Fast Feet Forward

A sport based early intervention trauma group protocol for UASC in Kent.

In collaboration with:

Virtual Schools Kent

Kent Kindness

Sussex Partnership NHS Trust

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Content:

Abstract :

Unaccompanied asylum seeking children not only have experienced trauma in their country of origin, they are also highly likely to have experience trauma on the journey they have made and in the assimilation process in the country in which they have claimed asylum. Early intervention trauma group work has been shown to be effective in reducing the subjective unit of distress and enhancing positive cognitions, which increases resilience to ongoing trauma.

This paper looks at the evidence for early intervention trauma work, the benefits and use of running as a form of bilateral movement and the findings of a pilot sports trauma group with unaccompanied asylum seeking children in Kent.

The findings show a significant rise in the validity of positive cognitions and an ecological reduction in subjective unit of distress of those participating in the pilot program. It evidences the validity of this protocol and shows promising results for future inquiry. It also gives recommendations for future pilots taking place as part of a participatory action research process.

Introduction

The fast feet forward is a trauma early intervention protocol to support Unaccompanied Asylum Seeking Minors in Kent.

The DSM-IV-TR (American Psychiatric Assessment, 2001) defines trauma as a traumatic event that requires that person to have experienced, witnessed, or be confronted with an event or events that involve actual or threatened death or serious injury, or threat to physical integrity of self or others and that the person's response involves intense fear, helplessness or horror.

This definition aligns with the reported experiences of Unaccompanied Asylum Seeking Children (UASC). It is not surprising then that as a cohort, such children have a higher incidence of post-traumatic stress disorder (PTSD) than the general population. It is recognised that they have significant trauma, triangulated by the original need to flee their home of origin, the physical migration journey, and the immigration process once they reach safety. For UASC, the immigration process is ongoing and a constant source of distress, as they attempt to navigate a sea of information and due to the risk that they may be refused leave to stay. Therefore, the risk for developing PTSD is known and there is a need to think about early intervention strategies, in that there is a need to immunise and protect a UASC from developing PTSD (Bronstein & Montgomery, 2013; Heide et al, 2014).

Recent data from an initial health screening in Kent compiled by Public Health reported that 45% of UASC are exhibiting post traumatic symptoms (Coyle, 2016). An audit undertaken by Sussex Partnership Foundation Trust (Draper, Simpson & Gordon, 2016) found that 87%

of UASC referred to their service were experiencing disordered sleep patterns; this being a significant indicator symptom of PTSD which supports Bronstein's and Montgomery's (2013) findings. That said Draper et al (2016) asserts that disordered sleep in the first year of arrival is due to the nocturnal sleep pattern shaped by the migration journey, rather than PTSD. Yet, it is also a symptom of PTSD.

The key question open to clinicians therefore is when do trauma symptoms and experience become a mental health issue and when is it a natural processing of events that needs to take place? The UASC health website has issued a 'watch wait and see' protocol that links into the Sussex Partnership Foundation Trust trauma pathway (Draper (2016). This protocol acknowledges that trauma symptoms in the early stages of recovery should be expected, but there is likelihood that they would be naturally processed by the UASC, given a safe and supportive environment. So the UASC will also need emotional protection which looks to mitigate the trauma and subjective distress experienced by the UASC, and to strengthen UASCs adaptive cognition (Jarero & Artigas, 2015).

The literature

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR is a comprehensive therapeutic approach that is compatible with all contemporary theoretical orientations (NICE 2005). It is the frontline treatment for trauma, with an emphasis on directly processing neurophysiological stored memories of events that set the foundation for positive health or probable pathology.

This modality is built on the premise that psychopathology is linked to earlier memories that were too disturbing in nature to have been completely processed by the brain. This incomplete process results in the brain storing the memory as it was originally experienced, with all things associated to the memory remaining the same. The memory is then quickly reactivated in a range of current situations, and formulates the emotional and behavioral responses. Inappropriate or damaging responses may then occur, and the pattern of responses does not shift with time (Shapiro, 1995; Shapiro & Laliotis, 2011).

The patient's guide to EMDR states that it uses either eye movement or other forms of rhythmic, left and right stimulation. It describes, much as Shapiro (1995) and Shapiro and Laliotis (2011) do, that a memory is 'frozen in time'rand can create triggers into the present which, once activated, can cause a negative impact on our daily function, interfering with the way we view the world and relate to others[i]. The intention therefore is to create an understanding of emotions and perceptions that lead to healthy and useful behaviours and interactions[ii]. The EMDR network describes a three branched protocol which targets past memory, present disturbance and future action. Processing is not through dialogue, but through a learning state which allows experiences to be processed and stored appropriately in the brain.

A number of protocols exist, specific to presenting circumstances. For patients diagnosed with PTSD, the adaptive information processing model is standard. From that model, further protocols have been developed for early intervention work. For example, Shapiro and Laub (2008, 2009, and 2015) recently developed a traumatic episode protocol (R-TED) for early EMDR interventions based on results from their randomised control trial of early intervention

EMDR with people who had experienced a community critical incident (Shapiro & Laub, 2015). The trial showed that participants who received EMDR therapy experienced a significant reduction of symptoms at a three month follow-up, compared with those who did not receive EMDR therapy.

There are recent examples of this approach being implemented with refugees experiencing current trauma. Zaghrout-Hodali et al (2008) explored EMDR group work with refugee children within an area of ongoing trauma. They found that even in acute situations the group protocol resulted in a reduction of symptoms of post and present traumatic stress, as well as an inoculation affect which increased personal resilience. Further, Jarero and Uribe (2012) found that EMDR was effective as an early intervention treatment by way of reducing the trauma for a group of adults who worked under extreme stresses in a human massacre situation. Jarero and Uribe (2012) suggest such treatment helped to prevent the development of chronic PTSD, and increased resilience. Such a response in resilience was also observed by

Jarero and Artiges (2015) who found that treatment effects were not only maintained, but that PTSD symptom levels continue to decrease over time.

Hensley's (2014) study on recent traumatic events and the use of EMDR found that it is an effective means of providing early treatment to victims of trauma, preventing the development of more severe symptoms of PTSD. Lumber (2009) developed the EMDR Integrative Group Protocol and suggested that following a traumatic episode, the need to return to a healthy and normal life as soon as possible is crucial. Tofani and Wheeler (2011) assert that the Integrative Group Protocol is essential in preventing, sensitising or progressive accumulation of traumatic memories.

Fleming (2012) reviewed the literature and concluded that EMDR is effective in the treatment of traumatised children and youth. Despite these reports, Heide et al (2014) suggest that the current evidence for EMDR as a treatment for traumatised refugees is still not in place and highlight the need to increase work and research using this methodology to bolster the evidence base for clinical use by practitioners. Heide et al (2014) assert that EMDR should be used only when the transcultural psychiatric principle is observed.

<u>Sport as a means to gain emotional wellbeing</u>

Sports England, through comprehensive research, has published articles about the benefits of sport for an individual, which include health benefits, an established link to enhanced educational attainment and a reduction in anti-social behavior[iii]. Their summery of current research shown in the Culture and Sport Evidence program: the drivers, impacts and value of sport report show that young people participating in sport have the higher levels of emotional health and wellbeing associated with higher economic social groups. Sport is therefore seen to act as an income compensator, especially when undertaken on a regular basis. This report also makes links between sport and health benefits with a reduction in costs over a lifetime of £45,800. This is thought to be an underestimation, as new understandings of the impact of such activities are becoming known.

Other sources reinforce these findings, such as Kyu, et al. in the British Medical Journal (2013) and the Royal College of Psychiatrists (2016) asserting that regular exercise prevents

chronic disease, is as effectively as medication, and reduces the risk of cancer. Piche (2014) found a link between educational attainments, enhanced concentration and attention and improved classroom behaviour. This also showed that 73% of parents whose child participated in sport reported increased mental health wellbeing. The Aspen Institute (2016) asserts that the Robert Wood Johnson Foundation at Harvard University also found that current participation in sport is a good indicator for future participation.

The Scottish Health Survey (2015) found that those needing psychiatric input were twice as likely to be sedentary than the general population. Stalhopoulou et al (2006) also found, in a controlled trial, a large effect for the advantage of exercise on patients suffering anxiety, depression and eating disorders. The Royal College of Psychiatry on their website[iv] assert that physical activity can, through the experience of control and wellbeing it creates, be as good as anti-depressants or psychological treatments.

Sports trauma protocol

Many of UASC arriving in Kent have experienced trauma which is complex in nature, yet such UASC are often not offered therapeutic or trauma support due to the relative lack of safety and security associated with being a young asylum seeker assumed to impede such work. There is also an understanding that the traumatic episode is ongoing as a result of the stressful immigration process taking place. Mental health workers supporting these children report that a referral for support is often made when a trigger episode is taking place associated with this, such as a home office interview. These events, stressful in themselves, also often re-activate emotional states associated with their other refugee experiences.

All UASC receive leave to stay in the UK until they are 18 years of age. During this time they are a looked after child in local authority care. Once over 18, they start the full asylum process and any contact with the home office is described as a time of intense stress and trauma. As already stated, there is a triangulation of the initial traumatic experiences associated with the 'need to flee', then the traumas from the process of migration and getting to a safer place, and the on-going nature of being in a 'temporary' position in their place of safety. It is important to draw attention to the term 'place of safety', which links to language about protecting children, something that is crucial to the UASC as they make the transition into adulthood.

Therefore the evidence that early intervention EMDR protocols do enhance resilience, even with people who are experiencing ongoing extreme trauma and stress, needs to be taken seriously in order to give these young people the best opportunities to recover and make the most out of their future possibilities. There is a need to pay careful attention to the age appropriate needs of UASC, and using a type of formulation that is none pathologising and connects with the cultural norms associated with this group of children Heide (2014). The EMDR protocol has therefore been modified to be suitable for a group session in a non-clinical setting, where it would be unrealistic and inappropriate to complete an EMDR protocol.

One of the things that are often requested by UASC is access to sport; many play football or cricket in the local town parks, try to join the gym or want to run. The protocol was therefore developed with the idea that there are benefits in the involvement of enjoying sport, and working together as a group using EMDR techniques. These young people have previously been forced into close survival experiences together, bound as kinship through the trauma they were suffering, but also always with the moving on, and therefore the dislocation of their relationships. It was envisaged that the sports trauma therapy would allow them to bond, but with an enjoyable purpose, and purpose is important. It is forward-looking. It is a driver towards the future. The benefits we thought to be valuable even from the exercise and process itself, could then be enhanced with the dialogical intensity of being together twice a week We saw this as a way of practicing how they might try to form relationships in new environments and learn to be safe.

Sport psychology literature identifies two uses of EMDR. The first is to help sports participants who have had a traumatic experience which impedes their return to sport, and its use is seen to be successful For example see Graham 2016. The second is its use to promote and improve focus, learning to avoid distractions, or replace negative self-talk.

Method:

The protocol was collaboration between Kent County Council, Virtual Schools Kent, Sussex Partnership NHS Trust and Kent Kindness. 29 UASC in Kent attended a six week, twice a week sport trauma protocol. Some were from two reception centres and were dispersed to other authorities and others were based in the community from different parts of the county.

The sports trauma protocol brings together the learning from EMDR and sport to support the natural processing of trauma through bi-lateral movement. It understands that the child will be experiencing disturbance as a result of both current and past events. In EMDR 'hot spots' are understood to be parts of trauma memories that cause high levels of emotional distress, and that are often re-experienced, either by internal triggers, or by external, current triggers which re-activate the original memories and distress. Memory is encoded in the brain in such a way that it is triggered by current experiences that remind us of the past through similar circumstances, intensity or emotion Seeman (2016). Holmes et al (2005) study into hot spots in PTSD showed that there was a high degree of match reported between intrusive images and hotspots. Nijdam et al (2013) found that there was a correlation between the focus on hot spots and successful trauma focused interventions. Therefore repeatedly focusing on hotspots and looking for their associated characteristics may help clinicians to enhance the efficacy to treatment.

In Kent, the UASC health project has piloted an early intervention group protocol using bilateral movement through specific bilateral exercises and running. The aim was to understand and modify presenting hot spots and to evaluate the effects of the therapeutic formulation, and also to provide a learning experience of how bilateral stimulation could be used to help with traumatic memories, worries and other psychological distress which the young people

could use once the program was completed. It ran a six week group, twice a week program, targeting memories or current distressing themes of the young person's choice, which would be the focus during the session. Measures taken were the validity of cognition (VOC) for positive cognitions associated with the memory or issue, and the subjective units of disturbance (SUD) scale. Both scores have been proven to be effective. Bae and Park (2008) found that the SUD score at the first session is significantly correlated with low level depression and state anxiety associated with distress from the impact of events, and this was likely to be the case with our target group.

We used existing clinical understanding drawn from sports research and EMDR Therapy to shape a sports trauma protocol that was used as an early intervention in the management of UASC trauma experiences. The work was therefore supported by sports coaches, mental health staff to provide psychological support, and interpreters who could orientate each UASC in their own language. This also enabled the young people could feel safe using the protocol, and able to make themselves 'heard' with confidence.

The translators and young people were orientated to the sports trauma work we were doing through an initial pre-program meeting that explained the bi-lateral movement and the protocol. And a second meeting took place with the young people to continue to support their understanding of the protocol and what they were experiencing. One young person was fascinated by the process and requested additional, more scientific information.

The sports element included fast feet ladder drills, circuits, strides, short interval training and beep tests which provided bi-lateral stimulation and could be used psychologically, combined with running. At times there were divergences to running, with short bursts of football or rugby as requested by those participating. As part of these clinical sessions the young people were also provided with running clothes and trainers, as well as post session food to enhance a sense of joint enterprise and wellbeing. One you person described doing sport before and stated that what we were doing together in the group was better and different. We were aware that the setting was non-clinical, and we had 4 clinicians working throughout the session to monitor and manage the intensity of the session. Our protocol was a simplified protocol, and our clinical expectations took into account Hyer and Solnle's (2001) clinical experience, from which they assert that at least half the time the ideal process and outcome of EMDR will be impeded from the simple protocol, and the clinician will have to use various additional strategies, such as cognitive interweaves, or additional safe place or other management strategies. We also had this experience of managing the clinical intensity with a group of active, multi-cultural, multi-lingual and multi-faith young people.

This meant that we worked with interpreters who helped the young people and facilitators to understand each other in the protocols being undertaken, explain the bilateral movement through running exercises and also participated in the process of being together. That said, it is difficult to know how much was actually understood and how things were being explained or translated.

The data:

This cohort of 29 young people is a fast changing and transient population. During the program the following transitions occurred.

- Dispersal
- Moved accommodation
- Absconded

Added to this young people were also unable to attend sessions due to the need to:

- Meet with the home office
- Be educationally assessed
- Attend mosque
- The need to self-manage the process of attending

The young people were asked individually to identify a memory or issue they wished to work on psychologically during the session. The sport coaches supporting this aspect of the protocol helped the young people to learn fast feet movement through ladder work and drills and then would do some high intensity running using the learnt fast feet movement.

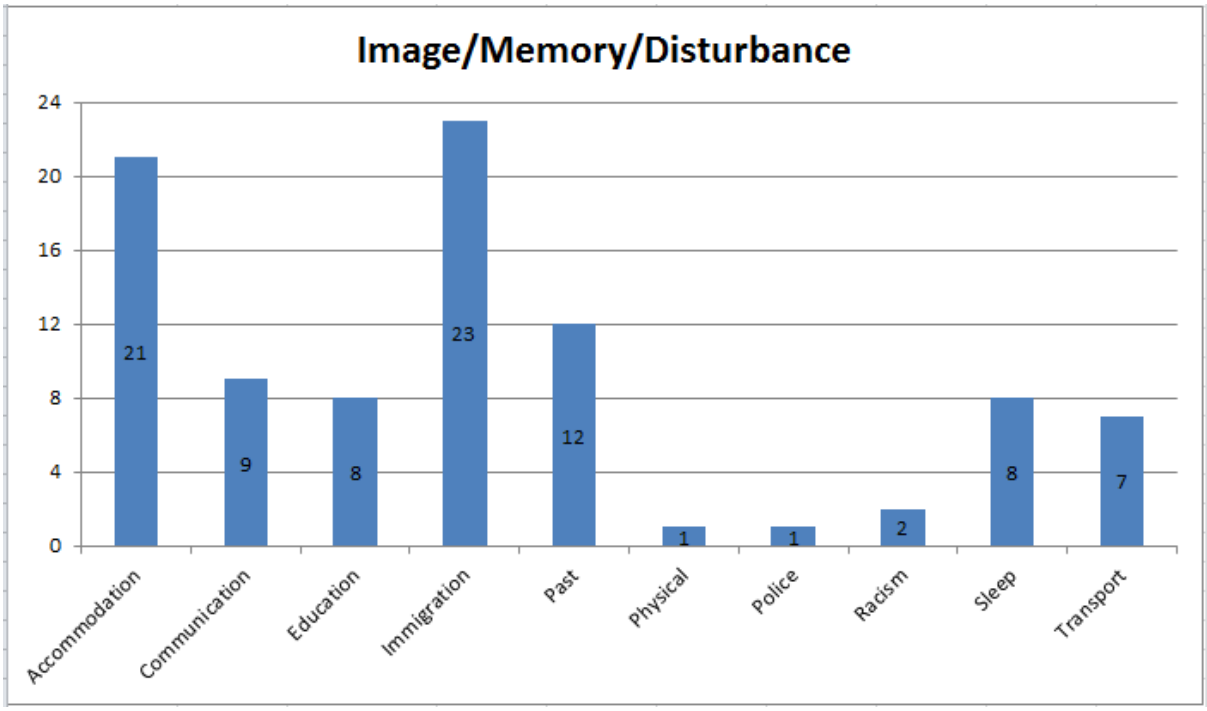
'Hot spots' have been described as 'points of inflammation' which if you ignore; they can lead to escalations in negative behaviours. This is seen in the reported experience from a young person that the hot spot he was using in the bi-lateral process would give him flashbacks to what he experienced in Libya.

The following hot spots were reported:

- Immigration
- Accommodation
- Lack of language/communication
- Past memories
- Lack of education
- Lack of sleep
- Lack of transport
- Experienced racism
- Loss of physical health

- Interaction with the police

The occurrence of hot spot reported was:



The correlating of subjective units of distress percentage per hot spot was:

SUD RESULTS	Pre-Intervention Mean	Post-Intervention Mean	Change %
Accommodation	8.333	6.429	22.86%
Communication	6.667	6.111	8.33%
Education	7.500	6.250	16.67%
Immigration	8.391	7.304	12.95%
Past	8.083	7.250	10.31%
Physical	8.000	7.000	12.50%
Police	8.000	6.000	25.00%
Racism	10.000	10.000	0.00%
Sleep	7.000	7.375	-5.36%
Transport	8.000	5.571	30.36%
Total	*7.477*	*6.560*	*12.26%*

There findings seem to validate the ecological argument in EMDR practice as although the disturbance levels have changed, Immigration which is the most reported hot spot remains high on the subjective unit of distress. The relatively small shifts gained are, we believe related to the context of the ongoing trauma that the extensive asylum process creates. The excep-

tion is that, accommodation, the second most reported hot spot, does shift more significantly. This may be in part as a result of some young people being moved from an area where they were experiencing racist abuse. (Therefore what we are seeing is the disturbance level responding to the change in circumstance, while being supported by the therapeutic process). In using the bi-lateral movement while the accommodation change occurred, it could have supported them to process the disturbance associated with this hot spot. . Also Draper and Gordon's (2016) work on UASC and sleep may be pertinent here, in that most of the young people were new to living in the UK and they were likely to have disordered sleep patterns associated to the journey they have made.

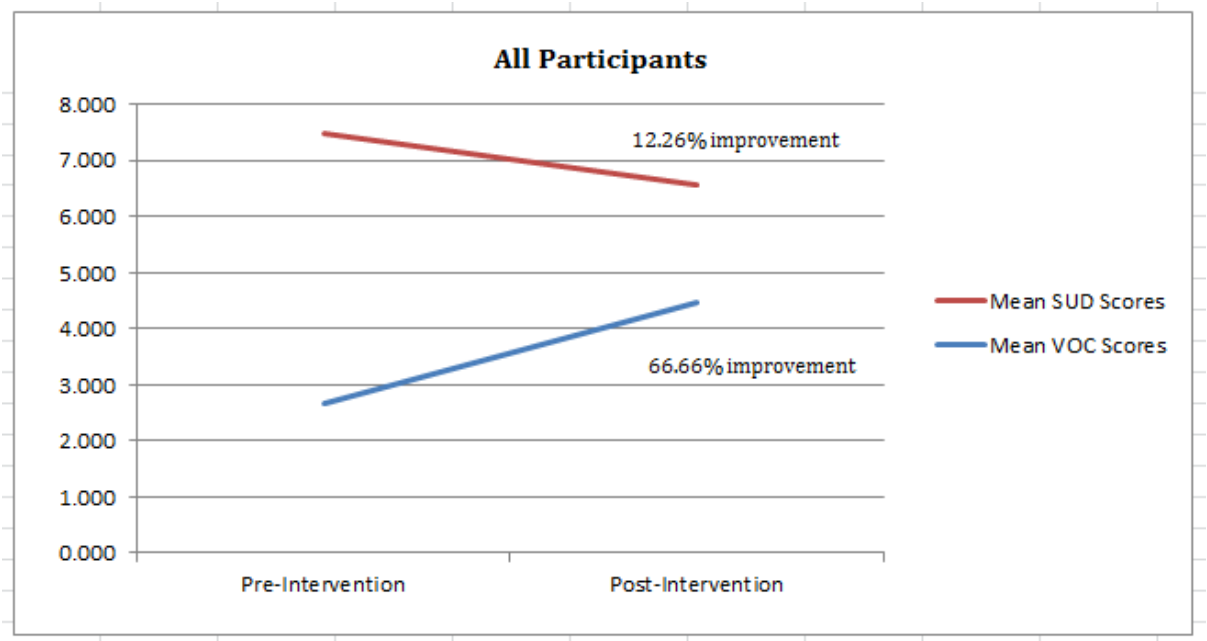
And the correlation between validity of cognition and hot spot was:

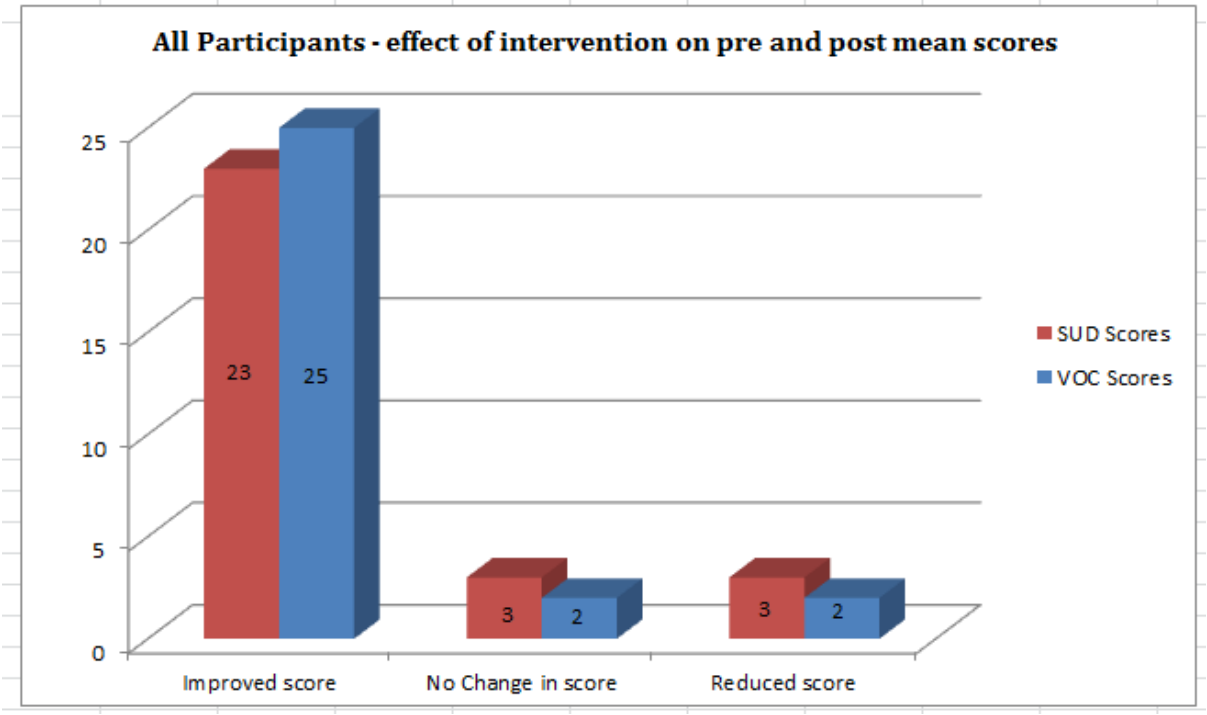
VOC RESULTS	Pre-Intervention Mean	Post-Intervention Mean	Change %
Accommodation	2.619	4.238	61.82%
Communication	2.333	4.667	100.00%
Education	2.125	4.500	111.76%
Immigration	2.565	4.826	88.14%
Past	2.917	4.667	60.00%
Physical	6.000	5.000	-16.67%
Police	7.000	6.000	-14.29%
Racism	1.000	2.000	100.00%
Sleep	3.000	4.250	41.67%
Transport	2.571	5.000	94.44%
Total	*2.676*	*4.459*	*66.66%*

It is interesting to notice that the changes in validity of cognition do not correlate to the changes seen in the subjective unit of disturbances. For example there was a large shift in the validity of the positive cognition for immigration and yet this was not seen in the same way with accommodation. There also seems to be a trend within the data in that high shifts in the validity of cognition result in reduced shifts in the subjective unit of distress. An example of this is communication where the validity of cognition result is 100% and yet the subjective unit of disturbance is 8%. This idea is enhanced by some young people who reported that when they did the bi-lateral movement they would focus on their positive cognition and this would make them feel happier. They also reported that when they were home they had less negative feelings. Another young person talked about using new positive cognitions to manage the disturbance of worries about his family and the positive difference this made.

The subjective units of distress were measured during current episodes associated with, and part of the original trauma events. The general finding for such subjective units of distress is that changes seen will be realistic in the circumstances so may not reduce significantly as they would once the young person feels the episode is over and they are safe. The subjective unit of disturbance will remain 'ecological' that is, appropriate to the circumstances. For example 'lack of language and communication' is not a single event, but a day to day experience which the young person cannot change, and resonates with the trauma of not being able

to communicate on the journey from their country of origin. Similarly 'lack of transport' is a continuous pressure which links to having to undertake dangerous journeys in fleeing to safety. This was true of the following findings:





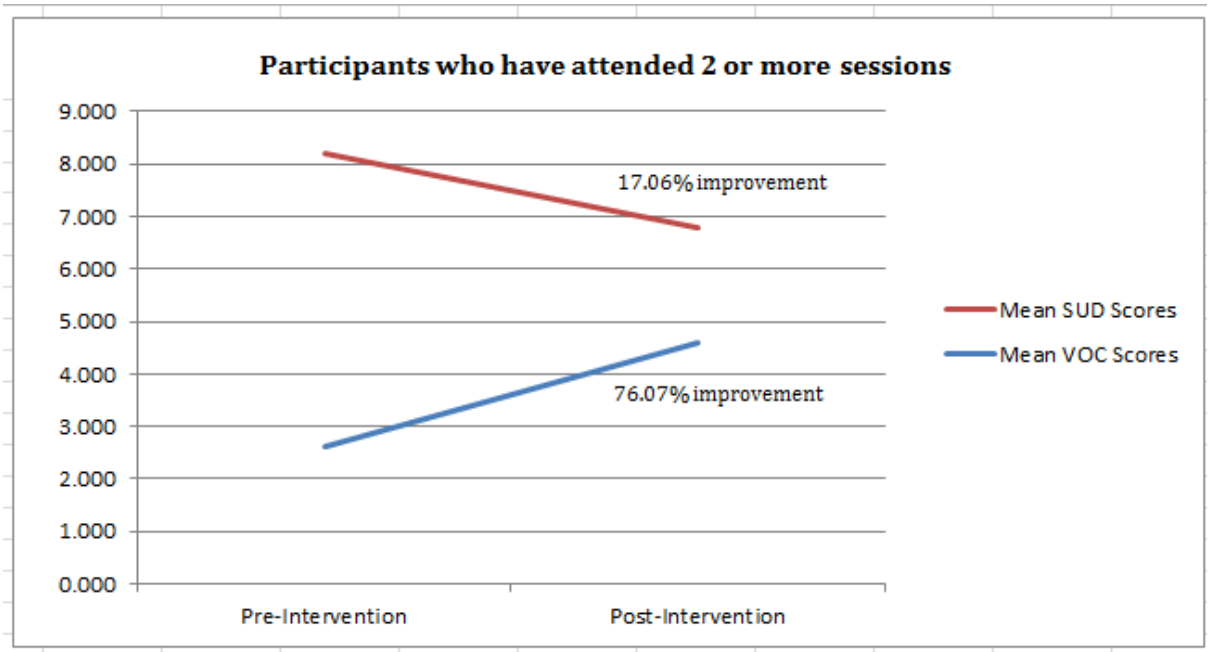
During the group sessions there were reported large shifts in validity of cognition to the positive cognition. Such large shifts are suggestive of the installation of the positive cognition taking place during the bi-lateral left/right movement embedded in the running activity. Kurn and Leeds (2002) found when working with childhood trauma, there are often high levels of presenting pre-treatment distress. Also in their work they found that negative images, affects, sensations and beliefs are defused and less valid, while positive imagery, affects, sensations and beliefs become enhanced and strengthened when a positive cognition is installed. The

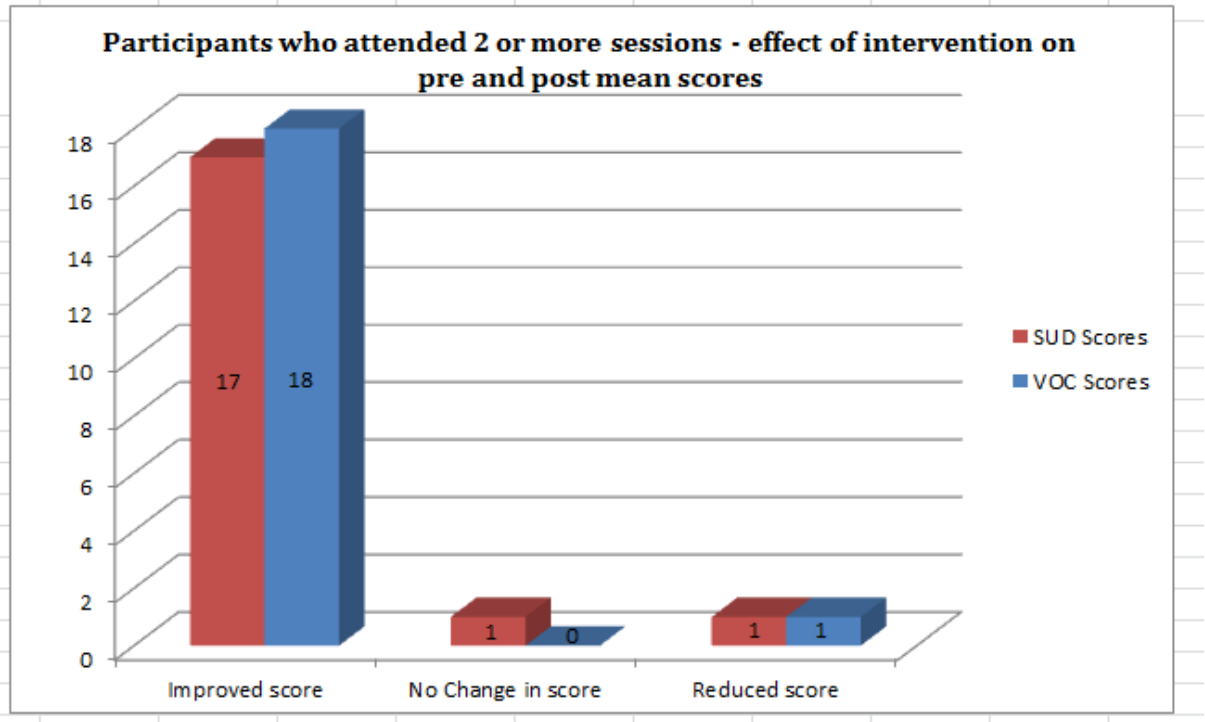
focuses of strengthening resources such as a positive cognition were found to be effective in reducing trauma related triggers. Therefore the large change in validity of cognition is suggestive of enhanced resilience

If this is true, the post session validity of cognition results shows that the sport trauma protocol is likely to be effective in reducing trauma related triggers due to enhanced and strengthened positive imagery and beliefs. Also the shift in subjective unit of disturbance is ecological and the level of reduction is less due to the continued exposure to hot spots.

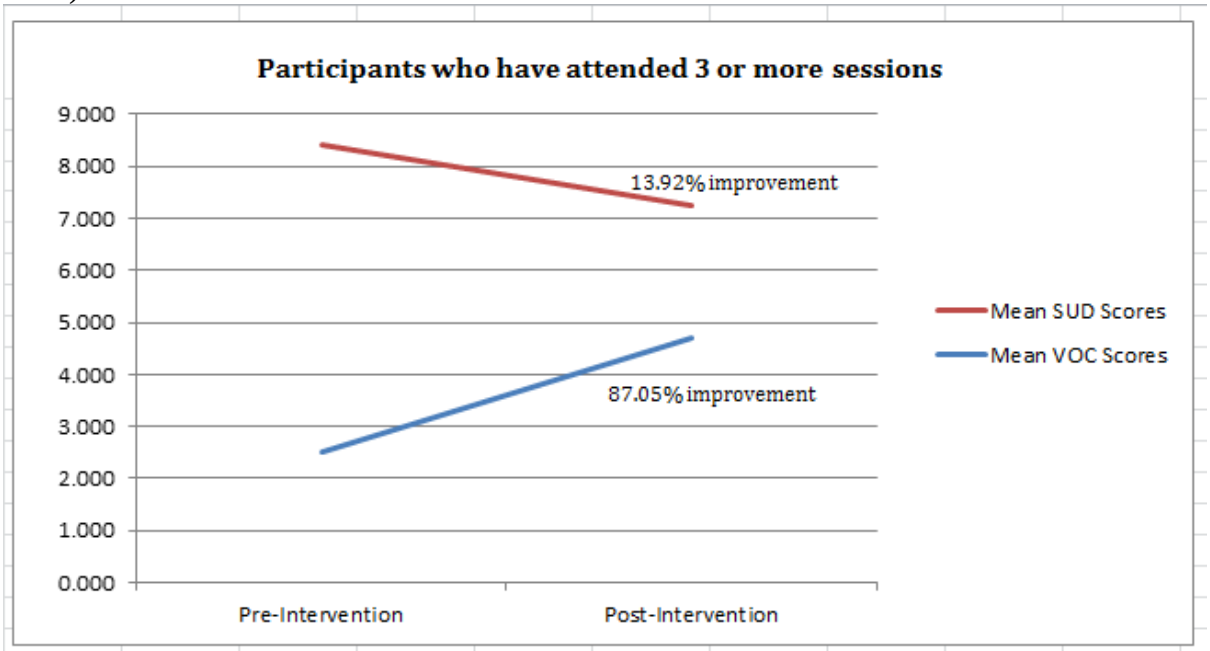
Further to this, extended participation in the protocol and bi-lateral movement increased the shift in validity of cognition and subjective unit of distress scores in the following ways;

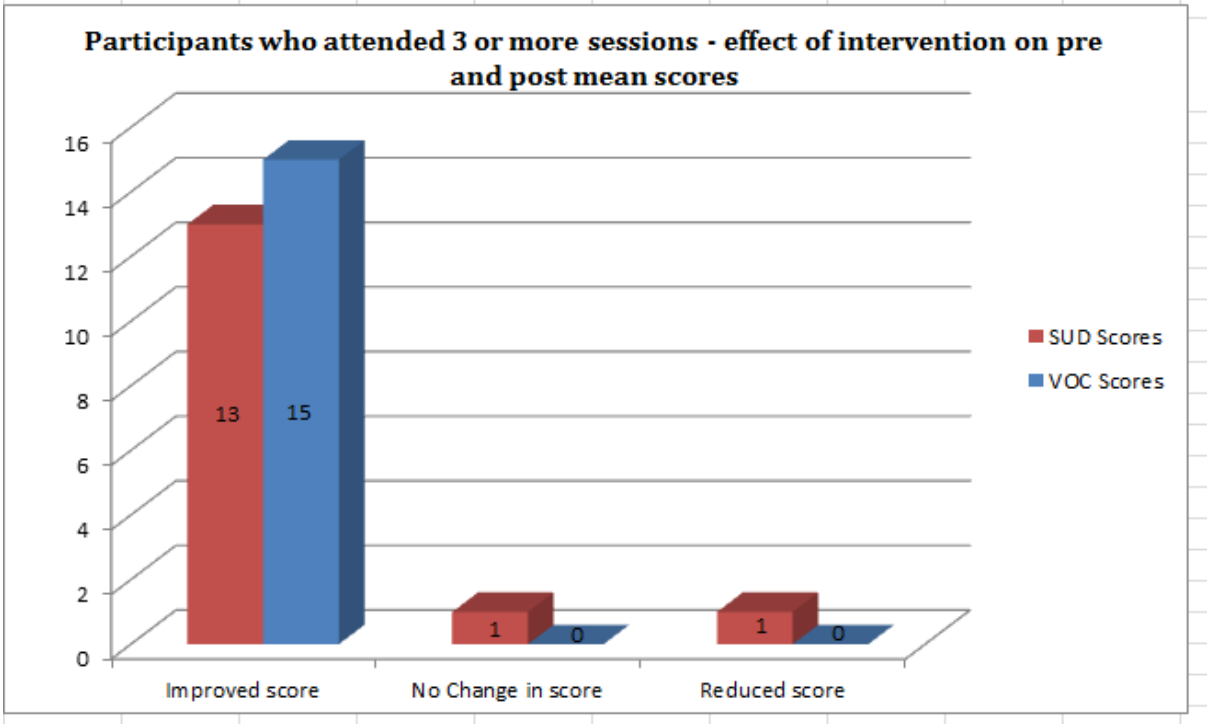
Participants attending 2 or more sessions (excluding those who attended only 1 session)


Participants who have attended 2 or more sessions
9.000
8.000
7.000
6.000
5.000
4.000
3.000
2.000
1.000
0.000
17.06% improvement
76.07% improvement
Pre-Intervention
Post-Intervention
Mean SUD Scores
Mean VOC Scores


Participants who attended 2 or more sessions - effect of intervention on pre and post mean scores
18
16
14
12
10
8
6
4
2
0
17
18
1
0
1
1
Improved score
No Change in score
Reduced score
SUD Scores
VOC Scores

Participants attending 3 or more sessions (excluding those who attended 1 session or 2 sessions)





Discussion:

Presenting hot spots, memories and themes:

Although we are asking each participant to focus on something disturbing to them in the present, we don't have the detail of specific episodes or memories. The protocol was designed not as therapy, but rather as a way to teach the use of bi-lateral movement which could go on to be used by the young person post the group program. This learning was experiential in that it was taught in the practice of using current issues or memories, such as the worry they expressed about their family members. However they are able to highlight, through their negative cognition, how the issue or memory they are presenting affects them by their description of fear, anger and sadness, and also the over-riding sense of psychological threat to self that is typical of a traumatic event. The types of negative cognitions expressed were, I am scared, I am isolated, I am alone, I am angry, I am sad. As already discussed, there is evidence to show that experiences reinforce the sense of threat, and lack of power or control, which are partly embedded in past traumatic experiences which led them to flee their country, which they experienced on their journey, or are experiencing now. Therefore the 'hot spots' or themes they are presenting as a current experiences, are likely to lead them to respond as they did in the original traumas. This is perhaps seen in the number of UASC who abscond post arriving in the UK. These continued responses lead to the pattern of limitation, stress, depression, lack of a sense of future, irritability, inappropriate self-soothing, avoidance of stimulating activity or challenging experiences, and the range of other ways of coping that become PTSD or other serious psychological conditions.

It was envisaged that this protocol would use this window of opportunity to introduce new practices, understanding and skills to help break this possible way of responding to the perceived and experiences of threat in the young people's current situation. Its main aim therefore is to prevent current experiences from becoming part of the cycle of trauma and they have already been exposed to and are continuing to respond to without skills and abilities to manage them, which might lead to further psychological, educational, social and behavioral negative consequences. The large shift in validity of cognition for communication which did not show a similar shift in the subjective unit of disturbance is a way in which the data is showing how this has worked therapeutically through the enhancement in perceived skills and abilities to support their attempts to speak English and to start to communicate with others. Keyfits et al (2012) write about the role of positive schemas in child psychopathology and resilience. They found in a study that positive schemas reduced levels of anxiety and depression and increased resilience and reduced pathology in children. This rise in validity to positive cognitions is therefore important and could have a direct impact on reducing responsive psychopathology.

The young people participating in the group reported taking up running in between sessions during the week. They asserted that they found the bilateral stimulation helpful in managing their distress levels and some reported being less upset after the group sessions. There were also some systemic interventions in which Social Workers were notified about racial harassment being experienced or abilities being noticed by those running the group. These interven-

tions came as a result of discussing their hot spots which in turn changed their current life experience in the response to the threat or compliment being made. These relational interactions were enhancers to the positive cognitions being created in the sessions.

The sports trauma protocol, combining as it does new physical skills , a psychological program, and a group experience, together with the support of translators and clinicians who can give them the experience of being listened to and validated, can play a vital part in helping them to manage the present better, and shape their capacity to deal with the future. It's creating potential habits in their management of future stresses or traumatic memories

Learning for subsequent pilot group

The findings are showing that intensity in the therapeutic process is important in enabling the subjective unit of disturbance to be reduced and the validity of cognition to be increased the more sessions attended. To increase the impact of the sports trauma therapy there is a necessity for consistent attendance which maximises the intensity of the therapeutic process taking place. To enable this to happen there is a need to reduce access to reception centers and to hold a closed group where there is support in place that enables each participant to attend each session.

Transport to the venue was an issue in the program and the ability to manage the different travel needs of young people coming from different areas with no financial support to attend did add to the inconsistency in turnout. Also these are adolescent boys with no daily parental support to nudge them to attend to what can be difficult sessions in which they re-visit through the bi-lateral movement difficult memories and emotions. It is therefore important to have the same personnel supporting them throughout the sessions and group. This was achieved in the first pilot and should be maintained in the second.

The venue itself was not consistent in the first pilot and when the venue became static and was ascetically pleasing, it supported the therapeutic process to be enhanced. It is important therefore to have a venue that can meet both the therapeutic and bi-lateral activity required by the therapeutic process.

Social workers who understood the work being undertaken gave clear messages to their young person of the need to consistently attend and the processing they may experience. Also the young people despite being briefed about the group and what it entailed still did not always make the links and connections in the moments. It is important therefore to ensure that a more detailed briefing takes place with both the social worker and the young person and that additional information is given to both so that they can discuss this together and have something to refer to when questions arise.

Conclusions

The increase in validity of cognition is a significant finding that could potentially increase resilience and reduce pathology. The ecological reduction in the SUD is important as in the context of constant flux and ongoing trauma; a small shift in disturbance is significant in the potential to maintain wellbeing. These coupled together further enhance the possibility of wellness and resilience.

There is a need to continue to evidence from a longitudinal perspective the effects of the sport trauma group and to consider and incorporate subsequent findings into the protocol being formulated.

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[i] See http://anapsys.co.uk/emdr.pdf
[ii] http://www.emdrnetwork.org/description.html
[iii] See https://www.sportengland.org/research/benefits-of-sport/ for further research and information.
[iv] http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/physicalactivity.aspx