CHAPTER 1

Cultural Competence and EMDR Therapy

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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

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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*

Competence 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 countervail 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 EDMRIA 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.

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