above 33, suggesting a diagnosis of PTSD. A psycho-educational session was followed by two EMDR-G-TEP sessions on two consecutive days. After treatment, the experimental group showed significant improvements in the IES-R. Improvements in the BDI-II were not significant, which may be due to the small number of cases, although the mean score decreased from 16.9 (mild depressive symptomatology) to 7.3 (no depressive symptomatology). In the control group, the stress scores remained the same.

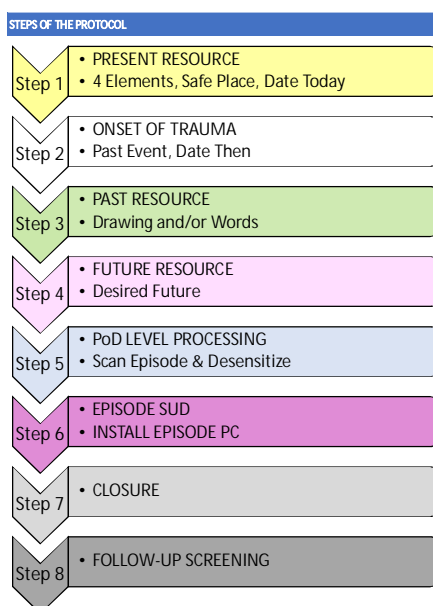
In a randomized trial, *Yurtsever et al. (2018)* treated 47 Syrian refugees in a refugee camp in Turkey with G-TEP who scored 33 or higher on the IES-R. The experimental group received 2 G-TEP sessions within 3 days and showed significantly lower IES-R scores after treatment than the control group. However, at the 4-week follow-up, these differences were no longer present, explained by the lack of external safety (potentially (re-) traumatizing stress in the refugee camp, confrontation with triggers). Average BDI-II scores of about 32 before treatment (severe depressive symptomatology) decreased significantly in the experimental group after treatment as well as at post-treatment survey, but not in the control group. The percentage of participants in terms of PTSD diagnosis decreased by 44.4% after treatment and was 38.9% at follow-up in the MINI. The control group showed no changes. The authors recommend conducting more sessions for better results.

Roberts (2018) treated 35 cancer patients with two EMDR-G-TEP sessions on consecutive days after an individual session for medical history and information. PTSD symptoms (SPRINT) and BDI-II scores decreased significantly at post-test and also one month later. Anxiety symptoms decreased significantly between the pretest and posttest (State and Trait Anxiety Inventory-STAI). This difference did not persist between pretest and follow-up. The author recommends conducting more than 2 EMDR-G-TEP sessions.

Tsouvelas et al. (2019) treated 20 professionals in a mental health department with G-TEP to help them better manage their work-related stressors. After a stabilization session, they processed a stressful event they had recently experienced at their workplace in a single EMDR G-TEP session. Stress scores on the IES-R and subjective distress (SUD) decreased significantly. Negative affect related to the workplace decreased in the Job Affect Scale.

The G-TEP course

The G-TEP method incorporates the eight phases of EMDR for trauma that occurred recently, and was investigated according to the manual by Elan Shapiro (2018), see Fig. 1



All participants have their worksheet (see Fig. 2) in front of them. In step 1, a general (not specified to the main issue) SUD "previously" is assessed and is followed by the "4-Elements-Exercise" (Shapiro, E., 2009), the *current resources* for stabilization (grounding, breathing, visualization, emotional and physical relaxation) which includes the Inner Safe Place. The positive thoughts, images, feelings and body sensations are reinforced and anchored with resource-strengthening, self-administered BLS (bilateral stimulations: butterfly hugs; Artigas et al., 2000). In the future, this technique can be used independently by the participants to better deal with stressful memories and feelings. Subsequently, the SUD "after" is assessed; if no stress reduction has occurred, the indication for individual therapy is examined, as these participants may not regulate themselves enough when processing severe stress.

Fig. 1: [Steps of the G-TEP protocol](#)

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Name/ Code: Date:

Step 3 PAST RESOURCE
Heading:

Step 2 PAST ONSET EVENT
Heading:
[0-10]

Step 5 PoD Level Processing

PoD 3
[0-10]
Set 3
Set 6
Set 9
[0-10]

PoD 2
[0-10]
Set 3
Set 6
Set 9
[0-10]

PoD 1
[0-10]
Set 3
Set 6
Set 9
[0-10]

Step 4 DESIRED FUTURE

I'm safe (enough) now. I have strengths
 I can cope I can (learn to) choose
 It happened / it's over. how to respond.
 I survived I have hope
 I did what I could I learned from it

Other:

Step 6 EPISODE level
Episode SUD: [0-10] 1. 2. 3.
Episode PC
1.
2.
3.

Step 1 PRESENT SAFETY
 Before After
[0-10] Earth - Air - Water - Light [0-10]
SAFE/CALM
PLACE:

TRAUMA EPISODE

DATE THEN DATE TODAY

2. Dat.:Before After
3. Dat.:Before After
4. Dat.:Before After

EMDR G-TEP WORKSHEET A1| Elan Shapiro 2017 © Extended as Multisession worksheet: M. Hemmerde

Fig. 2: G-TEP - worksheet

Step 2 names the initial event with which started the stress topic. Step 3 asks for a *past resource* (positive memory) and anchors it with the butterfly hug. Step 4 works out Positive Cognitions (the goal of the G-TEP work). After the resource parts Steps 1, 3, and 4, participants can share about their place of well-being, their good memories and their desired future. Thus, the Step 5 box for three stressful aspects (PoDs) centered on the worksheet is surrounded by resources. Using the "mental Google search" the first stress point PoD 1, which is anywhere on the timeline from the initial event to the present, is searched for and written/drawn in the center field and also its currently experienced SUD. The following bilateral stimulation is carried out by the participants themselves by tapping from step 1 (present safe place) and the relevant PoD field, while at the same time the eyes follow the hands from left to right. After the first set, patients briefly consciously perceive their thoughts, feelings, images, and body sensations. This is followed by the second set of BLS, another pause and a third set of BLS. After these first 3 sets, there is a conscious return to the originally noted PoD 1 and the *now* sensed SUD is entered (breaking the association chains and re-focusing on PoD1). This scheme is repeated two more times, so that 3 x 3 sets are tapped. In a renewed "Google search", a second PoD is identified, again closely associated with the episode topic, and processed according to the described procedure. The same is done with a third PoD in the same session. Step 6 serves as integration of this therapy process. Participants think back to the *entire stressful episode* and record the level of stress now triggered. They note the now coherent positive thought about the entire episode in Step 6. After sharing their positive sentences and insights, participants anchor their positive thoughts and the associated good feelings, images, and body sensations with the butterfly hug. In step 7, the conclusion takes place by repeating the 4-element exercise for stabilization and, if necessary, providing further containing exercises, such as the "inner safe". Step 8 checks whether further sessions are indicated.

Present study

The aim of this study is to examine the feasibility of implementing the G-TEP in the outpatient setting and its effectiveness in reducing the severity of various symptoms, regardless of diagnoses.

The psychotherapeutic practice that implemented this study is part of standard outpatient care in Germany. It treats children, adolescents and adults with a focus on depth psychology-based psychotherapy, systemic and family therapy, EMDR and trauma therapy.

Working assumptions

G-TEP treatment leads to significant improvement:

- of symptom severity in the experimental group pre-post compared to the untreated control group pre/pre – post-wait (T0 - T1)
- of symptom expression in the control group (pre- to post-treatment) (T0 - T2)
- of the average SUD values across the 9 PoDs (pre-post comparison for both groups)
- of the average episode SUDs from 1st to 3rd EMDR session in both groups
- of the pre-post treatment effects of the entire sample (T0 - T1/T2).

Participants

The sample consisted of 18 people (15 women, 3 men) aged 20 to 65. They were assessed for their interest in participation and their eligibility by a socio-educational assistant in the initial contact during the telephone consultation and were informed about the study. They received a written study description and gave their written informed consent to participate. Further discussion of the study occurred during the individual medical history sessions with the implementing psychotherapist prior to the start of G-TEP treatment. Because the aim was to reach a population as broad as possible, there were few exclusion criteria: acute psychosis and suicidality, severe dissociative disorders, and alcohol/drug abuse. Participants were asked not to start any other therapy or change their medication until the end of the study. An assistant randomly assigned them to the treatment group (TG) and the waiting control group (WCG) using the urn method.

According to ICD10, Chapter V (International Classification of Mental Disorders), the patients' symptoms can be assigned to the following disorders:

Initial diagnoses: F3 Affective disorders, F4 Neurotic, stress, and somatoform disorders.
Second and third diagnoses: also F6 Personality and behavior disorders.

Method

This study had a randomized and a single-blinded wait-list control group design (see Fig.3), in which a treatment group was compared with a control group. After testing of both groups (T1: post treatment of TG/post-wait of WCG) the WCG was also treated with G-TEP. In this study it is not required that the subjects' drastic stress – as is common in other studies – developed into PTSD, but in the sense of an *uncompleted episode*, it has burdening impacts on their lives up to the present time. After the first psycho-educational session, the EMDR G-TEP treatment sequence was repeated on three consecutive days, so that a total of 9 PoDs were processed.

The study leader decided to use four sessions, including 3 EMDR-G-TEP sessions, since the existing studies concluded with the recommendation to more than 2 EMDR-G-TEP sessions and this had proved successful in our own trial runs.

Assistance

A *clinical assistant* (graduate psychologist and EMDR therapist) was trained in G-TEP by the investigator and instructed in the procedure of the study. Her main tasks were: a) to observe and record the procedures during the implementation of the various treatment phases, b) to observe the reactions of the subjects during the therapy and, if necessary, to provide them with emotional support in case that participants dissociated or entered into a psychic abreaction, and c) to check compliance with the protocol. A *socio-educational assistant*, who had also been instructed in the study procedure, took over the initial telephone contact, the briefing of the test persons, and the control of the tests. Another assistant entered the data. No crisis intervention was necessary.

Measurement instruments

All tests used are self-assessment questionnaires.

The BDI II - Beck Depression Inventory (Hautzinger, 2006) measures the severity of depressive symptoms.

The IES-R - Impact of Event Scale (Wagner et al., 2012) measures symptoms of posttraumatic stress on three scales: intrusion/re-experience, hyperarousal and avoidance.

The DES II - Dissociative Experiences Scale (Bernstein-Carlson/Putnam, 1986/1999) measures dissociative symptoms on three scales: Absorption, amnesia and depersonalization/derealization.

The BSCL - Brief Symptom Checklist (Franke, 2017) inquires broad symptoms from nine scales: Aggressiveness/hostility, anxiousness, depressivity, paranoid thinking, phobic anxiety, psychoticism, somatization, insecurity in social contact, and obsessiveness, and three global indices including the GSI for global psychological distress.

The SUD-Scale (Subjective Units of Distress; Wolpe, 1990)

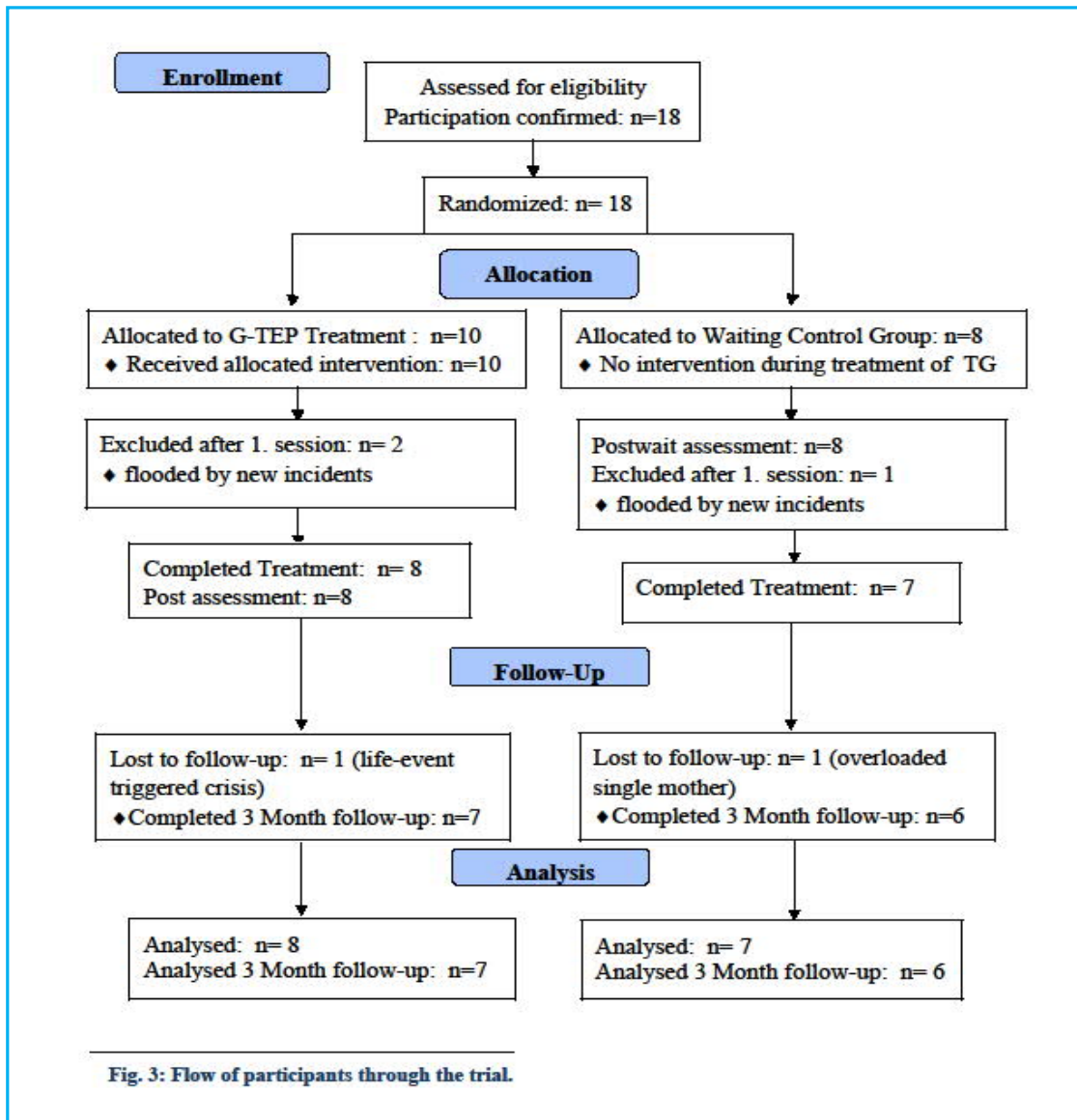
Measurement time points

- 1) **T0**: Before the start of treatment: treatment and control group.
- 2) **T1**: 2 weeks after treatment of treatment group: treatment (post) and control group (postwait).
- 3) **T2**: 2 weeks after treatment of the control group: control group (post).
- 4) **T3**: 3 months after treatment of the experimental and control groups.
- 5) **2-3 Individual follow-up interviews**: Integration; review SUDs of all PoDs; exploration of subjective benefits.

Treatment method and procedure

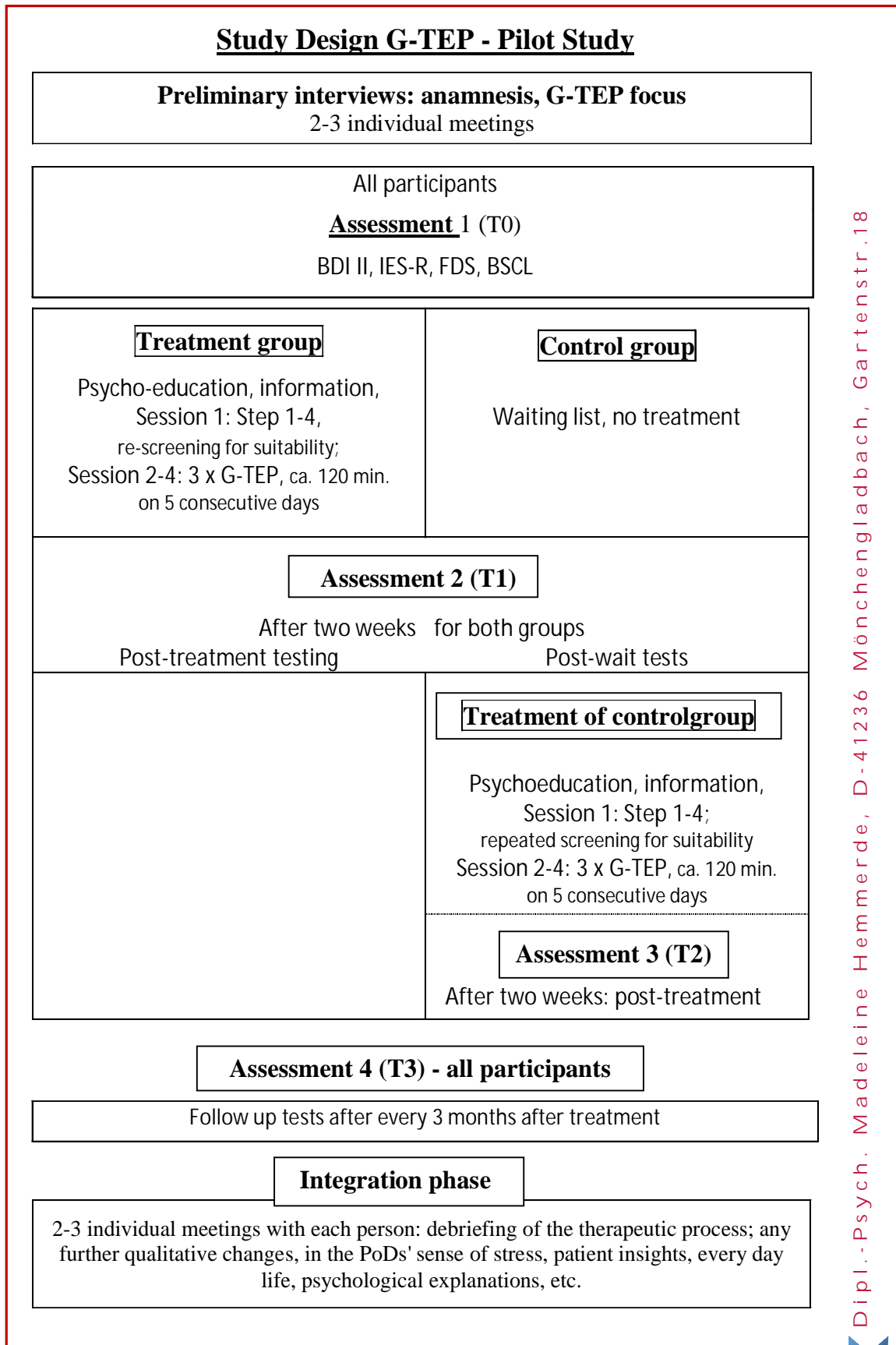
(Fig. 3, flow of participants) Of the 18 participants, 9 persons each were randomly assigned to the treatment group (TG) and the waiting control group (WCG). One participant had to be assigned to the TG due to illness treatment, so that there were now 10 participants in the TG and 8 in the WCG, but she dropped out again after the first session. At the first treatment meeting of the TG the participants were informed about possible effects of adversities and their maintenance as well as

the process of G-TEP treatment (psycho-education); then step 1-4 was delivered (resource development). The TG then received EMDR G-TEP treatment on three consecutive days, while the WCG remained untreated. After testing both groups (T1), the WCG received the same treatment. Only in the case of the latter, for organizational reasons, one day lay between the second and the third EMDR-G-TEP sessions. It was tested again 2 weeks later. (Fig.4) Finally, 2-3 individual interviews with the participants took place in order to integrate the therapeutic process, to survey/discuss any subjective-qualitative changes in the experience of stress and the processed PoDs as well as in everyday life.



After the first session (resource development), 3 subjects dropped out due to recent events: two from group 1 because they were too unstable for EMDR-G-TEP sessions, and one from group 2; however, the latter remained in the statistical analysis (comparison T0 - T1, TG vs. untreated WCG).

The therapist predetermined the speed of the BLS that could be adjusted individually as needed, and the duration of each BLS set at 30 seconds. Each session lasted approximately 2 hours of time.



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Fig. 4: Study design

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Data Analysis

Data analysis was performed using the Statistical Package for Social Sciences (SPSS 26; IBM Inc, Armonk, NY). Gender distribution in both groups was compared by Fisher exact test, and age differences were compared by Mann-Whitney U test.

Treatment effects were examined using analysis of variance with the variable group (treatment/waiting control group) as the between-subjects factor and measurement time as the within-subjects factor. The significance level was set at $p < .05$, corrected according to Bonferroni-Holm for the number of parallel comparisons (4 symptom scores).

There were more women ($n=15$) than men ($n=3$) in the sample. Both groups did not differ in gender distribution ($p=1.0$). The mean age, on the other hand, was significantly higher in the treatment group ($M=55.3$ yrs, $SD 13.7$) than in the control group ($M=40.9$ yrs, $SD 4.3$; $U=7.5$; $p=.008$).

Both groups started with approximately the same baseline value in each of the BDI II, BSCL and IES-R values. After the G-TEP treatment, there was a significant difference in the averaged values (Tab.1) comparing the treatment group with the control group: in all three tests, the TG values decreased significantly without any group differences (BDI II: $p=.020$; BSCL: $p=.007$; IES-R: $p=.001$). The control group also showed improvement in the respective test scores after their treatment. The total sample of 15 individuals who completed the treatment experienced a significant reduction in their respective symptom scores as well (BDI II: $p=.001$; BSCL: $p=.001$; IES-R: $p=.001$). (Fig.5a-c) There was no significant pre-post effect in FDS for both groups.

Tab.1: Comparison TG with WCG: T0 (pre) vs. T1 (post/postwait), and both groups T0 (pre) vs. T1/T2 (post)

| Test | TG (n=8) | | WCG (n=8) | | Statistic | Both Groups (n=15: TG=8, WCG=7) | | | | |
|--------|-----------------|------------------|------------------|------------------|--|---------------------------------|------------------|---|---|---|
| | Pre M (sd) | Post M (sd) | Pre M (sd) | Postwait M (sd) | | Pre M (sd) | Post M (sd) | Time | Group | Group x time |
| BDI II | 20,8 (15,33) | 11,88 (11,85) | 21,8 (13,86) | 22,37 (10,89) | $F(1,14)=6.92$, $p=.020$, partial $\eta^2 = .331$ | 22,3 (14,01) | 12,93 (9,18) | $F(1,13)=17.1$, $p=.001$, partial $\eta^2=.568$ | $F(1,13)=0.22$, $p=.647$, partial $\eta^2=.017$ | $F(1,13)=0.05$, $p=.832$, partial $\eta^2=.004$ |
| BSCL | 1,16 (0,92) | 0,63 (0,89) | 1,24 (0,92) | 1,2 (0,67) | $F(1,14)=9.87$, $p=.007$, partial $\eta^2 = .413$ | 1,23 (0,81) | 0,72 (0,65) | $F(1,13)=30.2$, $p<.001$, partial $\eta^2=.699$ | $F(1,13)=0.21$, $p=.655$, partial $\eta^2=.016$ | $F(1,13)=0.05$, $p=.832$, partial $\eta^2=.004$ |
| FDS | 9,91 (7,8) | 8,34 (8,04) | 15,13 (12,57) | 14,38 (10,64) | $F(1,14)=.092$, $p=.766$, partial $\eta^2 = .007$ | 12,95 (10,68) | 9,21 (7,21) | $F(1,13)=6.31$, $p=.026$, partial $\eta^2=.327$ | $F(1,13)=0.85$, $p=.375$, partial $\eta^2=.061$ | $F(1,13)=2.44$, $p=.142$, partial $\eta^2=.158$ |
| IES-R | 52,5 (22,75) | 27,63 (25,53) | 50 (30,27) | 53,50 (30,12) | $F(1,14)=18.56$, $p=.001$, partial $\eta^2 = .570$ | 52 (26,62) | 33,67 (25,85) | $F(1,13)=26.9$, $P<.001$, partial $\eta^2=.674$ | $F(1,13)=0.20$, $p=.666$, partial $\eta^2=.015$ | $F(1,13)=4.14$, $p=.063$, partial $\eta^2=.242$ |

The FDS showed significant group differences for the scores of dissociative phenomena at pretest between TG and WCG ($p=.766$), but no significant differences after treatment of TG compared to the untreated control group ($p=.766$).

Course of episode SUD after EMDR-G TEP treatments 1, 2, and 3

The comparison of the stress levels SUD related to the total stressful episode after the three individual EMDR-G-TEP sessions (Tab.2) showed that both the treatment and control groups bene-

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fitted significantly from the G-TEP treatment ($p=.003$). On average, the TGs first episode SUD dropped from 5 to 4 at the 3rd episode SUD; for the WCG, it dropped from a mean of 7 to 5.57. No group difference. (Fig.5d)

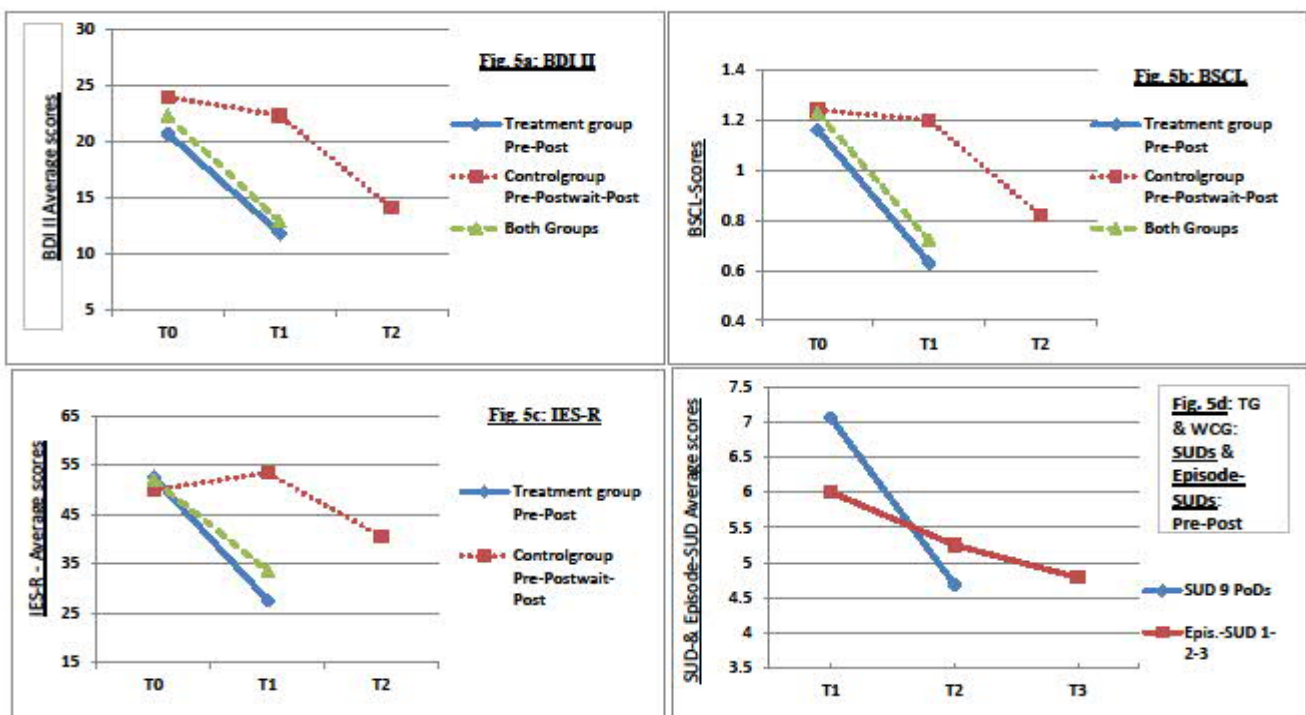
Tab.2: a) Comparison of mean stress level SUD 1 with SUD 4 across all nine processed PoDs.
b) Comparison of mean stress level of episodes SUD 1, 2 and 3.

| | TG (n=8) | WCG (n=7) | Statistic | | |
|---------------|-------------|-------------|--|--|--|
| | M (sd) | M (sd) | Time | Group | Group x time |
| SUD 1 | 6,92 (3,48) | 7,18 (1,77) | F(1,13)=43.96, $p<.001$, partial $\eta^2 = .77$ | F(1,13)=0.02, $p=.891$, partial $\eta^2 = .002$ | F(1,13)=0.02, $p=.883$, partial $\eta^2 = .002$ |
| SUD 4 | 4,61 (3,12) | 4,76 (2,8) | | | |
| Episode-SUD 1 | 5 (2,39) | 7 (2,38) | F(2,26)=7.34, $p=.003$, partial $\eta^2 = .361$ | F(1,13)=1.39, $p=.26$, partial $\eta^2 = .097$ | F(2,26)=7.2, $p=.495$, partial $\eta^2 = .053$ |
| Episode-SUD 2 | 4,63 (2,39) | 5,86 (3,13) | | | |
| Episode-SUD 3 | 4 (3,12) | 5,57 (2,82) | | | |

The comparison of the mean stress level SUD 1 with SUD 4 across all nine processed PoDs showed that both groups benefited significantly from the treatment ($p<.001$, no group difference). On average, the SUD 1 of the TG dropped from $M=6.92$ to $M=4.61$ at SUD 4 and the SUD 1 of the WCG dropped from $M=7.18$ to $M=4.76$ at SUD 4. (Fig.5d)

In addition, participants reported experiencing qualitative changes in themselves, e.g., improved self-awareness, greater consciousness about and insight into their stress topic, greater distancing from it, more calm handling of stressors, improved self-regulation.

This study also collected a three-month follow-up, the preliminary analysis of which indicates that the results from the post measurement were largely preserved. Since one person in each group did not participate in the follow-up test, the sample appeared too small to be presented here. These data will be incorporated in the evaluation of the larger overall sample from the continued study.



Interpretation - Discussion - Limitations

To our knowledge, this is the first study that examined the use of G-TEP in ambulatory standard care and its effect on broad symptoms independent of the diagnosis of PTSD. The G-TEP method proved to be feasible in an outpatient therapy setting. The G-TEP intervention achieved significant reductions in depression scores on the BDI II, trauma-associated stress symptoms in the IES-R, and general symptom burden on the BSCL in individuals with different symptoms/diagnoses. Based on a comparison of a treatment group with a waiting control group, the improvements were causally attributable to the G-TEP intervention. The level of subjectively experienced distress from the processed problematic events/issues decreased significantly after only three EMDR-G-TEP sessions. Since the age distribution between the experimental and control groups was significantly different and yet both had the same effect size in the post-treatment assessment, this suggests that the method has an age-independent effect. Since the number of participants was quite small, the statement cannot be considered as representatively secured. Nevertheless, the results show that it is worthwhile continuing this research approach on a larger population. Likewise, they show parallels to those of, e.g., Lehnung et al. (2017), Yurtsever et al. (2018). G-TEP could be an effective method to provide prompt intensive and brief/short-term therapeutic treatment to several people in groups, given the high shortage of psychotherapists, to provide them with initial relief and to do a valuable basework for further psychotherapy. It would be conceivable to offer G-TEP with multiple group sessions and provide even more significant relief. Why no significant changes occurred in the dissociation scores (FDS) is left to further research.

In this study approach, the focus of the topic was not always - as is usually the case with PTSD patients - clearly outlined by traumatic events, so that in the preliminary discussions with the individuals, particular importance was attached to elaborating the focus topic and, if necessary, some subliminal stressors associated with it. The experience from this pilot study shows that it is useful to write down both the focus topic and the initial event to put on the worksheet as a reminder for the participants. The same applies to the situation/topic, which must be identical at all test time points in the IES-R; it may be replaced unnoticed by another when it is no longer stressful. Sufficient time should be allowed for Step 1, as patients experience regaining more control over how they feel despite their personal burden and suffer loss of control, which can alleviate anxiety and increase confidence. The fact that an unplanned day of rest had to be placed between the 2nd and 3rd EMDR-G-TEP sessions in the control group was experienced positively by the participants, as they went into the last session more recuperated, without having fallen out of the inner process of the previous sessions. It is therefore recommended to place a rest day between the confrontational EMDR-G-TEP sessions to prevent overload.

Since the participants do *not* talk to each other about their *stresses* and they can express themselves by drawing instead of writing, G-TEP is a low-threshold method. In addition, the participants learn self-regulation methods that can still be used as psychological tools.

This study objective is about to be continued (with analyzing the follow-up data) to achieve higher representativeness with a larger population.

Notes

This study was conducted according to the ethical principles of the *Declaration of Helsinki*. It was subsidized by the social department of the city of Mönchengladbach. There were no conflicts of interest.

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