Advance Praise for Cultural Competence and Healing Culturally Based Trauma with EMDR Therapy

After reading Nickerson’s compelling and boldly comprehensive text, I have found myself sitting with clients in an entirely new way and so will you. With the multiple lenses offered in this book, you will start to think differently about the ways in which diverse cultural factors - social class, ethnicity, race, sexual orientation, religion, immigrant status, gender, discrimination, prejudice, and various disabilities interact to shape beliefs about oneself and one’s experiences in the world. This book will heighten your awareness and cultural sensitivity, broaden your knowledge, and increase your repertoire of EMDR interventions. I suspect that you will be deeply moved by the book’s many case presentations and ultimately left with a profound sense of hope and optimism about our capacity to help our clients heal.

—Deborah L. Korn, PsyD,
Senior EMDR Institute Facilitator and Specialty Instructor,
Training Faculty, Trauma Center at JRI

Finally there is a book that is thought provoking, insightful and rich in content, and which takes an in-depth look at the important role culture plays when treating trauma. With the strategies and protocols he provides in his book, Mark Nickerson has built a bridge for EMDR therapists to use our evidence based EMDR therapy to conduct more culturally effective trauma focused interventions. Mark’s understanding of inclusiveness is reflected in his collaboration with other EMDR therapists. This book is a true guide in cultural humility.

—Diane DesPlantes, LCSW,
Certified EMDR Therapist
Master trainer of Cultural Competency; New Jersey Department of Children and Families
Office of Training and Professional Development
EMDR International Association Board Director

This is definitely a book whose time has come. From multiple contributions around the world, each chapter brings significant insights into how EMDR therapy can be culturally attuned and yet efficacious in preserving the individuality of each client. Highly recommended for those therapists who work in multi-cultural settings.

—Esly Regina Carvalho, PhD.
Trainer of Trainers, EMDR Institute/EMDR Iberoamérica,
President, Trauma Clinic do Brasil/TraumaClinic Edições, Brasilia, Brazil

This book may be one of the most important contributions to EMDR therapy literature so far in this century. Nickerson has astutely gathered together a collection of compelling articles that highlight the struggles of individuals and groups who have tragically and traumatically been affected by discrimination and discusses how EMDR therapy may be utilized to help them heal. Respectfully presented, this book offers information, strategies, and deviations from the EMDR standard protocol to deal with these diverse populations. Cultural Competence and Healing Culturally Based Trauma should be on the bookshelf of every EMDR therapy clinician.

—Barbara J. Hensley, EdD, LPCC,
Author of EMDR Therapy: From Practicum to Practice (2nd Ed.),
EMDR International Association, Past President,
EMDR Research Foundation, Board Member,
Francine Shapiro Library, Creator and Curator

©Springer Publishing Company
This groundbreaking book edited by Mark Nickerson opens the field of psychotherapy to the importance of cultural competence. It gives the EMDR clinician the means of healing culturally based trauma by addressing a wide-range of important topics including social privilege and stigma, marginalized populations, LGBTQ concerns, and the special sensitivity needed when introducing EMDR Therapy to different cultures.

—Marilyn, Luber, PhD,
Author of EMDR SCRIPTED PROTOCOLS series,
EMDR Global Alliance Co-Facilitator

This book is a landmark contribution to EMDR therapy. In an increasingly culturally diverse society, clinicians need to understand the social forces and effects of culture, and how it shapes perceptions and consequently the memories that can become maladaptively stored. This will enable the clinician to develop a culturally informed treatment plan and provide more effective EMDR therapy treatment.

—Roger M. Solomon, PhD,
Senior Faculty, EMDR Institute

Having provided EMDR trainings in over a dozen countries and across three continents… I have learned that being blind to the culture you are teaching and practicing in can limit the effectiveness of what I believe is the psychotherapy of the 21st century. This volume gives the reader both the opportunity to see EMDR Therapy’s cross cultural applicability, as well as develop the sensitivity and ability to adjust this great therapy to the specific culture of the client sitting in the room. Since different cultures exist in the present in our offices, not across the ocean, this book is a must read for today’s EMDR therapists.

—Udi Oren, PhD,
Past president, EMDR Europe Association

This is a book of great scope and lucidity that examines the importance of culture and the impact of societal forces on individual and familial well-being, factors that have been frequently ignored by the field of psychotherapy. This scholarly offering is a clarion call highlighting the importance of cultural competence and will become an important contribution to the literature of our field.

—Uri Bergmann, PhD,
Author of Neurobiological Foundations for EMDR Practice,
Past president, EMDR International Association

This book delves deeply into the dimensions of EMDR therapy as it is applied to the hot spots of cultural challenges and cross-cultural differences. The EMDR community has made significant contributions to the latest critical and massive events occurring in Europe by working with victims of terroristic attacks and with the refugees and asylum seekers. Interventions have facilitated integration and adjustment into new cultures. A wide range of chapters in the book highlight innovative ways in which the EMDR approach and protocols can guide us amidst cultural differences, making adaptations when needed without losing efficacy.

—Isabel Fernandez,
President EMDR Europe,
Past President EMDR Italy
Cultural Competence and Healing Culturally Based Trauma with EMDR Therapy
Mark Nickerson, LICSW, is a psychotherapist with over 30 years of experience. He practices as a trauma treatment specialist in Amherst, MA. Mr. Nickerson is a graduate of Wesleyan University and the University of Michigan School of Social Work. He is on the faculty of the EMDR Institute and the EMDR Trauma Recovery Humanitarian Assistance Program, for whom he provides basic and advanced EMDR training sessions. He is a past president of the EMDR International Association, where he has served on the Board for the past 5 years. Mr. Nickerson conducts EMDR and other training sessions nationally and internationally on topics including treatment for problem behaviors and problematic anger; cultural competence and treating culturally based trauma and prejudice; conflict resolution; serving the needs of veterans and their families, and the effective use of EMDR protocols.

Trained as a social worker, Mr. Nickerson has a long-standing commitment to integrating the psycho and the social in his clinical work and teachings, as well as a passion for breaking down the barriers that divide people. Mr. Nickerson cofounded the Men’s Resource Center of Western MA, a unique organization that developed violence intervention services and offered support and educational services for men. He is the Director of Parent Education for the Hampshire County Court’s Bar Association, where he has developed two national award winning innovative programs designed to reduce and resolve interpersonal conflict. Mr. Nickerson is author of The Wounds Within (2015: Skyhorse, woundswithin.com), an exposé on the challenges for war veterans and their families. He also provides training sessions with the Veterans Education Project (markinickerson.com).
Cultural Competence and Healing Culturally Based Trauma With EMDR Therapy

Innovative Strategies and Protocols

Mark Nickerson, LICSW
Editor
To the shared vision that human beings prefer to live in harmony,

To all those committed to making this possible,

And to the belief that

Our differences make life interesting, yet we are all one under the sun.
Contents

Contributors xi
Foreword Rosalie Thomas, PhD, RN xiii
Preface xv
Acknowledgments xvii
Introduction xix

SECTION I: COMPONENTS OF AN EMDR THERAPY APPROACH TO CULTURAL COMPETENCE 1

1: Cultural Competence and EMDR Therapy 3
   Mark Nickerson

2: Integrating Cultural Concepts and Terminology Into the AIP Model and EMDR Approach 15
   Mark Nickerson

3: Healing Culturally Based Trauma and Exploring Social Identities With EMDR Therapy 29
   Mark Nickerson

4: Dismantling Prejudice and Exploring Social Privilege With EMDR Therapy 53
   Mark Nickerson

SECTION II: STRATEGIES FOR MARGINALIZED CULTURES 77

5: An Integrative Approach to EMDR Therapy as an Antioppression Endeavor 79
   Rajani Venkatraman Levis and Laura Siniego

6: Placing Culture at the Heart of EMDR Therapy 97
   Rajani Venkatraman Levis

7: Culturally Attuned EMDR Therapy With an Immigrant Woman Suffering From Social Anxiety 113
   Barbara Lutz

8: The EMDR Approach Used as a Tool to Provide Psychological Help to Refugees and Asylum Seekers 129
   Paola Castelli Gattinara, Antonio Onofri, and Cristina Angelini

©Springer Publishing Company
SECTION III: INNOVATIVE PROTOCOLS  145

9:  Legacy Attuned EMDR Therapy: Toward a Coherent Narrative  147
    Natalie S. Robinson

10: EMDR in a Group Setting (GEMDR)  161
    André Maurício Monteiro

SECTION IV: ADDRESSING SEXUAL/AFFECTIONAL ORIENTATION AND GENDER DIVERSITY  175

11: EMDR Therapy as Affirmative Care for Transgender and Gender Nonconforming Clients  177
    Sand C. Chang

12: EMDR Therapy With Lesbian/Gay/Bisexual Clients  195
    John M. O’Brien

13: Sex Assignment, Gender Assignment, and Affectional Orientation: Applying Continua of Congruence to Dismantle Dichotomies  209
    Earl Grey

SECTION V: SPECIFIC CULTURES AND SOCIAL STIGMA  229

14: The Transgenerational Impact of Anti-Semitism  231
    Ruth Heber and Karen Alter-Reid

15: Left Out and Left Behind: EMDR and the Cultural Construction of Intellectual Disability  247
    Joseph C. Yaskin and Andrew J. Seubert

16: “People Like Me Don’t Get Mentally Ill”: Social Identity Theory, EMDR, and the Uniformed Services  261
    Liz Royle

17: EMDR Therapy and the Recovery Community: Relational Imperatives in Treating Addiction  279
    Jamie Marich

18: EMDR With Issues of Appearance, Aging, and Class  295
    Robin Shapiro

SECTION VI: GLOBAL FRONTIERS OF EMDR INTERVENTION  303

19: Learning EMDR in Uganda: An Experiment in Cross-Cultural Collaboration  305
    Rosemary Masters, Elizabeth McConnell, and Josie Juhasz

20: Teaching and Learning EMDR in Diverse Countries and Cultures: When to Start, What to Do, When to Leave  323
    John Hartung

Index  341
Contributors

Karen Alter-Reid, PhD  Clinical Practice, HAP Trainer, Co-Director, Integrative Trauma Program, National Institute for the Psychotherapies, New York, New York

Cristina Angelini, MA  Clinical Practice, Gender-Based-Violence Expert, Child Specialist, Rome, Italy

Sand C. Chang, PhD  Clinical Practice, Kaiser Permanente and Independent Practice, Oakland, California

Paola Castelli Gattinara, MA  Cognitive Psychotherapy, Clinical Practice, MA EMDR Supervisor, Unit of Trauma Treatment of De Sanctis Clinical Centre, Rome, Italy

Earl Grey, PhD  Clinical Practice, Consultant, Director of Field Experience, School of Counseling, Walden University, New York, New York

John Hartung, PsyD  Clinical Practice, EMDR Trainer, Consultant, Director, Colorado Center for Alternative Psychology, Colorado Springs, Colorado

Ruth Heber, PhD  Clinical Practice, Assistant Clinical Professor, Psychiatry, Mount Sinai School of Medicine, Supervisor, Integrative Trauma Program, National Institute for the Psychotherapies, New York, New York

Josie Juhasz, MA, LPC  Clinical Practice, Institute and TR/HAP Facilitator, RTEP/G-TEP Trainer, Bend, Oregon

Rajani Venkatraman Levis, MS, CTS, LMFT  Clinical Practice, San Francisco State University, San Francisco, California

Barbara Lutz, PhD, MFT  Clinical Practice, Adjunct Faculty, The Chicago School of Professional Psychology, Chicago, Illinois; Adjunct Faculty, Hartnell College, Salinas, California

Jamie Marich, PhD, LPCC-S, LICDC-CS  Clinical Practice, Director & Lead Trainer, The Institute for Creative Mindfulness, Warren, Ohio

Rosemary Masters, JD, LCSW  Clinical Practice, Consultant, Founding Director, Trauma Studies Center of the Institute for Contemporary Psychotherapy, New York, New York

André Maurício Monteiro, PhD, MSc  Clinical Practice, EMDR Trainer, Consultant, Brasília (DF), Brazil
Elizabeth McConnell, MSW, LCSW  Clinical Practice, Pittsburgh, Pennsylvania

Mark Nickerson, LICSW  Clinical Practice, EMDR Institute/HAP Basic Trainer, Advanced EMDR Trainer, Consultant, Amherst, Massachusetts

John M. O’Brien, PhD  Clinical Practice, Consultant, Portland, Maine; Adjunct Faculty, University of Maine at Augusta, Augusta, Maine

Antonio Onofri, MD  Psychiatrist, Emergency Psychiatric Care Unit, Santo Spirito Hospital, Cognitive Behavioral Psychotherapist, Unit for the Treatment of Trauma, Centro Clinico de Sanctis, Rome, Italy

Natalie S. Robinson, LICSW  Clinical Practice, Consultant, Boston, Massachusetts

Liz Royle, PhD, MA  Clinical Practice, Consultant, Bolton, United Kingdom

Andrew J. Seubert, LMHC, NCC  Clinical Practice, Consultant, Seneca Lake, New York


Laura Siniego, MA, MFT  Clinical Practice, Daly City, California

Joseph C. Yaskin, MSS, LCSW  Clinical Practice, Bala Cynwyd, Pennsylvania
Foreword

When Mark Nickerson told me he was planning a book about EMDR therapy and cultural competence, I was thrilled. These are both topics that are near and dear to my heart. EMDR therapy, of course, because we know it is an effective and efficient therapy that can be used to resolve trauma and disturbing life events. EMDR therapy has provided impactful interventions around the globe following natural and human created disasters. EMDR therapy is well grounded in neurophysiology, so it works with our human brains and our adaptive information processing system to facilitate healing, regardless of the language or local customs. With little modification, it is effective across cultures. At the same time, it can be used to address past events, current circumstances and inaccurate beliefs that create and maintain divisions between cultures and social groups.

Identification with a culture or a social group can bring many strengths and resources to individuals. It can make us feel connected to each other and to our communities. We also know that many of these cultural or group identities can be divisive and can be a painful source of trials and hardships. EMDR therapy provides a unique approach that is particularly well-suited to exploring the impact of culture and/or social groups on the individual. We, as EMDR therapy clinicians, can help to break down the barriers that divide people from one another, ranging from someone stuck in anger, to someone hurting from exclusion, or those social barriers impacted by prejudice.

And why is cultural competence important to me? I’ve learned that being or feeling different, no matter how seemingly small or insignificant can have a big impact on the individual. My father’s family was tribal, both in heritage and lifestyle; my mother’s family was northern European. As a child, I didn’t understand the tension that existed because of these unaddressed differences, nor did I appreciate the impact that growing up in two worlds would have on me both personally and professionally. As an adult, I can appreciate the strengths that each perspective brings, as well as the challenges of trying to “fit in.” As a psychologist, I’ve been drawn to teach cross-cultural communications at the college level, to work with students and clients from a variety of backgrounds and cultures, and to appreciate the richness that comes from exploring the beliefs, values and customs of others. Through volunteer work with EMDR humanitarian programs and associations around the world, I’ve been challenged to better understand the strengths and limitations that individuals embrace from their cultural and social upbringing. I’ve also learned to listen for the challenges that a decreased sense of safety and self-worth, marginalization, or discrimination can bring.
As therapists, cultural awareness and cultural competence are particularly important topics today. An appreciation for the impact of culture has been embraced by the fields of social psychology and social work, but has not been well developed in areas of psychology or individual therapy. I'm reminded of earlier times when individual therapy was offered without any awareness or attention to the family. Eventually, the field recognized the need to develop a family and systems perspective. From that vantage point, clinicians began to appreciate the impact of attachment experiences on individual development and relationship skills. Today, no competent therapist would consider providing comprehensive therapy without asking about attachment experiences or assessing attachment patterns and consequences. To extend that contextual and dynamic model, an attempt to understand the cultural framework and the impact of those experiences on individual and social identity is not only logical, but the essential next step. Whether our social experiences and identity are resources of strength and resilience, or sources of pain, marginalization, or discrimination in all its damaging forms, they impact our individual health and the health of our communities and the world in which we live. Mental health practitioners have an opportunity and an obligation to develop cultural competence in addressing these concerns, and in helping to break down the barriers that they create. Again, EMDR therapy is an ideal approach. From our various disciplines, we can create a dialogue around cultural competence that will help to integrate the fields of social psychology, social work and psychotherapy. We can help to unite an effort towards cultural competency that not only guides our EMDR treatment, but also creates a common goal among members of the mental health field.

Mark Nickerson brings awareness, expertise, passion, and his own cultural humility to this groundbreaking work. Not only does he challenge EMDR therapy clinicians with a clear imperative to develop cultural competence, he also provides a thoughtful model to guide us. Cultural Competence and Healing Culturally Based Trauma with EMDR Therapy brings together a cogent model of competence that is familiar to many EMDR therapy clinicians. Mark draws from concepts used to assess general clinical competency and applies the domains of attitude, skills, and knowledge as a method to define EMDR clinical skills in the social and cultural arena. The contributing authors bring their own cultural sensitivity and expertise as EMDR therapy clinicians working with individuals and communities that have faced many challenges. Their wisdom and insight in the use of EMDR therapy to address the impact of social identity is invaluable. The reader will find much to assist in the development of cultural awareness and competence in general, and the application of the adaptive information processing model and specific EMDR therapy protocols in particular. Whether working with distinctly different cultures, or exploring the nuances and implications of exclusion or marginalization from the dominant culture or social group, this book gives the EMDR therapy clinician a useful model and specific, practical suggestions for the use of EMDR therapy to heal cultural wounds.

I hope you read it, and I hope you enjoy it as much as I have.

Rosalie Thomas, PhD, RN
Facilitator, EMDR Global Alliance
Board Member, EMDR Research Foundation
Past President, EMDRIA
Preface

The field of psychotherapy has frequently overlooked or minimized the importance of culture and the impact of societal forces on an individual’s well-being. Culturally aware eye movement desensitization and reprocessing (EMDR) therapy provides a powerful alternative to this omission. From conceptual to practical, this book explores the interface of culture and EMDR therapy.

Cultural experiences and societal dynamics, for better and for worse, are fundamental dimensions of every human being’s life and should be integrated into a general clinical approach. For many people, personal identity is intertwined with social identity and the welfare of one’s cultural groups. Culturally linked experiences and values can be sources of great meaning and sustaining personal resources. At the same time, hostile social forces of discrimination, stigmatization, and oppression can define or confine an individual’s sense of self and position in society. Whether explicit or more implicit, the many “isms” that persist in the world can limit human potential and threaten fundamental human dignity.

The movement for cultural competence is gaining greater recognition and momentum within the field of mental health. Service providers are increasingly aware of the need to keep step with an evolving multicultural world and to reverse the injustices that are perpetuated when cultural populations are marginalized and mistreated. As “culture-blind” psychotherapy models become obsolete, new approaches for culturally aware and effective intervention must be developed.

This book launches EMDR therapy both explicitly and dynamically into the broader movement for cultural competence. As EMDR therapy gains ever-broadening acceptance and stature throughout the world, it is only fitting that it aspires to excellence in this dimension. Indeed, EMDR therapy has the capacity to be a model of cultural competence for several reasons: EMDR interventions have already demonstrated effectiveness across a wide range of cultural contexts; EMDR humanitarian and membership organizations have reached out to serve culturally marginalized or underresourced populations throughout the world; the EMDR therapy model invites cultural awareness and attunement; and EMDR therapy’s top-level evidence-based effectiveness in trauma treatment can be readily directed toward healing the impact of culturally based trauma including the effects of social discrimination and oppression.

And yet, each individual practitioner must make a deliberate and informed commitment to embrace cultural competence. This book offers EMDR clinicians information and guidance to move cultural competence from the abstract realm of an ideal to the applied methods of the real. Though the desire for cultural competence is an aspiration that is never fully achieved, its pursuit is inherently rewarding and
This book is written for EMDR therapists, EMDR leaders and supporting organizations, and others who want to understand and develop what EMDR therapy can offer as a culturally competent intervention. In a wide array of chapters, over 20 authors share their wisdom and bring their expertise to life with clinical examples. Suggestions are offered for weaving the cultural dimension into all phases of treatment, starting with a careful assessment. Information from allied fields of social psychology and social work are integrated into the adaptive information processing (AIP) model to provide a more nuanced understanding of innately human social tendencies toward inclusion and exclusion, including the neurology of social categorization. This knowledge helps EMDR clinicians transform maladaptive memories to more adaptive ones by informing protocols to undo internalized oppression and dismantle social prejudice. Readers will come away with new theoretical frameworks, useful language and terminology, in-depth knowledge about specific cultural populations, and practical intervention protocols and strategies.

In the end, clients will benefit the most from this book when the societal context of their lives, both external and internal, is more fully understood and welcomed in their psychotherapy work.
Acknowledgments

I want to acknowledge the ongoing encouragement, support, and ideas that I have received from countless people along the path that has led to this book.

It is a privilege to showcase the work of each author in this collection. Their writings reveal a deep commitment to their work, the wisdom they have gained, and their innovative nature. When I first envisioned this book, I set out to try to cover this topic comprehensively by myself. What a breakthrough it was when I realized that a collection of voices could never be more fitting than for a book about culture and diversity, and what a relief when people stepped up to contribute. Their ideas helped me formulate my own.

I am grateful to Robin Shapiro, whose two *EMDR Solutions* books are models for the value of EMDR-themed books with multiple authored chapters. Hers and other such collections within the EMDR therapy literature offer a range of perspectives, are entry points for new ideas and emerging contributors, and build our EMDR community. I also appreciate Robin for being one of the first to write about treating culturally based trauma in EMDR therapy.

I thank Jane Porter, an EMDR clinician in my region, and others like her who heartily joined and contributed to my first EMDR study groups examining culture. Other close allies of mine who have advanced cultural consciousness within the EMDR community include fellow EMDRIA Board members Diane Desplantes, who has been a teacher to me as well, and Jim Cole, who had the nerve to train agencies in prejudice reduction. Also, I thank the many other kindred spirits in this work, including a dozen Jim Helling, Farns Lobenstine, David Eliscu, and Joany Spierings.

I am grateful to Francine Shapiro, not just for the obvious reason as the originator and developer of EMDR therapy, but for the 15-minute hotel lobby conversation 12 years ago, during which she encouraged me to integrate my cultural interests into the EMDR therapy model, and for her support since that time.

I want to thank Geneva Schmitt, who contributed both passion and objectivity to this project. She assisted me in providing editorial feedback to the authors, which they welcomed and appreciated. Ann della Bitta provided many valuable organizational suggestions. Finally, I thank Sheri W. Sussman from Springer Publishing Company, who sensed the time was right to make this book happen.
Introduction

In 2007, I organized a study group designed to help EMDR clinicians explore the traumatizing effects of social discrimination and to integrate this awareness more fully into EMDR theory and practice. Several local clinicians joined in this multi-year experience. All of us had prior interests in this area, and we worked as allies to expand our thinking and “test drive” these ideas on ourselves and with our clients.

Prior to the group, my training as a professional social worker taught me the importance of social forces, both positive and negative. Yet, as I became a psychotherapist, I was disappointed to see how little attention was paid to the cultural component in advanced clinical trainings, writing, and discussion.

Many years ago, a wise mentor referenced the feminist movement and pointed out that as a clinician you have a choice. You can work with a woman who is in a confining sexist marriage and treat “her problems” of depression and “low self-esteem” to try to get her spirits up. Or, you can help her see herself in a social context with many other women who have been systematically “kept in their place” by cultural messages. Shifting the framework moves the problem from the person to the social context. It opens doors to a new range of problem solving.

As trauma-informed EMDR therapists, we have tools to liberate our clients from the restrictive effects of socially experienced dehumanization. As Robin Shapiro (2009) noted, EMDR therapy “can root out destructive cultural or generational introjects. . . . EMDR can target the cultural transmission of racism, sexism, class expectations, and the increasingly narrow parameters of acceptable appearance, interests and personality. It can also transform the effects of the generational transmission of destructive beliefs, identities and emotional states. . . . We can help people accept themselves even when they are bombarded with external messages that they are unacceptable.”

The teachings of Francine Shapiro, originator and developer of EMDR therapy, convey great compassion for victims of trauma while bringing a theory and set of procedures that can be attuned to individual cultural context, help people recover from their adverse and traumatic experiences, and restore each person to their resilient potential.

In 2009 to 2010, I conducted a series of workshops titled Undoing Stigma: EMDR Applications in the Dismantling of Socially Based Internalized Oppression and Prejudice. Over 60 EMDR clinicians explored these issues in practicum sessions and agreed to keep detailed notes of their experiences. Frankly, the results of their reprocessing experiences were more impressive than I had anticipated and helped me further develop my thinking.
Along the way, I have learned how deeply committed many EMDR clinicians are to matters of social justice and diversity and how curious they are to explore ways EMDR therapy can help. The EMDR International Association (EMDRIA) special interest group on diversity and public practice has generated important contributions and created a bond among likeminded thinkers. David Eliscu (Eliscu et al., 2010, 2011) took initiative and organized two panel discussions of EMDR clinicians that offered valuable insight and guidance at EMDRIA conferences.

A major goal of this book is to explicitly move EMDR therapy into the discussion of cultural competence that is emerging within the field of mental health. In fact, I believe we can be a beacon of light within this realm. While there is ample evidence of cross-cultural effectiveness with EMDR treatment, relatively little has been written about the impact of culturally based trauma. I hope that this book helps build a body of knowledge that will more deeply embed cultural awareness into EMDR therapy and inspire more exploration, writing, and research.

Most immediately, the book will be a success if the many ideas offered throughout these chapters are put into use with your clients and create good results.

This book explores the interface of culture and EMDR therapy with a collection of chapters that cover a range of subjects and offer a variety of approaches. The book addresses the big conceptual issues as well as specific insights, strategies, and protocols that are brought to life with clinical examples. Please know that all clinical examples have been disguised to protect the identity of the client while maintaining the clinical truth of the points that are demonstrated.

This book is presented with the assumption that readers are EMDR trained and have a basic understanding of the core elements of EMDR therapy. So that attention could be focused on the integration of cultural issues, references are frequently made with limited explanation to the Adaptive Information Processing Model, the Eight-Phase approach of EMDR therapy, the Three Prong Protocol, Resourcing, and additional protocols and strategies that are frequently discussed in EMDR literature. Please make use of other EMDR texts as needed to further understand these fundamental EMDR concepts.

Finding common language about culture is both a challenge and a goal of this book. Efforts were made to use language that is current with updated perspectives, understandable, and acceptable to social groups being named. But getting it “just right” is impossible, so please be tolerant of some variations in language and terminology throughout the chapters. For example, becoming more familiar and fluid with pronouns that support gender diversity is a current linguistic challenge. In some cases, editorial decisions were made. For example, when discussing race and ethnicity, the term Black is used rather than African American, as it is more inclusive of people of African descent who do not identify as Americans.

In Section I of the book, I offer a collection of chapters with very different purposes. In Chapter 1, I define and explore the increasingly discussed concept of cultural competence and offer suggestions for how EMDR therapists and organizations can engage with and ultimately help lead this important trend. In Chapter 2, I integrate valuable terminology and knowledge from the fields of social psychology and social work to enrich the AIP model. I introduce information about how the brain processes social information and discuss the need for healing culturally based trauma and social prejudice. Chapter 3 focuses on clinical conceptualization and EMDR intervention strategies for treating culturally based trauma and exploring
social identities. In Chapter 4, I present an EMDR protocol for treating social prejudice, discuss social privilege, and offer a protocol to target issues related to social advantages and disadvantages.

In Section II, Chapter 5, Rajani Venkatraman Levis and Laura Siniego write explicitly about integrating “the sociocultural, political, and legal realities that permeate” many clients’ lives, and demonstrate uses of EMDR therapy as an “antioppression endeavor.” In Chapter 6, Levis illuminates multiple categories of “cultural wealth” and guides clinicians to help clients develop these qualities to bring culture to “the heart” of EMDR work. Barbara Lutz writes in elegant detail about her culturally aware EMDR therapy with a recent immigrant in Chapter 7. Her writing reveals how she uses self-reflection about her own cultural background to strengthen the therapy. In a particularly current global issue, Paola Castelli Gattinara, Antonio Onofri, and Cristina Angelini offer a window into their work with refugees and asylum seekers in Chapter 8. Their adaptations of the EMDR approach to meet the most pressing needs of their clients are instructive.

Section III explores two specific innovative protocols. In Chapter 9, Natalie Robinson outlines several straightforward methods to integrate EMDR work into the context of a client’s cultural ancestry, and conveys the potency of these methods. In Chapter 10, Andre Monteiro shares procedures for providing EMDR reprocessing experiences within the context of ongoing group-based therapy. He makes a compelling case for the added meaning that comes with reprocessing with group support.

Three chapters in Section IV explore different dimensions of identity as it relates to LGBTQQ (lesbian, gay, bisexual, transgender, queer, and questioning) issues. In combination, they dispel myths and misinformation, and help break down dichotomous either/or thinking. In Chapter 11, Sand Chang offers valuable information about affirmative care for transgender and gender nonconforming clients, and offers sage guidance for clinicians. John O’Brien talks about the realities, needs, and struggles for gay men and lesbians in Chapter 12. Earl Grey provides a fascinating protocol for helping a client assess his or her sex, gender, and affectional orientation along continua of characteristics in Chapter 13.

Section V includes several chapters that offer knowledge and insight into the experiences and needs associated with specific cultures, including the stigma they may battle, and provide specific recommendations for how the EMDR therapist can attune and help mold the EMDR approach to these groups. In Chapter 14, Ruth Heber and Karen Alter-Reid offer moving insight into the transgenerational impact of antisemitism and convey lessons that can be applied to treat the legacy of inherited trauma for other cultures, especially where oppression or genocide have been components. In Chapter 15, Joseph Yaskin and Andrew Seubert provide their long-standing expertise in working with intellectual disabilities, and speak of the power of EMDR therapy as an approach to overcoming socially dismissive attitudes.

In Chapter 16, Liz Royle presents her work with uniformed service workers in the United Kingdom, who must overcome mental health stigma to receive EMDR treatment. Addictions expert Jaime Marich portrays the profound value of the recovery community in Chapter 17, and offers ways that EMDR therapists can attune their treatment for clients in 12-step programs. In Chapter 18, Robin Shapiro offers clever strategies for helping clients undo the effects of culturally imposed social messages relative to physical appearance, aging, and social class.
Finally, Section VI includes accounts of efforts to bring EMDR to regions of the world with limited mental health services. In Chapter 19, Rosemary Masters, Elizabeth McConnell, and Josie Juhasz write about their important work in Uganda. With an attitude of cultural humility, they portray not only what they taught, but what they learned from those they met. In Chapter 20, John Hartung offers great wisdom from his extensive EMDR training around the globe. His deeply respectful approach explores the central questions of “When to Start, What to Do, and When to Leave,” and provides fascinating and useful guidance for those fortunate enough to help bring EMDR to underdeveloped regions of the world, and for others who want to understand and support this pioneering activity.

REFERENCES

Developing cultural competence as a professional is a journey, not a destination. The quest for cultural competence is an ongoing pursuit and viewing it that way is the first step. Applying a culturally aware framework can reshape how clinicians understand and approach their interventions. This chapter explores the concept of cultural competence as it is being developed within the field of human services delivery, and integrates these ideas and best practices into eye movement desensitization and reprocessing (EMDR) therapy.

A purpose of this book is to advance the conversation about cultural competence among EMDR clinicians, to add new concepts and tools to the discussion, and to inspire continued attention and innovation. A second purpose is to advance EMDR therapy recognition for cultural competence in the broader field of mental health.

As EMDR therapy gains ever-broadening acceptance and stature throughout the world, I believe that it is important that those committed to its continued advancement explicitly engage in the movement to define and aspire to cultural competence, both for the benefit of EMDR therapy and for the contribution that it can make in this dimension to the field of mental health. EMDR therapy is well-positioned to become a model for culturally aware and effective trauma-informed intervention. Currently, I believe that there are three distinct ways in which EMDR intervention demonstrates cultural competence:

1. A guiding theory, fundamental mechanisms of action, and other procedures that have demonstrated effectiveness and adaptability across a wide range of cultural contexts
2. A clinical model that supports cultural attunement and a growing body of knowledge specific to different client cultural populations
3. The capacity to successfully treat the effects of culturally based trauma

EMDR therapy has been approved as a top-level, evidence-based treatment for trauma by many organizations and associations including the World Health Organization (2013) and the American Psychiatric Association (Ursano et. al., 2004). EMDR therapy has been implemented throughout the world as chronicled by increasing reports validating its effectiveness as a culturally adaptable treatment. Additionally, EMDR humanitarian and membership organizations are reaching
out, sometimes through voluntary efforts, to serve culturally marginalized or underresourced populations throughout the world.

As individual EMDR therapists, striving for cultural effectiveness in our day-to-day clinical work is naturally aligned with our overall goals to best serve our clients. It behooves us to deliberately commit to an ongoing process of understanding and maintaining a culturally conscious approach. Indeed, as a collection of therapists, we have a solid base to build upon as individual EMDR clinicians are increasingly integrating their culturally aware insight and skills to improve their EMDR therapy work, as evidenced in the content of this book. The Francine Shapiro Library contains numerous citations to presentations and articles that reference a cultural component (emdria.omeka.net), although it is beyond the scope of this chapter to provide a literature review.

THE NEED FOR A CULTURALLY-AWARE APPROACH

Cultural experiences, positive and negative, are fundamental dimensions of every human being’s life. Well-being is intertwined with social relationships and the well-being of one’s cultural groups. For many people, cultural values and affiliations are powerful and sustaining components of their lives. As EMDR therapists, these are resources we can help our clients develop. At the same time, as trauma therapists, we must be aware that many of our clients have grown up under oppressive conditions and have experienced significant social stigmatization and discrimination. Hostile social forces of disregard, intolerance, exclusion, and worse have been directed at many clients simply because of the way they look and talk, their social position, and the families they come from, or who they love.

To maximize our effectiveness as clinicians, we need to embrace our clients’ full experiences including the role of cultural issues. While this seems like common sense, as psychotherapists we must understand that we operate in a broader “psychotherapist” culture that has been criticized for operating with a culture-blind approach that too often tries to separate “cultural” issues from “personal” issues.

Despite the fact that most psychotherapists have egalitarian values and are aware of the importance of cultural forces on a societal level, psychotherapy practice, including trauma-informed psychotherapy, has historically ignored or minimized the cultural context. Critics have described the Western psychotherapy model as being heavily influenced by a medical model that includes the preeminence of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) for diagnosis (which locates the problem within the individual and largely ignores etiology), the use of the DSM to determine “medical necessity” for insurance coverage, a focus on pharmacological interventions, the coopting of social workers toward an individual psychotherapy model rewarded with higher pay and higher status, and the established dominance of individually oriented treatment paradigms.

In a sobering caution about the risks of a “culture-blind” approach, Ridley (2005) cites over 80 studies showing that psychotherapists engage in discrimination during their clinical practice. In his review of research on this topic, he discovered that the following clinical decision points were influenced by prejudicial stereotypes: diagnoses, prognoses, referrals, treatment planning, selection of interventions, frequency of treatment, termination, medical therapy, reporting abuse or neglect, duty
to warn, involuntary commitment, deciding the importance of case history data, and interpreting test data. Ridley suggested other clinical behaviors might also be impacted, such as seeking consultation, developing empathy, expressing support, advocating for the client, and identifying with a client’s issues.

This culture-blind tendency to sidestep explicit attention to cultural issues may exist, in part, because therapists don’t know how to productively integrate culture within the psychotherapy model. Overcoming this obstacle will be explored throughout this book. Despite the potential for inherent bias within clinical mental health practice, a more culturally competent one-on-one psychotherapy model can create conditions for recovery and growth for individual clients.

DEFINING CULTURAL COMPETENCE

One of the most fundamental challenges to advancing the discussion about cultural competence in the field is simply defining the concept. The term cultural competence was established in the 1980s as part of a broad examination of the field of health and human services and their systems of care (Cross, Bazron, Dennis, & Isaacs, 1989). Since then, it has gained broader acceptance among individuals and organizations who seek to provide services that are culturally sensitive to a wide range of people.

In the original definition, culture is referred to as “an integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group” (Cross et al., 1989). This broader meaning of culture, which includes a range of socially salient groups in a person’s life, is an important dimension. In fact, within the literature, the terms cultural identity and social identity are often used interchangeably to connote a person’s identification with a larger group.

Competence is defined as “the capacity to function effectively” (Cross et al., 1989). A continuum of competence is depicted from one extreme to the other, which includes cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, cultural competence, and cultural proficiency. Although others have added to the growing body of knowledge, definitions, and practice suggestions, the core definition has remained stable and will provide the foundation for the concepts covered in this book.

Since the concept was established, many organizations have aspired toward cultural competence (Denboba, MCHB, 1993; Lavizzo-Mourey & Mackenzie, 1996; National Alliance for Hispanic Health, 2001; U.S. Department of Health and Human Services, & Administration on Developmental Disabilities, 2000; U.S. Department of Health and Human Services, & Substance Abuse and Mental Health Services Administration, 2004). From an organizational perspective, Betancourt, Green, and Carrillo (2002) proposed that cultural competence within broader systems of care should have the capacity to (a) value diversity, (b) conduct self-assessment, (c) manage the dynamics of difference, (d) acquire and institutionalize cultural knowledge, and (e) adapt to diversity and the cultural contexts of communities they serve.

Pedersen (2002) identified three components of clinical competence: (a) awareness/attitude, (b) knowledge, and (c) skills. Awareness was characterized as both an awareness of other cultures and an active effort by practitioners to assess
their own beliefs and values toward culture in general and different cultures in particular. This combination of external awareness and internal reflection has been echoed consistently by others as a core component of competence. Kaslow et al. (2004), for example, states that competence should include the capacity to evaluate and adjust one’s decisions through reflective practice.

Related to this need for internal reflection, Tervalon and Murray-Garcia (1998) introduced the concept of cultural humility as an important mindset or stance from which to approach cultural issues. They proposed that three factors are fundamental for cultural humility: (a) a commitment to self-evaluation that includes qualities of humility, (b) a desire to fix unjust power imbalances, and (c) aspiring to develop partnerships with people and groups who advocate for others. They point out that the commitment to self-reflect should be lifelong and can build the capacity to respond flexibly with newly acquired knowledge. Yet, they warn that any insights are of limited value if not implemented in culturally informed clinical approaches that convey an understanding of a client’s cultural experience, especially those who have endured social injustice. They emphasize that a commitment to diversity and undoing social injustices should be a collaborative effort with like-minded advocates for societal change.

Waters and Asbill (2013) have added that the term cultural humility is an attitude of openness from which one seeks to explore one’s own cultural perspectives and biases. Cultural humility generates a natural curiosity that motivates one to learn and expand understanding. Cultural humility entails suspending one’s own culture-centric views when entering the world of a client. Hook, Davis, Owen, Worthington, and Utsey (2013) describe cultural humility as the “ability to maintain an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to the [person].”

Other recommendations for cultural competence have been proposed. Goodman et al. (2004) suggested that counselors should act as “agents of change” and identified several competencies for a social justice approach to multicultural counseling, including (a) ongoing self-examination and self-awareness, (b) sharing power, (c) giving voice, (d) facilitating consciousness raising, (e) building on strengths, and (f) offering clients tools for creating social change. Gallardo, Yeh, Trimble, and Parham (2011) proposed six concrete stages of multicultural counseling: (a) connecting with clients, (b) conducting a culturally relevant assessment, (c) facilitating awareness, (d) setting goals, (e) taking action and instigating change, and (f) welcoming feedback and maintaining accountability.

Many of the professional organizations that represent the different mental health disciplines have made efforts to define and support cultural competence. Generally, these efforts fall into two categories: supporting diversity of membership and offering culturally attuned and effective services.

The National Association of Social Workers (NASW) highlights two major cultural forces requiring ongoing attention: the civil rights movement launched in the 1950s, including any disadvantaged and oppressed populations; and the increasing number of new immigrants to this country. An NASW statement acknowledges that “both helping professionals and society at large have a long way to go to gain cultural competence” while taking some pride in “social workers . . . longstanding history of understanding both people’s differences and the impact of social injustices on their well-being” (NASW, 2011). NASW Standards for Cultural
Competition and Social Diversity emphasize three dimensions for social workers: understanding culture and recognizing cultural strengths; having knowledge of specific clients’ cultures; and obtaining education to better understand social diversity and oppression.

The American Psychological Association Task Force on Inclusion and Diversity is developing a definition and standards for cultural competence and seeking to develop diversity among its membership. Their challenge has been described as “a complicated matter of defining diversity, attracting and engaging diverse members, sharing the power and accepting that the future will hold a very different climate of racial demographics” (American Psychological Association, 2011). The American Psychiatric Association has emphasized the need to assess and correct disparities in the delivery of mental health services related to cultural factors and to reduce stigma for those seeking care (psychiatry.org).

The International Society for Traumatic Stress Studies has established a diversity and cultural competence special interest group (SIG). The SIG has raised awareness of cultural factors and noted that “these factors mediate, moderate and in many cases, even determine traumatic exposure and post-traumatic response, such as through exposures to hate crimes, general community violence, forced internment, enslavement and other trauma or via contributing factors occurring within societies hostile to particular groups, such as social attitudes and actions contributing to a hostile environment” (International Society for Traumatic Stress Studies, 2016). The SIG also notes that “demographic characteristics may also be proxies for or directly counterbalance the effects of trauma through culturally-specific strengths and resilience factors” (International Society for Traumatic Stress Studies, Diversity and Cultural Competence SIG. Copyright ©2016 ISTSS. All rights reserved).

EMDR AS A CULTURALLY COMPETENT THERAPY: EMBRACING THE CHALLENGE

The Movement for Core Competencies

Having reviewed these and other efforts within the field of human services to define and implement cultural competence, my primary interest is in how these concepts can be effectively integrated into the application of EMDR therapy. Toward this goal, I believe it is wise to integrate another growing direction within the field of mental health, the establishment of general core competencies of clinical practice. This trend toward defining core competencies is a response to greater expectations for treatment outcome accountability. Generally speaking, these efforts tend to define competencies that are either evidence based as substantiated by research or are components that are generally considered to be essential for “best practices.”

The EMDR International Association (EMDRIA) is currently in the process of defining and developing clarity about core competencies for EMDR therapy. The purpose of this initiative is to articulate the components of effective EMDR practice for the benefit of practitioners and to assist trainers and consultants in their roles. As part of this process, the EMDRIA Standards and Training Committee conducted
a thorough survey of core competency models and selected a framework espoused by Len Sperry as the best tool available.

In *Core Competencies in Counseling and Psychotherapy* (2011), Sperry offers a comprehensive model for defining and developing core competencies. Sperry proposes six areas of clinical core competencies: (a) conceptual foundations, (b) therapeutic relationship, (c) intervention planning, (d) intervention implementation, (e) intervention evaluation and treatment, and (f) cultural and ethical sensitivity. Within each competency, the model calls for an articulation of the three dimensions necessary for effective clinical treatment: (a) knowledge, (b) skills, and (c) attitudes. These three dimensions echo the growing consensus of components for cultural competence within the field as previously cited.

As I seek to integrate the trend toward general clinical core competence with the specific momentum toward cultural competence, I believe that the Sperry model is a sensible choice through which to develop an articulation of cultural competence. The one twist I prefer is to list the three components in the order of (a) attitude, (b) skills, and (c) knowledge. This allows the use of the acronym ASK, which is not only easy to remember but also suggests an attitude of curiosity and humility that is a fundamental component to cultural effectiveness. As these components are interrelated and not linear, there is no reason the order cannot be changed.

**Applying the ASK Model to EMDR Therapy**

The ASK model provides EMDR clinicians and organizations a tool through which to outline and develop a vision of core competence. The following is an example of the use of the ASK model for this purpose. In it, I have included some of the concepts that already exist in the core competency movement and integrated them with some of the core dimensions of EMDR therapy, with a few specific examples. This is not intended to be comprehensive. Hopefully, future collaborative work among EMDR practitioners will refine these concepts and delineate more details.

**Attitude**

For the EMDR practitioner, a culturally competent clinical *attitude* is a state of mind that inherently understands and respects the role of culture in our society and in individual clients’ lives. This attitude embraces a multicultural perspective that values diversity along many dimensions. An attitude of cultural awareness begins with a capacity to understand and appreciate one’s own cultural background, which may necessitate creating opportunities for personal reflection to become aware of the strengths and difficulties that are associated with one’s own cultural experiences. When therapists do their own “personal work” to explore culture, they are more able to appreciate this dimension in their clients. From a base of personal awareness of culture, cultural competence requires a capacity for humility whereby the clinician understands the limitations of understanding that come with one’s own cultural perspective. Humility reduces assumptions about others and replaces it with an active curiosity to learn about cultural differences and show sensitivity to cultural needs.

An attitude of cultural curiosity seeks knowledge about a client’s cultural values, experiences, needs, and general ways of being. This knowledge can be acquired...
from the client, although the therapist should actively seek out information from other sources as needed. A culturally competent attitude should go beyond merely understanding the client’s experience and should be demonstrated by a commitment to active responsiveness to cultural needs.

Skills

Culturally competent clinical skills are the clinical steps used by the clinician. They are developed with a culturally aware attitude and guided by learned cultural knowledge. EMDR clinicians begin with the impressive standard EMDR treatment skills that have demonstrated a high level of cross-cultural effectiveness. EMDR therapy encourages the customized adaptation of Phases 1 and 2 (Shapiro, 2001) to meet client needs, including the client’s culturally related needs. Skills to attune other standard EMDR procedures for cultural effectiveness include building culturally sensitive therapeutic alliances as well as implementing culturally aware assessments, case formulations, and treatment plans. EMDR clinicians can employ culturally informed modifications to other aspects of the eight-phase approach as long as these modifications remain consistent with the adaptive information processing model (AIP) (Shapiro, 2001) and accomplish the primary goals of those phases.

There are many other additional specific skills that can be devised for cross-cultural effectiveness. For example, where language is a barrier, using fewer words and being sure to use culturally understandable metaphors is important. Other skills include conveying respect in culturally valued ways, sharing power by collaborating with the clients actively during the EMDR therapy process, being prepared to discuss cultural issues, allowing time for trust to develop, being able to self-disclose when appropriate, and conveying empathy for discrimination perpetrated upon the client’s culture and allying with needs for change.

Knowledge

Culturally competent knowledge refers to having an understanding of the importance of culture in general as well as an understanding about specific cultural realities of any particular client. A culturally curious attitude acquires knowledge as a natural and enjoyable part of attunement to the client’s cultural world. Knowledge can be gained from many sources. Knowledge about specific cultures includes the norms, values, beliefs, and needs of the culture. Even with general knowledge about a specific culture, it is important to not make assumptions that any one client fits a “cultural profile.” The clinician should assess the degree to which a client is attuned with these cultural ways, varies from them, or is in conflict with them.

Showing an awareness of cultural knowledge (a skill) can build trust. Some more specific examples of cultural knowledge include important aspects of communication such as forms of greeting and saying goodbye, the use and meaning of gestures, the meaning of eye contact, and norms for self-disclosure.

It is important to understand how the very process of engaging in EMDR therapy is viewed within a client’s cultural identities. There may be support for it or stigma against it. Relatedly, the therapist should try to understand how the issues central to therapy would be viewed within the client’s culture as well as within his or her family.
Again, this is only a partial formulation of content to demonstrate the use of the ASK model as a tool. It is my hope that as EMDR clinicians espouse and sustain a commitment to cultural awareness there will be increasing compilation and documentation of culturally effective clinical skills and valuable culturally specific knowledge. Chapters throughout this book provide just such information.

More on EMDR Therapy and the Frontier of Cultural Competence

Though I am making the case for EMDR therapy to be more explicitly defined and allied within the movement in the field toward cultural competence, we have much to offer. As mentioned earlier, EMDR provides three key components that catapult it to the forefront of trauma-informed cultural effectiveness by offering (a) a guiding theory, fundamental mechanisms of action, and other procedures that have demonstrated effectiveness and adaptability across a wide range of cultural contexts; (b) a clinical model that supports cultural attunement and a growing body of knowledge specific to different client cultural populations; and (c) the capacity to successfully treat the effects of culturally based trauma.

EMDR originator Francine Shapiro’s teachings have emphasized the importance of EMDR therapy as an integrative approach. Stewards of the development of EMDR therapy have skillfully balanced the need to maintain the core fidelity of the procedural components most essential to the transformative power of EMDR reprocessing with an openness and adaptability to the specifics of any one client’s uniqueness. Shapiro (2002) has stated, for instance, that “all psychotherapies must be practiced in the context of interlocking systems” and must include an appreciation of cultural context.

EMDR has demonstrated tremendous range as a cross-culturally effective therapeutic intervention. EMDR therapists are active on all six major continents and there is ample evidence that the fundamental components of EMDR intervention can be used effectively across cultures with compelling results. EMDR interventions, particularly those associated with EMDR humanitarian assistance programs, have treated many people in underresourced parts of the globe, often in countries with limited and underdeveloped mental health services. Even when there have been significant cultural differences between therapist and client, including not speaking the same language, the effectiveness of the EMDR treatment has been validated.

Some core components of EMDR that appear to contribute to its effectiveness with a wide range of cultural populations include that EMDR:

- Is client-centered
- Places are limited demands on language
- Works effectively with translators
- Can use non-verbal modalities (drawing)
- Can be implemented with group treatment methods
- Allows clients to keep memories private
- Accesses multiple memory components (cognitions, emotions, and body states)
- Includes simple self-assessment tools (VOC, SUDs)
• Requires no homework
• Integrates universal brain biology into AIP model
• Respects inherent healing mechanisms
• Adapts bilateral stimulation methods
• Builds on existing cultural resources/beliefs
• Incorporates mindfulness skills valued in many cultures
• Encourages therapist attunement and non-intrusiveness
• Allows for the problem to be identified in client’s terms
• Is effective for range of adverse experiences

Not only can EMDR standard treatment be adapted to different cultures, but it can be used to specifically treat the overall effects of culturally based trauma. This will be explored more in Chapter 3. The AIP model, the core theory behind EMDR methodology, offers a powerful framework through which to understand the constructive and destructive impact of cultural forces and other social dynamics. Generally speaking, the eight-phase approach, three-prong protocol, and many other EMDR protocols and strategies can be used successfully to treat culturally based trauma.

After reviewing the literature regarding cultural competence, clinical competencies, and assessing both the current effectiveness and potential of EMDR therapy, I generated a list of specific areas of focus for EMDR clinicians and EMDR organizations who are actively pursuing cultural competence. The chapters throughout this book provide extensive information and guidance to support clinicians along this path.

**Cultural competence focus areas for EMDR clinicians include:**

1. Understand the general importance of culture and the value of viewing individual client issues within a cultural context
2. Understand the important dimensions of culture to specific each client (including norms, values, beliefs, needs, etc.)
3. Maintain an attitude of curiosity and humility about other cultures while being aware of and seeking to overcome one’s own cultural biases
4. Adapt EMDR therapy methods to a client’s cultural context and needs
5. Provide psychosocial education to clients as appropriate
6. Empower clients in the face of culturally oppressive or stigmatizing conditions, including discrimination
7. Implement EMDR interventions that effectively treat the internalized effects of culturally based trauma
8. Implement EMDR interventions that effectively treat clients with culturally related prejudice and discriminatory behaviors, thus reducing the legacy of culturally based trauma
9. Support and ally with humanitarian efforts for social change including victim/survivor empowerment, social justice, and policy reform
10. Sustain EMDR therapist organizations which support the cultural competence of practitioners and which are culturally competent organizations

11. Seek ongoing education and training as needed to develop cultural competence

_Cultural competence focus area for EMDRIA as an organization include:_

1. Endorse, as an organization, the importance of cultural competence, diversity and inclusivity

2. Build and maintain cultural diversity of membership and leadership at all levels

3. Make EMDR treatment options available to and effective with people of all cultures

4. Define and develop standards of cultural competence within EMDR therapy and integrate them into overall core competency standards of EMDR therapy

5. Define and maintain cultural competence standards for EMDRIA approved educational programs, trainers, and EMDRIA approved consultants

6. Compile knowledge, and support education and training regarding culturally competent EMDR therapy

7. Support innovation and research related to culturally competent EMDR therapy

8. Promote to the public, mental health organizations and policy makers the ways in which EMDR interventions have demonstrated cultural competence and effectiveness

9. Collaborate regarding cultural competence with other EMDR and non-EMDR organizations

On the organizational level, the EMDR International Association (EMDRIA) has embraced the pursuit of cultural competence. The EMDRIA board of directors has established a Diversity and Cultural Competence Committee and an organizational policy is being drafted to make many of these specific focus areas a part of its organizational philosophy and goals. Some strategies that are underway include: recruiting, training, and retaining as EMDRIA members clinicians that meet diversity goals; establishing and maintaining standards for cultural competence in EMDR therapy practice; promoting trainings that are accessible and relevant to clinicians who serve diverse and underserved clinical populations and the practice settings; and supporting the development of effective treatment strategies to address the impact of social discrimination and culturally based adverse life experiences. The EMDRIA conference has sponsored two panel discussions on culture (Eliscu et al., 2010, 2011) as well as other culture related presentations. The commitment of EMDRIA and other EMDR organizations to ongoing attention and action will demonstrate leadership and can serve as a model within the field of mental health.

More globally, many EMDR clinicians and their supporting organizations are committed to bringing EMDR Interventions to underserved populations worldwide. Rolf Carriere, who has worked extensively with the UN, UNICEF, and World Bank, has estimated that over 500 million people globally suffer from unresolved trauma. EMDR humanitarian organizations have organized and sponsored EMDR trainings and interventions with a sense of mission that speaks volumes about the social awareness that exists within the EMDR professional culture.
An emerging frontier is the development of adapted EMDR treatment to fit the realities of the large numbers of people worldwide with little or scarce access to mental health services. EMDR innovations include implementing group treatment protocols and exploring the possible applications of EMDR interventions by paraprofessionals. Great care is being taken to balance innovative experimental approaches with the need to document procedures and evaluate results, so as to establish research-validated interventions. Early indications of these efforts are encouraging.

**SUMMARY**

Within the field of mental health, there is a much needed conversation about cultural competence. EMDR clinicians and organizations can actively join this discussion for mutual benefit. EMDR therapy has the potential to be a leader in the field because of the cultural adaptability of our treatment model, and its capacity for alleviating the effects of trauma, including culturally based trauma.

At the same time, cultural competence is an ongoing challenge, and it is important that all clinicians take a clear look at how they can apply the ASK model to enhance a culturally aware attitude, stretch their skills, and deepen their knowledge. Culturally competent EMDR therapy welcomes cultural awareness, embraces social and cultural identity, integrates the EMDR approach within a cultural context, and implements EMDR therapy to dismantle culturally based trauma.

**REFERENCES**


©Springer Publishing Company
CHAPTER 6

Placing Culture at the Heart of EMDR Therapy

Rajani Venkatraman Levis

PLACING CULTURE AT THE HEART OF EMDR THERAPY

If we are to achieve a richer culture, rich in contrasting values, we must recognize the whole gamut of human potentialities, and so weave a less arbitrary social fabric, one in which each diverse human gift will find a fitting place.

—Margaret Mead, anthropologist

The emergence of eye movement desensitization and reprocessing (EMDR) therapy as the premier treatment for posttraumatic stress disorder (PTSD) has been accompanied by a recognition of the healing role played by the relationship between EMDR therapist and client (Dworkin, 2005; Marich, 2009; Shapiro, 2001). In her 2012 client-centered exploration of what makes a good EMDR therapist, Marich highlighted the importance of empowering clients while Silver and Rogers (2002) recognized the need for therapist self-awareness. This chapter offers a culturally attuned approach to the therapeutic alliance and therapist self-awareness by placing culture at the heart of EMDR therapy. Such a practice facilitates healing through the integration of the five intermingling cultures identified by Vontress (1988)—universal culture, ecological culture, national culture, regional culture, and racioethnic culture. It further acknowledges that all aspects of counseling, including the relationship, diagnosis, treatment plan, and the intervention strategy, are influenced by the culture of both the therapist and client (Vontress, 2012, p. 9). In addition, it mitigates the risk of epistemic violence, or the therapist’s insistence on imposing a different worldview on the client, by acknowledging the impact of the therapist’s own socialization and values.

This culturally attuned practice of EMDR therapy embraces the historical and current realities of clients from culturally diverse backgrounds. It takes into account the trauma experienced by minority groups, defined by Corey, Corey, Callanan, & Corey (1988) as people who have been discriminated against or subject to unequal treatment. It does so by embracing the distinct cultural, subcultural, racioethnic, sociopolitical, and economic environments within which each client has been socialized. While revealing hidden targets related to social oppression and historical trauma, it simultaneously uncovers invisible and undervalued forms of cultural
wealth. Thus, it offers an expansive scope of healing by exposing deeper layers of trauma as well as the culturally congruent means of healing such wounds. Such a culturally attuned practice of EMDR therapy broadens the therapeutic lens as well as the possibilities for healing by using an integrative framework to place culture at the heart of therapy.

PRESENTING AN INTEGRATIVE FRAMEWORK

James and Prilleltensky’s (2002) framework provides a valuable integrative approach to mental health by honoring the culture and dignity of clients from diverse cultural backgrounds. This framework extends beyond the individual to include a cultural awareness of needs, norms, context, values, and social change. Comprised of four complementary considerations—philosophical, contextual, experiential, and pragmatic—it merges considerations like politics, philosophy, religion, and anthropology with social, moral, and cultural domains (James & Prilleltensky, 2002). Thus, it supports the practitioner in providing culturally attuned and effective services with increased awareness of her own cultural values and biases, as well as the client’s worldview (Malott & Schaeffle, 2015). The application of these four vital considerations can provide a more holistic understanding of the role of culture within the therapeutic arena.

Philosophical Considerations

James and Prilleltensky (2002) noted that each culture has a different set of social values, which shape the vision of the good person, the good life, and the good society. Philosophical considerations reveal that liberal societies emphasize autonomy and the rights of the individual, whereas collectivist societies emphasize the benefit of the greater good. Therefore, approaching clients from a collectivist culture in terms of self-interest, self-advocacy, or a purely internal locus of control may fit with a Western psychotherapy model, but lacks the necessary consideration of moral obligations and commitments linked with culturally congruent values. For example, many individuals in the West consider honesty to be a universal value. However, their understanding of honesty may be limited to the notion of truthfulness and, therefore, a refusal to lie, steal, or deceive in any way. In collectivist cultures, however, honesty may be better understood in terms of integrity or the adherence to a code of moral values that requires attending to fairness and honor first. In the latter culture, a man who does not have the means to pay for the drug that will save his mother’s life might make a conscious decision to steal it, while being in full integrity with his code of moral values, wherein family must be valued above all else. As a philosophical consideration, the therapist’s ability to identify her own values as only a possible set of values, but not as universal, is an important precursor to culturally attuned EMDR therapy.

Her: To reduce the awkward construction that results from using he or she, and because the author is female, the feminine pronoun has been used in referring to clinicians. For clarity, in narrative that does not contain a vignette, the masculine pronoun has been used with respect to clients.
Contextual Considerations

James and Prilleltensky (2002) identified contextual considerations as the actual state of affairs in which people live. A contextual assessment identifies the social norms and cultural influences on people’s choices and behaviors, as well as how this might affect their mental well-being. Cultural influences include the effects of historical trauma such as genocide, forced relocation, and internment camps. Duran (2006) emphasized that a culturally congruent therapist must be aware of oppression that has its roots in the colonization process, whereas Helms, Nicolas, and Green (2012) identified racism and ethnoviolence as forms of trauma. Ivey (2006) identified migration and immigration as trauma and Vontress (2012, p. 67) categorized the types of problems faced by immigrants into three groups: preimmigration problems, cultural anxiety, and postadjustment problems.

Other contextual considerations include the issue of universalism, or the presumption that psychotherapy theories are equally applicable to other cultures. Given that symptom expression is socially and culturally influenced, diagnostic categories are also socially constructed and may not apply outside of the practitioner’s culture (Watters, 2010). Thus, James and Prilleltensky (2002) encouraged practitioners to identify historic and prevailing sociopolitical conditions, as well as the applicable cultural, religious, and moral norms.

By establishing the intersectionality and positionality of therapist and client, the complex interplay of race, ethnicity, culture, gender, sexualities, immigration, age, and other factors becomes centrally located in EMDR therapy. Thus, both parties are able to explore how this interplay contributes to the construction of mental health as well as disease and distress.

Experiential Considerations

The experiential component of the integrative approach focuses on identifying wants, needs, and aspirations based on lived experience (James & Prilleltensky, 2002). This allows therapists to work toward the changes in each social context that would improve the mental health of the communities in which they work. This component may include actual, ideal, and desirable states of affairs as well as ways to affirm the dignity of each client.

A review of the literature reveals a wealth of hidden resources possessed by immigrant clients, including the aspirations that guide them (Delgado Bernal, 1998; Huber, 2009; Yosso, 2005). These valuable but often invisible resources, such as spiritual capital and navigational capital (see Phase 2: Preparation Phase), highlight the experiential dimensions of many minority groups. Other repeated themes echoed by clients from minority groups reveal the presence of widespread structural racism, heterosexism, discrimination, and microaggressions that have a negative impact on their physical, emotional, and mental health. An understanding of such experiential considerations allows psychotherapy to support healing in multiple domains by broadening the focus beyond the therapy room and from the individual to the community.
Strategies for Marginalized Cultures

Pragmatic Considerations

A thoughtful consideration of pragmatics seeks to bridge the gap between the actual state of affairs on the one hand, and desirable, ideal visions on the other hand. This allows both therapist and client to focus on therapeutic and social goals that can be realistically accomplished (James & Prilleltensky, 2002). Improvement of community mental health through social action and social intervention is a desired outcome of pragmatic thinking (Prilleltensky & Nelson, 1997).

One simple pragmatic goal for practitioners is to acknowledge the degree to which Western psychotherapeutic modalities are culture bound. By recognizing and addressing this, practitioners give appropriate consideration to how power is embedded in and conveyed through the therapeutic relationship. Thus, they become more transparent about the authority role of the EMDR therapist, as well as how the therapist is influenced by her own sociopolitical cultural system with its own set of values.

Viewed through this integrative framework, therapy may be yet another arena in which social hierarchy is reinforced. The average EMDR therapist in the Western World is White, educated, able-bodied, and upwardly mobile. This places clients from many minority groups in a challenging situation where the verbal adherence to neutrality begins to render the therapist’s racial, social, class, gender, and other privileges invisible, thereby reinforcing White, middle-class cultural and social norms. Even Therapists of Color\(^2\) have found this to be true, as their assimilation into Western cultural norms and the Western practice of psychotherapy places them in a privileged position, thus reproducing social inequalities. In spite of these challenges, the therapist’s own awareness of her position, culture, and values will allow her to be more effective in building a strong therapeutic alliance with a client from the minority group.

Acknowledging the stigma experienced by individuals with limited English proficiency is another example of a pragmatic consideration for English-speaking therapists in the United States. In this situation, naming the historical devaluation of Spanish and other heritage languages, as well as the challenges posed to nonnative English speakers, is a step in the direction of equal access for all. Addressing the English-only bias in the U.S. educational curriculum is an example of a social action that would serve to improve the collective morale and mental health of both Native and immigrant communities.

Pertaining to the EMDR community, training more Spanish speakers to provide EMDR therapy in the United States is one pragmatic goal. Motivating more EMDR therapists to become competent clinicians cross culturally is another goal that will have far-reaching benefits for community mental health. The use of cross-cultural team approaches with an emphasis on community-based interventions allows practitioners to mold their interventions in a more culturally sensitive manner.

\(^2\) Color: The intentional capitalization, which rejects the grammatical norm, represents a grammatical move toward social and racial justice through empowering this group and their resources. This rule also applies to “Communities of Color,” “CCWR,” and “Students of Color” throughout this chapter.
Phase 2: Installation of Community Cultural Wealth Resources in the Preparation Phase

This section identifies a culturally sensitive framework for increasing client resilience as well as strengthening the therapeutic alliance by building upon Yosso’s (2005) concept of community cultural wealth. Yosso (2005) defined cultural wealth as “an array of knowledge, skills, abilities and contacts possessed and utilized by Communities of Color to survive and resist macro- and micro-forms of oppressions” (p. 77). She described six forms of capital originating within Communities of Color—aspirational, linguistic, familial, social, navigational, and resistant capital—that comprise community cultural wealth and may often go unacknowledged or unrecognized. Huber (2009) added spiritual capital as an additional form of capital that emerged from her research. Earlier on, Delgado Bernal (1998) introduced the concept of cultural intuition, which highlighted that members of marginalized groups may have a unique sensitivity, perspective, and ability to interpret information based on their experiences. This is yet another hidden resource that needs to be named, acknowledged, and developed during the Preparation phase. Yosso (2005) wrote that these forms of resources are not mutually exclusive or static, but that they often build upon each other in dynamic processes. Since these assets may be entirely invisible from the perspective of the dominant majority, they may also have lost their importance and/or availability for an oppressed client.

While the original concept of community cultural wealth referenced Students of Color in institutions of higher education, this chapter expands on those terms. It proposes the umbrella term of Community Cultural Wealth Resources (CCWR) as an important resource for minority groups. CCWR have the potential to transform the process of EMDR therapy for the clients whose voices are in the margins. The acknowledgment and installation of the client’s invisible and undervalued resources restores the client to a more empowered version of himself. This, in turn strengthens the therapeutic alliance, creating a healthy foundation for the desensitization and reprocessing of trauma.

By placing culture at the heart of EMDR therapy, clients feel empowered to teach us what we need to know in order to be the best therapists for them. In alignment with the proposed integrative framework, a clinician can empower clients by owning her own expertise in EMDR therapy, but consistently highlighting that the client’s CCWR hold unique and important therapeutic insights as shown in the following text.

Community Cultural Wealth Resources

Aspirational Capital

Yosso (2005) defined aspirational capital as the resiliency that allows clients to maintain hopes and dreams for themselves and their children, even when faced with both real and perceived barriers. This is evidenced by many immigrant communities, including Chicanos in the United States, who demonstrate the ability to maintain consistently high aspirations for the future, even in the absence of objective means to achieve those goals. In addition, a family’s migration experiences are a form of cultural knowledge that helps many clients to feel connected to the
aspirational capital of the family. The following example demonstrates the use of aspirational capital in EMDR therapy.

Maria, 49, a recent immigrant, was referred to therapy as a victim of gang violence. During the Preparation phase, the therapist elicited Maria’s aspirational capital—the hopes and dreams that led her to the United States—by asking questions such as:

What made you decide to come to the United States?

and

What did you hope that your children might be able to accomplish by coming here?

Thus, the therapist highlighted Maria’s dreams for her children’s future that allowed her to face so many challenges thus far. Her resilience, as well as the belief that each of her children could have a better life, was then installed as a positive resource. This also strengthened the therapeutic alliance by reinforcing Maria’s experience of her therapist’s attunement and hope.

Some questions that may be helpful in revealing aspirational capital, depending on the cultural specifics of the client, include:

• During the hardest times before this, how did you keep going? What made you so determined to survive such difficult circumstances?

• Who, other than you, benefits from your being in this country/being out/being courageous/being alive?

• Who relies on your presence or your income for support?

• Are there other people whose dreams depend on your continuing to walk this path or for whom you are a role model?

Expanding the concept of aspirational capital as a valuable resource for other marginalized communities, we can modify these questions for individuals with disabilities and older adults, among others. For LGBTQ3 clients, a culturally attuned intake practice may include asking for both legal name as well as preferred name. The clinician’s acknowledgment of his or her chosen name places the client’s cultural context at the heart of therapy, as do the aspirations that led to the choosing of this preferred name. In the case of immigrants, the honoring of the client’s name in his or her own language, as well as the client’s adopted Western name (when there is one), is an opportunity to identify hidden targets related to colonization and oppression, while also highlighting the aspirational capital related to given and chosen names.

Linguistic Capital

Yosso (2005) identified linguistic capital as the intellectual and social skills attained through communication experiences in more than one language, style, or context. It can also describe a variety of skills related to language and communication that go beyond speech and the written word. The ability to communicate through

---

3 LGBTQ: This umbrella term includes lesbian, gay, bisexual, transgender, queer, and questioning individuals, although some may prefer other terms or no labels at all.
sign language, dramatic pauses, oral storytelling traditions, visual art, music, and poetry are other aspects of linguistic capital that may not be readily apparent to monolingual English speakers. The skills of culture-specific communication, including unique phonemes, tonal languages, gestures, gendered speech, and honorific speech, are other examples of linguistic capital. The use of memorization, math skills, and street smarts are important forms of linguistic capital that may even be demonstrated by clients who are functionally illiterate or underperform in the academic setting. Clients need to be acknowledged and validated for their ability to use such varied resources in order to navigate complex social and cultural situations.

Binh is a 10-year-old boy who often misses school. His school counselor is worried that he will not graduate from elementary school because he has missed too many days. When asked about his frequent absences, Binh mentions that he is the only one in his family who can speak English and is therefore needed as a translator. He has a younger brother with a neurological disorder and Binh has often missed school, in order to accompany his brother to the pediatrician, specialist doctors, and occupational therapist. Since none of these specialists speak Vietnamese, Binh is the only one who can help his family to access these services.

A therapist who highlights Binh’s poor attendance but fails to acknowledge his linguistic capital unwittingly emphasizes the dominant narrative that Binh is not benefiting from the education offered by the school. In a more culturally aware environment, instead of assuming that the current form of school-based learning is superior to all other forms of educational and cultural capital, equal emphasis would be placed on acknowledging and rewarding the ways in which Binh navigates an adult system, while acting as a translator of both culture and language. Reinforcing a client’s cross-cultural awareness, metalinguistic awareness, “real-world” literacy skills or street-smarts, and social maturity are ways in which a therapist can acknowledge and reinforce the linguistic capital that a client may not have recognized as a key survival strength. For example:

Jimena, who was a teacher in her village but now has to work as a housekeeper in her new country, has learned how to modulate her facial affect, vocal tone, and volume. She knows that speaking in the same authoritative tone of a teacher will not please her domestic employers and she has made the requisite adaptation, almost seamlessly. During the course of therapy Jimena begins to see this adaptation as her linguistic capital, rather than as a complete devaluation of her self-worth. By internalizing it as a strength, she finds a way to move past the shame about her loss in status from teacher to domestic help.

LGBTQQ clients often reveal a specialized understanding of the gendered nature of speech, language, and communication patterns. These can be installed as forms of linguistic capital, navigational capital, and resistant capital.

Familial Capital
Yosso (2005) stated that family capital refers to cultural knowledge nurtured among extended family networks and "engages a commitment to community well-being and expands the concept of family to include a more broad understanding of kinship."
A therapist may conceptualize that a client who is geographically separated from his family, sometimes with scant hope of reunification, is an isolated individual. Despite the distance, many clients benefit from the therapist’s acknowledgment of extended family networks that include immediate and extended family as well as friends, some of whom may have long passed on, as a vital and ever-present internal and external resource for some clients. For example, in the Latino culture, madrinas (godmother to the child) and comadres (the bond between biological mother and godmother) are often an important part of la familia, but because they are not blood relatives and seldom appear on a genogram, the practitioner might miss the opportunity to develop and install these valued resources during the Preparation phase.

Luna, a victim of domestic violence, was seen at the local domestic violence shelter for individual and group therapy. She reported a decrease in her feeling of isolation once she began to communicate with her familia through video chat technology. During the Preparation phase, the therapist created a family tableau, where she could visualize a scene with her whole family, relatives, alive and dead, all standing in a green meadow under a blue sky and smiling at her. This resource emphasized her aspiration and familial capital, and was often accessed by her as an anchor during reprocessing.

Here are a few possible questions that might elicit a more inclusive picture of the client’s familia.

• Whom are you supporting through being here in the United States?
• Who cares about you and misses you?
• When your familia would gather for happy occasions, who are some of the people you always looked forward to spending time with?
• We learn different things from different people. From whom did you learn lessons about love and friendship? Travel and adventure? Family values? Education? Faith and religion?
• Who in your familia would be proud that you are making a life for yourself in this country?
• Who in your familia inspired you to come to this country?
• If you could magically bring one person from your familia to be here with you right now, who would that be?

Despite the significance of family in many cases, it is always of relevance to note the exceptions. Some clients may not be able to count on their familial capital and may be estranged from their families, or may need support in creating strong boundaries from their family. Alternatively, some individuals receive support from their family-of-choice, which can also be installed as a valuable resource that represents both familial capital as well as social capital.

Social Capital
Yosso’s (2005) concept of social capital includes the networks of social contacts and community resources that provide instrumental and emotional support.
It references an individual’s ability to resolve crucial personal issues by tapping into social networks. Social capital can serve a bonding function, which “helps people get by,” or a bridging function, which “helps people get ahead” (Putnam, 2000). Thus, bonding capital supports individuals and helps them to cope, while bridging capital acts as leverage and helps people solve problems in order to get ahead (Briggs, 1998; Irwin, LaGory, Ritchey, & Fitzpatrick, 2008).

Churches, synagogues, mosques, gurdwaras, and places of worship provide spiritual as well as social support for many immigrant families, regardless of documented status. Religious traditions such as bar or bat mitzvah (Jewish coming of age tradition) or Khatam Al Quran (a Malaysian Muslim tradition for 11-year-old girls) augment bonding social capital, as well as familial capital and spiritual capital. Family gatherings and celebrations such as quinceañeras (the celebration of a girl’s 15th birthday, which marks the transition from childhood to womanhood in Latino culture) or Seijin-no-hi (Japanese coming of age tradition celebrated each January to honor 20-year-olds as they come into their maturity) offer culture-specific means for reinforcing social capital. The celebration of cultural festivals, traditions, and holidays, such as Diwali (the Hindu festival of lights), Chinese New Year, and the Gay Pride parade all represent valuable forms of bonding social capital and can be installed as resources during the Preparation phase.

Some older clients have a connection with their peers through community centers or senior centers. In a study that measured the five indices of social capital, that is, norms, trust, partnership in community, information sharing, and political participation, Kim, Auh, Lee, and Ahn (2013) found that partnership in community was significantly associated with lower levels of depression for older Chinese and Korean immigrants.

It is important to note that language usually plays a very important role in bonding and bridging, so therapists must endeavor to connect clients to social resources that honor the client’s language, culture, and context.

While bonding capital reinforces homogeneity, bridging capital links people to those of another social strata and is used as a strategy to secure economic stability, as well as upward mobility. Many immigrant, asylee, and refugee communities lack critical economic resources. However, social networks and community resources can offer a wealth of material and emotional support, as well as the means to economic sustainability and can be installed as useful resources. For Latino communities, rifas (raffles) and tandas (a form of rotating no-interest savings pool) are other ways of creating social capital and can be installed as resources that honor the client’s language, culture, and context.

Navigational Capital

Yosso (2005) defined navigational capital as the skills of maneuvering through social institutions that were not created with Communities of Color in mind. Expanding on that definition, this form of capital draws on the critical navigational skills found in marginalized communities as well as the strategies of resiliency that allow individuals to transcend the hurdles that they consistently encounter. Thus, navigational capital includes inner resources, social competencies, and cultural strategies that draw upon a lifetime of personal and community experiences of living as a marginalized individual.
The culturally attuned therapist plays a significant role in giving importance to the client’s experiential knowledge, as well as eliciting the alternative understandings conveyed by clients who do not belong to the dominant culture. Naming this capital acknowledges the resourcefulness and tenacity of culturally diverse clients, who manifest a high level of strategic intelligence in navigating their way to safety, better living conditions, and an improved quality of life for themselves and their kinship network.

For LGBTQQ clients, there are specific forms of navigational capital that the client may be able to identify when the culturally attuned clinician acknowledges that our society primarily operates under heterosexual and cisgender cultural norms. Sometimes, therapy might include the installation of navigational capital in the form of the client’s historic or ongoing ability to pass or not draw attention to his or her gender identification or sexual orientation. Other times, navigational capital may present as the finely tuned skill of the client to read the social environment and dress, act, or speak in certain ways that match, defy, or modify dominant expectations.

For clients who are living in poverty, their basic survival is a testament to their navigational capital. In spite of tremendous odds, these are individuals who have not given up and who have often acquired street smarts and specialized skills in order to survive. Acknowledging their navigational capital may also allow us to uncover the aspirational capital that sustains them. In the face of harsh realities, their ability to find enough food to live and finding shelter, even if only temporary, is a vital resource.

The following areas also offer opportunities to discover and install navigational capital as a resource.

- Honoring the mastery of living and surviving in two worlds, two countries, and two paradigms
- Acknowledging the distance traveled from place of birth and the resilience that allowed the client to navigate this dangerous journey
- How clients negotiate for their basic needs in an unfriendly environment, including a place to live, employment, food, education, medical aid, and more
- Reinforcing the aspirational and linguistic capital, which allow clients to navigate to and negotiate for resources when lacking dominant cultural capital
- The ability to function in an environment designed by and for able-bodied, heterosexual, cisgendered individuals

Resistant Capital

Resistant capital refers to the knowledge and skills that are generated or fostered through thought or acts that challenge inequality. Huber (2009) defined resistant capital as the “knowledge and skills developed in opposition to oppression, grounded in a legacy of resistance to subordination.” Resistance theories emphasize human agency by demonstrating how individuals negotiate with oppressive structures in order to create meaning of their own from these interactions (Solorzano & Delgado Bernal, 2001). Oppositional behavior that challenges inequality or combats assimilation serves the purpose of increasing self-esteem and preserving native culture. Solorzano and Delgado Bernal (2001) identified transformational resistance.
as a tool for naming, acknowledging, and addressing resistance as a resource, and a tool for empowerment and agency. Transformative resistant capital includes cultural knowledge of racism, sexism, and discrimination, as well as the motivation to confront and transform such oppressive structures (Yosso, 2005).

The Dreamers movement in the United States is an excellent example of transformative resistant capital. These students and young people who are children of parents who migrated without documents began pushing for legal alternatives by drawing attention to their plight as citizens without a nation. They mobilized the media into pointing out that there was no legal avenue for them to become lawful citizens of the United States and this movement spurred President Obama’s “deferred action” order effectively protecting their status.

The various social movements within the LGBTQQ communities that advocate for recognition of alternative social and sexual values are examples of transformative resistant capital. With a focus on equal rights for all, these movements have incorporated political activism and cultural activity, including lobbying, street marches, social groups, media, art, and research. Curran’s (2012) described how the marchers at NY Dyke March (and other similar events) attempted to take the power away from value judgments privileging monogamous heterosexual experiences by claiming and celebrating deviant identities. These are powerful acts of transformative resistant capital.

**Spiritual Capital**

From an existential perspective, it is the ability to make meaning of our difficulties, pain, suffering, and trauma, which allows us to transform it into healing (Duran, 2006, p. 74). Thus, spirituality and a connection to a reality greater than oneself serve as valuable resources for many culturally diverse individuals.

Religious and indigenous traditions, as well as ancestral beliefs and practices that are learned from one’s family, community, and inner self, act as a reservoir of hope and faith (Huber, 2009). Wearing a crucifix, lighting a candle, displaying a picture of La Virgen de Guadalupe, praying to saints, communicating with relatives who have passed on, a belief in the afterlife, and committing acts that might ensure a better afterlife are all ways in which Latino clients might practice varying forms of spirituality. Group prayer as a communal activity allows clients to connect to others, thus reducing their social isolation and reinforcing their social capital. In addition, the religious and cultural rituals that accompany birth, coming-of-age, weddings, and funerals allow many clients to overcome feelings of hopelessness and helplessness, and increase their feelings of well-being.

In the prevailing social climate of hostility toward Muslims in large parts of the Western hemisphere, a culturally congruent approach includes an understanding of the everyday challenges a Muslim client faces in staying connected to his or her faith-based practices. These may include the need to hide his or her religious beliefs, the lack of a prayer space at work, the banning of the client’s traditional clothing, or the pressure to consume alcohol or intoxicants at social gatherings. A culturally attuned therapist can play an important role in validating a client’s spiritual practice by installing it as a resource during the Preparation phase. This may provide the needed safety for the client to reveal important targets related to repeated instances of harassment, name-calling, racist, or discriminatory attacks on the client and others close to him or her.
Cultural Intuition

Most therapists are familiar with the notion of clinical intuition despite its rather elusive nature (Jeffrey & Stone Fish, 2011). Delgado Bernal (1998) articulated cultural intuition as a unique way of “knowing” that relates to both personal experience as well as collective experience, which includes community memory. The ability to accurately perceive a situation or assess others has greater importance for members of socially stigmatized or marginalized groups because of their status as a numerical minority who often experience prejudice and discrimination. Cultural intuition often involves deliberately utilizing the substance and expressions of one’s minority cultural experience in order to thrive and evolve. It is, therefore, a valuable, yet undervalued and invisible resource that can greatly empower clients in and out of therapy.

In her 2009 article, Huber highlighted how undocumented students develop intuition about the appropriateness of whom, when, and where to share information about their status. She suggested that this might be a navigational strategy “amassed from a lifetime of personal and familial experiences living as an undocumented Latina/o immigrant in the United States.”

Sociopolitical and cultural conditions also necessitate the evolution of social skills, such as gaydar. Gaydar, a popular culture term that refers to the ability of one individual to correctly identify the sexual orientation of another (Woolery, 2007), is another form of cultural intuition. Ambady, Hallahan, and Conner (1999) theorize that due to their numerical minority, the ability to identify potential romantic partners is of great consequence to gay men and women. They further state that due to antigay prejudice, “inaccuracy may have greater costs for gay men and lesbians, such as the risk of homophobic hostility and violence.” Thus, gaydar as cultural intuition offers protective functions, as well as social ones.

Delgado Bernal (1998) described four sources of cultural intuition as they relate to Chicana researchers: personal experience, existing literature, professional experiences, and analytical research processes. Often, therapists who identify with a minority group report that the four sources of cultural intuition, especially their own personal and collective experiences of immigration, migration, bilingualism, discrimination, marginalization, microaggressions, racism, sexism, and ableism, play an important role in therapy. Inviting clients to bring their cultural intuition into the therapeutic realm allows a more client-focused, strengths-based approach to EMDR therapy.

A culturally attuned therapist’s work offers many examples of cultural intuition interwoven with other forms of capital, especially aspirational, navigational, and spiritual capital. It may be beneficial to develop and install these resources during the preparation Phase and to use them as cognitive interweaves when processing might be blocked. For colleagues who come from the dominant culture, ongoing consultation with culturally diverse practitioners can offer relevant context and an expanded therapeutic perspective.

UNCOVERING TARGETS THROUGH THE INSTALLATION OF CCWR

Oftentimes in therapy, when a client has lied and/or chosen not to disclose certain information, it can be beneficial to set aside the Western notions of resistance and to explore how the client’s resistant capital, cultural intuition, and navigational capital...
may be guiding him to be protective of information. Thus, the therapist can help the client to use his CCWR to feel empowered rather than ashamed, which usually leads to a deepening of the therapeutic process. This acknowledgment of CCWR may serve to uncover targets that were invisible to either the clinician or the client, or both. While these targets may not be the reasons that the client entered into treatment, they may be linked to the client’s self-evaluations and Negative Cognitions, as well as historic or ongoing social oppression. Although the following list of targets is far from comprehensive, it offers a starting point from which therapists can pursue their own process of discovery.

1. **How I look**: Physical appearance, including skin color, hair, size, gender, ability, and other physical characteristics associated with stigma or discrimination
2. **How I speak**: Issues related to language, accent, cultural mannerisms, disfluencies, and speech impediments
3. **Whom I love**: Racioethnic and cultural identity, gender identity and sexual orientation, issues of loss, and conflicting loyalties
4. **How I see myself**: Historical trauma, immigration narratives, personal identity versus social identity, media portrayals, intersectionality
5. **How my family sees me**: Issues related to assimilation, acculturation, gender identity, sexual minority status, and conflicting loyalties
6. **How others see me**: Microaggressions, sexism, racism, ableism, discrimination, and issues of social identity, including issues related to colonization and social oppression, such as media portrayal
7. **Cognitive dissonance**: Related to any of the earlier aspects or related to personal, cultural, social, racial, and family identity

**SUMMARY**

Duran (2006) wrote that by understanding the sociocultural, historic, and political origin of their problems, individuals “can assume responsibility for their lives and gain an objectivity that has not been available to them until this moment of awareness.” An integrative framework, such as the one presented in this chapter, opens up the possibility of empowering clients through unearthing and healing such trauma. Furthermore, CCWR help therapists to privilege the client’s invisible resources through increased awareness of self and the intermingling of cultural influences. This type of cultural understanding has implications for therapist and client that will ripple outward in ever widening circles through the community, expanding the potential for individual and community healing through EMDR therapy.

**REFERENCES**


CHAPTER 18

EMDR With Issues of Appearance, Aging, and Class

Robin Shapiro

APPEARANCE MATTERS

Culturally defined “attractive” people are more likely to get the job (Gilmore, Beehr, & Love, 1986), the raise (Heilman & Stopeck, 1985), the mate (Jonason, Garcia, Webster, Li, & Fisher, 2015), higher status friends, and better grades (Begley, 2009) than less attractive people. Attractive children receive more attention, especially from strangers. Grade school children become more aware, each year, about the norms of appearance in their schools: what race, body shape, grooming, clothing, and facial structures are acceptable and what is shunned. Regional, social class, family, and gender mores dictate appearance parameters. And ubiquitous media images create often impossible-to-meet expectations of female and male beauty.

Some of our clients have been bullied for the way they look. Many are insecure about their appearance. Some have anxious bodies that overrespond to the threat of social rejection and go round and round with obsessive thoughts about their appearance. And some compulsively work out, starve, and/or have surgery after surgery in an attempt to have an acceptable shape.

As a therapist, your assessments will include your clients’ cultural contexts, attachment histories, trauma histories, temperaments, and actual appearances. As an EMDR therapist, you are going to look carefully at clients’ cognitions, emotions, and body sensations as you move through their distress. First, clear out the earliest traumas tied to appearance issues. Then, go after what’s left. The work naturally goes toward anger, then grief, and then acceptance for the reality of clients’ bodies or appearance.

You may want to use the Two-Hand Interweave (Shapiro, 2005a, 2005b) to help pinpoint the distress: “In one hand, hold the way you think you ought to look. In the other hand, hold the way you actually look. <Eye Movements (EMs)> What do you notice now?” Next, ask for the origin of the distress: “When and where did you learn that you were supposed to look like that?” Then target, with the standard protocol, the moment of the realization that there was a standard the client did not match.
GARDEN VARIETY FAT SHAME

Here is an example of a way-too-typical body-hating woman: “Jodi,” a 29-year-old, came to therapy to deal with a bad breakup. After clearing out the trauma-driven distortions and settling into the grieving process, we went after her hatred of her short, round, but not obese, body.

**Therapist:** Could you put the body you think you should have in one hand, and the body you actually have in the other? Stay with both of those for a moment. <EMs> What do you notice now?

**Jodi:** “The fat body hand feels disgusting!”

**Therapist:** When’s the first time it felt that way?

**Jodi:** “I was in sixth grade and watching the cool girls laughing together. They all were skinny and had great clothes, and I was a mess.”

**Therapist:** What would that girl say about herself?

**Jodi:** “I’m fat and ugly and no one should like me.”

**Therapist:** Looking back, what would your adult self say about that girl?

**Jodi:** “She’s okay. She was a working-class kid in a ritzy school and didn’t know the rules, but she’s a good kid.

**Therapist:** When you think about watching those girls laughing together, how true does it feel in your gut, one to seven, that you are good enough?

**Jodi:** “A one.”

**Therapist:** What feeling goes with that scene?

**Jodi:** “Self-disgust. I guess that’s shame.”

**Therapist:** How big is that, one to ten?

**Jodi:** “Nine.”

**Therapist:** And where in your body does that shame live?

**Jodi:** “In my curled up neck and shoulders.”

**Therapist:** Go with that. <EMs>

**Jodi:** “Now I’m remembering every time I saw a skinny girl. And I feel hopeless. I’ll never be like that.”

**Therapist:** [utilizing Jim Knipe’s “Loving Eyes” protocol (2015), which brings the adult sensibility to younger, shamed ego states:] Can you get in touch with the adult part, the one that thinks you’re good enough? Great, go back and get that sixth grader. Bring her up here. Show her around. I want you to imagine you and she are watching a movie of the skinny, rich girls laughing together with your kid looking on and feeling shame. <EMs> What does the kid see?

**Jodi:** “She sees a stupid, fat, yucky kid, who no one should pay attention to.”

**Therapist:** What does your adult see?
Jodi: "She sees that girl being ignored because she’s different in a lot of ways. And that kid isn’t horribly fat, just not skinny. I think she’s cute."

Therapist: Can that adult look over at the kid with loving eyes and explain that to her? Let her know that not fitting in isn’t about her appearance, or her goodness." <EMs>

Jodi: “Okay. I’m telling her. It’s taking a while for her to believe me.... Now she’s settling down, like a big sigh. She feels better.”

Therapist: How true does it feel now, that you’re good enough?

Jodi: “More now.”

Therapist: What’s keeping it from being true?

Jodi: “I’m still fat.”

Therapist: What’s the feeling now?

Jodi: “Angry!”

Therapist: Go with that! <EMs>

Jodi: [while processing] “I hate this body! I’ll never get another man ... I hate looking in the mirror.”

Therapist: How old is that?

Jodi: “Teenager, of course.”

Therapist: What was her input about her body?

Jodi: “Every movie, magazine, TV show, everything. And then all the weird social stuff.”

Therapist: I wonder what part of that equation deserves your anger.

Jodi: “Well, yeah. Fuck that media trying to sell me that stuff.”

Therapist: Go with THAT! <EMs>

Jodi: “I’m feeling better, but I still don’t like my fat.”

Therapist: Hold the body you think you should have in one hand again, and the one you have in the other. What do you notice this time?

Jodi: “The one I should have is not as skinny as it was earlier today! And I don’t feel disgusted anymore at the other one... more like sad.”

Therapist: Go with that. <EMs>

Jodi: “You know, it’s not so bad. I’ve got a healthy body. I’m in pretty good shape. I still do get hit on... I’m never going to look like a model, but I’m okay. I mean it. I’m really okay. It’s a seven, now.

Therapist: Where do you feel that okayness in your body?

Jodi: “My heart, and believe it or not, my stomach.”

Therapist: Go with that! <EMs>
FUNNY LOOKING KID

Ned had a round face, a large brow, and very large ears. He came from an upper-class family that prized “fitting in” above all else. As a baby, he was likely diagnosed as an “FLK,” a “funny looking kid,” the physician’s chart note for babies who may have Down syndrome, fetal alcohol syndrome, or an odd-shaped head. As an adult, he looked a little odd, but not unpleasant, and strategically grew his hair and whiskers to hide his face. He came to therapy for depression, and we quickly discovered the shame that kept him “hunkered down.”

In his therapy, we started early, using Maureen Kitchur’s (2005) strategic developmental model. Kitchur targets trauma in developmental order, positing that the client is developmentally older at each session, and will not be overwhelmed with early material in subsequent work. We started targeting attachment injuries in his early childhood (raised by the staff, not the favored child, etc.), moving on to bullying in grade school and middle school, and to his drug-and-booze-laden high school and college years. Targets tied to appearance included:

1. His father saying, “I never thought a kid of mine would look like you.”
2. Name calling and physical bullying from age 10 to 16.
3. His fear of rejection that kept him from asking girls out, which he never did in high school.
4. His reaction to other people’s reaction to meeting him for the first time—the “stare.”
5. Current beliefs that he will not be liked or connected to (despite having friends and a nice, connectable wife).
6. Fears of saying no because, “someone like me doesn’t deserve to.”

We used many future templates, including:

1. Running into the “double-take” people have at his appearance. How would you like to respond to that?
2. Saying “no” or “I want” and dealing with people’s responses.
3. Encountering his image in the mirror.

I pulled out a portrait-sized mirror and had him look at himself. What’s your response to seeing that guy? What would you like to say about him? What feeling arises? How big? Where is it? In the processing, he went through the anger, grief, and acceptance phases, ending with, “I’ve got a funny face and people are going to react, and I’m okay.” When we imagined the future instances of that, we came up with some funny things to say to new people, changing his dread to a possibility of playful connection.

In about a year of therapy, Ned’s depression abated as the trauma dissolved. He no longer saw himself as flawed, just “different.” And he had developed humor about his situation, a grand way of bringing perspective to his “funny-looking” face.
AGING

If we are lucky, aging brings wisdom and growing acceptance of ourselves and our place in the world. Aging inevitably brings bodily change: fat, wrinkles, and declining abilities. We go gray or lose our hair. It takes more effort to maintain strength. New illnesses crop up. Our sexual responses change or disappear. And as we watch our age-mates decline and die, and our own bodies fall apart, we face mortality.

Some people navigate the aging process with grace; grieving, then accepting the alterations of time. Others face their changes with fear and shame. Youthful images pervade media and advertising. For women, forever, and increasingly for men, smooth skin and firm bodies are social currency. For some men, losing bodily strength or the ability to get and maintain an erection is a loss of identity. EMDR therapy will not halt the aging process, but can assist people to mourn their former bodies and accept their current ones.

The Invisible Woman

“Betty,” a composite based on several clients and several conversations I have overheard, was 76, a retired manager, and depressed. She described her younger self as “quite attractive.” She said, “If I walked into a store or a party, people would stop what they were doing and say something. Now, I’m invisible. I can’t get help at the store. People don’t look up when I walk in a room. And it’s not just men, it’s everyone.”

We discussed the social aspects of aging and being seen, and the particular loss she had as a former “hottie” (her word). We had already processed some losses and earlier traumas, when we turned our attention to her appearance. When we processed the body she had versus the body she has, she moved through stages of grief: anger, sadness, hopelessness, and acceptance. The attention-from-others target went differently. We started with the present,

**Therapist:** Imagine walking into a store, and the clerk looks right through you and helps a younger woman. What do you say to yourself about that?

**Betty:** “I don’t exist. I’m not important.”

**Therapist:** What would you like to know about yourself?

**Betty:** “I’m here and I matter, dammit!” (VoC 2)

**Therapist:** When you think about that scene and not existing, what feelings are you having?

**Betty:** “Anger and helplessness.” (UD 8)

**Therapist:** Where do you feel that?

**Betty:** “Face, throat, and chest.”

**Therapist:** When’s the first time you ever felt that way?

**Betty:** “… A long time ago. When I was a kid, my mother was depressed, and sometimes couldn’t really react to me. I had no idea this was related.”

**Therapist:** Think about your mom not responding, feel that helplessness, and go with that.
We cleared early targets with her mother and some grade school incidents and Betty began to realize that she had received most of her good attention outside the family, from people responding to the cute little girl and the attractive older girl. She saw that she had leveraged her attractiveness for attention her whole life.

**Therapist:** So, Betty, were you a worthwhile person, besides your good looks?

**Betty:** “Sure. I was a good mother . . . I still am. And I did my work well. And I’m nice to people.”

**Therapist:** Where do you feel that goodness in your body? Go with that! [After we installed her sense of goodness, we came back to the future.]

*Imagine that store clerk again. What do you notice?*

**Betty:** “I’m just mad.”

**Therapist:** Go with that.

**Betty:** “I still feel stuck.”

**Therapist:** What do you want to do about it?

**Betty:** “Get her attention.”

**Therapist:** Do it! And go with that.

**Betty:** “I said, ‘Hey Miss, I was here first.’ and she waited on me.”

**Therapist:** How does that feel?

**Betty:** “Good!”

**Therapist:** Go with that!

We did another future template with social gatherings. With her new sense of okayness and assertiveness, Betty saw that she could directly ask for attention by approaching people she wanted to be with. In future sessions, she told me that it was working. “I no longer get the immediate attention that I’m used to, but I know how to make my presence known, and get what I need. And you know what? People like me anyway.”

**SUMMARY**

Appearance issues run through every race, class, gender, and culture and many of our clients. EMDR therapists are trained to work with the “real” trauma of war, sexual abuse, violence, cataclysmic events, and car accidents. The shame that underlies issues of appearance, aging, and socially constructed differences are necessary, appropriate, and helpful targets for many clients. The higher the social class, the more appearance-shaming (Fussell, 1992). People who had no overt abuse may have crippling social shame for minor variations in appearance. Ask your clients if they have any issues with the way they look. You may be surprised at the number of okay-looking men and women who report deep shame at the bodies they inhabit. 
REFERENCES


