Cultural adaptations of the standard EMDR protocol in five African countries

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Cultural & trauma theory and practice

- Psychological trauma-focused treatments have mostly been focused on theories and methods from high income countries. Cultural modifications are crucial when adopting methods in low income countries (Chowdhary et al., 2014; Patel et al., 2007; Wilson & Tang, 2007).
- Culture determines the expression of symptoms, the explanatory models of illness, coping and treatment (Osterman & De Jong, 2007)
- Clinicians, trainers, and researchers require cultural competency skills and a multicultural orientation (Hook et al., 2016; Osterman & De Jong, 2007; Watkins et al., 2019)
- Cultural adaptations to the EMDR protocol have been made to ensure culturally competency when working with clients from cultures in Europe and the United States (Spierings 2004; Hartung, 2017; Amara, 2017; Nickerson, 2017; Zimmerman, 2014)
- Decolonizing trauma theory and practice (Rothberg 2008) when using EMDR in Africa

Sub-Saharan Africa

- In Sub-Saharan Africa various war, natural, and man-made disasters, (neo)colonialism, and poverty contribute to the burden of trauma (Atwoli et al., 2013; Beiser et al., 2010; Bryant-Davis, 2019; Jenkins et al., 2015; Kane et al., 2016; Njenga et al., 2006; Okello et al., 2013; Verhey et al., 2018; Winkler et al., 2015)
- Mental health services are lacking trained mental health professionals (Lund et al., 2012; Patel et al., 2007).
- Trauma therapies in SSA include TF-CBT, EMDR, reconciliation processes, and spiritual and cultural therapies (Visser, 2015; Kane et al, 2016; Patel et al., 2007; Zingela et al., 2019).
- Since 2007 mental health workers in over 10 African countries have been trained in EMDR by HAP associations (Fernandez et al., 2014; Zimmerman et al, 2014; Masters et al, 2017).
- National EMDR associations and EMDR Africa have been established.

Publications about EMDR in Africa

- The experience of teaching EMDR in African countries (Masters et al., 2017; Zimmermann, 2014).
- South African: case study of the standard EMDR protocol with 3 cancer patients (Peters et al., 2002).
- Ethiopia: EMDR IGTP protocol (Artigas et al. 2009) decreased PTSD and anxiety symptoms in 48 adolescent refugees (Smyth-Dent, Fitzgerald, & Hagos, 2019).
- Democratic Republic of Congo: IGTP protocol and individual protocol with 37 young women who had been sexually assaulted, with a greater reduction in the SUDs in individual treatment (Allon, 2015).
- Uganda: mental health workers suggest that cultural adaptation of guidelines is important before using EMDR in the country, no specific suggestions were made on how to adapt the protocol (Kane et al., 2016).

Objective of the study

Describe the cultural adaptations African EMDR therapists make in the 8 phases of the standard EMDR protocol (Shapiro, 2001) when treating clients in 5 Sub-Saharan African countries.

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Since 2007, mental health workers in sub-Saharan Africa have been trained in eye movement desensitization and reprocessing (EMDR) therapy. This qualitative study used an Afrocentric design with thematic analysis to investigate adaptations to the EMDR standard protocol that make it culturally relevant for African clients. Participants were 25 EMDR therapists (three male, age range 32–60 years, $\bar{x} = 44$) from five African countries, who practiced EMDR for 1–11 years ($\bar{x} = 7$). All answered a survey questionnaire, eight participated in a focus group discussion, and two provided a supervision notes analysis. Participants found EMDR a useful and beneficial therapy and preferred it over other therapies because of its nonnarrative nature and quick results. We identified four areas in which African therapists consistently made adaptations to the standard protocol: wording of the protocol text, cultural expression of thoughts and emotions, stimulation choice, and simplification of quantitative scales. Based on the study results, we make numerous recommendations for cultural adaptions to the EMDR protocol. These include language changes to take into account the clients' "we oriented" communication; cultural interpretations of positive and negative thoughts and events; adding cultural activities such as dance, music, and religious practices as resourcing exercises; using hand gestures or the pictorial faces scale instead of ordinal scales; and using tapping for bilateral stimulation instead of eye movements, which were sometimes seen as "witchcraft." The relevance of the findings for EMDR practice and training are discussed. We recommend that African researchers further study the acceptability, use, and effectiveness of EMDR in their countries.

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Study participants (N=25)

- 23 female, 3 male; average age 44 (range 32-60 years)
- Social workers (3), counsellors (3), psychotherapists (3), counselling psychologists (8), clinical psychologists (7), and psychiatrists (1).
- Democratic Republic of Congo, Ethiopia, Kenya, Uganda, and Zimbabwe
- Practiced EMDR for 1-11 years ($\bar{x}$=7). Average 11 clients per week (range 2 to 30), EMDR therapy with 40% of the clients
- Clients: refugees, torture survivors, victims of sexual violence, persons with Ebola, HIV, disabilities, vulnerable children, sexual minority groups.
- Protocols used: Standard EMDR Protocol and EMD (a few use IGTP/GTEP)

Study methods

- Afrocentric qualitative design (Chilisa et al, 2016) to explore cultural adaptations:
  - Collective ownership of opportunities, responsibilities, and challenges
  - Researchers and the researched are interconnected and interdependent
  - Participatory co-creative process
- 25 practitioners answered a survey questionnaire
- 8 participated in a focus group discussion
- 2 provided a supervision notes analysis

Findings

- EMDR is a useful therapy which benefitted the therapists' clients.
- The most distinctive reason for choosing to use EMDR was the ability to provide therapy without a focus on narration:

  They don't want to talk, they say 'wave your hands, it will take away my problems
- Therapists described seeing results quickly. Clients express to feel relieved, some say it is magic, other say 'it's a brain thing'.

  Some clients say I have reprogrammed their brains
- Religious beliefs play an important role for the therapists and their clients, and God, Allah, or a higher Spirit were often called upon to provide support and strength for the client and wisdom to the therapist to conduct the EMDR sessions.

Phase I

- Start with Phase II and then go to Phase I
- Culturally appropriate metaphors of the AIP model: locally available food and (in)digestion, as well as wound and weeds metaphors
- Visual timelines drawn on a paper or with a stick in the sand or soil.
- Adaptation and translation of screening tools: standardized screening tools (PCL, IES, DES, etc.) are not culturally appropriate nor understood by the therapists' clients. The few (6/25) who did use the tools translated them and would read the questions to their clients when administering them.

Phase II – EMDR metaphors and ‘safe’ place

- Culturally appropriate metaphors of EMDR:
  - a river, sitting on a bus etc.
- ‘Happy’, ‘calm’ or ‘good’ place :
  - the word ‘safe’ is often a trigger to clients as ‘safe’ spaces do not necessarily exist in our reality
  - adding a person in the calm or happy place was common
  - adding religious beliefs and the omnipresence of their God.

My clients often include family members in their happy place. We can also not ignore the importance of God in this.

Phase II – container exercise

- Basket, bag, pot, pit instead of ‘container’: therapists used metaphors such as a basket, a box, a pot, a bag, a store, or a pit in the ground. Some also described it as a ‘vacuum’.

  Many of my clients live in refugee camps. We use buckets as ‘containers’, most households use these for fetching water, washing dishes, and clothes. It has a lid and can be closed.’

- Clients ask for the ‘container’ to be stored in the therapist’s office. They often feel this is a safe place to keep the container.
- Some would use actual objects in the container exercise.

2

3

1

4

‘Container’ examples from Ethiopia

1 & 2. Mesob - for joint family dining purposes on special occasions

3. Muda'y - to store jewelry and other valuables.

4. Agelgil – to carry food and to serve food for guests

Phase II – other resources and ‘stop’ signal

- Cultural and religious practices as resources: beliefs, dance, and song

  I use song a lot in my practice. Music means a lot in our context. It explains how we feel and helps us to feel better.

- Stop signal: most therapists used the hand sign. Some clients find it rude, because they would not want to ‘stop’ their therapist, who is often considered their superior or ‘doctor’. Instead check in more frequently with the client.

Phase III - cognitions

- Cognition: We versus I. Clients often have a plural cognition and start with ‘we are not safe’, or ‘we are bad’, as they experience trauma and suffering in close connection to others.

  ‘My clients cannot say I am safe now when their relatives are still in danger. They don’t think only about themselves, they only feel better if their family is also ok’.

- Good or blessed and bad or cursed instead of positive and negative cognitions:

  My clients refer to ‘a word of curse’ when describing their negative cognition. They have a sense of powerlessness ‘I’m cursed’. They often don’t have negative cognitions in the responsibility theme, it is the curse that is held responsible. […] They could say ‘"if I caught Ebola it is because I am cursed". If anything happens to me, I'm cursed. Yet when they look for a positive cognition they will say “I am blessed”, or “I can manage”.

Phase III - emotions

- Different explanations of emotions: the word ‘emotion’ itself does not exist in all languages, nor do all variations

‘To hear and to feel is the same in our language. I have to explain which one I mean every time I ask what the client is feeling, it is not easy for them to understand’

- Emotion is most often expressed as a body sensation

‘It is easy for my clients to express how they feel through telling me about their body, they often have pain in their body. I try to explain how the words connect to what they feel in their body, and connect to their heart’

Phase III – VoC and SUD scales

- Adaptation of VoC and SUDS scales:
  - hand movements (to show small to large size)
  - thermometer analogy
  - pictorial faces version used in EMDR for children (not the clown version).
- Some clients would fear to quantify their distress in numbers, as they believe this may cause misfortune:

> *'It is usually difficult for clients to quantify distress. They will often say, 'it is ok', as one may be worried that when you mention the suffering, it will happen […] if I mention the suffering aloud, then the misfortune will happen. I use colours to ask the client to show me how distressed they feel, I use white for SUD=0, green for SUD 1-3, orange for SUD 4-6, and red for SUD 7-10, they can point at the colour instead.'*

Phase IV – bilateral stimulation

- Tapping instead of eye movements preference as sometimes considered ‘witchcraft’. Sometimes better with a pen not to scare the client. Some said hand movements are ok and ‘magical’.

  ‘Some clients are positive about the hand movements and say you are doing something magical with your hands’

- Adjust mode of tapping or encourage self tapping when tapping is inappropriate

  ‘It is hard for me to tap on a female client’s knees, it would be considered inappropriate, but I can tap her hands if she puts them on a book or the table, or she can tap herself using the butterfly hug’

Phase IV – cognitive interweaves

- Cultural and religious interweaves

  'We often use the presence of God in our interweaves, this helps the client feel there is hope, and they are not alone, it gives them strength'

  'The importance of the divinity is to be taken into consideration, we often say "God has given him grace"'

Phase V - VII

- As mentioned above
- Container, ongoing unsafety / threat in many countries:

Regarding the desensitisation, it is not always possible to complete the protocol, clients can have many associations, we may have little time, and they are still under threat. I use a lot of stabilization and the EMD protocol

Conclusions

African therapists consistently made adaptations to the standard protocol in the following areas:

- wording of the protocol text
- cultural expression of thoughts and emotions
- stimulation choice
- simplification of quantitative scales.

Limitations

- Small sample size
- Views of representatives of five Sub-Saharan African countries only
- Did not measure effectiveness of the use of different EMDR protocols
- Did not study the perception of clients about the treatment.
- Did not include group protocol evaluations

Recommendations EMDR protocol adaptation

- Include language changes to take into account the clients' we-oriented communication
- Cultural interpretations of positive and negative thoughts and events
- Add cultural activities such as dance, music, and religious practices as resourcing exercises
- Use hand gestures or the pictorial faces scale instead of ordinal scales to measure VoC and SUDS
- Use tapping as the first choice of bilateral stimulation, eye movements can be offered as a second option.

Post-colonial trauma theory and practice

Trauma is a very complex phenomenon,
it is not only understood as acute, individual, and event-based,
but also as collective and chronic;
trauma can weaken individuals and communities,
but it can also lead to a stronger sense of identity
and a renewed social cohesion.

(Visser, 2015)

Recommendations on way forward

- EMDR Africa to develop a EMDR protocol adapted for use in sub-Saharan African countries
- EMDR Africa to train and supervise therapists in the use of the adapted EMDR protocol in collaboration with supervisors and trainers from EMDR Europe, EMDRIA, and EMDR Asia
- African researchers to further study the acceptability, use, and effectiveness of EMDR and adapted protocol in their countries, using culturally adapted data collection tools.

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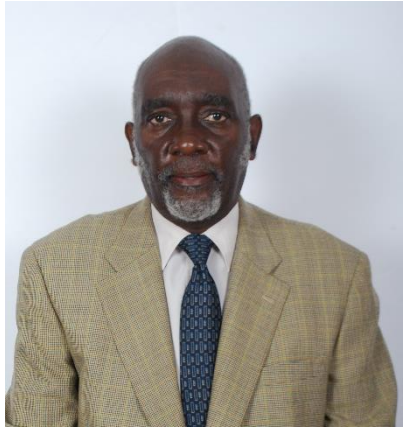

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