Effects of EMDR Group Traumatic Episode Protocol on Burnout Within IAPT Healthcare Professionals: A Feasibility and Acceptability Study

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Mental health professionals face a high degree of burnout. This study aimed to explore the effectiveness of Eye Movement Desensitisation and Reprocessing Group Traumatic Episode Protocol (EMDR G-TEP) at reducing distress and burnout in staff working within an Improving Access to Psychological Therapies (IAPT) service and if outcomes changed over number of sessions attended. Twenty-two staff attended and measures examining burnout and subjective distress ratings of the targeted memory were taken pre- and post-intervention and at one-month follow-up. 95.5% reported finding the sessions helpful. A statistically significant reduction was observed on total burnout and on personal and work-related subscales; and a significant improvement in subjective units of disturbance was also observed. There was no interaction between changes in burnout and number of sessions attended. EMDR G-TEP has the potential to offer a novel method to improve staff wellbeing within mental health settings. Further research is recommended.

Keywords: eye movement desensitization and reprocessing (EMDR); G-TEP; IAPT; NHS; burnout

Research suggests that long-term exposure to stressful work situations that are emotionally demanding can lead to burnout: A state of physical, emotional, and mental exhaustion (Schaufeli & Greenglass, 2001). Burnout has been shown to be problematic for many healthcare professionals, such as doctors (Benson & Magraith, 2005), nurses (Sabo, 2006), care workers (Costello et al., 2019), midwives (Beaumount et al., 2016; Creedy et al., 2017), and mental health professionals (Dreison et al., 2018); with research indicating there is an increased risk of burnout for these occupations compared to the general population (Shanafelt et al., 2015).

Burnout is widespread within the mental health field. Morse et al. (2012) suggested 21%–67% of mental health professionals experience burnout, which is double that of the general population (O'Connor et al., 2018). Research has suggested that therapists specifically are at a higher risk of burnout (Devilly et al., 2009) with some studies demonstrating UK trauma therapists have high risk of developing secondary traumatic stress (Sodeke-Gregson et al., 2013). Mental health professionals may work in a stressful environment where they are frequently exposed to listening to traumatic life experiences, emotional distress, and suicide ideation as part of their therapeutic role that may indirectly cause distress and vulnerability to burnout (Sjølie et al., 2017).

Staff Burnout

Improving Access to Psychological Therapies, or IAPT, is a relatively new model of psychological provision that aims to increase the availability of evidence-based treatments for mild to moderate depression and anxiety disorders within the UK National Health Service

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(NHS). Due to the nature of IAPT being characterized by high volume caseloads and target-driven for client recovery, IAPT practitioners are frequently exposed to stressful work environments that could increase the risk of burnout. However, research on burnout within IAPT settings is still rather limited. Walklet and Percy (2014) found almost 30% of IAPT staff met criteria for minor psychiatric disturbance. Steel et al. (2015) investigated burnout across eight IAPT services and found high levels of emotional exhaustion, a key element of burnout. Similarly, Westwood et al. (2017) found burnout in 68.6% of psychological wellbeing practitioners (PWPs) and 50% of cognitive behavioral therapist practitioners across 15 IAPT services. Preliminary research has shown trainee therapists in IAPT services are likely to experience higher degree of work-based stress than their colleagues who are already qualified (Owen et al., 2021).

There is a growing body of literature that recognizes the adverse outcomes of burnout on practitioners such as negative impact on mental and physical health (Ahola et al., 2005; Morse et al., 2012; Peterson et al., 2008), increased substance use (Rohland, 2000), and reduced job satisfaction (Maslach & Leiter, 2016). Furthermore, research has demonstrated negative effects to the wider organization through increased sickness, absence, and staff turnover (Morse et al., 2012; Paris & Hoge, 2010), but also negative effects to the client. A meta-analysis by Salyers et al. (2017) found negative relationships between therapist burnout and reduced quality of care, client satisfaction, and client safety; therefore potentially impacting the therapeutic relationship as practitioners may become less collaborative and patient-centered, which may impact overall client outcomes that are key for IAPT services.

Research has shown evidence of various interventions to alleviate burnout at both personal and organisational levels, such as cognitive behavioral therapy (CBT), reflective skills development groups, and educational training; although promising, the results are inconsistent and there is insufficient evidence to draw robust conclusions (Ahola et al., 2017; Dreison et al., 2018; Morse et al., 2012). In light of the impact of the COVID-19 pandemic, Miller et al. (2021) demonstrated self-care practice as a predictor of distress amongst mental health clinicians; however, this exploratory study indicates the need for further research into strategies to alleviate burnout within the mental health workforce.

EMDR in Group Settings

It has been widely recognized that eye movement desensitization and reprocessing (EMDR) is an effective treatment for trauma and posttraumatic stress disorder (PTSD; Chen et al., 2014; Cuijpers et al., 2020; Khan et al., 2018; Moreno-Alcazar et al., 2017). The majority of EMDR approaches are conducted as an individual therapy, which limits the number of people who can be treated when resources are strained. Thus, a number of researchers have looked at developing EMDR group-based interventions, primarily in response to natural disasters and military conflicts. For example, the Integrative Group Treatment Protocol (IGTP) was first introduced in 1998 (Jarero et al., 2006). IGTP has achieved good outcomes and been widely used across settings and countries (Jarero et al., 2014). It was originally developed for children and later adapted for adults. During the desensitization phase, each individual is asked to draw a picture that captures the most distressing element of the trauma and rate their Subjective Units of Distress (SUDs). They are then asked to look at the picture and engage in a number of butterfly hugs (crossing their arms and tapping themselves on the chest in a bilateral alternating fashion). After this they are asked to draw another picture and rate their SUDS and engage in further butterfly hugs. The process is repeated two more times. Finally, individuals are asked to draw a picture outlining their desired future and that is then installed while engaging with butterfly hugs. The advantage of this model is the ease by which it can get be scaled up and few number of sessions (often 1–2) needed to create a reduction on SUDS. However, it may be that only one target is worked on each session with fewer sets of bilateral stimulation (BLS) with eye movements which is a key component of the EMDR model. However, given the existing evidence supporting use of IGTP, it remains a potentially suitable interventions for a variety of settings.

A second group EMDR model known as Group-Traumatic Episode Protocol (EMDR G-TEP) was developed by Shapiro (2013) based on the EMDR Recent Traumatic Episode Protocol (R-TEP; Shapiro & Laub, 2008). EMDR G-TEP can be used for recent traumatic experiences or other significant life events that have an on-going impact, but do not necessarily need to be recent events (Shapiro, 2012). EMDR G-TEP aims to keep as much power as individual EMDR. It incorporates the eight phases of the original EMDR protocol in a uniquely developed worksheet.

A safety screening is built into the protocol to identify those not ready for group trauma processing (Lehnung et al., 2017). A unique feature of EMDR G-TEP is the use of "Google search" which is aimed at getting individuals to screen a traumatic episode from the beginning until a point of disturbance is identified to process. In comparison to IGTP, EMDR G-TEP may allow for processing of several targets, or points of disturbance (PODs), repeatedly coming back to target to ensure in-depth processing of the traumatic episode and maintaining containment. It also aims to facilitate deeper processing through more sets of BLS, using eye movements and tapping (Lehnung et al., 2017).

Research has suggested that group EMDR, after two treatment sessions, has been effective at reducing distress, PTSD, and depressive symptoms in a variety of settings and populations. EMDR G-TEP has been demonstrated to be effective with refugees (Lehnung et al., 2017; Yurtsever et al., 2018) and cancer survivors (Roberts, 2018). Effectiveness of IGTP was demonstrated with survivors of an earthquake in central Italy (Maslovaric et al., 2017; Trentini et al., 2018). Furthermore, the majority of these studies found that the effects were maintained at one-month follow-up (Maslovaric et al., 2017; Roberts, 2018; Yurtsever et al., 2018). A recent systematic review of group-based EMDR trials found 13 studies on IGTP four on G-TEP, and a further four examining integrative group treatment for ongoing trauma (Kaptan et al., 2021). The review concluded there is evidence for reduced symptoms of PTSD, depression, and anxiety, when compared to control groups, but that many of the studies were methodologically flawed and had a high risk of bias (Kaptan et al., 2021).

There has been limited research exploring the effects of group EMDR on healthcare professionals who are prone to burnout. Tsouvelas et al. (2019) investigated the effects of EMDR G-TEP on twenty professionals working with child abuse and neglect. After two treatment sessions, results demonstrated a significant reduction in participants' SUDs level, post-traumatic symptoms, and negative workplace affect. Similarly, Passoni et al. (2018) explored the effects of IGTP on dementia caregivers and found a significant reduction of burnout, depression, anxiety, and stress-related symptoms. Group EMDR may be a promising treatment for stressful experiences and events relating to the workplace where intense feelings can lead to a disruption of the information processing system (Valiente-Gómez et al., 2017) and increased vulnerability to burnout.

Purpose of the Study

Despite extensive research establishing burnout to be widespread within various mental health settings and an observed number of negative adverse outcomes to the practitioner, client, and wider organizations, there is no consensus within the limited research exploring how to alleviate burnout symptoms. To our knowledge at the time of writing, there has been no study exploring the effectiveness of EMDR G-TEP on burnout of mental health professionals, therefore revealing a gap in the literature and demonstrating the need for this preliminary research. The purpose of the current study was to explore the feasibility and acceptability of EMDR G-TEP at reducing distress and burnout in mental health staff in an IAPT setting and investigate if outcomes changed over the number of sessions attended.

Method

Procedure

A pre/post design was used. A total of four EMDR G-TEP sessions were held over a 4-month period from September 2019 to December 2019, with participants able to attend either one or two of these monthly sessions in which data were collected. Each session lasted for 1.5 hours.

The group generally consisted of 4–8 participants with one group leader and another clinician to provide support in case of participant distress. The group was facilitated by a qualified EMDR therapist, with completed High Intensity CBT training and training in EMDR G-TEP. In total there were three group leaders who were on rota facilitating the EMDR G-TEP workshops.

Participants

Participants were 22 staff members (19 female, three male) from Talking Change, a Primary Care IAPT Psychological Service (Portsmouth, UK) that volunteered to participate in the study. The staff were Psychological Wellbeing Practitioners (PWPs), trainee PWPs, CBT therapists, counsellors, and one Graduate Mental Health Worker. Service evaluation approval was gained from Solent NHS Trust and written consent was obtained from each participant prior to participating in the session. Participants were offered to attend one or two of the group sessions.

Treatment

The treatment provided the standard EMDR G-TEP procedure, which incorporates the eight phases of the original EMDR protocol in a group setting by

Figure 1. G-TEP worksheet.

allowing participants to work through a specifically developed worksheet (see Figure 1). The worksheet comprises a central area, which symbolizes the trauma material to be processed, and then four outer sections surrounding this, which represent past, present, and future resources; for example, a present safe place, a past positive memory/activity/event, and then a desired future. At the start, participants are led through a process to learn stabilization and containment exercises (four elements; Shapiro, 2007) before being asked to complete their past and future resources. After this, participants are asked to identify and focus on a point of disturbance (PoD) relating to the trauma episode by using what is called a mental "Google search." Each participant is then asked to rate their SUD level at the start, where zero represents no disturbance and 10 maximum disturbance (Shapiro, 2018). The PoD is then processed through self-administered bilateral stimulation (BLS) that incorporates eye movements by following one hand moving back and forth between tapping the "present safety" section of the worksheet, to the current PoD being processed. This is completed for three sets, and then they are asked to go back to the PoD and re-rate their SUD level. After nine sets have been completed for that PoD, a new "Google search" is completed looking for another PoD which is then processed in the same way. After processing three PoDs, an Episode Positive Cognition (PC) is installed before finishing the session with another containment exercise.

Measures

Following signed informed consent, participants completed the pre-intervention burnout measure (Copenhagen Burnout Inventory [CBI]; see Figure 2) and provided their initial SUDs prior to their first EMDR G-TEP session (Pre-Intervention—Time-point 1).

Copenhagen Burnout Inventory (CBI)

	Always	Often	Sometimes	Seldom	Never/almost never
How often do you feel tired?					
How often are you emotionally exhausted?					
Do you feel that every working hour is trying for you?					
Do you have enough energy for family and friends during leisure time?					
Are you tired of working with clients?					
Do you often feel worn out?					
Do you often feel physically exhausted?					
How often do you think: "I can't take it anymore"?					
Do you feel worn out at the end of the working day?					
. Do you sometimes wonder how long you will be able to continue working with clients?					
. How often do you feel weak and susceptible to illness?					
. Are you exhausted in the morning at the thought of another day at work?					

	To a very high degree	To a high degree	Somewhat	To a low Degree	To a very low degree
. Is your work emotionally exhausting?					
. Do you find it hard to work with clients?					
. Do you feel burnt out because of your work?					
. Do you find it frustrating to work with clients?					
. Does your work frustrate you?					
. Does it drain your energy to work with clients?					
. Do you feel that you give more than you get back when you work with clients?					

Figure 2. Copenhagen Burnout Inventory (CBI) questionnaire.

Burnout. The Copenhagen Burnout Inventory (CBI) questionnaire consists of 19 items in total, and measures 3 domains of burnout: Personal, Work-related, and Client-related; it has shown to have good reliability and criterion-related validity (Kristensen et al., 2005).

- The personal burnout section consists of six items, for example: "How often do you think: 'I can't take it anymore'?"
- The work-related burnout section consists of seven items, for example: "Do you feel that every working hour is trying for you?"
- The client-related burnout section consists of six items, for example: "Are you tired of working with clients?"

Answers to each item are given on a 5-point Likert scale: "Always or To a very high degree," "Often or To a high degree," "Sometimes or Somewhat," "Seldom or To a low degree," and "Never/almost never or To a very low degree." Total CBI scores ranged from 0% to 100% with higher scores representing a higher degree of burnout. CBI scores of ≤49 are considered "low burnout," 50–74 "moderate burnout," 75–99 "high burnout," and 100 "severe burnout" (Kristensen et al., 2005).

The reliability Cronbach's alpha in the current sample at baseline was good for CBI total ($\alpha = .88$) and fair for the subscales: Personal ($\alpha = .74$), Work-related ($\alpha = .73$) and Client-related ($\alpha = .75$).

During the session, the facilitator took participants through the worksheet (see Figure 1) following the EMDR G-TEP protocol described above. Participants completed a EMDR G-TEP Session Feedback Form (see Figure 3) immediately after the session to assess feasibility and acceptability, changes in SUDS scores, willingness to engage, and perceived level of resolution post-processing (Post-Intervention—Time-point 1). The feedback for the first session which was attended by the most participants are reported here due to the low numbers for the second session.

One-month follow-ups were completed with the administration of the CBI to evaluate the impact of the EMDR G-TEP session on overall emotional well-being and perceived impact on work and personal life (Follow-up—Time-point 2).

For those attending two sessions, the second EMDR G-TEP session (Time-point 3) was held on the same day, thus the 1-month follow-up CBI scores (Time-point 2) were also utilized as the second EMDR G-TEP session pre-measure (Time-point 3). These participants followed the same procedure with another 1-month follow up (Time-point 4) as depicted in Figure 4.

Statistical Analysis

The subscales and total scores of the CBI were analyzed to determine changes over time, and whether these differed between those who attended one or two sessions. For those who attended twice, the final CBI measure completed was used as the follow-up measure. A 2 (1 session attended vs. 2 sessions attended) vs. 2 (pre-group scores vs. follow-up scores after final group attended) mixed Factorial Multiple Analysis of Variance (MANOVA) was used. All participants completed the intervention and follow-up data so there was no need for an intent-to-treat analysis. A MANOVA was also used to compare scores before the first group between those who attended only one session and those who attended both sessions.

A repeated measures MANOVA was used to compare changes at the start and end of the session on SUDs and Willingness to Engage emotionally which were both rated on scores out of 10. The analysis was conducted separately for group one (all participants who attended at least one session) and group two (only those who attended two sessions). One participant did not complete all measures for group one but did completed CBI scores so was included in the sample.

Results

Self-Reported Changes

50% ($n = 11$) of the participants attended one session, 50% ($n = 11$) attended two sessions, and no participants dropped out of the study. Overall, after session 1, 95.5% ($n = 21$) of the participants said that they found the EMDR G-TEP session helpful, 4.5% ($n = 1$) stated that, by the end of the session, they had reached a complete resolution of the adverse advent, 36.4% ($n = 8$) stated it was resolved to a satisfactory level, 45.5% ($n = 10$) stated it was somewhat resolved, 4.5% ($n = 1$) reported it was not at all resolved, and 4.5% ($n = 1$) stated that they resolved it themselves.

After session 1, 68.2% ($n = 15$) stated that the session improved their overall emotional wellbeing as a result of the intervention. As shown in Table 1, when asked to describe changes in their emotional wellbeing, 22.7% ($n = 5$) reported they felt a lot better, 50% ($n = 11$) reported feeling a slightly better, 22.7% ($n = 5$) reported not feeling any different, 4.5% ($n = 1$) reported feeling slightly worse, and no participants reported feeling a lot worse. In terms of impact of the session on work and life outside of work: 13.6% ($n = 3$) reported a high level of impact in both categories, 27.3% ($n = 6$) and 40.9% ($n = 9$) (respectively)

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G-TEP Session Feedback form

Please complete the following form to help us develop our group sessions.

Date Completed:	Participant Number:
Did you find the group helpful? YES / NO Did you find the topics covered in the group relevant to you? YES / NO Overall, how would you rate your experience in the group (1= very bad 5= very good) 1 2 3 4 5	
What was the most helpful aspect of the group?	
What was the least helpful aspect of the group?	
What was your SUDS to begin with and what was your SUDS at the end? (0= no disturbance, 10=maximum disturbance) First SUDS: 0-10 Last SUDS: 0-10	
How willing were you before today's session to emotionally engage with the adverse event? (0=not at all, 10= completely willing)	
0 – 10 How willing are you now to emotionally engage with your adverse event? 0 - 10	
How much resolution do you feel you have reached in regard to the adverse event you were working on? Please circle your answer. Completely resolved Resolved to satisfactory level Somewhat resolved Not resolved at all	
What could be done to improve the sessions and make it more effective for you?	
Any other comments?	

Figure 3. G-TEP session feedback form.

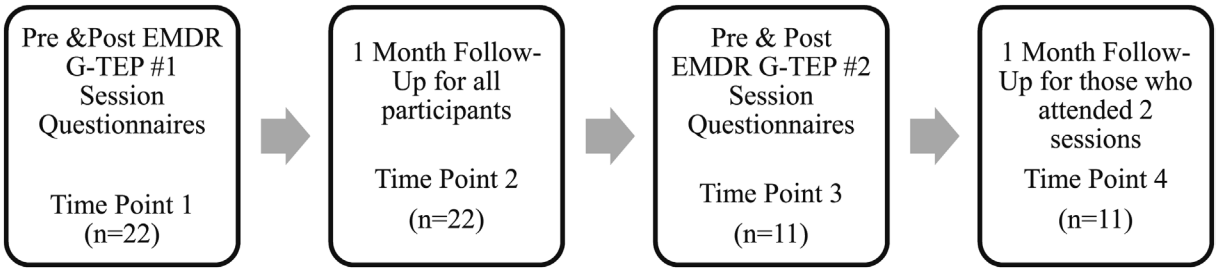

Figure 4. Diagram showing number of participants at each time point.

TABLE 1. Percentage of Self-Reported Changes to Description of Emotional Wellbeing After EMDR-G-TEP Session

Description of changes to emotional wellbeing	% (***n***)
I felt a lot better	22.7% (5)
I felt slightly better	50% (11)
I did not feel any different	22.7% (5)
I felt slightly worse	4.5% (1)
I felt a lot worse	0% (0)

TABLE 2. Percentage of Participants That Fall Within Each CBI Domain's Cut-Off Scores and the Range of Scores for that Domain Prior to the Intervention

	CBI domain			
	Total (*n*)	Personal (*n*)	Work-related (*n*)	Client-related (*n*)
Low (<49)	63.6% (14)	27.3% (6)	50% (11)	72.7% (16)
Moderate (50–74)	36.4% (8)	63.6% (14)	50% (11)	27/3% (6)
High (>75)	0% (0)	9.1% (2)	0% (0)	0% (0)
Range of scores (max 100)	21–62	21–75	21–71	8–54

reported a moderate/substantial impact, 36.4% (n = 8) and 22.7% (n = 5) (respectively) reported a minor level of impact, and 22.7% (n = 5) reported no impact for both categories.

Burnout

All 22 participants completed the CBI at all time points. As shown in Table 2, prior to intervention, for total overall burnout, 63.6% (n = 14) of practitioners had low burnout scores, while 36.4% (n = 8) had moderate burnout scores. The overall mean score for Total burnout was 43.90 (Confidence Interval: 38.39–49.42, Standard Deviation: 12.44) and scores ranged from 21 to 62.

Differences in Baseline Scores

A MANOVA showed no statistically significant difference in the pre-intervention CBI scores overall between those who attended one session and those who attended two sessions: Wilks' Lambda = .92, $F(3,18) = .51$ $p > .05$, *Partial* $\eta^2 = .08$.

Changes Over Time on CBI

A MANOVA showed statistically significant changes over time overall for all measures: Wilks Lambda = .52, $F(4,17) = 3.88$, $p < .05$, *Partial* $\eta^2 = .48$. There was no significant overall interaction for number of sessions × time: Wilks Lambda = .85, $F(4,17) = 0.77$, $p > .05$, *Partial* $\eta^2 = .15$.

Univariate analyses for individual scores showed statistically significant reductions in scores for the CBI Total; $F = 12.77$, $p < .01$, *Partial* $\eta^2 = .39$; CBI Personal subscale; $F = 11.25$, $p < .01$, *Partial* $\eta^2 = .36$; and CBI Work-related subscale $F = 13.22$, $p < .01$, *Partial* $\eta^2 = 40$. The CBI Client-related subscale was approaching statistical significance; $F = 4.12$, $p = .056$, *Partial* $\eta^2 = 17$. The mean and standard deviations pre- and final follow-up CBI scores are displayed in Table 3.

Changes in SUDs Scores

For the first group, everyone who attended at least one session, a repeated-measures MANOVA showed

TABLE 3. Mean and Standard Deviation for CBI Domains at Pre and Final Follow-up Intervention

CBI domains	Pre mean (*SD*)	Follow-up mean (*SD*)	Significance
Total (/100)	43.9 (12.4)	37.4 (10.6)	$F = 12.77$, $p < .01$
Personal (/100)	51.2 (14.8)	44.2 (11.8)	$F = 11.25$, $p < .01$
Work-related (/100)	45.6 (13.7)	39.6 (12.3)	$F = 13.22$, $p < .01$
Client-related (/100)	34.3 (14.3)	28.0 (14.8)	$F = 4.12$, $p = .056$

NB: Higher score means higher degree of burnout.

TABLE 4. Mean and Standard Deviation for SUDS and Willingness to Emotionally Engage With Adverse Event

	Start mean (*SD*)	End mean (*SD*)	Significance
Group 1 ($n = 21$)			
SUDS (/10)	7.86 (1.68)	3.76 (2.26)	$F = 57.83$, $p < .001$
Willingness to emotionally engage (/10)	6.57 (2.69)	8.28 (1.52)	$F = 12.82$, $p < .01$
Group 2 ($n = 11$)			
SUDS (/10)	7.36 (1.80)	3.64 (1.69)	$F = 19.06$, $p < .01$
Willingness to emotionally engage (/10)	6 (3.35)	8.36 (1.03)	$F = 6.11$, $p < .05$

NB: Subjective Units of Distress (SUDs): 0 = no distress/10 = maximum distress. Willingness to emotionally engage with adverse event: 0 = not at all/10 = completely willing.

a statistically significant change over time overall: Wilks Lambda = .20, $F(2,19) = 37.67$ $p < .001$, *Partial* $\eta^2 = .79$. Univariate analysis showed a statistically significant reduction in SUDs over time: $F = 57.83$, $p < .001$, *Partial* $\eta^2 = .74$, and an increase in reported willingness to emotionally engage with the adverse event; $F = 12.82$, $p < .01$, *Partial* $\eta^2 = .39$. For the second group, those who attended a second session, there was a statistically significant change over time overall: Wilks Lambda = .40, $F(2,9) = 8.74$ $p < .01$, *Partial* $\eta^2 = .66$. Univariate analysis showed a statistically significant reduction in SUDs over time: $F = 19.06$, $p < .01$, *Partial* $\eta^2 = .66$, and an increase in reported willingness to emotionally engage with the adverse event; $F = 6.11$, $p < .05$, *Partial* $\eta^2 = .38$. The mean and standard deviations pre and post intervention are displayed in Table 4.

Discussion

The paper aimed to investigate if Eye Movement Desensitisation and Reprocessing Group-Traumatic Episode Protocol (EMDR G-TEP) is an acceptable and feasible method to reduce distress and burnout amongst mental health staff within a UK IAPT setting, and secondly if the outcomes changed over the number of sessions attended. To our knowledge at the time of writing, this is the first study to evaluate the effectiveness of EMDR G-TEP on reducing burnout of IAPT staff; burnout has been shown to be widespread within various mental health settings with a number of negative adverse outcomes therefore demonstrating the need for this preliminary research.

Feasibility is suggested by the fact that the groups were sufficiently attended with four to eight participants per group, although the level of uptake from staff is not known. Acceptability is suggested by no drop-out from participants and the vast majority reporting that the intervention was helpful. Most participants reported some level of resolution of the adverse event, and the majority reported improved emotional wellbeing and a positive impact on work and life outside of work as a result of the intervention. In future research, a qualitative analysis of these perceived benefits may give further insight into the acceptability and perceived efficacy of this group-based intervention.

Our results suggested EMDR G-TEP was effective at reducing overall distress as indicated by a significant reduction in SUD scores in relation to the stressful event participants were processing during the sessions. This finding is consistent with previous research (Lehnung et al., 2017; Roberts, 2018; Tsouvelas et al., 2019; Yurtsever et al., 2018) that also demonstrated reduction in distress following EMDR G-TEP interventions in a variety of settings and populations. Our results also revealed a significant reduction in overall burnout and the Personal and Work-Related burnout subscales after 1-month follow-up; however, the reduction in the Client-Related burnout subscale was not statistically significant. Previous EMDR G-TEP studies have used participant groups who have experienced similar trauma contexts, for example, refugees (Lehnung et al., 2017; Yurtsever et al., 2018); however, participants in this study could bring work- or personal-related topics which may have affected the cohesion

of the group and willingness to commit to the intervention in front of others.

There was no interaction between the number of sessions attended and reduction in scores. This suggests EMDR G-TEP can be effective at reducing distress and burnout after just one session in an IAPT population. It is important to note that to our knowledge, no other study has investigated effectiveness of EMDR G-TEP after one session as other studies have used a minimum of two sessions (Lehnung et al., 2017; Roberts, 2018; Tsouvelas et al., 2019; Yurtsever et al., 2018), and this is the only study to investigate effectiveness of EMDR G-TEP on burnout specifically in mental health professionals. The potential effectiveness of a single session with this sample may have been possible because the severity of burnout in our sample was lower than in other IAPT studies (Steel et al., 2015; Westwood et al., 2017), with the majority of participants categorized as "low" or "moderate" levels of burnout, with only 9.1% of the sample categorized at "high" burnout on the Personal subscale. However, these comparative studies lack a commonly used method of outcome measurement for burnout, therefore demonstrating the need for cautious direct comparison in prevalence rates. It is also worth noting that in our sample, there were no differences in baseline burnout scores depending on the number of sessions attended.

Clinical Implications

In light of the coronavirus disease, the impact of the pandemic on the mental health of healthcare professionals requires consideration and workforce planning (Restauri & Sheridan, 2020) with a preventative approach (Raudenská et al., 2020). IAPT services are well placed to meet the predicted increase in demand for psychological support; however, this relies on a psychologically healthy workforce. Staff burnout is costly, and the provision of accessible psychological therapies within IAPT was originally proposed to support the economy by reducing absenteeism in the workforce due to poor mental health (Layard et al., 2007). However, paradoxically, staff burnout in IAPT has been shown to be within the higher end of the prevalence rates for burnout amongst mental health workers (Westwood et al., 2017), thus indicating the need to support those working in the provision of psychological therapies. EMDR G-TEP is a short and thus potentially cost-effective intervention, which can be delivered in a group setting, and our findings have shown the potential to support staff wellbeing within a healthcare environment. Early intervention can help to alleviate the cost of burnout on healthcare provision (Restauri & Sheridan, 2020) and this protocol can be delivered to multiple staff quickly and effectively. The ability to support staff wellbeing could be vital in navigating these unprecedented times for healthcare services nationally and globally. Furthermore, the EMDR G-TEP intervention has the potential to be delivered across a wider healthcare setting, not limited to psychological services and thus providing integral support to the delivery of the National Health Service.

Limitations

There a number of limitations to be considered. First, the small sample size necessitates a cautious approach to generalisation and the statistics used may have been under-powered. Although the research showed statistically significant reduction in overall burnout from pre-post scores, the absence of a control group limits the causal interpretation of this reduction. Extraneous variables may have influenced the stress and burnout vulnerabilities within the workplace such as use of supervision, years of experience, specialist trauma training, and self-management of wellbeing. The impact of personal trauma was also not accounted for within this study. As the presenting problems addressed in sessions were not identified, this may account for the non-significant reduction in client-related burnout, for example, if those attendees processed non-work-related material. The participant sample was self-selecting, which may have attracted participants who were more likely to be prone to greater levels of burnout. Staff may have felt incentivized to attend by the reduction in clinical caseload permitted by the service lead to attend (reduction of one clinical contact permitted). Thus the reduction in caseload could have contributed to the significant reduction in burnout. Furthermore, fidelity to the EMDR G-TEP model by the group leaders was not assessed. The measures were administered by a staff member within the same service, thus potential demand characteristics are acknowledged.

Future Research

Despite aforementioned limitations, the research presented warrants further exploration of the impact of the EMDR G-TEP protocol and staff burnout via a larger randomized control trial. Future research specifying the adverse event (personal, work, or client) targeted within the EMDR G-TEP session could assess any differential impact on CBI and whether this correlates with reduction in burnout dependent on the

content of traumatic material being processed. SUDS could be collated at all time points to open up exploration of change in distress over a longer time frame. Follow-up over a longer time period than a month is also warranted. The measurement and impact of other constructs, such as post-traumatic stress symptoms, quality of life, and overall level of functioning could also be examined following EMDR G-TEP sessions. These further measures could be supported by an assessment of the cost effectiveness of EMDR G-TEP and examination of staff sickness and attrition rates in IAPT with the option to extend the protocol across other NHS settings.

Conclusion

This study explored the effectiveness of EMDR G-TEP at reducing distress and burnout in NHS staff and investigated if outcomes changed over the number of sessions attended. A significant reduction in burnout was observed overall and within personal and work-related burnout. Further clarity with a larger sample and follow-up research is needed. Further robust research is warranted to explore the feasibility of EMDR-GTEP to support the wellbeing of healthcare professionals providing mental health support, within fast-paced and pressurized psychological therapy services.

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