SECTION I

ENHANCING CULTURAL COMPETENCE AND ADDRESSING CULTURALLY BASED TRAUMA AND ADVERSITY IN EMDR THERAPY

CHAPTER 1

CULTURAL COMPETENCE AND EMDR THERAPY

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Developing cultural competence 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 informed framework can reshape how clinicians understand and approach their roles and interventions. While the need for culturally informed professional practice has always existed, the urgent and non-negotiable call for it has steadily increased in recent years. In the United States, for example, multicultural demographics are rapidly changing toward greater diversity, and we continue to be a country that offers a haven for refugees and new opportunities for recent immigrants. Yet we are also a nation stained by racist slavery and the historical and ongoing exploitation and systematic marginalization of individuals within difference cultures and cultural identities. Systemic oppression and other forms of culturally based trauma and adversity are a global reality.

In an increasingly interrelated multicultural world, it is imperative that mental health professionals be a leading force in understanding and serving the needs of diverse cultural populations and identities. As advocates for mental well-being, we are professional leaders. And so, it is imperative that, within the field of psychotherapy, which deals so intimately with who people are and where they struggle, we invite and address the culturally related aspects of our clients' realities.

The remaining chapters of this book will provide rich illustrations of the many culturally related components of the human experience including detailed case examples, scholarly research, theoretically relevant information, and clinical recommendations for psychotherapy in general but, most specifically, EMDR therapy. EMDR therapy has distinguished itself as an evidence-based treatment for trauma and adversity that builds psychological resilience. This book is dedicated to expanding the culturally informed scope of what is addressed in EMDR therapy to include cultural attunement and an anti-oppressive approach.

This chapter aims to introduce and contextualize the book with a meta-professional exploration of the intersection of cultural competence and human services delivery and integrate these ideas and best practices into EMDR therapy. Key purposes of this book are to advance overarching principles and practices of cultural competence, to increase knowledge and skill levels among EMDR clinicians, and to inspire continued attention and innovation. Another purpose is to advance and ultimately help EMDR therapy distinguish itself in the broader field of mental health as a culturally informed trauma psychotherapy.

DEFINING CULTURAL COMPETENCE

One of the fundamental challenges to advancing the discussion about cultural competence in the field is simply defining the concept. The term "cultural competence" was first used in the 1980s as

part of a broad examination of the field of health and human services and their systems of care (Cross et al., 1989). Since then, it has gained broad acceptance among individuals and organizations that seek to provide services that are culturally sensitive to a wide range of people. Cross et. al. defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations" (Cross et al., 1989, p. 7). They defined "culture" 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, p. 7). This broad meaning of culture, which includes a range of socially salient groups in a person's life, is an important dimension of social identity.

"Competence" is defined as "the capacity to function effectively" (Cross et al., 1989).

Five essential elements of cultural competence were identified: (a) valuing diversity; (b) having the capacity for cultural self-assessment; (c) being conscious of the dynamics inherent when cultures interact; (d) having institutionalized culture knowledge; and (e) having developed adaptations to service delivery reflecting an understanding of cultural diversity (Cross et al., 1989, p. 8).

Since the concept was established, many organizations have aspired toward cultural competence and built upon these core concepts (Denboba, MCHB, 1993; Lavizzo-Mourey & Mackenzie, 1996; National Alliance for Hispanic Health, 2001; U.S. Department of Health and Human Services, & Administration for Children and Families, Administration on Development Disabilities, 2000; U.S. Department of Health and Human Services, Health Resources and Services, Administration, & Bureau of Health Professions Division of Medicine and Dentistry, 2004). From an organizational perspective, Betancourt et al. (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 the 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 cultural 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-García (1998) introduced the term of "cultural humility" as an important mindset or stance from which to approach cultural issues. This concept expanded upon Cross et al.'s (1989) third tenet of "having the capacity for self-assessment." 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-reflection 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 within 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 stated that 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 and entails suspending one's own culture-centric views when entering the world of a client. Hook et al. (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]."

In addition to an increasingly articulated need for cultural humility, others have proposed additional concepts, terminology, and recommendations for cultural competence. 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 et al. (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.

PROFESSIONAL ASSOCIATIONS STEPPING UP: THE MANDATE FOR CULTURAL COMPENTNECE

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) 2021 Amendments to their code of ethics includes and updated section on Cultural Competence which reads as follows:

a. Social workers should demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
b. Social workers should demonstrate knowledge that guides practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups. Social workers must act against oppression, racism, discrimination, and inequities, and acknowledge personal privilege.
c. Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction); recognizing clients as experts of their own culture; committing to life-long learning; and holding institutions accountable for advancing cultural humility.
d. Social workers should obtain education about and demonstrate understanding of the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.
e. Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients' use of and access to electronic technology and seek to prevent such potential barriers. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues. (NASW Code of Ethics, 2021, p. 2)

The American Psychological Association (APA) published updated guidelines in the *Monitor on Psychology* regarding multicultural guidelines, *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2018). These guidelines (partially reduced) include the following. Bold print emphasis provided by APA:

1. Psychologists seek to recognize and understand that **identity and self-definition are fluid and complex** and that the interaction between the two is dynamic… and appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond **conceptualizations rooted in categorical assumptions**, biases, and/or formulations based on limited knowledge about individuals and communities.
3. Psychologists strive to recognize and understand the role of **language and communication** through engagement that is sensitive to the lived experience of the individual, couple, family, group, community and/or organizations with whom they interact.
4. Psychologists endeavor to be aware of the role of the **social and physical environment**.
5. Psychologists aspire to recognize and understand historical and contemporary **experiences with power, privilege, and oppression**. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.
6. Psychologists seek to promote **culturally adaptive** interventions and advocacy within and across systems.
7. Psychologists endeavor to examine the profession's assumptions and practices within an **international context**, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.
8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger **biosociocultural context**, how identity evolves as a function of such intersections and how these different socialization and maturation experiences influence worldview and identity.
9. Psychologists strive to conduct **culturally appropriate and informed research**, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy.
10. Psychologists actively strive to take a **strength-based approach** … that seeks to build resilience and decrease trauma within the sociocultural context. (APA, 2018)

The International Society for Traumatic Stress Studies (ISTSS) 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" (ISTSS, 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" (ISTSS, 2016).

The EMDR International Association (EMDRIA) has embraced the pursuit of cultural competence. EMDRIA's multidimension policy on *Diversity and Cultural Competence* affirms organizational core values of diversity and inclusion and seeks "to ally with and contribute to the general movement toward cultural competence within the fields of health service provision, education and elsewhere." (EMDR International Association, n.d.-a, n.d.-b). The 2022 EMDRIA Board Goal for Racial Equity and Inclusion states: "EMDRIA actively engages in a process to eliminate structural racism and racial prejudice in our organization and repair the harm caused by White supremacy and racial inequities within our respective purviews." Objectives within this goal include review and of organization practices; increased awareness and accountability of trainers, consultants, and members; and increased resources to those impacted by structural racism. The EMDRIA.com website

offers a webpage dedicated to extensive Antiracism Resources. Importantly, EMDRIA has offered a steadily increasing number of presentations at the EMDRIA annual conference devoted to cultural awareness and responsiveness and increasing resources are being put into this focus. This increase has also been a credit to the increasing number of speakers prepared to speak on this topic.

THIS BOOK'S TITLE

It is important to note a lot of thought went into the book's title and the term "cultural competence." Some people have negative reactions to the term "competence" as it might suggest that some are competent and some are not, or that no one can be truly competent in this area. Many, including myself, often use other terms which you will see throughout this book. Different terms such as cultural humility, cultural responsiveness, cultural awareness, cultural attunement, and cultural congruence can have important nuances and are often more fitting or relatable. Yet as one follows the history of the terminology, cultural competence is the broadest "umbrella" term that encompasses all of the terms listed. Recently, many have emphasized the importance of "cultural humility"; however, it is important to clarify that this awareness has always been consistent with a culturally competent approach and does not more directly depict the other dimensions of cultural competence such as the development of important knowledge and skills. In a plenary presentation at the 2020 Annual EMDRIA conference, Black, Indigenous, and People of Color (BIPOC) EMDR therapists David Archer, Wendy Ashley, Quandra Chaffers, and Allen Lipscomb (2020) called for an expanding and evolving definition of cultural competence. They also advocated for a "culturally responsive" approach emphasizing that it is not just an *attitude* of cultural humility that is important, but *action*. Archer, Hernandez, Ashley, and Lipscomb have further articulated the need for a proactive anti-racist (anti-oppressive) approach to psychotherapy (Archer, 2020; Hernandez, 2020; refer to Ashley & Lipscomb, 2020, Chapter 8). The EMDR and Diversity, Community, and Culture SIG, currently led by Diane DesPlantes and Quandra Chaffers, has an active membership which has provided ongoing member-led education.

Additionally, we use the term "cultural competence" in our title because this is a book for mental health professionals, and the term "cultural competence" continues to be the term primarily used in fields such as medical healthcare, mental healthcare, education, and others. Our clear intention is to link EMDR literature, and this book in particular, to the broader professional discussion of cultural competence.

The term "culturally based trauma" is included within the book title because much of this book is about addressing types of trauma which is primarily caused or otherwise enhanced within a cultural and societal context. In Chapter 3, the fuller term *culturally based trauma and adversity* (CBTA) will be used to define and explore themes of culturally related trauma.

EMDR THERAPY AND CULTURAL COMPETENCE

So how does the individual EMDR therapist embrace cultural competence in their EMDR practice? First off, it need not be undertaken alone. In fact, that is almost antithetical to an appreciation of the group connection underlying the meaning of culture. As a collection of EMDR therapists, we are fortunate to have the solid base of a powerful psychotherapy method to build upon as we integrate culturally aware insight and skills to improve EMDR therapy work. Specific approaches and methods that are consistent with cultural competence will be described throughout this book

As EMDR gains ever-broadening acceptance and stature throughout the world, I believe that it is crucial that those committed to EMDR advancement work together to define and embrace cultural competence, both for the benefit of EMDR therapy and the field of mental health in general. Indeed, over the last 5 years in particular, there has been a steady rise in EMDRIA-published articles and conference presentations devoted to cultural considerations. EMDR therapy is well-positioned to become a model for culturally aware and effective trauma-informed intervention. Currently, I believe that there are five distinct ways in which EMDR interventions demonstrate 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 recommends assessing the importance of cultural identity and context;
3. A client-centered model that encourages adapting EMDR to the client's realities and needs;
4. A growing body of knowledge in the form of published articles and presentations documenting EMDR applications with different client cultural populations as well as useful and accessible non-EMDR information; and
5. The capacity to successfully treat the effects of adversity and trauma, which is increasingly being applied to 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 effectively throughout the world. EMDR regional membership organizations coordinate training and collaboration on all continents and there are over 50 national EMDR organizations. This alone speaks to EMDR as a culturally adaptable treatment. EMDR as a professionally guided intervention is least developed in economically underresourced regions of the world where mental health delivery is likewise limited. Nevertheless, EMDR humanitarian and membership organizations are reaching out, sometimes through voluntary efforts, to serve some of these culturally marginalized or underserved populations throughout the world. Additionally, EMDR informed organizations are developing trauma treatment methods to be applied by allied health professionals in areas of the world with insufficient mental health systems (Global Initiative for Stress and Trauma Treatment [GIST-T]). The Francine Shapiro Library contains numerous citations to presentations and articles that reference a cultural component of EMDR therapy (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 psychologically relevant 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.

While to anyone reading this book, it might seem obvious that embracing our client's cultural identity, values, and experiences is crucial to understanding and being accepted as a trusted therapist to assist them, this has not been the norm in our profession. Indeed, mental health professionals, including psychotherapists, have been criticized for operating with a *culture-blind* approach that has tried to separate "cultural" issues from "personal" issues (Ridley, 2005). While this "person first" approach may be well intended, salient aspects of who a person is are closely intertwined with their cultural identities.

A culturally inclusive approach recognizes that personal identity is meshed with cultural identity. However, despite the fact that most psychotherapists are thought to have egalitarian values and awareness of the importance of cultural forces on a societal level, psychotherapy practice, including trauma-informed psychotherapy, has historically ignored, minimized, or insufficiently recognized 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*, Fifth Edition (*DSM-5*; 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 (Ecks, 2016).

Also, when therapists are insensitive to cultural identities, contexts and needs, they are at risk of implicit insensitivity or prejudicial treatment. 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 prejudicial stereotypes influenced the following clinical decision points: 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. Clearly, cultural associations are operating implicitly even when we are trying not to make them explicit.

This 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.

EMDR AS A CULTURALLY COMPETENT THERAPY: EMBRACING THE OPPORTUNITIES AS CLINICIANS

Determining Best Practices and Core Competencies

How do we as EMDR therapists take the core dimensions of cultural competence and integrate them into EMDR therapy procedures? There is a larger conversation within the field of mental health about establishing evidence-based clinical practice guidelines as a resource for clinicians. Indeed, the EMDR Council of Scholars (COS) Project is a particular effort which is undertaking the development of clinical practice guidelines for EMDR therapy. These guidelines will be informed by research, theory, and best available evidence from clinical practices. Cultural competence is a necessary component of any clinical guidelines.

There is established knowledge regarding clinical guidelines development related to "core competencies" of clinical practice. In *Core Competencies in Counseling and Psychotherapy* (2011), Len Sperry (2011) 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.

I have used the Sperry model as a way of organizing and articulating steps toward cultural competence within EMDR. 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 competence. 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 develop and outline 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. To facilitate this, it is important to create opportunities for personal reflection. Chapter 4 and other chapters in this book expand upon the need for and strategies for self-reflection. 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 attuned attitude should go beyond merely conceptualizing the client's experience and should be demonstrated by a commitment to active responsiveness to cultural needs.

Another essential clinical attitude for cultural competence is an awareness of the impact of systemic oppression. This awareness guides an anti-oppressive approach that seeks to undo the impact of oppression and supports social justice and the need for social equity, diversity, and inclusion (Archer, 2021; Ashley, 2021).

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, 2018) to meet client needs, including the client's culturally related needs. Skills to attune other standard EMDR procedures for cultural effectiveness include building culturally conscious therapeutic alliances as well as implementing culturally aware assessments, case formulations, and treatment plans. Specific examples of these components can be found throughout this book. 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 (AIP) model (Shapiro, 2018) and accomplish the primary goals of those phases.

There are many additional 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 are 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 understanding 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 their 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 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 with the movement toward cultural competence, EMDR already has much to offer in this pursuit. 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. The development of EMDR therapy has 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.

Cross-Cultural Effectiveness

As mentioned, EMDR therapy has been used trans-globally. While there is still much information to be gathered about adaptations of EMDR to different regional and cultural populations, some core components of EMDR procedures that appear to contribute to its effectiveness with a wide range of cultural populations include that EMDR:

- is client-centered (client finds their own resolution or meaning);
- places 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 (Validity of Cognition [VOC], Subjective Units of Distress [SUD]);
- requires no homework, literacy, or translated client materials;
- integrates universal brain biology into the AIP model;
- respects inherent healing mechanisms;
- adapts bilateral stimulation methods;
- builds on existing cultural resources/beliefs (e.g., local mindfulness practices common to many cultures);
- encourages therapist attunement and non-intrusiveness;
- allows for the problem to be identified in the client's terms; and
- is effective for a range of adverse experiences.

Not only can EMDR standard treatment be adapted to different cultural populations, but it can be used to specifically treat the overall effects of CBTA. This will be explored more in other chapters. 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.

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 United Nations, UNICEF, and the World Bank, has estimated that over 500 million people globally suffer from unresolved trauma (Carriere, 2014). EMDR humanitarian organizations have organized and sponsored EMDR interventions and local trainings with a sense of purpose that affirms the societal consciousness and concern that exists within the EMDR practitioner 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. The Global Initiative for Stress and Trauma Treatment (GIST-T, n.d.) organization and Trauma Stress Relief (TSR) program implements trauma-informed "second aid" interventions for underresourced regions which bridges the gap between trauma "first aid" and the robust full EMDR therapy treatment procedures. This "mid intensity treatment" has been conducted by carefully trained allied health professionals and is another way to extend EMDR informed trauma treatment to those in need.

Making a Commitment to Cultural Competence: Setting Goals

Based upon a review of the literature regarding cultural competence, professional organizational recommendations, clinical competencies, and my own experiences within EMDR therapy, I have generated a list of specific areas of focus for EMDR clinicians and EMDR organizations who are

actively pursuing cultural competence. For clinicians, these are specific areas of focus that are further described throughout this book with relevant information and recommendations.

Cultural Competence Goals for Clinicians

1. Understand the general importance of culture and the value of viewing individual client issues within their unique cultural contexts (including norms, values, beliefs, needs, etc.).
2. Reflect upon the meaning and influences of one's personal cultural experiences and identities.
3. Maintain curiosity about other cultures with an attitude of humility which seeks to expand the limitations of one's own cultural perspective.
4. Adapt EMDR therapy methods to a client's cultural context and needs.
5. Assess for and treat the effects of culturally based trauma and adversity.
6. Empower clients in building resilience related to culturally based trauma and adversity.
7. Provide psycho*social* education to clients as appropriate.
8. Assess for and 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, anti-oppression approaches and policy reform.
10. Sustain therapist organizations which support the cultural competence of practitioners, and which are culturally competent organizations.
11. Seek ongoing education and training as needed to continue to develop cultural competence.

Cultural Competence Focus Areas for EMDR Organizations

These include the following:

1. Endorse explicitly, as an organization, core values aligned with cultural competence including the importance of diversity, inclusivity, societal equity, and anti-oppression values and policies.
2. Build and maintain cultural diversity of membership and leadership at all levels.
3. Strive to make EMDR treatment options available to and effective with people of all cultures and economic capacities.
4. Define and develop standards of cultural competence within EMDR therapy and integrate them into overall core competency standards within EMDR therapy.
5. Define and maintain cultural competence standards for EMDR-approved educational programs, trainers, and 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.

These goals are meant to inspire and guide reflection that leads to action. They are simply one set of recommendations that can be used to identify one's own priorities for personal and professional growth.

SUMMARY

Within the field of mental health, understanding and aspiring for cultural competence is a non-negotiable one-way path forward. Yet, it is important that this be a collective effort involving learning and collaboration. As EMDR clinicians and organizations, we have the potential to be leaders in the field of the culturally adaptive and effective trauma informed treatment, to embrace and build cultural resources and resilience, and to address the effects of culturally based trauma and adversity.

The content of this book seeks to be consistent with the emerging positions of NASW, APA, ISTSS, EMDRIA and prominent definitions of cultural competence. Indeed, the book's core purpose is to deepen the clinician's understanding of approaches to cultural competence in general psychotherapy and within EMDR therapy. The pursuit of cultural competence is an ongoing challenge, and the ASK model is offered in this chapter to help organize an approach that enhances a culturally aware and responsive attitude, enhances clinical skills, and deepens knowledge.

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