The EMDR Integrative Group Treatment Protocol in a Psychosocial Program for Refugee Children: A Qualitative Pilot Study

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The current study evaluated the eye movement desensitization and reprocessing integrative group treatment protocol (EMDR-IGTP) delivered within a novel psychosocial program for child refugees. One Libyan and seven Syrian children, aged 6 to 11 years 10 months (five boys), received four 3-hour sessions, with IGTP in the second session. The study investigated whether IGTP would be valuable for child refugees whose trauma symptoms failed to reach Child and Adolescent Mental Health Service thresholds. In addition, the project aimed to identify cultural hurdles that may hinder access to Western psychological approaches. Qualitative data were collected from eight children, two therapists (an eye movement desensitization and reprocessing [EMDR] practitioner and a family care worker), and a focus group of four Arab interpreters. The qualitative design involved children completing rating scales at the beginning and end of each session and the Subjective Units of Disturbance (SUD) scale for traumatic memories before and after EMDR-IGTP. Therapists reflected on outcomes in a postintervention report, and the interpreters discussed cultural challenges in a focus group. IGTP appeared to lead to reduced internal distress and perceived increases in emotional awareness for children. Therapists' reports affirmed reduced disturbance and highlighted the cultural sensitivity of IGTP. The interpreters' focus group emphasized the challenges of language, the stigma of mental illness, and the differing levels of communicative control across cultures. Future studies of IGTP, embedded within psychosocial programs for refugee children, need to utilize experimental research designs including culturally sensitive outcome measures.

Keywords: children; refugees; trauma exposure; eye movement desensitization and reprocessing integrative group treatment protocol (EMDR-IGTP); recovery; cultural sensitivity

Child refugees are arguably one of the biggest global challenges of our time. Fifty million children have been made refugees over the past decade because of disasters and war. Child refugees have experienced and witnessed a wide range of trauma exposure, including beatings, rapes, detention, murder, bomb blasts, missile attacks, house demolitions, and sniper fire (Barron, Abdallah, & Smith, 2013). In a recent small-scale study of child Syrian refugees coming into Germany (n = 100), 79% of children experienced a death in the family, 40% witnessed violence, and 30% experienced violence (Mall & Henningsen, 2015). The number of adverse childhood events for refugees can reach six per child (Panter-Brick et al., 2018).

Refugee traumatization, however, is better understood within a trajectory of trauma from homeland to final destination. Beyond the horrors of homeland, the journey en route to escape can involve a range of traumatic experiences such as sexual exploitation, deprivation of basic needs, and violence. Arrival in a new country, for example, can result in detention, uncertainty of asylum procedures, and prejudice, as well as drug dealer violence. Finally, acculturation and resettlement are not without their stresses and traumas, including racism, discrimination, and difficulties in accessing entitlements and services such as schooling and clothing (Barron, 2016). Clinical experience suggests that while refugee children may

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demonstrate a period of wellbeing in a new country they may over time become more alienated retreating into their own troubled world (Eisenhruch, 1991).

The resultant symptoms for child refugees are both physical and psychological. High numbers of children experience tooth decay, respiratory problems, infections, and parasitic conditions. Around 10% of children arriving into Germany needed acute medical care (Mall & Henningsen, 2015). On the other hand, child refugees experience high levels of psychological distress, including posttraumatic stress, anxiety, depression, dissociation, and complicated grief (Barron et al., 2013). The Health of Londoners Project (1999) suggested that most refugee health problems are related to psychological issues linked to trauma, isolation from friends and community, racism or discrimination and most problems are related to the difficulty adjusting to the change in life circumstances. Some researchers argue that children's symptoms are better understood as developmental trauma, rather than posttraumatic stress disorder (PTSD), given the pervasive consequences of cumulative violence and intergenerational trauma (van der Kolk et al., 2009). The experience of childhood traumatic events can then be detrimental for the individual's long-term well-being, affecting his or her physical and emotional health with social and economic consequences to society (Felitti et al., 1998).

Despite the numbers of refugees, the traumatic experiences, resultant symptoms, and trauma-specific interventions for child refugees are in their infancy, and few have been evaluated. One program that has been evaluated is the eye movement desensitization and reprocessing (EMDR)-Integrative Group Treatment Protocol (IGTP) developed by members of the Mexican EMDR Association for children in crisis following Hurricane Pauline in 1997 (Artigas, Jarero, Alcalá, & Cano, 2014; Artigas, Jarero, Alcalá, & López Cano, 2009). EMDR-IGTP has been applied to a variety of adverse contexts including earthquakes, floods, hurricanes, ferry disasters, ongoing war, interpersonal violence, child refugees, and an airplane crash (Fernandez, Gallinari, & Lorenzetti, 2004; Jarero & Artigas, 2014, 2015; Jarero, Artigas, & Hartung, 2006; Jarero, Artigas, Montero, & Lena, 2008). Findings consistently indicate that children experience reduced symptoms of posttraumatic stress. EMDR-IGTP has also been used effectively with adults caught up in geopolitical conflict (Jarero & Artigas, 2010) and found to be useful in contexts where individual psychotherapy has been impractical in reaching large numbers of children (Jarero et al., 2006).

Theoretically, underpinning EMDR-IGTP is the Adaptive Information Processing (AIP) model (Solomons & Shapiro, 2008). AIP explains that when a traumatic event occurs, strong feelings or dissociation may interrupt the connection with more adaptive information held in other memory networks, resulting in incomplete information processing, such as feeling shame for being assaulted even though it was "known" to be an unprovoked and planned attack. As traumatic memories are stored in their raw sensory form, the original event can be triggered by sensory fragments similar to the original event and re-experienced "as if" the experience was happening again, that is, posttraumatic stress symptoms. For the body's natural healing to take place, AIP postulates that the traumatic memory needs to be reaccessed, and contradictory information introduced.

Integrative Group Treatment Protocol

EMDR-IGTP was developed for early intervention with children exposed to a traumatic experience, designed to be part of a more comprehensive treatment program, and aimed to identify children's ongoing treatment needs (Jarero & Artigas, 2009). It aims to facilitate empathic and supportive engagement to help children normalize reactions to trauma, confront traumatic material in smaller chunks, express emotions, access dissociated material, reduce posttraumatic stress symptoms, and increase a sense of competency. EMDR-IGTP was, therefore, embedded into the current psychosocial program to help children process their traumatic experience and to identify further needs. IGTP was also selected because it has been effectively adapted to different global cultural settings (Gelbach & Davis, 2007; Maxfield, 2008) and used effectively with refugees (Wilson, Tinker, Hofmann, Becker, & Marshall, 2000).

Regardless of language and utilization of different forms of bilateral stimulation (BLS), the evidence suggests EMDR-IGTP is an efficient and effective treatment (Adúriz, Bluthgen, & Knopfler, 2009). In relation to child refugees, a small number of studies have been conducted. Evidence from psychology teams working in Turkey found that EMDR-IGTP led to reduced Subjective Unit of Disturbance (SUD) scores and positive outcomes for Syrian refugees within individual sessions (Kurtmazler & Kurt, 2016, March 17). Within a context of ongoing violence, Zaghrout-Hodali, Alissa, and Dodgson (2008) delivered the EMDR butterfly hug group protocol with seven Palestinian children, aged 8–12 years, living in a refugee camp in occupied Palestine. The adapted

protocol omitted negative and positive cognitions, the validity of cognition, and the body scan. Children experienced reduced posttraumatic stress and peritraumatic stress symptoms and presented with increased resilience. The authors concluded that EMDR-IGTP was effective within acute contexts of ongoing violence. In an earlier unpublished study, presented at the International Society for Traumatic Stress Studies annual conference, Kosovar-Albanian refugees in Germany (Wilson et al., 2000) similarly reported reduced subjective disturbance, indicating promising results.

EMDR-IGTP has also been successfully incorporated into multicomponent programs, resulting in reduced trauma symptoms. For example, EMDR-IGTP was successfully integrated into a two-session program involving mindfulness resulting in reduced distress (Courtois & Ford, 2009). Building on this integration, Jarero, Roque-Lopez, Gomez, and Givaudan (2014) examined treatment responses for 34 child victims of severe interpersonal trauma, aged 9–14 years. All attended a week-long residential psychological recovery camp, which combined 3 days of EMDR-IGTP with varied resource building experiences (e.g., massage, spiritual conversations, heart coherence, and theatrical workshops) and one-to-one EMDR therapy. The latter included Buddy the Dog, a narrative of a beaten dog, and how he was helped with EMDR (Meignant, 2007). This creative but time-consuming intervention resulted in a significant drop in SUD score and posttraumatic stress symptoms. The authors argued the various activities strengthened positive memory networks, which facilitated processing by enabling children to focus on the memory and not be submerged in the traumatic experience. The adaptability of EMDR-IGTP to sit alongside other psychosocial interventions is a potential strength. EMDR-IGTP can easily be incorporated into child friendly group approaches for children and families who might not normally access talking therapies.

Cultural Challenges of Western Programs

A significant risk for Western programs delivered for Middle East refugee children is the cultural mismatch. In addition, the Middle East has a higher level of stigma toward mental illness and is less acknowledging of the importance of the child's voice (Barron & Abdallah, 2015). Healing tends to be viewed from a spiritual rather than secular perspective, and a predeterministic view of God can lead to an over-acceptance of tragedy and its consequences (Hammad, Kysia, Rabah, Hassoun, & Connelly, 1999). Confusion can also occur because of different word meanings. For example, family may signify something more akin to past Scottish clans (Minas & Silove, 2001). Any Western programs then need to be sensitive to the differing understandings of child, family, and healing.

The use of interpreters also brings challenges. Interpreters can be from opposing sides in a conflict, despite being from the same country. Making mistakes with selecting interpreters can lead to threat and potentially traumatization (Barron & Abdallah, 2015). Therapists also have to trust that interpreters are translating accurately and in a culturally sensitive manner. Therapists may, at times, find themselves having to interrupt discourse between interpreter and client in order to check out what is being said (Minas & Silove, 2001). In short, Western therapies, including EMDR-IGTP, have to adapt to the circumstances of other cultural understandings and the practice issues of working with interpreters. To the authors' knowledge, to date, there has been no exploration of the use of interpreters in applying EMDR-IGTP.

The Current Study

The current study sought to (a) evaluate the value of including EMDR-IGTP within a psychosocial program for child refugees from Syria and Libya who may be showing signs of emotional distress, (b) consider the integration of music-based activities to support the engagement of children and facilitate their process, and (c) explore how program delivery could be adapted to be culturally sensitive. As this was a novel program delivered in a new context, a pilot evaluative case study design was utilized. The study involved children's pre- and post-IGTP self-ratings of disturbance and session activity ratings; therapists' views on the appropriateness and effectiveness of EMDR-IGTP; and Arab interpreters' perspectives on cultural appropriateness of EMDR-IGTP.

Methods

Research Design and Ethics

The qualitative case study design involved children completing outcome and session rating scales at the beginning and end of each session and a SUD scale for traumatic memories before and after the EMDR-IGTP session. Therapists reflected on program process and outcomes through completing a post-program report. To better understand emergent cultural challenges, a focus group of four Arab interpreters was held. Ethical approval was granted by the CHUMS (Community Interest Company) ethics review board and by the University Research Ethics

Committee involving active signed informed assent/consent from children and families, therapists, and interpreters.

Organizational and Geographical Context

The current project was a collaboration between two social enterprise companies: (a) Bevan Healthcare, providing medical assessments and treatment for families in need, and (b) CHUMS, who provide a range of child mental health services in the East of England, including emotional well-being, trauma, and traumatic bereavement services. CHUMS comprise a multiprofessional team experienced in working with trauma and empirically based interventions. The project took place in West Yorkshire, a region with an ethnically diverse population of 531,200, ranked the 19th most economically deprived local authority in England. Six hundred and fifty refugees were received into the area in the last 3 years from Afghanistan, Iraq, Iran, Syria, Eritrea, the Democratic Republic of Congo, Sudan, and Ethiopia. Child refugees had suffered significant trauma from war, bereavement, loss of friends, family and others left behind, the difficulty of coming to a new culture, isolation, language and cultural differences, racism (in their home countries and the United Kingdom), trafficking, rape and sexual abuse, gender-based violence, torture, and imprisonment. The project explored what could be delivered to children who were unable to access statutory child mental health services that appeared ill-equipped to support children with such traumas and language and cultural barriers.

Participants

Participants were eight child refugees, two therapists, and four additional interpreters.

Child Group Members. The children were five boys and three girls aged 6–11.10 years (6 years, 7.10 years, 8.4 years × 2, 8.10 years, 10.3 years, 11.9 years, and 11.10 years). One boy was from Libya, and the others from Syria. From parental and self-reports, children had experienced witnessing bombings ($n = 3$), dead bodies ($n = 4$), mass killings ($n = 3$), mothers with cancer ($n = 2$), father's death, houses under fire, missile attacks, seeing amputees, and being in refugee camps. Presenting symptoms included flashbacks, sleep difficulties, and nightmares ($n = 3$); behavior difficulties ($n = 2$); and poor school performance. Only one child, a boy, had a mental health diagnosis (attention deficit hyperactivity disorder). None of the children were receiving mental health support.

Children were identified by a subjective assessment of trauma at routine medical appointments. They were categorized based on the traumatic events experienced by the child, as reported by parents. Selection criteria included family stability (having been granted refugee status for 5 years with the right to stay in the country and for parents to work), similar cultural origins, shared Arabic language, and primary school age. Fictitious anonymous identifiers are used for children in the results section.

Therapists. The two therapists were male. The EMDR-IGTP therapist was a consultant counseling psychologist and an experienced EMDR practitioner (RH). The family care worker was a music and psychology graduate who ran recreational therapy groups within CHUMS. The two therapists completed a posttreatment report, which was subsequently analyzed by the second author (IB).

Interpreters. The four interpreters in the focus group did not participate in the provision of the psychosocial group. They consisted of three native Arabic speakers from a variety of Middle Eastern origins and a fourth English native speaker, who were employed through refugee support agencies in Bedfordshire. They attended a training session from RH on PTSD and trauma in children and on the content and delivery of the psychosocial program and then discussed their thoughts in the focus group.

Psychosocial Program

CHUMS has a history of running successful group programs for children, using creative approaches to foster social support, normalization of symptoms, and meaning-making for those who have experienced trauma of bereavement (Siddaway, Wood, Schulz, & Trickey, 2015). The focus of this pilot group was to promote similar approaches to enhance the emotional well-being of refugee children exposed to trauma. The primary goals were to help children feel safe, grow in emotional awareness and resources, and process any traumatic experiences. A four-session program was developed, which incorporated EMDR-IGTP, within the second session. The sessions were of 3 hours duration and utilized art- and music-based interventions to engage children (Stallard, 2005). The program aimed to assimilate in a child-friendly way new positive associations, help the processing of traumatic memories, promote resilience for the future, and increase the sense of perceived

mastery of potentially distressing emotions that were previously avoided (Solomons & Shapiro, 2008).

The combination of activities including fitness, arts, and crafts has been shown to decrease insecurity (Panter-Brick et al., 2018), and although a small effect, the authors argue such an approach is useful, particularly if other services are not available due to high thresholds for Child and Adolescent Mental Health Service teams and the cultural stigma around mental health difficulties. Music therapy is a growing area of research for anxiety, depression, and PTSD. Music-based intervention has been shown to sustain engagement over talking forms of CBT (Trimmer, 2017). Carr et al. (2012) identified the effectiveness of treating PTSD for patients who had not responded to CBT therapy, noting the primary goals were to foster safety and encourage the use of music to communicate emotional material and alleviate re-experiencing. The secondary goals of music therapy were identified as socialization, reduced anxiety, and relaxation. Research with children in Northern Ireland who presented with behavioral and emotional problems showed music therapy significantly improved their self-esteem, communication skills, and long-term social functioning (Porter et al., 2017).

Program Staff

The psychosocial group was facilitated by the aforementioned two therapists, two volunteers, and two interpreters. One volunteer was male and a general practitioner, and the other a female nurse. Both ran routine medical checks for the families at Bevan Healthcare. The two interpreters were Syrian Arabic translators, one male and one female. Both were known to the families from their work interpreting for housing and medical needs in the past. Neither had direct experience of the war in Syria and had been living in the United Kingdom for a significant period of time. Prior to program delivery interpreters completed a 3-hour training session on the signs and symptoms of trauma, a basic understanding of the problems children may have faced as well as program theoretical underpinnings, activities, and technical language. It was during this training that the structure of the day was amended to include a culturally sensitivity time for prayer.

Program Composition

Session 1 involved creating a positive, safe environment for the stabilization phase, including video clips for psychoeducation and music/cartoons as representations of emotional states encouraging the children to relate to the concept of emotions and the expressions of these through sound. Session 1 also introduced the use of BLS as drums and kalimbas when discussing and identifying emotions. Children also experienced the butterfly hug technique and belly breathing, a relaxation technique. In addition, the children were introduced to a chocolate manufacturing metaphor for good and bad memories. Good memories are represented as having the right ingredients to make them edible, bad memories therefore lack some of the ingredients and can produce unpleasant tasting chocolate or even cause a disruption to the manufacturing business. Further resources were developed using the Tree of Life (TOL; Ncube-Millo & Denborough, 2006) to reconnect the children to their country of origin and their own and family strengths as well as providing a reference for a theme of trees and bird migration which ran throughout the 4-week program. The TOL has been used in a variety of applications with children including developing cultural strengths and increasing self-concept (German, 2013).

The second session involved discovering degrees of emotion through sound volume and frequency of rhythm and drawing a safe place installed by butterfly hugs. Despite previous research (Hamdan-Mansour, Abdel Razeq, AbdulHaq, Arabiat, & Khalil, 2017), all children were able to generate a positive, safe place, including parks, playgrounds, and a mosque. The concept of bad memories and how they can make you feel was introduced. Bad memories were described using the chocolate metaphor where the factory uses the wrong ingredients, causing the machinery to break down and the need for an engineer to help fix it. This session included the delivery of EMDR-IGTP, where children were encouraged to draw their traumatic memories and reprocess these through tapping. Because of limited available space, all children sat around one large table. Children, with a support worker beside them, completed their drawings and used the butterfly hug individually at their own pace, until positively associated drawings were produced. The session ended with a "migratory birds" healing narrative that provided reasoned choices for leaving home to find safety elsewhere (Kurtmazler & Kurt, 2016).

Session 3 involved further emotional expression but as a group playing instruments together as a band. The children were given the opportunity to add any other resources or positive memories to their TOL and were introduced to an additional healing narrative: "the seed." This promoted the idea of posttraumatic growth. The children drew new trees grown from seeds they were given and used these to make a shared forest to create a safe home for a cuddly "refugee" toy.

The final session was developed as a reward for attendance to ensure data collection of the outcome measure. A group "family" trip to the Yorkshire Dales was arranged. This completed the program theme introducing the families to an English forest and learning how it sustains life there. Activities included leaf collecting, memory sticks, and psychoeducation.

Measures

SUD Scale. To report the distress related to their "bad memories," children were asked to rate the amount of distress they felt when thinking about their target bad memory while doing the artwork during EMDR-IGTP. This was scored on a scale from 0–10 (Wolpe, 1973), where 10 equaled the most disturbance and 0 equaled no disturbance. Children could report this in pictorial form if they wished.

Child Rating Scale. Children completed a rating scale at the end of each session to evaluate their experience of the session activities (SRS; Duncan et al., 2003). This involved asking children to stand on a number 0–10, laid out on steps, to evaluate how much they enjoyed the session.

Therapist Reflections. Therapist reflections were recorded in a postgroup report written by the therapist and family care worker. The report, jointly created, involved retrospective views on the following main headings: processes and outcomes of the program, the cultural challenges experienced, and the lessons learned for future program development.

Arab Interpreter Focus Group

In order to understand the cultural challenges within program delivery, the principal researcher (RH) conducted a focus group of interpreters ($n = 4$). Interpreters were asked (a) their perception of what cultural challenges exist in the delivery of a Western program to children from an Arab culture, (b) why these challenges arise, and (c) what are the most useful ways to prepare or respond to such challenges. Notes of the focus group were recorded verbatim by the principal researcher.

Analysis

Differences in SUD scores were compared pre- and post-IGTP. RH conducted the initial thematic analysis on the therapists' reflections contained within the project report and on focus group data. Themes were extracted using Braun and Clarke's (2006) systematic approach to thematic analysis. That is, statements quoted in the report by therapists were listed under common themes of meaning. Using the same process, statements made by interpreters in the focus group and analyzed as a group response were listed for common themes of meaning. These themes were then checked against the narrative of the project report to ensure the names for themes provided an accurate representation of the report contents. The latter was conducted by RH and the family care worker together. A comparative analysis was then applied across therapist, interpreters' statements, and themes to identify similarities and differences between themes across the two participant groups. This comparative analysis was initially by RH and then by an independent researcher (IB), the latter a professor in psycho-trauma studies. Inter-rater reliability of report and focus group statements and themes was provided by an independent analysis of matched themes from statements by RH and IB and is reported as a percentage of agreement of theme names. Inter-rater reliability involved checking themes against participant statements recorded under each theme within the project report.

Results

EMDR-IGTP Treatment Responses and SUD Scores

Children attended all the sessions except for the second week where two girls from the same family did not attend because of bereavement in the community. As a consequence, the girls received EMDR-IGTP when the other children experienced an extended music activity in another room in Session 3. Prior to EMDR-IGTP, where children rated their disturbance numerically, all rated 10. Child refugees were, therefore, reporting the highest levels of internal disturbance. Pictures similarly indicated high levels of disturbance. Following EMDR-IGTP, SUD scores substantially reduced for seven of the eight children, whether communicated by numbers and/or in pictures (see Table 1). Where numbers were reported, all SUD scores reduced to zero. Post-IGTP pictures, in contrast to pre-IGTP pictures (sad faces), included smiling happy faces, again indicating a significant shift in emotion. One child spontaneously rated happiness a 10 following EMDR-IGTP.

Figures 1–4 show an example of the sequence of processing in pictures. The girl LL, aged 10 years 3 months, drew her target memory as two sad people and one lying on a bed. A sad face hovers above both of them, indicating the sadness. She rated this 10. After the first set of BLS, she drew another picture

TABLE 1. Summary of EMDR-IGTP Outcomes

Participant	Age	Pre-SUD Score	Post-SUD Score	Therapist Postsession Quotes
Boy M	6	Picture of sad faces	Picture of happy faces	Two SUD score pictures, the first scary monsters, and the second smiling faces. He said "Everyone is happy."
Girl LL	10.3	10	0	Processing got stuck and needed a cognitive interweave. The session ended on a positive. Seeing self as older and in a new school. … SUD Score reduced from 10 to 5 and then to 0.
Boy AD	8.4	10	0	Positive movement through series of pictures. Very happy final picture of family smiling.
Girl AM	11.10	Picture of "Building on fire"	Picture of two smiling faces	Pictures changed from building on fire with words "after this I feel sad" to two smiling faces—a positive sequence.
Boy AB	7.10	10 "Sad"	Picture of three happy faces	A series of pictures suggesting the movement of sad people to final picture of three happy faces.
Boy O	8.10	10	0	A series of negative pictures which were unresolved in sessions. Processing continued in Session 3. Another series of pictures ended with a picture of the world and comment. "I'm happy, love the World."
Boy AL	11.9	10	0 "A lovely dream"	Showed positive reprocessing linking to a future dream at the end.
Girl AY	8.4	–	–	Was unable to produce a series of pictures and could not sit still for these exercises.

Note. SUD = Subjective Units of Disturbance Scale.

of the two people, this time happy, scoring a 5. Her third picture was more negative. Again, there were two figures: One, possibly male, was looking sad. The other figure was lying down with the head separated from the body. The therapist felt that this child required further processing to enable more positive information to be accessed rather than being left with a potentially negative memory. The girl was unable to think of another picture after BLS, so the clinician offered a cognitive interweave. He asked "How big were you when the memory had happened?" After further BLS, the girl drew another picture that showed

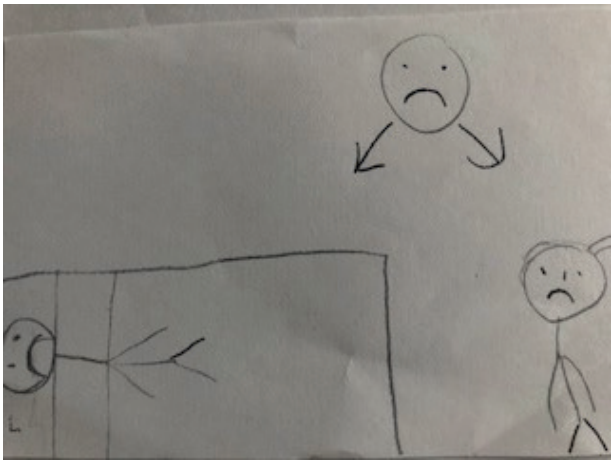

FIGURE 1. LL, aged 10 years 3 months, drew her target memory. SUD score = 10.

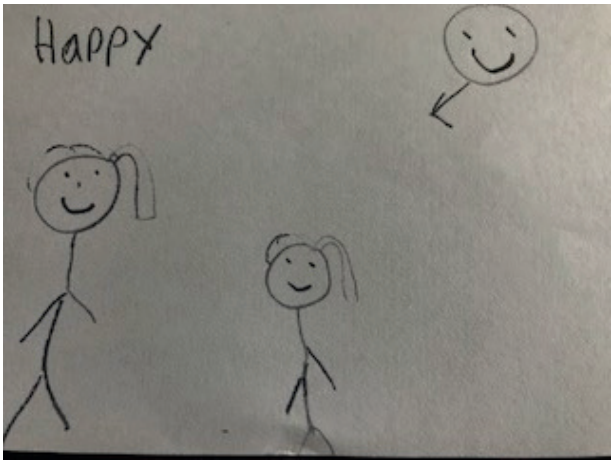

FIGURE 2. The same people from LL's target memory, but happy. SUD score = 5.

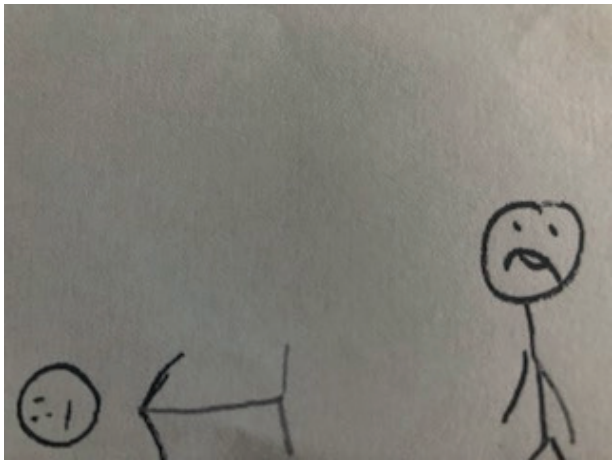

FIGURE 3. LL's third drawing.

herself when younger and sad and on the opposite side of the page a bigger version with a smiley face. After further BLS, the girl drew herself standing large next to her new school saying she was now safe in school. Again from an AIP model, this series of pictures shows how processing can become stuck with linked negative memories. Introducing the concept of time enabled her to put the events into her linear narrative and separate them from her current safety in her new school, something she enjoys considerably and describes as "happy and safe."

To exemplify the nature of change, more details are provided for specific children. One boy AL, aged 11 years 9 months, drew his first target memory of a hospital being bombed in Syria. His drawing showed the aircraft bombs and explosion with people shouting for help. He rated this picture a 10 on the SUD scale. After BLS, he drew his family arriving in Lebanon by plane, a positive picture, with a low SUD score of 1 out of 10. After further BLS, he drew his final picture, his dream of the future. In this picture, he drew himself as the prime minister and his family members all with professional jobs. He wrote next to this a "lovely dream" and scored his distress as zero. From an accelerated information processing model, this series of pictures indicates a movement in thought processing with new adaptive information of safety being incorporated into the bad memory facilitating a positive view of the future. Table 1 shows each participant, his or her age, and his or her reported SUD scores pre- and post-IGTP. In addition, therapist comments made following the EMDR-IGTP session and recorded in the project report are noted for each child.

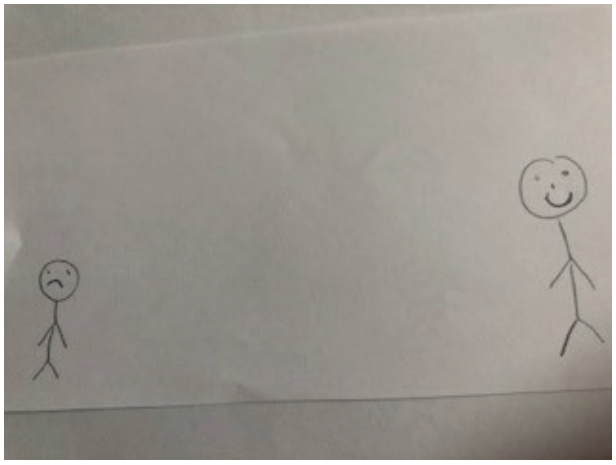

FIGURE 4. LL's drawing showing herself on the left as younger and sad, and on the right as older and with a smiley face.

Other children showed simpler processing starting with sad faces and experiences and then ending up drawing happy faces. One boy O, aged 8 years 10 months who presented throughout with the most severe symptoms, was invited to repeat EMDR-IGTP on the third week. In this session, he arrived in an agitated state, speaking quickly, and hiding behind the sofa. He was taken from the group and provided with individual EMDR-IGTP to encourage his processing during this session. He drew a series of angry and sad faces with indistinct objects. One picture appeared to be a plane dropping bombs injuring someone. This was virtually identical to the previous week's picture. The processing continued, and his final drawing was a World. During this session, balloons were used to draw maps of Syria and the United Kingdom and how close they were. With this final drawing, this boy said "I'm happy, love the World."

Child Subjective Rating of Group Activities. Three children did not engage in SRS numerical scoring: one child (M) drew pictures, and two other children (O and AY) did not participate. The five children who rated activities reported enjoying playing music, with four out of five children rating it at 9 or 10. Safe place was also enjoyable, with scores ranging from 7 to 9. The least enjoyed activity was "facing bad memories," with scores of 0. The most enjoyed activities were the music exercises and the healing narrative. Table 2 summarizes child ratings for the activities of playing music, experiencing a safe place, developing a healing narrative, and facing a trauma memory.

Encouragingly, following processing, children who recorded a rating score were highly positive about enjoying their healing narrative activity.

Themes in the Therapist Reflections

A high level of inter-rater reliability was achieved for the number of statements listed under the seven identified themes (58 statements vs. 59 statements equaling

TABLE 2. Session Rating Scores (SRS) for Group Activities

Participant	Age	Facing Trauma Memory	Music	Safe Place	Healing Narrative
Boy M	6	Sad face	Happy face	Happy face	Happy face
Girl LL	10.3	0	9	7	8
Boy AD	8.4	0	9	10	10
Girl AM	11.10	–	–	–	Smiling face picture
Boy AB	7.10	5	10	10	10
Boy O	8.10	–	–	–	–
Boy AL	11.9	0	10	9	10
Girl AY	8.4	–	–	–	–

Note. Blank cells indicate child did not provide a rating.

98% agreement) identified from therapist reflection. The second rater IB perceived separate statements were made for the need to test the assumption for a more narrow group age range.

Psychosocial Program Is a Nonpathological Way of Working. Therapists' nine statements highlighted how the psychosocial activities of the group combined with EMDR-IGTP were a nonpathological way of working with a focus on client strengths and resources and the generation of hopes for the future. "Children were also able to identify personal strengths and hopes for the future, rather than being seen as children of illness." All participants, except for one child, "tolerated EMDR-IGTP at an emotional level." The group-based approach was perceived to fit well with more of "a communal understanding of help and healing." Therapists perceived EMDR-IGTP to be "the most effective part of the treatment program" partly because of the "reported reductions in SUD scores by children."

Client Selection, Assessment, and Monitoring. Therapists identified a series of issues captured by the theme *client selection, assessment, and monitoring*. Therapists thought two children (boy O and girl AY), because of their nonresponsiveness, were not suitable for the program at this time. Therapists also raised a question about the wide age range of the group and wondered whether a narrower age range may be more facilitative for the group process. In order to enhance the delivery and effectiveness of the program, therapists thought it important to involve school staff more closely in future client selection, assessment, and monitoring of progress. This assumption needs to be tested. Key learning points for this (future) process would include increased communication with teachers and school staff in selecting and establishing a fuller understanding of each child. This would also be beneficial in establishing credible lines of measurement in changes to the child's mental well-being. Feedback from teachers pre- and post-support would aid the attribution of meaningful change to outcome measures as a result of the group. It would also be preferable for the initial assessment team to use prescreening questionnaires to determine the level of psychological distress to ensure a more homogeneous group.

Engaging Children and Families Through Social and Education Goals. This theme includes therapist reflections regarding the challenges of engaging refugee children and families in therapy. Advice from interpreters following the initial training sessions suggested that social and educational goals should be sensitive to cultural aspirations. "From the start it was identified how difficult it can be to engage refugee families in mental health approaches and that the group needed to be developed to reflect the popular cultural wish to help their children to develop strong social connections and improve their academic performance and subsequent life chances." Preliminary discussion with interpreters prior to the commencement of the group also identified how an educational reward may be a motivating factor for attendance; this would also facilitate postgroup outcome measures to be completed. As a result, the fourth session was introduced as an educational reward.

Challenges for Program Delivery. The project faced concerns from the start in the level of problems faced by the children and the lack of available support within the local community. The pilot aimed to develop an easily accessible group that could be therapeutic and engaging but was developed from a Western psychological perspective. "Therapists faced a range of challenges that feed into future program delivery: discovering the wide age and developmental range, different cultural understandings between East and West as well as different Middle Eastern

understandings, the lack of appropriate culturally sensitive measures to assess the extent of traumatization, similarly the lack of standardized outcome measures to assess child progress." While the age range was in line with previous groups run by CHUMS, the academic ability of the children varied considerably and should be considered in future delivery of such groups.

Interpreters as a Valuable Resource. The previous theme covers the wide range of benefits and resources that therapists perceived the interpreters brought to delivery of EMDR-IGTP embedded in a psychosocial program. "Interpreters were a valuable resource not only in the delivery of the program but also in discovering and addressing cultural sensitivity for future program development." Significant issues to be addressed include development of shared cross-cultural conceptualizations of daily lived experience, for example, what it means to be a refugee family in the United Kingdom, as well as exploring the meaning that underpins specific terms such as trauma and the impact of cultural myths and stigma about mental health. The need for interpreter involvement was identified throughout the delivery of the program; in planning, during sessions in terms of responding to live understanding, and afterward in debriefing, when issues not seen or understood at the time by therapists could be explored. Therapists emphasized the importance of interpreters being highly trained. "High caliber interpreters are a necessity. Without these, it is unlikely the program would work. In addition, further work needs to be done with interpreters to identify the best way of quantitatively and qualitatively measuring the difficulties and group outcomes."

Music as a Cultural Facilitator. In terms of embedding EMDR-IGTP into a psychosocial program for refugee children, therapists identified the role of music as central to developing shared cultural understandings between Western therapists and children from the Middle East.

> In between the activities we often had time to chat with the children and get to know a bit more about them and their new life in the UK. Having worked with Muslim children in Luton, I came across the music of a popular Muslim Lebanese R&B singer who sings both in Arabic and English. ... This song worked well in that it uses both English and Arabic in its lyrics exemplifying a balance between western and eastern harmony.
>
> Music worked really well, with the children taking turns to express their own but also guessing each other's emotions through their instruments. During the task we saw changes in rhythm, dynamics, and even instrument choice suggesting that they could identify differences in the expression of each emotion. … It's worth noting that although still strongly linked to their home culture and music, all children had been living in the UK for over a year. ... This was further evidenced by talks I had with the children about any American or British artists they liked to listen to on either YouTube or the Radio, the children were able to identify names such as Taylor Swift and Beyoncé as artists they were familiar with.

This suggests a mutual point of connection between cultures, a language that could be easily shared without interpreters and that links to the emotional state of the child.

Group Sessions as Assessment for Individual and Family Work. Finally, therapists reported that the group enabled "identification of further child and parental needs to be addressed." After one session, the behavior of one of the boys prompted a discussion with his father about activities at home. Through the interpreter, it was uncovered that he was being allowed to play computerized war-based games with an age rating of 18. Apparently, the father "did not understand the age restriction labeling on the games he was buying." This highlights one of the potential unforeseen dangers facing the families moving to the United Kingdom; information of this nature may be rarely, if ever, included in support and integration packages.

Themes From the Interpreter Focus Group

A high level of inter-rater reliability was achieved for the statements listed under the identified themes for the interpreters' focus group (32 vs. 34 statements equaling 94% agreement). Four main themes were identified when reviewing the assessment and activities of the pilot group: understanding mental health, psychological and cultural language/meanings, the interpreter's role, and the importance of relationship and culture. The second rater also identified the need for a more extended discussion to be held.

Understanding Mental Health. The interpreters reflected on the translation of "mental health" as having certain connotations among Arabic speakers. The translation, they felt, was associated with

TABLE 3. Comparison of Therapist and Interpreter Themes

Therapists	Interpreters
Nonpathological way of working	Understanding mental health
Client selection, assessment, and monitoring	Psychological language
Engaging children and families through social culture and education	Interpreter's role
Challenges for future program delivery	Relationship factors and culture
Interpreters as a valuable resource	
Music as a cultural facilitator	
Group sessions as an assessment for individual and family work	

"madness" and therefore met with a certain amount of resistance. On discussion, it was felt that using the term *"psychological health"* translated in a more culturally appropriate manner and would promote more conversation about related issues.

Psychological Language. Interpreters noted that a number of terms used in mental health were new to them, and that there was not a direct translation into Arabic. As a consequence, interpreters expressed the need for explanation and building of understanding in order to translate appropriately. This was particularly evident in the translation of outcome measures. In contrast, other terms were recognized as translating well, in particular: *anxiety, depression,* and *behavioral problems*. When discussing traumatic events or distressing experiences, it was felt that the use of phrases like "hard times" and "psychological shock" needed further discussion with families to deepen the understanding of the meaning for children.

Interpreter's Role. The role of the interpreter within sessions and the understanding of some word meanings, for example, posttraumatic stress, was raised as an issue in the focus group. Interpreters acknowledged that more conversation before and after each session to identify the requirements of the therapist could facilitate their translation. In this regard, interpreters could offer additional clarification of what is being asked. Interpreters' increased understanding could lead to more appropriate translation and language. It may be helpful for interpreters to receive training in trauma symptoms and psychological intervention.

Relationship Factors and Culture. The perception of a power imbalance between the client and clinician was discussed, and a belief expressed that some Arabic-speaking clients may prefer a more directive approach to sessions with instructions on next steps and supports being clearly explained. The interpreters felt that in the future, the parents may wish to know more about the actual content of the group and its role in their children's psychological health to feel they still had an element of control. The metaphor used by the interpreter was the parents being the "driver of their vehicle," and the clinician is "helping to navigate." It was felt that such a discussion early on would be beneficial. Interpreters also expressed difficulties in communication around trust, particularly with unaccompanied asylum seekers. The consequences to disclosure of events were related to family reputation in the community, with one interpreter saying "Support your brother be he an oppressor or oppressed," indicating the strength of family bonds despite the circumstances.

The importance of the therapeutic relationship was also noted in the completion of questionnaires, with a suggestion that form filling may not be culturally sensitive as "the Arab wants to talk." The implication being that the cultural norm of expressing oneself through collaborative conversation was important to facilitate the best understanding of the individual's presenting problem. Further discussion also noted that the rating scales may be completed more accurately if they were used as the basis of the conversation. Finally, it suggested that one-to-one meetings with parents may be the most appropriate setting to provide a confidential, safe place for honest and meaningful reporting.

Comparison Across Children, Therapists, and Interpreters

Children's reduced SUD scores and shift from sad to happy faces for EMDR-IGTP were supported by therapists' reports of reduced child distress. Therapists' comments on children's growth in emotional awareness also complemented children's SUD scores. Therapists' and Arab interpreters' comments also complemented and contrasted with each other (Table 3). Both therapists and interpreters identified the benefits of the program as culturally sensitive and a nonpathological way of working. In contrast, interpreters emphasized the stigma of mental health, the importance of culturally sensitive language, the differences in communicative control, and the quality of relationships as inhibiting program effectiveness. Therapists, on the other hand, focused on interpreters as a resource, the need for good training

for interpreters, and the use of music as one way of breaking down cultural barriers. Therapists also focused on client selection, engagement, assessment, and monitoring involving family and teachers.

Discussion

The current study found therapists' perceived EMDR-IGTP to be the most effective component of a new psychosocial program developed for Syrian/Libyan child refugees although rated the lowest for enjoyment. Children communicated the music activities and safe place as highly enjoyable, whereas, and not surprisingly, children experienced little to no pleasure in facing the traumatic memory. This was not an assessment of the effectiveness of treatment but a subjective view of the processing component within the group as a whole and compared to the other group activities. The additional psychosocial components, rated high for enjoyment, were able to provide a strong engagement factor for the children, enabling them to access the trauma-processing components of the group. Children were also perceived to develop their emotional awareness as a result of the group's overall context of trust, therapist empathic engagement, and age-appropriate healing narrative to enable understanding of life events. The latter emphasizes the importance of therapeutic relationship, empathic engagement, and shared perspectives, goals, and plans, as necessary, but not sufficient for trauma resolution (Greenwald, 2013). Therapists' perceptions were affirmed through clinically significant reductions in children's subjective disturbance scores. Children were also reported to be more able to identify their personal strengths and perceived to be more hopeful for the future. The intense work with the children and positive, supportive relationships also enabled therapists to identify children's ongoing needs and refer to appropriate services postgroup.

In short, the current study adds to the small number of studies that highlight the effectiveness of EMDR-IGTP as a trauma processing component within a wider psychosocial program (Courtois & Ford, 2009; Jarero, Roque-López, & Gomez, 2013). The study also affirms that EMDR-IGTP embedded within a psychosocial program may be an effective treatment for child refugees (Jarero & Artigas, 2015; Wilson et al., 2000; Zaghrout-Hodali et al., 2008), in this study, Syrian/Libyan children settled in the United Kingdom. The program was perceived by therapists to fit with Syrian/Libyan cultures because of the group-based nature of delivery and the related communal understanding of trauma and healing. Similar findings have been found with cognitive behavioral group programs delivered in occupied Palestine (Barron & Abdallah, 2015). In addition, therapists emphasized the importance of good-quality interpretation and the use of trained interpreters as factors that facilitated cultural sensitivity (Minas & Silove, 2001).

In contrast, therapists were concerned about a range of factors to consider for client selection including what country the children come from, the language they use, their cultural understandings, their age, and their gender. Client selection was seen as addressing who to include and exclude as well as any flexibility in decision making. Finally, therapists considered client selection factors to interact with each other in terms of the fitting into the group as well as the program.

Cultural Challenges

Both therapists and interpreters identified a wide range of cultural challenges for the whole program, rather than specifically EMDR-IGTP. These included (a) the differing conceptualizations of mental health between East and West and the problem of stigma of mental illness in Arab cultures, (b) some psychological terms did not have a direct translation into Arabic and/or there were new psychological terms and concepts that needed further exploration, and (c) a confusion of roles between therapist and interpreter, leaving interpreters wanting more information about the nature of traumatization and resultant symptomology. Therapists, on the other hand, were cautious about translators going beyond interpretation and therapists losing control of the conversation. The latter was perceived to create a possible risk of harm for traumatized children. As a useful resource, the National Child Traumatic Stress Network (NCTSN)_ provides a framework to enable therapists to anticipate and plan for these and other cross-cultural issues (National Child Traumatic Stress Network, 2006). Interpreters reported that child disclosure of family information is interpreted as an act of betrayal from an Arab family perspective. Family bonds were described as closer than in the West, where family loyalty in the Middle East was expected because of fears about family reputation in the community. This was perceived to be a significant factor in children's reluctance to share. In addition, refugees had been targeted for racial abuse in the local community, and the sense of safety for the family may have been compromised with the parents communicating their sense of insecurity, intentionally or otherwise. The group did provide an initial brief talk for parents

on the goals of the group, but future programs may be better served by completing full assessments with families that include the verbal delivery of outcome measures within the context of a conversation and discussion with the aid of interpreters.

Interpreters also highlighted that children in the Middle East expect more direction with explicit step-by-step instruction, rather than the more choice-oriented way of communicating in the West. In this regard, the EMDR-IGTP sessions with a protocol structure may have been more attuned than the more free-flowing creative activities in other sessions. Finally, given the Arab focus on spoken rather than written language, routine outcome measures and screening questionnaires were seen by the Arab interpreters as a less effective way of enabling children to respond. The current study then not only affirms the value of interpreters in working with refugees but also identified a range of challenges that need to be addressed in preparation (d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007).

Limitations

Because of the novel application of EMDR-IGTP within a new psychosocial program, a qualitative design was utilized. Such a design, however, does not provide a measure of the size of change nor does it infer generalizability. Sample sizes of children, practitioners, and interpreters were small, and therefore, not all issues are likely to have been identified. Feedback from individual interpreters who had worked with the program, rather than others in a focus group, may have yielded more information on the experiences during the program. Lack of digitally recorded data raises questions of bias and reliability. While routine outcome measures were built into the program, the lack of training for interpreters meant the prescores were invalid, and the postprogram education session did not include the therapists and was run by the volunteers who were unable to complete the data collection. In the future, therapist involvement in the collection of pre- and post-questionnaires with conversations with the family is paramount for future evaluation of projects such as this. With these limitations, extendibility of research is more appropriate than generalizability of findings.

EMDR-IGTP utilizes the eight phases of EMDR with group and art therapy models. The butterfly hug is used for BLS (Jarero & Artigas, 2014; Shapiro, 2001). Studies have used a range of terms to describe EMDR-IGTP such as the EMDR group protocol, the children's EMDR group protocol, and the butterfly hug protocol (Jarero & Artigas, 2015), which has led to some confusion of what was actually evaluated. In addition, there have been a number of adaptations to the protocol such as the IMMA protocol, which uses a bracelet as an anchor for positive resources (Laub & Bar-Sade, 2009). It appears, however, that the treatment may be very robust, with adaptations reporting good results.

Conclusions

This study identified that embedding EMDR-IGTP into a novel psychosocial program led to children's reduced distress, identification of personal strengths, and increased hope for the future. This was evident in reduced child SUD scores and therapist perceptions. The EMDR-IGTP component was reported as the most impactful part of the program, although the psychosocial elements of the group were rated as highly enjoyable, and may be key in engaging children in group programs when the less enjoyable processing of traumatic memories may be required. Challenges included client selection, engagement, the stigma of mental health in Arab cultures, the confusion of psychological and cultural language, and the different expectations of power and communication across cultures. Well-trained interpreters and music were reported as facilitative factors bridging cultural differences. The importance of shared understanding before, during, and after delivery between therapists and interpreters was seen as essential.

Recommendations for Practice

EMDR-IGTP should continue to be embedded into and potentially expanded within an evolving psychosocial group-based program for child refugees. Further consideration needs to be given to the selection process and age range of the children. Standardized screening measures delivered prior to program delivery would facilitate the selection of children with clinical levels of PTSD, although these may be best delivered as part of an assessment conversation with parents. Groups of children with similar developmental levels may help with matching cognitive ability and program content. Interpreters need training to understand the aims, theory, and practices of EMDR-IGTP and psychosocial program delivery, including the process of change with EMDR to provide the best support for group delivery.

Recommendations for Research

Further exploration is needed of therapist, interpreter, and child experience of EMDR-IGTP. Experimental research designs would bring more rigor to analyzing the effectiveness of EMDR-IGTP as a component within psychosocial programs. Child and parental standardized outcome measures provide a measure of symptom change, for example, for posttraumatic stress, anxiety, depression, and complicated grief. Inclusion of longitudinal evaluation would assess the maintenance of gains and the development of posttraumatic growth. Given the complexity of cross-cultural groups with traumatized children, unintended negative consequences should be explicitly explored. Finally, children are more likely to suffer PTSD if their parents have also developed PTSD. These parents are less likely to notice the symptoms in their children and seek help (Meiser-Steadman, Smith, Yule, Glucksman, & Dalgeish, 2016). Further research could consider parental PTSD and how a parent component to the group may facilitate further change.

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