Randomized Controlled Trial: Self-Care Traumatic Episode Protocol, Computerized EMDR Treatment of COVID-19-Related Stress

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Healthcare workers and mental health clinicians are at heightened risk for mental health issues while they support their communities during the COVID-19 pandemic, and early psychological intervention is crucial to protect them. The Self-Care Traumatic Episode Protocol (STEP) is a computerized intervention adapted from the Eye Movement Desensitization and Reprocessing Group Traumatic Episode Protocol (EMDR G-TEP). This study evaluated the effectiveness of STEP for mental health clinicians in the context of COVID-19. Thirty-four mental health clinicians were randomly allocated to treatment ($n = 17$) or waitlist ($n = 17$). The Generalized Self-Efficacy Scale (GSE) and Depression and Anxiety Stress Scale (DASS-21) were completed by the treatment group at baseline and 1-week follow-up postintervention and by the waitlist group at baseline, preintervention, and 1-week follow-up postintervention. Pre–post comparisons showed a significant decrease in depression, anxiety, and stress for Immediate Treatment, $t(15) = -3.64$, $p < .01$, $d = .73$, and for Delayed Treatment, $t(15) = -3.53$, $p < .01$, $d = .68$, There was also a significant increase in general self-efficacy for Immediate Treatment, $t(15) = 2.87$, $p < .05$, $d = .46$, and Delayed Treatment, $t(15) = 3.72$, $p < .01$, $d = .56$. The randomized controlled trial (RCT) indicated that STEP may be effective in increasing general self-efficacy and reducing symptoms of depression, anxiety, and stress among mental health clinicians in the context of COVID-19. Further research investigating the potential of utilizing the STEP intervention on a larger scale and with other populations is needed.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; COVID-19; depression; stress; self-efficacy; Self-Care Traumatic Episode Protocol (STEP)

Individuals across the globe are currently coping with the COVID-19 pandemic, a life-threatening and life-altering event that has the potential to lead to psychological issues that outlast the event. Individuals may be experiencing increased feelings of loneliness and isolation, fear and anxiety, depression, or symptoms of posttraumatic stress (Fiorillo & Gorwood, 2020). The prevalence of these symptoms is exacerbated by quarantine, self-isolation protocols, stigmatization, and rapidly changing information (Shigemura et al., 2020). Some individuals may resolve these symptoms without assistance, but others require intervention. Treatment access has been limited by the inability to meet in-person, and many interventions are now delivered virtually.

Self-efficacy related to coping could serve as a protective factor for mental health and healthcare workers (Vagni et al., 2020). Those with lower levels of self-efficacy related to beliefs that they cannot cope with COVID-19 may be at higher risk for symptoms of depression and anxiety (Xiong et al., 2020). Therefore, effective self-care interventions that reduce distress and negative beliefs related to COVID-19 may increase self-efficacy and serve as a protective factor for mental health.

This article describes research investigating the effectiveness of a low-intensity psychosocial intervention for COVID-19 related symptoms of depression, anxiety, and stress. The study's computerized protocol used a modified version of eye movement desensitization and reprocessing (EMDR) therapy (F. Shapiro, 1995). This modified version was originally designed as a manualized group treatment for early intervention (E. Shapiro, 2014), which was adapted into a video format.

The Mental Health Impact of Disasters in Frontline Healthcare Workers

In the aftermath of the events of September 11, 2001, many American mental health workers reported pushing themselves beyond their professional and working with more severely distressed clients than suitable for maintaining their own mental health (Seeley, 2003). Previous epidemics, including the 2003 severe acute respiratory system (SARS) outbreak, demonstrated a large toll on healthcare workers' mental health as they reported significant levels of psychological distress, anxiety, stress, and fear (Wu et al., 2020). The SARS epidemic was considered a traumatic event by almost all healthcare staff surveyed (Lin et al., 2007).

During the current crisis, healthcare workers are at a greater risk of contracting COVID-19 than the general population because many lack adequate protective equipment while in close contact with patients with COVID-19 (Torales et al., 2020). This is causing considerably more distress, anxiety, depression, and symptoms of posttraumatic stress disorder (PTSD) in those caring for patients with COVID-19 than those caring for other members of the population (Cai et al., 2020; Lai et al., 2020; Wu et al., 2020). As a result, those working in emergency units, intensive care units, and infectious disease wards, which have higher rates of patients with COVID-19, are at a higher risk of poor mental health (Naushad et al., 2019). When healthcare workers are quarantined due to possible or confirmed infection, they experience higher rates of substance use or dependency, avoidance behaviors, and posttraumatic stress than healthcare workers who are not required to quarantine (Brooks et al., 2020). Longer durations of quarantine are linked to poorer mental health outcomes (Brooks et al., 2020). However, it is important to note that all healthcare workers, regardless of the patients they are working with, are currently experiencing heightened depression, anxiety, distress, and insomnia (Lai et al., 2020).

It is crucial to acknowledge the mental health impacts on healthcare workers and to design interventions to reduce these effects. Further, treatment should address barriers to accessing the services, such as the inability to meet in person, to ensure those who require assistance can receive it. Early intervention may help prevent burnout, mental exhaustion, and increasing mental health problems (Fiorillo & Gorwood, 2020). At the time of this study, we found no research that specifically investigated the mental health outcomes for mental health practitioners in the context of the COVID-19 pandemic.

Low-Intensity Psychosocial Interventions

In their guidelines for the treatment of depression, the United Kingdom's National Institute for Health and Care Excellence (NICE, 2009) recommend a stepped approach. For the mild and moderate symptoms of depression, such as those addressed in the current study, they recommend "low-intensity psychosocial interventions: individual guided self-help based on the principles of cognitive behavioral therapy (CBT), computerized cognitive behavioral therapy (CCBT), and a structured group physical activity program" (p. 9).

Stress and nonclinical anxiety are also typically treated with low-intensity psychosocial interventions. Commonly used interventions are guided CBT strategies, physical exercise, and mindfulness. Guided CBT strategies are self-administered and short-term treatments in which the client has some limited contact with a therapist or trained paraprofessional (NICE, 2020). Treatment often uses self-help material, including books and evidence-based manuals.

Research has shown that guided CBT strategies with frequent, but short, duration support from (para) professionals significantly decreases depressive symptoms compared to waitlist (Karyotaki et al., 2017; NICE, 2020). Other effective low-intensity interventions for depression include structured physical activity programs which significantly decrease symptoms of depression, with results comparable to those found in antidepressant treatments (Dinas et al., 2011), and mindfulness-based interventions which have been shown to significantly reduce symptoms of depression compared to waitlist (Blanck et al., 2018; NICE, 2020).

Computerized Cognitive Behavioral Therapy

In their Updated Depression guideline, NICE (2020, p. 170) recommends CCBT as a primary treatment intervention. It defines CCBT as a structured CBT program, delivered via CD-ROM, DVD or the internet, with content similar or identical to that used

in face-to-face standard CBT treatment. "Direct staff input is usually limited to introducing the programme, brief monitoring and being available for consultation" (p. 170). As of 2015, there were around 100 CCBT programs available (Cai et al., 2020). Examples of CCBT include the recent COVID Coach, developed by the U.S. Department of Veterans Affairs (2020), which is a free mental health app for smartphones. It provides self-help tools including psychoeducation and coping skills, with the goal of helping people manage stress and depression (U.S. Department of Veterans Affairs, 2020). Another example is MoodGym, an Internet-based CCBT program developed by the National Institute for Mental Health Research at The Australian National University, with the goal of helping people manage symptoms of depression and anxiety (MoodGym, n.d.). MoodGym is formatted as an online, interactive self-help book with five modules, a workbook, and anxiety and depression assessments (MoodGym, n.d.).

CCBT has been found in numerous studies to be effective in reducing symptoms of major depression, social phobia, panic disorder, generalized anxiety disorder, and stress (Andrews et al., 2010; Davies et al., 2014; Luo et al., 2020). A meta-analysis of 22 studies indicated CCBT demonstrated short- and long-term benefits coupled with high patient adherence and satisfaction (Andrews et al., 2010). Another meta-analysis conducted by Luo et al. (2020) concluded CCBT interventions were as effective as in-person, face-to-face CBT treatment in reducing symptom severity. However, due to the high variability among all available CCBT programs, each intervention program should be thoroughly evaluated prior to implementation.

Potentially related to this heterogeneity in content, quality, and duration, there are conflicting findings regarding client adherence and dropout with CCBT programs, with some studies suggesting there are high dropout rates within some CCBT programs (Twomey et al., 2017). Further, evidence for effectiveness is stronger in experimental conditions than clinical settings (Andersson et al., 2009). With Internet-delivered programs, clients should be carefully screened to reduce the likelihood of individuals completing programs that are not designed for the type or severity of mental health issues they are aiming to address (Cuijpers & Andersson, 2009).

Eye Movement Desensitization and Reprocessing

EMDR therapy is a trauma-focused intervention in which clients focus on a traumatic or disturbing event, while engaging in eye movements orbilateral stimulation (BLS) guided by a therapist (Shapiro, 2018). EMDR is an evidence-based, World Health Organization- (2013) and American Psychiatric Association-endorsed (2004) trauma intervention (International Society for Traumatic Stress Studies [ISTSS], 2018). Meta-analyses have shown its efficacy in the treatment of depression (Sepehry et al., 2021), anxiety (Yunitri et al., 2020), and PTSD in adults (Mavranezouli et al., 2020), and in children and adolescents (Moreno-Alcàzar et al., 2017).

EMDR therapy is guided by F. Shapiro's (1995) adaptive information processing (AIP) model. This model views most symptoms as arising from unprocessed distressing experiences and hypothesizes that full processing of the traumatic memory will result in symptom resolution.

EMDR Early Intervention

An "early intervention" is treatment that is provided within 3 months of a traumatic incident (ISTSS, 2019). Eight EMDR early intervention protocols have been evaluated in 23 studies, including eight randomized controlled trials (RCT; Matthijssen et al., 2020). The promising results, with significant decreases in PTSD symptoms, provide preliminary evidence for EMDR therapy's efficacy as an early intervention.

The protocol used in this study is a variation of one of these early intervention protocols, the Group Traumatic Episode Protocol (G-TEP). The G-TEP was developed for early intervention with groups of individuals who have experienced a traumatic event (E. Shapiro, 2018). It is a highly manualized treatment. The protocol allows clients to work individually and quietly on their personal material, in a group setting, but with very limited interaction with the therapist and other group members.

Research has shown that G-TEP significantly reduced symptoms of posttraumatic stress, anxiety, and depression in those experiencing prolonged distressing events, including patients receiving cancer treatment (Roberts, 2018), workers exposed to child abuse and neglect (Tsouvelas et al., 2019), and refugees with traumatic memories of war (Lehnug et al., 2017; Yurtsever et al., 2018). The EMDR G-TEP intervention was also associated with a reduction in the risk of psychological trauma for Ukrainian mental health workers who were supporting individuals on the frontlines of a war zone (Snisar et al., 2019).

EMDR Interventions for COVID-19

The social distancing requirements and frequent lockdowns associated with COVID-19 have presented

many challenges for psychotherapists, who have had to change treatment delivery from in-person to virtual settings. Guidelines were developed by the EMDR International Association (Rollins et al., 2020), and articles have been written proposing ways to provide standard EMDR procedures while accommodating these changes (e.g., Fisher, 2021; Laliotis, 2020; Solomon, 2020). Some new EMDR protocols, including stabilization techniques, early intervention, and self-care, were developed for COVID-19 related distress (Luber, 2020). These new protocols require research to determine if they are effective, safe, and useful.

STEP Intervention

The Self-Care Traumatic Episode Protocol (STEP; Moench, 2020a, 2020b) is a computerized intervention adapted from the EMDR group treatment, G-TEP. STEP was developed by the first author, a registered psychologist. She also created the videos that are used in the STEP procedure with consultation from Elan Shapiro, the developer of G-TEP (E. Shapiro, 2015).

STEP (Moench, 2020a, 2020b) is a computerized, clinician-assisted, 90-minute intervention. It is based on the principles of the AIP model (F. Shapiro, 1995) and assumes that effective processing of the distressing memories using EMDR treatment will result in symptom resolution. STEP was developed to be used remotely with mental health clinicians and medical staff to help reduce stress, anxiety, and improve self-efficacy. Combining psychoeducation, stabilization activities, processing, and containment strategies, its goal is to enable clients to remain present while they process a distressing episode, preventing the accumulation of overwhelming memories, so that clients can continue working effectively in their important roles.

STEP is a modification of G-TEP. During both procedures, clients are asked to focus on a memory that caused current disturbance. STEP differs from G-TEP in that STEP is used individually and G-TEP is usually done in a group setting, and group members have time to get to know one another and to share their strengths and learning from the procedure with other members of the group (E. Shapiro & Moench, 2015). G-TEP is a clinician-administered group protocol where the clinician is present while the group members participate in the protocol. STEP is a computerized protocol in which treatment is provided with therapist monitoring during individual assessment, after the "4 Elements" activity, and following protocol completion. To ensure that STEP clients come to a place of calm at the end of the program, there are additional containment strategies within STEP to help clients set aside any remaining distress. There are also additional safety mechanisms within the STEP procedures to ensure the client's suitability to participate in a computerized protocol. See Figure 1 for a full description of the protocol.

The STEP Protocol

STEP includes a telephone and assessment screening, followed by a 90-minute computerized procedure in which the videotaped therapist presents material and guides the client through the protocol. See Figure 1.

Telephone Clinical Screening and Preparation

Potential clients are screened for suitability in a telephone interview. Clients complete a test battery to ensure their suitability and email the completed measures to the therapist. Once the client is determined to be appropriate for treatment, they are provided with access to the STEP computerized program. When the client receives access to the protocol, they complete another set of questions to again screen out any people with severe mental health issues.

First Video: STEP Self-Care Introduction

This video briefly describes the process of the intervention and provides some information on early intervention and EMDR.

Second Video: 4 Elements

This video instructs clients in the use of the 4 Elements exercise (Shapiro, 2007), which teaches grounding, breathing, increased salivation, and the creation of a calm place. Before and after the exercise, clients rate their distress using the Subjective Units of Disturbance (SUD) scale (0 = *no disturbance* 10 = *worst possible*).

Online Screening

Clients who are able to decrease their SUD level (to 7 or below) following the 4 Elements activity are given access to the next video. Clients whose SUDs level does not decrease are referred for treatment by a licensed mental health practitioner.
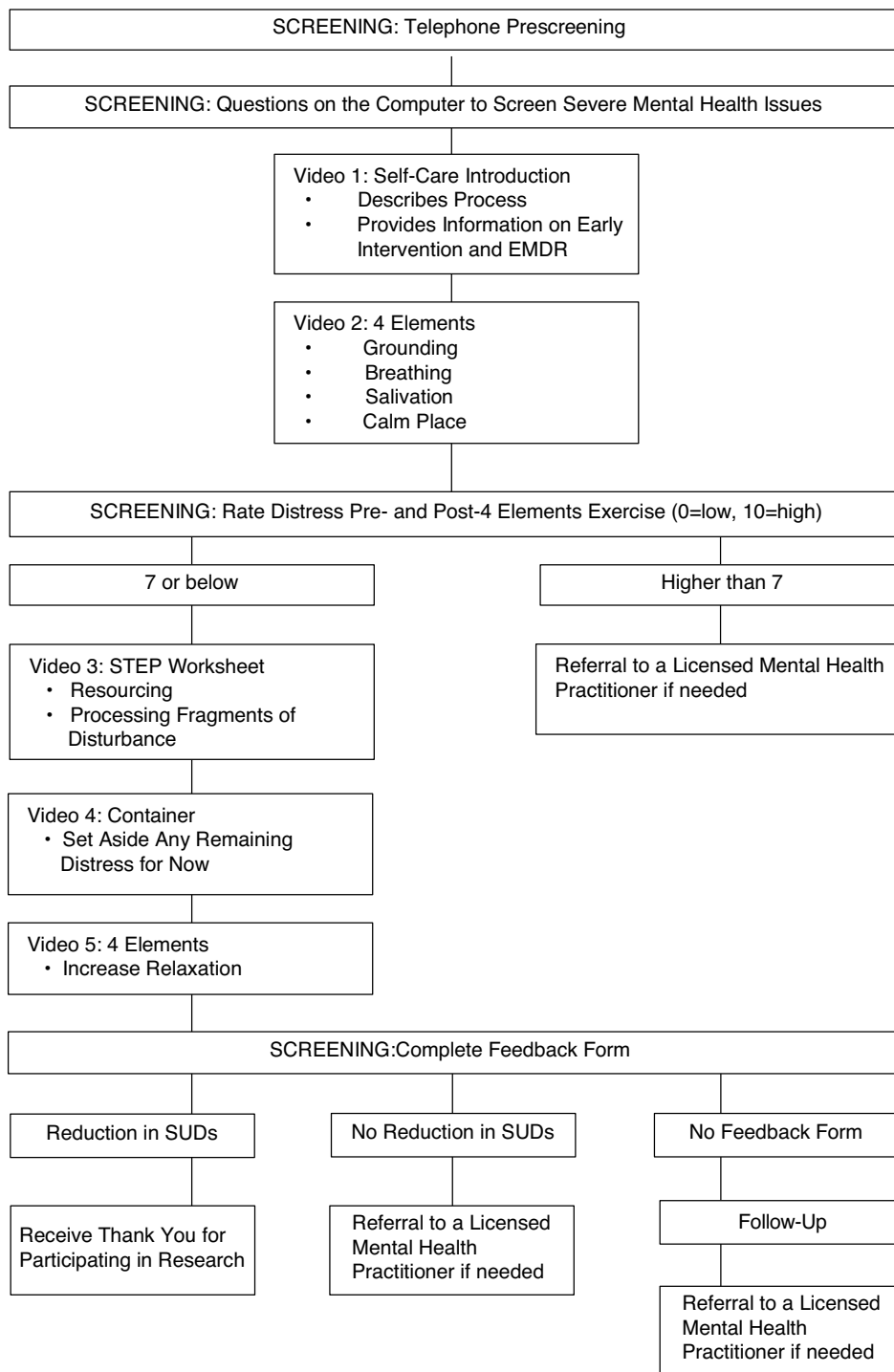
Figure 1. Protocol template.

Third Video: STEP Worksheet

This video guides the client through the STEP processing, using a worksheet modified from the G-TEP. Clients are guided through resourcing exercises with a reminder of a positive time in their past, positive thoughts they would like to believe about themselves now, and finally, guided through distancing the fragments of the disturbance. Clients identify three memory fragments, called Points of Disturbance (PoDs), that are related to the targeted memory. They rate the SUD for each PoD. The video guides them to focus on each PoD while tapping from one side of the worksheet to the other while following their hand with their eyes and listening to bilateral beats. They

provide the SUD score for each PoD three times while processing and again when processing is completed. They provide a SUD score for the entire episode. Then, clients find a suitable positive cognition that fits the memory of the event after processing.

Fourth Video: Closure

The next video, the container exercise, assists the client in allowing things to be set aside in order to move forward with the necessities of life and work.

Fifth Video: Relaxation

The final video is the 4 Elements exercise, which assists clients in calming their mind and body to relax before they leave the program.

Clinical Screening

After completion of the computerized STEP procedure, clients email their feedback form outlining their SUD levels throughout the protocol along with any feedback. If the participant does not send in the participant feedback form, the therapist checks in with the participant to see if any follow-up is needed.

Method

The current study was designed to identify the effectiveness of the STEP protocol as a brief self-care resource for mental health clinicians within the context of COVID-19. More specifically, we aimed to determine to what extent STEP assists mental health clinicians to increase their self-efficacy, and to decrease stress, anxiety, and depression.

Participants

Potential participants were recruited through a mass mail-out on an email list for local EMDR clinicians in June 2020. Forty respondents responded positively. Prior to assessment, six potential participants disengaged. Of the 34 participants who began the study, one in each of the Immediate and Delayed Treatment conditions did not complete the posttreatment measures. See Figure 2.

Thirty-four participants were interviewed in the telephone screening by a Master of Counselling graduate student in her last year of the program, supervised by the first author. Participants were considered

suitable for study inclusion if they met the following criteria: they were willing to participate voluntarily in treatment; they provided written consent; and were licensed mental health clinicians who had taken basic EMDR training. Participants were excluded if they disclosed severe levels of clinical distress, if they were concurrently receiving psychological treatment during the study period, or if they endorsed suicidal intent.

No participants were excluded during the screening. The 34 participants included master's level clinical social workers ($n = 8$), Canadian Certified Counsellors ($n = 4$), master's or PhD-level registered psychologists ($n = 21$), and psychiatrists ($n = 1$).

Design and Procedures

The study was a controlled randomized trial, with a pre–post between subjects' comparison of immediate treatment and waitlist conditions. There was also a pre–post within subjects' comparison of treatment effects for each of the Immediate and Delayed Treatment groups.

Therapists were blind to the randomized allocation of groups during the initial screening telephone call. Following the screening, participants were allocated to Immediate Treatment or Waitlist/Delayed Treatment using a randomization sequence based on a random number table. Participants were randomized by a research assistant.

Participants received emails outlining dates to access the STEP intervention and to complete the assessment measures. If their scores on the assessment measures indicated they were experiencing clinical distress, the participants would be contacted and referred to other services. Both conditions completed assessment measures at time 1. The Immediate group then received treatment. Then both groups completed assessment measures at time 2. Then the Delayed Treatment group received treatment, after which they completed assessment measures at time 3.

Participants in both Immediate and Delayed Treatment conditions accessed the 90-minute computerized STEP online. After each participant completed the intervention, they completed the feedback forms and emailed these, which included their SUD scores, to the first author. The SUD scores were checked to see if scores had reduced. If not, participants would be encouraged to attend therapy with an EMDR therapist to complete the processing of the distressing memories which the participant was working on during STEP. (Note that all participants' SUD scores decreased and none required further treatment after
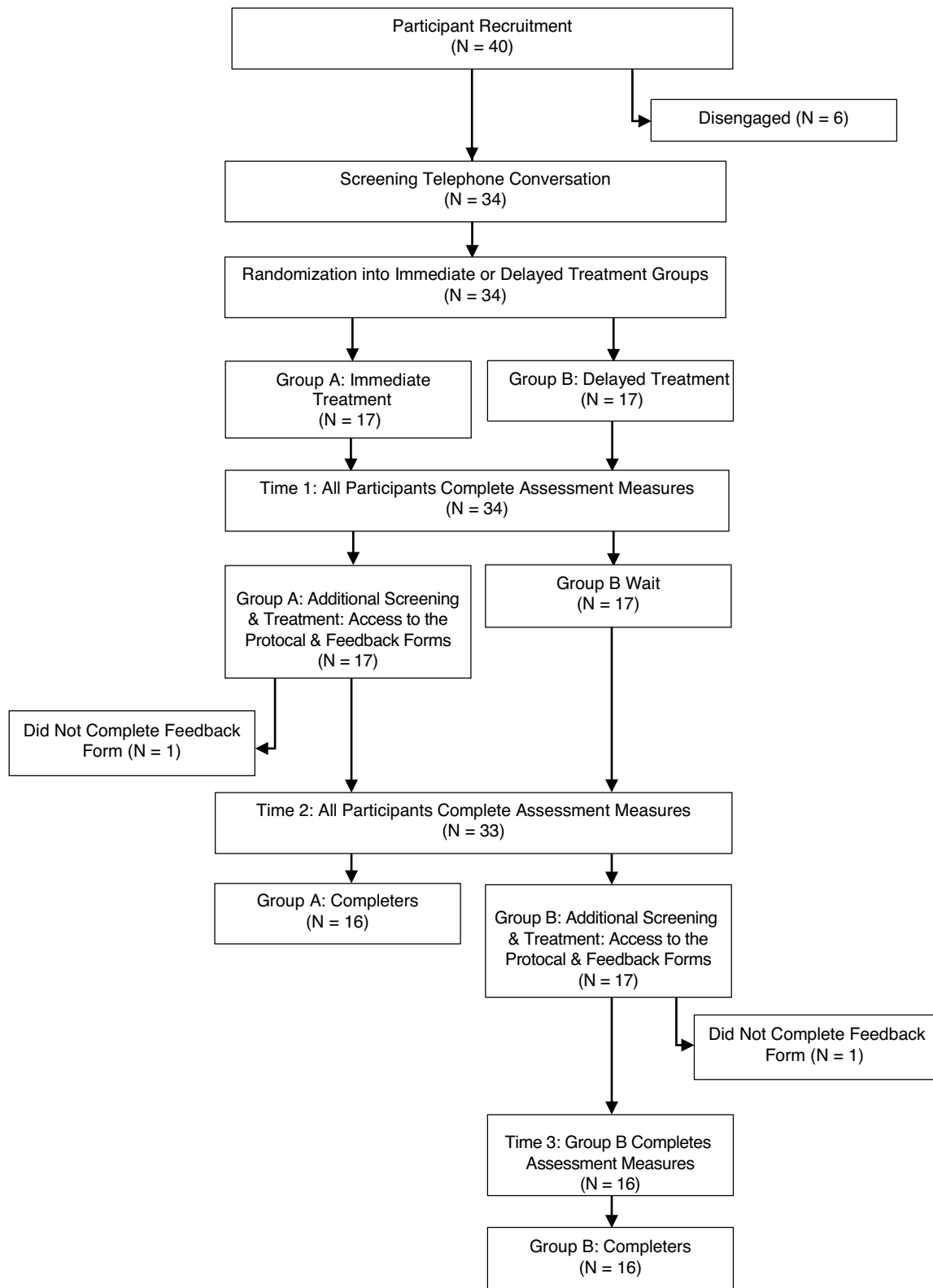
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                   │ Delayed Treatment Groups (N = 34)     │
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              │ Treatment (N = 17) │   │ Treatment (N = 17) │
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                   │ Time 1: All Participants Complete      │
                   │ Assessment Measures (N = 34)           │
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Figure 2. Study design.

completing STEP.) One week following intervention, participants completed the postmeasures and emailed them to the first author.

Treatment

Therapists had direct personal contact with each participant during the initial telephone screening and preparation. Subsequent contact consisted of emails containing measures to complete, thanking participants for completion, informing them of the dates they would gain access to the protocol, outlining the amount of time remaining to complete the protocol or measures, and sending feedback forms following completion of the protocol. Additional contact was planned for the situation in which a participant was unable to lower SUD scores, with the purpose of providing the participant with a referral to other clinicians for more intensive treatment. (This was not needed during the study, as all participants reported lower SUD scores.)

Therapists were the first author and a Master of Counselling graduate student in her last year of the program.

Treatment followed the STEP procedure (see Figure 1). The intervention required participating in a 1.5-hour, video- and worksheet-guided STEP intervention protocol, to be completed in its entirety in one sitting. Within the intervention, participants watched a series of videos, using the protocol to assist in processing any points of disturbance that would come up in relation to the current situation that they have found distressing or what may happen in the future in relation to the COVID-19 pandemic. Participants were asked to target the COVID-19 episode from the onset of COVID-19 until now or even into the future.

Assessment

Assessment measures were delivered via email pre- and postintervention. Participants completed the Generalized Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995) and the Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995). Participants randomly assigned to the Immediate Treatment group were required to complete these assessments two times, once at baseline (time 1 after completing consent) and 1 week following the STEP intervention (time 2). The Waitlist/Delayed Treatment group completed the assessments three times, once at baseline (time 1), a second time 1 week after the intervention group completed their STEP intervention (time 2), and again 1 week following their intervention (time 3).

The GSE is a 10-item assessment of perceived self-efficacy, which relates to goal setting, positive views of an individual's own capabilities, and the ability to cope and recover from adverse events (Schwarzer & Jerusalem, 1995). It has been validated cross-culturally within Germany, Poland, and South Korea to be a reliable and valid measure (Luszczynska et al. 2005). Reported internal reliability has been reported to be between 0.84 and 0.90 for a sample of Serbian undergraduate students (Lazić et al., 2018). Results of this study also supported the GSE's convergent validity (Lazić et al., 2018). The GSE demonstrates acceptable internal consistency levels, item discrimination, and precisely measures levels of general self-efficacy (Scherbaum et al., 2006).

The DASS-21 is a widely used 21-item assessment for depression, anxiety, and stress (Lovibond & Lovibond, 1995). The DASS-21 measures a wide variety of symptoms for each category. This includes dysphoria and devaluation of life for depression, situational anxiety and autonomic arousal for anxiety, and difficulty relaxing and irritability for stress (Lovibond & Lovibond, 1995). Lee (2019) verified the convergent, discriminant, and nomological validity of the DASS-21 cross-culturally within the United States and South Korea. In a nonclinical sample of adults from the United States the internal consistency reliability of the depression, anxiety, and stress subscales was 0.91, 0.80, and 0.84, respectively (Sinclair et al., 2012). The mean score for DASS-21 in a nonclinical sample was 17.8 (standard deviation [SD] = 20.18) (Sinclair et al., 2012).

Participants also completed a feedback form with SUD scores and the following yes-or-no questions: "Overall, did you find the STEP program helpful?"; "Did you find the 4 Elements video lowered your stress rating?"; "Did you find the STEP self-care videos lowered your SUDS rating (level of distress around what you processed)?"; "Would you recommend the STEP program to a colleague?"; and "Do you think this would be a safe and helpful protocol for others to use on a larger scale (e.g. medical staff, first responders, teachers, etc.)?"

Data Analysis

The data were analyzed using SPSS version 26. Descriptive statistics were run on each dependent variable scale (DASS-21 and GSE). For the between-groups design (Immediate Treatment vs. Waitlist), the statistical significance of comparison between multivariate means was defined by Hotelling's T-squared test, a multivariate version of the t-test. Hotelling's

T-squared was used instead of multiple *t*-tests because it takes into account dependent variable correlations, which in this case was moderate between the DASS-21 scores and the GSE scores ($r = -.54$). Furthermore, Hotelling's T-squared provides some control over the alpha level and Type I error rate, as well as providing a global measure of the effects on the dependent variables. Discriminant function analysis was then used to determine which of the dependent variables contributed to the group separation that was found from the Hotelling's T-squared test.

For the repeated measures designs, paired *t*-tests were done to determine whether the mean differences between the two sets of data stemming from the pre- and postintervention questionnaires (DASS-21, GSE) were statistically significant. These univariate tests were used because of the low correlations between the pre- and postintervention score means ($r = .13$ and $r = .25$). Cohen's *d* was used to calculate the effect size (where $d = 0.2$ is considered small, $d = 0.5$ is considered medium, and $d = 0.8$ is considered large).

Results

From the overall sample with 34 participants, 33 participants were included for the multivariate analysis ($n = 16$ for treatment group; $n = 17$ for waitlist group). One participant from the treatment group was dropped from the analysis because the participant did not answer the DASS-21 and GSE questionnaires. The results of the multivariate Hotelling's T-squared test revealed significant differences between the treatment group and the waitlist group on the composite dependent variable, $F(2, 30) = 5.22$, $p < .05$, Wilks' Lambda = .742. Partial eta-squared values reveal that the effect of the intervention explained 25.8% of the variance in outcomes. Significant Hotelling's T-squared was followed by discriminant function analysis. The discriminant analysis yielded one discriminant function (Wilks' Lambda = .742; $p < .05$). The structure matrix indicates that the scores of both scales GSE ($r = .93$) and DASS-21 ($r = -.74$) contributed strongly to the differentiation between the two groups. The intervention appeared to lead to an increase in general self-efficacy and a decrease in depression, anxiety, and stress, and general self-efficacy appeared to have contributed more to the group differences (reflected by the significant omnibus *F* test) than the DASS-21 (see Table 1).

Pre–Post Within Subjects Comparison

From the overall sample with 34 participants, 32 participants were included for the paired *t*-test analysis. One participant in the Immediate Treatment condition was dropped from the analysis because the participant did not answer the post DASS-21 and the post GSE questionnaires. Also, a participant from the Delayed Treatment condition was dropped because they did not answer the post DASS-21 and the post GSE questionnaires. One analysis was done for the Immediate Treatment condition ($n = 16$), and a separate analysis for the Delayed Treatment condition ($n = 16$). The results show that after the Immediate Treatment intervention, the decrease in depression, anxiety, and stress was significant, $t(15) = -3.64$, $p < .01$, with a medium Cohen's effect size of $d = .73$. Similarly, the increase in general self-efficacy was significant $t(15) = 2.87$, $p < .05$, with the computation of medium Cohen's effect size of $d = .46$. The results were replicated in the Delayed Treatment condition. There was a significant decrease in depression, anxiety, and stress, $t(15) = -3.53$, $p < .01$, $d = .68$, and a significant increase in general self-efficacy, $t(15) = 3.72$, $p < .01$, $d = .56$.

Feedback Form

32 of the 34 participants answered the questions on the feedback form (see table 2).

TABLE 1. Means (and *SD*) for Pre–Post Scores on the DASS-21 and GSE

	DASS-21			GSE		
	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Immediate	12.50 (8.42)	7.38 (5.35)		33.31 (3.86)	35.06 (3.70)	
Waitlist	14.59 (11.20)	15.06 (7.18)		31.53 (3.76)	30.94 (2.89)	
Delayed		15.06 (7.18)	8.06 (12.72)		30.94 (2.89)	32.69 (3.36)

Note. DASS = Depression and Anxiety Stress Scale; GSE = Generalized Self-Efficacy Scale; *SD* = standard deviation.

TABLE 2.   Responses on Feedback Form

	Yes	No	No Response
Was the program helpful?	32	0	2
Did the STEP videos lower your SUD rating?	30	0	4
Would you recommend STEP to a colleague?	32	0	2
Is STEP a safe helpful protocol, suitable for use on a larger scale?	31	0	3

Note. STEP = Self-Care Traumatic Episode Protocol; SUD = Subjective Units of Disturbance.

Discussion

The results demonstrated statistically significant decreases in depression, anxiety, and stress as measured by the DASS-21, paired with statistically significant increases in general self-efficacy, as measured by the GSE. First, results suggested that the STEP program was significantly better than waitlist. Second, the Delayed Treatment group results replicated the Immediate group results. And third, while the participants' scores decreased in depression, anxiety, and stress, their scores increased in self-efficacy.

When giving feedback on the STEP intervention, 94% of participants found the program helpful, 86% found the STEP videos lowered their SUD rating, and 94% would recommend the STEP program to a colleague. About 91% of participants thought STEP would be a safe and helpful protocol for others to use on a larger scale. None said it was unhelpful, unsafe, or would not recommend it. Some did not answer the yes/no questions evaluating the protocol. As such, the STEP intervention appeared to be useful for the participants. The promising results have led us to begin developing versions of STEP for use with groups and others in frontline positions, including the police and teachers.

Treatment Conceptualization: EMDR Therapy and the AIP Model

EMDR therapy is based on the AIP model, which states the mind is naturally predisposed toward health and healing (F. Shapiro, 2018). Pathology is viewed as the result of inadequately processed memories or blocks in the information processing system. When information is adequately processed, connected with appropriate associations, and integrated into a positive schema, then the pathology is resolved. EMDR therapy activates the distressing memory in conjunction with BLS to move the information toward adaptive resolution. BLS is thought to aid processing by taxing working memory and stimulating the orienting reflex and activating a parasympathetic response

(F. Shapiro, 2018). In this study, participants utilized the STEP intervention and BLS to process a disturbing memory related to COVID-19, and the associated PoDs.

Low-Intensity Interventions

The United Kingdom's NICE (2009) recommends low-intensity psychosocial interventions such as individual guided self-help interventions based on the principles of CBT. Guided Internet-delivered interventions are typically self-administered, short-term, and have limited contact with mental health professionals (NICE, 2020). STEP is a self-administered, short-term, limited contact intervention. It is highly manualized and based on G-TEP (E. Shapiro, 2014), an existing evidence-based intervention. Guided Internet-delivered interventions have been found to significantly decrease depressive symptoms compared to waitlist (Karyotaki et al., 2017). EMDR therapy effectively reduces depressive symptoms as a standalone treatment or addition to CBT (Matthijssen et al., 2020; Sepehry et al., 2021).

EMDR Early Intervention

Early interventions are provided within 3 months of a distressing event (ISTSS, 2019). However, previous research has shown that the vast majority of individuals impacted by a disaster do not receive the assistance they require at the time, and many only seek help years later (Shultz et al., 2017). As the delay between the distressing event and treatment lengthens, severity increases (Newman et al., 2014). Particularly, early intervention with frontine healthcare workers is crucial to help prevent burnout, mental exhaustion, and increased mental health issues (Fiorillo & Gorwood, 2020). Some individuals will resolve their trauma symptoms without assistance, but others will require intervention.

Memories of recent trauma are often more fragmented and disorganized than the consolidated memories of historical trauma. However, by quickly

targeting distressing memories, reducing symptoms, and beginning processing, EMDR early interventions may reduce their cumulative effect (E. Shapiro, 2012).

The STEP intervention is a variation of the G-TEP, an evidence-based EMDR early intervention. Many EMDR early interventions are of brief duration and target the recent distressing event only. The ISTSS (2019) notes that single-session EMDR interventions have emerging evidence for their efficacy. In this study, the STEP intervention was used as a single-session intervention. When utilizing EMDR early interventions, it is crucial to ensure safety and containment for both the client and therapist (E. Shapiro & Laub, 2008). The STEP intervention ensures client safety by screening out those with severe mental health issues, monitoring participant SUDs, including additional containment and relaxation components, and referring for further clinician-administered treatment when needed.

Client Safety

It is the opinion of the authors that it is imperative to have appropriate screening to ensure the intervention is appropriate for the severity of the client's concern and symptoms. For those who are not suited to the intervention, it is important to refer them for work with a licensed mental health clinician. During the STEP intervention in this study, participants had contact with a mental health worker during the prescreening interview conducted via telephone, as well as check-ins via email. The client would be referred if their answers on the telephone prescreening indicated they were experiencing levels of distress not suitable for the STEP intervention, suicidality, or other complex mental health issues. Clients were monitored throughout and would be offered a referral if they did not experience a reduction in their SUD level after the initial 4 Elements exercise, which indicates they were having difficulty regulating, or at the end of the protocol if they were unable to lower the SUD levels while processing. Many CCBT interventions include screening measures prior to treatment, similar to the STEP intervention (MoodGym, n.d.). In this study, no participants were referred at any point during the procedure.

Computerized Interventions

Similar to CCBT, STEP is a highly structured, Internet-delivered intervention consisting of low levels of contact with a mental health worker. STEP is similar to many CCBT interventions, such as the

COVID Coach app, developed by the U.S. Department of Veteran's Affairs (2002), in that it offers psychoeducation and coping strategies. However, STEP's goal is to process memories of disturbing events using the EMDR G-TEP (E. Shapiro, 2018) procedure. The EMDR G-TEP has been shown to decrease symptoms of posttraumatic stress, anxiety, depression, and stress in those experiencing prolonged distressing events, including cancer treatment (Roberts, 2018), exposure to child abuse and neglect through work (Tsouvelas et al., 2019), and exposure to war-related events in refugee camps (Lehnug et al., 2017; Yurtsever et al., 2018).

Most CCBT interventions require six to eight treatment sessions. One advantage of STEP is that it appears to provide rapid effects in a single session. In this study STEP was used as a one-time intervention, which is different from what is offered in CCBT; however, it is plausible to use STEP on an ongoing basis as needed for self-care. This would require further research to test the efficacy and safety of STEP in this application.

CCBT is an Internet-delivered, self-help intervention based on the principles of CBT (Cai et al., 2020), and is recommended by NICE (2006) as an option in the stepped care model of treatment for depression. CCBT programs are highly variable and differ in content, delivery, and quality. STEP is an Internet-delivered, self-help intervention based on the principles of EMDR therapy. Providing access to low-intensity psychological treatment to aid in self-care and processing of disturbing memories may help reduce the impacts of recent distressing events. Internet-delivered therapies are becoming more common during COVID-19, as self-isolation measures designed to reduce the spread limit access to in-person therapies.

STEP is not meant to limit or replace high-intensity interventions, such as care from a psychologist or trained mental health clinician. It is a low-intensity intervention designed to allow individuals to receive help at the level of assistance they require in a safe and accessible way. For individuals with distress that is easily processed during the STEP computerized intervention, we may be able to target and process unconsolidated memory fragments before the memories become maladaptively storedreducing the need for psychological interventions related to COVID-19 in the future. Considerations are being given to how to safely utilize the STEP protocols with groups online. Current projects are underway looking at a tiered approach to intervention utilizing the computerized protocol with additional built-in mechanisms

for safety, along with assessment tools to assist the therapist in selecting potential guidelines for working with STEP Solo (individually), STEP Together (small groups), or immediate referral to one-to-one treatment. Additionally, the use of the STEP platform with closer clinician monitoring and for wider populations is currently being investigated.

Study Limitations

This pilot study has several limitations. The use of a local sample and inclusion of only EMDR-trained clinicians as participants may limit the generalizability of the results. Additionally, the STEP intervention needs to be tested in larger studies and other populations, such as first responders or other frontline workers. This study did not conduct a follow-up after the conclusion of the study; further research should include a follow-up to investigate the long-term effects of the STEP intervention. Due to the limited number of questions included in the DASS-21, this study analyzed the overall DASS-21 score and did not differentiate among decreases in depression, anxiety, and stress. Further studies may consider alternate measures to test each category separately: that is, depression, anxiety, and stress. Pretreatment participant scores on the DASS-21 were in the nonclinical range, and thus results may not generalize to populations with clinical symptoms.

Conclusion

We all must come together to protect and enhance the mental health of those in our communities and, at this juncture most crucially, the mental health of frontline workers. In this study, the STEP intervention effectively reduced symptoms of depression, anxiety, and stress in EMDR-trained mental health clinicians in the context of COVID-19, in addition to increasing levels of general self-efficacy. As healthcare systems around the world are overwhelmed during the pandemic, it is crucial to develop and implement interventions for our frontline workers, including mental health practitioners.

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