EXPLORING EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) AS A CULTURALLY RESPONSIVE CAMBODIAN MODEL OF THERAPY

by

DESIREE M. SEPONSKI

(Under the Direction of Denise C. Lewis)

ABSTRACT

It is estimated that between 1.5 and 3 million Cambodians were killed between 1975-1979 as a result of the Khmer Rouge genocide. The victims were primarily highly educated individuals and their families, including government officials, doctors, lawyers, professors, teachers, and psychotherapists. As a result of the devastation, Cambodia is still struggling to educate its country and recover from the economic, political, and psychological damage caused by years of turmoil. The current climate is further complicated by the recent rise of an HIV/AIDS epidemic throughout the country, which has raised the death toll of the second generation of post-war survivors, leaving orphaned children to be raised by their older family members or to live on the streets. A project was developed to address the aforementioned crises by engaging Cambodian therapists at the Royal University of Phnom Penh (RUPP) in exploring a culturally responsive therapy model. With commitments to providing the community with improved mental health services, responding to stakeholder needs and issues, and creating an understanding of cultural sensitivity, responsiveness, and respect for Cambodian therapists and clients, this
dissertation utilized responsive evaluation methodology to explore Eye Movement Desensitization and Reprocessing (EMDR) as a culturally responsive model of Cambodian therapy. Data were triangulated across multiple stakeholders including EMDR trained students therapists (N =16), the RUPP department head, program head, professors/lecturers, clinical supervisors, and peer supervisors serving as cultural advocates and an advisory board (N =11), EMDR workshop participants (N=54), and Koh Pech crisis response therapists (N = 14) using numerous methods including a focus group, interviews, surveys, case illustrations, and live supervision observation. Qualitative and descriptive findings are mixed surrounding the clinical effectiveness of EMDR, yet converge on EMDR currently not being culturally responsive, but having future potential with serious adaptations. Emerging findings are discussed in detail and suggestions for improvement are provided.

INDEX WORDS: Cambodian therapy, responsive evaluation, Eye Movement Desensitization and Reprocessing, EMDR, culturally responsive therapy
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DEDICATION

This dissertation is dedicated to my best friend, who I am lucky enough to call my husband. On the first day of graduate school, you surprised me with the sweetest letter in my car, promising to always be my biggest supporter. I’m pretty sure at that time you didn’t think it would include living in the sweltering heat of Cambodia for ten months, cooking and cleaning more than your share for six years, and proof-reading an endless amount of papers. Thank you for your love, encouragement, and willingness to take this journey with me. Without you, it would not have been possible.
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written letter after letter to help me with scholarships, jobs, and the Fulbright. Thank you to my academic mother, Dr. Denise C. Lewis. You took me under your wing, encouraged and guided me from my very first few steps on campus, and led me to the wonderful world of Cambodia. Thank you for sharing your passion with me, and I am honored to be one of your little seeds. To Dr. J. Maria Bermudez who is my MFT and feminist role model, thank you for mentorship, encouragement, and positive aura—your honest feedback, immense love for the field, and dedication to rigorous research has helped me grow as a woman, therapist, and scholar (and mass producer of tables in manuscripts).

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CHAPTER 1
INTRODUCTION

Exploring Eye Movement Desensitization and Reprocessing as a Culturally Responsive Cambodian Model of Therapy

Traditional therapy models, including those from marriage and family therapy, psychology, counseling, and social work, reflect Western values and norms and may be inappropriate for use with many non-Western cultures. In the postmodern era of embracing diversity and multiple realities, many marriage and family therapists and researchers are beginning to examine how they can make these models culturally sensitive to minorities, immigrants, and refugees in the United States (US). However, most have failed to examine the applications beyond the US borders and in clients’ native homelands. And, for whatever reason it may be, limited funding, lack of know-how, or disregard for research, this work is not even being done by the therapists and researchers in their own non-Western countries. It is time that therapists go beyond simply “being aware,” understanding and appreciating differences, and adapting individual interventions to actively responding to the needs of their clients by using models that have theoretical underpinnings, underlying assumptions, and basic tenets that are consistent with those of non-Western clients (Carlson, 1999) and promote social justice for those clients, their families, and the surrounding communities.

The current study seeks to explore the use of Eye Movement Desensitization and Reprocessing (EMDR) as a culturally responsive Cambodian model of therapy, and to disseminate the emerging data to therapists in Cambodia and in the US. This responsive
evaluation study is committed to engaging the participants, Cambodian student-therapists, in rigorous education and therapeutic practice, responding to stakeholder needs and issues, providing the community with improved mental health services, and creating an understanding of cultural sensitivity, responsiveness, and respect for Cambodian therapists and clients.
CHAPTER 2
LITERATURE VIEW

First, it is important to note that, in reviewing the literature on culturally responsive therapy, a primary challenge is discerning the application and transferability of past studies and previous knowledge to the current population. Just as there is no single “American” culture, there is no single “Asian” culture (Carlson, 1999); each subgroup and country has its own identity and within and between-group differences, including values on the positions of respect and power, family member roles, communication patterns, attachment styles, and emotional expressions (Carlson, 1999). Thus, what is culturally relevant and responsive for Korean, Japanese, and Chinese Asians, may not be responsive or sensitive to Cambodian Asians, who have experienced genocide, live in severe poverty (Alkire & Santos, 2010), and are less Westernized than their fellow Asians.

On the other hand, as previously mentioned, there is little research on culturally responsive therapy conducted in general, much less for a poverty-stricken Cambodia, where all books and professional life was demolished during the Khmer Rouge reign. Hence, like previous studies, the current review will use “Asian” as a broad sweeping term applied to Cambodians, but acknowledges that there is more to learn about within and between-group differences and therapy in Cambodia to be truly culturally sensitive, relevant, and responsive.
Cambodia: A Brief Background

It is estimated that between 1.5 and 3 million Cambodians were killed between 1975-1979 as a result of the Khmer Rouge genocide (Kamm, 1998). The victims were primarily highly educated individuals and their families, including government officials, doctors, lawyers, professors, teachers, and psychotherapists (Kamm, 1998). As a result of the devastation, Cambodia is still struggling to educate its country and recover from the economic, political, and psychological damage caused by years of turmoil (Kamm, 1998; United Nations Development Programme, 2006). The current climate is further complicated by the recent rise of an HIV/AIDS epidemic throughout the country (Center for Disease Control and Prevention, 2006), which has raised the death toll of the second generation of post-war survivors, leaving approximately 300,000 orphaned children (United Nations Development Programme, 2006) to be raised by their older family members or to live on the streets. Psychological services, family therapy, and trauma treatment are desperately needed.

There exists a cavernous gap in the research literature on the current psychological practices in Cambodia. The only empirical study known to the author was a groundbreaking qualitative review of peer-selected mental health practitioners (N = 15) from psychology, social work, and psychiatry from the clinical and social policy levels (Stewart, Tsong, & Peou, 2010). Epidemiological statistics ranked especially high in anxiety disorders (40-53%), depression (11.5-42.4%), and Posttraumatic Stress Disorder (7.3-28.4%). To treat these patients, Cambodia has only 35 psychiatrists, with 10 these working in a hospital setting for only 4 hours a day, seeing 200 clients within that time span; due to low salaries, they must work other jobs in the afternoon (Stewart et al.,
Most clients, however, do not seek psychological treatment due to stigma and the belief that the symptom’s origins/causes are spiritual (ancestral, curses, karma), physical (having a “weak heart” or too much work), or psychologically induced from “too much thinking” (Stewart et al., 2010). Prior to seeking treatment with a mental health professional, clients will first try to working within family coping, next seek help from the traditional sector (fortune teller, monks, traditional healer), and then see a general practitioner. As a result, they will have tried many medications, treatments, and herbal remedies that have often exacerbated original symptoms, sometimes over a span of 20 years. When they finally do come to therapy, they want advice or medicine as a quick fix (Stewart et al., 2010).

Poverty is another therapeutic hindrance, both for the clients and mental health practitioner (Stewart et al., 2010). At the governmental level there is lack of organization, conflict among leaders, limited funder interest, inconsistency with funding and influx of medication, lack of human resources, and a decentralization of mental health (Stewart et al., 2010). At the community level, services are scant and scattered and there are limited human resources. The current human resources are limited in training, critical thinking, and self-awareness due to education standards (Stewart et al., 2010). Finally, individuals, while extremely resilient, are impacted by the multitude of trauma from past decades (genocide, war, poverty), unresolved issues with the justice system (Khmer Rogue Tribunal), parenting issues resulting from generations of trauma, and extreme poverty (Stewart et al., 2010).

Despite all of the previously mentioned challenges, Stewart et al. (2010) is somewhat hopeful for the future of psychology in Cambodia. The Ministry of Health has
incorporated mental health as a concern, non-governmental organizations (NGOs) and RUPP are providing psychology education, and community members are slowly becoming more aware of psychological treatment. They provide suggestions that a centralized mental health association is created, public psychoeducation is provided, and a model of Cambodian mental health and a culturally sensitive practice, which are less medical and more holistic, client-centered, strengths-based, and non-hierarchical are created (Stewart et al., 2010).

This study responds to the needs of the community and addresses the aforementioned crises by engaging Cambodian student-therapists at the Royal University of Phnom Penh (RUPP) and seeking to explore EMDR as a culturally responsive therapy model to be used with Cambodian clients, including grandparents raising grandchildren, orphans, families affected by HIV/AIDS, survivors of the Khmer Rouge genocide, victims of tsunamis, typhoons, and community disasters, couples, and families. It is necessary to identify a culturally responsive model of therapy because 1) the country experienced a genocide and is still suffering during the recovery, 2) the educated psychotherapists were killed and formal therapy knowledge died with them, 3) the psychotherapy books were destroyed, with the current imported books written in English or French (Stewart et al., 2010), and 4) the current therapists are being trained in Westernized models of therapy due to the lack of Cambodian books and research. To best help the Cambodian mental health clients, marriages, and families, models of therapy should be examined for cultural responsiveness before being implemented, and a new model developed if necessary.
Defining Culturally Responsive Therapy

Defining culturally responsive therapy is no small task itself. In the review of several on-line databases and thorough read-through of 60+ articles with the keywords culturally responsive therapy, no article formally defines culturally responsive therapy or gives concrete steps to being culturally responsive. To the contrary, many used the terms culturally competent, culturally sensitive, and culturally responsive interchangeably. This causes problems for researchers in operationalizing, measuring, and cross-comparing culturally responsive therapy studies, as well as for therapists in understanding what is required to be culturally responsive.

It is commonly suggested that cultural competence builds on cultural sensitivity. As Furman et al. (2009) explains,

…culturally competent practice focuses on the need for a general sensitivity to cultural factors that may influence clients. Being sensitive to cultural variables can be conceptualized as holding a cultural lens to human behavior and making allowances for the possibility of cultural influence. However, to avoid stereotyping, it is important that the clinician recognize the existence of within-group differences as well as the influence of the client’s own personal culture or values. Cultural competence is then aspirational at best and requires the continuous development of practitioners’ cultural sensitivity, awareness, knowledge, and skills (p. 167).

As such, sensitivity is more of a worldview, whereas competency is the cultural knowledge and ability to act (Sue, 1991; Sue, Arredondo, & McDavis, 1992). In this paper, I define cultural sensitivity as having a culturally inclusive worldview and knowledge base about other cultures for which to have respectful interactions and an appreciation for the cultural variations (Lynch & Hanson, 2004). Culture competency is defined as “the ability to think, feel, and act in ways that acknowledge, respect, and build on ethnic, [socio-] cultural, and linguistic diversity” (Lynch & Hanson, 2004, p. 43);
working to develop this cultural knowledge base is often difficult due to the shifting social dynamics of a group, the lack of heterogeneity, varying levels of acculturation, stressful client workplace and economic situations, health disparities leading to mental health misdiagnosis and misperceiving of medications, and culturally unresponsive social welfare and mental health systems (Furman et al., 2009) but culturally competent therapists work diligently to gain this insight.

This paper utilizes the explanation of *culturally responsive* therapy as provided by family therapy researchers Carlson, Erickson, McGeorge, and Bermudez (2004), who make several theoretical and conceptual distinctions between culturally competent and culturally responsive approaches:

Culturally competent approaches make the following assertions: 1) one can become culturally competent by learning thoroughly about another culture, 2) one can depoliticize inherent power differentials and the dominant culture’s oppression, discrimination, and colonization of minority peoples and cultures, and 3) dominant culture outsiders can stand as experts on the insider minority peoples’ cultures and needs. In contrast, culturally responsive approaches have the following qualities: 1) It is informed by feminism, Just Therapy, and critical race theory and understandings of power, privilege, oppression, racism, and sexism, 2) this approach relies on insider/local knowledge and experience to inform all aspects of clinical work, 3) clinical work must be accountable to minority community members and their experiences, and 4) rely on accountability structures such as the use of cultural advocates and advisory boards to ensure work does not replicate dominant power structures.

Clearly, cultural competency and responsiveness are similar in intention, but diverge theoretically and conceptually in regards to the acquisition of knowledge, the distribution of power, and the role of the expert. It is important to emphasize that culturally responsive therapists rely on the local knowledge and are accountable to the local community and their unique needs, whereas culturally competent therapists assume they can acquire cultural knowledge and act as an expert in that community.
Bermudez (2008) further explains that, “in addition to being culturally self-aware, sensitive, and informed, a therapist or service provider adapts a program or clinical approach to meet the needs and cultural traits of persons from a specific group” to be culturally responsive. These traits go beyond one’s nationality to include race, class, gender, sexuality, religion, socioeconomic status, age, physical and mental ability, and ethnicity; cultural groups can therefore be arranged as broad as persons experiencing immigration, poverty, sexual diversity, or physical ability differences, etc. (Bermudez, 2008). For the sake of clarity, I will provide the meanings of ethnicity, race, and culture as used in this paper, based on definitions provided by Turner, Wieling, and Allen (2004, p. 260-261):

*Culture* refers to the sum total of the ways of living built up by a group of human beings and transmitted from one generation to another. It alludes to elements such as values, norms, beliefs, attitudes, folkways, behavior styles, and traditions that are linked together to form an integrated whole that functions to preserve the society.

*Ethnicity* refers to a person’s identification with a group of people of the same race or nationality who share a common and distinctive culture. Ethnicity points to connectedness based on commonalities (e.g. religion, nationality, region) whereby distinctive facets of cultural patterns are shared and where transmission over time creates a common history.

*Race*, traditionally a biological concept, refers to a group of people related genetically (albeit this inference is highly controversial due to negligible traces of genetic variation among humans and the historically racist use of genetic difference to oppress certain groups) by common descent, blood, and heredity. People of the same race may, or may not, share a common culture.

To become culturally responsive to these multiple layers of identity, Bermudez (2008) suggests that a therapist can:

1. Understand how the intersections of your identity afford you your privilege and oppression;
2. Examine your white, middle class, racist, sexist & homophobic stereotypes and biases;
3. Track your problematic thoughts and behaviors & notice when you direct them;
4. Make extra effort to reach out to minority populations;
5. Remember to have them feel welcome;
6. Have cultural images or objects in your office to show appreciate for culture;
7. Be sensitive to language barriers and be flexible with pace in session;
8. Ease into conversations with informalities and then start business;
9. Establish your credibility, but be appropriately open about yourself to increase the client’s trust;
10. Ask if there is anything you can do for them as a family;
11. Ask if they need information about a particular problem or issue;
12. Be an activist for social justice issues.

In addition, Furman et al. (2009) suggest that a culturally responsive clinicians be aware of their personal biases and worldviews, criticize their own background and knowledge, understand how race and class are related to therapy, examine their own privileges, and accept and acknowledge these biases (p. 172), as well as work to build a working alliance by being clear on their professional certifications, the treatment plan, and perhaps some of their personal background. Thus, it is important for providers to know the cultural values of the clients, their own personal values, and to have culturally responsive interventions. Table 1 provides a summary of Bermudez’s (2008) suggestions on how to apply these suggestions when working in a group.

Failure to be culturally responsive can result from not recognizing and acknowledging one’s privilege and oppression, attending clinical supervision, being willing to grow, recognizing one’s own biases and stereotypes, or appreciating the client’s local knowledge (Bermudez, 2008). This failure may be signified in clinical signs including clinical impasses, client “resistance”, therapist frustration, emotional reactivity, feelings of incompetence, and abrupt client termination (Bermudez, 2008).
Table 1
Suggestions for Culturally Responsive Group Therapy

1. Start by asking what they know about a topic, and only provide psychoeducation at the end, as an alternative and not “the” way.
2. Conduct groups and provide resources and materials in their language or context.
3. Amplify strengths and validate their way of resolving conflict, parenting, coping, etc., before challenging or offering another way.
4. Be extra sensitive to the stigma of seeking help or services. Make use of reframing.
5. Give participants a chance to react to the program.
6. Support the legitimacy of all family forms.
7. Be flexible in how the program is implemented—maybe a check-in at the middle point to identify areas where more information or process is wanted.
8. Incorporate time for connection, support, and creating new networks.
9. Provide childcare whenever possible.

Note: Suggestions adapted into table format from Bermudez (2008).

Cultural Adaptations vs. Cultural Responsiveness

With the recent focus on cultural sensitivity, awareness, and competency, there has been a push for culturally responsive family therapy models for minority populations. However, many of these emerging “culturally responsive therapies” are more cultural adaptations of pre-existing interventions than developing or identifying models that are theoretically and technically culturally responsive for a unique population. In other words, instead of evaluating models on their usefulness to a unique population, models are valued as inherently good based on empirical validation (findings predominantly on clinical practice with White, middle-class, American, patriarchal populations) and are adjusted to fit the minority client. There are few, if any, evidence-based research studies where the findings have been replicated, cross-validated, randomly assigned, and containing one or more ethnic groups that have examined psychotherapy efficacy for minority groups (Turner et al., 2004). Most studies, interventions, theoretical tenets,
therapy models, service delivery methods, and prevention services pertain to White, middle-class, European Americans (Bermudez, 2008; Turner et al., 2004), and are used to gauge whether the therapy works and can be used on other populations.

These etiological and methodological problems in studying ethnic minority populations have resulted in the poor planning, conducting, and disseminating of intervention and psychology studies (Turner et al., 2004). Turner et al. (2004) explain that this is due to

…the lack of conceptual, theoretical, and methodological frameworks that appropriately position communities of color [and ethnic minorities] within a historical, political, and socioeconomic context that can adequately account for the lived experiences of various ethnic minority groups…thus leading to the development of clinical theories and interventions that also neglect, minimize, or completely disregard the significance of culture and ethnicity in the lives of families (p. 257).

This dearth of rigorous research directly affects the clinical treatment of ethnic minorities by limiting access to culturally responsive interventions and programs and evidence-based therapies (Turner et al., 2004). These shortcomings can be attributed to problems with the lack of conceptual clarity (including culture, ethnicity and race), problems with etiology, theory and methods (including not looking systemically, being theoretically driven, using strong methods and designs, or looking at macro-level issues), and methodological issues, including difficulties with research access and high rates of attrition, inappropriately using a comparative design, and clustering groups to label them as “other” or “non-White” (Turner et al., 2004).

Instead of ethnicity being a variable to “control for” or “compare against” it should be a variable of focus, helping to orient and conceptualize the design and research question, and directly influencing the implementation of the clinical program or
intervention (Turner et al., 2004). Theories should be highly culturally specific, the community members should be encouraged to collaboratively participate from the initial stages and educated on how the research will affect them, and the study should look at how the clinical program directly affects that unique population and their dynamic needs, as opposed to making them fit the norms of another group or comparing them as “non-White” or “other” (Carlson et al., 2004; Turner et al., 2004).

It will take systemic awareness, education, and political change to promote transformation in research, mental health systems, and the creation of culturally responsive therapies. As Braithwaite (2006) explains,

To promote mental health throughout US society, in diverse communities and for all individuals, there is a dire need for positive system changes, beginning with policies to expand mental health services to make them more comprehensive, more culturally responsive, more accessible, and more affordable. Formulating such policies will require commitment from the federal and state governments, insurance providers, clinicians, social service agencies, educators, the criminal justice community, employers, and clients of mental health and substance abuse services (p. 1724).

Marriage and family therapy (MFT) clinicians and researchers, in particular, are called to consider the applicability of theories, models and interventions across cultures and ethnic groups, including considering external forces, such as funding agencies, government mandates, and professional organization directives, as well as internal factors, such as theories, models, and the discipline value to serve the underprivileged and the underrepresented (Turner et al., 2005). In essence, “…we must ensure that our research priorities, research questions, populations of interest, methodological advance, and clinical interventions are properly funded and translated into public policy as well as into the priority lists of national funding agencies” (Turner et al., 2004, p. 265). Thus, MFTs should consider how their theories, models, interventions, and programs translate across
cultures and ethnicities, whether they are effective and efficient, and if not how they can make it so. Reproduced from Turner et al. (2004), Table 2 provides guiding questions for MFT researchers and clinicians, Table 3 provides suggestions for building culturally informed research, and Table 4 provides a systemic paradigm based on contextual disparities.

One way to address these theoretical and methodological issues, in a theoretically consistent manner with culturally responsive therapy, is by using McDowell and Fang’s (2007) feminist-informed critical multicultural methods to support social equity within one’s research agenda. They define critical multicultural research as “research that is (a) informed by critical, feminist, and multicultural theories; (b) supportive of equity and inclusion; and (c) centered on the concerns of those inhabiting traditionally marginalized and oppressed social locations” (p. 551). In this method, the researcher must recognize and consider the interlocking oppressions of gender, race, class, sexual orientation, nation of origin, culture, ethnicity, age, and abilities that merge at intersections of political, social, and historical realities (p. 550). This can be accomplished by amplifying marginalized voices, interrogating the politics of knowledge construction, ensuring research benefits to those being studied, attending to culture and context, holding ourselves accountable for our own multicultural competence, and using diverse research methodologies to support cultural democracy (p. 550). The methods employed in the current study, which will be describe in a later section, build on the Turner et al.’s (2004) suggestions and utilize the feminist-informed critical multicultural methods suggested by McDowell and Fang (2007) by drawing upon the responsive evaluation methodology. The few studies that have used such rigorous methods will be discussed below.
Table 2
Guiding Questions and Recommendations for MFT Researchers and Practitioners

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<th>Guiding questions for researchers</th>
<th>Guiding questions for MFT practitioners</th>
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<tr>
<td>1. What are your motivations for conducting research that involves families/communities of ethnic minority?</td>
<td>1. What are your motivations for conducting clinical work with families/communities of ethnic minority?</td>
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<td>2. If your research does not involve families/communities of ethnic minority, how do you justify your decision?</td>
<td>2. If your clinical practice does not involve families/communities of ethnic minority, why do you believe this to be the case?</td>
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<td>3. What paradigm/s inform your research agenda and how do they affect participants/communities involved in your research project?</td>
<td>3. What paradigm/s inform your clinical framework/s and how do they affect your clients? Does it vary according to cultural and ethnic background?</td>
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<tr>
<td>4. Who gets to decide “what” is studied? What questions are asked? Who benefits? What populations are involved and how?</td>
<td>4. How is it determined what cultural groups are more likely to constitute your clinical population? How do you engage with these communities? Who benefits?</td>
</tr>
<tr>
<td>5. What is your role/responsibility as a researcher vis-à-vis communities of ethnic minority?</td>
<td>5. What is your role/responsibility as a MFT practitioner/trainer/supervisor vis-à-vis communities of ethnic minority?</td>
</tr>
<tr>
<td>6. How does your ethnic and racial background inform the type of research that you conduct with communities of ethnic minority?</td>
<td>6. How does your ethnic and racial background inform your clinical work with communities of ethnic minority?</td>
</tr>
<tr>
<td>What do you believe are the politics and ethics involved in conducting research with communities of ethnic minority?</td>
<td>7. What do you believe are the politics and ethics involved with working/not working clinically with communities of ethnic minority?</td>
</tr>
</tbody>
</table>

Note: Table reproduced from Turner, Wieling, and Allen (2004).
Table 3
*Recommendations for Building a Culturally Informed Program of Research*

| 1. Seek out previous research and applicable theories |
| 2. Explore non-mainstream/non-traditional sources. |
| 3. In conceptualizing the focus of study, maintain a balance between shared versus distinct characteristics. |
| 4. Use culturally appropriate measures and when this is not possible, provide a rationale for not using them including possible consequences. |
| 5. In data gathering strategies, take into account the context(s) in which the participants’ conduct family life. |
| 6. Explore the full range of funding options including private and public sources. |
| 7. Become familiar with the research interests and foci of funders. |
| 8. Also pursue local foundations in funding research. |
| 9. Research and anticipate funders’ application of timelines. |
| 10. Go to the community to understand how they currently understand the problems at hand. |
| 11. Explore what the participants will get out of this research. |
| 12. Make sure that members of the community are included in meaningful ways at all levels of the study. |
| 13. Include Principal Investigator and Co-Principal Investigators who have cultural expertise. |
| 14. Avoid the trap of “captive” audiences. |
| 15. Engage communities from which participants come as an effective strategy for both recruiting and maintaining samples. |

*Note: Table reproduced from Turner, Wieling, and Allen (2004).*

**The Spectrum of Culturally Responsive Therapy Studies**

Previous studies have suggested a plethora of ways to provide a culturally responsive therapy. At the far ends of the spectrum, some researchers have suggested purely theory-based practice (without suggesting interventions), while others have suggested utilizing only common-factors (which allow them to focus less on culture) or ignoring culture all together. Respectively, on the theory end of the spectrum, Furman and Collins (2005) suggest a social constructionist theoretical model as a culturally
sensitive practice whereby the therapist works to understand the client’s worldviews and how these may differ from the therapist’s and other individual’s worldviews.

Table 4

_A Systemic MFT Research Paradigm Based on the Contextual Premise of the Existence of Cultural and Ethnic Disparities_

<table>
<thead>
<tr>
<th>Research Priorities</th>
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</thead>
<tbody>
<tr>
<td>External forces established by funding agencies</td>
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<tr>
<td>Internal forces informed by MFT field’s ideological orientations and values</td>
</tr>
<tr>
<td>Specific Areas of Research</td>
</tr>
<tr>
<td>Continuum of mental health disparities linked to culture and ethnicity</td>
</tr>
<tr>
<td>Varying levels of prevalence, degree of chronicity, and impact on social and public policy</td>
</tr>
<tr>
<td>Theoretical Frameworks</td>
</tr>
<tr>
<td>Continuum of theoretical conceptualizations ranging from individual to systemic orientations</td>
</tr>
<tr>
<td>Methodology and Method of Inquiry</td>
</tr>
<tr>
<td>Continuum ranging from quantitative to qualitative and a combination of multimethod approaches for</td>
</tr>
<tr>
<td>research involving communities of color</td>
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<tr>
<td>Continuously developing—not yet well established</td>
</tr>
<tr>
<td>Unit of analysis</td>
</tr>
<tr>
<td>Continuum—individual, couple, family, community</td>
</tr>
<tr>
<td>Engagement strategies</td>
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<tr>
<td>Identification of community</td>
</tr>
<tr>
<td>Establishing relationships</td>
</tr>
<tr>
<td>Needs assessment</td>
</tr>
<tr>
<td>Forming Collaborative partnerships for research process</td>
</tr>
<tr>
<td>Data collection</td>
</tr>
<tr>
<td>Develop culturally specific strategies for recruitment and retention</td>
</tr>
<tr>
<td>Use culturally appropriate methods of inquiry</td>
</tr>
<tr>
<td>Data analysis</td>
</tr>
<tr>
<td>Interpretation of data of data should be culturally and theoretically informed</td>
</tr>
<tr>
<td>Interpretation and dissemination of findings</td>
</tr>
<tr>
<td>Need for broader impact—publication and other media outlets, clinical training, communities of color</td>
</tr>
<tr>
<td>Translational Research</td>
</tr>
<tr>
<td>Incorporating research findings into preventive and clinical interventions</td>
</tr>
<tr>
<td>Efficacy and Effectiveness Research using Multiple Methodologies and Strategies</td>
</tr>
<tr>
<td>Inform future iterations of theoretical, methodological, and model development</td>
</tr>
</tbody>
</table>

Note: Table reproduced from Turner, Wieling, and Allen (2004).

Harper and Lantz (1996, p. 9) suggest that by developing the following 8 skills, one can _transcend_ the need for understanding cultural variables to practice with cultural sensitivity via “curative factors” which are: respect for the client’s worldview, hope,
helper attractiveness, control, rites of initiation, cleansing experiences, existential realization, and physical intervention. Similarly, Patterson (1996) suggests that, “Multicultural counseling is generic in nature, and therefore all counseling is multicultural. Thus multiculturalism has joined the movement toward a universal system of counseling” (p. 227). He goes on to suggest that we are all becoming one population with everyone needing special skills to fit unique needs, thus all therapy is multicultural and cannot be “watered down” to fit a unique population. Clearly, there all flaws in each of these approaches of being culturally responsive, as they are either too philosophical/theoretical and difficult to apply, are atheoretical, or ethnocentrically ignore the privilege of the white, middle-class, American, patriarchal (Bermudez, 2008; Chan & Lee, 2004; Turner et al., 2004), clients for whom these “multicultural” models are created and compared.

More middle-spectrum suggestions have been made, which integrate both theory and intervention. For example, Chen, Kakkad, and Balzano (2008) suggest that evidence-based practices should be culturally adapted in service delivery, intervention, therapeutic relationship, and components of the treatment in response to the client’s culture beliefs, attitudes, and behaviors. And while their points are valid that, in past decades, there has not been a clear definition of multicultural competence but instead an ambiguous, philosophical idea with no practical guidance and no minimum competencies, that evidence-based practices are needed for minority/marginalized populations, and that clinicians’ cultural awareness, knowledge, and skills should be used with the client system (Chen et al., 2008), simply adapting a pre-existing evidence-based practice is not best practice, does not guarantee that the positive results hold for that population,
especially given the intervention changes, and does not ensure that the theoretical background of the model will be consistent with the clients world view. In fact, other researchers have argued that the preexisting empirically based therapies may be harmful and/or ineffective when used on minority clients, as they ignore the needs of marginalized populations (Waites, Macgowan, Pennell, Carlton-LaNey, & Weil, 2004).

Along the same lines, researchers have proposed theoretical therapy models for minority populations that assume Westernized values and worldviews. Case in point, Comstock et al. (2008) suggest a model for multicultural social justice counseling that they propose goes beyond the therapist having self-awareness, cultural knowledge, and culturally responsive helping skills to creating “a healing [that] takes place in the context of mutually empathic, growth-fostering relationships” (p. 279). This relational-cultural theory is similar to client-centered, Rogerian therapy, which asserts that healing occurs through the therapeutic relationship, but also includes deconstructing the obstacles in cultural and relational contexts. And although it is agreeable that culturally responsive therapy needs to go beyond symptom relief and helping interventions to being theoretically sound and addressing social justice issues of eliminating the multiple forms of cultural oppression, marginalization, and social injustices (Comstock et al, 2008), this relational-cultural theory model can not be applied to every culture as the creators suggest. Unique cultural needs, values, and worldviews must be taken into account. Not all populations will desire a deep relationship with the therapists, and not all clients will want to deconstruct the context in relation to their problem. To be completely culturally responsive it seems necessary to test the entire model with that unique population or to create an emerging model based on their needs.
Foundational Culturally Responsive Therapy Studies

Several researchers have developed programs to explore culturally responsive therapies for minority populations in the United States. These studies have addressed program type, delivery, and content, the use of cultural advisory boards and cultural consultants, recruitment strategies, and social service delivery, and found that responding to the clients’ cultural needs increases the positive outcomes of therapy (Carlson et al., 2004; Lu, Organista, Manzo, Wong, & Phug, 1991; Powell, Zambrana, and Silva-Palacios, 1990; Waites et al., 2004.)

Powell et al. (1990) designed and implemented a culturally responsive parenting program by interviewing 121 Mexican immigrants and Mexican-American mothers on their preferences for the group, including delivery mode, group composition, sources of child development and parenting information, and program context. The purpose was met two fold: to create a program that is culturally responsive to group needs, and to recognize the differences between groups and to accommodate to the needs of the two groups, who had many similar program preferences, but were also different in some aspects. Their findings revealed many within group differences, demonstrating that one cannot assume just because the ethnic background is “Mexican” that all Mexicans are the same, as they differ via acculturation, immigration experiences, etc. Some helpful culturally responsive actions gleaned from this study include combining setting and location formats, providing a wide range of reading materials, including immediate and extended family in the meetings, establishing rapport before group involvement, and emphasizing preprogram experiences (Powell et al., 1990).

In another program-building study, Carlson et al., (2004) conducted a culturally
responsive Narrative Therapy project for Latinos in their community. Local community members educated the therapists on their experiences and insights on racism and oppression as Latinos. Cultural advocates were then utilized to provide an emic, local, approach and provide an insider expert and consulter role to the therapists and to act as advocates for the clients. Further, they used an accountability board of locals to consult on the program. Based on the needs and views of all of the stakeholders, including the advocates, clients, therapists, and consultants, they worked to address the inequalities and pursued the goal of educating local Latinos to be marriage and family therapists and to examine and dismantle the historical inequities that have previously stopped this process. The identification of locals as experts, use of cultural advocates and an accountability board, and working for community empowerment were useful ways to create a culturally responsive therapy program (Carlson et al., 2004).

Culturally responsive therapy program development has also occurred in the public service sector. Waites et al. (2004) describe the use of a culturally responsive model for family group conferencing as an alternative to the traditional child welfare system. With focus groups used to provide guidance on how to proceed, they utilized a community-based program development approach and, 1) worked with families whose voices are usually marginalized, 2) used a coordinator who was not a part of the case to create comfort in being a part of the team, 3) invited the entire family, 4) adapted the process around their needs of time and location, 5) prepared the family for participation, 6) provided sufficient information without imposing agency values, 7) left the family with privacy to negotiate, 8) negotiated with the final plan, and 9) reconvened as necessary. They found that, in addition to the previous steps which rely on local
knowledge, it is important to create a comfortable location, often within the community, to recognize the critical traditions, to be aware of the cultural identity (language, customs, etc. of the profession), to provide interpreters, training, ethnically similar coordinators, etc., to include elders, and to have community outreach and education programs unique to their needs.

Therapist variables have also been shown to make a difference in culturally responsive therapy. Lu et al. (2001) examined the dimensions of culturally sensitive clinical styles between Latino and non-Latino clinicians when working with Latino immigrant clients. They found that Latino clinicians displayed more culturally relevant interpretations, were less directive, intrinsic, and power-directed, put more emphasis on self-disclosure, case management, use of the native language with the client, and crisis intervention, whereas the non-Latino clinicians were more directive and instrumental. To demonstrate cultural responsiveness, Latino therapists addressed the father first, developed relationships, provided concrete referrals and assistance, gave more insight into how cultural adjustments and issues influenced the family, and used culturally appropriate gestures and body language. Their findings that bilingual non-Latino White clinicians demonstrated more cultural competence and sensitivity than monolingual non-Latino whites suggest that linguist/cultural match and capabilities are valuable between cross-cultural client and clinician. So, while both may have been culturally sensitive, it is necessary to demonstrate culture competence and implement the culturally responsive skills (Lu et al., 2001).

Overall, these studies show the need for culturally responsive therapies and interventions, which include adapting the program type, delivery, and content, making
use of cultural advisory boards and cultural consultants, utilizing innovating recruitment strategies, modifying social service delivery, educating therapists, and including a wider range of participants. More examinations of culturally responsive clinical processes, styles, and interventions are needed, as research is moving from having cultural knowledge or sensitivity via a knowledge based cultural competence, to build on cultural sensitivity and focus on the clinician’s self-awareness, clinical outcomes, and accountability of using that knowledge (Lu et al., 2001).

**Ethnic-Specific and Culturally Responsive Therapy with Asian Clients**

Therapeutic studies of Asian clients in their native lands are nearly non-existent, and culturally responsive therapy studies of Asian American clients are also very low in number. However, those that exist demonstrate the need for culturally responsive therapies and therapists, and that ethnic specific treatments are more beneficial and cost-effective than traditional therapy treatment for Asian clients.

In their study of Asian ethnic-specific services, Lau and Zane (2000) found that Asian American clients who used ethnic-specific services had a better clinical treatment outcome, including a significant relationship between cost-utilization and clinical outcome, suggesting that ethnic-specific focus is more effective and efficient for mental health care for this minority group. This ethnic-specific treatment was culturally responsive by recruiting ethnic personal, modifying treatment practices that are presumably more culturally relevant, fostering a familiar atmosphere, and locating the services near the population’s community. Surprisingly, this ethnic-specific service was more cost effective because clients who received the culturally responsive therapy were
less likely to lapse into crisis, and therapy was therefore shorter and cheaper (Lau & Zane, 2005).

Therapist styles and qualities have also been shown to impact the outcome of culturally responsive therapy. For example, Asian American therapists, who are more relational in achieving style (behavioral strategy used to achieve goals) than non-Asian American therapists, are viewed by their clients as implementing more culturally responsive therapy approaches (Lu, 1994). Similarly, Zhang and Dixon (2001) examined the differences between culturally responsive and culturally neutral counselors by having 6 therapists interview 60 Asian students. Only the culturally responsive therapists greeted and said goodbye in the student’s native language, had a map and artifacts in their office, and expressed interest in the student’s home countries. Findings revealed that culturally responsive therapists were rated as more of an expert, attractive, and trustworthy and that the participants found the therapists more capable of being helpful in resolving academic or school problems, more capable of being helpful in resolving personal or social problems, more open to a different culture, and more capable of relating to people of different cultures. Clearly, the culturally responsive therapists were preferred. Zhang and Dixon suggest that showing overall interest and appreciation for the other culture and heritage is helpful.

More in-depth information and applicable suggestions are needed to identify and implement culturally responsive therapies, especially outside of the US mainland. While many authors have suggested the need for counselors to have knowledge of other cultures, few provide concrete suggestions, approaches, and interventions for culturally responsive and cross-cultural counseling. Some have suggested that therapists modify
communication styles, therapeutic interventions, goals, client expectations, strategies, and theoretical orientations, but there is little guidance on how to actually implement this.

**Need for Culturally Responsive Therapy in Cambodia**

According to Carlson (1999), clients from different cultures vary in many ways, including:

1. The experience of pain
2. What they label as a symptom
3. How they communicate about the pain or symptoms
4. Their beliefs about cause
5. Their attitudes toward helpers (doctors and therapists)
6. The treatment they desire or expect (p. vii).

Researchers and clinicians need to be aware of the changing values, stigmas, and what constitutes symptoms, diagnoses, and family problems, how these fluctuate across demographics, incidence reports, and severity levels, and the consequential affects on the utilization and delivery of mental health services, family systems, and communities (Turner et al., 2004). The intersections of race, culture, ethnicity, nationality, age sexuality, and economic status of the individual, as well as the historical, political, and cultural context, sources of research funding, institutional affiliation of the research, agency, researcher, individual, and community biases, and research focus and methods influence the process and results of culturally sensitive, competent, and responsive therapy studies (Turner et al., 2004). Understandably, for therapy to be successful, it is crucial that the therapist is aware of these cultural differences and their own cultural biases.

In general, Asian cultural norms include strong support from family, a strong sense of obligation, a heavy focus on educational achievement, a strong work ethic, loyalty, a high tolerance for loneliness and separation (Yu, 1999, p. 17), values of
modesty, humility, and self-restraint (Chan & Lee, 2004) and a focus on the family, as opposed to the individual (Hu & Chen, 1999). The primary family relationship is the parent-child relationship, with the husband in charge of providing and representing the family in public and the wife in charge of the children, the family well being, and the financial matters (Chen & Lee, 2004). Furthermore, emphasis is placed on harmony, social order, education, humility, modesty, and family honor (Hu & Chen, 1999). For Asians, to have failures or misbehaviors is an area of shame (Hu & Chen, 1999). To teach children these social roles and expectations to “keep face”, they are punished by name-calling, teasing, harsh criticism, scolding, and shaming when misbehaving (Chan & Lee, 2004).

In the face of medical and mental health ailments, many Asians utilize traditional medicines, including soul calling, exorcism, chanting, spiritual healing, and ritualistic offerings (Chan & Lee, 2004) as opposed to Westernized medicines. Causality of the conditions are often attributed to diet, fate, violating taboo, divine punishment, and other spiritual attributions (Chan & Lee, 2004); when the conditions are a severe disability, the families often react with shame and do not seek formal treatment (Chan & Lee, 2004). When working with Asian clients, therapists must be aware of these values and therapeutic models that may directly conflict with them. For example, in American therapy, it is a basic, underlying assumption that individuals have the ability to change their futures via hard work and determination. However, in Cambodia, individuals generally assume their situation is destined by fate and believe they have little control over changing this life (Chan & Lee, 2004); however, they recognize that their actions in this life can affect change after reincarnation. Clearly, this belief does not align with
Western-therapy modalities and an existing model needs to be adjusted or a new one developed for cultural relevance, sensitivity, and responsively in helping Cambodian clients cope or change.

**Eye Movement Desensitization and Reprocessing**

Eye movement desensitization and reprocessing (EMDR) is an integrative, manualized psychological treatment based on the Adaptive Information Processing (AIP) model. This model emphasizes the brain’s dual-hemisphere processing system and posits that one’s unprocessed, disturbing memories are the basis of maladaptive behaviors, thoughts, emotions, and individual pathology (Shapiro, 2007). This model was chosen to be studied in Cambodia at the request of RUPP. The model 1) was taught to Master’s level psychology students at RUPP as a mandatory part of their traumatology course, 2) is being implemented by these student-therapists for the first time ever in Cambodia, 3) has drawn considerable attention from Trauma Aid Germany (TAG)/Humanitarian Assistance Program (HAP) Germany, a British Cambodia-based EMDR supervisor, and the Cambodian community, 4) is being taught, through TAG/HAP Germany interests and funding, to a second wave of Cambodian student-therapists, and 5) has not be empirically validated or researched for cultural responsiveness in Cambodia.

**Overview of EMDR and AIP**

According to the AIP model, new events and stimuli are processed by the brain and assimilated into the pre-existing networks (Shapiro, 2007). For example, when one sees a paperclip, one needs to have previous experience of knowing or using a paperclip to know how to use it. In a healthy individual, learning and experiencing how to use this paperclip will inform the person with future uses—for example, continued use of a
paperclip in the traditional pattern, or as a way to pick a lock, clean a crack, use as a key-ring, make a chain, temporarily tailor your pants, etc. When new stimuli and events are not assimilated into these memory networks, become “stuck”, or are unable to connect with adaptive networks, pathology results. Until the memories are reprocessed, this dysfunction continues despite counterexamples. Continuing with the previous example, if a person steps on paperclip, severely injures their foot, and does not reprocess the memory, they will continue having a fear of, or negative reaction to, using paper clips despite continuous observation of seeing others use papers clips in the office, on TV, and in their home.

These maladaptive behaviors, fears, emotions, and thoughts are seen as the symptoms of unprocessed, dysfunctionally stored memories of earlier experiences (Shapiro, 2007). Thus, present problems and distressing reactions are outcomes of earlier, unprocessed memories and events that are triggered by current events. The procedures and protocol of EMDR are designed to access the dysfunctional, misstored, unprocessed memories and stimulate and reprocess those memories with adaptive resolution. The AIP suggests that when these dysfunctional memories are “stuck,” they are misstored in only one hemisphere of the brain, and inaccessible to the opposite hemisphere and other existing networks. To connect and reprocess between hemispheres, EMDR incites bilateral stimulation (BLS) of the brain via side-to-side or diagonal eye-movement, alternating tapping on the hands, or alternating sounds in each ear. After resolution and assimilation into the memory structures, rapid learning occurs whereby the new, reprocessed memory lays the groundwork for neurological networks to connect. Memories are accessed, desensitized, and reprocessed using a 3-phased, 8-stepped
protocol. Table 5 describes this protocol. The following terms are defined in *The EMDR Approach to Psychotherapy: EMDR Humanitarian Assistance Program Basic Training Course Manual* (p. 108):

*Adaptive Information Processing*: The distinct information processing model that represents the cornerstone of the EMDR approach to psychotherapy and guides clinical practice.

*Bilateral Stimulation (BLS)*: Eye movement, tapping or auditory alternating stimulus used as dual attention stimuli (external focus) as client simultaneously focuses on some aspect of the internal experience.

*Channels of Association*: Events, thoughts, emotions, etc., within the targeted memory network that spontaneously arise during reprocessing of the identified target (Touchstone Memory and/or node).

*Eight Phases*: History, Preparation, Assessment, Desensitization, Installation, Body Scan, Closure, Reevaluation.

*EMDR Approach*: Problems/issues are viewed as based in unprocessed physiologically stored memories impacting present thoughts, emotions, and behaviors.

*Negative Cognition (NC) = Negative Belief*: Negative belief of self associated with unprocessed dysfunctionally stored negative incidents.

*Positive Cognition (PC = Positive Belief)*: Positive belief that is more adaptive and is the desired perception of self identified in relation to the unprocessed, dysfunctionally stored negative incident.

*Subjective Units of Disturbance Scale* (SUD 0-10): Scale used to measure the level of distress associated with a memory where 0 is no disturbance/neutral and 10 is the highest disturbance/distress.

*Target*: Term used for the incident focused upon for reprocessing within the agreed upon treatment plan (Target focused upon during the Assessment Phase).

*Touchstone Memory*: The identified earliest incident that established the dysfunctional, unprocessed memory network.

*Validity of Cognition Scale* (VOC 1-7): Measurement of how valid or true the PC feels as one focuses upon the target where 1 is completely false and 7 is completely true.
Uses of EMDR

The use of EMDR has been documented with an array of populations, symptoms, and diagnoses, including performance anxiety, sex offenders, couples, families, in group settings of victims of manmade and natural disasters (Ricci, Clayton, Foster, Jarero, Litt, Artigas, & Kamin, 2009) medically unexplained symptoms (MUS) including somatoform disorders, phantom limb pain, and functional syndromes (Van Rood & de Roos, 2009), but is empirically validated only with Posttraumatic Stress Disorder (PTSD) (Bisson & Andrew, 2007). The EMDR Humanitarian Assistance Program (HAP), a non-profit organization dedicated to training local mental health professionals worldwide to work with traumatized clients and promoting EMDR research, has programs in over 70 countries worldwide including Ireland, Rwanda, Kenya, The United States, Turkey, The Middle East, Colombia, El Salvador, Ukraine, and Uganda (HAP, 2011). Eye movement desensitization and reprocessing has been applied in many Asian countries including Sri Lanka, Cambodia, Thailand, Indonesia, Japan, and China.

Despite its worldwide use and acclaimed clinical successes, it is a highly controversial model of psychotherapy. Critics have criticized the un-testable AIP theoretical underpinning as “neurobabble” (Rosen, Lohr, McNally, Herbert, 1999), questioned the validity, reliability, and accuracy of measurement of the SUD as a treatment outcome (DeBell & Jones, 1997; Lohr et al., 1992) with only one supporting study (Kim, Bae, & Park, 2008) and suggested that the EMDR protocol itself is simply a repacking of Cognitive Behavioral Therapy (CBT) (Richards, 1999) and exposure therapy (Devilly, 2002) with eye-movements that add nothing but pizzazz. While a scholarly discussion on the pros, cons, and of empirical validation is certainly worth
<table>
<thead>
<tr>
<th>Phase</th>
<th>Purpose</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase One</td>
<td><strong>Client history</strong></td>
<td>• Obtain background information</td>
</tr>
<tr>
<td></td>
<td>• Indentify suitability for EMDR treatment</td>
<td>• Administer standard-history taking questionnaires and diagnostic psychometrics</td>
</tr>
<tr>
<td></td>
<td>• Identify processing targets from positive and negative events in client’s life</td>
<td>• Review of criteria and resources</td>
</tr>
<tr>
<td></td>
<td>• Administer standard-history taking questionnaires and diagnostic psychometrics</td>
<td>• Ask questions regarding (1) past events that have laid the groundwork for the pathology, (2) current triggers, and (3) future needs</td>
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<tr>
<td>Phase Two</td>
<td><strong>Preparation</strong></td>
<td>• Prepare appropriate clients for EMDR processing of targets</td>
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<td></td>
<td>• Stabilize and increase access to positive affects: (Calm/Safe Place)</td>
<td>• Educate regarding the symptom picture</td>
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<td></td>
<td>• Teach metaphors and techniques that foster stabilization and a sense of personal self-mastery and control</td>
<td>• Teach metaphors and techniques that foster stabilization and a sense of personal self-mastery and control</td>
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<tr>
<td>Phase Three</td>
<td><strong>Assessment</strong></td>
<td>• Access the target for EMDR processing by stimulating primary aspects of the memory</td>
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<td>Phase Four</td>
<td><strong>Desensitization</strong></td>
<td>• Process experiences and triggers toward an adaptive resolution (0 SUD level)</td>
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<td>• Fully process all channels to allow a complete assimilation of memories</td>
<td>• Use “Cognitive Interweave” to open blocked processing by elicitation of more adaptive information</td>
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<td>• Incorporate templates for positive experiences</td>
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<td>Phase Five</td>
<td><strong>Installation</strong></td>
<td>• Increase connections to positive cognitive networks</td>
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<td></td>
<td>• Increase generalization effects within associated memories</td>
<td>• Enhance the validity of the desired positive belief to a 7 VOC</td>
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<td>Phase Six</td>
<td><strong>Body scan</strong></td>
<td>• Complete processing of any residual disturbance associated with the target</td>
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<td></td>
<td>• Ensure client stability at the completion of an EMDR session and between sessions</td>
<td>• Use of guided imagery or self-control techniques if needed</td>
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<tr>
<td>Phase Seven</td>
<td><strong>Closure</strong></td>
<td>• Brief regarding expectations and behavioral reports between sessions</td>
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<td></td>
<td>• Evaluation of treatment effects</td>
<td>• Explore what has emerged since last session</td>
</tr>
<tr>
<td></td>
<td>• Ensure comprehensive processing over time</td>
<td>• Reaccess memory from last session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Evaluation of integration within larger social system</td>
</tr>
</tbody>
</table>

merit, it has been the focus of other papers (Davidson & Parker, 2001; Nowill, 2010; Poole, de Jongh, & Spector, 1999; Richards, 1999; Rosen, Lohr, McNally, & Herbert, 1998; Rosen et al., 1999), and is not of this dissertation. Priority in this dissertation is understanding the Cambodian experience of EMDR and how it works with that population, as opposed to validating the model itself.

Previous findings support that EMDR may be useful to Cambodian therapists and clients. EMDR also parallels the values and needs of Asian families, as Asians generally prefer brief therapy, desire quick change without insight or focusing on the minute details of the problem, are solution-oriented rather than emotionally focused, and prefer solution-talk as opposed to problem-talk surrounding a crisis (Chang & Yeh, 1999; Ng, 1999).

Based on the review of the literature, the basic values of Asian families, the needs of many Cambodian clients, the request of RUPP, and consistent with responsive evaluation methodology, this study will explore the use of EMDR as a culturally responsive Cambodian model of therapy. The primary research questions will be:

1. How do Cambodian therapists experience the use of Eye Movement Desensitization and Reprocessing?

2. Can Eye Movement Desensitization and Reprocessing be used in Cambodia as a culturally responsive model of therapy?
Theory

In addition to the AIP theory that informs Eye Movement Desensitization and Reprocessing, Just Therapy and Feminist and Critical Theories guide this study. These theories inform Carlson et al.’s (2004) explanation of culturally responsive therapy, are consistent in their ontological, epistemological and theoretical underpinnings, and can be interwoven to examine and discuss the multiple intersections of race, ethnicity, class, gender, nationality, etc. and how culturally responsive therapies should address these identities in minority clients.

Feminist Theory

There are many types of feminism and no one definition. However, all include the purpose of rethinking gender and power, especially in regard to women’s subordination and other subordinations related to the intersection of race, class, gender, ethnicity, age, sexual orientation, nationality, and physical ability. Osmond and Thorne (1993) list the following central themes in feminist theorizing: feminist scholarship begins by assuming the centrality, normality, and value of women’s (and girls’) experiences; feminist scholarship takes gender as a basic organizing concept; feminist scholars insist that gender relations must be analyzed in specific sociocultural and historical contexts; since feminist scholars start with women’s experiences and with structures of gender, they have continually questioned any unitary notion of “the family”; feminist scholarship emphasizes social change and favors methodological approaches that are value committed; feminists want not only to know about the world, but also to change it (p. 592-593).
Applied to family therapy, Feminist Family Therapy is a philosophy, political perspective, and lens for viewing the world that does not have a set of interventions or guidelines as models do (Haddock, Zimmerman, & MacPhee, 2000). Feminist scholars and researchers have provided suggestions in accord with this philosophy, which include exploring the impact of socialization on the problem, educating clients on egalitarian and mutually respectful relationships, teaching all people, regardless of gender, to recognize and express their emotions, and encouraging clients to share responsibility for the relationship, family, and home (Braverman, 1988; Chaney & Piercy, 1988; Haddock et al., 2000; Wheeler, Avis, Miller, & Chaney, 1988). Especially important for this study are the non-pathologizing stance, normalizing and centrality of the participants’ experiences, and feminist notion of praxis with a critical awareness and effort to create change. (Thompson & Walker, 1995).

**Just Therapy**

Similar to feminist theories, the Just Therapy approach is committed to the cultural, gender and socio-economic equity of clients, and to eradicating social discrimination. According to its creators, “Just therapy is a reflective approach…A fundamental feature of Just Therapy is the attention paid to the broad cultural, gender, social, spiritual, economic and psychological contexts underlying the problems experienced by those with who therapists work” (The Family Center, 2009). Just Therapists work to go beyond pathologizing clients’ suffering from external contexts, to helping in understanding and actively changing them.
Critical Theory

I will broaden Carlson et al.’s (2004) use of Critical Race Theory, to general Critical Theory, as to address more than race in culturally responsive family therapy. This theory is consistent with Feminist theories and Just Therapy. Critical theory is a framework that focuses on how “injustice and subjugation shape people’s experiences and understandings of the world” (Patton, 2002, p. 130). A humanistic theory, Critical Theory aims to “explain the social world, criticize it, and empower the audience to overthrow it” (Fay, 1987, p. 23). Thus, the theory is applied to explore how the research can not only understand the phenomenon, but critique and change the situation (Patton, 2002). The focus can be on race, class, gender, ideologies, discourses, education, religion, social institutions, (Patton, 2002), and general social conditions (Fay, 1987). In regard to culturally responsive therapy, Critical Theory can be applied 1) to explain how previous models have not been culturally responsive but have been ethnocentrically pushed upon minority populations, 2) to criticize the ways that this lack of sensitivity has been kept in place; and, 3) and to empower researchers and therapists through action research to learn about and identify a model that is culturally responsive.

Summarized

A synthesis of the Just Therapy framework and feminist and critical theories provides a powerful lens for understanding and interpreting Cambodian stakeholder’s beliefs, values, needs, perspectives, and experiences when exploring a therapy model as culturally responsive. Through the integration of these theories, sociohistoral and cultural factors are viewed as systemic influences, as opposed to problems linearly due to individual or familial behavior. For example, the poverty in Cambodia would be
considered as a function of the larger systemic socioeconomic conditions and discriminatory laws and policies, whereby the individuals, families, and communities are impacted. Child abuse, while valued as dehumanizing and unjust in all cases, would be explored in light of all family member’s experiences, the social norms for physical punishment, and the impact of intergenerational transmission of trauma on parenting skills. Injustices, manifested as inequality in access to work, education, healthcare, and basic needs would be considered when explaining how models are pushed upon Cambodians, criticizing why a model has not been developed, and empowering locals to develop a responsive model.

The integration of theories frames the conceptualization of the project, methods, analysis, and interpretation of findings by focusing on the uniqueness and normalcy of the participants within the Cambodian context, instead of pathologizing and colonizing by comparing as “outsider” or “other”. This collaborative, informed not-knowing stance enhances and strengthens the international relationships (Horne & Matthews, 2006) between researcher and participants. Unlike other theories that lack emancipation and empowerment components, the findings in this study can be used to make practical and applicable suggestions for improving the current situation.
CHAPTER 3

METHODS

Evaluation: A General Description

This study utilizes the methodology of responsive evaluation. To best understand this specialized method, it is important to begin with the basic definitions and an overview of evaluation. An *evaluand* is the item, problem, program, situation, or issue being measured for worth or value. In this case, the evaluand would be a model of therapy. It is necessary to gather the relevant standards for the evaluand and to determine the inside and outside boundaries of the evaluand; for example, considering the stimulus error, is the effect correctly accounted for—is a positive outcome (decrease in depressive symptoms) really the product of the therapy itself, or was it the participants (demographics, change in marital status, etc.), the time of day, the therapists, etc. (Stake, 2004, p. 18). *Criterion* means an “important descriptor or attribute” and a *standard* means “the amount of that attribute needed for a certain judgment” (Stake, 2004, p. 5)—in other words, how good something needs to be. So if a decrease in depression is a criterion, then moving from eight crying outbreaks to two crying outbreaks per day (for a total of six less outbreaks) is a standard. *Expressive* standards and criteria are those that emerge during the evaluation and are not realized by the evaluator as relevant or necessary until that point in the evaluation (Stake, 2004, p. 7). *Quality* is in reference to the characteristics of an evaluand—for example, empathic, empowering, engaging (Stake, 2004). In general, there are no fixed or set standards in evaluation or any standard or
“best practice” ways of setting them (Stake, 2004, p. 8). The criterion and standard in a culturally responsive therapy study will likely be related to how the model meets the cultural, ethnic, religious, spiritual, familial, etc. needs of the clients. For the sake of this paper, the terms researcher and evaluator will be used interchangeably.

The general purpose of an evaluation study is to judge the value, worth, or merit of what is being evaluated. Worthen, Sanders, & Fitzpatrick (2003) elaborate that, “…evaluation is the identification, clarification, and application of defensible criteria to determine an evaluation object’s value (worth or merit), quality, utility, effectiveness, or significance in relation to those criteria” (p. 5). Thus, any product, process, program, or item can be evaluated and the evaluation can be done by an insider, outsider, or one’s self. Evaluation can be viewed as a type of action research due to the self-evaluation of one’s context/process/situation and one’s self to improve things in one’s contexts (Stake, 2004), and can be used to evaluate therapy models and interventions by therapists, clients, and/or supervisors.

Goals and Logic of Evaluation

According to Stake (2004), the following roles are central to the purpose of evaluation: assessing goal attainment, aiding organization development, assessing contextual quality, studying policy, aiding social action and legitimatizing the program, and deflecting criticism. Secondary aims include assuring accountability, accrediting programs, estimating cost-effectiveness, and granting awards or standings. This would allow one to use evaluation methods to assess the use of the culturally responsive therapy model, examine how it works within the given context, to influence policy and social action surrounding the community and funding for the implementation of the culturally
responsive therapy, and to estimate the cost-effectiveness and cost-efficiency of the culturally responsive therapy model.

To achieve these goals, evaluators often use the following logic to determine the value and merit of the evaluand (Fournier, 1995, p. 16):

1. *Establishing criteria of merit.* On what dimensions must the evaluand do well?
2. *Constructing standards.* How well should the evaluand perform?
3. *Measuring performance and comparing with standards.* How well did the evaluand perform?
4. *Synthesizing and integrating data into a judgment of merit or worth.* What is the merit or worth of the evaluand?

However, many evaluators have critiqued these goals and methods of logic. For example, Stake (2004) states that the previously mentioned logic does not usually happen this simply or linearly because many evaluators do not know the criteria or standards in advance. Even if the criteria are known, they are usually set too high, making it necessary to keep re-evaluating as time progresses. And finally, and perhaps most alarming when considering culture, these goals and methods of logic do not always meet the needs of the stakeholders, take into consideration stakeholder context, culture, power, biases, needs, or beliefs, and are not responsive to the emerging issues or needed changes.

To address these shortcomings, Stake (1975) proposed the methodology of responsive evaluation, which builds on the basic evaluation principles and responds to the stakeholder issues and contextual properties. This model can be used to consider the client and therapist context, culture, power, needs, beliefs, family values, and individual needs in considering a culturally responsive model of family therapy, and is more appropriate than the basic models of evaluation, which often neglect marginalized stakeholders’ needs. This is especially important in culturally responsive therapy.
research, as the purpose of culturally responsive therapy is to respond to the participants, so the methods should do the same.

**Responsive Evaluation**

Responsive evaluation (RE) focuses on the particular problems of a particular program in a particular program context. As an interpretive, naturalistic, responsive, particularistic, qualitative approach (Stake, 2004, p. xii), responsive evaluation allows the researcher to responsively focus on the issues that are of priority to the stakeholders and practitioners, to develop a rich experiential understanding, and to provide information for improvement (Denzin & Lincoln, 1994). With a focus on the quality of the processes, the evaluator seeks to understand how people perceive and experience what is going on (Stake, 2004). Abma (2005) describes responsive evaluation as,

…an orientation to evaluation that generates qualitative evidence about the effectiveness of programs. Evaluation criteria to assess the program’s effectiveness are not only derived from the goals and intentions of policymakers, but include a wide range of issues and as many stakeholders as possible, including policymakers, managers, practitioners, community and target groups…responsive evaluation is a disciplined form of inquiry that results in qualitative evidence…it enhances the understanding of human behavior, it promotes holistic-thinking, offers contextual information and brings in the perspective of the community or target group (p. 279).

Thus, responsive evaluation seeks to have holistic quality, to seek an understanding of the nature, merit, and worth of the evaluand (Stake, 2004), to gain that understanding from as many stakeholders as possible, and to respond naturally to the way people are naturally (Stake, 1975). In culturally responsive therapy research, this may include gathering information from supervisors, trainers, therapists, adult clients, children clients, families and friends of clients, the front desk workers who take the money and schedule the appointments, caseworkers, and perhaps funding agencies.
It is important to understand that the focus is on the program quality via the perspectives of the participants; it is not so much whether the program has inherent value itself, but whether the participants perceive and experience it as valuable. In responsive evaluation the evaluator is also often considered a stakeholder and so his/her perceptions are also taken into account. Stake (2004) explains that,

Responsive evaluation is a search for and documentation of program quality. It uses both criterial measurement and interpretation. The essential feature of the approach is responsiveness to key issues or problems, especially those experienced by people at the sites. It is not particularly responsive to program theory or stated goals; it is responsive to stakeholder concerns. The understanding of goodness rather than the creation of goodness is its aim. Users may go on to alleviate or remediate or develop or aspire, but the purpose of this evaluation is mainly to understand (p. 89).

This is a clear divergence from traditional evaluation where the focus is on the value of the program itself, not necessarily if the program is valuable to a given population. In the case of minority or marginalized populations in need of culturally responsive therapy treatment, the model has no value if it is not applicable and usable for that population; the researcher is not seeking to understand the goodness of the model for model development itself, but to understand how the participants experience the model and the issues with the model. This is consistent with culturally responsive therapy as it is accountable to the minority community members and their experiences, as opposed to empirically validating or researching a model of the sake of knowledge, and relies on their local knowledge to inform the clinical work. Table 6 depicts the consistencies between responsive evaluation and culturally responsive therapy.

**What is Responsiveness?**

Similar to culturally responsive therapy, within the context of responsive evaluation, to be responsive means to be “client-centered” (Stake, 2004, p. 101) and
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<th>Culturally Responsive Therapy</th>
<th>Responsive Evaluation</th>
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<tr>
<td><strong>Epistemology</strong></td>
<td>Social Constructionism</td>
<td>Social Constructionism</td>
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<tr>
<td><strong>Theoretical Underpinnings</strong></td>
<td>Interpretivism, Feminism, Just Therapy, Critical Race Theory, Relies on insider/local knowledge, Use of cultural advocated and advisor boards as accountability structures</td>
<td>Interpretivism, Naturalistic, Responsive, Particularistic, Qualitative</td>
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<tr>
<td><strong>Attention to Context</strong></td>
<td>Focus on socio-political and socio-cultural contexts, Consideration of neighborhood, communities, and support systems, Recognize social, cultural, and historical contexts</td>
<td>Focus on socio-political and socio-cultural contexts, Recognition of social, cultural and historical contexts</td>
</tr>
<tr>
<td><strong>Attention to Culture</strong></td>
<td>Consider traditions, values, worldviews, and life experiences, Attention to subordinations related to the intersection of race, class, gender, ethnicity, age, sexual orientation, nationality, and ability</td>
<td>Attention to the culture of the organization, worldviews of each individual, and the experiences of each individual and in relation to one another</td>
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<tr>
<td><strong>Methods</strong></td>
<td>Client-centered, Use of non-traditional measures to address factors that affect recruitment and retention such as poverty, language barriers, structural racism and segregation, social isolation, and distrust towards institutions, Measures designed to fit population</td>
<td>Client-centered, Flexible, innovative, adapting, and emerging to fit the needs of the participants, Responsive to concerns, key issues, problems, language, contexts, and standards of an array of stakeholder groups, Measures designed to fit population</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>Clients and Families, Community members, Therapists and Supervisors, Advisory board, Cultural advocates, Any stakeholders possible involved</td>
<td>Stakeholders at multiple levels, Various levels of hierarchy, Desire to find conflicting or a wide array of views and experiences, Accountable to minority community members and their experiences, Relies on local knowledge</td>
</tr>
<tr>
<td><strong>Findings</strong></td>
<td>Accountable to minority community members, Use of accountability structures to avoid replication of dominant power structures</td>
<td>A description of the quality of the process via the experiences of the stakeholders, Feedback given throughout the process of evaluation for immediate change</td>
</tr>
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**Outcomes**

<table>
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<tr>
<th>Understand the phenomenon</th>
<th>An understanding of whether the participants perceive and experience the evaluand as valuable</th>
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<tr>
<td>Go beyond pathologizing participants in regards to external contexts to actively changing them</td>
<td>Users can use the data to alleviate, remediate, develop, or aspire within the evaluand</td>
</tr>
<tr>
<td>Explain roots of non-responsiveness</td>
<td>Does not aim for generalizability, but naturalistic generalization may occur</td>
</tr>
</tbody>
</table>
| Criticize dominant power structures | **Outcomes**

respond to concerns, key issues, problems, language, contexts, and standards of an array of stakeholder groups. These studies are,

…steadfastly responsive to the chronological activity, the perceptions, and the voices of people associated with the evaluand…[they are] responsive because many of the important meanings of organization and accomplishment and goodness are situational, reflecting, and responding to the locality of the evaluand. Responsive evaluation studies emphasize social issues and cultural values as well as personal and programmatic dilemmas (Stake, 2004, p. xv-xvi).

The aim of culturally responsive therapy is to respond to the needs of the clients, and this methodology supports the intention of being client-centered and responding to the needs of the participants. So, when studying a culturally responsive therapy, the methods adapt to fit the needs of the participants and clients instead of testing the model to find the outcomes.

The action of “respond” has not been formally defined in any responsive evaluation articles known to the author, but from the actions taken in previous studies one can deduce that to “respond” is an action that the evaluator steadfastly takes to adapt the evaluation to the stakeholder concerns and issues. This may be changing the criteria, including additional stakeholders, educating stakeholders, etc. to make the evaluation fit the needs of the stakeholders. Stake (2004) defines this quality of responsiveness as

… a general perspective in the search for quality and the representation of quality in a program. It is an attitude more than a model or recipe. No matter what the
role or design for evaluation, it can be made more responsive or less. Being responsive means orienting to the experience of personally being there, feeling the activity, the tension, knowing the people and their values. It relies heavily on personal interpretation. It gets acquainted with the concerns of stakeholders by giving extra attention to program action, to program uniqueness, and to the cultural plurality of the people. Its design usually develops slowly, with continuing adaptation of evaluation purpose and data gathering in pace with the evaluator becoming well acquainted with the program and its contexts (p. 86).

The disposition is a predetermined, intentional stance taken by the evaluator to become immersed in the context, personal with the stakeholders, and action oriented and dedicated to accommodating to the stakeholder needs and issues. In many ways, this is similar to the idea of cultural competency and sensitivity in attitude, and to culturally responsive in action—meaning that the researcher has background knowledge (cultural competency) and sensitivity, but actually takes action to respond to client needs. In the field of culturally responsive therapy research, this would mean that, instead of just interviewing and measuring the outcome, one would take action to change the methods, make the participants more comfortable, work within the context, develop culturally appropriate measures and instruments, and include more family members or clients. In responsive evaluation and in culturally responsive therapy’s Feminist, Just Therapy, and Critical Theory underpinnings, the researchers and therapists have intentional worldviews to actively respond to the stakeholders both within the therapy and study and beyond. This is similar to and consistent with the feminist notion of praxis, the putting one’s theoretical beliefs for equality and social change into action and applied practice (Thompson & Walker, 1995).

**Epistemology**

As a type of action research with a focus on the context, time, and place, responsive evaluation is never value free (Small & Uttal, 2005). It is important to
consider and openly acknowledge this value-based epistemology, especially the “
‘epistemological’ perception of quality” (Stake, 2004, p. 6):

If you are inclined to think that the value of an evaluand is more or less entirely constructed by people through their perceptions, choices, and judgments, your synthesis strategy is likely to be different. Even if you are inclined to think the program has intrinsic value but find it too difficult to discover, then it makes more sense to attend to criterial performance less and concentrate more on the people having useful perceptions, choices, and judgments (Stake, 2004, p. 171).

This question of whether it is the quality of the process itself or the experience of the process via the participants will affect one’s design, instrumentation, observation, analysis, and synthesis. When a researcher is responsive, and focuses on the individuals opinions, contexts, perspectives, etc. they receive rich data on the inside perspective of the program, but may lose the credibility of standardized criterion measurements that are provided to compare and contrast standardized measurements between groups (Stake, 2004). This may affect the use and acceptance of the findings, depending on the audience. Thus, concentration on one unique population will promote culturally responsive therapy for that community, but will not necessarily be generalizable to other groups. So, it meets the culturally responsive therapy tenets of being accountable and concerned about a unique group, but does not necessarily empirically validate the model, instead showing that it is valuable for that particular population. If a researcher is working in reverse, with an intent to support that the model’s validity, instead of having the participants as the center of the focus, they are more likely to create a design and utilize methods that support the model fits, as opposed to being concerned about ways to better adapt it to make it fit. For example, the findings could suggest that symptoms are reduced, however the therapy may be viewed as unproductive for the clients who may
have seen it as intrusive, offensive, did not desire symptom reduction, or the level of reduction was not sufficient although perhaps statistically significant.

Responsive evaluation is theoretically rooted in interpretivism (Denzin & Lincoln, 1994; Stake, 2004, 2005), which is epistemologically informed by social constructionism. Social constructionism posits, “all meaningful reality, precisely as meaningful reality, is socially constructed” (Crotty, 1998, p. 55, emphasis in original). Thus, our culture and social interactions are both the source of our human thought and behavior, and are bi-directionally affected by our thought and behavior (Crotty, 1998). These dominant discourses of our culture and society often determine what we perceive as “real” (Wetchler, 1996).

Social constructionist researchers and therapists, therefore, assert that we cannot accurately observe an individual, couple, or family because “what we see is colored by our previous beliefs and interactions with the family” (Wetchler, 1996, p. 130). All that we know about the clients is created through meaningful interaction with those clients, and is constantly changing. Thus, there is no “normal development” or “normal family,” meaning is not predetermined but created within the context, emotions and experiences are not internal states but context-driven, and therapists and researchers do not have expert insight but co-construct meaning with clients (Wetchler, 1996). This view gives the client freedom to be himself and to be “normal” for who he is, and does not place the minority group as the “outlier” or non-white group. Furthermore, theoretical therapy models and interventions themselves do not have inherent value that is waiting to be discovered, but that value is constructed via interaction with that model. Thus, even if a theory has been empirically validated with one group or numerous groups, that does not
make it intrinsically good—if it does not work with a unique population, then do not use it or force it to work, regardless of its success with others.

**Theoretical Orientation**

Social constructionism is the epistemology underlying the interpretivist theoretical orientation, which “looks for culturally derived and historically situated interpretations of the social life-world” (Crotty, 1998, p.66, emphasis in original). In this worldview, individuals interpret and understand the world in which they live via subjective experiences based on the situation, and social, cultural, and historical contexts (Creswell, 2007). Thus, one cannot think, act, or behave independently of their background and personal interpretations of the current situation. Interpretivist researchers desire to understand how others make sense of their world, and recognize that their own personal, historical, and cultural backgrounds tint their interpretations (Creswell, 2007). The Just Therapy, Feminist, and Critical Theory underpinnings of culturally responsive therapy are consistent with the responsive evaluation social constructionism epistemology. Both recognize that clients are affected and view experiences via their own context and social, cultural, and historical contexts and responsive evaluation methods reveal these perceptions and experiences for an emerging culturally responsive therapy. Further, using responsive evaluation/culturally responsive therapy pushes the researcher and therapist to recognize their own background and context and how those influence the emerging knowledge and interpretations.
Subjectivity Statement

Role of the Researcher

Like action researchers, academicians who are responsive evaluators must work to establish the partnership, including finding collaborators and identifying stakeholders, determining the research questions, including research questions for social action, anticipating changing research questions, making adjustments, modifying the research design, stating their stake in the research questions and measures, and balancing authority and expertise to be egalitarian and partnership (Small & Uttal, 2005). Responsive evaluators must be comfortable with ambiguity and understanding that their measures may not be able to be predetermined and that they will have to readjust the design to the context (Abma, 2005).

Within these tasks, the evaluator has the ongoing roles of interpreter, educator, facilitator, and Socratic guide by interpreting meanings and beliefs, educating stakeholders on various experiences, organizing the dialogue and context, and probing for new ideas, truths, experiences, silenced voices, and underlying values, respectively (Abma, 2005). According to Abma (2005), researchers must have strong interpersonal, communication, and negotiation skills, as well as genuine empathy whereby they can relinquish the role of expert and adopt the collaborating and power-sharing roles of interpreter, facilitators, educator and Socratic guide. It is beneficial for the evaluator to spend time in the field to best understand the community and build relationships.

These roles are consistent with the culturally responsive therapy underpinnings and culturally responsive therapy researcher roles, as they work to give voice to the marginalized, to balance the power within the research, and to create social change.
Further, the emphasis on local knowledge and the willingness and dedication of the evaluator to adapt to the client needs is present in both culturally responsive therapy and responsive evaluation.

**Biases of Evaluator/Researcher**

Consistent with feminism and Just Therapy, the responsive evaluator must be reflexive (Stake, 2005), attentive to power, especially their own power, perspectives, and positions on the research process and relationships (Small & Uttal, 2005) and aware and open about his own role as stakeholders. An evaluator who is outside of the culture of the evaluand may misinterpret the stakeholder group’s meanings and struggle between balancing the power and completing the evaluation in a timely manner. Sensitivity to the needs of the group and their boundaries and a healthy understanding that some stakeholders are skeptical of the evaluation process and may not accept the formal reports will help the evaluator in the reflexive process. This does not mean that the evaluator must comply with all wishes, but that it is necessary to self-correct when mistakes are made and to be transparent. This reflexivity and transparency can be incorporated with peer reviewing and meta-evaluation-- constantly looking for checks and reviews along the way (member checking, peer reviews, reanalyzing, etc.) (Stake, 2004). In accord with interpretivism and social constructionism, the responsive evaluator’s interpretations are not seen as biases to bracket out, but as a way to enhance the experience and evaluation of the program (Stake, 2004). However, one danger bias of evaluators is to treat their group or ideas too favorably, whether in a negative or positive light (Stake, 2004). This bias should be kept in the forefront of the evaluator’s and meta-evaluator’s minds. This emphasis on power and potential research biases is consistent with culturally responsive
therapy, where the therapist/research works to balance and be aware of their power and biases.

In many ways, I have personal biases and experiences with the current research topic. First, I am a level-1 EMDR trained therapist; I attended the training six weeks prior to moving to Cambodia, and have had a complete session with one client. While in Cambodia, I presented at two international conferences, and was accepted at a third, on EMDR and culturally responsive therapy. Second, I am a feminist-informed therapist and researcher who works diligently to consider how the client’s and my cultural values have an impact on therapy. For example, I work with marginalized populations in my current clinical practice. When assessing clients, I consider the intersection of their race, class, gender, and ethnicity before giving a diagnosis; I often ask myself, “Are the client’s problems and symptoms a reflection of societal oppression or situational? Or, do they ‘truly’ have a biological or personality imbalance?”

Finally, I am a therapist and researcher who has lectured on Solution-Focused Therapy in Cambodia and have implemented Solution-Focused Therapy with Cambodian clients in Cambodia. During the summer of 2008, I traveled to Cambodia with Dr. Denise Lewis to help establish a therapy outreach project that serves grandparents raising their grandchildren. In collaboration with the Royal University of Phnom Penh and the Maryknoll non-governmental organization, we developed a booklet, *My Grandmother and Me*, in regards to the identified need in the community to address the stigmatization of children and families affected by HIV/AIDS and the family relationships influenced by the infection and affection of HIV/AIDS.
This booklet is informed by Narrative Therapy and Solution-Focused Therapy, as it seeks to identify the positive aspects of the grandmother-grandchild relationship and re-write their story in their preferred narrative as opposed to the cultural stigmatization. The intention of the booklet sharing is to affirm the grandmother’s role in the child’s life, to affirm the grandchild’s role in the grandmother’s life, and to change the language used when describing their relationship. Thus, the relationship will not only be the result of a loss of parent, but of love and intergenerational exchange. To pilot this booklet, I supervised four Cambodian therapists and conducted co-therapy with them with nearly 45 children.

Although I have had successful personal experiences as a Solution-Focused therapist and with Solution-Focused teaching and therapy in Cambodia, I am not biased to this model over, or in comparison to, EMDR; I am simply passionate about finding a culturally responsive Cambodian model of therapy, whatever it may be. However, in the spirit of genuine transparency, I must admit my frustration and anxiety as an evaluator/researcher about the complete switch of the evaluand from Solution-Focused Therapy to EMDR after I had arrived in Cambodia (to be discussed in a later section); while it is consistent with responsive evaluation for this to occur, my frustration is with the host site contact, as he knew this information in advance, but did not tell me until after I had prepared the original project, IRB, substantial grant funding, training, etc. on Solution-Focused Therapy. It was explained to me that he may have feared I would not come to his university if he told me the truth, so he waited until I had moved to Cambodia. Although this is a cultural issue that is likely valid, it only minimally relinquished my frustrations but is something I will be careful to address in future studies.
This frustration was further complicated by his illegal immigration to the US after a team of colleagues and I helped him attend a conference in Boston, Massachusetts. Not only did I feel used for putting my family name and contact on his Visa application, I felt enraged to be left in Cambodia, without a contact for the promised host site support, and actually doing many of the tasks that trickled down from his position, voluntarily and free of pay. This additional stress was a constraint for me personally, as well as the study.

With regard to my own cultural influences, I recognized the many ways that I must have been reflexive and attentive to my own power in the evaluation process. I recognized there are many ways that I am an outsider (Patton, 2002) in this study. I am not Cambodian, have not lived in such severe poverty, am a member of the White, Christian, educated, middle-class Euro-American group that often forces my culture and ideas on others, and am privileged to have therapeutic models “normed” on my culture.

To further tip this power imbalance, I was the students’ instructor, clinical supervisor, and the researcher/evaluator. While Cambodians defer power to outsiders in most situations, especially to those who are more educated, I feel that my less-educated EMDR position helped me share the power with the students; the majority of the time they would still defer to me as the expert on EMDR, but I constantly reminded them that they are the experts on EMDR in Cambodia, they have more training than me, and even asked for their thoughts and ideas on EMDR—I think this created a sense of empowerment and some shared power. Ironically, at the same time, my status as an educated American, native English speaking ability, and minimal training in EMDR elevated my voice and gave me power to speak openly and freely with other foreign instructors and supervisors.

On the other hand, gender is the main part of my identity, and I am still considered
“young”, and this may be perceived as less powerful in Cambodia and with the other foreigners. I recognized the power I have and diligently worked to balance that as ethically and culturally appropriately as I could. Perhaps most importantly, I recognized how my role as a doctoral student needing to complete her dissertation put me in a vulnerable position of being too accommodating, or being too pushy to get the work done. These are important issues that I kept in mind as I immersed myself in this study and that I was reflexive and journaled about.

**Methods**

Similar to other clinical studies, responsive evaluation studies generally take the form of case studies whereby open-ended interviews, on-site observations, and document reviews are utilized. However, this is not always the case, as responsive evaluation relies less on formal and more on natural and causal conversation (Stake, 1975, 2004, 2005). Thus, in accord with the model’s interpretivist stance, methods should be interactional and adaptive to best understand the context, experiences, and multiple perspectives (Denzin & Lincoln, 1994). These methods can include e-mail, telephone, and in-person interviews, group interviews, focus groups, live observations, surveys, client records, narratives, snapshots, and videotapes (Stake, 2004). Some are more fitting for given circumstances: focus groups are good for gathering beginning information, and questionnaires and paper surveys provide quick demographics and frequencies, but they can be used at any time if needed. Use of creative methods, such as journaling and art, is also encouraged. For example, Abma (2005) utilized conversational interviews and storytelling workshops to educate stakeholders on other stakeholder perspective, allowed them to respond to one another in a safe manner, encouraged the participants to interact,
and promoted dialogue and stakeholders to raise their own questions. Therapeutically, one could use family photos, art, and stories. Feminist-informed, critical, multiculturalists family researchers McDowell and Fang (2007) have suggest the use of these diverse methodologies to support social equity and amplify marginalized voices.

The overall goal of the method is to have quality data (Stake, 2004). This requires interviewing the right people, using the right instruments, finding good indicators, and responsively rooting the interview, survey, and questionnaire questions in what has been cited in the literature, previously described by the stakeholders or observed in historical artifacts and documents. In the beginning, and consistent with the interpretivist worldview (Creswell, 2007), it is best to ask global and general questions to get the overall meaning. (How do you feel about the issue? How do you perceive it?). Reviewing and piloting the methods is encouraged before the data gathering stage (Stake, 2004).

Because the focus and questions of RE are specific to the program’s here and now (Stake, 2004), there is never really a control group and programs are not generally compared against each other. One can use “reference programs” which are control groups to compare to treatments or programs, or one can use last year’s program results (Stake, 2004). It is more common that everything is member checked and compared across categories within the evaluation itself. However, when studying CRT, the population is not likely to have previous studies to compare and cross-comparing between cultural groups is counterproductive.
Flexible, Responsive Design

Similar to action-research in terms of being a dynamic process needing flexibility, (Small & Uttal, 2005), the design of a responsive evaluation study must be emergent and flexible in order to respond to the issues and problems of the stakeholders (Abma, 2005). The design can be outlined initially, but is sensitive to ongoing changes (Stake, 1975) and therefore likely to change, adjust, and adapt regularly to accommodate the local context and cultural, social, behavioral, and economical factors (Abma, 2005), and to improvise and adapt to the changing needs to the issues, stakeholders, context, and resources (Berk & Rossi, 1999). Thus, the initial design is tailored to the unique project, and revisions and modifications are made in response to the program needs revealed by the data (sometimes contrasting data) that is integrated and synthesized from multiple sources at multiple levels (Berk & Rossi, 1999). This is different from other research that aims for generalizability, as responsive evaluation is genuinely interested in the local needs and willing to make modifications at the inconvenience of the researcher, the risk of simplicity and the need for large amounts of data.

These initial plans are often based on the valuable first impressions of the evaluator (Stake, 2004), who continues challenging these impressions and other impressions and findings that emerge. Observation is especially necessary in early stages and the evaluator utilizes impersonal, unobtrusive measures to challenge the findings and views, and focus on the good and the bad of the program and stakeholders behaviors. Special attention is paid to the fact that the information is from multiple sources, and the evaluator works to validate each of those sources equally. Stake (2004) explains, “We sometimes speak of multiple realities—differences in perception so robust that they
influence the recognition of meaning, propriety, and worth” (p. 93). In the case of culturally responsive therapy research, this would mean giving equal voice to the clients, families, therapists, and supervisors, using an advisory board and consultants, recognizing that these individual perceptions are influenced by the experiences and life histories of those participants, and utilizing innovative methods to accommodate and amplify each of these voices.

It is important for the evaluator to,

…pay attention to what is happening in the program, then to choose the value questions and criteria. He should not fail to discover the best and worst of program happenings. He should not let a list of objectives, or an early choice of data gathering instruments, draw attention away from the things that most concern the people involved…he should not presume that only measurable outcomes testify to the worth of the program (Stake, 1975, p.15-16).

These measurements should respond to the observations of the unique program and the unique issues of the group, which is made throughout the evaluation. This allows the researcher to respond to the emerging issues and needs of the program and the stakeholders (Stake, 1975). So, while it may be easier for one to use predetermined or popular scales, both the culturally responsive therapist and responsive evaluator would be more interested in using measures to fit the population, which may mean being flexible with the inventories or developing new measures.

To respond to the issues, the methods need to be flexible to accommodate the present, ever changing moment. Often, but not always, this entails a case study format that uses observation or interviews (Stake, 2004). The evaluator’s role is to find the problems and key issues of the program, which will usually entail observing, interviewing those involved, and examining documents. So, observation, document analysis, and interviewing are not just a part of the data collection, but a way to plan and
focus for the program design, which needs to be flexible, innovative, and adaptive (Stake, 2004). From the beginning, the responsive evaluator, like the culturally responsive therapist, recognizes that they do not have inside expert knowledge and therefore call on the insider to design the study and gain a better understanding of their experience of the evaluand.

Seonski and Lewis (2009) provide an example of flexible responsive evaluation methods utilized in a qualitative study on therapy with Cambodian orphans and their caregivers (without actually identifying it as responsive evaluation). The study began with a university therapy program requesting aid from the researchers, and the researchers meeting with the university, clinicians, and a non-governmental agency to explore the evaluand, criteria, and standards. A therapy program was then developed by the researchers and adapted with the researchers, stakeholders, and advisory committee to meet the language and cultural needs of the clients. The program was then implemented, with adaptations continuously made to meet the time, resource, therapeutic, educational, family, and language needs of both the clinicians and clients.

**Steps to Creating/Doing a Responsive Evaluation**

Due to the responsiveness to each unique program, responsive evaluations do not have a predetermined, step-by-step model. The steps described in this manuscript are those described by the founder of responsive evaluation, Robert E. Stake (1975, 2004, 2005). These steps and descriptions were chosen because Stake is widely publicized and highly regarded in the field, his writings provide clarity to the novice evaluator, and this model has been applied in a wide array of disciplines including education (Carnwell & Baker, 2007), medicine (Curran, Christopher, Lemire, Collins & Barrett, 2003),
psychology (Koopman, Beelen, Gerrits, Bleijenberg, Abma, de Visser, 2010), international health policies and promotions (Mercado-Martinez, Tejadad-Tayabas, & Springett, 2008), and English as a second language (Pawan & Thomalla, 2007). Further, and perhaps of most importance, Stake’s description and use of the model is consistent with the epistemological and theoretical background of culturally responsive therapy used in this paper.

Prominent Steps

From the onset of the evaluation, the evaluator and hiring agency must negotiate the contract of the evaluation and be clear on the evaluator’s role, the evaluand (Stake, 2004), and what legitimizes the evaluation for the stakeholder (i.e. test scores, behaviors, specific language etc.) (Stake, 1975). In culturally responsive therapy research, this would include meeting with the advisory board, consultants, and stakeholders to determine each person’s role. After these have been outlined and agreed upon, the following prominent events in a responsive evaluation occur (Stake, 1975):

1. Talk with clients, program staff, audiences.
2. Identify program scope.
3. Overview program activities.
4. Discover purposes, concerns.
5. Conceptualize issues, problems.
6. Identify data needs, re. issues.
7. Select observers, judges, instruments if any.
8. Observe designated antecedents, transactions, and outcomes.
9. Thematize; prepare portrayals, case studies.
10. Winnow, match issues to audiences.
11. Format for audience use.
12. Assemble formal reports, if any.

These events occur multiple times throughout the evaluation, are not sequential or linear, often co-occur and are returned to at various points. Table 7 outlines suggestions of Stake’s (1975) steps applied to culturally responsive therapy research.
<table>
<thead>
<tr>
<th>Responsive Evaluation Steps (Stake, 1975, 2005)</th>
<th>RE Applied to Culturally Responsive Therapy</th>
</tr>
</thead>
</table>
| 1. Talk with clients, program staff, audience, etc. | - Talk with stakeholders including clients, friends and families of clients, therapists, supervisors, case managers, secretaries of the agencies, community members, insurance companies, etc. to gather information on their observations, perceptions, and experiences of the therapy model  
- Identify cultural advocates and create a cultural advisory board  
- Learn the culture, values, traditions, needs, and language of the stakeholders |
| 2. Identify program scope | - Orient self to the community  
- Observe therapy and community traditions and interactions  
- Meet with various persons to find out what is of value to the stakeholders  
- Utilize documents and artifacts to gain background knowledge on the therapy and its use in the community |
| 3. Overview program activities | - Identify the activities surrounding therapy, including who attends sessions, how many sessions clients average, what is the cost of the therapy, how does the therapy influence the socio, cultural, and political environment, and how is impacted by these pressures?  
- Explore the role each stakeholder and the context play in the therapeutic process.  
- Determine the intentions and desired outcomes of the therapy for each stakeholder. |
| 4. Discover purposes, concerns | - Identify the concerns of each of the stakeholders.  
- Work to amplify marginalized voices.  
- Gather impressions of the therapeutic worth from various individuals whose opinions differ. |
| 5. Conceptualize issues, problems | - Create a plan of potential issues and purposes of the evaluation. For example,  
  - Are the theoretical model’s underlying epistemological and theoretical tenets consistent with cultural values?  
  - How does the model respond to the unique needs and values of the client/therapist/family?  
  - Do the interventions and goals meet client needs?  
  - Who is included in therapy? Why? How does this affect the client and system?  
  - Are the therapeutic outcomes satisfactory?  
- Review identified issues with the stakeholders, cultural advisory board, and cultural advocates.  
- Redefine and revise the issues to be evaluated, if needed. |
| 6. Identify data needs, re. issues | - Determine the type of data needed for the evaluation.  
- Consider methods that are responsive to the needs of the stakeholders (role-playing, case notes, interviews, observation, measures, focus groups).  
- Arrange data collection at the convenience of the clients, family, community, and therapists. |
| 7. Select observers, judges, instruments if any | - Invite appropriate persons to observe and engage in the therapy and comment.  
- Determine measures or create new instruments to meet the needs of the unique population.  
- Ensure that the instruments measure what the stakeholders view as important, as opposed to being convenient for the evaluator. |
| 8. Observe designated antecedents, transactions, and outcomes | - Begin more “formal” data collection.  
- Adapt and re-create methods based on stakeholder needs.  
- Continually check quality and accuracy of data; encourage member checking.  
- Provide feedback throughout data collection; if something is or is not working, reveal. |
| 9. Thematize; prepare portrayals, | - Create narrative, portrayals, case studies, charts, graphs etc. to depict tentative findings. |
In early stages of research, including having initial discussions with the stakeholders, and identifying the program scopes, the evaluator often uses the following substeps (Stake, 2005, p. 223-224):

| 9. Thematize; prepare portrayals, case studies | • Create narrative, portrayals, case studies, charts, graphs etc. to depict tentative findings.  
• Check quality of records and interpretations.  
• Gather reactions for stakeholders and identity the relevance and accuracy of findings. |
| 10. Winnow, match issues to audiences | • Allow stakeholders to react to the various findings.  
• Work to represent concerns of each group (clients, therapists, families, community, etc.) |
| 11. Format for audience use | • Provide feedback in useable format for various stakeholders.  
• Consider the use of various publication formats: client portfolios, pamphlets, presentations, role-plays, documentaries, art, radio, poem, narratives, and manuscripts. |
| 12. Assemble | • Create reports that are valuable and useable to the needs of the unique population. |

Step 1: Identifying the issue topic;  
Step 2: Looking up the topics in some source books or source engines;  
Step 3: Identifying some helpers;  

For an evaluation to be successful and useful to the stakeholders, the evaluator must know the issues, culture, language, and needs of the stakeholders for whom the evaluation is being completed. This information can be gathered through spending time in the field and through learning about the needs and issues of the people (Stake, 1975). Through interviews, document analysis, and examining photographs, artifacts, and local historical pieces, the evaluator can gain invaluable knowledge about the program before the implementation (Stake, 2004).

By reading about the common issues of the population, the evaluator gains a background understanding and gathers potential questions to ask the stakeholders. These are not necessarily questionnaire-type questions, but more a guide to know what the
population is potentially facing. Of course, the evaluator “should not pander to desires for only favorable (or unfavorable) information, nor should he suppose that only the concerns of evaluators and external authorities are worthy of discussion” (Stake, 1975, p. 20). The background information should contain a wide array of issues, voices, and opinions about the program. Consistent with culturally responsive therapy’s Feminist, Just Therapy, and Critical Theory worldviews, the evaluator should also identify power imbalances and marginalized persons.

It is helpful to draw on a wide range of sources to gain an in-depth understanding of the case (Stake, 2004, p. 447):

- The nature of the case, particularly its activity and functioning,
- Its historical background,
- Its physical setting,
- Other contexts, such as economic, political, legal, and aesthetic,
- Other cases through which this case is recognized, and
- Those informants through whom the case can be known.

The questions the stakeholders are asked and the background exploration are specialized specific to the program here and now (Stake, 2004). When examining and evaluating the evaluand, it is important to consider and examine the processes, and personal, contextual, and historical needs (Stake, 2004, p. 261). Consistent with culturally responsive therapy, local meaning is important (Stake, 2005) as responsive evaluations, like case studies, focus on the experience knowledge of the participants and the influences of contexts, including the social and political (Stake, 2005).

After the background has been explored, the program problems, also called issues, need to be identified. Stake (2004) defines these issues as “tensions, problems, organizational perplexities, unscheduled costs or hidden side effects—things that go wrong with programmatic effort. The term issue draws thinking toward the immediacy,
interactivity, particularity, and subjective valuing, especially those awarenesses already felt by persons associated with the program” (p. 89). The evaluator then chooses a few issues around which to focus the study, which helps determine the merit of the situation but doesn’t replace the goal of evaluating the merit (Stake, 2004).

The instruments and methods of data collection must then be decided according to how to best measure the evaluand's merit and value. It is acceptable and to have both standards-based (generally quantitative) and responsive evaluation (generally qualitative) in the same study (Stake, 2004). Initial measurements should be used to gather initial criterial data to get a sense of what is going on and a general description (the stats, frequencies, or narrative description). This initial data gathering is primarily interpretation, which helps determines the merit of the evaluand, and is obtained by many types of judgment (Stake, 2004).

While meeting with the stakeholders, it is crucial to identify the standards, whether those standards are formal, a group “norm”, or within one’s head. These levels of acceptability can be multidimensional or be based on a compensatory model (which lets one scale accommodate for lowness in the other). Or, it may be a multiple cutoff, where all criteria must be met (Stake, 2004). They are also likely to vary by stakeholder.

With these issues in mind, the evaluator begins to use various methods (focus groups, interviews, observations, role-playing, surveying, etc.) to evaluate the evaluand’s antecedents, transactions, or outcomes. Whether the antecedents, transactions, or outcomes are evaluated depends on the focus on the evaluation.

As the evaluation continues, the way the evaluand is perceived begins to change—as the measurement changes the performance, the performance changes the
measurement. The evaluation begins to mature and adapt during the analysis and synthesis. “The responsive synthesis has its moments of emergence and transformation, but most of the process is experiential and evolutionary, from initial impressions to the final realization of quality” (Stake, 2004, p. 179). As these changes in the perceptions of the evaluand occur, ongoing review is needed from all of the stakeholders and the researcher (Stake, 2005).

Throughout this process of change, it is appropriate and expected to give feedback to better the process, which also helps refine the list of what to focus on (Stake, 2004). So, if the evaluator becomes aware of something that is not working, he/she gives immediate feedback at that moment, to implement in the process, as opposed to waiting until the end. Process use “refers to the acceptance of knowledge and the personal and organisational learning processes that occur during the evaluation process” (Abma, 2005, p. 288). The process use is facilitated by the participation of the stakeholders, which builds their confidence in the information and the applicability of its use in their unique context. This is one of the key benefits of responsive evaluation—providing immediate feedback to responsively fit the needs of the stakeholders, as opposed to withholding beneficial information. Thus, consistent with culturally responsive therapy, the point is to respond to the needs of the clients and to give immediate feedback to change the model and adapt it to meet the needs of the clients/participants, as opposed to purely testing the model, as is.

Finally, although it is not a part of the program itself per se, it important to consider the content of training, the topics, subject matter, skills, and knowledge taught (Stake, 2004) when considering the merit of the program. This would include making
sure the syllabus and content were appropriate, that the trainer was realistic and properly trained, that the students had learned the basics before the complex lessons were taught, and that learning had occurred. This does not necessarily have to be another in-depth evaluation, but can be a part of the background that the evaluator examines.

**Participants**

Because responsive evaluation is a method of inquiry whereby the design emerges from the issues and concerns of the stakeholders, as many stakeholders as possible should be included. These issues and concerns are obtained through in-depth conversations with the stakeholders, especially the marginalized and silenced voices. Often, these individuals fear stepping out or speaking due to the systemic repercussions. It is the researcher’s job to create an environment of openness, respect, inclusion, and engagement (Abma, 2005) where the participants can interact and engage in dialogue that is non-confrontational or attacking. It is crucial to create an environment where the power-balances are shared; from a feminist perspective, these marginalized, silenced voices can never be equal, but the researcher can attempt to flatten the hierarchy as much as possible. Abma (2005) suggests this can be achieved via in-depth interviews to gain “thick descriptions” or to create a homogeneous group and use this information to educate other stakeholders on the experiences. Securing thick descriptions provides factual details, allows one to generalize local, context-bound knowledge to a larger system (which can be decided by the reader), and makes sure that the biases of one group does not dominate the evaluation. Because responsive evaluation works to balance the power, open dialogue for all voices to be heard, examines the values, biases, and group power imbalances, is attentive to the context, and works to eliminate the domination of marginalized groups, it is consistent
Multiple voices, diverse points of view, and continuous observations are included to reduce the chance of biases (Stake, 1975). Not only does this provide an abundance of valuable data, but helps to identify the exceptions and outliers that demonstrate the complexity and unrepresentative voices (Stake, 2004). According to Stake (1975, p. 23), the evaluation should reveal the “multiple reality,” where the complexity of multiple truths and opinions are represented. The researcher uses observations and negotiations of various stakeholders to gather narratives, portrayals, and documents to find the issues, values, and biases held by the individuals and group. Much of this is informal, at first, but formal records are kept (Stake, 1975). These voices and biases can be represented in multitude of ways and media, including narratives, maps, graphs, exhibits, taped conversations, photographs, and audience participation. Because the data are from multiple perspectives, interpretive, and socially constructed, ambiguity is tolerated (Stake, 2005). So, while it is not necessary for the stakeholders to reach a consensus on the criteria, it is necessary for each participant to have a share in the power and process for change (Abma, 2005).

In addition to the stakeholders sharing equal power with each other, the stakeholders have shared power with the evaluator, which is consistent with culturally responsive therapy’s feminist views. Similar to action research, which uses the voices of the local community to generate knowledge and change within that community (Small & Uttal, 2005), responsive evaluation honors the “tacit knowledge” of the participants (Stake, 2004, p. 286). These local voices are seen as having value and privileged
knowledge that can contribute equally to the project (equal to the academician) (Small & Uttal, 2005). As suggested by Stake (2004), “The people empowered set the standards; the disempowered find those standards a perpetuation of their dependence” (p. 283). Therefore, consistent with culturally responsive therapy, the evaluator must work diligently to examine those standards, identify who set those standards, recognized how those standards influence stakeholders (powerful and marginalized) differently, and give equal voice and power to the perceptions of those standards in evaluating the program. So, while the stakeholders are central to the evaluation, and their voices and standards are not to be ignored, it is ultimately up to the evaluator to discern the main standards of the evaluand (Stake, 2004, p. 176), especially in times of disagreement. In responsive evaluation, it is important to help as many participants as possible to participate, to increase their interest, to incorporate the research into everyday activities so the evaluation is less time consuming and as non-intrusive as possible (Abma, 2005), and to ensure stakeholders that participating is worth their time (Stake, 2004).

**The Current Study**

Consistent with the previously discussed steps by Stake (2004), this study utilized a flexible, responsive design. The planned evaluation and preliminary design focused on the use of Solution-Focused Therapy (SFT) at the Royal University of Phnom Penh (RUPP), Phnom Penh, Cambodia. These plans developed from a pilot study (Seonski & Lewis, 2010) using SFT in Cambodia. However, upon the researcher’s arrival, the host site explained that they preferred the evaluation of EMDR in Cambodia for several reasons: 1) the original host contact had moved into an administrative position and the new contact was not able to provide the support needed to study SFT; 2) 16 Masters-level
clinicians had just been trained in level 1 of EMDR and were being trained that semester in level 2 as a mandatory requirement of their traumatology course; 3) the host site felt it would be easier to collect data on EMDR; 4) no studies on EMDR had been conducted in Cambodia and they were concerned about the culturally relevance of the model; and 5) the Trauma Aid Germany/Humanitarian Assistance Program Germany was providing funding to train RUPP students in Cambodia on EMDR. Thus, the evaluand was changed to EMDR to respond to changing needs of the issues, stakeholders, context, and resources (Berk & Rossi, 1999). In addition, the initial interview guides and measures were changed to better explore the use of EMDR in Cambodia.

Participants

This study utilized a purposeful, criterion sample (Patton, 2002). Masters-level students (N = 16) at the RUPP in the department of psychology served as the primary EMDR student-therapist participants. The RUPP program was chosen as the project site because it is a highly respected Cambodian university, has recently started a Master’s in Psychology program, has requested the aid of American instructors to teach at the university and to help train Masters-level student therapists (Miriam Muslow, personal communication, March, 15, 2008), and was involved with the initial SFT pilot project conducted by Seponski and Lewis (2010). The native Cambodian students at RUPP are bi-lingual in Khmer (the native Cambodian language and name of the majority ethnic group) and English, making communication between the researcher and students feasible.

The initial criterion for EMDR student-therapist participants were:

1. Participants must be Master’s level psychology students at RUPP
2. Participants must be willing to implement EMDR with an individual, couple, or family
3. Participants must be minimally trained in Level 1 EMDR
The first criterion was based on the fact that EMDR requires Master’s level training, and the only Master’s level training clinic in Cambodia is at RUPP. The second criterion is important because the study focuses on clinical application and the students should have experience implementing the model; in addition, it is important to have knowledge and insight whether this model works for Cambodian individuals, couples, and families. The third criterion was implemented because EMDR has a formal training and only students educated through that training program are certified to practice EMDR.

Sixteen students were invited to participate. Of those sixteen students, thirteen participated in formal interviews (11 individual, 1 dyad interview). Interviews lasted between 1-3 hours and were conducted at a location, time, and date chosen by the participant. Of those thirteen interviewed, five also participated in the focus group. The focus group was conducted at a location, time, and date chosen by the participants and lasted 2.5 hours. Ten students provided case illustrations (two of those did not do the interviews, four did interviews, and four others did both the interviews and focus group.). Twelve students were observed during clinical supervision, and all students were observed during clinical internship case presentations. Four of the students participated in all types of data collection, and the average times participating was 3.4. Informal follow-up and conversation was done with students throughout the study (for example, after sessions, during lunch, during class, etc.). Table 8 provides the types and frequencies of participation.

At the time of their interview, student ranged between 0-40 hours of EMDR clinical experience, 4-55 hours of EMDR supervision, and (N = 3) had attended EMDR training level 1, and (N = 8) had attended EMDR training level 1 and level 2. Four
students were trained in level 1 & 2 EMDR in Cambodia, and were also being trained by HAP EMDR in level 1 & 2 with a traumatology prerequisite in Thailand. Due to the small number of EMDR student therapists in Cambodia, and because 5 students did not complete the form, additional demographics are not provided in a table to protect participant identities.

Table 8
*Number of Participants by Participation Type and Frequency*

<table>
<thead>
<tr>
<th>Type of Participation</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed in class/clinical presentation</td>
<td>1</td>
</tr>
<tr>
<td>Observed in class/clinical presentation and interview</td>
<td>2</td>
</tr>
<tr>
<td>Observed in class/clinical presentation and case illustration document</td>
<td>1</td>
</tr>
<tr>
<td>Observed in class/clinical presentation, case illustration document, and clinical supervision observation</td>
<td>1</td>
</tr>
<tr>
<td>Observed in class/clinical presentation, clinical supervision observation, and interview</td>
<td>2</td>
</tr>
<tr>
<td>Observed in class/clinical presentation, clinical supervision observation, case illustration document, interview, and focus group</td>
<td>4</td>
</tr>
<tr>
<td>Observed in class/clinical presentation, clinical supervision observation, interview, and focus group</td>
<td>1</td>
</tr>
<tr>
<td>Observed in class/clinical presentation, clinical supervision observation, case illustration document</td>
<td>4</td>
</tr>
</tbody>
</table>

Because this project was through the RUPP psychology department, the department head, program head, professors/lecturers, clinical supervisors, and peer supervisors served as an advisory board and cultural consultants (N = 11). Fifteen faculty/administrators/supervisors were invited to participate as an advisory board/cultural advocates. Of those sixteen, eleven participated. Nine were formally interviewed (7 individual, 1 dyad interview), and five were observed in supervision (two
of those five observed were not interviewed). Interviews lasted between 1-3 hours and were conducted at a location, time, and date chosen by the participant. Informal follow-up and conversation was done with the formally interviewed and observed faculty/administrators/supervisors throughout the study (for example, after supervision sessions, during lunch, during class, etc.). Four who did not participate were out of the country, but expressed interest in the study; they did not choose to participate via email or Skype interview. Faculty/administrators/supervisors were from five different countries, and had varying levels of education including Master’s, PhDs, and MDs (psychiatrists). Their local knowledge was used in reviewing previously used models of therapy, guiding the researcher with programmatic, teaching, and supervision questions, and learning about the culture of the university, community, and clients. Due to the small number of faculty, administrators, and clinical supervisors at RUPP, additional demographics are not provided in a table to protect participant identities. Further, the differences between faculty and administration opinions are not delineated due to the small number and because some hold both positions.

Eight months into the evaluation of EMDR in Cambodia, a community disaster occurred on November 22, 2010 at Koh Pech whereby approximately 500 individuals were killed in a stampede. Koh Pech is a man-made island with amusement-park rides and retail shopping. Thousands of Cambodians were on Koh Pech Island to celebrate the country’s water festival holiday. Due to the lack of infrastructure in Cambodia, poor electrical system, and corrupt police force, a stampede resulted from individuals being electrocuted on the main bridge linking the island and Phnom Penh. Police reacted by throwing water on the “fainting” crowd, thereby causing more electrocutions and
hysteria. They then accepted bribes to help individuals off of the bridge, and the
government denied any wrongdoing or that the deaths were caused by electrocution. In
reaction to the devastation, the local EMDR supervisor invited bachelors-level RUPP
psychology students to participate in an EMDR crisis intervention. As a response, the
inclusion criterion was modified to include the bachelor’s level students; a survey was
developed and disseminated to examine their experiences. Fifty-four bachelors students
were invited to complete the survey; fourteen participated, but two were removed
because they were written in Khmer and time and funds were exhausted, prohibiting
translation. Because the bachelors level therapists only used EMDR in that single setting
and did not have Level 1 training, they were not further interviewed for this study. The
evaluator is currently helping one of the RUPP Master’s students develop a Master’s
Thesis project to explore this phenomenon. This stampede disaster will be referred to as
Koh Pech throughout this dissertation.

A total of 21 individuals were interviewed, 10 provided case illustrations, 17 were
observed during supervision, 5 participated in the focus group, 16 observed in case
presentations (in addition to the researcher and co-lecturer), and 14 bachelor’s students
completed surveys. Table 9 summarizes the number of participants.

Table 9

<table>
<thead>
<tr>
<th>Participant Status</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master’s level students</td>
<td>16</td>
</tr>
<tr>
<td>Faculty and supervisors</td>
<td>11</td>
</tr>
<tr>
<td>Koh Pich crisis responders (bachelors students)</td>
<td>14</td>
</tr>
<tr>
<td>Workshop participants</td>
<td>54</td>
</tr>
</tbody>
</table>
Finally, it is important to note that it would be consistent with responsive evaluation and culturally responsive therapy research to include the voices of the therapy clients. However, these clients include children and elders, making them vulnerable populations, especially because of their life in a developing nation. Therefore, this dissertation utilized the reports of the student therapists as a foundation for a larger study that includes the voice of the marginalized clients.

**Recruitment**

Master’s level participants were recruited in their psychology classes via email (Appendix A), personal invitation (Appendix B), and through word of mouth. Bachelor’s level participants were recruited in their psychology classes via personal invitation (Appendix B) and through word of mouth. Utilizing word-of-mouth recruitment methods has been found to be the most powerful and preferred, with a positive initial experience, especially in small communities where reputation spreads quickly (Rodriguez et al., 2006). Within the recruitment process, the participants were educated on the importance and value of their participation, informed that it is completely voluntary, encouraged that it is time and cost efficient by utilizing their class requirements, and is beneficial to their community. Student-therapist participants were provided with an honorarium of classroom materials (pens, jump drives, etc.) worth $4.00 USD for each time they participated. The amount was decided in conjunction with a cultural advisory board (consisting of the RUPP psychology department head, Master’s chair, faculty, instructors and the clinical supervisors) to assure the reward was similar to other studies and comparable to most families’ earnings, so participants did not feel coerced to participate (Rodriguez et al., 2006). As a reward for cultural advocates/advisors, a digital audio-
recorder and a digital video-recorder were donated to the RUPP Department of Psychology for their use. The reward was decided in conjunction with a cultural advisory board (consisting of the RUPP psychology department Master’s chair and advisor and faculty/instructors) to assure the reward was similar to other studies and comparable to most families’ earnings, so participants did not feel coerced to participate (Rodriguez et al., 2006). It was suggested that the researchers provide a group reward for the cultural advocates/advisors because they are working for the department and want to promote its success instead of participating for personal gain (income, etc.). Bachelor’s level students were not given an incentive as decided in conjunction with a cultural advisory board (consisting of the RUPP psychology department Master’s chair and advisor and faculty/instructors) (Rodriguez et al., 2006).

Procedure

The procedure was consistent with and followed Stake’s (2004) twelve steps of evaluation as described in the proceeding sections. The financial and time parameters for data collection were set by external grants obtained by the researcher; the researcher was funded to live in Cambodia for 10 months, and data were collected between March 2010 and January 2011. Consistent with responsive evaluation, data analysis proceeded throughout the study. Participants were asked to member-check the transcripts and to confirm the researcher’s interpretation. The department head, program chair, other professors, and clinical supervisors were invited to confirm the interpretations, as well. The researcher discussed, throughout the process, how and when the information and preliminary findings should be disseminated (in addition to the dissertation).
Month 1.

After completing an initial pilot study in 2008, and 1.5 years of planning for the current study in conjunction with RUPP, the researcher arrived in Cambodia at the RUPP in March 2010. The researcher met with the stakeholders including assistant dean, department head, the Master’s program chair, Master’s program advisor, and other professors to learn more about the university, the program, the students, and the therapy in Cambodia. These individuals agreed to act as a cultural advisory board. In the first meeting, the researcher clarified the expectations of her role and reminded the site of her dissertation needs. In the second meeting, the researcher, who was initially asked to teach as an instructor on Solution-Focused therapy and evaluate the use of the model in Cambodia, was notified that the site would not be offering this course and preferred that she evaluate EMDR. Consistent with responsive evaluation and culturally responsive therapy, the researcher began the steps to adapt the evaluation, which included gaining permission from her dissertation committee members, contacting the local EMDR supervisor and university faculty, and re-writing the Internal Review Board (IRB) protocol. To learn more about the Cambodian culture, the researcher immersed herself in the culture by attending local events and plays, visiting museums and historical sites, and enjoying the local cuisine with the stakeholders. To learn to speak, read, and write the language, the researcher began Khmer language lessons. Through this two-month period of immersion, the evaluator worked to learn more about the evaluand, criteria, and standards via the various stakeholders and the context.
Month 2.

The researcher continued immersing herself in the local culture as well as orienting herself to the academic and EMDR community by spending time on campus with students and faculty, teaching guest lectures at the university, and meeting with the faculty EMDR supervisor to gain support for the EMDR evaluation study. The EMDR supervisor was extremely supportive and offered to help the researcher in anyway possible and granted permission for the researcher to attend EMDR group supervision. The researcher attended group supervision for the next six weeks, observing and participating in the supervision sessions and learning more about the therapy, who attends sessions, how and where the clients are seen, and how the stakeholders (faculty, students, supervisors, clients) feel about EMDR in Cambodia. Books and manuscripts on EMDR, Cambodia, and therapy in Cambodia were reviewed for additional insight. The researcher attended local therapy conferences on Testimonial Therapy and Genocide therapy for a richer understanding of other models and client needs.

Month 3.

Supervision was suspended for the summer due to conferences and the EMDR supervisor being out of the country. The researcher met with faculty and administrative stakeholders to learn more about the political and program environments and how the EMDR student-therapists and EMDR practice/training were impacted by these pressures. During this time, the researcher was asked and agreed to team-teach a class on cultural competency with a clinical internship case presentation component. Near the end of the month, the Master’s Program chair, the researcher’s primary host contact, asked to be sponsored to attend a conference in the United States on traumatology; with the
researcher’s help and Visa sponsorship, permission was granted and the individual left for the United States. He did not return and remained in the US illegally.

**Month 4.**

At the same time she was managing many of the Master’s Program chair’s work tasks after his emigration, the researcher began team teaching the course on cultural competency and learning more about the various student perspectives on and experiences with EMDR, which ranged from being enthused and seeking more training to completely disagreeing with its use in Cambodia and the program. In the class, many students presented on their use of EMDR, compiled video demonstrations using EMDR, and their peers gave suggestions and raised concerns on the implementation. The researcher also attended and presented at the first annual EMDR Asia conference; six of the student-therapists and the EMDR supervisor also attended and two presented on the use of EMDR in Cambodia during a typhoon crisis response. Presentations on the use of EMDR in Southeast Asia and developing nations provided insight on unique needs of the populations, how the interventions and goals of EMDR need to be explored, and varying therapeutic outcomes.

**Month 5.**

The researcher continued teaching the class, meeting with the faculty and administrators and EMDR supervisor to revise and redefine the issues of concern. The researcher worked to amplify the concerns of the student-therapists, who had less power because of their position of lower education level and less clinical experience. A plan for data collection at the convenience of the stakeholders was created, and methods decided at the suggestions of the cultural advisors. The RUPP held a multinational conference and
a session was presented on EMDR. Audience members expressed both interest in and confusion about this “new” model of therapy. In the greater Cambodian context, Kaing Guek Eav, also known as Duch, who supervised the infamous S-21 prison where as many as 16,000 Cambodians were brutally tortured before being executed during the Khmer Rouge Regime, was sentenced to only 19 years in prison (Extraordinary Chambers in the Courts of Cambodia, 2010). Many Khmer Rouge survivors were outraged and further grieved the corrupt justice system, Duch’s appeals continue at the time of writing (Cambodian Tribunal Monitor, 2011).

**Month 6.**

Formal data collection began with individual semi-structured interviews of faculty, administrators, and student therapists. Semi-structured 1-2 hour interviews with the student-therapists were conducted by the researcher to 1) examine their experience of using EMDR with their clients, and 2) explore ways to responsively adapt the model and evaluation process. Semi-structured 1-2 hour interviews with the faculty and administers were conducted by the researcher to 1) examine their perceptions of the students using EMDR with clients, 2) explore ways to responsively adapt the model and evaluation process, and 3) learn more about EMDR within the Cambodian context. Semi-structured interviewing provides the interviewer with an interview guide to follow and cover, but allows the interviewer to deviate from the original question to follow-up and probe the participant on their leads (Bernard, 1995). Appendix C contains the semi-structured interview guide for student-therapist. Appendix D contains the semi-structured interview guide for cultural advisors and consultants. After each phase of interviews, a more
focused semi-structured interview guide was developed for the next phase. Basic demographics of the participants and their clinical experiences were also obtained.

Supervision sessions resumed this month, and the group supervision session was observed. In the class, students expressed their experiences and thoughts on EMDR through role-plays on video and in-class discussion. Appendix E contains the demographics form.

Adherence to the model and clinical application was observed through triangulation of the data: 1) student-therapists took case notes of each session with each client, which included a) the clients’ feedback on the session (SUD and VOC) and b) how therapists felt the session progressed and how well individual interventions were received; 2) student-therapists were supervised in sessions by the EMDR supervisor; 3) student-therapists had group supervision time with the EMDR supervisor to discuss the cases; and 4) student-therapists practiced on their peers in group supervision and were observed by the EMDR supervisor and the evaluator. These data prompted the students to discuss how they felt they have adhered and deviated from the model and to describe when and why. In this dissertation, the case notes, journals, and session observations were not further analyzed because consent was not obtained from the clients.

Month 7.

Interviews with the student-therapists and faculty/administration continued. Group supervision session dates were changed, one cancelled, and the only one conducted was observed. Consistent with responsive evaluation, as meaningful data emerged, it was shared with the stakeholders and necessary adaptations made: Mid-month, preliminary findings were shared with the cultural advisory board and
consultants. Based on the data that suggested most Cambodians do not know about EMDR, and many RUPP students do not know or understand the model either, the administration requested the evaluator conduct an EMDR workshop at the university. The evaluator agreed, and responded by sending an email to all EMDR student-therapists, peer supervisors, and EMDR certified supervisors in Cambodia in a call for presenters. Four student-therapists and one peer supervisor confirmed.

At the end of the month, a focus group consisting of student-therapists (N =5) was conducted at the convenience of the stakeholders to explore their thoughts, reflections, and concerns on EMDR as a culturally responsive Cambodian therapy and on implementing EMDR. In addition, their perceptions of the evaluand, criteria, and standards were reviewed again. The focus group approach is a group interview that encourages members to interact with each other and to discuss the central topic (Morgan, 2001). This group approach allowed the researcher to gain many perspectives of the phenomenon, compare responses, and explore the group’s common knowledge of the topics of interest in the study, and for the other participants to agree with or refute what is being said (Morgan, 2001). In addition, focus groups have been shown to “facilitate culturally anchored research” by identifying the cultural knowledge and language of the group, and helping to develop the framework, constructs, and instruments of a cultural study (Hughes & DuMont, 1993, p. 775). It also promotes the amplification of marginalized voices, which may feel more powerful in numbers. In this case, it gave the students power to share their opinions of the model.

The focus group was held at the Royal Café outside of the Royal University of Phnom Penh, in a comfortable room with dinner and drinks to create a relaxed
atmosphere (Morgan, 2001). During the focus group, the researcher served as a moderator and took field notes of conversations and information on environment, mood, tones, gestures, and other contextual information (Fontana & Frey, 1994; Morgan, 2001). Appendix F contains the focus group interview guide.

The moderator used a more structured approach in which she was an active part of the group, presented questions surrounding the central topic (Appendix D), answered members questions, directed discussion toward the questions, “refocused” the conversation when needed, and clarified when she had questions (Morgan, 2001). This approach was chosen, as opposed to a less structured approach, because the purpose of the focus group is to review what they have learned, explore any ways they think it will/will not be culturally responsive, to balance the powers in the group so all participants feel safe to share, and to discuss the challenges associated with other interventions. Adaptations, changes, and additional education were provided to respond to group needs. At times, the group spoke in Khmer with each other as a way to more clearly conceptualize and explain their perceptions and experiences; these were then translated by the researcher.

Month 8.

Formal interviews with student therapists, faculty, and administration continued. All but one supervision session was cancelled, and the EMDR supervisor recorded that session for the evaluator who could not attend. The EMDR Workshop planning sessions were held on two Saturdays for two hours each and the evaluator, all presenters, and one administrator attended. The evaluator was the primary organizer but encouraged the stakeholders to create the content, which they did. At the end of the month, an
international HAP EMDR team visited Cambodia to provide EMDR supervision and to recruit participants for the next wave of HAP EMDR training. The evaluator was not invited to attend the meeting until two days before it occurred and was then invited by a student. The evaluator could not attend due to a conflicting meeting.

**Month 9.**

Formal interviews with student therapists, faculty, and administration continued and supervision sessions were observed. Early in the month, the evaluator contacted the international EMDR team to set up a meeting on EMDR in Cambodia; at the meeting, she presented the preliminary findings to give insight on how EMDR is working in Cambodia and the concerns of the students. The meeting was attended by two of the EMDR team members, one faculty/administrator at RUPP and the evaluator. Informed consent was not obtained from the team members and data were not collected. A debriefing conversation was later held with the RUPP faculty/administrator who attended.

Mid-month the EMDR workshop was held. Over 88 attendees from over 5 countries participated. Participant evaluation forms (N = 54) from the EMDR workshop were utilized in the document analysis of this study. Because these were anonymous program evaluations, and not interviews or data originally collected for the purpose of this dissertation, these individuals were not contacted for additional information.

At the end of the month, a community disaster occurred whereby approximately 500 individuals were killed in a stampede. Within 12 hours, the EMDR supervisor contacted all individuals in Cambodia trained in EMDR for a crisis-response intervention. Bachelor’s level students at RUPP were also invited to the training. The first training occurred within 24 hours of the incident, and an additional training at RUPP within four
days. Attendees were trained on the EMDR Emergency Room Protocol (ERP) by the EMDR supervisor. The evaluator attended and participated in the first training, and a note taker attended the second. Student-therapists and bachelor’s students began seeing survivors and their families at a local hospital within 3 days of the initial incident. Foreign trained EMDR therapists acted as supervisors and support for the locals who were practicing the EMDR ERP. Therapy rounds were conducted twice a day for two hours each time with any clients/families that were willing to participate. A 45-minute debriefing was conducted with the student-therapists after each session by the attending supervisor. The evaluator attended one session in the hospital and acted as a supervisor and assisted with tapping one client’s feet while a student-therapist implemented the protocol.

Month 10.

Formal interviews with student therapists, faculty, and administration continued. Group supervision was cancelled due to the EMDR ERP crisis response sessions. Further, the EMDR supervisor decided to return to her home country and discontinue EMDR supervision and treatment in Cambodia. Surveys were distributed and collected to the bachelor’s level students 3 weeks after the final EMDR ERP sessions. Appendix G contains the crisis response survey. A second group of bachelor’s students was selected from the university to attend the HAP EMDR training program. At the end of the month, the evaluator presented the preliminary findings at RUPP to faculty, students, and administrators. They were invited to confirm the researcher’s interpretations, provide additional information, and ask questions.
Analysis

Responsive evaluation data can be coded and stored in several ways (Stake, 2004), and there are multiple ways to analyze the data. In general, the responsive evaluator codes and interprets continuously throughout the evaluation, logging and checking all of the material including the people, places, narratives, quotes, and photos, taking notes, and making memos (Stake, 2004). Because of the high cost of time and money, and because there is little need for exact quotes or languaging, the evaluator does not usually audio-record all of the interactions, but types up notes and member checks the quotes with the members after the interviews (Stake, 2004). These codes, notes, logs, and files are extremely important, as described by Stake (2004): “Responsive evaluation goes more deeply into interpretation along the way. Then, coding can be the procedure that pulls the story together. The interpretations of each observation or interview reside both in coded information and in records describing particulars unique to each case” (p. 130). Memos, codes, and data from the current study followed the suggestions outlined above, but were audio taped, were stored on the evaluator’s computer in her room under double lock and key, and were managed by hand, as opposed to qualitative software.

In large evaluation studies, including the present one, the triangulation, meta-evaluation, and critical reviews start early and become more formal to establish trustworthiness (Stake, 2004). Looking at the preliminary data helps shape the rest of the qualitative analysis and study. As suggested by Stake (2004), the interviews were constructed, transcribed (with corrected English and member-checked to verify the evaluators interpretation), and coded and the memos were examined for verification patterns. Instruments and questionnaires were revised as often as necessary. Plans,
outlines, flowcharts, and a routine were utilized to help the evaluator focus on both the evaluation and the analysis. This was done via memoing, setting up schedules, meeting with “critical friends” etc. to keep on track throughout the study. A project log, which included goals, activities, personnel, outside support, dates, names, changes in plans, and context is very necessary, and was kept (Stake, 2004).

When moving into the analysis, Stake (2004, p. 160) suggests that it may mean looking at the following parts and then synthesizing the data:

1. Beneficiary needs,
2. Program goals,
3. Evaluation criteria,
4. Evaluation standards,
5. Synthesis weights,
6. Staff and beneficiary performances,
7. Program costs.

In reviewing whether a family therapy model is culturally responsive, the evaluator may consider each stakeholder’s perspectives, the cost of the therapy, the reduction of symptoms, the comfort of the client, whether the criteria and standards were met, etc.

The evaluator coded the data based on these seven parts in mind, and then looked for patterns, which are “consistencies, repetitious happenings, contingencies or covariation, occasionally cause-and-effect relationships” (Stake, 2004, p. 162). The patterns were “criss-crossed” for reflection between patterns and data (Stake, 2005, p. 450). The synthesis then gave meaning and interpretation to the analysis to pull it all back together (Stake, 2004).

Similar to other analyses, the findings were examined with caution. Abma (2005) reminds us that “Qualitative data are more than just ‘mere opinions,’ because they are generated in a systemic way,” thus we must be systemic about our analysis (p. 287).
Thus, the perceptions of merit were considered from multiple levels, comparisons were made across groups and across time, instrument and procedure strengths and weakness were considered, and response and participation rates taken into account (Stake, 2004). Everything was member checked based on the willingness of the participants. In both RE and CRT, it is necessary for the analysis to be clear, intentional, recorded, and repeatable to hold the researcher and therapist accountable and to balance the power.

The analysis followed the procedures of the constant comparative analysis as described by Charmaz (2006), which was selected due its social constructionist underpinnings that are consistent with interpretivist methodological approach and fit the needs of the data. It is an abductive process which:

“…includes reasoning about experience for making theoretical conjectures and then checking them through further experiences. Abductive reasoning about the data starts with the data and subsequently moves toward hypothesis formation…abductive inference entails considering all possible theoretical explanations for the data, forming hypotheses for each possible explanation, checking them empirically by examining the data, and pursing the most plausible explanation” (Charmaz, 2006, p. 103-104).

A generative study is important because it allows the researcher to ask broad questions surrounding the evaluand and gather demographics to determine the meanings the participants, themselves, assigned to these topics (Creswell, 2003). Based on participants’ answers, questions were re-constructed and alternative methods used during the constant comparison analysis as necessary (Charmaz, 2006; Strauss & Corbin, 1990). The constant comparison method and question re-structuring allows the researcher to ask questions to reach theoretical saturation (Charmaz, 2006; Strauss & Corbin, 1990), which is when additional data do not add depth or additional meaning in explaining the phenomenon.
The analysis of this study began with listening to the interviews on a digital recorder within one week after each interview, and taking notes on the emerging, preliminary findings. Consistent with culturally responsive evaluation, these preliminary findings were compiled over time (March 2010-January 2011) and across participants, and shared with the host site throughout the evaluation; measures, questionnaires, and understanding of the evaluand were adjusted as necessary to gather richer data and respond to the stakeholders’ views, experiences, and inquiries. After the completion of data collection in January, 2011, a more formal analysis began to satisfy the requirements of this dissertation and to ensure academic rigor in future peer-reviewed publications. This analysis phase began with listening to the interviews on a digital recorder and transcribing the data-rich formal interviews and focus groups as needed (the English was corrected, and member-checked to verify the researchers interpretation), creating/adding memos regarding the environment, including mood, tones, and gestures to transcribed pages (Emerson, Fretz, & Shaw, 1995), matching narratives to interview notes to help preserve affective, temporal, and spatial environmental characteristics (Emerson et al., 1995), and then a thorough read-through of the transcripts, with note taking in the margins (Creswell, 2007). Documents, artifacts, and other data media were complied. Because exact word-for-word transcription is not necessary for responsive evaluation, and because this type of transcription would, in fact, not be helpful for this type of population due to languaging difficulties, the final transcripts were more rich, narrative accounts with selected quotes; during the interview the evaluator would member-check and verify their understanding of what the participant had said, and these final transcribed narratives were offered for member checks to willing stakeholders.
The first step of analysis was open coding, in which the researcher labels concepts that are salient in the text (Charmaz, 2006; Creswell, 2007; Strauss & Corbin, 1990). Constant analysis proceeded to uncover trends, patterns, and topics in need of further exploration in the proceeding interviews. In this open coding phase, data were reviewed word-by-word and then line-by-line to identify the maximum number of possible topics covered in narratives and in interview notes (Charmaz, 2006; Emerson et al., 1995; Strauss & Corbin, 1990; 1994). Consistent with Charmaz (2006), gerunds were utilized to reveal the consequential actions and outcomes. This flexible, action-oriented coding helps the researcher by:

- Breaking the data up into their component parts or properties,
- Defining the actions on which they rest,
- Looking for tacit assumptions,
- Explicating implicit actions and meanings,
- Crystallizing the significance of the points,
- Comparing data with data,
- Identifying gaps in the data (Charmaz, 2006, p. 50).

In these initial stages of coding, the researcher paid special attention to the in vivo codes, which are the participant’s meanings, understandings, and precise languaging that express their views of the evaluand.

The identification of topics lead to more focused scrutiny whereby trends and themes emerged into categories (Charmaz, 2006; Emerson et al., 1995; Strauss & Corbin, 1990). Using the categories from open coding, the researcher identified a central phenomenon (Creswell, 2007), and then began the second stage, axial coding. Axial coding involves relating the patterns and subcategories to the main categories by focusing on the contexts, conditions, actions, interactions, and consequences that influence those categories (Charmaz, 2006; Creswell, 2007). Next, the researcher completed selective
coding, which is a more abstract level of axial coding in which a story line is created (Charmaz, 2006; Strauss & Corbin, 1990). Within selective coding, the research identifies how all of the categories relate to the core category. Finally, the data were then entered into a conditional matrix (Charmaz, 2006; Strauss & Corbin, 1990, 1994), specifically the conceptually clustered matrix (see Miles & Huberman, 1994), which allows for the comparison between responses and participants to explain the central phenomenon (Miles et al., 1994).

**Trustworthiness**

Like other qualitative methodologies, it is important to ensure quality with validation and trustworthiness strategies, which include 1) member checking (via the members reviewing the transcripts and analysis), 2) triangulation of the data (which can be mixed methods or multiple perspectives), and 3) researcher journaling (reflexive writing of the evaluation process and the researcher’s role) (Abma, 2005). Technical steps, such as replication, nonverbal operationalization, triangulation, and creating a list of participants to observe, judge, and respond to can also be used to enhance the reliability (Stake, 1975). Ongoing review is needed during the case study from all of the stakeholders and the researcher (Stake, 2005), as member checking and quality control is essential to a successful responsive evaluation (Stake, 2004). Critical friends, review panels, and meta- evaluators should be an active part of this process (Stake, 2004).

Meta-evaluation is “evaluation of the quality of an evaluation; a determination of the strengths and weaknesses of a study of program quality. It can be formal or informal; it can be done by the evaluators themselves, by coworkers, and by outsiders” (Stake 2004, p. 180). So, the meta-evaluator can reanalyze small amounts of key data, evaluate
the role of the evaluator throughout the process and ask critical questions of the evaluation to confirm the data and make it more meaningful. At times it may confirm and at times further differentiate (Stake, 2004).

Stake (2004, p.185), who reformatted and reconfigured Norman Denzin’s (1970) ways of triangulation, suggests that data can be triangulated with regard to each of six dimensions:

1. Time. (Does the meaning of the observation remain the same at different times of the day, week, year?)
2. Space. (Does the meaning of the observation remain the same from one place to another?)
3. Persons. (Does the meaning of the observation remain the same with different groupings observed?)

* Differences in personal perspective can be considered at three levels*
   a. Across persons. (Do interpretations change from one lone person to another?)
   b. Across interactive persons. (Do meanings change from one family or group to another?)
   c. Across larger collectivities. (Do meanings change from one large organization to another?)
4. Investigators. (Does the meaning of the observation remain the same with different investigators?)
5. Theories. (Does the meaning of the observation remain the same when studied against different theoretical perspectives, such as Special Education versus Disabilities points of view?)
6. Methods. (Does the meaning of the observation remain the same when obtained with different data-gathering methods, such as observation and interview?)

In a CRT study, this would include comparing across persons (therapists, clients, client families, agency workers, etc.), across families, across the community, across the evaluators, across the model, Feminist, Just Therapy, and Critical Theories, and across methods. One may even compare across measures and inventories, perhaps measuring symptom reduction in several ways.

Triangulation, especially in RE and CRT studies, goes beyond confirmation to possibly providing alternative meanings (Stake, 2004). “Good evaluation is partly the
search for particularity and uniqueness. Triangulation is a search engine. It is a win-win inquiry because if it finds confirmation, more confidence can be placed in the interpretation, and if it finds disconfirmation, that may increase the recognition of diversities and multiple realities. Triangulation is one of the most important processes of program evaluation” (p. 186). Of course, it is not necessary to triangulate all pieces of data or all assumptions, but the more thorough the triangulation, the more opportunity for uniqueness to emerge and the higher quality of validation.

To establish trustworthiness in this study, the researcher implemented many rigorous steps as suggested above by Stake (2004). To establish credibility, the researcher spent 10 months in the field (in addition to the 12 weeks previously) and journaled for the entire research process. Second, the data were triangulated in several ways including across participants, across the semester, across clinical experience levels, across client types, against theories, and from data such as interviews, observations, documents and case notes. Third, peer reviewing was used; peer reviewing is similar to inter-rater reliability, in that it checks the research process with a peer debriefer (Creswell, 2007). In this study, Dr. Denise C. Lewis, a researcher on Cambodian families and my major professor, was the peer reviewer. I provided Dr. Lewis with coded sections of the transcripts, asked her to review the codes, and compared notes to ensure coding validity (Creswell, 2007). In addition, Dr. Lewis and my doctoral committee, Drs. Maria Bermudez and David Wright, challenged me, as the researcher, with questions regarding methods, literature review, and interview guide simplicity and understandability (Creswell, 2007). Member checking with the participants was utilized to ensure that my analysis is correct in interpreting the cultural meanings of the participants. Finally, and
congruent with culturally responsive therapy, I used an advisory board or cultural consultants of professors and the NGO leaders to hold the research process, findings, and evaluator/researcher accountable and culturally responsive. Throughout the process, I used this board or the consultants as both review panels and critical friends, while personally continually conducting a meta-evaluation to make sure the work remained meaningful. My doctoral committee, who will ask critical questions and make sure the evaluation work was rigorous, also conducted this quality assurance.

**Generalizability**

Although the focus of a responsive evaluation is on a unique program and context, readers are able to make naturalistic generalizations through the vicarious experiences written by the researcher (Stake, 2005). The evaluator, with all the data from all the sources, having completed the analysis, makes a synthesized judgment on the merit of the program (Stake, 2004). A “thick description” is provided to describe the multitude of voices and to show how the complex processes work within the program (Small & Uttal, 2005). The researcher creates an opportunity of vicarious experiencing for the audiences by portraying the tone, mood, and experience. For example, if participants feel exhilaration, despair, or anxiety, the audience should feel it via the thick descriptions (Stake, 1975). The audience members will also be synthesizing while reading, which can lead to vicarious experience by them adding their own experiences.

Through these “thick descriptions” and resulting vicarious experiencing, the researcher works to develop “naturalistic generalizations, which are grounded in the vicarious experience and tacit knowledge of the case reader” (Denzin & Lincoln, 1994, p. 538). Because the naturalistic generalizations emerge from the participants’ rich
experiences and tacit knowledge, the themes that are generated are likely to be valuable to others outside of the context being evaluation and readers examine their own experiences to make decisions to take action. Stake (2004) explains that,

“If some particular knowledge is based largely on personal experience, in our minds it exists as naturalistic generalizations (Stake & Trumbull, 1992). But as soon as we put that knowledge into words, the statements become propositional generalizations. Naturalistic generalizations are conclusions based on experience and intuition, good and bad…responsive evaluation seeks to facilitate audience understanding and considerable reliance on naturalistic generalization powers. Narrative reports facilitate vicarious experience, without too much neglect of formal description and probative inference. The idea is that audiences are going to use the thinking powers habitual to them, so evaluators should help them” (Stake, 2004, p. 248).

So, while the primary focus of responsive evaluation is on the unique context and understanding local concerns and local improvement, and the purpose is to go beyond developing generalizable knowledge to uncovering and addressing the concerns within the bound setting, including the politics and concerns of the given stakeholders, formal generalizations and conclusions are made and descriptions for vicarious experiencing and naturalistic generalizations are given (Stake, 2004). So, for example, therapist readers using CRT for one Southeast Asian group may be able to use some of the findings to apply to another Southeast Asian group, from one collective culture to another, or from one native group to their refugee group, all based on vicarious experiencing and naturalistic generalizations of the reader.

To establish transferability, the qualitative term most often used to replace generalizability, the researcher described the results of the current study in a thick, rich description (Patton, 2002). To increase dependability, the researcher provided a detailed description of the methods and had her graduate committee complete a dependability audit during her defense (Patton, 2002). To increase confirmability, the researcher
requested that the participants review the transcripts, participated in the analysis if they were willing (they confirmed, denied, and re-interpreted relevant information during the preliminary results presentation), and reviewed the findings (Patton, 2002). Finally, as is necessary to evaluate the success of critical change (Patton, 2002), this study helped the researcher to work to clearly articulate the nature of the injustices, build the capacity of those involved by training the students, and identify potential change-making strategies by assessing the usefulness of EMDR.

**Ethics**

Ethical treatment of the stakeholders is a key piece in both responsive evaluation and culturally responsive therapy. Permission for this study was obtained from the University of Georgia Institutional Review Board (IRB) as well as the Ministry of Health via the United States Embassy in Cambodia. Rodriguez et al. (2006) suggest that researchers consider reading the informed consents to the participants, shortening the consent, or offering alternatives such as tape recordings of the forms for clients who are working with non-native speaking researchers or have limited reading and writing abilities. Thus, the researcher obtained informed consent for participation from each participant by a) providing them with a clearly and simply written informed consent to be signed or b) reading the consent form to them and acquiring verbal consent on a digital audio voice recorder, whichever the participant preferred.

During qualitative interviews, participants often discuss very personal information (Creswell, 2007). Some participants even describe the process of telling their story as “therapeutic” (Gale, Odell, & Nagireddy, 1995). Therefore, the researcher was mindful of the purpose of the study, maintained confidentiality, clarified her multiple roles of trainer,
clinical supervisor, and researcher/evaluator, and clarified the roles of the participants. The research team included the main researcher, a doctoral student in the Marriage and Family Therapy program, and her major professor, an experienced Cambodian researcher.

In the present study, there were no more perceived risk than might be expected for a person describing personal thoughts and experiences in a psychology course or clinical supervision, in general. To minimize psychological stress, questions were presented in a semi-structured format. All interviews were conducted in such a way that (1) the participant was able to proceed at her own pace, and (2) the participant was able to withdraw at any time. Should a participant have experienced moderate to extreme amounts of stress, she was provided (in advance during the consent process) referral to the RUPP campus psychotherapy clinic. It was expected that some participants would gain positive psychological benefit by talking about their experiences, having individual clinical supervision, and learning a new model of therapy, and students confirmed this.

I expected no social, legal, economic, physical discomfort, or stress. Risks associated with the interviews may have lead to some psychological discomfort as the participants thought about their experiences and challenges as a therapists. Some participants may not have wanted to fully disclose their challenges with the model because of the political and departmental conflicts surrounding the model. However, the risk or harm or discomfort was not expected to be more than in daily life or from routine class or clinical supervision. During this study, the evaluator was not the clinical supervisor responsible for the students’ practicum supervision or client supervision; the evaluator served only as a course instructor who consulted clinically, and was a co-
supervisor who evaluated their internship practicum case presentation. No supervision hours for the evaluator’s candidacy for Approved Supervisor for the American Association for Marriage and Family Therapy (AAMFT) were accrued as a part of this study.

Confidentiality

Ensuring the safety of the participants and stakeholders via confidentiality and/or anonymity is a crucial component of responsive evaluation. While it may provide richer data to reveal the names, places, etc. it can expose the participant, putting them in compromising and risky positions. Too little information, however, will cause the reader to draw on stereotypes (Stake, 2004). It is the evaluator’s responsibility to obtain consent and permission, and to err on the side of caution, while creating rich narratives and vicarious experiencing for the reader.

All personal and place names in this study were changed to pseudonyms and identifying characteristics were removed from any data that may be seen by anyone other than the research team. Only the research team had access to data containing identifiers. Reports or presentations of these data are primarily in aggregate form. Individual identities were obscured through composite descriptions of individuals when any report or presentation contained direct quotes. Each participant was offered the opportunity to review data the researcher acquired from them, the phone number and address of the principal-investigator and co-investigator were provided during the consent process, and the participant were encouraged to contact either to review the data. The researchers were willing to correct any information that the participant believed was a misrepresentation of her information. Notes containing identifying characteristics were kept under lock and
key, and a list of pseudonyms was kept in a separate, secure location. In addition, the documents/audiotapes/videotapes were kept under double lock and key. No one other than the research team had access to the tapes.
CHAPTER 4

DISCUSSION OF FINDINGS

“We cannot bring the clothes of the West and give it to our people to wear—it is a different size and different style.”

Different from many other types of evaluation studies, and certainly different from traditional experimental studies, ambiguity is tolerated in the final report of a responsive evaluation because the data are from multiple perspectives, interpretive, and socially constructed (Stake, 2005). It is not necessary or truthful for the researcher to state consensus was reached if it is not (Stake, 1975). Thus, evaluators should state both the merits and shortcomings of the programs and, by using thick descriptions and descriptive portrayals, give the readers opportunities to use their own professional judgment on the program. The evaluator may choose to summarize their evaluation and the overall worth, but must make it clear that this is just an opinion and speculation (Stake, 2004). As Stake (2004) explains,

With visualizations of space, empathy for people, narratives and vignettes, the responsive evaluator provides the reader with a vicarious experience, some sense that each reader was there in person. The evaluator does not duck the responsibility for completing the study with value judgments of his or her own, but adds value statements and vicarious experience to a reader’s existing experience (p. 93).

Thus, it is important that the evaluator makes the evaluand very clear to the reader (Stake, 2004), describes the merit and shortcomings, considers all of the stakeholders when giving recommendations (Stake, 2004, p. 230), defines the jargon, uses narratives for vicarious experiencing so that one can make naturalistic generalizations (Stake, 2004),
and adapts the feedback in a manner that can be understood by the audience and in a format that is responsive to their needs (Stake, 2004). At times, it may be hard to describe what is responsive about the study via the report itself (Stake, 2004), but this may not be of essence depending on the audience and report intent. Finally, it is important to describe how the results can be used and that the evaluator uses his role to advocate for the improvement of the program on behalf of the stakeholders (Stake, 2004).

In terms of CRT, the evaluator may have ambiguous findings due to the multiple perspectives of clients, therapists, supervisors, etc. While this is expected and normal, the evaluator must be clear about this ambiguity. The use of thick rich, descriptions will allow the reader to determine the use and generalizability themselves. Thus, it is crucial for clear language that is jargon free and understandable for the stakeholders (clients, therapists, etc.) who will be using the information. This includes describing the findings, providing uses and ways to apply the findings, making suggestions on how to improve the model, and considering multiple ways to disseminate the findings to best serve the target population.

Applying the principles of RE and CRT, the final reports of this evaluation were adapted for the intended audiences to clearly relay the findings, applications and limitations. From this study, it was expected that: 1) EMDR will be explored as a potentially culturally responsive model for use in Cambodia. 2) The resulting information on EMDR will be used by Cambodian therapists and US therapists who work with Cambodian clients (both in Cambodia and abroad), and will serve as a springboard for exploring how these types of counseling can be adjusted for other cultures. 3) Information will be disseminated to Cambodian therapists on the use of EMDR and
specific interventions. 4) Information will be disseminated to American therapists on the use of EMDR with Cambodian clients and suggestions for use with other non-American clients. This dissemination included presentations at conferences such as the annual national conference for the American Association for Marriage and Family Therapy. Preliminary, emerging findings were provided to RUPP during data collection, once for meeting with Trauma Aide Germany, and once as a Master’s Program meeting. Manuscripts will also be submitted to The Journal for Marital and Family and Journal of Couple and Relationship Therapy. The findings that follow are presented to meet the needs of the researcher in fulfilling the requirements of her doctoral dissertation.

Evaluation of EMDR

Consistent with Stake’s (2004, 2005) assertions that findings may be ambiguous and contrasting, the findings in this study were often conflicting between participants and situation-based. The researcher strove to provide a clear picture, rich quotes, and descriptive adjectives that represented the approximate number of participants (a few, many, most, all etc.). Because this study involved a small, identifiable group, exact numbers of individuals that agreed or disagreed on various topics are not provided to protect the participants. To further protect the identities of the participants, they were given pseudonyms combing their participant type and a unique number for each group. For example, S1 represents student participant number 1 and CA 1 represents cultural advisor number 1. Table 10 describes the pseudonyms assigned.

Answering the first question, “How do Cambodian therapists experience the use of Eye Movement Desensitization and Reprocessing?” was somewhat easier than the second, “Can Eye Movement Desensitization and Reprocessing be used in Cambodia
as a culturally responsive model of therapy?” The Cambodian therapists were more than willing to share their experiences of using EMDR and to suggest adaptations. Making a clear-cut decision of whether EMDR can be used a culturally responsive model was less decisive. Overall, it appears that EMDR is not currently responsive to Cambodian needs, however both participants and the evaluator feel that with serious adaptations it could be made responsive. It also brings forth the question of whether “responsive” is continuous or dichotomous. If the former, the researcher would give it a three out of ten, with ten being completely responsive and zero being completely non-responsive. However, this is also up for the reader to determine. Seven categories emerged: 1) general psychology challenges, 2) overall opinions, 3) EMDR protocol concerns, 4) training, 5) supervision, 6) community context, and 7) political contexts. These categories and their respective themes are represented in Table 11. The following sections define and discuss them in detail. It is important to note that these findings are compared and contrasted with

<table>
<thead>
<tr>
<th>Role</th>
<th>Group Prefix</th>
<th>Unique number per group</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>S</td>
<td>1</td>
<td>S1</td>
</tr>
<tr>
<td>Cultural Advisor</td>
<td>CA</td>
<td>1</td>
<td>CA1</td>
</tr>
<tr>
<td>Workshop Participant</td>
<td>W</td>
<td>1</td>
<td>W1</td>
</tr>
<tr>
<td>Koh Pech Crisis Response Team Member</td>
<td>KP</td>
<td>1</td>
<td>KP1</td>
</tr>
</tbody>
</table>
previous research; however, consistent with CRT and RE, these comparisons are brief and limited because of the uniqueness of this population and it’s needs.

Table 11
*Categories and Emerging Themes*

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Psychology Challenges</strong></td>
<td>Limited understanding of psychology</td>
<td>How does the past affect me now?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not a typical way to think current problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited understanding of trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited understanding of the brain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited understanding of intergenerational transmission of trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited understanding of secondary trauma</td>
</tr>
<tr>
<td></td>
<td>Last resort</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private with problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Therapy within community</td>
<td>Lack of privacy</td>
</tr>
<tr>
<td></td>
<td>Difficulty recruiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapport building timely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not full-time therapists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Therapy is very brief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dissemination issues</td>
<td>How to disseminate research?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How to train others?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How to teach clients?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How to make psychology credible?</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>Strong dichotomies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on personal experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on experienced client progress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Works but is it successful</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desire long-term outcome evaluation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients want advice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Usability depends on client</td>
<td>Income, education, expectations</td>
</tr>
<tr>
<td><strong>EMDR Protocol Concerns</strong></td>
<td>Introduction</td>
<td>Clients feel intimidated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients don’t really care about models</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients ashamed not to know about the brain, etc.</td>
</tr>
<tr>
<td></td>
<td>History taking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Validity of Cognition Scale (VOC,</td>
<td>Difficulty understanding PC and NC</td>
</tr>
</tbody>
</table>
| Negative and positive | Clients do not generally think like this  
|                      | Need list in Khmer  
|                      | Difficulty expressing emotion  
| Subjective Units of Disturbance Scale (SUD) | Difficulty understanding scaling  
|                      | Idea for tangible scale (rice) or drawing  
|                      | Need long term follow-up and Khmer tested measures  
| Safe place | Useful  
|            | No abstract places  
| Scaling | Too abstract  
|          | Need tangible  
| Physical changes | Assess face  
|                  | Assess body  
|                  | Physical changes noted  
| Language/translation | Translated, back translated, official  
|                     | Too complex/time consuming to do in session  
|                     | Wording changed (high and low)  
|                     | Some words and concepts do not translate  
| Bilateral Stimulation (BLS) | Hypnosis  
|                     | Magic  
|                     | On-lookers find strange  
|                     | Believe: strong either end  
| Structure | Sequence of questions,  
|          | Time of sessions  
|          | Metaphors  
|          | Buddhist activities  
|          | Positively provided guidelines  

**Training**

| Language issues | Khmer  
|                | Clear English  
| Timing issues | Length  
|                | Dates  
| Clear requirements | Course  
|                    | Supervision Hours  
|                    | Attendance  
| Outside of course | Not mandatory  
|                    | Not university required  
| Location       |  
| Additional skills needed |  

**Supervision**

| Positive benefits | Responsive to learning needs  
|                  | Confidence increased  
| Location |  
| Cost |  
| Time | Time of day  
|      | Holidays  
| Methods of learning |  
| Communication | Phone, text, email, etc  
| Clear requirements |  
| By whom |  

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To understand the use of EMDR in Cambodia, one must first understand the challenges facing the field of psychology, in general. In the category of general psychology challenges, the following themes emerged: 1) limited understanding of psychology, 2) last resort, 3) private with problems, 4) therapy within community, 5) difficulty recruiting, 6) rapport building timely, 7) not full-time therapists, 8) therapy is brief, and 9) dissemination issues. In accord with Stewart et al. (2010) who found similar results, each of these elements impacts the implementation of therapy and therapeutic change, and must be taken into consideration when examining the cultural responsiveness of EMDR in Cambodia.

Limited Understanding of Psychology

All participants expressed that the limited understanding about psychology in Cambodia greatly hindered the therapeutic progress. Clients have difficulty understanding about the brain, trauma (a psychological or emotional wound resulting from an extremely stressful or life-threatening experience which produces lasting distress), secondary trauma (trauma experienced when helping or listening to someone...
who has been traumatized) and intergenerational transmission of trauma (trauma passed between generations which may affect attachment and parent/child relationships) These concerns were supported by the workshop participants who stated:

Many Cambodians do not understand clearly about mental health problems so I think it is difficult to use EMDR in treatment. W42

I think there are many people who do not understand about mental problems yet because when we are psychologists or psychiatrists, they do not think it is useful or works with psychosis. W42

I worry because Cambodian people have little understanding about EMDR and mental health. So it is an obstacle for the people to believe in treating mental problems in Cambodia. W18

This limited understanding of psychology makes it difficult to apply all models, not just EMDR.

The study of psychology, itself, is relatively new in Cambodia. The RUPP was the first university to offer a degree in psychology, opening a program in psycho-pedagogy in 1994, and was the only university offering psychology as a discipline until 2009. Now, it is the singular university with a Master’s in Counseling and Clinical Psychology Program and will graduate its first cohort in summer 2011. Due to the lack of psychology education, most practicing “psychologists” have bachelor’s degrees but no graduate-level training. At this time, Cambodia does not have a licensure requirement and anyone can practice as a “psychologist”. Participant S6 pointed out the need for licensure and ethics boards to protect Cambodian clients and give credibility to the profession both within the country and the larger world.

Because of psychology’s newness, clients often confuse the role of psychologist and medical doctor, and think they are coming to get medicine or “just to talk”.

Paralleling Chan and Lee’s (2004) finding that Asians utilize traditional medicines,
Cambodians believe in the effectiveness herbal remedies and medicines, so when they do not get these from a counselor they are confused, disappointed, and may not return. If they do not see immediate improvements, they terminate their relationship with the psychologist because they decide that therapy is too expensive. To address this issue, one faculty member, CA6, suggested giving them something tangible. Like the “clever” monk who throws water, gives bracelets, and chants to scare their problems away, she suggested giving bracelets or another item to represent good luck and happiness. This type of treatment is helpful for the Cambodian clients, she explains, “if they believe it in their mind it will help their hearts and keep them peaceful.” This suggestion is consistent with previous findings that ritualistic offering and spiritual healings are powerful psychological interventions for Asians (Chan & Lee, 2004).

Supporting the findings of Stewart et al. (2010), S5 explained that, because most people do not understand psychology, their own mental health or how to cope, they think that psychologists themselves are crazy. Even fellow staff members at her NGO view her as crazy because she respects and tries to help the clients, whereas the other staff people act differently, “when the client has a mistake, they will take away supports” as a punishment and lose faith in the client. Similarly, the families of the students think psychologists are crazy. Participant S1 gave the example of his village chief calling his parents fools and “crazy” for letting their son become a fortuneteller—the village interpretation of what a psychologist does. The chief continued to berate the family for spending hard earned money to learn fortunetelling skills and for allowing him to travel to Indonesia, Malaysia, and Thailand to continue his education (funded by others), so the
family now reports that he is a teacher. Another participant, S5, shared that people tell her that she will never get married because no one wants to marry a psychologist.

As a result, several students explained that they do not even tell clients that they are a therapist or a psychologist. As one participant, S16, stated, “They just don’t understand about that. We just tell them about our job and about what we do and that we come to visit people and help people to find some solutions and discussion about the situation or problem.” She goes on to explain that in addition to others not really understanding what a therapist is, they often misunderstand and think that therapists “know all thing things in their hearts and in their head”. So they think that psychologists can read their minds and know everything about them, a skill that is frightening to many people in rural provinces.

Comparable to Stewart et al.’s (2010) findings, focus group participants repeatedly noted that clients’ limited education impedes rapid therapeutic progress. For example, they must explain to clients why the clients have headaches, about mental health symptoms and diagnosis, what mental health is, why they have trauma, and even what the brain is and how it functions. One participant stated that typhoon victims who were illiterate could not learn or understand the concept of the brain. Further, when introducing the idea of EMDR and the AIP, clients do not understand what the brain is, how it works, what it means for the brain to not be working, and confuse this with their brain being broken. Due to translation, the words “work” and “brain” are technical and difficult to explain. Thus, teaching clients about the brain is time consuming and worrisome to the clients. Trying to rephrase the terms to say that EMDR is “changing memories” is equally as frightening. One participant shared that giving a metaphor that
the brain is like a machine or engine was somewhat helpful, but this metaphor was also
difficult for the least educated. To demonstrate a client’s lack of understanding,
participant S5 shared that one client, in keeping with animistic beliefs common in
Cambodia, asked her to use EMDR with a tree’s spirit to reduce the trauma of the tree
and, thus, help the client’s symptoms.

As described by participants, Cambodian clients do not associate current
problems with past traumas and often have problems with remembering. In light of other
research (Chan & Lee, 2004), this could be explained by the Asian view of fate impacting
the present. Thus, when the student therapists are working to get the touchstone event
(the earliest memory associated with the trauma) many clients become exhausted or
complain of headaches. They then say they do not want to review it again. Consistent
with the findings of Change and Yeh (1999) and Ng (1999), clients prefer future oriented
discussion around a crisis. This makes history taking and assessment phases in EMDR
extremely difficult.

These aforementioned challenges were certainly evident with the Koh Pech crisis
response intervention:

I think most of the people in the hospital think my interventions are new for them,
and the methods, sometimes they wondered why I did like this because
Cambodian people have limited education and they don’t know about psychology
or have enough knowledge with psychology. KP 6

I think some clients find it very difficult to adopt this technique because of our
culture. They’re so scared or a little bit afraid to have it used on them. They may
be confused with hypnosis or anything like that they have experienced. KP 2

Overall, the limited understanding of psychology impedes therapeutic progress; this is
further complicated for the client by the perceived oddity of brain functioning and the
BLS of EMDR.
Last Resort

Clients in Cambodia are living in abject poverty, most cannot afford mental health services, and those that can choose to spend money on material objects. Thus, clients who do come to therapy are coming as a last resort, and have very serious traumas making them difficult clients to treat. Students reported that if they are willing to pay for therapy, their problems must be very bad and their lives out of control. Consistent with findings of Stewart et al. (2010), CA10 reports that they will have tried a monk, traditional healer, and other herbal remedies, medicines, and treatments. As a result of waiting so long and having no success with these multiple treatments, the original symptoms are exacerbated.

Private with Problems

In agreement with existing literature (Chang & Yeh, 1999; Ng, 1999), Cambodian clients do not generally share their problems with strangers. Similar to the shame experience of other Asian clients described by Ng (1999), S5 explained, “Because when they have a problem and they don’t want to tell their story, they just keep it inside and built-in…and sometimes they are scared to tell us because they feel ashamed. They feel ashamed to talk about sex,” she says, referring both to conjugal intercourse and that of the sex worker. Clients do not like talking about problems, and are “very lazy to speak” about them. One participant, S15, explained that if you ask them to explain a lot they will say, “I am okay, I am okay” and will not come to the next session. Focus group participants felt that EMDR may be better than other models of therapy with regards to Cambodians not liking to talk about past experiences because it does not ask clients to talk a lot and does not delve into past, unrelated events.
This preference for privacy has a direct impact on doing EMDR in open settings, as clients are easily distracted when their “individual therapy” is held in a group room. Participant S3 described the crisis response action for typhoon Ketsana in 2009 where individual therapy was done by 10 therapists for 10 clients in a large group room. He responded with “My god, why would we do the EMDR therapy in a great room that is not safe, it is not confidential?” He depicted low educated individuals from the rural provinces as not being able to work because they were looking around at other people and listening to others’ problems. However, once he requested an individual room he says the clients felt more comfortable as evidenced by sharing more and providing longer answers. One participant, CA1, expressed that maintaining confidentiality is especially important because clients do not want to “lose face”, and do not even tell private stories within their families. So, the therapist may be the only person they trust and the only person they think can help with their problems.

**Therapy within Community**

Many participants explained that it was a challenge to use EMDR because of the public setting of therapy in Cambodia. Unlike the US and other Western countries where therapy is very privatized and more likely to occur in a private or at least confidential setting, therapy in Cambodia is conducted any place that therapist and client can find, such as outside in front of a tree, in the client’s home, or even in a public room. One student, S16, explained that using EMDR and BLS is impossible for her because she works in the rural provinces and conducts therapy outside under trees. It is common to have on-lookers and the “strangeness” of BLS draws nosy neighbors for a closer look, compromising confidentiality and the reputation of both the therapist and client. She
explained that this is strange, awkward, and embarrassing for the therapist, clients, and bystanders.

In support of Chen et al.’s (2008) suggestions that interventions must be adapted for minority populations via service delivery and Powell et al.’s (1990) findings that Mexican immigrants experienced better clinical outcomes when setting format and location were responsive their needs, participants emphasized the need for considering and adapting the therapeutic setting when implementing EMDR. One member of the focus group proposed the idea of “mobile counseling rooms” which would be a van to go to rural provinces so they could have a confidential place to do therapy. Applying previous findings that ethnic-specific services located within the populations community are more cost efficient (Lau & Zane, 2005), one should highly prioritize finding ways to adapt EMDR for the Cambodian therapeutic setting.

**Difficulty Recruiting**

Difficulty with recruiting clients was expressed by nearly all participants, including students, faculty, and workshop participants. This included recruiting clients to attend therapy as well as retaining them beyond the first session. The focus group participants stated that they need more clients for practice, as well as for conducting EMDR research. Participant CA7 explained that students,

…are getting some practice but, in general, they are getting too little practice with clients because they have a full NGO job where they are not doing therapy full time—but most are not doing any. They are doing the counseling the NGOs offer. They are doing counseling in their spare time or internship so the program reduced the face-to-face hour requirements.

Early termination is another issue, as CA10 explained that, “EMDR works during the six or seven sessions, but because the fees charged in the clinic are expensive, it
makes the Cambodian client only come for six or seven sessions, and when they get a big bill they stop.” However, she notes that “even delivering it for free does not work well, because when the clients don’t pay, they don’t work…it is taken for granted.” This was a challenge for all of the students, who had difficulty meeting their Master’s internship requirements due to lack of client interest. Considering Bermudez’s (2008) point that abrupt termination may indicate a lack of cultural responsiveness, it may not be that the clients are “terminating prematurely” through their own lack of dedication, but that they are choosing not to participate in a therapy that is unfitting to their needs with regard to session number.

**Rapport Building Timely**

Because of the newness of psychology, need to explain the counseling process, and cultural values of privacy, rapport building is crucial and time intensive. Most participants reported spending 2-3 sessions to build rapport with clients. One therapist explained that she does the history taking and safe place for the first four sessions to establish rapport with the client. This is a challenge, however, as the NGOs or foreigners overseas who often fund clients only agree to pay for a given number of sessions. It is a double bind between giving the client culturally appropriate therapy and meeting payment deadlines. With regard to EMDR, it is a challenge to complete history taking quickly and move to BLS (accommodating to the fact clients do not return more than 1-3 sessions) without disrupting the rapport and trust building that is so essential. If one moves too quickly, the client will not trust the therapist; if one does not move quickly enough, the client will not see results before they terminate. Considering the native’s desire for rapport building and Lu’s (1994) findings that Asian clients respond better to
therapists with relational achieving styles, meaning they are more encouraging, collaborative, and relationship oriented, one must carefully consider whether sacrificing the benefits of rapport building is worth using a model that does not embrace it.

**Not Full-Time Therapists**

None of the students in this study were full-time therapists and none expected to be after completion of their degree. This is for many reasons, but primarily because psychologists in Cambodia are underpaid and these students can get higher paying jobs with their advanced degrees as administrators at NGOs. Another factor is that therapy work in Cambodia is taxing due to all the genocide survivors and sex workers. As S14 explained, “there is always a sad story and a lot of transference and counter transference.” She notes that it is hard work “...to use our mind and to think and to observe what the other cannot see. It’s very tiring and uses a lot and our head. It’s an abstract tool. “ At the end of the day, she is tired and cannot laugh and smile as the job is so difficult.

Because students are working for other agencies, they do not always have a choice on the therapy model they can use. Most agencies do not know about EMDR, and in some cases EMDR is forbidden. As CA10 explained, “I introduced the idea of using EMDR with children and some people to the organization, but I was rejected…she [the boss] had strong objections on using EMDR in that organization, even with the children and even if I offer it for free I’m not allowed. They had strong objections and she just sad ‘no, its not a good model’.” Some NGOs have their preferred methods so students do not get to choose their model of therapy. Most NGOs do a type of psychosocial or psychoeducation—they teach clients about life skills, networking, and community referrals. Many organizations prefer art therapy, psychodynamic or CBT. Also, if co-
facilitators of groups are not certified in EMDR it cannot be used. In light of Braithwaite’s (2006) suggestions that systemic change needs to occur at the individual, organization, and societal levels to promote mental health treatment, it could be suggested that EMDR practitioners need to promote and educate NGOs on EMDR as a part of treatment. From a feminist lens, this would include careful consideration of who should do the educating: considering the Cambodian context, student-therapists do not have the financial means or social status to lead this type of work, and the foreigners who are pushing the model should take an engaged responsibility.

**Therapy is Very Brief**

Consistent with previous findings that Asians generally prefer brief therapy and quick change (Chang & Yeh, 1999; Ng, 1999), one of the main issues experienced by students and faculty alike is that Cambodian clients attend therapy only briefly, often only 1-3 sessions. One participant, S3, explained that in his 14 years doing therapy in Cambodia, he has seen over 100 clients and most did not come back for more than a few sessions. Focus group participants felt EMDR may be better than other models of therapy because it can be brief, thus accommodating to many clients who do not attend therapy for a long period of time. However, CA7, like other cultural advocates, was critical about the models’ claim to rapid treatment and uniqueness. Clients in Cambodia, she continues, are uneducated about therapy and what it is—such rapid change would not even be possible with an inexperienced Western client. Many participants felt that a brief model like solution-focused therapy may be a better fit because it is brief, future-focused, and builds on client strengths and resources to solve current issues.
Dissemination Issues

A primary barrier to community mental health education is limited dissemination opportunities. Inadequate funding and a lack of centralized communication limits ways to train therapists, teach clients and families, make psychology credible, and share research findings. Many students expressed that they try to promote EMDR within their family and friends, and some have even practiced on them. Workshop participants gave the following requests:

Please develop an EMDR association and train MA level mental health workers. W40

Train the NGO staffs for working with traumatized clients. W 15

It should have [a] program to spread out the information about EMDR to the normal people by TV, radio, workshop, and shared experience. W36

While these are excellent suggestions, participants stated these would be hard to achieve because Cambodians do not have Internet readily available in their homes, do not read newspapers “for fun,” and that most news spreads via word-of-mouth or radio. Thus, reaching a wide-audience would require many modes of communication, which is expensive, requires outside funding, or is extremely slow. Furthermore, without a Cambodian Psychological Association, participants did not know who would take on this task, and felt that NGOs would continue acting as individual groups. Again, pertaining to Braithwaite’s (2006) suggestions that systemic change needs to occur at the individual, organizational, and societal levels to promote mental health treatment, educating and promoting EMDR at a systemic level needs to be an integral part of treatment. Considering the previously described community needs of education on psychology in
general, to be consistent with the theories underlying culturally responsive therapy, this would also mean educating on the meanings of psychological treatment.

Summary

This category sheds light on the research questions “How do Cambodian therapists experience the use of Eye Movement Desensitization and Reprocessing?” and “Can Eye Movement Desensitization and Reprocessing be used in Cambodia as a culturally responsive model of therapy?” by describing the psychological context of Cambodia. Without considering these themes, the implementation of EMDR therapy would be ineffective and possibly even harmful. Applying feminist theory to question the notion of “normal”, and just therapy and critical theory to consider the social, economic, and psychological contexts underlying the problems, it is important not to infantilize or demean Cambodians for their lack of education about Western psychology. As Chan & Lee (2004) point out, Cambodians have their own methods of treating psychological problems via traditional medicines and rituals. We, as outsiders, are bringing in our models, and consistent with culturally responsive therapy tenets, must value the local knowledge in whether and how it fits in Cambodia. At the same time, in light of critical theory (Fay, 1987), as privileged therapists and researchers with abundant literature and funding we must continue to criticize some of these contexts that exacerbate the psychological symptoms (poverty, genocide, etc.) and work to empower locals to find models that are culturally responsive. For example, Just Therapists (The Family Center, 2009) would work to help clients understand the affects of poverty on their lives and find ways to change them, without pathologizing the client.
Overall Impression

Determining whether EMDR is a culturally responsive model of therapy for Cambodians was not an easy, clear-cut process. When participants described their opinions, an “overall impression” category emerged with the themes of 1) strong dichotomies, 2) based on personal experience, 3) based on experienced client progress, 4) works but is it successful, 5) desire long-term outcome evaluation, 6) clients desire advice, and 7) usability depends on client. Participant CA1’s explanation provides a good summary of overall impressions: “We cannot bring the clothes of the West and give it to our people to wear—it is a different size and different style. We should adapt it to make it fit with us. We do not cut our leg or head to make it fit with us to wear their clothes. We do not cut ourselves to fit them, we cut the clothes to fit us.” Participants’ responses varied on the success of EMDR; however, consistent with Carlson (1999), all agreed that there are many within-group differences in Cambodia, so one cannot say that EMDR works well with all clients there, or that any theory in general could do this.

Strong Dichotomies

Like many of the critics and proponents of EMDR in the research literature (Poole et al., 1999; Richards, 1999; Rosen et al., 1998; Rosen et al., 1999), the responses of the participants varied from a strong belief in to a strong dislike for EMDR. However, all agreed that changes need to be made in EMDR to make it culturally responsive to Cambodian needs, especially with regards to simplifying and translating the language and making it more natural. Responses on client reactions ranged from no change at all, to clients becoming worse, to clients “healing” in one session and reporting, “I’m very lucky” and telling all their friends and family about EMDR. One participant, S3, even
reported that his clients called his cell phone to tell him about drastic improvements between sessions. Another participant, S5, told that some clients become so emotional that they “could not calm down or control themselves” when she uses EMDR, and “their eyes will roll back and sometimes they will twitch.” Faculty members, as cultural advisors, were also passionately divided on their opinions of EMDR in Cambodia. Some had observed and seen it work well within sessions, whereas others, like EMDR critics (e.g. Rosen et al., 1998; Rosen et al., 1999) felt that it was wrongly deemed the “silver bullet, end-all-be-all” and that students used it prematurely in sessions and without enough education.

Both sides agreed that it is necessary to compare and contrast between therapeutic models and to take the best of all and adapt them based on Cambodian needs. As S2 stated, “You do not wear peacock feathers because you’re not a peacock,” so Cambodians should not use non-validated, non-adapted Western models because they are not Western people. With the appropriate adaptations, many felt it could successfully work in Cambodia; however, as discussed by Waites et al. (2004), unsuccessful adaptations or failure to adjust models can be harmful to clients (these will be discussed in the “protocol” category). Workshop participants expressed hopefulness that EMDR may work with trauma, stress, anxiety, depression, sexualized women, victims of domestic violence, street children, Khmer Rogue Survivors, civil war survivors, and those affected by natural disasters (storms, floods, etc.) and to help individuals, family, community, and society.
Based on Personal Experience

Opinions on the successfulness of EMDR were most often based on personal experiences, both from being clients during supervision and with their classmates, as opposed to SUD and VOC score changes. This highlights the component of culturally responsive therapy (Carlson et al., 2004) whereby locals assess therapeutic change with their own measures as opposed to those put forth by foreigners. One student, S1, gave an example from using EMDR in his own life. He explained that during the training session, he chose an example of his father committing physical violence against him as a child. He could not understand why no one protected him and felt very bad about himself. As a result of a 1-hour EMDR session, he said he could remember his grandmother and brother trying to help him, and that the session moved him to fall on the ground with uncontrollable emotion. As a result, he said that “I feel better … I smile…I realize that it’s over and its gone” and can now talk about the trauma and realize he is safe. Another student said that he experienced change within himself at the EMDR training and this made him believe in the power of EMDR; this belief was intensified when his classmates practiced on him during supervision, and when he also saw results when he practiced on them. Some participants reported using the butterfly hug and stabilization techniques on themselves, for example, before a presentation or sleeping.

Other participants stated that they did not experience any progress with EMDR on themselves or when they worked with classmates. Some students suggested this was because “we’re not yet skillful” but still did not think it would have worked. One student, S14, who chose not to continue with the training, said she did not see personal changes but did see changes with one client via changed SUD scores, body and facial expressions,
and increased nightmares. However, she was not convinced that these changes were long
term and still questioned the therapy outcome. Students who had negative experiences or
non-effective experiences like these decided either not to use EMDR, or even not to
continue with the training because they were too busy and felt other models were better.
Interestingly, although these students did not personally believe in the use of EMDR for
themselves or their clients, they were more than supportive of their colleagues who
believed in its use. Many of these students gave conflicting answers that their peers both
laughed at the model, and would just say their SUDS were going down during
supervision, but at the same time reported client progress; overall, the general impression
was that they supported their classmates if their classmates truly thought their clients
were improving.

**Based on Experienced Client Progress**

As with most therapeutic evaluations, participants in this study heavily evaluated
EMDR based on the clients’ clinical progress, but again did it in a culturally responsive
way by utilizing their own local values of client report and physical observation (Carlson
et al., 2004). Participant CA8 states that students began believing in EMDR when they
saw change with the supervisor’s clients and their clients from typhoon Ketsana. One
student, S1, told of doing EMDR with a typhoon survivor. Initially he worried that he
could not work with her because “she had so many family problems and so much
trauma.” However, after seeing her for only three sessions, her SUDS decreased to zero,
and her VOC increased to seven. He said, “I didn’t believe it and thought EMDR was
magic for her. And I didn’t believe it. And I asked her, ‘Do you think it works for you?’
and she said, ‘Yes, I feel better!’ and I realized that this is the answer.” Another student
reported similar feelings when her client reported a SUDs decrease within 20-30 minutes. She said it was “unbelievable” but that after she checked several BLSs and clear body-scans, she believed it and was happy.

On the other hand, some students who repeatedly saw progress on others, such as in the training session or heard their classmates discuss their own personal changes reported that EMDR was “unbelievable”. One student, S9, gave the example of what he called “magic, unbelievable” change in his training session where one of the attendees was cured from a lifelong cat phobia. He reports that her SUDs decreased to zero, her VOCs increased to 7, and she was able to pet a cat outside of the training the next day! His disbelief stemmed from not believing that the “client” could remember back to childhood, and not believing someone could change that rapidly. He expressed doubt at another instance where one classmate “EMDRed” another classmate out of quitting the master’s program; doubt again stemmed from the rapid change as well as questioning the student-therapists ability to really even do EMDR with such skill so quickly and whether EMDR can even be used for this type of problem. Nearly every student expressed this doubt initially, and over half still held it at the end of the study.

Works but is it Successful

Consistent with the tenets of culturally responsive therapy, students and faculty both questioned what it means for EMDR to “work” in Cambodia. As S3 explained, “If EMDR works that does not mean that we can apply it to the client—is it successful?” In this case, participants voiced that “working” in the sense that it reduces SUDs and increases VOCs does not mean it is successful. Aligning with feminist thought (Osmond & Thorne, 1993) which would question the meaning of “working” and “successful” for
Cambodians, participant CA5 explained that one must consider the therapeutic goals and needs of the clients, as well as their quality-of-life and local lingo in Cambodia. In addition, as participant CA8 denoted, EMDR works with the highly educated, but what is lacking is empirical evidence on which groups and diagnoses it affects. So far, he has heard it works well with single-event traumas such as natural disasters but is comparable with other trauma treatments for multiple-impact trauma. This is in stark contrast with the worldview of one foreigner who reported that EMDR is certain to work because it is “culture free and everyone has a brain”. She did not consider what “to work” means for local individuals. Further, like Harper and Lantz (1996) who felt that their model could transcend culture via “curative factors,” this non-Cambodian faculty lacked cultural responsiveness to consider the client’s worldviews on whether change occurs via brain reprocessing.

One participant, S3, explained that in order to make EMDR and Western theories relevant to Cambodian culture, the therapist must understand the Cambodian culture. He gives the parable of the monk and the fish.

For example, the monks live in their culture and they do not understand about the fish culture. When they see the fish, they see it flap in the water and so they go to save the fish. But when they take the fish out of the water, the fish dies. They want to save the fish so they remove the fish from water—they don’t understand that the fish culture lives in water. They [foreigners] always think that their way is a better way than the Cambodian culture. If we want to make progress, we must understand about the Cambodian culture.

In summary, to assess EMDR’s successfulness is to go beyond measuring the SUDs and VOCs—it’s to determine and then measure “success” for the client. Many researchers have questioned the validity, reliability, and accuracy of the SUDs measure in EMDR (DeBell & Jones, 1997; Lohr et al., 1992), and it has only been validated in one EMDR
study known to the researcher (Kim et al., 2008); it would therefore make sense that Cambodians also question its validity, as it has not been validated there.

Desire Long-Term Outcome Evaluation

It is difficult to do follow-up evaluations because clients terminate pre-maturely with many coming only to a few sessions. Student therapists wondered, “What happened to the client?” who had made some progress but abruptly terminated. This causes the therapists to question EMDR’s long-term effectiveness and whether it facilitates a short-term or a long-term change. In consideration of Bermudez’s (2008) point that premature termination can indicate that therapists or models are not culturally responsive, this too must be considered. Focus group participants repeatedly expressed the need for “scientific proof” and as way to show effectiveness of EMDR in Cambodia. Further, they point out that many Cambodians and some Westerners (e.g. Rosen et al., 1998; Rosen et al., 1999; Davidson & Parker, 2001) do not accept the proposed validity and efficacy of EMDR so it should be evaluated before continuing to apply.

Students proposed measuring this change with PTSD and Depression scales normalized in Cambodia and used by other mental health NGOs, such as the Hopkins 22, as well as getting the client’s point-of-view on EMDR therapy. Currently, only a few students use these normalized scales in their daily clinical practice. They primarily determine client change based on client report, the therapist’s observation of facial and body changes, how the clients interact with their family and in their community, and changes in the client’s house (cleaner, re-arranged). When the researcher pointed out the discrepancy in how they currently determine client change by observation and client report but are requesting a more stringent evaluation of EMDR with standardized
measures scored over time, they explained that they simply do not believe that change can occur so quickly and last for a long period of time. EMDR proponents have expressed frustration at being judged “more harshly” than other models (Devilly, 2002), however critics point out the EMDR is the only model to make such “miraculous” claims (Devilly, 2002; Rosen et al., 1998; Rosen et al., 1999). Most participants agreed that, if a client still reported progress at a 1-year follow-up, especially on a normalized scale, they would then believe in the use of EMDR in Cambodia.

It was also suggested that the researcher be an outsider so natives feel like they can be honest, and that the researcher should also ask the client about the long-term effectiveness of EMDR and not just the therapist (as in the current study). As S9 explained, clients often feel pressured to provide positive feedback on EMDR: “They just give all the good things about the EMDR. But you can always see how they tell the truth in their bodies, and how they feel and whether they think about it or not.” Participant CA5 emphasized the importance of not giving leading statements to sway the clients. Overall, the following quote relays the general consensus that EMDR may work, but it needs empirical validation over time:

It can be a good type of therapy for applying in Cambodia as long as the people who use this kind of therapy do good research on how to apply it and that it fits to Cambodian context. I think any therapy can be good for Cambodia as long as it fits our conceptions here. KP3

Participants desire an evaluation of client symptoms over time via client report on standardized measures normalized in Cambodia. Similar to Bermudez (2008) and Turner et al.’s (2004) suggestions, these evaluations must gauge whether EMDR works for Cambodians clients as a unique group with unique needs, and not base “success” on outsiders’ values.
Clients Want Advice

Contrary to therapeutic values in the West, but consistent with the findings of
Stewart et al. (2010), participants repeatedly expressed that Cambodian clients want
direct, concrete, advice:

Cambodians want to get advice and get instruction. S1

Clients desire advice and for the therapist to do something for them. If the
therapist does the BLS, sometimes the client feels like they have wasted their time
and money and does not return. CA10

The client depends on the counselor [for advice] because in Cambodian culture
they are not living independent lives. They are not living independently,
Cambodian people, from birth to old man. They depend on others. They depend
on each other, they depend on their parents, they depend one old people; they
depend on the teacher; they depend on the monk. They are all very connected. So,
when they come to meet the counselor, they depend on the counselor. They are
hopeful. So the Cambodian culture is like this and you cannot change Cambodian
culture. For example, if the client comes to see a therapist and the therapist says
‘Yes, yes that sounds very bad. I think you can think about it on your own,’ the
client will not like this—they will only come for one session. S3

Both students and cultural advisors explained that Cambodian clients like Cognitive
Behavioral Therapy (CBT) because they like the directiveness, and EMDR needs to be
accommodating to this value. If the client does not feel that either tangible goods
(medicine) or advice has been received before leaving the session, the client is not likely
to return. As explained by Carlson (1999), therapists must be aware of and
accommodating to the treatments clients’ desires, as it affects clients’ utilization of
services.

Traditionally, EMDR therapy takes a nondirective approach and allows clients to
proceed at their own pace. However, students and supervisors alike agreed that
Cambodian treatment needs to be developmentally and culturally appropriate, with an
“on the tracks,” (directive) therapist. This was successfully achieved via supervisor report
with Typhoon Ketsana, where they did the treatment in the community and the students were able to successfully adapt the protocol and work “on the tracks” with the clients.

**Usability Depends on Client**

Consistent with Carlson’s (1999) finding that clients from the same culture can vary in their treatment desires across demographics, for Cambodians, usability of EMDR depends on the client’s education level, socioeconomic status (SES), symptoms, and previous experiences (or lack-there-of) with therapy. Clients with higher levels of education and SES were seen as having better outcomes:

EMDR works very well with Cambodians who have a higher education. It works very well, for example, with the Masters students because they know EMDR very well, they have a strong cognition, and they understand about the EMDR process…but if they are people from provinces or have never gone to school, it is difficult. They ask ‘what does it mean,’ and ‘what is the therapist saying to them’. They don’t understand what a cognition is and what positive and negative cognitions are. It takes a long time to explain to them. S3

Easier to use with educated, but even they find it “strange.” CA10

Most agreed that EMDR works with a “limited class, like the educated people”. The terms highly educated and lowly educated were based on whether or not the clients had graduated high school. Clients who are educated have an easier time understanding, however even those clients experience difficulties. The students explained that even though they and their classmates are trained in EMDR, they too have challenges. Many cultural advisors also reported hearing others say EMDR works well with the high paying, well educated, English-speaking Khmer that are seen by foreigners. In general, EMDR takes longer with low-educated clients regardless of their trauma origin. As CA6 explained, “working with grass-roots people is quite new, and this is step-by-step.”
Students desired knowledge on which types of clients were best fitted for EMDR treatment, and personally experienced that EMDR works best with clients whose problems have a clear, trauma related component such as natural disasters, domestic violence, traffic accidents, trafficking, and the Khmer Rogue. Faculty repeatedly expressed concern over whether students had the background knowledge to discern when and when not to use EMDR.

Once you have a hammer everything looks like a nail. This is how EMDR is – they think they can use it on everything. And what effect will this have on helping and the way you approach problems? The students may not be able or have the background to be able to see the full range and EMDR as a part of tools, not the whole tool. CA3

Some students’ actions and ideas supported that faculty’s concerns. Much to his supervisor’s dismay, one student decided to use EMDR before even meeting his client. However, most were more discerning:

I think it works with some kinds of client situations. It depends on how bad their symptoms are, their beliefs, and knowledge. KP 13

This quote represents the majority of participants’ thoughts, however others were more adventurous in applying it widely. This has been a huge concern in the research literature, with many believing the EMDR makes claims of therapeutic applicability without empirical validation (Nowill, 2010; Rosen et al., 1998; Rosen et al., 1999).

Acceptance of EMDR by clients as a valid treatment also varies based on their previous clinical experiences:

It works with the clients best who have never been to therapy before…So clients who have had psychodynamic therapy or art therapy before feel strange and feel worried and anxious when I start to introduce EMDR. CA10

And some clients simply resist treatment:
Some clients do not believe that EMDR works and they “reject it” and laugh, or think it is crazy. Their level of compliance with and confidence in EMDR is shown in their face, especially their eyes, breathing, and the way they behave. S3 Overall, the factor with the greatest impact was the client’s education level. Clients with higher levels of education were more likely to understand the process and therefore spent less time in the introduction to EMDR. They also had an easier time understanding VOCs and SUDs. It is important to emphasize that it was easier, but not necessarily easy—few student therapists, if any, found EMDR easy to use with Cambodian clients.

Summary

Consistent with the larger body of EMDR literature, the themes in this category suggested strong supporters and critics of EMDR. An overarching theme was that participants desired more research on EMDR in Cambodia to confirm or refute its success. Culturally responsive measures and indicators of success were suggested to determine whether EMDR is “successful” as opposed to “working” as indicated by foreign-imposed SUDs and VOCs scores. Paralleling the suggestions of Turner et al. (2004), the studies proposed by the participants emphasize that the Khmer ethnicity (the dominant ethnic group of Cambodia) should not be a variable to control for, but should be the variable of primary focus, and within-group differences considered across demographics (Carlson, 1999). Drawing on suggestions by McDowell and Fang (2007), the research should be informed by critical, feminist, and multicultural theories, and centered on the concerns of the natives, as opposed to trying to validate EMDR for the sake of EMDR’s popularity (more to be discuss on this in later categories).
EMDR Protocol Concerns

Most would agree that the core of EMDR is its protocol. This category was the largest concern for participants and contained the most emerging themes including 1) introduction, 2) history taking, 3) Validity of Cognition Scale (VOC), 4) Subjective Units of Disturbance Scale (SUD), 5) safe place, 6) scaling, 7) physical changes, 8) language/translation, 9) bilateral stimulation (BLS), and 10) structure. Overall, participants expressed that the protocol needs to be adapted to fit Cambodian culture and clients. Some words and ideas are “too particular” or do not translate in Khmer (the official Cambodian language), while other concepts themselves seem to be or are actually countercultural.

Introduction of EMDR

Students overwhelmingly agreed that introducing EMDR as suggested by the manual, with rich detail and a thorough explanation of the brain and reprocessing trauma, was unhelpful and that the clients felt anxious, afraid, and ashamed at not understanding the concepts. Even when they used simple words and phrases, and normalized the process of trauma, clients worried they would “get into more trouble” or “go crazy”. Therapists suggested that clients should not be given too much information, especially that the brain does reprocessing. Instead, they suggested simple metaphors. One participant compared EMDR to an antiseptic:

It’s like you have a cut, and then you clean the wound with an antiseptic cleanser. It acts like an antivirus. You can feel the pain, but its just temporary and the body can help to reprocess it. But you need something to make it heal and to make it clean and fresh. So that is how EMDR is to make it refreshing. CA10

Another student pointed out that she does not tell clients if she is using CBT or SFT, so why should she tell them that she is using EMDR. She says she does not like to, and that
they feel uncomfortable about the process of EMDR. Likewise, members of the focus group unanimously agreed with the idea that “clients do not really care about which technique we use,” as long as they are seeing progress.

**History Taking**

Overall, students felt that EMDR’s clearly laid out history taking process was helpful, and used this even when they were not using EMDR. However, they felt this process was too rushed in EMDR and too difficult for the clients, as they are not used to talking about their traumatic past.

It makes the client think a lot...we need to think or create easy questions or an easy questionnaire to make the client answer easily and not ask them to think too much. Sometimes, when we ask them to review past experiences it gives them a headache. Further, they don’t want to relive many of the past traumas. S14

One faculty member who observed a live EMDR therapy session expressed concern that the student therapist had decided to use EMDR based on the referral information regarding traumatic loss, without even seeing the client first. Then, he quickly progressed into BLS in the first session, with minimal time spent on history taking and safe place. Even after the client reported his SUD was zero and did not return, the participant still worried about the therapeutic change and the student-therapist’s decision to use EMDR so quickly and without consideration for Cambodians’ traditional grieving patterns. It seems that the student’s quick progression to BLS was based on his value that the BLS promoted change, whereas the faculty member saw value in the discussion of the history. According to Carlson (1999), it would also be important to consider how the client believes change occurs, and whether BLS is consistent with this worldview.

This previous example is one rare exception of rapid history taking. Most students struggled with establishing rapport, completing history taking, and finding a safe place in
less than 4 sessions although EMDR recommends doing it in the first. Many factors complicate the timing, such as time spent teaching the client about therapy in general, EMDR as a model, the brain, and what to expect, establishing rapport, gaining much needed trust, and finding the traumatic targets and touchstone moment. Participant CA5 pointed out that Cambodians are not able to work on a stream of association with the past, and others point out that this is intensified because clients do not want to talk about the past and the Khmer Rogue, but just want to move on.

After seeing these challenges for nearly 2 years, the supervisor began to agree with the students that the way EMDR is introduced and history taking need to be adapted. She re-emphasized that clients want treatment now, so they will not come for more than 2 sessions. With a maximum of 1-3 sessions, she recommends that history taking be reduced and one must be careful not to emotionally and psychologically activate Cambodians (in terms of re-experiencing the trauma), as they lack the social supports to contain it. Thus, as CA2 suggests, “It is important to stabilize and then work on the current trauma instead of floating back—the float back is too hard so you must start in the now.” CA8 adds that, “Its our past event theory, maybe there’s something wrong about approaching it like that,” indicating that the clients should have the right to exercise their values of not associating the past with the present. This is one example of the EMDR protocol’s flexibility to change in that it can shorten or lengthen the history-taking phase; however, this may not be considered “true” EMDR by some if it adapts the protocol (not doing the float back, not starting with the earliest trigger). An additional concern is why the supervisor waited two years to give students permission to change the protocol in this manner. Culturally responsive therapists value local knowledge; yet this delay indicates
that the supervisor took considerable time before becoming convinced of the need to consider culture as a mediator of EMDR’s effectiveness. One on hand, it was her responsibility to teach the students and ensure that the problems were with the protocol and not the implementation; however, from a feminist perspective, “trusting the protocol”, as the supervisor suggested, gave power to EMDR and devalued local knowledge.

Validity of Cognition Scale (VOC, positive and negative)

Of all aspects of EMDR, the VOC emerged as the most challenging. Participant CA8 noted that VOCs are continuous problems for the clients, and even for the students after both Part 1 and Part 2 trainings. First, Cambodians do not really talk about their feelings, and often confuse feelings and emotions. Take, for example, their phrase used when greeting one another: instead of “how are you” they ask “are you happy now, are you happy today?” Participant S1 explained that if you asked “how are you today?” the client might think you are crazy, that you will try something bad, or that you are asking how their body feels. Instead, they may respond by telling you they have a headache. Consistent with Carlson (1999), participants reported that clients “emotions” were physical symptoms.

Second, as S1 explains, “Cambodians do not know what a cognition is so you must make it simple.” He continues by suggesting examples, “‘how do you believe about yourself?’ You have to combine it with other words like, ‘Do you think you are a bad person?’ ‘How do you think about yourself?’.” Cultural advisors emphasized this point:

People with low literacy level, they have little knowledge. They cannot do critical thinking. For example, if you require them to do anything like ‘Recall your good experiences,’ or ‘Recall your bad experiences,’” they have to think, ‘What is a good experience’ or ‘What is a negative experience’ And probably they’re stuck
and they don’t know what is good and what is negative and what is bad.’ Therefore you must change the words and adjust to the education of the person. CA6

You cannot say ‘negative cognition’ you must say ‘What do you think about yourself now?’ and ‘How would you like to be in the future?’ CA2

One faculty member further explained that while the negative and positive cognitions were abstract and confusing themselves, placing the negative and positive cognition questions so closely together make it even more complicated; if you ask clients to talk about their negative cognition, and then tell you about their positive cognition, they have difficulty recalling and changing quickly at the moment. This is due in part to their inability to think critically as well as the culture of not regularly discussing feelings and emotions. Workshop participants supported this view:

Using EMDR with Cambodian clients is difficulty because they have a hard time concentrating and it is hard to think about both a happy experience in the past and then they have a problem. W28

It is necessary to restructure the order of the questions so that the negative and positive experiences (VOCs) are not asked so closely together.

Third, as participant CA5 pointed out, Cambodians do not experience subjectivity like in the West, but objectivity. Along those lines, S1 explains that VOCs are not the normal way for people in Cambodia to think and gives the example that, in cases of domestic violence people do not think they are bad but think “I was born into a bad family”. It is a collective experience (Carlson, 1999). When Cambodians do experience feelings they experience bodily sensations or somatic symptoms. Paralleling Carlson (1999), as participant CA3 describes, Cambodians express mental health symptoms in a bodily way, and feel that the causes are spiritual or ancestral. So, they may perceive current problems as being a result of having angered an ancestral spirit. They do not
handle problems by talking, but by traditional treatments (monks and offerings, traditional healers and rituals, herbal medicines, etc.). Talking about their problems outside of the family may be counter-cultural. Their strong interest is in receiving medication because they experience the symptoms physically. They will say they are sad by saying “I can’t sleep. I have low energy.” Some felt that, although EMDR is more foreign than even regular counseling because of its BLS and VOCs, it may be good if therapists can appeal to the immediate, short term impact and bodily responses (as is done with the body scan).

Another suggestion, given by S2, is that clients are given a list of emotions or feelings from which to choose, or that these are written on cards and the client chooses one from the table. Therapist S8 suggested simply giving them a list of negative and positive cognitions written in Khmer so the therapist does not have to translate. One participant states that this is similar to a monk’s book, in which a list of problems is written and the monk pronounces the clients feeling and symptoms without the client’s input. In a way, the monk is like a fortuneteller and will say, “you feel unlucky”, etc. and then tells them to pray to Buddha. Overall, the participants suggested that the current VOCs are not culturally responsive and need to be adjusted to Cambodian ways of expressing and experiencing emotions.

**Subjective Units of Disturbance Scale (SUD)**

The successes and challenges associated with measuring the client’s SUDs were closely aligned with those of scaling, in general. Many students described numerous client successes where SUD levels significantly dropped to zero, or to an ecologically valid point. Yet, even these students described challenges getting clients to quantify their
level of distress. As one participant, S3, said, “How can they tell their heart or mind with a number?” Several students explained that they used art as a way of measuring the SUD. Participant CA 10, gave the example of a woman drawing a body and choosing a color to represent how she felt. With each BLS, the woman re-colored (assuming change) a part of the body that corresponded with the change. So, the client began by coloring the body black, and would color over with yellow to show that she felt better or happier. The original picture would show a decrease in the black.

CA7 noted that she was under the impression that students are not sure EMDR is really working with their clients, doubted the SUDs validity, and felt uneasy. She heard many of the students say their clients got worse, and that the supervisor just normalized this and said that, “EMDR is working or getting into their system”. CA7 said she worries about this, and it is her understanding that the SUDs should go down some (even with ecological validity). She wonders if the treatment is re-traumatizing the client, if the BLS started with the touchstone or most serious experience, and whether the students are properly trained to take care of this or take this in mind (a process known as abreaction). While she agreed that some discomfort is normal with a new method, she felt it would be nice for the students to have more positive experiences with EMDR, and that their insecurity may transfer to the client. The supervisor also worried that clients may feel like they have to appease the therapist with SUD change. Overall, the main concerns were 1) how to help the clients scale their emotions, 2) whether the SUD truly indicated client change, and 3) if students were able to work with clients when their SUDs increased as opposed to decreased. Again, considering the tenants of culturally responsive therapy (Carlson et al., 2004), an additional concern is why the supervisor and EMDR community
did not rely on the locals’ knowledge and adapt the SUD scale, but instead stated that EMDR is working and that it must be trusted. Are they certain it isn’t re-traumatizing?

**Safe Place**

The safe place technique was the most accepted aspect of EMDR. Many students noted using the safe place technique sans BLS even when they were not doing EMDR but were using another model of therapy. They explained that the safe place technique is a good way to get the client to relax and feel calm. Participant S5 simply tells them to close their eyes and to think about the safe place, what they smell, and what they hear. She suggests a waterfall, seaside, or anything that makes them happy. Often, she says, they chose to be with their families or children, and they speak more easily and freely after spending time imagining this safe place.

However, even the safe place had to be adjusted to fit the client. As one participant explained (S3), the understandability of the safe place depended on the client’s education, and highly educated people could understand him and follow directions. However, people with low education cocked their heads to the side with confusion; they did not believe that they have a safe place or understand the words. The idea of safe place is “magic and unbelievable”. This was complicated with by their inability to imagine:

> It’s quite a bit hard for Cambodian people to imagine a good place as a safe place. That maybe they can experience a good place is hard to imagine because they have never learned to imagine. S1

On the whole, participants experienced success with the safe place when they were more directive with the client (telling them to imagine the smell, taste, sound, sights, etc.), gave ideas of safe places (waterfalls, the beach, etc.), and used the term “calm place” instead
of safe place. Due to challenges with imagining, clients had difficulty thinking of an abstract safe place, but considered places like the royal palace, ancient temples, and beach to be their calm place.

**Scaling**

Most students noted that one of their key challenges was with asking clients to scale their SUDs and VOCs. As one participant, S2, said, “I feel it is the opposite of Khmer culture because the Cambodian culture never asks something like that because it is a visible picture…I think it is too difficult…it is copied from the foreigners.” Instead, he suggests using something tangible, like a bowl of rice and then removing or adding rice to symbolize the numbers. S8 suggested writing the list with Khmer numbers, at minimal, and including faces depicting the emotions on a scale if possible. Students noted that scaling is even difficult for them, and they are educated. Faculty and students alike found scaling is simply too abstract for the Cambodians who have difficulties with imagining and critical thinking.

**Physical Changes**

Consistent with fact that clients’ symptoms were expressed as bodily sensations, the clinicians most trusted measure was the clients’ physical reactions. After EMDR, clients noted feeling “light in her head”, “not feeling heavy”, and that their “body feels better”. Some clients did not even describe their VOC with thoughts or emotions, but only with feelings in the body, and accepted these bodily changes as evidence of therapeutic improvements. Changes in sleeping, frequency of nightmares, smiling, lifted shoulders, and decreased fidgeting also indicated improvement:

They showed that they felt better by smiling and telling directly that they wanted to do more or try more. I also saw their mood change, and their bodies were in a
more relaxed position. A few people started to ask for more help with other problems and gave good feedback about how it helped them positively. KP3

Even therapists who expressed mistrust in the SUD and VOC scores trusted the observable physical changes and reports to some degree. Accommodating to the clients’ values on what constitutes symptoms and change may increase utilization and successfulness of services (Turner et al., 2004), and could easily be implemented in EMDR with a heavier focus on physical changes.

**Language/Translation**

All participants agreed the EMDR protocol needs to be translated into Khmer. One participant (S1) explained that “sometimes we have to read the protocol in English and then we translate it and apply it in Khmer. Sometimes its not easy for us, so we need to translate it for us to read and work with the client.” This adds extra time during the sessions (to read and then translate) as well as stress for the clinician. Further, students such as S5 shared that because there are so many technical words, their self-confidence and the desire to use EMDR is decreased.

One unique challenge with translating from English to Khmer is that the Khmer language is hierarchically-user based. For example, when speaking to someone about their eating habits, you would completely change words if you were talking to the King, a monk, an elder, children, low-class and high-class, or about animals. This similar issue arises during therapy; the words must be adapted to fit the different levels of people (high literate and low literate).

I think Cambodian culture is a very broad idea, because it is a collective society. And also, EMDR is new for Cambodia, and we have just worked with some clients only—we have not applied it in all provinces yet, so some things will need to be changed in the future to adapt to the culture of the other provinces where the culture is different. I think we use simple words, but it is sometimes hard to do. I
mean we need to use the words of the common people but the talk of psychology is not normal. S1

If you do not adjust the language, rural, lower-educated people will feel scared, ashamed, or like you are being too formal. This can also be harmful to therapy if they feel pressured to act like the therapist, provide unbalanced respect for the therapist, or monitor what they say to please the therapist. From a feminist perspective (Braverman, 1988; Chaney & Piercy, 1988; Haddock et al., 2000; Wheeler et al., 1988), culturally responsive therapy works to share power and recognizes that unbalanced power can be damaging to the therapeutic process.

Participants were divided concerning on whom the translation responsibility fell. Some felt it was the duty of the supervisor and clinicians, whereas others felt that, if the foreigners were pushing the model in Cambodia and had resources to translate, it should be their job. Members of the focus group agreed that it was not only the supervisor’s task, but that the Royal University of Phnom Penh psychology department should be in charge of the translation, as the documents need to be translated into Khmer, back translated, and done so by Cambodians who best understand the terms. In addition, the translation needs to be “credible” by an authorized authority. They suggested that it would take nearly 2 years to complete, and should consist of a multidisciplinary team. Right now, however, they felt too busy to lead the task themselves, as they were working and completing a Master’s degree. The supervisor confirmed that the students were simply too busy at this time, working full-time at their jobs, studying in a Master’s program, completing clinical internships, looking for part-time jobs, and caring for families, so the translation must wait until they have completed courses. She suggested, however, that it was not necessary to translate the entire manual but that translation should be done for the protocol and
needed scales, as the research section would be too timely and cumbersome. However, even if a translation were created, she worries that a Cambodian translation may not be “comprehensive enough for Trauma Aid Germany” because they have such high standards. While this may be of importance to the supervisor herself, translation is critical for forming a culturally responsive therapy that would be of value to the natives (Carlson et al., 2004) and may not necessarily conform to the expectations of the larger EMDR community.

Students began translating the protocol during their interim supervision between training Part 1 and Part 2. Some students have taken it upon themselves to translate the entire manual alone, but have not shared it with their classmates. One Participant, S4, expressed frustration over classmates who say they will translate and help, but never do. At the time of this writing, no one knew where the latest draft was located, no one knew how much had been translated, and no group was willing to accept the challenge of translating the document.

**Bilateral Stimulation (BLS)**

Clients saw the bilateral stimulation movements as strange, confusing, magical, and hypnotic. Most students expressed that when initially learning EMDR, they thought as S1 did, “It’s not going to be a good therapy and you cannot apply it with the Cambodia client. It’s a crazy techniques, and people will think you’re crazy.” And while students began to believe in BLS, clients and observers were not always so sure:

They see it as a type of massage therapy or hypnosis or even attaching. And then, they see it as a waste of their money and missed work, and they feel like they did it [EMDR] and that the therapist didn’t do anything to them. CA10

If I did it with villagers, they might think that I am using magic on them. Eye-movements and tapping are similar to magic techniques. Magic is not good in
Cambodia; magic can’t be good. It can be bad because some magic people do bad things to people; they exploit them. They do it to get benefits from other people…for other people, other villagers [who are watching] they believe that you get power to get the benefit. S16

I am afraid the others will be confused that using EMDR will make them crazy. I am afraid the other people will think I am using hypnosis on them. I am afraid the other people do not believe this method can help them. W26

Further, the touching of the BLS or sitting closely can be “difficult” between different sexes and ages. When men or women, young and old, sit too closely or touch, the client and therapist feel uncomfortable and socially inappropriate. Participants explain:

I will always question that in Cambodian and its cultural appropriateness. I think that it’s not culturally appropriate to do that to a woman [if you are a man]. CA4

My level of understanding of the EMDR intervention is good, but in the Cambodian context people will find it a bit unusual. For example, Cambodian people are not used to being touched by another too much. I think people might feel a bit uncomfortable with the technique. KP3

At times, other methods of BLS were experienced as better than the others. Students reported that the visual and auditory BLS were frightening, whereas the tapping was okay. This was supported by participant CA7 who suggested that, “in Asian countries tapping seems to work better—it is similar testimony therapy where they have physical contact with massaging, stroking, etc. to make them feel better- a lot of bodily contact”. Others reported that all BLS were distracting, and that both therapists and clients and got “bored” during this process. In some instances, BLS was disturbing and broke their concentration and memory.

Finally, as described by participant CA8, therapists had difficulty with translating “go with it”, even when the students were practicing among themselves. The concept, which is a critical component of the BLS, was abstract, did not translate well, and often
took time to explain to clients. While BLS may be a key component of EMDR, it was not easily used in the Cambodian context.

**Structure**

Therapists in this study valued the structure and clear order provided by the EMDR protocol. Focus group participants all expressed appreciation for having structure when using EMDR—they noted that this gives them confidence and direction when working with clients. Most students echoed this:

> The specific guidelines of what we should do and how we can follow it is easier than other theories that we just learn in general. So, it is good for me that I know what to apply with my clients who have trauma. When I know what EMDR can work with, I know what I can do with my clients. Or, sometimes, even if I do not know what to do with the client, I can use a part of EMDR, like tapping, for traumatic events in their lives. S1

Nearly half of the participants suggested adding more psychoeducational components to EMDR, as this addition has been experienced as working very well. Similarly, using some Buddhist perspective or story that parallels the client’s problem was encouraged. Focus group members pointed out that it is important “not to forget our competence in Buddhist principles” and to integrate Buddhism into EMDR, creating an EMDR “Amok” which means “mixture” in Khmer. They gave the ideas of integrating water sprinkling, meditating, putting a flower or candle in place during the session, or putting up a Buddhist picture. The cultural advisors also suggested incorporating more Buddhist rituals and traditions into EMDR therapy. For example, one could treat the client by filling up a jug of water and throwing it over the client’s shoulders to symbolize the strong water washing away the problems or throwing water on the client to help with concentration. Another idea that has worked well and is influenced by Brahmanism is to wrap the client in a white sheet and sprinkle rice on them from head to foot. The client
then shakes off the rice (representing the problems going away) and the monk keeps the cloth representing that the problems stay at the pagoda locked into the cloth. This could be adapted in therapy by giving the client a jar and keeping their problems in the therapist’s office.

On the whole, adding the aforementioned suggestions from the VOC theme that the sequence of questions be changed, the structure of EMDR was helpful to the students by providing a clear, nearly step-by-step format. However, Buddhist and Khmer rituals need to be integrated into the protocol to make it more culturally responsive and relevant.

**Summary**

Emerging themes and participant concerns in this category are consistent with previous research that states Asian clients prefer traditional medicine and spiritual healings (Chan & Lee, 2004) express symptoms in bodily manifestations (Carlson, 1999), and value models (Hu & Chen, 1999). The EMDR protocol must be adjusted to fit these needs, and further considered as to whether the epistemological and theoretical underpinnings of the AIP are in direct conflict with Cambodian values. From an integrated feminist, critical theory, social justice lens, additional questions for consideration are as follows: Why are additional cohorts being trained in Cambodia if the protocol has not been adjusted? Why has the protocol not already been adjusted given that multiple therapists have voiced their concerns? How can one really claim that EMDR is “working” simply based on SUDs scores if the protocol causes so many problems? How can Cambodians integrate their rituals and still be accepted as EMDR therapists by the larger EMDR community? Feminist theory would acknowledge the power and privileges afforded to the foreigners who have created this model, implemented it, have
the funds and ability to conduct research, and are able to modify the protocol at their discretion; Cambodians with little, if any power, in the EMDR community due to lack of funds, English-speaking ability, and limited publication opportunity rely on that foreign power and are at the mercy of others to make much needed changes.

Training

Overwhelmingly, most students agreed that the Cambodian trainer (US based) was good, brief, educated, and responsive to their learning needs. They appreciated that attending an EMDR training gave them a properly validated certification in using EMDR, as opposed to other models that do not give certificates. In fact, some felt most confident in using EMDR (as opposed to using other models) because they had had an official training. Students and cultural advisors voiced numerous concerns for future trainings. Themes in the training category were 1) language issues, 2) training issues, 3) clear requirements, 4) outside of course, 5) location, and 6) additional skills needed.

Language Issues

Nearly all participants agreed that the Cambodian based EMDR training in Phnom Penh was clear and understandable. Evaluations of the trainer were positive because he spoke clear English, gave examples, and did not go into as much detail. However, most faculty members questioned the amount of information the students retained due to their own English-speaking abilities. Based on their experiences of having the students in class, they were aware that some students only understand 20% of conversations in English and struggle with reading and writing. One participant, S15, who is a strong English speaker estimated understanding 65-70% of what the trainer said; therefore, she had to read the manual later and ask questions during supervision. This
begs to question how much other students, with a lower level of English-conversation capability, understood.

One participant, who was involved in multiple trainings in multiple countries, explained that having the training in Khmer, or at least being conducted by a native English speaker is necessary. The participant gave the example that in one training the trainer spoke English as a second language and everyone of the trainer’s ethnicity understood her English accent, but that the participant (who was not of the speakers nationality) did not, and this greatly hindered understanding and communication.

**Timing Issues**

The initial training was attended “voluntarily” during a national holiday. Because of this, students could not receive class credit for the training as they should have for mandatory class assignment and had to make up the additional hours outside the parameters of the normal classroom, thus doing “a whole lot more than 45 hours” as required by the university. It is important to note, that unlike other Khmer holidays where students are required to be in their home region with their families, the supervisor assured this training was not held over such a holiday.

Most participants suggested that the trainings be spread over more days, given longer and more frequent breaks, and allow for more practice of the techniques. Some noted being too tired to really pay attention and to fully understand. Students and faculty also felt that the training should be during a convenient time and that they be given more time for intense practice.
Clear Requirements

Many participants reported that they and their classmates felt pressured to attend the EMDR trainings and supervision sessions. They noted feeling unsure about the university class requirements versus the “voluntary” EMDR requirements, and whether it was really voluntary at all. Many students could not even explain to the researcher which parts were class requirements, EMDR requirements (Part 1 or Part 2), and which parts were voluntary outside of class requirements. They feared upsetting their instructor or their supervisor, as well as receiving bad grades for the course. Most expressed concern with the financial constraints and confusion—one student told of a mandatory $20.00 they had to pay and could only recuperate if they attended classes; his frustration stemmed from this being a large sum of money, as well as feeling held hostage to attend the classes and supervision. It is important to consider this sum in the context that 68% of Cambodians live on less than $2.00 USD per day (Alkire & Santos, 2010).

Faculty also witnessed the stress of the students and expressed worries that students’ rights were not being taken into consideration. CA7 explained that the students were split; they felt the instructor was too strict and put too much stress and hassle on them, and some felt exploited because they had to see so many cases with the supervisor dictating when they had to see them. Students were exhausted at the end of the day, sometimes still having to see three clients in a row. The faculty felt that this was not good for students’ own self-care and that it could lead to burnout for the students. At the same it, the faculty pointed out that students complain if you demand little things so is it hard to judge “if they were so quickly over the top of their capacities or were they really overworked?”
Participant CA8, who is EMDR trained and has been a clinical supervisor, suggested that the training and supervision requirements for certification need to be adapted from the original EMDR Institute requirements, with expectations and benefits outlined in advanced. CA8 further proposed that “participants, when they go to training, should know that the training takes 6 months and that there are two trainings and they must attend all supervisions; it should be 30 supervisions, and they should have a contract to sign and have to pay to make sure they are engaged.” This would protect the students so they knew what they were signing up for, keep them motivated, and reduce excuses to a minimum. Overall, the EMDR training was complicated by participants’ English-speaking ability, feeling exhausted during the training, and not having clear requirements and expectations.

**Outside of Course**

A large part of frustration with the training, expressed on behalf of the students and faculty, was that EMDR was not originally part of their university trauma course, and was given in lieu of the traditional content. Many faculty members were outraged, and felt that the instructor should have followed the original, agreed upon syllabus and taught the students basics of trauma. Complications were exacerbated when four students were precluded from attending part two; CA7 reports that this was “quite damaging for the students because they felt discriminated against.” Nearly a year after the official course, students still did not know their grades as some continued with EMDR part two, others took an exam in lieu of part two, and the supervisor lost their final papers. It was complete confusion. As a result, the department decided that future cohorts will not have EMDR training within the program and it will be up to the student to participate. Instead,
they will have a lesson about EMDR in class or even some exercises. Supervision will also be outside of the course. Cultural advocates pointed out that EMDR is a specialized method that even students in developed nations, with a strong educational background, are not learning it until they are more advanced. Faculty felt that beginning this EMDR training in the students’ first semester was premature. In summary, they are not discouraging EMDR in Cambodia, they are discouraging it from being taught within a Master’s curriculum as a mandatory course before the students have learned the basic techniques of counseling and treatment planning.

Many students reported that they were only doing EMDR because of the course requirements and were only continuing with supervision because of the need to complete the degree and feeling pressure from the instructor. One participant, CA8, noted that in training Part 1, the students were not very interested because it was new, just wanted to get through the degree and graduate, and expressed general feelings of “Why am I here?”. The supervisor agreed that it would be best to have this outside of a course, however an additional training would be costly for the participants and they would have to find outside funding from NGOs or donors.

**Location**

Overall, students noted that trainings in Cambodia were easier with regard to travel and days off work. Faculty noted hearing that students were not happy with the actual location of the training in Phnom Penh and the regulations around it; however, they felt that it was difficult to discern the exact nature of the problems. CA7 heard that students preferred to have the teaching at RUPP although the supervisor’s place is nicer (seating, air conditioning, central location). Students felt it gave trainers too much power
and departmental rules were ignored off campus. On the other hand, the supervisor and a few students preferred the supervisor’s office because of the university’s sparse environment.

**Additional Skills Needed**

As indicated within previous themes, students and faculty recognized that students needed additional training prior to learning EMDR. Some students did not have bachelor’s degrees in psychology (and were only in their first semester of a Master’s degree during part 1 training), most lacked clinical experience, and one student could not even explain the meaning of the acronym, PTSD. The supervisor and trainer were not aware of this until Part 1 training, so many hours of supervision were needed to get students up to speed.

Participant CA5, who was teaching the students while they were taking EMDR, felt students were ill equipped on the general basics of counseling and noted that most had not even seen clients. For their written assignments, they were unable to synthesize and “lifted entire sections.” He questioned what they really comprehended. Not having these basic skills and a solid foundation could lead to re-traumatizing clients, he feared. In agreement with CA5, participant CA3 noted that staffing with professors, observing students in class, sitting in on program meetings, and knowing the students’ level of English, how much they can understand, and limited class attendance helps him know their limited EMDR ability. He felt that most of the students demonstrated a lack commitment to the program and education. Another cultural advisor added that the students had an extreme “lack of commitment—they did not care but just wanted to get a master’s. They didn’t care if it was a master’s in standing on their head—they just wanted
a degree to hang up.” However, as CA3 pointed out, it is important that, “There is a wide range of students at RUPP…and the education system is working out the kinks—students do not attend class and do not have the motivation and dedication, overall. They do not understand trauma or neurology,” however they are some really great students.

In particular, faculty expressed concerns over their background trauma knowledge in general and about stabilization, how to select clients, disassociation, cognitive aspects, re-traumatizing, how to slow the process and calm the client, signs of hyperactivation and re-orientating to present, somatic processing and awareness, the body and breathing, meditation and relaxation techniques, and on working with clients of trafficking, domestic violence, and sexual abuse. To be clear, the faculty were not criticizing these students as individuals, but recognized this as a systemic education problem throughout Cambodia.

The supervisor had mixed emotions on the ability and preparation of the students. She was originally requested to teach EMDR in Cambodia in 2005, however the caliber of students was not high enough. She later considered training community nurses, who had direct communication and interactions with clients, but decided to wait until RUPP had a Master’s program. This cohort seemed to be the perfect timing, as the “caliber of students is better and they are earning grades on their own merit instead of their parents paying for their grades.” On one hand, she reports that she taught them 30 hours of traumatology background before Part 1 EMDR training and felt that they were prepared. On the other hand, after beginning the training, she realized how little clinical experience and understanding they truly had, and how much supervision and practicum time they would need.
One participant, CA8, who was present at one of the trainings, noted the biggest issues were that the students in Part 1 training did not understand concepts in general. He was not sure if students comprehended the main ideas, and faculty members were not able to assess how much the students really understood. Smiling and nodding, he continued, did not indicate understanding. He pointed out that the basic starting place for the students was teaching them that the past can affect the present—the students did not already know this, and could not understand the idea of the self as separate from the whole because the idea of self is not common. He continues that they therefore had difficulties with understanding the VOC and the concept of cognitive restructuring.

Many students explained that they did not initially believe that EMDR worked in Cambodia during training Level 1. One participant, S1, explained that during the first training he laughed and thought it would never work. He suggests that this is because the training was very short and they did not learn psychotraumatology or stabilization techniques. However, after additional EMDR training in Thailand, where he learned skills on stabilization and information about the brain, he said “when we learned more information about EMDR that was a kind of motivation for us” and he began to believe in its implementation in Cambodia.

Most participants desired more training on the brain, stabilization, and the AIP. Focus group participants pointed out the need for a physiology or neurology course to give them the basics on how the brain works and is interconnected with the total body. Overall, the students feared they didn’t remember the phases well enough or understand enough about EMDR. Further, they were frustrated by their perception that EMDR was being pushed as a type of “cure-all” for mental health problems in Cambodia. The
students requested that future trainings contain case illustrations on specific mental health
diagnosis in Cambodia, as well as a compilation of clients types, diagnoses, and
symptoms that have been empirically evaluated and validated.

Several students alluded to the fact that they also needed self-of-the-therapist
skills for working with traumatized clients. Over half of the students discussed the
challenges of working with clients impacted by multiple traumas, and several described
experiences of secondary and vicarious trauma. Participant S5 explained that she goes to
her supervisor and cries after seeing her clients; she also feels the impact of
intergenerational trauma from her parents who survived the Khmer Rogue.
Unfortunately, her experiences were not unique, as other students told of stories of family
torture, war, and famine as well as client experiences of human/sex trafficking and
prostitution. Participant CA8, who co-taught a course on self-care, stated that students
were “ill prepared to take care of themselves. There is no awareness of clients affecting
them…some students were freaking out and needing help…self-of-therapist awareness is
low and they did not understand the concept that they could be traumatized by their
clients.”

Summary

Faculty and students agreed that the students needed additional knowledge prior
to attending and EMDR training. For some students, the opportunity to study in Thailand
for a second EMDR training provided that education. Others still felt that their
understanding was lacking and this discourages them from using EMDR. While this
category may vary from other EMDR training students, in the sense that the traditional
EMDR training was “confounded” by being intertwined with a university course, it was
still the way the Cambodians experienced EMDR training and influenced their perceptions of EMDR. In comparison to Carlson et al.’s (2004) training of therapists, this training was comparable in that it aimed for sustainability and tried to accommodate to the learning needs of the participants. However, it was not responsive in giving students a voice on the timing, location, and participation requirements.

**Supervision**

Both Cambodian and Thai supervisors conducted supervision; however, only four of the students were supervised by the Thai group (as only four were trained there as well). Within this category, 1) positive benefits, 2) location, 3) cost, 4) time, 5) methods of learning, 6) communication, 7) clear requirements, 8) by whom, and 9) power imbalances emerged as themes.

**Positive Benefits**

Many students expressed positive gains from EMDR supervision. Many students and Khmer faculty fondly viewed the Cambodian based supervisor as a pioneer of EMDR in Cambodia.

I think supervision has been my positive experience. When I have worked with supervision, I get supervised by my supervisor here in Cambodia, or I go to Thailand, but supervision here is the most. I need my supervisor here quite often and she supervises me. So, I feel like she has my back and can help me. And right now, I feel a bit scared because my back is going to her country. S1

The supervisor is very encouraging of me and EMDR. S5

From the perspective of the supervisor, successes included that the clients were grateful for treatment from the therapists, the students reported that therapy worked, and that the students had her encouragement and supervision. Constraints included long gaps in supervision while she was away, changes and fluidity in who attended supervision, her
own energy, and trusting that the students could do EMDR and that they followed the protocol. She thought more students would use EMDR if their internship supervisors were more encouraging. All agreed that students who attended EMDR supervision had more confidence.

**Location**

Similar to the complaints surrounding the location of the initial training, most students disliked commuting to the supervisor’s office for supervision. The supervisor explained that her center provided a more comfortable atmosphere in comparison to the run-down feeling at the university. Despite this, students complained that the university is a more convenient location, as many of them work at RUPP during the day and found it easier to remain there for evening supervision. Further, they lacked all power (the limited amount they had, anyhow) when off campus and in “her center,” but felt they had some control or support of the department when in the university setting. For example, if the supervision sessions had been on campus the administrators would have been more aware of the additional requirements placed on the students and advocated on behalf on the students that those be removed or reduced. But, because the supervision was off-campus, most administrators and faculty were unaware of when and how often supervision occurred.

**Cost**

In the second year of supervision, the supervisor requested each supervisee attending the supervision session contribute $2.50 to cover the costs of the room, air conditioner, and refreshments. She explained that because people are coming after work, snacks should be served. The remaining funds were to be set aside to start the EMDR
Cambodia Association. Nearly all of the students and many of the faculty found this demand (it was mandatory) to be too high, as students are living on limited income and supervision was a mandatory part of their course. They desired an input into how supervision was conducted and that requirements not be changed without their consent.

**Time**

Initially, supervision sessions were held twice a month for 1.5 hours each. Students were “strongly encouraged to attend,” reports the supervisor. Many students reported feeling exhausted and unable to concentrate during supervision because it was at the end of the workday. One student expressed concern over the safety of working with clients when she was already this tired. On the other end of the extreme, the supervisor felt that supervision really needed to be in 4-hour blocks, because 1.5 hours is just too short—however, the context does not support this intensive supervision. The time aspect was also frustrating for students because they felt the supervision sessions were beyond the “time requirements” for the university course credit, but they were “strongly encouraged “ to attend. Some believed that, between the lines, this meant mandatory and absence would affect their grades. Most students received their certificate for attending the required supervision in Part 1.

**Methods of Learning**

Participant CA8 explained that the training sessions were brief and students were going through the motions and fumbling. He noted that the Cambodian learning process is different and students do not pick up the EMDR training style; they learn in different ways and need more practicums, as the initial “training is a tiny layer of the cake,” and “things started to click for them after their practicums”. Unfortunately, however, most did
not show up for their supervisions and the supervisor had to “scare them into coming to supervision”. He attributed this to students just being students—like in the West, the Cambodians just want to graduate. But these supervision sessions are crucial to their understanding of EMDR, and he feels they should be required to attend thirty hours of supervision before being certified.

Students expressed the need for continuous practice and regular, close supervision. One student explained that he appreciated being watched while working with clients in live-sessions. The current Cambodian supervisor would ask them questions about working with clients, and when they didn’t know what to do she would help them. Students also benefitted from observing the supervisor practice/role-play and took notes on her process. Faculty who attended the supervision confirmed the immense benefits of the students doing role-plays, and the supervisor constantly checking-in. Students added to their base knowledge by reading books on EMDR. Koh Pech therapists also felt that the supervisor adapted the training to fit their level of understanding:

In my opinion, I think it was a good training because the trainer trained us how to work with EMDR techniques and how to work with people in a very careful way. What I liked the most about the training was that the trainer explained what we are there for at the hospital (respect, support clients, and prevent further problems). KP3

To help therapists process their actual clinical experiences from sessions with their clients, they were occasionally asked to be “clients” within group supervision with the supervisor as “therapist”. One student, in particular, repeatedly brought up a traumatic experience in an EMDR session where his client had severe abreactions and he had to call for the nurse to deescalate the client. The supervisor worked to process this with the student in practicum. Faculty expressed concerns over cases like this student’s, and
whether students had the self-awareness to process cases during supervision. As CA8 stated, with EMDR there may be a risk of vicarious trauma, especially if the students don’t know how to care for themselves, and the occurrence of vicarious trauma is hard to assess. He continues that, “Cambodians save face so they do not announce not understanding—don’t want to show weaknesses and failures. And this is an important part of developing as a therapist.” So, when asked about their own self-of-the-therapist within supervision sessions, they will often nod although this does not indicate agreement or understanding but is more of an acknowledgement of hearing the words spoken.

Finally, many students and faculty suggested that the use of live video observation or live session observation would be helpful in EMDR supervision. However, there are challenges because nearly all supervisors are foreign and do not speak Khmer.

**Communication**

One issue that affected students’ supervision attendance was the lack of clear communication on behalf of the supervisor. Sessions were regularly cancelled or rescheduled at the last minute, and weekly session dates were often changed. The supervisor, operating from a Western point of view, would email the students a few hours before. However, most students in Cambodia do not have regular access to email and prefer text messages. Students noted a great deal of frustration at the inconsistency of supervision and lack of clear communication.

**Clear Requirements**

Participants repeatedly expressed the need for the clarity on supervision requirements, including what was required as part of the university course, Part 1
certification, Part 2 certification, and what was voluntary. Participant CA8 suggested increasing the EMDR requirements for the Cambodian participants to additional supervision hours because that is where the “real learning occurs”. Unanimously, faculty, students, and supervisors stated that clearer requirements need to be given to future trainees.

**By Whom**

Students were also concerned about who would be providing their supervision now that the on-site supervisor was leaving. The new Trauma Aid Germany/Humanitarian Assistance Program EMDR training team plans to conduct regular, monthly phone supervision sessions and occasional on-site supervisions. The previous supervisor (in Cambodia), who was also worried about how current EMDR therapists and the new students being trained would be supervised, said she would remain available via Skype. One student expressed that he feared for the safety of his clients and the future of EMDR without an in-country EMDR supervisor:

> It’s not good. Like me and the other groups that are coming in [new EMDR students being trained], they are very young and also their English is not good. So, to talk by phone or Skype is just not very supportive of EMDR. If we can, it’s better to meet fact-to-face because a lot of problems could come. When we talk by phone, data-sharing information is not the information we want to share. I mean, it’s not flexible enough for us. S1

He further explained that because of the need to set supervision appointments and accommodate to time zone changes, supervision would be tricky in case of an emergency and that they really need supervision after every third session. A solid plan for supervision has yet to be developed.

Faculty members also expressed concern over supervision with regard to the credentials of who is supervising the students and the potential dual relationships. In
particular, the RUPP department requires a Ph.D. equivalent of instructors and supervisors, and that they not have employer/employee and instructor/student relationships at the same time. Many faculty members were unclear if this was occurring and expressed concern over potential power imbalances.

**Power Imbalances**

Students experienced and faculty observed power imbalances between the therapists and supervisors. This imbalance is inherent in the student-teacher, supervisee-supervisor relationship, however most felt that the imbalance was intensified in this particular scenario. Some students felt that performing poorly in front of the supervisor would result in “losing face”. One student, S16, expressed that asking the supervisor for help, or the supervisor intervening, when they were working with a client, caused her to “loose face” or “affected the confidence of the client on the therapist”. Another student, S15, noted worrying when she receives live EMDR supervision because she fears her supervisor, who is also her teacher, will evaluate her poorly. Further, she is embarrassed to make mistakes in front of her peers, some of whom have had more training, which will result in “losing face”.

The largest concern expressed by the faculty was that the supervisor intimidated the students. As mentioned early, she “scared them” into attending supervision and “strongly encouraged them” at other times. Students also expressed being afraid to tell the supervisor their challenges with EMDR and ideas to change it because she would simply tell them to “Trust the process” or “Trust the protocol,” reducing their ideas to simple misunderstandings of the model.
This power imbalance could be explained by many factors, including those already mentioned as well as the foreigner-native relationship whereby foreigners are seen as smarter and all knowing. Regardless of the origin, this imbalance directly impacted the students’ experiences of supervision and EMDR.

**Summary**

Similar to the training category, the supervision category is not necessarily the traditional EMDR format but is the students’ experiences of how EMDR supervision works. Again, in comparison to Carlson et al.’s (2004) training of therapists, this supervision was comparable in that it aimed for sustainability and tried to accommodate to the learning needs of the participants. However, it was not responsive in giving students a voice on the timing, dates, cost, location, participation requirements, or attendance.

**Community Context**

In addition to the general challenges of implementing psychological treatments in Cambodia, the community needs and context greatly hinder clients’ progress in EMDR treatment. Consistent with Stewart et al. (2010), the emerging themes of 1) material needs, 2) poverty, 3) therapy location, and 4) financial situation greatly effect the daily lives of Cambodians. Participants repeatedly emphasized that therapeutic treatment without consideration of these factors is of little use.

**Material Needs**

Culture advocates continually expressed the concern that Cambodian families are facing lack of food, shelter, income, access to health care, educational opportunities, basic needs, and mental health needs. Participant CA3 explained that there is a link
between poor mental health and poverty—one can counsel someone poor for many years, but this may not impact their living situation. EMDR considers the context but it does not address social inequities (i.e. poverty, lack of access to work, education, and health care, etc.) within the therapy. Therefore, even if the client’s symptoms decreased they would still have the larger systemic problems; so, EMDR is helpful to a certain degree but addressing the larger problems that impact their mental health is what is needed.

Participant CA3 suggested that a social work model may be more appropriate with giving skills and referrals, and counseling may not be the most appropriate or relevant intervention to change their situation. Most faculty and students agreed that the current need in Cambodia is basic foundational counseling with psychosocial support, as opposed to focusing on all the past traumas (which is important too, but not as pressing). They explained that EMDR is like a unilateral treatment that focuses on the treatment and the trauma, and not the conditions that they are living in, their SES, the poverty, and lack of education. One cultural advocate stated that for someone who is a Khmer Rogue survivor and living in abject poverty, the individuals would have to take loans for daily expenses, their children would be having a hard time getting nutrition, and they may develop a drinking or drug problem—EMDR would not fix these problems.

As a concrete example, participants explained that, while natural disaster survivors do need some type of psychological support, their primary needs are material, food, and shelter. As S9 explained, “Most importantly the people from Typhoon Ketsana needed material support. The first thing, because their house was blown out and they lost all their shelter, so the government tried to support that…I’m not sure if EMDR could really help them…I think they need something else, any food, shelter, and all that.” Koh
Pech therapists and supervisors, who recognized that clients needed food, water, and medical treatment first, and mental health treatment second, also voiced this concern. During the crisis response EMDR training, the supervisor instructed the student therapists to first ask if the clients needed food or water; however, observing supervisors reported that the therapists did not do this, and that the “food” given to them was in fact instant coffee without clean water. These rations were distributed by the nurses on behalf of the government.

**Poverty**

Both students and faculty overwhelmingly agreed that poverty-related issues are many of the key contributors to mental health stressors in Cambodia (for the purpose of this study, poverty is used to describe a daily way of life, whereas a financial stressor is seen as temporary situation). “These people live with a constant sense of urgent desperation just trying to live day-to-day seeking jobs and money and food,” CA3 explained. One example, given by S5, is that clients who have had long-term illnesses and mental health problems are especially poor, as they often must sell off everything they own and abandon their families to move to Phnom Penh for treatment.

As a result, poverty alleviation needs to be a key component of mental health therapy. However, most felt that EMDR did not address these needs.

It’s not hard to discuss EMDR with the higher educated people because they don’t have problems with finances. But its very hard to work with poor families because you can help with the emotional problems, but even if they can understand it and you can help with that, EMDR does not help with the financial part...so when the come back to their homes, the problems will come back, they will still have their problems again. S15

I think you need to teach people the other things, like how to feed their families. Then you teach them the mental health and social consequences of abusing your child and that kind of stuff…they need medicine and they need food. CA4
The dichotomy between social work and therapy in Cambodia is a false one, participants explained. Working to alleviate poverty, improve clients’ mental health, and enrich family functioning must be simultaneous and integrated into therapeutic practice.

Many faculty and some of the students also pointed out that there are many mental health needs but only a few therapists in Cambodia. Thus, some individual models like EMDR are not really responsive to the larger needs of Cambodia’s people. As expressed by one workshop participant, W9, “We still don’t have enough human resource about EMDR because for using EMDR you need to have proper training”.

Some faculty suggested what really needs to be used is more of a “community-based mental health”. In response to the need for community-wide education, the larger traumatized culture, and impoverished communities, a group approach is necessary. For most, this included seeking change at the larger, political level. There have been many cases cited where individuals have been victims of domestic violence, trafficking, and acid burn crimes, but their perpetrators have not be charged after paying bribes to law officials. This adds a complicated layer to an already devastating trauma. Participant W7 stated that EMDR might address this trauma on an individual level:

It is the best method for healing in Cambodia because Cambodia used to have many problems such as the war, and the law is not strict and so on.

However, most agreed that, no matter which model of therapy was used, it needed to address the political climate and do it on a large-scale approach. For example, with testimonial therapy the accounts of the clients are used to motivate political change. In Cambodia, the therapeutic testimonies of the Khmer Rogue survivors are provided to the courts as an official record of the atrocities; this empowers the client, promotes the telling of their narrative, and supports them in seeking justice for their torture and that of their
unburied relatives. Focus group members pointed out how this was created in another country, but adapted and used effectively in Cambodia. CA3 indicated that in some ways models like testimonial therapy might be hard to implement because it is contrary to Cambodian culture to experience the problem as an individual and to share it in public. However, it addresses the shortcomings of the legal system, empowers the clients, and incorporates a blessing.

**Therapy Location**

Therapists and clients in Cambodia need a safe place for conducting therapy, and the lack of confidentiality often affects the type of therapy used. As previously mentioned, therapy occurs anywhere convenient for the client, including in the home, outside by a tree, or in a public room; rarely are private, individual counseling rooms afforded. Participant S5 chose to use Solution-Focused therapy because its solution-oriented, strengths-based approach enabled her to help clients in the hospital. Many of her clients shared a very public hospital room with numerous other patients only separated by a sheet. She worries that if she tried to use EMDR that others would hear the conversations and her clients would “lose face” talking about their problems; this is especially true for men who do not traditionally cry in Cambodian society. This fear of using EMDR is further complicated by the fact that she only sees her clients once a week, and there are no other therapists on staff. Therefore, if her clients were activated during EMDR and could not self-soothe during the week, they could not see her or another therapist for an emergency session. She worries that they would die “upset” and “emotionally stimulated” before she could return to see them.
The public therapy setting is also inconvenient for the therapist. As explained by the Koh Pech therapists:

The first time I felt nervous. I was afraid of the patients in the hospital because I had never been to the hospital before. KP 10

Sometimes it was difficult to find a good moment to reach the clients. The atmosphere in the hospital room disturbed the process once in a while. A few clients gave an indirect feeling that they wanted to maybe not be touched. When I asked them, they said ‘ok’. There was not really a convenient place to stand or sit comfortably to do the tapping. KP3

This was similar for the clients and therapists during the typhoon Ketsana crisis response. Initially, therapy was conducted in their rural province at a local home; the follow-up sessions were conducted in Phnom Penh and the clients were brought to the Phnom Penh by bus. Sessions occurred simultaneously in one large room, with nearly ten client/therapist dyads. That night, clients slept in the therapy room, together on mats. The supervisor explained that the clients reported this as one of the positive therapeutic moments—being at the therapy center, away from their homes, with an air-conditioner and television—that is, the large group therapy was in keeping with collectivist notions. This experience is in stark contrast to what Westerners might expect in therapy and must be considered when they are implementing their Western models in Cambodia. CA2 pointed out that therapists must be flexible to do therapy in general and EMDR in particular in Cambodia—doing it behind “closed doors” may be countercultural as onlookers would be curious about the need for secrecy. It is a delicate balance of cultural sensitivity and confidentially for the client.

**Financial Situation**

In addition to many Cambodians experiencing poverty as a way of life, other Cambodians struggle to balance their finances due to the downfall of the economy, with
their livelihoods impacted by the decrease in tourism. When they are forced to choose between paying for life’s necessities or much needed therapy, they must choose the former:

The number one compliance issue is not depression, it’s whether they’ll have enough food. So, they either have enough money for food, or enough money for therapy—and they go for food. CA4

I am afraid the clients cannot pay for treatment. And they also do not believe in this method yet because the treatment is used without medicine or material to support them. It is abstract for the client. W11

Some victims don’t want to meet me and my friends because we are students and have no money or gift for them. And some victims, when they see me and my friends with no money or gift, they sleep. KP 9

Some participants tried to respond by seeing clients for free and saw it as a way to giving back to fellow Cambodians. Others reported that they disagree with seeing clients for free, because then the clients have no real investment. One idea was to provide group therapy, as it is more cost efficient. It is important to realize that most individuals do not have funds to pay for long-term therapy, and self-funded clients still struggle to pay everyday bills. Many clients are funded by NGOs, but only for a set number of sessions.

Summary

Echoing the concerns of Braithwaite (2006), themes in this category depicted a need for systemic awareness, education, and political change to promote transformation in the mental health system in Cambodia and the creation of a culturally responsive therapy. At this time, EMDR considers the context but does not make a direct attempt to promote political, economic, and social change. As expressed by the participants, this is critical for the improvement of Cambodian clients’ mental health status as well as the betterment of the larger community.
Political Context

The political context surrounding EMDR, both at the general level of foreign influence to the larger interplay between countries and the EMDR Institute and EMDR International Association (EMDRIA), directly impacted the implementation and acceptance of EMDR in Cambodia. Both students and faculty felt the external pressures, and questioned the origins of outside interest in Cambodia. It was a delicate balance of best meeting the needs and requirements of all funders, trainers, and project managers while obtaining the much needed therapeutic education and treatment in Cambodia.

Three themes emerged, 1) foreign influences, 2) EMDR politics, and 3) students caught between.

Foreign Influence

Some students expressed concern over why EMDR is being introduced to Cambodia. The majority of the faculty also criticized the foreign push to use EMDR, and suggested it was “foreigners pushing their pet projects” and Cambodians, desperate for funding and education and fearful of saying “no”, complying.

If EMDR is going to improve their quality of life in any way, that’s great, but the time, energy, and money spent to implement EMDR could be used in better ways with a longer lasting effect. If EMDR is someone’s project, that’s good but other stuff should be focused on now, especially with the education level and understanding where it is now. CA3

Some faculty, like many EMDR critics (e.g. Devilly, 2002, Richards, 1999), hotly contended that EMDR is really nothing more than an integrative therapy of cognitive restructuring, exposure therapy, hypnotherapy, and general trauma therapy, but re-packed with eye-movements. This frustration was best summarized by one participant who pointed out that foreigners are bringing in this model, yet the foreigners are sensitive to
criticism about the model and unwilling to adjust or change it. The natives wonder why, if the foreigners are so interested in “helping Cambodians”, do they not listen to the locals who suggest changes or have meetings with locals on integrating it in the curriculum before they do so. If the foreigners truly cared, they asked, wouldn’t they have translated the manual or adapted the scaling and other questions by now? The focus group pointed out it is being done for the Thai, so why not for them? Consistent with Carlson (1999), several participants noted that EMDR has been demonstrated to be beneficial in other Asian countries, but Cambodians and other Asians have between group and within group differences. They expressed interest in knowing how therapists in China, Indonesia, Thailand, India, etc. have adapted the protocol and explained technical terms to locals. They also stated needing funding to research and translate EMDR in Cambodia.

The majority of participants, students and faculty alike, questioned why Cambodians need EMDR specifically, and why this model is being pushed so hard if it has not been evaluated and is not currently being empirically validated by the foreign implementers. Participant S2 said, “Why do we need to do EMDR—do they want to help Cambodian people, or do they want to promote EMDR in the world?” Many people suggested involving the local therapists in a true action research study to evaluate how EMDR works from both their own and the clients’ perspectives.

Both students and faculty expressed worries of Cambodians being used for different reasons, including foreigners making a profit, pushing their own ideas, agendas and EMDR needs (i.e. EMDR trainer’s certification, obtaining grant funding, etc.), as well as exploiting them for research and publication purposes. “To be honest, the
supervisor also runs a business, I think she wants to help, but asks us to go along,” indicating that S9 knows the supervisor may care about the needs of Cambodians, but her primary interest is business. This was viewed differently by the supervisor, who recently changed her business to an NGO so she could support humanitarian projects such as the EMDR training and EMDR therapy to natural disaster survivors in Cambodia. It is also important to note that the supervisor reports being asked by one of the RUPP EMDR-trained faculty to teach EMDR to RUPP students for several years, and has only recently taught the course due to increased ability of the students.

There was also a lot of discussion about an EMDR association in Cambodia. However, some participants like S2 asked, “But what does it mean to make an EMDR association. Does that mean something to Cambodian people, or does that mean something to EMDR?” Focus group participants agreed that an EMDR association would be beneficial, but what would be most beneficial for all of Cambodia would be a psychology association in general. They were unclear about the current existence of such an association and who the leaders would be or were, but they desired to help take on that role. If an EMDR association was formed, S8 suggested the following:

1.) Members are student therapists from RUPP;
2.) Additional training is provided, both here and abroad;
3.) EMDR workshops (3-4 hours) are given by experts and experienced clinicians;
4.) An EMDR project is developed to research applied clinical service in Cambodia.

The overall consensus by participants is that an EMDR association may be helpful, but what is really needed is an overall Cambodian Psychological Association to unite all psychotherapists instead of excluding some from the beginning.
EMDR Politics

The overall international politics surrounding EMDR and disconnect between the EMDR Institute and EMDR International Association (EMDRIA) directly impacted the experiences of the Cambodian therapists. Per participant report, these politics have forced many EMDR supervisors to leave Southeast Asia and return to their home countries, including the one from Cambodia. The Cambodian-based supervisor explained this is sad because she was here for capacity building, and has done so successfully in Thailand and Cambodia. She stated that she attempted to create collaboration between the groups, however the other group was nonresponsive to her attempts, emails, and phone calls. She worried that not providing an in-country supervisor would mean that their supervisees would contact her, and she could not refuse. She truly wanted to help Cambodia but could not manage the additional responsibility of more supervisees.

Participants felt that the politics appear to revolve around power, grant funding, EMDR accreditation standards, and who should be trained (nurses, students, counselors, etc.). With regard to their Cambodia-based supervisor, her certification as either an EMDRIA or Institute recognized trainer/facilitator/supervisor influenced whether she could serve as a supervisor to the Trauma Aid Germany EMDR project; the two will not accept the other’s standards for trainers, facilitators, and supervisors. One participant, CA7, talked with TAG who said they were not satisfied with the original training that the students had received—they were worried about live supervision, personally observing how the students used EMDR, the students not having enough theoretical knowledge, and the research (she said she read between the lines); they also wanted to make the students future trainers in Cambodia, as they too claimed to be working for sustainability.
Many individuals agreed with CA2, who stated, “Trauma Aide Germany is going to do what Trauma Aide Germany wants to do. They’ve got their minds set on Southeast Asia.” Faculty were equally divided on how they perceived this group, but most agreed that they were playing with a strong hand and questioned their interest. A few cultural advocates felt strongly that Cambodians are already being trained, and this additional group confused matters and was somewhat irresponsible by training them and not having an in-country supervisor. The current in-country supervisor offered services but was not invited, and often overlooked, for Trauma Aid Germany/Humanitarian Assistance Program EMDR meetings; other faculty members were also excluded from the meetings. However, almost all agreed that the Trauma Aide Germany trainings were in-depth (perhaps too much so for the student level) and addressed many of the needs for additional training. Regardless of the interest group and funders, participants overwhelmingly agreed with focus group members that “EMDR is trying to show the world that it is the best” and it was implemented not just for the sake of the locals but for the promotion of EMDR itself.

**Students Caught between**

Student and faculty expressed concern over the students being put in the middle of EMDR politics and foreigners “pet projects”. Some voiced feeling used as a part of supervisors’ own desires to become certified EMDR trainers or others to promote projects. However, the host-country supervisor pointed out that had she not offered their training as a part of her own facilitators training, and funded the entire training through her own grants and business, it would have cost nearly $1,100 for each participant—
something no Cambodian student could afford without their own NGO or a foreign donor paying.

Students noted extreme awkwardness when working with each of the EMDR groups and when talking about one group to the other. Several students and faculty reported this to the researcher on numerous occasions. One faculty noted that students continually expressed discomfort, both directly and indirectly, about being caught in the fire between the groups. They felt loyalty to their host-country supervisor and did not know who to invite to meetings, with whom to discuss future projects and translation, and who to involve in the future of EMDR in Cambodia. Many noted feeling excited for the opportunity to work with TAG and have funding for employment, but that they were very sad to see their supervisor leave and worried about the future of EMDR in Cambodia and the safety of their clients without weekly, live supervision.

Summary

Themes in this category depicted political influences at the international and local levels that directly impacted the cultural responsiveness of EMDR. Furman et al. (2009) suggest that culturally responsive clinicians be aware of their personal biases and worldviews, criticize their own background and knowledge, understand how race and class are related to therapy, examine their own privileges, and accept and acknowledge these biases (p. 172), as well as work to build a working alliance. It does not appear that many of the foreign EMDR implementers take this approach with their research and clinical training. Instead, they are replicating the dominant power structures that keep many Cambodians clients oppressed and their actions are disempowering the Cambodian therapists. To make EMDR culturally responsive, from a critical theory lens, these very
implementers need to consider how they are ethnocentrically pushing EMDR in Cambodia and work with the therapists on action research to learn more about how EMDR is or is not responsive.
CHAPTER 5
CONCLUSION

In exploring EMDR as a culturally responsive model of Cambodian therapy, this study amplified the often silenced voices of the native stakeholders. While their experiences differed on how well EMDR “works” as measured by changes in VOCs and SUDs scores, participants overwhelmingly agreed on the many changes needed to make EMDR culturally responsive and “successful” as measured by client change over time with standardized measures. Within the categories of general psychology challenges, overall opinions, EMDR protocol concerns, training, supervision, community contexts, and political contexts emerged threads of desired change, adaptation, and translation to make EMDR more user-friendly and understandable. These requests were often coupled with a slight dissatisfaction at these changes not being made earlier, when participants initially voiced concerns and needs to supervisors and trainers. Yet, despite the long road ahead of adapting and translating EMDR, and their many concerns, stakeholders overwhelming expressed their belief that EMDR could be a successful model of trauma treatment in Cambodia.

Consistent with the tenets of culturally responsive therapy (Carlson et al., 2004), participants emphasized the importance of purposively responding to the Cambodian culture, Buddhist beliefs, context of poverty and desperate need for food, materials, and education, and clients’ desires for advice and brief therapy. Further, therapists and Cambodian therapies need to promote social justice and systemic change to eradicate the
disparities and injustices suffered by Cambodia people. This would include EMDR trainers, supervisors, and governing boards examining how their own roles replicate dominant power structures that oppress Cambodians.

For EMDR to be successful for both the clients and therapists, the EMDR protocol needs to be translated into Khmer, VOC and SUD scales need to tangible/visible, physical changes need to be considered when measuring client change, and the BLS needs to adjust to client-therapist gender and the location of the therapy. For clients, a basic lesson on psychology needs to be given, the introduction to EMDR should be simplified, and the structure reorganized to parallel Cambodian thought processes. For therapists, the trainings and supervisions must be restructured to accommodate the therapists’ preferred time, location, and cost, as well as their ways of learning and areas where they need additional knowledge. A culturally responsive model of therapy would be responsive to the needs of both clients and therapists.

Strengths

Many critics question whether evaluation, especially responsive evaluation, is research. Because responsive evaluation is systemic (Stake, 1975), systematic, and produces evidence (Abma, 2005), Stake (2004) suggests that, “All formal evaluation studies…even ones that are short or misguided—are research studies” (p. 246). Stake (2004) elaborates that “...when we make a systematic effort to discover the activity, meanings, and values of an entity (evaluand), then it is both evaluation and research” (p. 43). This argument is further supported by the fact the responsive evaluation studies generally take the form of case studies, which are valid forms of research and help to
refine theory and provide exceptions and outliers to the theory or limits of
generalizability (Stake, 2005).

To strengthen the rigor and wide-spread acceptance of the evaluation, the
National Research Counsel created the following list to guide researchers and evaluators
to create evidence-based or science based research: Stake, 2004, pg. 245):

- Post significant questions that can be investigated empirically.
- Link research to relevant theory.
- Use methods that permit direct investigation of the question.
- Provide a coherent and explicit chain of reasoning.
- Replicate and generalize across studies.
- Disclose research to encourage professional scrutiny and critique.

Stake (2004, p. 246) further pushes evaluators, stating that:

- Evaluation should be empirically developed around significant questions about program quality.
- Evaluation studies should be linked to three sets of theories: the formal theories of social sciences, the systems of thinking of the humanities, and practice-based professional experience.
- Multiple methods should be used to permit direct investigation of the value of questions.
- Evaluators should provide a coherent and explicit chain of their own reasoning, but include judgment data from participants whether or not their own reasoning is coherent and explicit.
- Evaluators should triangulate key data, draw in other studies as relevant, and particularize or generalize, as circumstances require.
- Evaluators should submit the process and findings to professional scrutiny and critique.

It is clear that evaluation counsel boards and researchers themselves are pushing the field of responsive evaluation to be rigorous, intentional, and even more research-oriented for acceptance and potential generalizability. Researchers exploring CRT can and should strive to adhere to these guides to provide empirically validated minority therapy and to assure best treatment practices. These suggested RE guidelines are consistent with CRT, and will promote stronger findings, and push the evaluator to be clear with intent,
consistent with theory, and rigorous with design and implementation to create a strong model of therapy. Therefore, while the focus is on the unique population, and the purpose is not necessarily to be generalizable, promoting strong research allows for cross-comparison, creates a research foundation for future studies, and may help in application to other populations. In a sense, there seems to be a tension created between being responsive to the situation and creating rigor. However, being responsive itself is seen as a form of rigor in culturally responsive therapy. Utilizing that strength, as well as all of the points listed in this section by both the National Research Counsel and Stake (2004), this study provides a rigorous research evaluation on culturally responsive therapy.

Additional strengths include the multiple angles of data triangulation across time, persons, settings, and locations, numerous types of data collected, and the dedication to amplifying stakeholders’ voices. It also accommodated the unique needs of the stakeholders, and took the cultural and political climate of Cambodia into account in many ways. First, it addressed the current socio-political needs and the request of RUPP. Second, it required no financial investment on behalf of the host site, but instead utilized their resources of the student-therapists and internship sites with existing clients. All funds were secured by the researcher through grants including the Fulbright Fellowship and The University of Georgia Graduate School Social Sciences Award. Third, the students at their internship site conducted the therapy, which is a mandatory requirement of the Master’s in Psychology program. Fourth, the students are bi-lingual in Khmer (the native Cambodian language) and English, making communication between the researcher and students feasible. Finally, this project spanned many months, accommodating the
Cambodian tendency to span a project for a longer period of time in comparison with American standards.

Methodologically this study was the first to describe and depict how using the responsive evaluation methodology is beneficial in studying culturally responsive therapy because they are both epistemologically and theoretically informed by social constructionism and interpretivism, are consistent with Feminist, Just Therapy, and Critical Theory worldviews, and aim to respond to the unique needs of a given population. Utilizing responsive evaluation allowed the researcher to adapt to the changing issues and needs of the participants, utilize flexible methods, rely on local knowledge to inform the research, be accountable to minority members, and depend on accountability structures including cultural advocates and advisory boards, all of which are essential to developing, implementing, and identifying a culturally responsive therapy. Finally, the emerging findings from responsive evaluation were instantaneously revealed and implemented during the study, which further met the immediate needs of the participants.

**Potential Limitations**

Like all methodologies, whether qualitative, quantitative, or mixed method, responsive evaluation has its tradeoffs. As explained by Stake (2004),

A responsive predisposition has important consequences. The evaluation work changes as the program changes, thus making some initial decision about instruments, data sources, and standards less relevant. With some changes in program and evaluation responsive to those changes comes less opportunity to aggregate banks of quantitative data…The evaluation gets closer to people, and so raises the risk of getting emotionally involved with certain groups or positions, The evaluation hears subtle differences in language; initial designs featuring rough categories and correlations may be found less useful. And through all of this, if interpretation becomes more important than criterial measurement, it
becomes not just a difference in focus of attention but a difference in what is considered meaning and evidence (p. 88).

Using responsive evaluation allows the evaluator to gain more intimate knowledge of the program and what is going on as opposed to exact description and criteria (Stake, 2004). The purpose of responsive evaluation, which includes a deeper understanding of a particular program in a particular context, requires in-depth, personal probing and rich context-driven information, which does not always coincide with collecting statistically driven data. Furthermore, it is built on human interaction, making it difficult for evaluators to get close to all people in a program due to limited time, space, and resources.

It is a delicate balance between having enough or too much data, as “working with more than a few criteria and issues enhances the views of the program, but tends to spread the evaluation resources thin. Efforts to triangulate key observations and interpretations increase the validity of the data, but risk giving too much attention or too small a view” (Stake, 2004, p. 102-103). And, the determining factor may depend on the planned intent of the evaluation report—to publish in an academic journal, disseminate widely, or to use solely by that program. Family therapy researchers working with minority and marginalized population who use RE may find their work challenged by critics who value more generalizable work. Again, this goes back to the epistemological stance—to work for the unique population or to work for generalizability? According to the tenets of CRT, the purpose is to work for the unique population at the risk of critics, and to work for social justice to reform the patriarchal values of academia that may not support the RE methodology.
Like all research, this study has limitations like those previously mentioned. First, the study interviewed only the therapists and cultural advisors about their perceptions of EMDR and did not interview the clients. Second, the interviews explored the experiences of the efficacy and experiences of EMDR, but did not measure the actual clinical change via outcome measures over time, as the stakeholders would have liked. Third, because of the small, identifiable sample some rich quotes could not be shared to protect the participants. Finally, while the study provided a thick, rich description of the experiences of the therapists, there was not be enough data to further refine or develop the AIP theory underlying EMDR, as could be done utilizing Grounded Theory or researching for years in the field. However, this study will serve as a strong base for doing so in future studies.

**Implications for future research and clinical practice**

This area of study on culturally responsive therapy in Cambodia, and EMDR as a means of that, would further benefit from additional research on how clients experience EMDR therapy and therapeutic change over time. First, however, the EMDR protocol, trainers, and supervision need to be adjusted to accommodate to the needs of the Cambodian stakeholders as described in this study. In particular, the protocol needs to be officially translated and piloted on both high and low education populations. After these changes, an evaluation of EMDR across demographics of SES, education level, ethnicity, age, and gender needs to be conducted to re-consider the cultural responsiveness and identify additional needs.

The application of this study by international EMDR trainers could enhance the training, supervision, and implementation of EMDR in other countries by considering ways to make it more culturally responsive. For example, participants in this study
suggested making the scaling exercises tangible by moving rice in and out of a bowl to represent SUD change. Other countries that identify with these scaling challenges may find this adaptation helpful.

Finally, this study gleans insight for international funding agencies, researchers, supervisors, and trainers into how they may be perceived by the locals and natives when they “push their pet project,” even if well intentioned. Cross-cultural work is challenging and difficult, and key components of cultural responsiveness include recognizing one’s own power and privilege, relying on local knowledge, being accountable to natives, and using cultural advocates and advisors (Carlson et al., 2004). When one lacks cultural responsiveness and commitment to the local population, the entire implementation of the therapy model (training, supervision, therapy) is jeopardized.

The findings from this study, while specifically emerging with regards to EMDR, could be applied when studying other models of therapy in Cambodia. Stakeholders were generous in sharing their therapeutic needs, beliefs, and values as experienced by Cambodian therapists. Cambodian clients, therapists, and the greater community would greatly benefit from a culturally responsive model (s) of Cambodian therapy that is theoretical consistent with their worldviews and addresses change systemically at the individual, familial, and societal level; determining whether it is EMDR or a better fitting model is yet to be determined.
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APPENDICES

Appendix A
Email Letter to Participants

Hello Faculty, Students, and Affiliates of the Royal University of Phnom Penh,

I hope this email finds you doing well, and enjoying your time before your semester begins. My name is Ms. Desiree Seponski and I am a doctoral candidate in the Child and Family Development Department at the University of Georgia. As a part of a Fulbright grant, I will be teaching and researching at your university in the Department of Psychology and living in Cambodia for almost 1 year. Through teaching classes and attending supervision, I have been fortunate to meet many of you already.

I am contacting you to tell you about a research study I am conducting that will be easy and useful to participate in. My dissertation research study is entitled “Exploring Eye Movement Reprocessing and Desensitization (EMDR) as a Culturally Responsive Cambodian Model of Therapy.” The focus of this study is on how Cambodian therapists can use EMDR with their clients as a culturally responsive model of therapy. In other words, we will be exploring how this model does, or does not, meet the needs of your clients based on their values and culture. If you or someone you know is a student, faculty, instructor, or affiliated with the Master’s of Psychology program and would like to participate in my study, please contact me at dmpaulin@uga.edu. It is also helpful for faculty, instructors, and associates to serve as cultural advocates/advisory board to explain how they perceive the use of EMDR in the community and its presence on the program.

If you choose to participate in this study, there are many ways that you can share your experiences and perceptions. I am flexible to your time schedule, and willing to do individual or group interviews, to observe classes, sessions, and supervision, and read letters, emails, and documents—whichever methods will best relay your ideas. It will require 1-10 hours from you (based on your time availability), will not disclose your personal information to anyone with your name on it, and will not cost you anything, but may be very beneficial in helping your clients get the culturally responsive therapy they need.

Through your descriptions and others like yours, I hope to ultimately answer the questions, “Can EMDR be used in Cambodia as a culturally responsive model of therapy?” and “How do Cambodians experience the use of EMDR Therapy?”

As a token of my appreciation, participants will receive a reward for their participation. Student-therapists being interviewed will receive a school-related reward (flash drive, pens, notepads, books) valued at $4.00 USD for each time interviewed. As a reward for the participation of lecturers, faculty, and clinical supervisors as cultural advocates/advisors, a digital video recorder and a digital voice recorder will be donated to the Royal University of Phnom Penh Department of Psychology for use of all faculty, instructors, and affiliates. Your participation is greatly appreciated and valuable to your community and country.

Thank you in advance for your time and attention.

Sincerely,
Desiree M. Seponski
Ph.D. Student
Department of Child and Family Development
Marriage and Family Therapy Program
dmpaulin@uga.edu
Appendix B
Personal In-class Invitation to Recruit Participants

Hello Students
Welcome to class today.

My name is Ms. Desiree Seaponski and I am a doctoral candidate in the Child and Family Development Department at the University of Georgia. I will be teaching at your university this summer in the Department of Psychology and living in Cambodia for almost 1 year. As you may already know, I will be teaching your marriage and family therapy course for Master’s level students. I would like to tell you about a research study I am conducting and invite you to participate in it. It will be easy for the students in the class to participate in and very rewarding for both you and your clients.

My dissertation research study is entitled “Exploring Eye Movement Reprocessing and Desensitization (EMDR) as a Culturally Responsive Cambodian Model of Therapy.” The focus of this study is on how therapists can use EMDR with their clients as a culturally responsive model of therapy. In other words, we will be exploring how this model does, or does not, meet the needs of your clients based on their values and culture. It is very important to identify a therapy model that is responsive to your culture, instead of using westernized models that may not be appropriate. If you or someone you know is in the Master’s psychology program, is taking the course, and would like to participate in my study, please contact me at dmpaulin@uga.edu.

If you choose to participate in this study, I will ask that you allow me to use your papers and discussions from the class in the study. It will require no more time from you, will not disclose your personal information to anyone with your name on it, and will not cost you anything, but will be very beneficial in helping your clients get the culturally responsive therapy they need. If you choose not to participate, it will not affect your class grade or attention in any way.

Through your descriptions and others like yours I hope to ultimately answer the questions, “Can EMDR be used in Cambodia as a culturally responsive model of therapy?” and “How do Cambodians experience the use EMDR?”

Participants will receive a reward for their participation of XXXX. Your participation is greatly appreciated and valuable to your community and country. Please consider being a crucial part of this study.

Thank you in advance for your time and attention.
Sincerely,
Desiree M. Seaponski
Ph.D. Student
Department of Child and Family Development
Marriage and Family Therapy Program
dmpaulin@uga.edu
Appendix C  
Semi-Structured Interview Protocol

1. What has been your experience with using EMDR?
   • What were your positive experiences?
   • Did you have any difficulties? If so, please describe them.
   • Were there times that you were uncomfortable?
   • Please describe any changes or adjustments that you have to make when using EMDR.
   • Please describe any times you had to deviate from the model.
   • Do you feel that this model is responsive to your culture?
     o Probes: time, number of sessions, persons attending therapy, values, relationship between client and therapist, epistemology and theoretical orientation.
   • Are there times it is easier to use (certain clients, certain diagnoses/crises)?
   • If there were things you could change about EMDR, what would they be? Why?

2. How do you think your clients experienced EMDR?
   • What occurred in the sessions to lead you to this conclusion?
   • Do your clients try to return to “talk therapy” as opposed to EMDR?
   • Explain times you have noticed your clients responding to EMDR.
   • If you have asked your clients how the sessions went, please describe their responses.
   • Using the concept of scaling, where 1 is horribly and 10 is perfectly, describe how you think EMDR worked with your clients.
   • Were there changes in the SUD and VOC level during sessions?
     o How?
     o If not, why do you think hindered this?
   • Have there been certain cases where EMDR did not work?
   • Have there been certain cases where EMDR seemed to work better than others?

3. How do you think your clients’ families experience EMDR?
   • Describe your work using EMDR with families.
   • Do your clients refer to their families in individual sessions?
   • How do your clients describe their therapy progress and their families’ reactions?
   • How do you perceive the EMDR affecting the clients’ families?
   • What occurred in session to make you believe this?

4. You are learning a lot in terms of how to use a manualized treatment model. Do you incorporate EMDR into your own worldview?
   • Are you using this in solving your own problems? If so, please describe.
   • Do you talk with your friends/family about their problems? If so, please describe.
   • Are you using this in helping your friends and family to solve their problems? If so, please describe.
   • What adaptations have you made to the treatment model to better fit your worldview?
Appendix D
Semi-Structured Interview Guide
Cultural Advocates & Advisory Board

1. What is your role in the department?
   • Have you had experience working with the students using EMDR?
   • What has that experience been like?
   • As an affiliate of the psychology program, I am aware that you have experience and training in working with clients in Cambodia. What things are important for therapists working with clients in Cambodia to know?
     o Values
     o Challenges
     o Culture
     o Traditions
     o Family structures

2. IF EMDR TRAINED: What has been your experience with using EMDR?
   • What were your positive experiences?
   • Did you have any difficulties? If so, please describe them.
   • Were there times that you were uncomfortable?
   • Please describe any changes or adjustments that you have to make when using EMDR.
   • Please describe any times you had to deviate from the model.
   • Do you feel that this model is responsive to your culture?
     o Probes: time, number of sessions, persons attending therapy, values, relationship between client and therapist, epistemology and theoretical orientation.
   • Are there times it is easier to use (certain clients, certain diagnoses/crises)?
   • If there were things you could change about EMDR, what would they be? Why?

3. How do you perceive others using EMDR?
   • Probe: successes and failures
   • What has happened to make you think this?
   • From what you know about EMDR, how do you think it fits with Cambodian:
     o Culture
     o Beliefs
     o Needs
     o Therapy Traditions

4. In your experience, what models of therapy work well in Cambodia?
   • Why?
   • How do these models compare to EMDR?
Appendix E
EMDR Participant Information

Name: ____________________________
Sex: ____________________________
Age: ____________________________
Nationality: ____________________________
Religion/Spirituality: ____________________________
Affiliation with RUPP (student, instructor, etc.): ____________________________
Name of Undergraduate Program Attended: ____________________________
Completion of Undergraduate Degree? ____________________________
Program type (psychology, social work, etc.): ____________________________
Name of Master’s Program Attended: ____________________________
Completion of Master’s Degree? ____________________________
Program type (psychology, social work, etc.): ____________________________
Name of Doctoral Program Attended: ____________________________
Completion of Doctoral Degree? ____________________________
Program type (psychology, social work, etc.): ____________________________
EMDR Training (none, Part 1, Part 2): ____________________________
Hours completed of EMDR Supervision: ____________________________
Are you an approved EMDR Supervisor? ____________________________
Number of clients you have used EMDR with, to date: ____________________________
Number of sessions you have used EMDR, to date: ____________________________
Your preferred model of therapy:
On a scale of 1-10, with 1 being the lowest and 10 being highest, please described your familiarity with EMDR.
1 2 3 4 5 6 7 8 9 10
On a scale of 1-10, with 1 being the lowest and 10 being highest, please described your comfort with using EMDR.
1 2 3 4 5 6 7 8 9 10
On a scale of 1-10, with 1 being the lowest and 10 being highest, please described your view of EMDR being responsive to Cambodian client needs.
1 2 3 4 5 6 7 8 9 10
Additional comments, questions, or concerns:

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Appendix F
Semi-Structured Focus Group Protocol

- What has been your experience of learning EMDR?
- As a therapist and a Cambodian native, how do you think EMDR will work with your clients?
- How will EMDR be culturally responsive?
- How will EMDR not be culturally responsive?
- Which intervention do you think will be most helpful? Why?
- Which intervention do you think will be least helpful? Why?
- Are there things I can do to be more responsive to your needs?
- Does anyone have anything they would like to share?
Appendix G
Koh Pech Survey

Questionnaire about the intervention to clients at Kosamak Hospital
who injured at Koh Pech bridge

1. What year are you in the bachelors program?

2. How did you feel the training was?

3. Did you attend the EMDR workshop before the training?

4. What was your level of understanding of the EMDR intervention?

5. What was your level of ease with implementing the intervention?
6. How many days did you go?

7. How many clients did you see?

8. How many clients did you see progress with?

9. What happened that showed you there was "progress"?

10. Please describe any complications.

11. How do you think people watching reacted to your interventions?

12. How long did you spend with each client, on average?