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How Art Therapy and EMDR Help Asylum Seekers and Refugees Move Towards Healing Trauma: A Literature Review

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Abstract

In the past ten years, there has been a significant rise in the number of asylum seekers and refugee populations worldwide (UNHCR, 2022). Displaced individuals are extremely vulnerable to mental illness because of the compounded trauma experienced in their countries of origin with the stress of immigration, asylum seeking, culture shock, and language barriers. PTSD is affecting 500 million individuals globally, and refugees are especially susceptible to having these symptoms (Farrell, 2020). Art therapy and EMDR are identified as the most promising modalities for treating such trauma.

This literature review examines the various ways EMDR and art therapy have been applied to treating trauma and PTSD for refugees and asylum seekers. Topics such as efficacy, cultural competency, versatility, cost-effectiveness, and ability to accommodate displaced individuals with diverse psychological needs are explored, as well as how EMDR and art therapy can help with memory restoration and healing complex trauma and PTSD.

The review concludes that for displaced populations there have not been enough robust studies conducted to affirm these practices as evidence-based. Most studies lack sufficient sample sizes, do not identify PTSD according to DSM, and do not use proper randomization. Among other important criteria, long-term follow-ups are rarely conducted (Farrell, 2020). However the paper argues that there is indeed enough evidence to invest significant efforts into further research of these modalities specifically for refugee populations.

Keywords: PTSD, EMDR, art therapy, reconstruction of memories, refugees, displaced people, asylum seekers, case studies

How Art Therapy and EMDR Help Asylum Seekers and Refugees Move Towards Healing Trauma: A Literature Review

Introduction

In this literature review, I will be exploring EMDR as a treatment for PTSD for refugees and investigating how it helps them move out of the fight-and-flight response and toward developing resilience and a wider understanding of their circumstances through narrative reconstruction. I will also examine art therapy as a new modality showing much promise in the field of healing PTSD and trauma in displaced populations and investigate its similarities and differences as well as areas of overlap with EMDR as treatment. It is important to identify the available treatment options in order to understand how to best address the refugee crisis, and how to create an accessible and scalable treatment for the ever-growing population of displaced people. I will examine ways in which these two modalities can be used together and where each one shows more superiority in treatment and/ or incompatibility. Since many of the current studies are only partially conclusive and need further investigation, I will be delineating where knowledge exists on the subject and where it still needs much more development so that the frame for future research and discovery can be clearly defined.

With increased global conflicts and climate-related catastrophes, the displaced population of refugees and asylum seekers has been growing exponentially in the past decade (UNHCR, 2022). According to the UN Refugee Agency (UNHCR), there are 108.4 million forcibly displaced people worldwide escaping persecution, unrest, human rights violations, and the impact of the environmental crisis (UNHCR, 2022). This shows an increase of over 80 million people since 2011 with exponential growth noted by published UN studies (UNHCR, 2011). The

most recent data for 2021 and 2022 shows a tremendous increase in the refugee population by nineteen million people (UNHCR, 2022). This means that one out of every seventy-four people on the planet is impacted by this phenomenon. Twenty-two percent of the displaced population is still residing in camps and has access to a very limited supply of food, water, medicine, and mental health (Zadeh & Jogia, 2023).

Because many individuals that are part of these populations are low-income and do not have permanent homes it is challenging to ensure that they receive proper psychological care. Asylum seekers can spend up to ten years waiting for their asylum paperwork and fearing the possibility of getting sent back to their country of origin (Schouten et al., 2019). They often come from different cultures and countries with a variety of family structures, support, and experiences regarding trauma. Although these environments are supposed to offer safety and healthcare, many times they fall short. Asylum seekers are habitually placed in tight living quarters with very congested spaces. In these environments, situations can quickly escalate to violence leading to more traumatization and feelings of lack of trust and safety (Dorter, 1998). This is resulting in a growing mental health crisis as many of the refugees and asylum-seekers have already been traumatized in their countries of origin while being exposed to the additional stressors from the process of immigration, compounded with loss and uncertainty. Asylum seekers cannot hold jobs and don’t have access to activities that give them a sense of purpose or a permanent place to live. Oftentimes they lack basic rights that refugees and residents possess. Many of them wait, up to ten years, to get asylum in very stressful environments having to tell and retell their stories in order to convince solicitors to help them move their case forward. In addition, many of them don’t speak a language such as English well (if they are settling in an

English-speaking country), while the nature of their acceptance or denial can depend directly on their ability to communicate their stories clearly and concisely (O'Neil et al., 2017).

Untreated symptoms of trauma and PTSD can lead to mental illness. Displaced populations are at a higher risk of developing mental illness due to the hardships they face. In order to heal, the individuals have to go through a process of reprocessing traumatic memories and reestablishing more resilient narratives. Traumatic memory is typically processed in two ways, the first way occurs if an individual is able to process it with the help and support of their family and friends and go through appropriate stages of healing, another is they place the traumatic memory behind a wall. In the latter case, this leads to symptoms of PTSD where trauma symptoms such as images, sensory, and sound sensations stay active and contribute to hyperarousal and hypervigilance that can stay with an individual for years and can lead to worsening of symptoms (Talwar 2007). The reason for this memory dysfunction is the unprocessed nature of the content.

As part of the literature review, I have collected sources that investigated art therapy and EMDR as treatments for trauma and PTSD for displaced populations. My main mode of research was conducted through searching databases, picking out appropriate literature, note-taking, color coding, and compiling information. The collected data included efficiency of treatment, versatility of treatment, cost-effectiveness, and impact of treatment on healing fractured memories. My findings suggest that both art therapy and EMDR fields need more robust comparative studies. The Art therapy field in particular would benefit from a more rigorous research culture that would gain more visibility and acceptance within the committees that make decisions on grant allocations. More studies on combining art therapy and EMDR would also be beneficial.

Method

I utilized the literature review research method to seek the answers to the question of how art therapy and EMDR can help asylum seekers and refugees move towards healing trauma. I used search engines, such as Google Scholar and Lesley University Library in order to find literature, using word searches such as EMDR, EMDR history, EMDR for refugees and asylum seekers, EMDR and PTSD, EMDR, and trauma. I analyzed different types of literature, including journal articles, books, literature reviews as well as dissertations. Zotero served as a place to organize and save the selected literature. I also utilized printouts to highlight parts that needed a more detailed investigation.

My process of data analysis was to discover the main themes using color-coding literature by topic that correlated to the headings in the literature review. Some of the areas that I color-coded are methods used as part of the studies, as well as conclusions, discussions, and data. The color coding helped me create topic sections in my capstone and kept them organized as I added more information and created an overall flow. Note-taking and organization of articles manually and within Zotero were also implemented. This helped me maintain the source list and create easy access to descriptions, important quotes, and pertinent information for each article. The research included qualitative, quantitative, art-based, and mixed methods literature as well as systemic reviews and analysis.

Anticipated Outcome

The anticipated outcome of my thesis was a comprehensive review of both EMDR and art therapy as it pertains to the treatment of trauma and PTSD for asylum seekers and refugees. The areas where the two modalities overlapped and where they both had strengths and weaknesses were revealed as the result of the review. New insights were developed based on a comparative analysis of the literature. The hope was to contribute to the research in this area and

to further inspire others to investigate these populations and understand how both EMDR and art therapy can help heal this growing crisis. Because art therapy is not as well studied as EMDR, reviewing all the literature that pertains to refugees/ asylum seeker's PTSD and trauma care helped to consolidate that knowledge and allow one to gain a deeper understanding of what has been studied and as well as how to take the research further in order to draw more attention to art therapy as a treatment for refugees and asylum seekers. This will in turn inspire more research and deeper investigations by future scholars. My insights from the capstone will also enable a deeper experience at my next internship at NOVA Bucks, victim's services, at which both EMDR and art therapy are implemented as part of the treatment model. Lastly, I also hope to contribute and work with refugees from Ukraine and Russia post-graduation who are fleeing the war and are in much need of support.

Literature Review

More than half of the displaced individuals who are exposed to traumatic events will develop delayed post-traumatic stress disorder (PTSD) (Macgowan et al., 2022). The symptoms that are correlated with PTSD include flashbacks, hyperarousal, difficulty sleeping/ nightmares, emotional numbness, avoidance, muscle tension, physical pain, fragmentation, and dissociation (Schouten et al., 2019). An inability to construct cohesive memories is often the result of the mind not being able to cope with traumatic events and is often part of the core symptomology. The effect of traumatic memories is disorganization and fragmentation resulting in an inability to create a coherent narrative (Tessitore, 2022). Additionally, meaning-making, emotional expressions, and somatization can all be impacted, reflecting on the individual's ability to connect to their past, present, and future experiences (Tessitore, 2022).

Many refugees and asylum seekers struggle from traumatization and symptoms of post-traumatic stress disorder (PTSD) due to experiences of violence, loss of homeland, involuntary

migration, and resettlement (Harrison et al., 2019). The well-being of displaced individuals represents one of the largest mental health crises in the world today (Tessitore, 2022). In addition to the traumatic experiences they endured in their homeland, the period of transition can lead to additional stress and trauma and exacerbate pre-existing conditions (Zehetmair et al., 2019). Because of that, refugees and asylum seekers are a vulnerable population at risk of developing mental illness (Zehetmair et al., 2019). In order for them to avoid exacerbation of past mental challenges they need to work on processing and healing their trauma. This is difficult due to their financial status, the impermanence of their living accommodations as well as the challenges they are facing in their new homeland, such as loss of community, loss of purpose and social role, loss of occupation, loss of family, limited ability to act, unemployment, inability to communicate, loss of agency due to uncertainty about their future, and poverty. Furthermore, despite the obvious need for mental health and psychosocial support this population often goes unnoticed and there are no set standard protocols in place to provide proper mental health interventions (Zehetmair et al., 2019).

Most trauma research addresses singular traumatic events and trauma in Western cultures that are not experiencing war, natural disasters, and other atrocities. Because of that, much of the studies and literature do not address complex PTSD. There is debate that treatments and protocols currently available may not qualify as a treatment for complex trauma and PTSD as many complex sufferers have difficulty exploring and processing traumatic memories (ter Heide et al., 2014). Additionally, many of the studies work with refugees who have been resettled in a new country and have lived there for ten years or more (Good & Hinton, 2015). This means that treatment is not addressing the more acute stages in the life of refugees and asylum seekers and is not catching symptoms before they lead to more serious conditions. Many of the current

studies also do not have sufficient data that satisfies all of the research standards regarding the efficacy of the protocols they describe, and many of them state that further research with larger randomized studies is much needed (Good & Hinton, 2015).

The modalities that are currently highlighted as showing promise for working with refugees and asylum seeker populations include eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy, narrative therapy, somatic experiencing as well as art and drama therapy. To dive deeper into understanding traditional modes of therapy and their relationship with art therapy, I have narrowed my study to reviewing EMDR and art therapy. EMDR is an approach to the treatment of PTSD that has been recently identified as the treatment of choice in treatment guidelines for trauma work with displaced populations (ter Heide et al., 2014). Art therapy is a more recent addition to trauma healing with these populations showing a lot of promise (Acarturk et al., 2015).

PTSD

Historically the PTSD diagnosis was developed due to a cluster of symptoms that appeared within the veteran population in the 1970s following the Vietnam War. The concept first appeared on the scene in DSM-III as an explanation of emotional war wounds, and soldiers experiencing feelings of overwhelming psychological distress (Good & Hinton, 2015). The second lineage of PTSD developed as a diagnosis related to trauma, sexual abuse, and domestic violence. Rape went through several stages of classification, and finally became classified as sexual abuse in the 1970s. In the 1980s the array of symptoms related to sexual abuse was finally classified as PTSD (Good & Hinton, 2015). The combination of PTSD symptoms experienced by veterans with those of childhood rape victims and sexual violence in childhood and throughout lifetime is what contributes to PTSD diagnosis today. Furthermore, more recently a distinction has been made between PTSD and complex PTSD, the latter describing multiple

traumas and symptomology. The complex diagnosis includes all of the other symptoms of PTSD plus emotional dysregulation, relational disturbances, maladaptive thinking, and somatic distress (ter Heide et al., 2014). This diverse representation of symptoms combined into the DSM diagnosis of PTSD omits many of the other associated symptoms as it is an extreme oversimplification of the actual distress that the clients are feeling (Good & Hinton, 2015). As part of this oversimplification, the DSM description of PTSD does not take into account the multiplicity of cultural experiences of PTSD throughout the world, such as somatic symptoms which are more prevalent in certain cultures. Many professionals in the field feel that somatic symptoms should be one of the main clusters in PTSD and there is a lot of evidence that some of the non-western cultures experience more of these types of symptoms than other symptoms defined in the DSM (Good & Hinton, 2015). There is also a vast amount of literature dedicated to trauma treatment and processing memories with a strong focus on somatic experiences and memory. Somatic experiences are known to affect fear and bodily responses as reactive mechanisms while memory processing focuses more on the storage and retrieval of traumatic memories accompanied by somatization and bodily declarative memories (Acarturk et al., 2015). These responses can greatly affect the client's ability to be objective in the moment, create a narrative, and their openness to new emotions and experiences (Acarturk et al., 2015). Additionally, many of the trauma treatment protocols are designed to treat clients on an individual level. Alternatively, in war-torn countries, the treatment may need to be collective (Acarturk et al., 2015). Lastly, trauma and PTSD treatments that are prevalent in the field today may not be appropriate for refugees and asylum seekers as it is more catered to individuals in peaceful states not reflecting the needs of refugees fleeing war, torment, and persecution (ter Heide et al., 2014).

Statistically 20 percent of individuals who experience trauma develop PTSD (Good & Hinton, 2015). The consensus is that it has to do with insecure attachment. Individuals who have insecure attachment and experience a multitude of traumatic events are more prone to develop symptoms of complex PTSD (Good & Hinton, 2015). Many of the refugees and asylum seekers fall into these categories as they come from areas of devastation and unrest (Good & Hinton, 2015). There is some debate about whether doing attachment work first with these individuals will create better results for trauma treatment (Gattinara et al., 2016).

The pioneer of PTSD treatment is Pierre Janet, as he was responsible for developing a three-phase trauma treatment protocol which is widely used today. The protocol is formed through 3 stages - stabilization, processing, and rehabilitation (Good & Hinton, 2015). There is some disagreement in the field regarding the stages of treatment and whether following Janet's model of a three-phase approach is the appropriate model of treatment with this population (Good & Hinton, 2015). One of the reasons is that some refugees do not believe that they need to process traumatic memories in order to heal or they are unable to do so (ter Heide et al., 2014). Additionally, many trauma treatment protocols advocate for developing a safe and trusting relationship with the therapist as a first part of the protocol which is often not possible in the environment that refugees and asylum seekers inhabit. Lastly, the latest trauma research provides evidence that refugees may still have great benefits from the treatment model that does not include the phased approach (ter Heide et al., 2014).

Trauma and Fractured Memory

Traumatic memories disrupt normal psychological and physiological responses. They are typically incomplete and lack coherence and therefore result in a hyperactive limbic system. According to Talwar (2007), memories associated with trauma are more easily organized in

implicit memory which is accessible through non-verbal modes of communication. When the link between explicit and implicit memory is broken, a patient can keep cycling unable to organize the memory into a sequential story and therefore unable to integrate it. The explicit area of the brain that is impacted by this process is associated with words, planning events, and identifying factual information. The same area is responsible for speech, particularly the Broca region. In trauma clients, inactive prefrontal lobes are related to the dissociation that many patients experience. This explains why it is so difficult for them to verbalize their experiences. Additionally, according to Van Der Kock (2002), memories coexist with sensory imprints in which emotional and perceptual parts are more accessible than declarative ones. Traumatic memories are often separated from consciousness and stored and organized into memory as sensory perceptions which can in turn show up as obsessions, ruminations or behavioral reenactments. The clients can act adaptively under ordinary circumstances and experience activated PTSD symptoms under what the body perceives as stress. According to Van Der Kock (2014) unless the patients become aware of the split and integrate it into a story this can lead to the deterioration of the regular functioning of that individual. The treatment has to help identify which events happened then and now and integrate the separated elements of the memory. Getting in touch with body sensations and tolerating those emotions that are associated with trauma is one of the ways to heal. According to Talwar (2007), it is said that trauma patients process trauma from the body to mind and not the other way around. This means that in order to properly process trauma, therapists must implement non-verbal modalities to help their patients (Talwar, 2007). The body serves as a gateway to working and reconnecting an individual with their somatic and sensory responses and implicit memories. Peter Levine and Pat Ogden both have modalities that have the somatic approach that looks at the shape of these imprints on the

trauma as sensations on the body. They believe that by becoming more aware and tolerant of body sensations can help one move towards healing and integrating traumatic experiences (Van Der Kock, 2014).

EMDR

Eye movement and desensitization and reprocessing (EMDR) is a multifaceted therapeutic method informed by Freud's, Jung's, and Klein's methodologies as well as attachment theory, and narrative approaches (Robinson, 2016). EMDR is a traditionally recommended modality for PTSD (ter Heide et al., 2014). EMDR has been recommended as a treatment of choice for PTSD by the National Institute of Clinical Excellence (ter Heide et al., 2014). In the West many refugee centers are using it as a guideline. Although there is much evidence in regard to EMDR and PTSD this doesn't generalize to evidence that EMDR is efficient in working with refugee populations (ter Heide et al., 2014). Historically EMDR was established by Francine Shapiro. EMDR works with a recall of traumatic memories while simultaneously moving eyes left and right, tapping or oral stimulation as a way to create a dual-attention, bilateral stimulation that allows one to integrate trauma. There is evidence that bilateral stimulation increases access to episodic memories as well as components of working memory allowing for more ease in processing of traumatic experiences (ter Heide et al., 2014). When healing is possible symbolization and meaning-making processes are the aspects that help individuals integrate traumatic experiences (ter Heide et al., 2014). Traditionally EMDR uses eight stages as part of the treatment protocol. It combines various approaches such as psychodynamic, cognitive-behavioral, and experiential. Typically, EMDR protocols include processing past experiences, presenting triggers, and creating templates for future actions (Macgowan et al., 2022). This process allows the transmutation of maladaptive patterns where

the patient experiences dysfunctional stored memories into a metabolized resolution that results in a positive shift in psychological health (Yurtsever et al., 2018).

The challenge with EMDR is that 30 percent of the population that has experienced severe trauma at an early stage in addition to many traumatizations at later stages cannot be helped by EMDR. This is because clients who have complex trauma with trauma related to attachment insecurity are not able to tolerate EMDR as for them re-exposure to the traumatic experiences leads to re-traumatization (Schouten et al., 2019). There is some debate regarding whether a longer stabilization protocol could contribute to a better success rate for these individuals (ter Heide et al., 2014). It is also believed that this strategy will decrease the high dropout rate that is common in refugee and asylum seeker communities (ter Heide et al., 2014). As another possibility, Blind2 Therapist Protocol can be utilized. The Blind 2 Therapist Protocol is an innovative protocol by Farrell et al. (2020) that describes a variation on EMDR that allows clients to process memories without verbalizing them. It gives patients a choice and allows those who are affected by shame and deep trauma to process their emotional and somatic content without revealing the details of their trauma and memory. The method is less effective than the standard EMDR however it gives those patients who otherwise would not opt for EMDR exposure treatment another choice that can contribute to their healing effectively (Farrell et al., 2020).

There is also a variety of lengths that can be offered with EMDR treatment which can further customize the client's experience. The traditional EMDR protocol is eight sessions. However, in the most recent article by Wippich et al. (2023) EMDR presented a protocol that can be administered in a minimum of three sessions and still show a positive impact on PTSD symptoms. Another solution that has been implemented in one of the studies in order to make EMDR more accessible to refugee and asylum-seeking populations is group EMDR / EMDR- G-

TEP. According to Yurtsever et al. (2018) good results were produced through group work, 60 percent of the patients experienced significantly reduced symptoms of PTSD and depression and no longer qualified for PTSD diagnosis maintained at four weeks post-follow-up. EMDR-G-TEP is less effective than individual therapy, but it can be a good option especially if refugee centers do not have a budget for individual therapy. It also allows the clients to process their memories collectively, which is often recommended for refugee and asylum seeker populations.

There are a variety of ways in which EMDR specialists implement cultural considerations as part of their protocols. The study by Acarturk et al. (2015) provides a good example where Syrian refugees were treated using EMDR with very careful cultural consideration. The clinic was set up in a daycare center so that the refugees could see a therapist under the pretense of dropping off their children. This was a way to work through stigma in their culture. Additionally, as part of this consideration, women and men were seen by same-sex therapists to accommodate their cultural needs. Implementing culturally competent treatment for refugees promotes the building of therapeutic alliances as well as more open sharing of the patient's narratives which, in turn, allows for better processing of traumatic circumstances.

Another variation to EMDR is EMDR-R-TEP which addresses the criticism of only addressing the latest traumatic event with this modality. In the study by Gattinara et al. (2016), a protocol was laid out that illustrates the possibility of treating multiple traumas. This is a multifaceted approach that permits the patient to be in charge of their own process identifying one traumatic episode after another. This allows the patient to work with multiple traumatic episodes and repeated traumas (Gattinara et al., 2016). As part of the steps in this protocol, Gattinara et al. (2016) describe imaginary work which is often used in art therapy interventions

that promotes a patient's visualization of a safe space promoting adaptive memory-building as a way to cope with a traumatic event.

Lastly, the newest addition to EMDR is EMDR Legacy. This protocol incorporates narrative therapy, archetypal visualization, and genogram as well as EMDR therapy to process multigenerational trauma (Gattinara, 2016). This therapy was specifically developed to treat refugees and victims of discrimination, persecution, and natural disasters who suffer from multigenerational trauma (Gattinara, 2016).

Art Therapy

Art therapy provides an alternative treatment for trauma and PTSD. Trauma art-based therapy originated in the 1930s and started to be labeled and acknowledged as art therapy in the 1970s when hospitals started to incorporate it more widely inpatient (Baker et al., 2006). In the past decade, there has been a substantial increase in interest in expressive methods such as art therapy as ways to heal in social, emotional, and psychological domains as well as in relationship to trauma and PTSD (Annous et al., 2022). Most evidence supporting art therapy as a modality for PTSD work is created through case studies or expert opinions (Schouten et al., 2019). According to Baker et al. (2006), there are many reasons why art therapy has had more difficulty generating robust studies. Much of it is due to a lack of funding. Art therapy falls into both artistic practice and therapeutic process which is often identified as outside of the scope of the humanities criteria for grant applications. On the other hand, if the proposal is submitted through a medical pathway, the reviewers in those fields don't have the proper expertise to examine such proposals (Baker et al., 2006).

Art therapy is a multidisciplinary modality that draws from different fields such as education, neuroscience, counseling, and visual arts amongst others. It also utilizes different

approaches such as narrative art therapy, mindfulness, person-centered art therapy, cognitive behavioral, gestalt, and others. Art therapy exists between three variables: the therapist, the client, and the artwork, creating a neutral space for processing that allows for diminishing some of the relational challenges with a focus on the expression of the client's inner world (Davis et al., 2023). Annous et al. (2002) describe art therapy as a process that includes three methods of engagement in the therapeutic process which are non-directive, directive, and combined. According to AATA, the main purpose of art therapy is to reduce distress, facilitate insight, improve the function of cognitive and sensorial faculties, foster resilience, self-awareness, and self-acceptance, facilitate/enhance social interactions, reduce conflict in the client's lives, further social change, and cultivate resilient thought processes (Zadeh & Jogia, 2023).

Art therapy utilizes many different media such as drawing, painting, collaging photography, sculpting, and craft making amongst others. Each medium allows for different types of expression and processing. Even though the theory and technical side of art therapy can be eclectic, what unifies the approach is art as a language of expression (Annous et al., 2022). The process of artmaking can facilitate positive experiences that decrease hyperarousal, increase attention and mindfulness, and calm the mind which works well in the three-stage treatment model often proposed for trauma and PTSD. The visually represented traumatic memories can be imaginably reworked through the process of art-making (Davis et al., 2023). As noted by Annous et al. (2002) in the traditional model of treatment, the first stage is typically stabilization. It is followed by a reduction of symptoms, integration, and future focus/ making meaning (Shouten et al., 2015). Generally, art therapy utilizes a systemic approach which consists of an exploration of art materials, developing a creative work, and expressing personal reflection regarding the work and the process (Zadeh & Jogia, 2023).

Techniques such as collage are reported to promote non-verbal communication and help with processing grief and loss (Zadeh & Jogia, 2023). Group art therapy leads to the development of social skills, rebuilding trust, and creating new bonds and support systems that asylum seekers desperately need. It helps to build a sense of belonging and safety that is often lacking in their environment (Zadeh & Jogia, 2023). The utilization of photography as part of the Photographic Interview protocol helps to bring more coherence to personal narratives which helps to integrate the fractured nature of the memories responsible for the symptoms of trauma and PTSD (Tessitore, 2022). It also helps to build better connections between words and images as well as shift patients to a more adaptive way of interpreting past and present events.

As part of the healing process, art therapy can integrate the left and right sides of the brain which can in turn lead to the integration of trauma. Talwar (2007) showcases several protocols influenced by EMDR that integrate the left and right sides of the brain using art therapy. Throughout her bilateral art protocol, she shows how both sides verbal and non-verbal can be engaged in art therapy and can lead to a greater sense of organization in the brain. She believes that art therapy can encourage memory integration from both sides of the brain by utilizing both hands, shifting from the dominant hand to the non-dominant one to process memory or emotion. Another protocol that she described involves drawing on the wall while walking back and forth towards the table with laid-out containers of paint and away from them and the drawing to examine it at a farther distance. These types of interventions give a client a way to get in touch with their sensory awareness which in turn can lead to regulation.

Processing memories through visual form is optimal for some patients who have difficulty speaking about their experiences. Art therapy can target the non-verbal core of traumatic experiences (Talwar, 2007). Many times, those experiencing PTSD can recall

sensations, memories, and smells associated with a traumatic event they experienced years after it had happened. Art therapy helps regulate hyperarousal and emotions associated with the trauma through treatment work related to sensory imprints (Talwar, 2007). For some individuals, it is enough to visually express their experience in order to facilitate healing (Schouten et al., 2019). The non-verbal visual processing of trauma can slow down or delay verbalization allowing more time for stabilization and processing. It can lead to a more gradual and easily tolerated exposure through activation of physiological and cognitive processes (Davis et al., 2023; Schouten et al., 2019). This in turn leads to a decrease in avoidance and integration and a more gradual and stable process of reexamining the trauma narrative. This helps to integrate the implicit and explicit memory through the act of art-making creating a more coherent story (Davis et al., 2023). Furthermore, traumatic experiences are often visual and sensory based and are stored in implicit memory, the art therapy process can easily access this implicitly stored traumatic material through the act of expression. According to Schnitzer et al. (2021), art therapy could also work well as a lead into other modalities such as EMDR as it helps clients overcome avoidance of traumatic material. He believes that once avoidance is alleviated it will be more possible for clients to engage with other modalities such as EMDR and cognitive behavioral therapies (Schnitzer et al., 2021). Schnitzer et al. (2021) also hypothesize that art therapy works better for individuals who have more extreme trauma history as it helps to work through the shame and intensity of the traumatic experiences. Additionally, attachment work is part of psychological approaches that are often incorporated into art therapy. This approach is very beneficial to individuals with complex trauma that includes childhood traumatization as they have to create their foundation for treatment with attachment work before any trauma processing can be conducted (Schnitzer et al., 2021).

There is a lack of consensus on whether art therapy can be a reliable modality in regard to setting up a personal practice beyond meetings with the therapist. According to Kalmanowitz et al. (2017) one of the challenges in implementing art therapy can sometimes be that some participants are less likely to implement it on their own. Some participants thrive in continuing to implement art therapy beyond the therapeutic settings whereas others prefer the presence of a therapist (Kalmanowitz & Ho, 2017).

Discussion

Five themes emerge from my analysis of the literature on trauma and PTSD care for refugees and asylum seekers they compare EMDR and art therapy via several categories; including: the efficacy of treatment, versatility, cultural accommodations and relevance, cost-effectiveness, and ability to transmute traumatic memories. Within the first category, I described why both modalities are not yet considered evidence-based approaches specifically for asylum seekers and refugees with complex trauma and PTSD. As I discuss the versatility within each modality I also cover a variety of treatment protocols and I contrast and compare their ability to treat diverse populations. As part of the cultural accommodations, I discuss both the utilization of culturally relevant media and materials within art therapy as well as incorporating cultural and societal norms as part of treatment in both modalities. Cost-effectiveness factors are explored examining the ability of these modalities to be practiced in group settings, as well as the number of sessions needed for effective treatment. Lastly, traumatic memory integration and trauma healing are also examined for both modalities.

Efficacy of Treatment

Although EMDR is effective and has been recommended as a treatment of choice for PTSD, the studies do not provide concrete evidence that EMDR is efficient in working with

refugee populations (ter Heide et al., 2014). The study by Acarturk et al. (2015) is the first of its kind to show evidence of the efficacy of the use of EMDR in non-western asylum-seeking populations living in refugee camps. It states that their EMDR protocol was able to reduce the PTSD and trauma symptoms and maintain this reduction for 11 weeks. However, evidence is still insufficient in meeting gold standards as this study had many limitations, including a lack of formal diagnosis for PTSD, the small population size, the inability to conduct follow-up assessments, and improper evaluation of treatment fidelity amongst others. Additionally, therapists participating in that study were only trained in level I EMDR which is incomplete in regards to basic training which includes levels I and II (Acarturk, 2015). As part of the conclusion statement in this study, Acarturk et al. (2015) explained that a larger more robust study is needed. Additionally, according to Macgowan et al., when Gattinara and colleagues reviewed nine studies, they were also able to provide evidence that EMDR facilitates improvements in trauma and PTSD symptoms. However, these studies were also methodologically flawed and therefore could not affirmatively prove the efficacy of EMDR. These studies represent overarching methodological difficulties for all the studies I encountered in my research. Additionally, EMDR integration in low-income countries and settings has been incredibly low which means that refugee populations have very limited access to this modality (Ferrell et al., 2020). Lastly, according to Baker (2018), EMDR and other traditional protocols also have a high dropout rate of fifty percent.

In comparison, art therapy is not yet presented as a recommended approach. It is showcased as a promising approach with insufficient evidence for the treatment of PTSD because there are not enough clear case studies supporting its effectiveness. For example, according to Schouten (2019), qualitative research identifies that art therapy can reduce multiple

PTSD symptoms such as depression, hyperarousal, reexperiencing, and anxiety. There is also a consensus amongst experts that it can facilitate resilience and improve self-esteem and emotional regulation. Many experts in the field recommend art therapy as a trauma treatment especially because it has a unique quality of making the implicit explicit and facilitates gentle processing of traumatic memories (Schouten et al., 2019). However, the studies all fall short in terms of quality, sample size, and meeting the criteria for systemic reviews. Most evidence supporting art therapy as a modality for PTSD is created through case studies or expert opinions (Schouten et al., 2019). It is also difficult to find studies in which art therapy is implemented alone and not in combination with other modalities (Zadeh& Johia, 2022). Additionally, funding is difficult to acquire for art therapy research as the field doesn't fit into standard categories that are allocated by grant committees. More funding needs to go into art therapy research for trauma as well as the integration of multidisciplinary teams to review and approve proposals in order to create more robust evidence-based studies that show valid measures and clear data (Baker et al., 2006). Art therapy can also be a good lead into more verbally based modalities like EMDR. Once traumatic experiences are unmasked using art therapy, they can be processed further with a verbally based modality like EMDR. The combined approach can alleviate avoidance and help individuals become more comfortable with processing their traumatic materials. According to a comprehensive study by Schouten et al. (2019), EMDR has a dropout rate of 50 percent due to clients not being able to process traumatic memories, whereas art therapy only had a 25 percent dropout rate. This is lower than any other therapy recommended for PTSD (Schouten et al., 2019). Schnitzer et al. (2021) showed that combining art therapy and EMDR can lead to good results. It could potentially lead to a decrease in the dropout rate in the EMDR portion of treatment by as much as 50% (Schnitzer et al., 2021).

Versatility

Both EMDR and art therapy combine an array of theoretical orientations. EMDR is practiced with a variety of standard protocols and non-standard protocols. In the studies that I encountered standard protocols are predominantly applied. In comparison, art therapy is much more versatile as it utilizes more variables including different approaches, materials, and methods of engagement. For example, art therapy has protocols that utilize bilateral stimulation, but it also has many other modes and ways of working with clients such as photographic interviews, narrative art therapy, body mapping, mask making, embroidery, and many more. Standard EMDR appears more limited in that respect (Talwar, 2007; Zadeh & Jogia, 2023).

Variations such as EMDR-G-TEP, EMDR-R-TEP, Blind 2 Therapist Protocol, and legacy attuned EMDR have expanded the potential of EMDR beyond the traditional model (Robinson, 2016). Although traditional EMDR protocols are tied to bilateral processing technology, there is flexibility within the structure of non-traditional protocols. Gattinara et al., (2016) explain that the EMDR protocol created by Gonzales and Mosquera in 2012 showcased a flexible model that is less sequential, it builds on a spiral, starting with a periphery working with behavioral issues and building up to stabilization and resilience which can then start addressing traumatic memories. According to Hartung (2016), the practitioners that she trains share that most of their clients prefer nonstandard protocols because they are more culturally sensitive and incorporate other approaches with EMDR to suit the individual or group that is being treated. These non-standard protocols can include culturally relevant modalities and apply proper dosing of bilateral stimulation, regulating the speed and the amount of stimulation that a patient is receiving based on what they can tolerate (Hartung, 2016). There are a lot of similarities between

art therapy and non-standard EMDR protocols in their versatility, creativity, and ability to accommodate clients with various needs and cultural backgrounds.

However, an EMDR therapist has to be trained in nonstandard protocols along with standard EMDR in order to be able to implement more versatility and flexibility in their practice. In Baker et al. (2018) it is noted that most clinicians do not use trauma-focused treatment when treating PTSD even when they have received training in it because they believe it can be very activating for the clients. Additionally, according to Farrell et al. (2020), especially in low-income countries the issue also extends to not having enough professionals who are qualified or trained and experienced in trauma treatment and lack in competency. For example, the study by Acarturk et al. (2015) states that they utilized therapists who only have level I EMDR training. Whereas traditional EMDR requires training in levels I and II. This means that these therapists are most likely not trained in EMDR non-traditional protocols and do not have enough training to be able to customize EMDR treatment for each client or group.

Blind 2 Therapist Protocol shows a lot of potential in regard to treating trauma for those individuals who experience fear and shame in relationship to trauma and do not want to verbally disclose their experiences. I see a lot of correlation between the Blind 2 Therapist Protocol and the benefits of art therapy. However, art therapy offers more versatility regarding the gradual transition from non-verbal mode, expression, and use of imagination than the Blind 2 Therapist Protocol.

Legacy attuned EMDR was specifically created to address multigenerational trauma and therefore is a great option for refugees as well. It combines genograms, reestablishing life narratives with imaginal practices of safe space, archetypal figures, and traditional EMDR therapy (Robinson, 2016). However, I have only seen it mentioned in one source that explored

innovative strategies for EMDR. Likely, most therapists working with refugees are not trained in legacy attuned EMDR. Furthermore, according to Robinson et al. (2016), no research shows clinical studies that include legacy attuned EMDR even though he believes it would be most effective for refugee populations.

Art therapists on the other hand are typically trained in a wide spectrum of treatment models and have experience working with individuals and in groups cross-culturally, utilizing both verbal and non-verbal modes of communication. Therefore, it is also easier to put together a protocol with art therapy that addresses each individual or a particular group's needs.

Cultural Accommodations and Relevance

Art therapy is culturally friendly as it is easy to draw from an individual's tradition and culture and make that part of art therapy interventions and protocols (Zadeh & Jogia, 2023). A good example of this was presented in Baker (2006) article where needlework and quilting were utilized with a group of Bosnian grandmothers. Needlepoint was a way to connect to their culture and experience of individualism and empower them. In that way, art therapy can function as another language of communication for refugees and asylum seekers. Artmaking and crafting have the advantage of being more familiar to most populations because drawing and crafting are often part of the childhood experience in many cultures (Zadeh & Jogia, 2023). Whereas EMDR is completely foreign to most refugees, and they have to spend time being educated about this modality. This is often part two of the EMDR protocol and is typically included in the second step of the traditional intervention. The equivalent challenge with art therapy is that art making can also be stigmatized in some cultures or some adult individuals might have had a negative experience with art as a child or can also feel that art making is for children (Baker, 2006). There are solutions that art therapists implement in these cases. For example, art therapists may take

additional time to help make those clients feel safe and comfortable enough to try it out. Once that safety is established it often leads to exploration (Dorter, 1998). As part of EMDR cultural accommodations are met through cultural norms rather than through the nature of the modality. According to the study by Acarturk et al. (2015) during the EMDR treatment, the following accommodations were offered for the asylum seekers – hiring of Syrian interpreters to conduct interviews, providing psych education for EMDR and PTSD to combat cultural stigma, and spreading the word to individuals with strong social networks. They also scheduled sessions to coincide with cultural norms as Syrians prefer to stay up late and wake up late. They set up the therapy clinic in the kindergarten daycare center so that when parents came to receive therapy it could be under the guise of bringing kids to daycare. They have also matched up the sex of the therapist and the client because that is what is culturally appropriate (Acarturk et al., 2015). The Baker (2006) article provides a good example of when such cultural norms were not met. For example, when the same-sex art therapist norm was not implemented in Bosnian men's groups it was met with resistance. This leads to the conclusion that art therapy has the potential to utilize culturally relevant materials as well as cultural norms to create more efficacious protocols for trauma treatment.

Cost Effectiveness

Art therapy is cost-effective as it is a modality that can be easily implemented in both an individual and group setting. In addition, it is relatively inexpensive to get access to a pen, pencil, and paper to begin the work (Zadeh & Jogia, 2023). According to EMDR research, it can also be both time and cost-effective as it can be performed in 3 sessions (Wippich et al., 2023). In comparison, according to (Dorter,1998) even one session of art therapy can make a difference in temporary stress relief, allowing one to visually convey their feelings, and strengthen their

sense of identity. Because displaced people are often transferred to other centers or disappear each session has to be treated as a stand-alone (Dorter, 1998).

EMDR doesn't include additional work outside of the psychological setting which can be an advantage as all the work is done during the therapy sessions (ter Heide et al., 2014). This can also be a disadvantage cost-wise as some refugees get moved to different locations and are not able to complete the therapeutic sequence. Art therapy on the other hand is a modality that can be potentially implemented outside of the therapy session. This is advantageous as it could speed up their process and allow for more clients to receive therapy. According to Schnitzer et al. (2021), participants in one of the studies were able to take art therapy directives outside of the therapy space. Additionally, Baker et al. (2018), describe the potential of utilizing limited therapist involvement as part of art therapy protocols. This could save cost by involving the therapist intermittently throughout the healing process. According to Baker et al.,(2018), the results of their study have limited confidence therefore more studies can investigate this possibility further.

Lastly, according to Hartung, (2016) EMDR has been taught to paraprofessionals in a variety of locations that suffer from mass devastation due to war or natural disasters. Because there are not enough practitioners otherwise it increases efficiency and cost-effectiveness. I have not encountered literature that pertains to teaching professionals without licensure for art therapy in these types of settings but I imagine that it would also be optimal.

Ability to Transmute Traumatic Memory

Art therapy has the advantage of inducing a parasympathetic state and at the same time reaching into the unconscious and pulling out buried traumatic material through implicit memory and non-verbal communication. The art-making process also increases tolerance to the traumatic material and therefore allows for access to information processing. According to Schnitzer et al.

(2021), it allows for gentle work and works well for patients who have not seen benefit from traditional therapy.

Traditional EMDR targets core traumatic memories along with somatic and body memories as well as visually imprinted information. During EMDR protocols the client is focused with dual attention on these elements going through them sequentially. According to Davis et al., (2023) studies dual attention leads to a reduction in hyperarousal and leads to relaxation. It also stimulates the client's information processing system in order to help them integrate all four of these components as well as reimagine and reexamine the triggering memories transforming them into adaptive future functioning (Farrelle et.al 2020). For clients with complex traumatization or impacted by shame and guilt or fear of retribution this traditional model does not work well. EMDR Blind 2 Protocol (B2T) is a non-traditional protocol that offers a more effective way of processing traumatic memories in these cases.

Blind 2 Therapist Protocol is based on non-disclosure, and processing trauma without verbalization. In my opinion, despite its efficacy and possible benefits related to the lack of retraumatization, it appears less organic and more based on decided avoidance given that the clients don’t reveal anything about their trauma nor trauma-related cognition (Farrelle et.al 2020). On the other hand, it allows those who would not otherwise engage in therapy to engage in a process that often results in a decrease in PTSD symptoms. Additionally, Farrell et al. (2020) recognized that after the B2T protocol for some clients traditional EMDR could be used more effectively. It would be interesting to conduct a study comparing art therapy protocol to B2T as well as another study comparing a protocol that transitions from art therapy into EMDR and B2T to EMDR.

Just like B2T art therapy helps to work through shame and guilt which are often at the core of the trauma experience for immigrants and asylum seekers (Schnitzer et al., 2021). It is more apt to help an individual take their processing slower and more gradually lead them to make non-verbal verbal. Art-making is a language in its own right and can help to bring to the surface and articulate their thoughts about the traumatic events they experienced as well as to bring new meaning, insight, and healing to the traumatic memories. Additionally, with art therapy, the process of non-disclosure and transition to partial or full disclosure can happen organically. The use of diverse art materials can also help unconscious materials to spontaneously emerge as a visual language and facilitate healing (Farrell et al., 2020).

Dual attention is something that both art therapy and EMDR utilize to transmute traumatic memories. In EMDR it is through the use of mental imagery and bilateral stimulation while in art therapy it is through the kinesthetic movement and concrete imagery. Dual attention combines mindful attention on the present while processing the traumatic memory from the past. It does that by taxing working memory and creating space for overwhelm and emotional responses as it provides some emotional distance from a traumatic event. Patterned activities such as drawing and painting as well as dual stimulation in EMDR short-circuit traumatic memory through the nature of repetitive movement allowing for the expansion of attention and healing (Davis et al., 2023). This also invites cross-pollination of both modalities as adding creative expression to EMDR can concretize the image and give it the possibility of being reworked in order to reach resilience and bring healing.

Summary and Implications

Both art therapy and EMDR treatments for PTSD are supported by clinician's experience and small studies. They both need more rigorous studies in order to conclusively showcase their

efficacy. Art therapy however has an additional hurdle of having difficulties securing funding because it doesn't fall into the medical, applied arts, or humanities categories when proposals for grant studies are submitted and because experts on these committees do not have the necessary expertise for proper proposal evaluation (Baker et al., 2006). Also, art therapy does not yet have systematized and robust protocols in place to show statistically significant results. This is an area where there is a lot of room for growth in art therapy as a field (Baker et al., 2006).

The traditional EMDR model is very rigid and oftentimes does not work for highly traumatized populations of displaced people (Ferelle et.al., 2020). However, non-traditional EMDR and art therapy protocols have a lot in common as they incorporate other approaches and can vary the protocol steps and timelines therefore accommodating diverse populations of clients with wide-ranging degrees of traumatization. Art therapy shows precedent for treating more difficult clients because it can allow for non-verbal processing that can eventually lead to verbalization. EMDR Blind 2 Therapist protocol also offers a form of non-verbal processing that could be coupled with traditional EMDR at a later stage. Art therapy has the advantage of offering the process of art making as an expressive language which is very versatile both in terms of approaches, content, and materials making it more adaptable for processing complex trauma. I would recommend designing a protocol for a comparative study of art therapy and EMDR Blind 2 protocol in terms of efficacy and cost-effectiveness as related to refugee / asylum-seeking populations. It would also be interesting to study whether these two orthogonal healing modalities can be integrated to create a more powerful healing approach, especially for patients with complex trauma and PTSD.

Art therapy and EMDR both offer cultural considerations in order to make their protocols more efficient and culturally sensitive. However, in my opinion, art therapy has the

advantage of using material consideration as part of its cultural accommodations. EMDR on the other hand is less familiar as a modality and therefore requires more time to educate the patient. However, at times stigma and negative association with childhood artmaking can create a barrier to utilizing art therapy which can be a negative aspect in terms of acceptance of the approach. Both art therapy and EMDR can utilize cultural norms as part of their protocols. In my experience of different studies, I have seen a stronger presentation of this in EMDR protocols than in art therapy-related protocols. My guess is that because at times art therapists place more emphasis on material consideration, while they are less sensitive to cultural norms. I believe taking into account both material and cultural considerations makes the best healing environment for the refugees.

Art therapy is cost-effective as most art therapists have more generalist training and having access to paper and simple art materials is fairly inexpensive. Art therapy can also be used by clients outside of the therapy sessions in order to continue recovery beyond the therapy room whereas traditional EMDR can only be performed by a specialist and cannot be implemented beyond the treatment protocols. Art therapy lends itself more easily to group therapy. The shortest art therapy treatment protocol can also be as short as one session where EMDR has to use at least three.

Lastly, art therapy dives deep into the unconscious and is able to bring to the surface material that is long forgotten. It can utilize different media to address different types of traumatization and apply sensorial and kinesthetic processing. Art therapy is described as a gentle method that can start non-verbally and lead to verbalization. On the other hand, EMDR utilizes 4 categories somatization, visualization verbalization, and body sensations. All four are processed while using bilateral stimulations. For some individuals, impacted by shame or guilt

verbal processing can be retraumatizing, in that case, non-verbal protocols are optimal. Art therapy provides visual language to aid more gradual and gentle processing that works well for these populations. Both art therapy and EMDR use dual attention to break trauma-induced patterns by increasing mindfulness and body awareness. More studies should be conducted comparing the two approaches in regards to how their efficacy compares to each other with similarly designed protocols and with different combinations of the two modalities.

Limitations

Limitations of the study include utilizing only two databases, and only selecting peer-reviewed articles and books that are in English. This could exclude some important publications in other languages. Also, as an author, I may have a bias towards art therapy as I have studied and practiced art therapy and have no direct experience with EMDR.

Conclusion

In this study, I asked the question: how do art therapy and EMDR help asylum seekers and refugees? Both art therapy and EMDR have a variety of protocols that address different populations and various symptoms and presentations of PTSD. Art therapy carries more variables as it incorporates different approaches, materials, and cultural references in its practice. Both modalities utilize cultural consideration although art therapy has the extra advantage of utilizing culturally relevant art processes and materials as part of that consideration. Both EMDR and art therapy present cost-effectiveness through a reduced amount of sessions and group therapy. Both modalities utilize dual stimulation as part of breaking free by short-circuiting traumatic memory. There are also several avenues in which the two modalities can be integrated that increase their potency and efficiency. One such example is when the traumatic images imagined are brought into concrete processing through art therapy and another by beginning

treatment with art therapy to transition into EMDR. My hope is that more robust studies are conducted with both modalities and that clinicians cater their treatments to the needs of their population as different groups and individuals respond better to different modalities. I believe that both art therapy and EMDR show great potential for helping this mental crisis. One of my findings is that more robust studies need to be conducted that specifically target these populations. Art therapy as a field has to continue to build a culture that cultivates a more robust approach to conducting studies, it needs to be integrated by more rigorous learning at the university level and beyond. The professionals in the field also need to advocate for ways of securing experts on grant committees that can successfully review applications.

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THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor:_____ Raquel C. Stephenson_____ **_____**