Mental Health in Cameroon: The Challenge of Treating Trauma. Case Study of Treatment Using the EMDR Protocol

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DOI: https://doi.org/10.47772/IJRISS.2026.10100421

Received: 23 January 2026; Accepted: 28 January 2026; Published: 09 February 2026

ABSTRACT

This article presents a case study on the effectiveness of EMDR therapy in treating traumatic grief in Cameroon. The patient, aged 29, underwent nineteen sessions following the sudden death of her sister and her infant son. The intervention, based on the Adaptive Information Processing (AIP) model, targeted the most disturbing memories, particularly an intrusive image related to her sister's death. The results show a significant reduction in emotional distress to a tolerable level. The introduction of a symbolic exercise—writing a letter to the deceased—promoted cognitive and emotional integration, facilitating acceptance of the loss and psychological reorganization. This study highlights the clinical and cultural relevance of EMDR in Cameroon and confirms its potential as a therapeutic tool for complex grief and trauma, even in contexts where mental health remains poorly integrated into healthcare practices.

Keywords: EMDR, grief, trauma, Cameroon, mental health, psychotherapy

INTRODUCTION

Eye Movement Desensitization and Reprocessing (EMDR) therapy is a therapeutic approach that has provided ample evidence of its ability to treat trauma. It has proven to be effective for a wide range of clinical complaints and pathologies, including grief (Solomon & Rando, 2007). The grieving process, particularly when it becomes complex or prolonged, can profoundly alter the psychological, biological, and social functioning of bereaved individuals. Approximately 7-10% of bereaved individuals develop prolonged grief, which manifests itself in a significant disruption of daily life, intense and varied emotional suffering, an increased risk of severe mental disorders, and several other associated pathologies (Spicer, 2024).

Traditional therapeutic approaches, such as grief-focused cognitive-behavioral therapy, have proven effective; however, EMDR (Eye Movement Desensitization and Reprocessing) is increasingly being explored as a complementary or alternative modality with proven scientific effectiveness (Cotter et al., 2017; Sprang, 2001).

Emdr

EMDR, developed by Francine Shapiro in the late 1980s, is based on the hypothesis that unprocessed traumatic memories are stored in the form of dysfunctional or traumatic memory networks and that bilateral stimulation, which can take several forms (eye movements, tapping, etc.), facilitates their adaptive reprocessing (Shapiro, 1995). etc.) facilitates their adaptive reprocessing (Shapiro, 1995). Although the scientific community is still debating the specific role of this bilateral stimulation, with some suggesting that it is mainly a disguised exposure effect, the diagnostic effectiveness of EMDR in post-traumatic stress disorder is widely supported (Ying-Ren Chen et al., 2014).

The application of EMDR to the treatment of grief is based on the **Adaptive Information Processing (AIP) model** and incorporates theoretical frameworks drawn from attachment theory, the concept of continuing bonds, and complex grief processes developed in particular by Solomon (2018). Solomon and Rando (2007) emphasize that EMDR can be integrated into at least six processes necessary for adaptive assimilation of loss, including the

activation of positive memories of the deceased and the cognitive reorganization of painful losses . Pilot studies and clinical cases show promising results: Sprang (2001) compared EMDR to a conventional approach to grief, observing a more rapid reduction in PTSD symptoms and an increase in positive memories in the EMDR group. Similarly, some authors have reported that, in a randomized clinical trial, the effect of EMDR on grief and post-traumatic stress symptoms was equivalent to that of cognitive-behavioral therapy.

Objective of the article

This article aims to explore, through a **clinical case study**, the effectiveness of the EMDR protocol in the treatment of recent grief. The study aims to describe in detail the implementation of the eight-phase protocol, measure the clinical effects using psychometric tools (SUD, VOC, etc.), and discuss possible mechanisms of action in light of the existing literature.

EMDR and grief

What is grief

Grief is a psychological, emotional, social, and sometimes physical reaction to the loss of a loved one. It is a process of emotional adaptation following a loss (of a loved one, a job, a relationship). Grief has an emotional dimension, but also a physical, cognitive, philosophical, and vital behavioral dimension in human behavior. It is a universal process but experienced in a unique way, influenced by the individual's personality, the nature of the loss, the sociocultural context, and the support resources available (Worden, 2009).

The stages of grief

One of the best-known models is that of Kübler-Ross (1969), which identifies five stages in the grieving process:

- Denial phase: refusal to believe in the loss, emotions seem absent.
- Anger or indifference phase: a state of discontent at not having been able to prevent the loss. The causes and the culprit are sought.
- Bargaining stage: negotiating with oneself or with those around them, searching for a solution to the loss while knowing full well that it is impossible.
- Depression stage: sadness due to the loss, feeling that one will never get over the grief.
- Acceptance phase: understanding that the loss is inevitable, that accepting is not the same as forgetting.

It should be noted that not all stages are necessarily experienced, and they do not always occur in the order listed above. This model, although influential, has been criticized for its linear view of grief. In reality, the stages may occur in a non-chronological order, be repeated, or be absent, depending on the individual (Marrone, 1999).

Some more recent approaches to grief based on the dual process model propose two types of activities that bereaved individuals alternate between: loss orientation (crying, remembering, feeling pain, etc.) and restoration orientation (adapting to the new reality, resuming social roles, etc.). These processes are generally alternatives found in bereaved individuals (Stroebe & Schut, 1999).

Adaptive Information Processing Model

EMDR therapy is an integrative psychotherapy that has been used effectively with people experiencing various forms of grief. In the EMDR assessment phase, when a client has experienced bereavement, it is vitally important to understand and assess the risk factors mentioned in order to understand the client's current likelihood of developing a more complicated and prolonged bereavement response and the areas to be addressed in treatment (Domingue et al., 2023; Leeds & Shapiro, 2000). In addition, some research has shown that a positive therapeutic

alliance and good resource development at the beginning of treatment leads to a greater reduction in symptoms of prolonged grief (Glickman, Katherine & Wall, 2018).

In recent years, the use of EMDR with bereaved individuals has become increasingly common due to its therapeutic effectiveness. Salomon and Rando (2012), studying Shapiro's work, provided important information on the importance of implementing EMDR in existing grief settings, taking into account the three components of EMDR reprocessing: past, present, and future. As presented by Shapiro in her work, Hornsveld et al. (2010) examined the effectiveness of eye movements in reducing the emotionality of memories related to loss. Compared to other forms of stimulation, eye movements showed significantly greater reductions in the ability to focus on the memory related to loss and the emotionality of the memory, making it more effective.

EMDR therapy and grief treatment

The Adaptive Information Processing (AIP) model is the basis for the EMDR therapy developed by Shapiro (2001). This model proposes that when the AIP system is functioning normally, experiences, including painful ones, are integrated adaptively into memory networks. However, when faced with traumatic events, such as sudden or unresolved grief, this processing can be blocked, leading to dysfunctional information storage. EMDR aims to reactivate the information processing system through bilateral stimulation (eye movements, sounds, tapping) while focusing on the painful memory. This allows traumatic information to be reprocessed and integrated in a more functional way (Shapiro, 2001; Sprang, 2001; Moser et al., 2017). In the same vein, it helps transform dysfunctional beliefs into more adaptive thoughts (e.g., "I can't live without her" to "I can continue my life without her while keeping her memories").

METHODOLOGY

Therapeutic setting

The intervention was carried out in a psychotherapeutic consultation setting in a hospital by a practitioner (clinical psychologist and psychotherapist) trained in EMDR psychotherapy levels 1 and 2, in accordance with current ethical clinical guidelines (Cameroonian Society of Psychology, 2021). The intervention protocol respected the principles of confidentiality, non-judgment, and patient autonomy, with **informed consent** obtained for the anonymous use of clinical data for scientific purposes (American Psychological Association, 2017).

Case presentation

Ms. Fifi, 29, a senior executive in the financial sector, married for three years and without children, was referred urgently by her occupational physician for psychological care. The consultation took place six days after the death of her older sister and her sister's infant.

The medical history reveals a strong emotional dependence between the patient and her sister Ella, described as a quasi-maternal figure. Ms. Fifi also reports having invested in a particularly close bond with her sister's children, whom she considered her own.

The traumatic event occurred in an obstetric context: the infant died one day after birth, before Ella had been able to bond with the child. Three days later, Ella died as a result of severe preeclampsia. Ms. Fifi says she was present throughout the hospitalization and recounts an experience of shock, characterized by a feeling of unreality and a persistent refusal to accept the doctors' announcement of the death: "I don't believe it's real, I can't accept it. In fact, no doctor told me about my sister's death, and I feel like time has stopped there at the hospital. I know she's still in intensive care and will get better (...) Honestly, I came to see you because the doctor told me to."

Emotionally, the patient expresses marked guilt (for not having detected the seriousness of the illness, for not having been able to protect her sister): "My sister and I were very close. Some people thought she was my mother. I should have noticed that she wasn't well. I tell myself that I don't really deserve her," intrusive

ruminations, a sense of loss of identity, and major difficulty in projecting herself into the future. She verbalizes distress centered on both the loss of her sister and that of the infant, reinforced by her emotional and symbolic investment in the latter.

The initial clinical assessment revealed maximum distress (SUD = 10/10. Quantitative assessment); neurocognitive disturbance, with a central negative cognition ("I don't think I should live without them"); the presence of suicidal thoughts in a depressive state; an inability to restore adaptive functioning; traumatic aspects related to the absence of a formal medical announcement of death and the persistence of painful memories of the past related to the deceased.

EMDR protocol applied

At the time of writing this article, with the patient's consent, a total of 19 psychotherapy sessions had been conducted. It should also be noted that work with the patient is continuing to this day. The treatment followed the EMDR protocol in accordance with the AIP model, but with a therapeutic feature that we chose to unblock cognitions.

In this article, we will limit ourselves to phase 4 (desensitization) of the protocol, as the 19 sessions conducted concerned only one target. This case was conducted following a freehand clinical approach.

Targeting plan

The issue chosen was: repeated crying

Current triggers:

- Every time I enter the room I had prepared for my nephew;
- Every time I see clothes I bought for him;
- Every time I see a photo of her;
- Every time I see my sister's husband;
- Every time I eat;
- Every time my phone rings and I see my phone's wallpaper;
- Every time I see my sister's daughters;
- Every time I find myself alone in a room;
- Every time I see my friends' WhatsApp statuses;
- Every time I see one of the clothes she bought me;

The most disturbing situation is "every time I see a photo of her." She reports crying intensely for hours, loss of appetite, sadness, self-loathing, disgust with life, feeling that she doesn't "deserve" her current life without her sister.

Past experiences

- When I was separated from my parents to go to another country (age 8)
- When my classmates made fun of me and called me fat (when I returned to Cameroon and was enrolled in a new school: age 12)

- When my mother yelled at me and said I wasn't her daughter (age 18)
- When I discovered certain secrets about my father's life (age 18)
- When I learned that I had difficulty conceiving (23 years old)

Future scenarios

It should be noted that at this stage and during this session, the patient did not formulate any future scenarios because she felt she did not deserve to live.

Phase 3 - Evaluation

Target 1: "Every time I see a photo of her"

Image: when I see her lying on the table in intensive care

Negative cognition (NC): "It's my fault"

Positive cognition (PC): "I did my best"

(VOC): 2/7

Emotions: Deep sadness, guilt.

SUD: 10/10

Location of bodily sensation: Burning sensation in the stomach and heaviness in the shoulders.

Phase 4: Desensitization

During the first session, we noticed a connection between the two deaths and an inability to separate them. Each time, we had to change the rhythm and number of SBAs (15-20-30; sometimes faster than others).

Account of the first desensitization session

→ I see her lying on the operating table (note that she never attended her sister's operations).

→ I should have at least allowed her to hold her son in her arms

→ I feel like I separated them

→ I feel warmth throughout my body

→ Initial situation then SBA

→ I have a tingling sensation.

→ I should have attended my nephew's funeral

……. This first session lasted 1 hour and 23 minutes, with a SUD of 6/10.

During the first week, we had a series of five sessions in view of the distress observed in the patient. After ten sessions, it was necessary for us to create breakthroughs in the patient, who refused to believe in her sister's death. To do this, we recommended that she write a letter to her sister. However, we did not give her any instructions or tell her the reason for the letter.

At the next session, this letter was the focus of our session. In a role-play, the patient read the contents of the letter aloud. The breakthrough came first when she finished reading and then when we suggested that she go home and give the letter to her sister. This phase prompted nearly 30 minutes of silence and crying on her part. The EMDR protocol recommends cognitive weaving when cognitions are blocked. We chose a form of bibliotherapy to generate this cognitive weaving.

DISCUSSION

The results obtained at the end of the psychotherapy sessions show a significant improvement in the patient's psychological and emotional functioning, reflecting the relevance of this approach in the treatment of traumatic grief. From the very first sessions, the gradual desensitization of memories related to the loss reduced the emotional intensity associated with intrusive images and guilt, as illustrated by the decrease in the SUD score to a tolerable level.

The use of reading and writing a symbolic letter to the deceased sister was a major therapeutic turning point, facilitating a cognitive link between the emotional and rational levels of the experience. Although not strictly part of Shapiro's protocol, this technique is a relevant cultural and clinical adaptation of the AIP model, confirming that therapist flexibility is a key factor in the success of EMDR. These results are consistent with the conclusions of previous studies (Sprang, 2001; Solomon & Rando, 2012; Glickman et al., 2018) that highlight EMDR's ability to reduce emotional distress and promote adaptive integration of memories related to loss.

In terms of context, this case study demonstrates that EMDR can be applied effectively in a Cameroonian hospital setting, provided that certain conditions are met: qualified training of the therapist and consideration of cultural dimensions. Finally, although the clinical improvement observed is notable, certain limitations should be highlighted: the exploratory nature of a single case study, the absence of standardized long-term post-treatment measurements. Nevertheless, this is justified by the complexity of the case, which is still being treated at the time of writing.

CONCLUSION

This case study clearly illustrates the relevance and therapeutic power of EMDR in the treatment of grief-related trauma in Cameroon. Through the clinical follow-up of Ms. Fifi, who was grieving in the context of multiple and sudden loss, the application of the EMDR protocol highlighted not only the ability of this approach to desensitize painful memories, but also to gradually restore psychological coherence and identity altered by trauma.

More broadly, this case highlights the need to strengthen the role of evidence-based psychotherapies in the field of mental health in Cameroon, which is still largely dominated by biomedical and spiritual approaches. The integration of EMDR into local clinical practices is a promising avenue for the treatment of complex trauma, particularly that related to sudden loss, disasters, and social violence. This study calls for greater institutional and scientific recognition of EMDR psychotherapy as an effective, adaptable, and culturally relevant treatment tool in African contexts.

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