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A Critical Analysis of the Utilization of Eye Movement Desensitization and Reprocessing (EMDR) Psychotherapy with African American Clients

Allen Lipscomb
California State University Northridge, allen.lipscomb@csun.edu

Wendy Ashley
California State University Northridge, wendy.ashley@csun.edu

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Abstract

Eye-Movement Desensitization and Reprocessing (EMDR) is a psychotherapeutic intervention designed to decrease distress associated with traumatic memories. EMDR has been validated and confirmed by the American Psychiatric Association (APA) as a primary treatment for Posttraumatic Stress Disorder (PTSD) and has been recognized as effective by the World Health Organization and the Department of Defense. Multiple studies reflect EMDR's capacity to heal the brain from psychological trauma; thus, clients are able to immediately experience the benefits of psychotherapy that previously took years to obtain. However, despite EMDR's efficacy, there are minimal references to diversity, culture, or context in EMDR research and literature. EMDR protocol has no adaptations or recommendations for utilizing this approach with African American clients, promoting an antiquated *one size fits all* treatment orientation. Without consideration of the lived experiences of African Americans and context that includes acknowledgment of stigma, shame regarding help-seeking, and historical trauma, this lens obscures the relevance of identity, privilege, power, and inclusion in treatment. Therefore, it is imperative to critically examine how EMDR treatment can be utilized to alleviate PTSD distress within a framework of oppression. The authors utilized an anti-oppressive, Critical Race theoretical perspective to examine four case studies of African American clients who received EMDR interventions to gain insight into the unique nuances that arise during treatment. Emphasis will be placed on critiquing the treatment protocol, the positionality of the clinician, and clinical implications for future anti-oppressive practice with African American clients utilizing this model.

Keywords: EMDR, Anti-oppressive psychotherapy, African American, Case studies, Critical analysis, Culturally relevant adaptations

A Critical Analysis of the Utilization of Eye Movement Desensitization and Reprocessing (EMDR) Psychotherapy with African American Clients

Eye-Movement Desensitization and Reprocessing (EMDR) has an eight-step standardized psychotherapy treatment protocol that has been validated and confirmed by the American Psychiatric Association (APA) as a primary treatment for Posttraumatic Stress Disorder (PTSD; Shapiro, 2012). With attention to the past, present, and future, EMDR focuses on past disturbing events and memories, current situations that trigger distress, and the development of skills and attitudes for future positive actions. Based on an Adaptive Information Processing model, EMDR founder Francine Shapiro (2012) hypothesized that if the information related to a distressing or traumatic experience is not fully processed, the initial perceptions, emotions, and distorted thoughts will be stored as they were experienced at the time of the event. These unprocessed memories often form the foundation of many mental disorders. As the client is asked to visualize the most prominent aspect of traumatic memory from their past, the clinician initiates bilateral stimulations through visual, auditory, or tactile external stimuli in a side-to-side pattern (Shapiro, 2002; 1989). Research supports the efficacy of the EMDR model, and it has been recognized by the American Psychological Association (APA), World Health Organization, California Evidence-Based Clearinghouse for Child Welfare, Department of Veteran's Affairs, Department of Defense and Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (Lipke, Shapiro, Hoffman, & Maxfield, 2009; Luber & Shapiro, 2009; Schubert & Lee, 2009; Shapiro, 2002, 2012, 2014).

Research supports EMDR as an effective trauma treatment with multiple populations. EMDR has shown to be effective with those diagnosed with Acute Stress Disorder and PTSD, anxiety, depression, adults, children, and adolescents (Leeds, 2016). However, despite EMDR's efficacy, there are minimal references to diversity, culture, or ethnicity in EMDR research, and there are no adaptations to EMDR protocol or recommendations for utilizing this approach with African American clients. As a result, an archaic *one size fits all* treatment orientation is promoted. Without consideration of the lived experiences of African Americans and context that includes acknowledgment of systemic racism, deeply rooted cultural and spiritual beliefs that impact mental health, historical trauma, and reluctance and shame regarding help-seeking, a *one size fits all* lens obscures the relevance of identity, privilege, power, and inclusion in treatment.

Because African Americans must consistently navigate racialized oppression in most, if not all areas of their lives, their lived experiences and trauma(s) may be intricately connected to experiences of racism and inequity. Thus, EMDR is likely to activate both trauma and oppression with clients of color. EMDR researchers, clinicians, and practitioners rely on the lived experiences of clients to direct the interventions presented during treatment sessions; without protocol adaptations for clients of color or the emergence of oppression related material, researchers, clinicians, and practitioners are challenged to select culturally relevant appropriate intervention strategies. Thus, EMDR's efficacy and application among African American clients need further exploration to identify methods of relieving trauma-related distress with the added obstacle of past and present individual, interpersonal and systemic oppression, and racialization.

The purpose of this article is to explore the experiences of African American clients who received EMDR treatment through case studies. African American EMDR recipients (n=4) were interviewed about their experiences receiving EMDR treatment using the 8 phase treatment protocol, cultural sensitivity of the clinician, intersectional inclusion of identities when providing treatment, and overall comfort with the treatment protocol. Data obtained through case studies

and interviews provide comprehensive feedback for the EMDR community on the perspective from people of color receiving EMDR treatment to improve culturally relevant treatment and increase efficacy with African American clients.

Literature Review

Traumatic experiences have the potential to overwhelm the brain's capacity to process information. Following disturbing life events, there may be on-going interaction of the traumatic memory with environmental triggers and stresses. This may cause re-experiencing of the traumatic event, with accompanying psychophysiological reactivation and psychological distress (Shapiro, 2012). Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment designed to alleviate the distress associated with traumatic memories (Valiente-Gómez et al., 2017). EMDR is based on an Adaptive Information Processing (AIP) model that proposes that present problems are rooted in earlier experiences that have not been properly stored in the brain and need to be reprocessed (Shapiro, 2012). As a result, the disturbing event has been stored in the brain as it was originally experienced with the emotions, physical sensations, and beliefs fundamentally unchanged (Shapiro & Laliotis, 2011). Despite the time that passes or whether the person remembers it, the memory remains intact by the brain's inherent information processing system, providing a foundation for current responses and behaviors.

The proper application of EMDR as a comprehensive treatment approach addresses past, present, and future experience and behavior. EMDR utilizes an eight-phase treatment protocol that addresses a wide range of clinical complaints caused or exacerbated by prior negative experiences. These phases represent a step-by-step formal way of exploring and reprocessing past experiences that impedes an individual's daily functioning resulting in present maladaptive behaviors (Shapiro & Laliotis, 2011) along with the positive experiences needed to bring a client to optimal adaptive functioning. EMDR's three-pronged approach of past, present, and future guides the clinician in identifying and processing (1) the relevant past experiences that inform the client's problems in the present; (2) the present ongoing experiences that continue to trigger maladaptive responses to current life demands; (3) templates of future actions to optimize the client's capacity to respond adaptively given the current context of their lives (Shapiro & Laliotis, 2011). As the brain processes the memory, it is properly filed away along with other memories. As with neutral memories, the stored information can be retrieved when needed to understand new experiences (Solomon, Solomon, & Heide, 2009).

EMDR therapy esteems the physiologically stored memory as the primary foundation of pathology and the application of specifically targeted information processing as the primary agent of change (Shapiro & Laliotis, 2011). EMDR therapy has a unique approach to the reprocessing of distressing memories. While other approaches focus on symptom extinction and competing response, EMDR therapy asks the question, "what does this mean to you?" (Suzuki et al., 2004). The aim of EMDR therapy is to alter original trauma memory to achieve an adaptive reconsolidation. EMDR therapy relies less on language than other therapy methods. EMDR does not require creating a narrative, verbal disclosure of details, reliving traumatic experiences, or homework (Ho & Lee, 2012). As a result, EMDR is considered equally efficacious to other trauma treatments but requires less time. When comparing prolonged exposure therapy, cognitive behavioral therapy and, EMDR therapy, it has been found that all are about equally effective, but EMDR is less time-intensive (Schubert & Lee, 2009).

Trauma Survivors

Trauma survivors come from an array of backgrounds. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the criteria for Post-Traumatic

Stress Disorder (PTSD) includes experiencing a traumatic event, witnessing an event as it occurred to someone else, learning about an event that occurred to someone close to them, or through the course of their job (i.e., first responder or social worker), they may be repeatedly exposed to the details of an event (American Psychiatric Association, 2013). These individuals may experience distressing memories as a result of their trauma, which commonly takes the form of vivid and distressing sensory impressions from the trauma. The sensations are predominantly visual and subjectively seem to be occurring in the present moment rather than being memories of past events (Michael, Ethers, Halligan, & Clark, 2005). Trauma memories may occur for extended periods of time, which has the potential to impact the individual's mental health; for many, this results in PTSD, depression, distrust, affect dysregulation, panic, substance dependence, self-harming behaviors, shame, difficulty focusing, and functioning impairments (Bryant-Davis & Ocampo, 2005). Furthermore, chronic stress from trauma memories may affect one's physical health and may include illnesses such as hypertension, hyperlipidemia, obesity, cardiovascular problems, fibromyalgia, irritable bowel, chronic fatigue, whiplash, and other pain syndromes (McFarlane, 2010).

Trauma Survivors of Color

Racial/ethnic minorities may be more negatively impacted by trauma exposure due to repeated exposure. Historically, minorities in the United States have experienced systemic sponsored violence perpetrated against them. Examples include violence through the trans-Atlantic slave trade, abusive detainment, sexual assault, murder, brutality, family separation, forced assimilation, denial of rights and resource access, and mass incarceration (Pieterse et al., 2012). Even when acts of aggression are not direct, racial minorities still may be impacted by intergenerational trauma. Research reveals that the trauma of the elders of a community impacts the descendants through storytelling, giving warnings, modeling behaviors, and the survivor's approach to parenting, including racial socialization (Hughes et al., 2006). For immigrants and their descendants, the intergenerational trauma may take the form of forced migration as a result of a conflict, natural and chemical disasters, famine, and xenophobia (Bryant-Davis, Adams, Alejandre, & Gray, 2017). After the migration, they may have experienced stigma, racism, and discrimination along with anxiety surrounding familial and country separation.

There is evidence suggesting that trauma survivors of color experience higher levels of trauma exposure (Gillespie et al., 2009; Ghafoori et al., 2012) and exhibit greater occurrences of PTSD, likely due in part to experiences of the ongoing individual, interpersonal and systemic marginalization (Bryant-Davis, Adams, Alejandre, & Gray, 2017). Some scholars have posited that many ethnic minorities are not experiencing posttraumatic stress but are experiencing ongoing traumatic stress because of the continued widespread exposure to racism, violence, and intergenerational poverty (Leary, 2005). However, increased trauma exposure alone has not been found statistically significant to fully explain increased PTSD in racial minorities (Pole, Best, Metzler, & Marmar, 2005). There are implications that contributing factors may be due to the nuances of oppression and marginalization; however, it is challenging to control for every race-based infraction. Though there are several studies that focus on racialized trauma (Wamser-Nanney, Cherry, Campbell, & Trombetta, 2018; Terwilliger, Bach, Bryan, & Williams, 2013), covert and institutionalized racism is often minimized because it is challenging to quantify. In order to better assess the racialized trauma, it is essential to consider the role of microaggressions, covert and/or nonphysical racist incidents (Bryant-Davis & Ocampo, 2005), and consider the role of power (Helms, Nicolas & Green, 2010). Racism parallels sexual assault and intimate partner violence in that each of these acts is motivated by the need to impose one's

sense of power over someone who is afforded less power within an established social structure (Bryant-Davis & Ocampo, 2005; Carter, 2007). Therefore, trauma survivors of color become susceptible to chronic traumatization due to compounding forces within society.

Despite elevated exposures to trauma, ethnic minority trauma survivors may have protective factors within their coping responses. For example, minority groups may have faith-based beliefs regarding adapting, accepting, or processing trauma events. Ghafoori and colleagues (2012) examined the association between race/ethnicity and symptom severity of PTSD, generalized anxiety disorder (GAD), and depression in an urban clinical sample of 170 Black, Hispanic, and White trauma-exposed adults. The study found the Black participants had the highest level of positive reframe coping associated with decreased depression symptom severity compared to the other groups in the study. Further implications may be due to the role religion has within the Black community. The study found a significant relationship between the Black participants and increased religiosity. Religious teachings foster a sense of hope (Cooper, Thayer, and Waldstein, 2014; Lizardi et al., 2008), which may increase one's ability to reframe positively, and therefore decrease depressive symptoms (Ghafoori et al., 2012). Black people in the United States have been socialized to adopt positive coping strategies such as perseverance and searching for the good (Schwartz & Meyer, 2010). They may receive culturally-based socialization messages inspiring them to move forward with their life despite the traumatic stressors they encounter.

Evidence-Based Therapy for Trauma Survivors of Color

There is a dearth of research available regarding evidence-based treatment for trauma survivors of color. Many of the protocols, approaches, and services are designed to assist survivors to promote a mainstream, color-blind approach to their interventions (Gillum, 2008). As a result, many racial/ethnic minorities are not receiving the full benefit of treatment due to the lack of culturally appropriate interventions. Mainstream interventions have often failed to reach certain racial/ethnic minority populations for various reasons, from language barriers to the isolation of these populations from mainstream society because of cultural differences, prejudice, and racism (Owen, Tao, Imel, Wampold, & Rodolfa, 2014). Furthermore, many mainstream interventions fail to deviate from their standard modes of operation and dissemination, which often are not effective in reaching minority populations (Owen, Tao, Imel, Wampold, & Rodolfa, 2014).

Although the clinical consequences of trauma exposure are well documented, few studies have investigated racial/ethnic differences in post-trauma symptoms in treatment-seeking adults (Ghafoori et al., 2012). Some studies found that trauma survivors of color may benefit from narrative therapy, individual treatment, relational factors, and critical consciousness development coping (Aymer, 2016; Helms, Nicolas & Green, 2010). For trauma survivors, treatment must begin with a thorough assessment, including a full history of race-based experiences, which may or may not be the primary presenting problem, as well as a full assessment of post-trauma symptoms (Helms, Nicolas & Green, 2010). An assessment without consideration of racialized experiences can result in racial and ethnic minority survivors being underserved. With this framework, treatment would focus on affect regulation skills, processing the traumatic narratives, and building positive therapeutic relationships (Briere & Scott, 2015). However, it should be noted these studies focused more on race-based trauma instead of racialized trauma survivors. Further research is needed on effective evidence-based practices for trauma survivors of color.

EMDR for Trauma Survivors of Color

EMDR therapy acknowledges the brain has difficulty integrating traumatic memories, connecting them with similar memories, and storing them (Solomon, Solomon, & Heide, 2009). However, does the protocol acknowledge racial/ethnic trauma survivors may have increased exposure to their presenting trauma due to the reaffirming nuances of racial oppression? If the approach of EMDR therapy is to integrate traumatic memories with similar memories, one may assume the similar memories would need to be neutral memories in order for the traumatic memories to be integrated and appropriately stored. However, due to racial/ethnic oppression and marginalization, there may be challenges with integrating trauma memories to other memories based on the nature of the experiences. Trauma survivors of color may hold other memories outside of the presenting trauma that affirms feelings of powerlessness, unworthiness, and hopelessness due to their racial/ethnic minority status. For example, a Latinx female receiving EMDR therapy may have a presenting problem of feeling powerless due to prior sexual abuse. Though she may receive EMDR for the sexual trauma, does the therapy appropriately address and store other oppression based (examples include race and gender-specific) memories that are not the presenting problem but may reinforce her feelings of powerlessness?

Trauma memories are central to EMDR theory and therapy. They are viewed as the primary sources of much psychological disturbance. Much of the work of EMDR clinicians involves undoing the damage done from improperly stored memories of longstanding large and small traumas (Shapiro, 2012). Although research has begun to identify culturally relevant psychotherapy for racial minority trauma survivors, less is known about EMDR therapy being an effective intervention for this population. This study attempts to investigate the impact EMDR has on trauma survivors of color. It is essential to consider the ways in which this treatment method has on racial/ethnic minority trauma survivors in order to meaningfully treat diverse populations and ignite further research to promote culturally relevant treatment options. If not, we further marginalize minority populations from healing past traumas by providing psychotherapy that neglects and undervalues the traumatic impact and nuances of societal oppression.

Methodology

Case Study Narratives

The majority of EMDR research studies have been conducted utilizing a quantitative research methodology. While those research studies are highly valid and informative, they do not always capture the lived experiences of people of color due to their reflection of the dominant research quantitative method; as a result, attention to marginalization communities of color is frequently absent in the majority of EMDR research (Denzin & Lincoln, 2011). We approached this research using a qualitative interpretive method (Elliott, 1999) to seek out those case study narratives and stories people of color do not often feel comfortable or safe sharing. These case studies and narratives were especially important for gaining access to the clinical experiences of people of color having participated in EMDR treatment—not only their process but also to the meanings and internalization of their unique EMDR therapy experiences. The following case studies (n = 4) include narratives, themes, and quotes from people of colors' treatment experiences of EMDR. Their salient traumatic memories/experiences and their unique challenges faced when engaging in EMDR treatment will be highlighted. In addition, their interpersonal exchanges and relations with the treating therapist will also be emphasized. The participants were recruited via convenience and snowball sampling and were selected based on their willingness to share their EMDR treatment narratives.

Through comprehensive interviews, four African American participants offered detailed narratives of their EMDR treatment experiences. Participant demographics for these narratives are detailed in Table 1. Notes from these narratives and comments from other participants were extensively reviewed by the authors. Initial and thematic coding was utilized to identify several preliminary themes among the participants' responses (Charmaz, 2011). Final narrative and case study themes were established after each author independently then collectively analyzed the materials for content analysis. Content analysis traditionally provides some interpretation of a cultural product, which is critical to this exploration given the cultural significance of the research (Deese, 1985).

Table 1
Case Study Participant Demographics

Demographic Characteristics	Client - Participant 1	Client - Participant 2	Client – Participant 3	Client – Participant 4
Ethnicity and Race and age	*Black/AA 28 years old*	*Black/AA 50 years old*	*Black/AA 33 years old*	*Black/AA 54 years old*
Sexual Orientation	*Heterosexual*	*Heterosexual*	*Bisexual*	*Heterosexual*
Gender Identity	*Cisgender male*	*Cisgender female*	*Cisgender female*	*Cisgender female*
# of EMDR Sessions	*5*	*4*	*1*	*2*
Target Memory	*Physical and Sexual Abuse*	*Sexual abuse and Domestic Violence*	*Physical and Sexual abuse*	*Sexual violence (IPV) and childhood sexual abuse*

Results

Case Study Themes and Quotes

A. Lance 28-year-old AA male

- *"While EMDR has worked for me, I was nervous initially because I was not sure what the EMDR training was about… even after Doc told me about this form of therapy. I said Doc, you trying to take me to my sunken place?"*
- *"After my first session, I remember having a lot of memories that were repressed come up and I was flooded with different emotions. I remember calling my adopted mother and telling her about all things I remember that she would do to me while growing up and how she treated my adopted dad. She tried to talk but I quickly shut her down and demanded I finish"*
- *"During the time that I was receiving the EMDR training I got into many arguments with my ex-girlfriend and punched out her car window out of aggression. I was also hit by a car while walking across an intersection."*

- *"I felt like I could trust my therapist providing the EMDR training because he was an African American male, and he also dressed nice."*

B. Deborah, 50-year-old AA female

- *"I wasn't sure what to expect when it was first introduced to me. I was apprehensive to start and even when I started after several sessions in I still felt like it was weird."*
- *"While I trusted my therapist I did not trust the treatment and myself. It created some strong feelings of resistance."*
- *"I gave it a couple of sessions and so much came up to the point where I decided that I would rather talk about my stuff then to have it rushing up full speed ahead. There is some stuff that I refuse to talk about or even allow myself to go there—I don't think that I would ever be ready…it's just too painful"*
- *Honestly, I didn't feel 100% comfortable and trust that I could handle what this type of therapy would bring up. I don't like to not be in control of myself and my surroundings…that feeling does not feel good to me. You know…we Black women don't like surprises like that…we got enough shit to worry about."*

C. Trinity, 33-year-old AA female

- *"I told my therapist I was afraid to do EMDR. I had done it before because it sounded like a good idea, and something I didn't want to work on came up and scared me. The previous therapist was a White woman, and I could tell she got scared too. I was willing to do it again because my current therapist prepared me for things to come up that weren't in my control. We were able to develop a plan to help me if I got overwhelmed."*
- *"I chose an African American female therapist because I believe she can understand my experiences. She, like me, is a woman of color with real life experiences. I felt like previous therapists could understand me, but not all of me."*
- *"I have been very irritable. I feel very angry and powerless. I get in fights with my family and my boyfriend and my daughter. I feel paranoid that other people are watching me. I feel like I am out of control sometimes."*
- *My EMDR session was VERY upsetting. I brought my aunt in case I needed help. When I started feeling those old memories come up, I couldn't talk. My mouth felt too small. I had to lie down. I could only go a few rounds and I needed a warm drink. But my therapist and my aunt took care of me. And I went home and went to bed. But I was scared. I didn't like it at all."*
- *"I have been really harmed by men. As a Black woman, men have always thought they could do what they wanted with me. I have also been hurt by my church the same way. The world is full of predators. I feel like I need to be in control all the time to be sure that I am prepared to take care of myself."*
- *"After my EMDR session, I was upset for a while and I needed help to calm down. I slept really soundly afterward and was pretty agitated the next couple of days. But then I experienced a calm. It was so quiet and different from my usual anxiety that I was actually worried something was wrong with me."*
- *"I don't know if EMDR helped me. I think I did it wrong. But I have felt much better lately"*.

D. Zelda, 54-year-old AA female

- *"I came to therapy with a lot of years of recovery under my belt. I know my issues and what I can deal with myself."*

- *"One of my best friends is a Black therapist. I asked her if she knew another Black female therapist and that's how I got my current therapist. I wasn't willing to see and trust someone else that couldn't understand me. Also, I wanted someone who had specialization in trauma work."*
- *"I have had a lot of loss in my life. I lost a parent and separated from my husband. I have been very angry at myself for the decisions I make – such as dating my current boyfriend or giving family members money. When I was using I made a lot of bad decisions. Today, I always strive to do the right thing."*
- *"I was initially against EMDR. It sounds too hocus pocus for me. I am also not sure I wanted to talk about some of the really bad things that happened to me. I know my therapist would understand but I also don't want anyone to see me be emotional and weak."*
- *"My traumas relate to my childhood and some things that happened when I was using. I am in recovery, but I have a lot of shame about being a stereotypical Black woman who used drugs."*
- *"My EMDR sessions were fine. I didn't like remembering those memories and I didn't like my therapist seeing me cry. I felt surreal and exposed afterward. I told my therapist I didn't want to do it again. I didn't see how it would be helpful to recall those memories. The worst part was the shame I felt about being so vulnerable."*
- *"I just got better. I was in therapy about 2 years and near the end, I started feeling better. I got more confident, made better decisions and felt freer. [EMDR was within last 4 months of treatment] I don't think EMDR was or was not helpful, but I do think therapy was helpful."*

Table 2
Emergent Themes & Subthemes

EMDR Treatment	Therapist Positionality	Feelings/Emotions	Client Experience
Subthemes:	*Subthemes:*	*Subthemes:*	*Subthemes:*
Uncertain about EMDR	Trust in therapist	Fearful	Overwhelmed
Afraid to mess up EMDR	Identity of therapist	Ambivalent	Flooded
Unwilling to associate (+) to EMDR	Therapist power	Shame/weak	Powerlessness
Fear of EMDR's potential to harm	Pacing	Aggression	Exposed

Discussion

The aim of this study was to explore the unique experiences of African American clients receiving EMDR treatment. The results suggest that EMDR therapy, although effective, is not always the right approach to treatment for many African Americans because it does not allow them to stay in control—control of their emotions, reactions, and thoughts. Alternately, if African American clients utilize EMDR, they may need a different approach than standard protocol dictates. One size fits all approaches are antiquated and fail to address the racialized and oppressive reality of marginalized groups living in the United States (Alegria et al. 2010). This is vitally important for African Americans, considering the long history of mistreatment from the medical and mental health systems as well as stigma and reservations regarding therapeutic

efficacy. African American clients need to know at the beginning that they have the right and empowerment to direct their therapeutic treatment process. They need to know that this is not an authoritative relationship, where the therapist is in charge and dictates what happens to them. Unless it is a truly collaborative process, it isn't a safe space.

Therapists providing EMDR with African American clients need to have a solid knowledge of historical injustices and empathy regarding the impact of historical and current inequities for people of color. Failure to understand these traumas promotes disconnection and microaggressions, impacting both the therapeutic relationship and ultimately treatment success (Sue & Sue, 2003; Sue et al., 2007). For example, EMDR providers should have a keen understanding that many African Americans are reluctant to seek mental health therapy due to distrust in large medical care facilities and settings, originating from historical experiences of racist, biased, and oppressive treatment services. Differentiating a historical experience from social stigma or lack of psychological mindedness is essential in developing a genuine therapeutic alliance. Critical consciousness about the socio-political-historical underpinnings that pervade treatment and the therapeutic process is not only necessary but ensures the psychological and emotional safety of the client while receiving EMDR treatment and thereafter. Culturally responsive clinicians need to feel confident in their engagement with African American clients and understood enough to be transparent (i.e., both inter and intra culturally), which are crucial factors in fostering an anti-oppressive empowering therapeutic EMDR experience.

EMDR is an evidence-based trauma treatment. However, providing trauma treatment is not the same as providing trauma-informed, anti-oppressive trauma treatment. While exposure to one traumatic event increases individual and community vulnerability, communities subjected to historical or structural violence are disproportionally impacted by trauma and its effects (Kimberg & Wheeler, 2019). Historical trauma, microaggressions, racism, sexism, and homophobia are oppressive experiences directly associated with emotional trauma (Kucharska, 2018; Nadal, 2018; Williams, Metzger, Leins & DeLapp, 2018). These oppressions based on traumatic experiences (including racism, sexism, classism, transphobia, xenophobia, colonization, political, historical, and intergenerational trauma) involve exposure to and lived experiences of interpersonal, institutional, or structural forms of oppression (Nelson, 2019). Living in a "racialized context" (Franklin & Boyd-Franklin, 2000, p. 34) while engaging in a therapeutic context that continues to inadequately address race and ethnicity (Sue et al., 2007) may result in psychological invisibility (Franklin & Boyd-Franklin, 2000) for African Americans in clinical environments. Visibility is crucial for the grounding African American clients need to stay present for EMDR intervention; invisibility promotes feelings of powerlessness, exposure, and lack of control reported by the participants. Similar to traditionally understood trauma experiences, these events have an impact on neurobiology, behavior, internal and interpersonal interaction (Kimberg & Wheeler, 2019). Thus, trauma exposure encompasses more than an acute or chronic traumatic event(s), and trauma-related oppression is a critical element in effective trauma treatment for African American clients.

Trauma specific interventions, such as EMDR, can only be enhanced by the addition of cultural humility and acknowledgment of oppression-based trauma. Sue et al. (2007) stress the importance of awareness of the treatment provider's culture and awareness of the worldview of their diverse clients as critical for effective service delivery to racial minority clients. To not engage Black clients around traumatic experiences related to racialization (as well as other intersectionality factors) promotes a colorblind ideology, leaving clients exposed to overwhelming fear, shame, confusion, and disillusionment (Franklin & Boyd-Franklin, 2000;

Rattan & Ambady, 2013). Oppression deriving from systemic, organizational, interpersonal, or individual inequities persists in therapeutic spaces, even if they remain unaddressed. White clinicians adopting a colorblind approach or avoiding addressing race with Black people can unintentionally create impasses for clients of color or impair performance (Norton, Sommers, Apfelbaum, Pura & Ariely, 2006; Sue et al., 2007). Cultural humility in this context considers the lived experiences of Black (or other marginalized) clients and the relationship between the powerlessness of the trauma, their intersectional identity, and the power dynamics between them and the therapist. Power imbalances in any part of the therapeutic environment can trigger traumatic memories (Kimball & Wheeler, 2019), thus, providing space for and consistent acknowledgment of oppressive experiences are essential.

Translated into practice skills, safety is a key foundational element for effective trauma intervention. Most mental health professionals are White, trained primarily in Eurocentric service delivery models, and believe they are not racist or biased, despite the power and privilege dynamics between themselves and clients of color (Sue & Sue, 2003; Sue et al., 2007). EMDR, like many treatment protocols, are often unknown or unavailable to communities of color. Further, the therapists practicing EMDR are largely White and do not represent the racialization and marginalization of African American clients. Therefore, culturally relevant adaptations are necessary for treatment success. An example of this is regarding pacing. All of the participants in this study referenced the significance of understanding what EMDR was, possible consequences, and how they might experience benefits, at a pace considerably slower than the standard EMDR protocol. African American clients must feel aligned with their therapist for effective therapy to occur; racial, cultural, or ethnic differences notwithstanding. White therapists who are not aware of their privilege and social location may not thoroughly understand their clients as racial beings, increasing their likelihood of inadvertently engaging in racial microaggressions; as a result, minority clients may perceive them as biased, prejudiced, and mis-attuned (Sue et al., 2007).

A final cultural adaptation is trust and the capacity to be seen in relation to problem presentation, history, trauma experiences, and racial (and/or other intersectional) identity. All the participants disclosed that they felt safer to try EMDR treatment based on their trust in the therapist. Trust of the therapist is not established only by racial similarity. Although seeking out a therapist of similar demographics can promote healing and provide greater acceptance and legitimacy to promote true rapport (Franklin & Boyd-Franklin, 2000). What researchers learned from these clients is that it is not enough to focus on the trauma alone. Racial consciousness is a critical consideration in White therapists' ability to effectively treat Black clients (Helms & Cook, 1999). Because mental health professionals carry power, it is incumbent upon the therapist to initiate a dialogue regarding race in therapeutic spaces. From responding to microaggressions or reacting to their own racialized material, clients are less likely to confront their therapist and more likely to question their own perceptions or drop out of treatment altogether (Sue et al., 2007).

Recommendations for Psychotherapist Utilizing EMDR with African American Clients

1. Spend more time providing psychoeducation on the front end
   Clarify. What is EMDR and how does it create change? How might clients maintain a level of control while engaging in EMDR? Prepare them for activation in other areas (such as oppression based memories or experiences) and acknowledge a) it is a normal part of the process; b) you are able to manage and tolerate these experiences; and c) what they can do if they become uncomfortable or overwhelmed by these memories

2. Therapist transparency regarding positionality and social location in therapy
How does power and privilege play a role in the treatment process and how does it create barriers and distrust in the work? Who are you as the therapist? How might your privilege become challenging while engaging in trauma work, especially with oppression-based trauma?
3. Create a safer space for client and build a trusting relationship with the therapist
This comes from the consistency in how the therapist shows up in the therapeutic space. Therapists need to build an authentic relationship and foster community prior to starting EMDR with African American clients by inquiring about who they are and incorporating their lived experiences (their histories, their narratives and ultimately—their strengths) into the therapy space.
4. Therapist must spend more time to get the client used to how this method will impact the client's experience with EMDR (e.g. feeling overwhelmed).
What memories might this bring up? What are other experiences (trauma, racialized or other) that might come up as we unpack these memories?
SUGGESTION: Therapist would benefit from creating a racialized experiences timeline with the client prior to initiating bilateral stimulation to address race-based traumatic experiences that might not otherwise come up or get addressed in treatment.
5. Therapist to provide follow up at the end of session and afterward. Preparation for leaving includes sensitivity to external world and racialized reality.
Creating time at the end of a session to support clients putting the symbolic "armor of protection" or "protective mask" back on prior to leaving. Acknowledging feelings of vulnerability, exposure, irritability and validating aggression as it may relate to racialized discomfort experiences that came up in treatment due to life experiences. Ultimately, follow up sessions can focus on anger/powerlessness or whatever themes emerge during EMDR treatment to mitigate its impact on day to day functioning.

Conclusion

While this article does not represent all African American clients' experiences who have received EMDR treatment (due to the small sample size), it does provide common themes based on experiences while receiving this form of treatment. This article sought to explore the experiences of African American clients receiving EMDR psychotherapy treatment. The authors utilized an anti-oppressive, Critical Race theoretical perspective to examine case studies of four African American clients who received EMDR in order to gain insight into the unique nuances that arise during treatment. Emphasis was placed on critiquing the treatment protocol, the positionality of the clinician, and clinical implications for future anti-oppressive practice with African American clients utilizing this model. Findings indicate that adaptations such as slower pacing, inquiries regarding identity, racialized experiences and oppression-based trauma, and clarification regarding the EMDR process may be key to effective EMDR treatment with African Americans. Further, the awareness of significant African American historical trauma by White therapists, acknowledgment of their own racial identity and social location, and willingness to explore power and privilege dynamics in therapeutic spaces may reflect the critical consciousness necessary for African American clients to benefit from this approach.

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