Cultural Adaptations of the Standard EMDR Protocol in Five 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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Although traumatic events negatively impact people from various cultural groups on all continents, psychological trauma-focused treatments have mostly been focused on theories and methods from countries in the Global North. In order to effectively work with clients who differ from their own cultural groups, clinicians and researchers require cultural competency skills (Osterman & De Jong, 2007). From the 1980s onward, the imperative of cultural competence and a multicultural orientation in psychotherapy and clinical supervision has been recognized (Hook et al., 2016; Watkins et al., 2019). Attention to the interplay between culture and concepts of health or illness, expressions of distress, and healing beliefs and practices is needed when treating clients with psychological and psychiatric problems, because culture determines the expression of symptoms, the explanatory models of illness, coping, and treatment (Osterman & De Jong, 2007).

The current study used an Afrocentric qualitative design to explore the cultural adaptations in trauma-focused treatment. It sought to determine the cultural adaptations African EMDR therapists make in the eight phases of the standard EMDR protocol when treating clients in their respective countries.

EMDR Therapy

Eye movement desensitization and reprocessing (EMDR) therapy is an eight-phase psychotherapeutic treatment approach, used to treat persons with traumatic stress symptoms since 1989 (Shapiro, 2001). EMDR is one of the two treatments for stress and trauma recommended by the World Health Organization (WHO) (Tol et al., 2013). A large number of randomized controlled trials worldwide have documented its positive effects, including a rapid decrease in symptoms of posttraumatic stress disorder (PTSD) (Mavranezouli et al., 2020). Research has documented successful cultural adaptations of individual and group EMDR protocols with refugee populations and communities affected by man-made and natural disasters in Asia, Europe, the Middle East, and North and South America (Acarturk et al., 2015; Hurn & Barron, 2018; Jarero et al., 2014; Lehnung et al., 2017; Mehrotra, 2014; Rasolkhani-Kalhorn, 2005; Seponski, 2011; Ter Heide et al., 2014).

EMDR therapy is based on the adaptive information processing (AIP) model (Shapiro, 2001) which assumes that successfully processed life experiences are stored and "digested" in an appropriate way and create adaptive memory networks. When experiences are traumatic, the processing may be unsuccessful, affecting the memory network: persons may experience intrusive and disturbing images, thoughts and beliefs, emotions, and body sensations. The goal of EMDR therapy is to identify and reprocess these disturbing memories (Shapiro, 2001; Shapiro & Forrest, 2001; Shapiro & Laliotis, 2011).

The standard EMDR protocol consists of eight phases. In Phase 1, "client history," the goal is to identify the client's current problem and the undigested memories that are at the root of this problem. In Phase 2, "preparation," the stability of clients is assessed, the EMDR process is explained, and the different bilateral stimulation (BLS) options, including eye movement and tapping, among others, are explored. Stabilization exercises such as the "safe place" and "container" are practiced to ensure the client can stay in their window of tolerance during the processing. In Phase 3, "assessment" the therapist accesses the target memory for EMDR processing. The components of a memory are defined by the worst representation of the traumatic event, such as an image, a sound, or a taste. A negative belief about the self when thinking about the traumatic experience is identified. A positive cognition that the client would like to believe about himself or herself is then defined. The validity of this positive cognition is measured by the Validity of Cognition (VOC) scale, where 1 is completely false and 7 is completely true. The client is then asked to describe what emotion(s) they feel when they think of the event. The level of emotional disturbance of the traumatic event is measured on the Subjective Units of Disturbance Scale (SUDS), with 0 representing no disturbance and 10 representing maximum disturbance. In Phase 4, "desensitization," the traumatic memory is reprocessed using BLS. In this phase the client reprocesses the information and makes associations, which connects dysfunctional stored memories to an adaptive memory network. If reprocessing is blocked, there are different techniques to unblock the process; a common way is for the therapist to intervene using cognitive interweave techniques. Reprocessing continues until the SUDS reaches 0. In Phase 5, "installation" the

goal is to install the positive cognition with a validity score of 7 (completely true) on the VOC scale, while thinking about the memory. In Phase 6, the "body scan" the therapist checks whether there are still negative body sensations associated with the traumatic memory. In Phase 7, "closure" the therapist and client complete the process, checking to make sure the client is ready to leave and knows the reprocessing may continue in between sessions. In Phase 8, "reassessment," which mostly takes place in a subsequent session, the therapist evaluates the client's progress (Shapiro & Forrest, 2001).

The Standard EMDR Protocol was developed based on the experiences of Francine Shapiro when she was using EMD (Shapiro & Forrest, 2001). Eye movement desensitization (EMD) is still used in specific situations to reduce symptoms targeting only one dimension of a memory, while avoiding spontaneous associations with other memories by returning to the target after each set of BLS. EMD reduces activation, increases stability, and is indicated for use in clients who can easily become emotionally overwhelmed (Shapiro & Laliotis, 2011). Various other individual and group protocols have been developed (Artigas et al., 2009; Shapiro, 2015), as well as protocols to respond to specific symptoms and situations (Shapiro & Laliotis, 2011).

EMDR in Sub-Saharan Africa

In most sub-Saharan African countries the burden of traumatic stress is high due to various war, natural, and man-made disasters, and the lack of mental health services (Atwoli et al., 2013; Beiser et al., 2010; Jenkins et al., 2015; Kane et al., 2016; Njenga et al., 2006; Okello et al., 2013; Verhey et al., 2018; Winkler et al., 2015). Unfortunately many low-income countries lack trained mental health professionals, and the treatment gap is huge (Lund et al., 2012; Patel et al., 2007).

Since 2007 African social workers, counselors and psychologists in Burundi, Cameroon, the Democratic Republic of Congo, Ethiopia, Kenya, Rwanda, South Africa, Sudan, Tanzania, Togo, Uganda, Zambia, and Zimbabwe have been trained in EMDR by various EMDR humanitarian assistance program (HAP) associations from the United States, France, Germany, Israel, Netherlands, Spain, and Switzerland (Fernandez et al., 2014; Zimmermann, 2014). Very little is known about the use of EMDR in sub-Saharan Africa. Masters et al. (2017) and Zimmerman (2014) described the experience of teaching EMDR in African countries (Masters et al., 2017; Zimmermann, 2014). However, only a few publications are available on its actual use and the outcomes of EMDR therapy in African countries.

In South Africa, a study about the use of the standard EMDR protocol with three cancer patients showed beneficial outcomes (Peters et al., 2002). A study in Uganda among 19 mental health workers suggested that cultural adaptation of guidelines is important before using EMDR in the country, though no specific suggestions were made on how to adapt the standard protocol (Kane et al., 2016). In Ethiopia the EMDR integrative group treatment protocol (IGTP) protocol (Artigas et al., 2009) was administered to 48 adolescent refugees, with a significant decrease in PTSD and anxiety symptoms after EMDR treatment (Smyth-Dent et al., 2019). In the Democratic Republic of Congo the same group protocol was tested and compared in 2008 with individual EMDR therapy with 37 young women who had been sexually assaulted, with a greater reduction in the SUDS scores in women who received individual treatment (Allon, 2015). With the exception of the Allon study, no information is available on the cultural adaptations the African EMDR therapists made to the protocol in the reports on these studies. Cultural modifications are crucial when adopting therapy methods from high-income countries for use in low-income countries (Chowdhary et al., 2014; Patel et al., 2007; Wilson & Tang, 2007).

EMDR Cultural Modifications

EMDR therapy was originally developed by Shapiro in the United States. As its use has spread around the world, various authors have suggested cultural adaptations of the protocol to ensure it can be used with persons from different cultural backgrounds. Cultural adaptations of individual and group EMDR protocols have been described by therapists and researchers from Asia, Europe, the Middle East, and North and South America (Acarturk et al., 2015; Allon, 2015; Hurn & Barron, 2018; Jarero et al., 2014; Lehnung et al., 2017; Mehrotra, 2014; Rasolkhani-Kalhorn, 2005; Seponski, 2011; Ter Heide et al., 2014; Woo, 2014). The EMDR-IGTP has also been successfully used with children and adults in various low-resource settings (Artigas et al., 2014; Jarero & Artigas, 2012; Wong, 2018).

Spierings recommended the use of culturally appropriate metaphors when explaining trauma and stressed the importance of "intercultural competence." She defined this as "a structured way of building therapeutic relationships with patients from different cultures and building trust" (p. 3, Spierings,

1999). This concept was further developed by other therapists in Europe and the United States (Amara, 2017; Hartung, 2017; Masters et al., 2017; Nickerson, 2017).

Nickerson (2017) highlighted the imperative of cultural competence. He asserted that EMDR clinicians can employ culturally informed modifications to each of the eight phases as long as these modifications remain consistent with Shapiro's AIP model and accomplish the goals of each phase. He encouraged EMDR clinicians to develop cultural awareness so that they could attune standard EMDR procedures for the cultural setting, build cultural sensitive therapeutic alliances, and take cultural aspects into consideration when implementing assessments, case formulations, and treatment plans. Hartung (2017) described the importance of understanding the cultural practices and customs when teaching and using EMDR in different societies in Asia, Europe, and the Americas. He acknowledged the differing cultural concepts about mental health which were reflected in the history of mental healthcare in different countries.

Spierings (2004), Hartung (2017), Amara (2017), and Zimmerman (2014) proposed the following adaptations of the standard protocol to make it more culturally appropriate for persons from cultures from the Global South:

In Phase 1:

- Use prayer when starting a session if this helps the client (Spierings, 2004).
- Consider past and ongoing trauma when taking the client's history and use indirect ways of asking for this, as many clients may feel unsafe or embarrassed when talking about their psychological symptoms (Amara, 2017; Spierings, 2004).
- Use the life-line technique to take history, and to select only a few targets for processing when making a treatment plan (Spierings, 2004).
- Include positive memories on the timeline to allow the client to view their life from the past through the present to the future. If the negative memories outweigh the positive, take additional time to find positive memories and build additional resources (Hartung, 2017).

In Phase 2:

- Start with stabilization and resourcing exercises prior to reprocessing or switch back and forth while taking the clients' history (Phase 1), as many clients feel very unsafe (Hartung, 2017; Spierings, 2004).
- Focus on resource development and building affect tolerance, making use of the healing rituals, objects, and symbols of the client's culture. These resources are utilized both before and during EMDR (Spierings, 2004).
- Start with stabilization exercises as soon as possible (Amara, 2017).
- For the safe-place exercise with migrants, consider using "family" as the safe place (Spierings, 2004) and consider using the word "comfortable" rather than "safe" place (Amara, 2017).
- For the safe place, consider using places related to religion or ancestors (Spierings, 2004).
- To explain BLS, use elements of the client's culture, such as ritual dances or other rhythmic movements (Amara, 2017).

In Phase 3:

- Use simple explanations and language in the assessment phase (Spierings, 2004; Zimmermann, 2014).
- Negative cognitions (NC) and positive cognitions (PC), clients from group-oriented cultures may prefer those with a "collectivistic orientation" (Woo, 2014) that include family, group, or community (Spierings, 2004).
- Be aware that clients from various cultures find it difficult to verbalize an "emotion" (Zimmerman, 2014); that some have no experience with metacognition—thinking or talking about thoughts (Allon, 2015); and that abstract concepts such as "self-esteem" may have no meaning (Hartung (2017).

In Phases 4, 5, and 6:

- Target body sensations with people who have difficulties expressing negative beliefs and emotions (Hartung, 2017).
- Avoid eye movements in cultures where they might be associated with witchcraft or prohibited practices (Zimmerman, 2014).
- For cognitive interweaves, use the client's religious beliefs where appropriate (Spierings, 2004).
- In cultures where public displays of emotion are strictly prohibited or emotional suppression is valued (Hartung, 2017), monitor clients' level of arousal and use standard EMDR procedures to ensure that clients remain within their window of tolerance (Shapiro, 2001).
- Do not require that SUDS scores reduce to 0 or 1 if the person has experienced a lot of trauma or

is in an uncertain or unsafe situation (Spierings, 2004).
- Be careful with conducting the body scan, as this may trigger other traumatic material (Spierings, 2004).

In Phase 7:

- To close the session, focus on positives by asking "What is the most important thing you experienced today?" followed by a short set of BLS, the question "And what does this say about you?" (Spierings, 2004).
- Use standard EMDR session closure strategies, (Shapiro, 2001) such as
  - The container technique, asking the client to visualize putting the material in a box and closing it
  - The light stream technique
  - Having the client identify a realistic and appropriate support system
  - Reminding the client of ways to handle emotions and provide self-care

Most of the suggestions for cultural modifications have been made by EMDR trainers and therapists from the Global North working with refugees and migrants in Europe and the United States. Some have worked with populations of different cultural backgrounds in countries in the Global South. While some of the modifications may be applicable for use in sub-Saharan Africa, most have been proposed for refugee and migrant populations now living in the Global North. Very little is known about the cultural adaptations EMDR therapists living in sub-Saharan African countries have made when using EMDR with African clients. In this article we aim to describe how a group of African EMDR therapists have used EMDR in their practice and have adapted the EMDR protocol to their context and target population.

Method

Design

The study used a qualitative exploratory design with an Afrocentric approach. Afrocentric approaches in research have been proposed and used by various African scholars (Chilisa, 2012; Mkabela, 2005; Owusu & Mji, 2013). They aim to push the boundaries of international development theory and practice and to and decolonize, indigenize, and envision new evaluation tools and practices in research in Africa (Chilisa et al., 2016). Afrocentric research emphasizes sharing and collective ownership of opportunities, responsibilities, and challenges in the research process (Chilisa et al., 2016). In Afrocentric study designs, the relationship between the researchers and the researched is one of interconnectedness and interdependence. The process is participatory throughout. In our study, participants had met each other at EMDR trainings in the region and had discussed the need to document the experience of EMDR in Africa in various other meetings over the past years.

The study methods consisted of a jointly designed qualitative written questionnaire about the use of EMDR, a focus group discussion, and analysis of supervision notes of two EMDR Europe supervisors who worked with African therapists over a period of 10 years. Data was collected during an "EMDR for children" training organized by Trauma Aid France and EMDR Uganda in Kampala, Uganda, in November 2019, followed by online (focus group) discussions among the authors in January and February 2020.

Data Collection Process

The Questionnaire. The questionnaire was developed by the authors of this article and included questions about the participant's training, number of clients seen and treated using EMDR, types of protocols used, ways to measure clients' progress, and adaptation of the eight phases of the standard EMDR protocol. Two EMDR therapists (one with an academic background) who were part of the training drafted the initial survey questions about the use of EMDR in Africa. The questions were further discussed with and modified by other members of the EMDR Africa community present at the training in November 2019.

At the training all participants were requested to complete the final version of the survey questionnaire. In total, 25 out of 26 training participants completed the questionnaire. All therapists who completed the questionnaires voluntarily participated and consented to having their responses described anonymously in a publication.

While this could be called a "convenience" sample in research language of the Global North, the authors feel it is important to point out that in collecting this information it was important to stay true to the Afrocentric research approach in which researchers plan and execute evaluations together with the participants, not as outsiders but as part of the group. In Afrocentric research the participants need to know the evaluator to be able to share knowledge (Chilisa et al., 2016). The quality of the data would be very different if a randomized sample of therapists had

been approached by e-mail, as the participants need to know the evaluator before they can entrust their knowledge, and need to be able to discuss the questions together.

The Focus Group. During the training in which the survey data was collected, the 26 participants chose representatives from five countries to engage in further discussion about the creation of an EMDR Africa Association. From this group of representatives, eight were asked to participate in a focus group discussion which would discuss the questionnaire outcomes in more depth. The two authors who initially drafted the questionnaire purposefully selected eight therapists from the group of representatives, ensuring each participant had a minimum of 5 years' experience in using EMDR and taking into account gender and country representation.

The focus group discussion was held via video conferencing. It was organized by the first and second authors (F.B.M. and A.D.), who had been part of the survey questionnaire development and who provided the training during which the questionnaire was administered. They summarized the questionnaire data and presented this to the focus group for further discussion. They made notes of the focus group discussion and shared the notes via e-mail with the group for further inputs. The members of the focus group are the authors of this article.

The focus group discussion conversed on cultural adaptations to the standard EMDR protocol, systematically discussing each phase of the protocol. Based on the questionnaire outcomes specific themes were checked and elaborated upon. For Phase 1, themes that include timeline, past/present/future, definition of trauma, explanation of the AIP model, and float back were specifically highlighted and questioned. For Phase 2, specific exercises such as the safe place, container, grounding exercises, and stop signal were discussed. Each step in Phase 3 was discussed: the image, negative and positive cognitions, defining the emotion, the use of the VOC and SUDS, and body sensation. For Phase 4, the discussion focused on any difficulties faced or changes made during desensitization, for example, focusing on the image, the type of stimulation used, clients' window of tolerance, and the use of cognitive interweaves. Experience of installation in Phase 5 and the body scan in Phase 6 were discussed. To understand the cultural adaptation of how sessions are closed, questions were asked around closing procedures for both complete and incomplete sessions in Phase 7, as well as reevaluation of clients in Phase 8.

The Supervision Notes. Two EMDR therapists who are EMDR supervisors and trainers were asked to share in writing their observations on cultural adaptations and changes they have made and have seen their trainees and supervisees make in the standard protocol. They provided their inputs in the form of a report, illustrating adaptations they and their trainees make in each phase of the standard protocol. These inputs were also discussed with the focus group discussion members.

Participants

The therapists who answered the survey questionnaire were three males and 22 females. Their professional backgrounds included social workers (3), counselors (3), psychotherapists (3), counseling psychologists (8), clinical psychologists (7), and psychiatrists (1). Their countries of origin include the Democratic Republic of Congo (1), Ethiopia (4), Kenya (4), Uganda (14), and Zimbabwe (2). The average age was 44 (range 32–60 years).

The focus group participants included eight therapists: one from the Democratic Republic of Congo, two each from Ethiopia, Kenya, and Uganda, and one from Zimbabwe. There were three male therapists (2 clinical psychologists, 1 counseling psychologist), and 5 female therapists (1 counselor, 1 psychotherapist, 1 counseling psychologist, 1 clinical psychologist, and 1 psychiatrist).

The EMDR supervisors and EMDR trainer who provided supervision notes are registered with EMDR Europe and have trained and supervised over 60 EMDR practitioners in African countries. Both have worked in Kenya, Uganda, and Zimbabwe and have respectively 10 and 25 years of experience working with African clients. They are currently working in Kenya and Uganda respectively, and have daily contact with both clients and trainees.

The Researcher—Participant Relationship. The authors were among the eight focus group discussants and among the 25 respondents who answered the questionnaire. They were not separate "researchers," but participants and cocreators of the process in which the use of EMDR in Africa was discussed and formulated in this article. This evaluation process reflects what Chilisa (2016, p. 324) calls "the African logic of circularity," which opposes the "linear logic" of evaluation methods used in the Global North. In this process the "African participants" are not passive recipients of knowledge, but people who can own and coproduce knowledge.

The relationship is not one of hierarchy but one of coproduction.

Data Analysis

The qualitative questionnaire outcomes, focus group discussion, and summaries of supervision notes were manually analyzed by the first two and last author following a thematic approach using framework analysis and a matrix-based system for organizing, reducing, and synthesizing data (Braun & Clarke, 2006). A code book was developed during the focus group discussions. The thematically organized data were then reviewed and synthesized into meaningful themes and quotes were selected to highlight, explain, or describe relevant themes. Data saturation was discussed by the analysis team. The responses were divided in three thematic sections: training in and use of EMDR, general comments about EMDR and its use and effectiveness, and cultural adaptations in the eight phases.

Results

Training and Therapists' Use of EMDR

All therapists were trained by EMDR trainers from European countries or the United States. They all completed level I and II training and 10 hours of supervision after level I and 10 hours of supervision after level II with either EMDR Europe or EMDRIA trainers. They all received an additional 5 hours of supervision after level I EMDR children's training. Some mentioned it had been challenging to complete their supervision hours, as they had limited access to the Internet, and trainers were often not available for supervision in person after providing their trainings in Uganda.

Therapists had been working for 6–27 years with an average of 14 years. All were currently using EMDR as one of the treatment methods in their practice, and had used EMDR for 1–15 years with an average of 7 years. The majority (23) were seeing adults and children in their practice. Their client population consisted of an average of 56% adults and 43% children. The therapists saw an average of 11 clients per week (range 2–30) and used EMDR with 40% of these clients.

The therapists mostly use EMDR with specific groups of clients, including refugees and displaced persons due to armed conflict, Ebola survivors, torture survivors, victims of sexual violence, persons with chronic illness and disabilities including HIV, orphaned and vulnerable children, and sexual minority groups.

> "I use EMDR with refugees and displaced populations; they have experienced a lot of trauma. This is my main client population." Therapist, Uganda

The majority used the standard EMDR protocol in their practice and work with individuals. Therapists explained that for clients with ongoing trauma, stabilization and the EMD protocol are utilized.

> "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." Therapist, DRC

Ten of the therapists had been trained in and used the IGTP protocol (Artigas et al., 2009) when providing therapy in groups. Only two participants mentioned being trained in and using the Group Traumatic Episode Protocol (G-TEP) (Shapiro, 2015). Some mentioned that working with groups is difficult as clients prefer to have individual sessions as they worry about others finding out they have mental health issues.

General Observations on EMDR and Its Use

The therapists described finding EMDR a useful therapy in their setting, which benefited their clients. The most distinctive reason for choosing to use EMDR was the ability to provide therapy without a focus on narration, since many clients find narration difficult.

> "They [the clients] don't want to talk, they say 'wave your hands, it will take away my problems."' Therapist, Ethiopia

The therapists described seeing results quickly and feeling EMDR has helped many clients. Clients provide positive feedback and feel relieved; some clients say it is magic, other say "it's a brain thing."

> "Some clients say I have reprogrammed their brains." Therapist, Zimbabwe

The majority of the therapists experienced some difficulties explaining to their clients how EMDR works, as clients are often not familiar with psychotherapy in general. They did not experience more difficulties in describing EMDR and the need to come back for regular sessions compared to describing other

types of therapies, including trauma-focused cognitive behavioral therapy.

Most therapists did not use standardized rating scales; in their experience most clients did not understand the Likert scales and some felt that the questions were not culturally appropriate. They explained that the majority of their clients come from low-income settings, and some are illiterate. The therapists often used very simple descriptions translated in their local language to explain and use EMDR with their clients.

> "Your brain stores information. When something happens it creates a memory. You can think of what happened in the past because your brain created a memory. When a bad memory is stored well, it does not disturb you so much anymore after some time. Sometimes it is stored in a bad way, and we need to process that memory again to store it in a better way. You can think of it as a compound with different huts. If the problem is stored in a hut it is safe; if it is still out in the compound, it keeps going around and affects you all the time you cross the compound. In EMDR we want to store your memories in a way that feels safe and does not make you feel bad. Not in the past, but also right now, and tomorrow and next week." Therapist, Uganda.

All therapists in our study explained that religious beliefs play an important role for them 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.

Cultural Adaptions in the Eight-Phase Standard Protocol

Table 1 summarizes the changes therapists in our study proposed to make in the eight-phase standard protocol. Aside from the description of negative and positive cognitions, no significant differences in adaptations were noted between respondents of the five countries.

Phase 1. Most therapists recommended not making adaptations in Phase 1, but using the explanation of the AIP model as learned in their training, mostly using the food and indigestion metaphor with particular food examples from their area. Some used the metaphor of a wound which gets infected when not cleaned well. One participant used a metaphor of weeds that need to be removed by their roots contrary, to just cutting them above ground. Some therapists used a visual timeline and would draw this on paper or in the sand with a stick. Most therapists did not use standardized screening tools, such as the PTSD Checklist for *DSM-V*, the Impact of Event Scale, or Dissociation Experiences Scale. They stated these are neither culturally appropriate nor understood by their population. The ones (6/25) who did use standardized screening tools translated them into their language and would read them to their clients when administering them.

Phase 2. In Phase 2 the majority of the therapists in our study used culturally appropriate metaphors that would fit the environment of the client (e.g., a river, sitting on a bus) to explain EMDR. The major adaptations made in Phase 2 were in the safe place and container exercises. All preferred to use the word "happy," "calm," or "special" place instead of safe place, as the word "safe" is often a trigger to their clients, and "safe" spaces do not necessarily exist in their lives. Often clients asked to add a person in their safe place, which most therapists accepted. Many clients associated the "happy," "good," or "calm" place with religious beliefs and the omnipresence of their God.

TABLE 1. Adaptations Made in Each Phase of the Standard Protocol

Phase	
1	Culturally appropriate metaphors of the AIP model Use of a visual timeline Adaptation and translation of screening tools
2	Put Phase 2 before Phase 1 Culturally appropriate metaphors to explain EMDR Happy or calm place instead of "safe" place Basket, bag, pot, pit instead of "container" Cultural and religious practices as resources Different sign for stop signal
3	Cognition: We vs. I Good and bad instead of positive and negative cognition Different explanations of emotions Adaptation of VOC and SUDS
4	Tapping instead of eye movements Include divine powers in cognitive interweaves
5–8	No other than mentioned above

Note. AIP = adaptive information processing; EMDR = eye movement desensitization and reprocessing; SUDS = Subjective Units of Disturbance; VOC = Validity of Cognition.

"My clients often include family members in their safe place and other resourcing exercises. We can also not ignore the importance of God in these." Therapist, DRC

A few therapists ask their clients to draw their safe place, and find that clients often draw trees.

"When my clients draw their safe place, they seem to always include a tree. Trees are protective, they give shade.'" Therapist, Kenya

The word "container" was not understood by many clients, and 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." Therapist, Uganda

"When we use the word 'container' clients think of a container truck for transport; it is easier for them to imagine a basket, the local type with a lid in which you keep food." Therapist, Kenya

The majority of therapists narrated that clients asked the "container," in form of a pot or bag, to be stored in the therapist's office. They often feel this is a safe place to keep the container.

In the grounding exercises the therapists added dance and music. Some therapists sang songs with their clients to make them feel stronger and happier. Religious beliefs were often used as resources for clients, mostly commonly reciting religious texts, prayers, 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." Therapist, Zimbabwe

For the stop signal most people used the hand sign. However, a few pointed out that clients find it rude because they would not want to "stop" their therapist, who is often considered their superior or "doctor." When therapists felt the client was reluctant to use the stop sign they checked in more frequently during the process to ensure the client was still okay to continue.

At least half of the therapists started with stabilization and resourcing exercises (Phase 2) before taking the full history (Phase 1), as they often had very distressed clients and felt they first had to "offer" something to ensure the clients will feel some benefits and will return for the full treatment.

Phase 3. In Phase 3 therapists often found it challenging to find a cognition that starts with "I" instead of "we." Culturally most clients live together in large households and have shared responsibilities; the therapists explained that just making the client feel better about themselves does not help sufficiently. 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 their next of kin.

"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 okay." Therapist, Uganda

The terms *negative* and *positive cognition* were sometimes translated as "bad thoughts" or a "thought that is cursed," whilst positive cognitions were called "good" or "blessed" thoughts. A therapist from the Democratic Republic of Congo explained that the fear of being cursed is very powerful, and needs to be taken into account when defining cognition.

"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.'" Therapist, DRC

"I often explain the positive and negative cognitions as good and bad. I call it the double-sided mind, the Godly side and the satanic side; this helps my clients understand." Therapist, Uganda

The use of the VOC and SUDS was challenging to some; most therapists in our study used hand movements (to show small to large size), a thermometer analogy, or the pictorial faces version used in EMDR for children. A number pointed out that if clients did understand the scales they tended to want to please the therapist and would just say that the number reduced, as they felt it was expected. This was less evident when therapists used hand movements or pictorial faces. However some of the faces which were given to the therapists during training were not culturally appropriate (e.g., clowns) or did not have a lot of similarities with the shape and color of faces their clients

identify with. In the Democratic Republic of Congo, several clients would fear to quantify their distress in numbers, as they believe this may cause misfortune; drawing or showing it nonverbally is possible instead.

> "It is usually difficult for clients to quantify distress. They will often say, 'It is okay', 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." Therapist, DRC

In some countries therapists found it difficult to elicit emotions from clients. Often psychoeducation was required about different emotions before a client could identify the emotion. Some explained that the word "emotion" itself does not exist in their local language.

> "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." Therapist, Uganda

Many therapists accepted a more limited description (e.g., "I am feeling bad") in case of language difficulties or the client's limited understanding. They explained that their clients often express their trauma and pain in body sensations. Only in the DRC did therapists feel it was harder to express body sensations.

> "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." Therapist, Ethiopia

Phase 4. In Phase 4 some therapists described clients as initially wary of the use of eye movements, thinking of it as "witchcraft." Other therapists mentioned that using eye movements was fine, but that it was better to use a pen or object than the hands alone, so as not to scare the client. A few therapists mentioned that hand movements were okay and that clients actually saw it as something positive and magical.

> "Some clients are positive about the hand movements and say you are doing something magical with your hands."

Most clients preferred tapping as a method. Nevertheless tapping posed a challenge in some countries where a client cannot be touched by a therapist of a different gender for cultural reasons. Some therapists allowed the clients to do their own tapping by using the butterfly hug for processing. Most, however, only used the butterfly hug during resourcing exercises.

> "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." Therapist, Uganda

> "This is a sensitive subject. It is generally recommended that the therapist is older than the client and the client and therapists are of the same gender. If a female therapist has to help an older male patient, she should not do tapping but only eye movements." Therapist, DRC

Therapists felt comfortable adapting cognitive interweaves to the reality of the client and their context. The majority used religious interweaves, which clients felt helped by.

> "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." Therapist, Kenya

> "The importance of the divinity is to be taken into consideration; we often say "God has given him grace." Therapist, DRC

Phases 5–8. In Phases 5–8, therapists did not make many adaptions aside from adaptation already made in Phase 3 described earlier.

Discussion

This article described the adaptations made by therapists in five African countries which enabled them to use the EMDR protocol for clients in their setting. The most significant adaptations were made in the Phase 2 stabilization and resource exercises, and in the Phase 3 descriptions of negative and positive cognitions, the VOC and SUDS, emotions, and body sensations.

Our findings do not recommend a theoretical approach that differs from Shapiro's (2001) AIP model. EMDR therapy encourages the customized adaptation of Phases 1 and 2 (Shapiro, 2001) to meet clients' needs, including the clients' cultural needs (Nickerson, 2017). However, we argue that cultural, social, political, historical, and economic factors and local

resources must all be taken into account when adapting and using the standard eight-phase EMDR protocol in Africa.

We identified four areas in which African therapists consistently made significant adaptations to the standard protocol: different wording of the protocol text, cultural expression of thoughts and emotions, stimulation choice, and simplification of the VOC and SUDS. It is essential that international EMDR associations and related training bodies inform themselves of these four areas and make related changes for future training and use of EMDR in sub-Saharan Africa.

Different Words Within the Protocol Text

Firstly, we argue for different *wording of the protocol text*. Our analysis determined the imperative of therapists finding appropriate translations in their setting that resonate with the clients' daily life and way of communication. The word "safe" is triggering for many clients as clients often do not and may never experience living in a safe environment during their lives. We suggest renaming the "safe place" exercise to the "good" place exercise in Phase 2. In Phase 3 we recommend that therapists find appropriate alternatives for words that do not exist in their local language. For example, the word "emotion" does not exist in some Bantu languages, which are spoken in different East and southern African countries. Further, cognitive interweaves used in Phase 4 also need to reflect the cultural and spiritual beliefs of the client. Religious beliefs are very important for most therapists and their clients.

Cultural Expressions of Thoughts and Emotions

When importing the EMDR protocol in countries in the Global South, we have to make it accessible and understandable. Therapists must consider cultural descriptions and be sensitive to local expression of thoughts and emotions. It is essential that the text of the Phase 3 targeting sequence plan be simplified in various settings. As previously noted by Zimmermann (2014), this text is built on the educational culture and psychological concepts from the Global North. Recommendations resulting from our analysis include changing "positive and negative cognitions" to "good" and "bad" thoughts. We also recommend the use of collective as well as individual cognitions during the assessment and installation phases (Phases 3 and 5). We suggest having different lists of cognitions, both individual and collective, to ensure we take into account the value of African cultural concepts. This is consistent with recommendations by Spierings (2004), who explained that the protocol question "what does it say about you as a person" assumes a sense of individuality, a notion of being this specific person with these specific attributes. The question does not recognize the more collectivistic orientation in Global South countries. Therapists in various African countries often interact with the whole family or even community when treating clients. Even when seeing individual clients, one has to take into account the interconnectedness of this client with their family and community.

Stimulation Choice

Our findings suggest the value of offering the different types of available stimulation, and *starting with tapping rather than eye movements*, because many clients perceive the eye movements as witchcraft. Tapping might be more culturally appropriate in many of the sub-Saharan African countries. Eye movements should not be abandoned, but may be offered as a second or third rather than first BLS method. Unlike other countries in which BLS is evident in indigenous healing traditions and religious ceremonies, we did not find similar movements in our setting. However, we did not specifically investigate possible collaborations between indigenous healers and therapists. Abdul-Hamid & Hughes (2015) described how the ritual movements of Sufism may involve a form of BLS which could be incorporated in EMDR in the Middle East and Muslim world (Abdul-Hamid & Hughes, 2015). We think this might also be relevant in some African countries with a majority Muslim population, and needs to be further explored in future studies in a larger number of African countries. Amara suggests explaining the biological aspect of the BLS process by making universal links with similar elements of the subject's culture, for example, ritual dances or movements (Amara, 2017). Hartung (2017) encourages asking after and where possible including indigenous healing traditions in the EMDR process, and gives an example of using drumming as a resourcing and stabilization strategy. In our study the use of dance and music was suggested by therapists; this often included drumming as accompaniment to songs and dance and also involves some repetitive movements that could be beneficial when linking this to consistent BLS patterns. Therefore, we argue that the beliefs about BLS and possible connections to dance, music, and rituals in Africa must be taken into account, and we advocate for further studies investigating the effects of different types of BLS on clients in different African

countries, as well as collaborative research with indigenous healers to further explore the benefits of collaborative treatment. In the medical field such collaborations have been explored and are under development, especially in the treatment of HIV-positive and psychiatric patients (Homsy et al., 2004; Robertson, 2006; Zingela et al., 2019).

Simplification of the VOC and SUDS

Our study identified the challenges of using the VOC and SUDS in many African communities. We argue for *simplification of the VOC and SUDS* in settings where a large group of the population has not been exposed to the visual Likert scale and where some are illiterate. We argue for a critical reflection on the design of the scales, which are based on an educational system and measurement which originates in the Global North. In many African countries oral traditions are stronger, and storytelling, music, dance, and drama contribute to narratives and show the importance of events. Rather than using numeric ordinal scales to enable clients to share their level of disturbance, we suggest using hand movements, visual scales showing pictorial faces which resemble persons of African origin, or items or examples from stories, such as a cracked or broken water pot. Our study found that most participants did not use standardized screening tools in their practice for the same reason. Screening tools have been used in research studies in a number of African countries and have been translated in various African languages. It might be helpful to create linkages between researchers who have such tools available and EMDR therapists to further assess which tools can be easily administered and are culturally appropriate and helpful in EMDR treatment.

Group Protocols

Only a few of our study participants were trained in EMDR group therapy. African EMDR therapists would also benefit from the opportunity to master the EMD protocol, the ongoing trauma protocol, some group protocols, and complex trauma protocols as all of these have great utility in African countries. In an earlier study which explored the beliefs of mental health workers in Uganda, most participants believed that group psychotherapy is advantageous over individual therapy (Kane et al., 2016). The main reasons mentioned in the study were the large client populations and small number of qualified counselors, and belief that a group method is more culturally appropriate and hence more effective than individual therapy. There has only been one study which compared EMDR group and individual treatment (Allon, 2015). It was conducted in the Congo and found individual therapy to be superior. Research is needed to show if EMDR group protocols need similar cultural adjustments as the standard protocol, and how individual and group protocols compare.

Expanding EMDR Therapy and Trainings in Africa

Based on the findings from our study, we recommend that training programs recognize that trauma is an ongoing or recurring experience in African settings, and that they modify the trainings accordingly. Zimmerman (2014) asserted that in societies devastated by war, famine, or political violence, it may be impossible for EMDR trainees to find simple cases to practice EMDR when trying to complete the initial training requirements. Future trainings need to take into account this reality.

In 2020 a group of African EMDR therapists started the process of establishing an EMDR Africa Association. Various attempts have been made to bring therapists together to create consensus about the way EMDR is used, adapted, and validated for use with clients in sub-Saharan African countries. One important step that is needed is the certification of EMDR therapists from African countries to train and supervise fellow African therapists. While most HAP associations have been keen on providing supervision remotely after providing level I and II training, therapists have not always received regular supervision due to logistic challenges as mentioned by the participants in this study. The effectiveness of short-term classroom-based trainings for mental health workers has earlier been questioned (Kane et al., 2016).

If EMDR is to be offered to more clients in more countries, the growth of a training force of African EMDR therapists is needed. Efforts to this effect have been made and therapists in Uganda, Kenya, and South Africa are completing their training as EMDR supervisors. National EMDR organizations have been set up in some countries including South Africa, Ethiopia, Kenya, Madagascar, and Uganda to develop criteria and ways to standardize EMDR training and supervision and create awareness about the treatment in the respective countries (Ochieng et al., 2020). Sharing and monitoring the implementation of the culturally adapted eight-phase model can help improve the uptake of EMDR, and could improve fidelity to the

guidelines across African countries. A review of studies on the use of guidelines have showed an improved uptake of and fidelity to new clinical guidelines in low-income countries (Chakkalakal et al., 2013).

Strengths and Limitations

Limitations of the study include the small sample size. Our findings were limited to the views of representatives of five sub-Saharan African countries only, and did not assess the effectiveness of the use of different EMDR protocols or the perception of clients about the treatment. Most of the participants used EMDR as an individual treatment method, and only some had been trained in the group protocols. The study focused primarily on the individual treatment protocol. We recommend that researchers from African countries evaluate the use and effectiveness of EMDR in future studies using African research models and integrate the use of cultural knowledge and experience in further applications of EMDR on the continent.

The strength of this study is that it was conducted by EMDR therapists, practitioners, and supervisors from African countries. It used an Afrocentric qualitative design, and collected data through the use of survey questionnaire, a focus group, and supervisor's notes. The thematic analysis identified important themes. Some of these themes were previously articulated by various colleagues who have worked with clients from various cultural backgrounds and have trained EMDR therapists in various cultural settings (Amara, 2017; Hartung, 2017; Nickerson, 2017; Spierings, 2004; Zimmermann, 2014). The strength of the current study is that it is grounded in the realities of African EMDR therapists, supervisors, consultants, and trainers. The recommendations arising from this study are practical and achievable, and have the potential to make EMDR therapy more accessible and culturally relevant in Africa.

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