

go with that

magazine

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A person's hands are shown holding a black fabric face mask. The mask is held up in front of the person's face, which is mostly obscured. The mask has the words "WE NEED A CHANGE" printed on it in white, bold, uppercase letters. The background is dark, and the lighting highlights the texture of the mask and the person's hands.

WE NEED
A CHANGE

EMDR & RACIAL TRAUMA

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On the Cover

Tragic deaths of our Black brothers and sisters that made the news this past summer have created a societal tipping point as we begin to have our collective eyes opened to the systemic oppression and silence that Black, Indigenous, and People of Color (BIPOC) Americans have faced for centuries at the hands of White Americans. Although it feels overwhelming to make a difference against this system, that is what many of you as trauma therapists signed up to do. We look to see how EMDR can mend divides to heal trauma, raise awareness, and advocate for those who need it most.



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CREATING GLOBAL HEALING, HEALTH & HOPE

Letter from the Executive Director

MICHAEL BOWERS, MA; EXECUTIVE DIRECTOR, EMDRIA

Dear Colleagues:

I'm writing to let you know about some changes coming in 2021 regarding the *Journal of EMDR Practice and Research (JEMDR)*.

For years EMDRIA members have been able to choose to have a printed copy of the *JEMDR* if they wished, in addition to online access to the Journal. In the last decade, there have been increases in costs associated with printing, mailing, and administrative overhead that EMDRIA has absorbed to make these printed copies available. Simultaneously, increases in dues in the last decade and more have not kept pace with inflation and an overall rise in costs for these and other items.

EMDRIA remains committed to keeping membership dues as low as possible while still providing relevant and valuable services. The online access to the *JEMDR* will always remain available to members. Still, we now need to institute a fee for the costs associated with receiving a

printed copy of the Journal.

We will not raise dues in 2021. However, beginning with the first issue in 2021, any member who wishes to receive a printed copy of the Journal will need to purchase a print copy subscription. The cost will be \$20 (\$5/issue) for an annual printed copy subscription. If you are receiving a printed copy of the *JEMDR* in the mail and wish to continue to do so, you will need to purchase a printed copy subscription before January 31, 2021. This will also be the case if you have had online access only and now wish to begin receiving a printed copy of *JEMDR*. And please remember that everyone will still receive online access to the *JEMDR* as part of your membership dues, regardless of whether they purchase a printed copy subscription.

We wanted to give you notice of this change as early as possible. Specific instructions for how to purchase a printed copy subscription of *JEMDR* will be coming to you soon in another email and through the *E-News*.



Thanks for your continued membership. EMDRIA will do everything in its power to keep costs low and continue to improve our services and the value of membership. We wish you the best in this season. Please take care and stay vigilant with the virus spread. We hope you can practice good self-care and stay resilient as we all work to help others.

Sincerely,

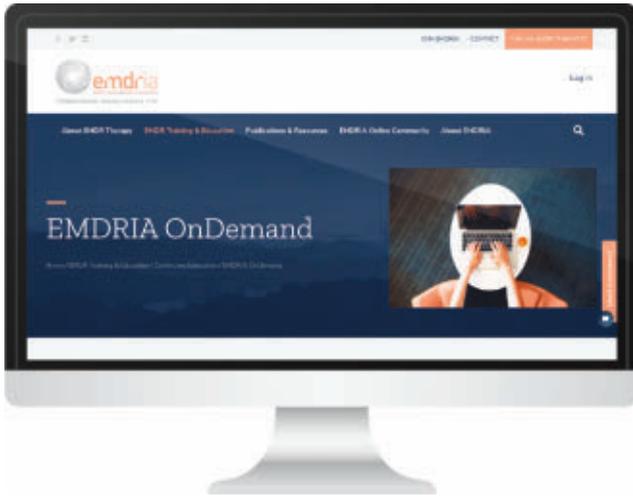
Michael Bowers, MA
Executive Director, EMDRIA

EMDRIA Website Now Translated into 100 Languages

EMDRIA now offers its website in almost 100 languages. You can translate any EMDRIA page you are on into the language of your choice. Language translation is also a fantastic option for your potential patients who might need EMDR information translated into their native

language. However, please note that once you sign in to your member account and visit Impexium (association management system/database) for invoices, member dues, etc., you will not be able to translate this website into another language. Also, when you log in to the Communi-

ties pages, you cannot translate the discussion groups either since the Communities pages are hosted on the Higher Logic website. Visit www.emdria.org and choose the "Select Language" dropdown box on the website's top right navigation bar to see all language choices.



OnDemand Gets a Makeover

Our OnDemand portion of the website is now revised and open. We moved to a provider that offers a more enhanced experience for our members. OnDemand reopens with new content. We have added presentations from the 2019 and 2018 Annual Conferences. Visit this landing page www.emdria.org/emdr-training-education/continuing-education/emdria-on-demand and log in to view the content.



EMDRIA Has a New Address

As we've reported before, EMDRIA's office staff started working remotely in the spring because of the global pandemic. The association decided not to renew its office lease that expired at the end of November as the team will continue to work remotely. We do have a new flexible office space with Regus. The new address for mail and package delivery is:

7000 North Mopac Expressway,
Suite 200,
Austin, Texas, 78731-3013

The phone number and website address remain the same.

MEMBER TIP Therapist Directory Page

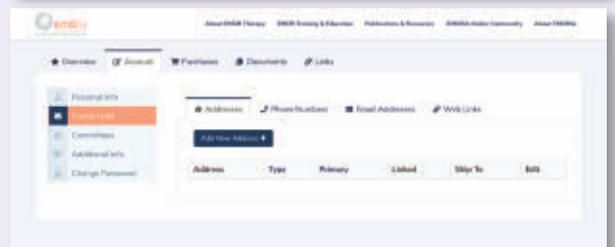
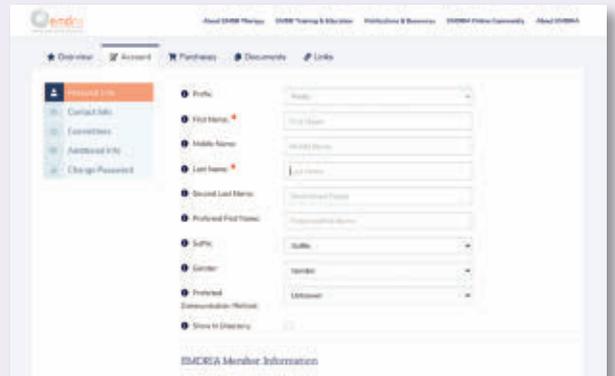
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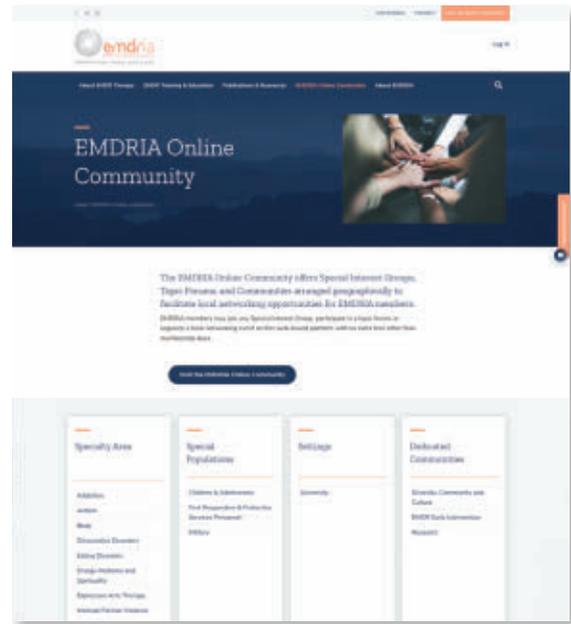
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UPDATE

Special Interest Group Gets New Name

The new Diversity, Community, and Culture SIG, formerly the EMDR and Public Practice and Diversity SIG, provides a forum for dedicated discussions regarding intersectional clinical issues of interest relevant to communities of color and LGBTQ communities. The membership invites clinicians who are working with (or who are interested in working with) these issues in underserved and diverse communities, especially in community mental health to participate. We also desire to promote the advancement of clinicians from these communities through the process of becoming consultants and trainers. The SIG practices and embraces anti-racism, cultural humility, and social justice. Visit <https://www.emdria.org/emdria-community> and see all of our SIGs and other communities.



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RACIAL TRAUMA, NEURONS, AND EMDR: THE PATH TOWARDS ANTIRACIST PSYCHOTHERAPY

BY DAVID ARCHER, MSW, MFT



Society has a problem with the concept of race. This concept is both remarkable and disturbing. It drives and maintains so much suffering yet is a highly malleable construction based on social policies and political opinions. Race impacts our psychotherapy. It is much more than skin deep, being that it permeates the life of the individual who seeks help and the one who provides it. The client and therapist are both caught in a world where decisions regarding whether their lives matter are based not so much on their contribution to the world but on the world's attribution of their life's value based on their skin color.

Race has an exceptionally strong impact on our emotional, physical, and economic wellbeing. It also affects our trauma histories. Despite the fact that as a general concept, race is fake. It's not real; it's a social construction (Rutherford, 2020). But for clients who are either White (or "racialized" into privilege), or BIPOC ("racialized" into disadvantage), these fake realities create real consequences.

History will remember the year 2020 for the impact that COVID-19 has had on the global population. We will also remember it for the #BlackLivesMatter

movement; the protests by people of all races sparked around the world due to the murders of African American men and women at the hands of White police officers. Much like COVID, we cannot predict the scale that this trauma will have on later generations. But regardless of any individual's race, because of the scale and exposure to the repeated videos of police violence, we have all been touched by this second viral pandemic, the trauma of Anti-Black racism. Taking this into account, these issues are especially important for EMDR practitioners.

Mark Nickerson (2017) introduces his text on cultural competence by citing a researcher named Ridley (2005), explaining there are over 80 studies that demonstrate that psychotherapists engage in discrimination during their practice. Nickerson goes on to list how discrimination affects every clinical activity we undertake: treatment planning, diagnosing patients, seeking consultation, and managing our countertransference.

Francine Shapiro (2002), the founder of the EMDR International Association, wrote that the practice of psychotherapy must occur with an understanding of the interlocking systems that a client is

a part of and an acknowledgement of their cultural context. Based on the current sociopolitical context, if psychotherapists are to properly serve the public, which has also been affected by the trauma of racism, it is in their best interest to familiarize and increase the level of their racial consciousness. Professionals must be aware of the vital consequences that racial trauma places on the public and the next generation of psychotherapists. But something must change in the approach.

Previous diversity training models are insufficient for managing the social problem of racism as it exists in society. An approach based on the tenets of critical race theory (CRT) and anti-oppression may help to shed light on racial issues in our countries, and one day may be able to assist psychotherapy practices so that clinicians can finally treat racial trauma at its core.

This article is composed of four main sections. The first section relates to a discussion on CRT and the social construction of race; Secondly, differential factors commonly observed between Black and White clientele will be highlighted followed by Young's five categories of social oppression; thirdly, the concepts of racial trauma, neurological aspect related to PTSD, and the process of allostatic load will be explored; and finally a critique of cultural competence will be presented, accompanied by recommendations for cultivating an antiracist approach to psychotherapy.

PART ONE: **Critical Race Theory and the Social Construction of Race**

Although race is largely seen as a social construction and racial designations are non-scientific (Rutherford, 2020), race has significant impacts

Despite not being scientifically valid categorizations, the pseudoscientific categories of “Black” or “White” have significant consequences. People generally see the color Black from a negative perspective of “darkness” and the word White as reflecting “light” or neutrality.

on the daily activities of those who are labeled as being BIPOC (Black, Indigenous, People of Colour). Despite not being scientifically valid categorizations, the pseudoscientific categories of “Black” or “White” have significant consequences. People generally see the color Black from a negative perspective of “darkness” and the word White as reflecting “light” or neutrality. Mohammed and Smith (1999) explain that “Black” people may then come to see themselves as “Black” in addition to seeing themselves as people. Generally speaking, the color Black has largely negative connotations as opposed to White, which naturally will lead to a different lived experience depending on whether one considers themselves to be Black. Conversely, White people often do not connect their race to their everyday experiences (Mohammed and Smith, 1999) or their identity (Todd and Abrams, 2011). For this and many other reasons, in North America, racial minorities may see themselves as exceptionally different from those considered the racial majority.

If society acknowledges that systemic racism is real, it means that there is a benefit in a social and political system that privileges Whiteness over Blackness. The term White Supremacy implies that there are preferences and advantages for Whiteness in our society. This implies that there is a disadvantage to being Black. The polarity of colors and their people is thus maintained; it can be argued that White Supremacy is therefore contingent on Black suffering, which creates homeostasis in social systems. Both White Supremacy and Black suffering are normalized and generally accepted around the world.

Although Whiteness carries privileges and advantages in societies that see Black as being generally disfa-

vored and undesired, there are still costs incurred when one is in a situation where they are meant to be the ideal. Of course, White people suffer as well in this destructive homeostatic pattern. White Americans complete suicides at a substantially higher rate than Black Americans. In 15 years Ivey-Stevenson and colleagues (2017) found that the total amount of recorded suicides for White Americans between 2000-2015 was over 450,000, while in that same period, it was roughly 31,000 for Black Americans.

Alexander, Barbieri, and Kiang (2017) found that regarding substance abuse, specifically related to opioid mortality rates, the White American population appears to have approximately double the rate of death compared to Black populations.

For anorexia nervosa as well, there may be racial disparities. Although this disorder is especially challeng-

ing for those who are affected by it, even having a higher mortality rate than several other psychiatric disorders (Arcelus et. al, 2011), symptoms become especially prevalent when women subscribe to so-called “mainstream” White body ideals (e.g. thinness). Adhering to these ideals increases the chance of developing symptoms of this terrible disorder regardless of one’s racial categorization (Gordon et.al, 2010).

To appropriately address issues relating to race, clinicians must review tenets that have already been widely discussed from the lens of Critical Race Theory (CRT). Derrick Bell and his colleagues, who were in the field of legal studies, originally developed the theory and the following tenets (Delgado & Stefancic, 2012). Understanding these principles will promote a common vocabulary and improve comprehension when discussing race and

racism in North America.

Delgado and Stefancic (2012) explain that there are six basic tenets:

1. Racism Is Ordinary

The experience and the influence of racism are common and widespread throughout the world. Its influence and impact stretches throughout various fields of study and institutions. Racism is not just limited to specific occupations or individuals. All people are susceptible and have all normalized some aspects of racism.

2. Racism Serves a Purpose

Granting a privilege of Whiteness over other racial identifiers serves a function in our society. Based on what the authors consider as “interest convergence,” White people gain both material and psychic benefit from Anti-Black racism. For example, rich White people benefit economically, and more impoverished White people benefit



psychologically. For the former, creating a caste-based system can facilitate exploitation and strategies for financial gain. For the latter, there is a false sense of security, knowing that there is a group of individuals who may be “worse off.”

3. Race Is a Social Construction

As has been previously mentioned, race holds minimal biological, genetic, or scientific merit (Rutherford, 2020) as a concept. Race as a concept is pseudoscientific in that while there are certain physical characteristics which may vary between groups, higher-order traits related to personality, intelligence, and creativity are universal. Still, racial stereotypes frequently disregard the universality of human experience and commonality. People often emphasize the differences between groups rather than the similarities.

4. Differential Racialization

The process of racialization is different for each racial group and can also differ with time. African Americans may have a different experience from African Canadians. Chinese Americans may have a different experience from Latin Americans. Additionally, stereotypes about specific racial groups can change with time. Racial categorizations carry a function and can change depending on the economic and social goals of a country.

5. Intersectionality

Kimberlé Crenshaw popularized this term where she explains that “various forms of inequality often operate together and exacerbate each other... What’s often missing is how some people are subject to all of these [forms of inequality], and the experience is not just the sum of its parts.” (<https://time.com/5786710/>

There is both an impact at the micro and macro levels; more than just the impact on one’s mental and physical health, systemic racism also impacts an individual’s capacity for upward mobility and financial security.

kimberle-crenshaw-intersectionality) No individual has one unitary identity. A White feminist can be Jewish. A Latinx lesbian can be an atheist. There is no monolith. All people have varying overlapping identities.

6. Unique Voice of Color

Because of the diverse realities of individuals from different racial groups, we all gain from hearing from the experiences of other racial groups. The perspective of the Latinx individual differs from that of the Indian. As a Black psychotherapist, there are events that I can relay and experience that a White psychotherapist cannot see and experience and vice-versa.

While this article will mainly focus on the effects of Anti-Black racism from a North American perspective, we still would need to hear from members of our diverse and global EMDR communities of color to get the full spectrum of the challenges that we are all facing.

PART TWO: Differential Factors and Young’s Five Faces of Oppression

Black (potential) clients do not seek out therapists at the same frequency as White clients for various reasons. It can be due to various systemic barriers and discrimination (Beach et al., 2011; Barton et al., 2016). Additionally, there are cultural perceptions that Black people do not feel as much pain as White people— such as numerous reports that Black women are provided epidurals at a lower rate than White women during pregnancies (Glance et al. 2007). Furthermore, there is a general cultural distrust from Black people toward White institutions (Dempsey, Butler, & Gaither, 2016). One of the most frequently cited reasons for this cultural distrust is the



Tuskegee Syphilis Study (Freimuth et al. 2001).

Despite these differences, Dempsey, Butler and Gaither (2016) explain that there are several differential outcomes experienced by Black people which differ from White people. African Americans experience higher rates of severe mental illness, inpatient admissions, misdiagnosis rates, depression, PTSD diagnoses, and dual diagnosis comorbidity. Despite these discrepancies, there are still lower rates of receiving mental health care treatment.

Additionally, researchers have generally found that there are lower rates of health-related services for Black people, lower rates of couple satisfaction, and higher rates of marriage dissolution (Beach et al, 2011). Compared to White respondents, Black youth and students have comparatively lower success in high school, lower levels of university participation, and lower rates of achievement

than White counterparts. Black people generally have higher rates of unemployment and higher rates of poverty (Kelly et al., 2013).

Many people are well aware of these disparities in part because racism is ordinary. Racism is also systemic because its consequences and effects are multi-dimensional. There is both an impact at the micro and macro levels; more than just the impact on one's mental and physical health, systemic racism also impacts an individual's capacity for upward mobility and financial security. Any discussion about racism must include this analysis of difference and dichotomy, which illustrates the interplay of White Supremacy and Black Suffering, but must also include another form of categorization: Capitalism's economic system. There is a confluence between the economic and social system, which plays an enormous responsibility in the disparities experienced by Black people

when compared to White people.

Taking into account all of the above, it is clear that Black people experience a different reality and an environment that is hostile (Phelan & Link, 2015). But it is necessary to consider the impacts of the economic system, namely the impact of socioeconomic status (SES), and what role it plays in one's life. SES has often been shown to be implicated in multiple health disparities between populations. (Dempsey, Butler, & Gaither, 2016; Kelly et al., 2013). Researchers have also found that lower SES status appears linked to higher incidences of adverse childhood experiences (Metzler et al., 2017). Still on the topic of SES, Reeves, Rodrigue, and Kneebone (2016) discussed a number of ways that poverty impacts our communities. They categorized it as the "five evils of poverty," which are:

1. low income,
2. lack of education,

3. no health insurance,
4. living in a poor environment, and
5. having no members in the family with a source of employment.

The authors found that these five categories of disadvantages clustered around race and were consistently higher in both Hispanic and Black respondents compared to White respondents.

Poverty and inequity are forms of structural violence and are integral components for the maintenance of the system of racism. While there are limitless means of enacting structural violence and oppression, Young's (2014) Five Faces of Oppression are widely cited and discussed in social work circles. The Five Faces of Oppression are categories that help to conceptualize oppression across the social and political landscape.

PART THREE:

Racial Trauma & Allostatic Load

Racial Trauma

Comas Diaz, Hall and Neville (2019) introduce their article by explaining that racism is responsible for multiple social and racial health disparities, that racial microaggressions affect physical and mental health, and that African Americans are exposed to racial discrimination more than any other group.

The authors explain that racial trauma, or race-based stress, refers to the events of danger related to real or perceived experience of racial discrimination. (p.1)

The authors explain that this type of trauma is unique in that it attacks not only the individual and their sense of self but also the community to which they belong. Additionally, the more people experience racial trauma,

the more they become predisposed to additional mental health challenges.

Bor and colleagues (2018) studied the effects of police killings on the general public, depending on the victim's race. They specifically measured the impact that it would have on White and Black Americans, depending on whether the victim was White or Black. The authors explain that there are present-day racial disparities that are still concerning. They found that mortality due to police force may be higher than statistics

The authors explained that at the time of writing their article, Black Americans were nearly three times more likely than White Americans to be killed by police, with the disparity more considerable for those who are unarmed at the time of the event.

suggest. Additionally, the authors explained that at the time of writing their article that Black Americans were nearly three times more likely than White Americans to be killed by police, with the disparity more considerable for those who are unarmed at the time of the event.

The study was quasi-experimental, meaning that the results allowed for a larger causal inference degree than other studies. The authors found that whenever police would kill unarmed Black Americans, this would be associated with worse mental health for Black Americans than for White Americans. The authors also discussed that in addition to the killings, there was an additional impact from the repeated viewings on television, social media, and other sources. Constant exposure exacerbated the mental health burden causing distress and

requiring more time off from work.

Exposure to police killings of unarmed Black victims did not cause this same mental health burden on White Americans, and neither did exposure to police killings of White victims. The authors explain that it is then not only the act itself, but the meaning ascribed to these killings—the historical and social components of it, which appears to carry an unseen impact.

The authors summarize their findings by suggesting that the results align with other racial disparities in

the United States. They decry the lack of accountability and history of violence directed toward Black Americans through law-enforcement, state-sanctioned violence, and Black genocide. All of this contributes to legitimizing Anti-Black racism and also points toward reduced public opinion toward Black people and the value of their lives.

What is especially important is that many White people cannot experience this in the same way as the Black population. Hence it is likely that in a system that sees itself as White and unaffected, there may be an underestimation as to the true significance of the traumatic impact police killings or other forms of racial trauma may have on its population and group membership. Therefore, when describing racial trauma it is especially important to understand that is triple-pronged:

The Five Faces of Oppression

Cultural Imperialism

Young conceptualizes cultural imperialism as the universalization of a dominating group's perspective and experience above other groups. In a social context that privileges Whiteness, Whiteness becomes the standard, and other groups can become stereotyped and labeled as "other." An example of this relates to how we teach through a Eurocentric perspective (Williams, 2019) and how other perspectives are not seen as the "default."

Gilbert (2006) talks about how psychotherapists base many counseling orientations on conceptions of human nature, which are based on cultural assumptions of the "self" from a Westernized perspective. Additionally, our conceptualization of mental illness and diagnosis can differ depending on the cultural context of the client (Hinton & Simon, 2015).

Exploitation

This refers to a powerful group's ability to use the labor and energy of an oppressed group for the benefit of the more powerful and usually to the detriment of the laborer. This dynamic, in a way, denotes class privilege. Examples within the therapy field of exploitation can, in some cases, be related to unpaid internships, which often are prevalent in female-dominated fields (Shade, & Jacobson, 2015; McHugh, 2017).

Powerlessness

Powerlessness is often represented as circumstances where there is a clear imbalance of power or influence, which can occur either through action or through a title. Hierarchical imbalances are often present in employer versus employee relationships. Young explains that the powerless are more often relegated to a position only to receive instructions but rarely capable of giving them. Even in academic contexts, regarding instances of sexual harassment, the more marginalized one's social identity, the more at risk they are of becoming victimized (Herbenick et al., 2019). Gender and power are vital aspects which concern professional misconduct in the psychotherapy field (Capawana, 2016).

Marginalization

Young considers marginalization as the most dangerous of the faces of oppression. Large groups of people, through labeling, can be excluded from participating in society, thus having little to no impact on their self-determination or survival. Marginalization presents itself in academic circles with regards to underrepresentation of Black and Hispanic groups as faculty members in higher education (Williams, 2017). Marginalization leads certain groups to become both invisible and stereotyped, yet also prevents them from participating by offering an explanation or rebuttal for their mistreatment.

Violence

Violence is widespread in the media and the history of the formation of North America. But violence is not limited to just events which transpire at the physical level. Black people are also subjected to damage from racial microaggressions (Williams et al., 2016) and other acts of perceived discrimination (Adam et al., 2015). It is then not only the act but also the context that the action occurs in. Young explains that violence becomes especially problematic when it occurs in a social context that accepts and permits it. The normalization of violence toward specific groups causes it to become both a social injustice and a social practice.

These categories widen our perspectives on how racism, which operates under various faces of oppression, is not limited to name-calling. It can also be multifaceted and complex. Williams' (2019) explains that racism is based on (both micro and macro) attitudes and behaviors that disadvantage individuals or groups because of their group affiliation. When talking about Anti-Blackness and systemic racism, the crucial aspect to consider is that these concepts are embedded into our institutions, social systems, and policies to benefit White people at the expense of non-White people. Individual and systemic racism feed into one another and support one another. There are many heads to this hydra, and each manifestation can be as dangerous as the next.

1. influenced by past historical events,
2. re-occurring and retraumatizing by present events, and
3. impacts the future perceptions that others have on the group.

The question to be posed is what are some of the neurobiological ramifications of racial trauma?

While racial trauma is not as of this time of writing, a “clinical diagnosis,” the effects of racial trauma are similar to post-traumatic stress disorder (PTSD). Although it is not a diagnosis in its own right, Williams

and colleagues (2019) suggest that racial trauma can merit a DSM-5 diagnosis of PTSD in certain conditions, as well as when certain ICD-10 criteria are taken into account. (https://www.apa.org/pubs/highlights/spotlight/issue-128). PTSD is associated with thought intrusions, avoidance, negative alterations in mood or cognitions, and hypervigilance (American Psychological Association, 2013). From a neurological basis, PTSD is seen as a loss of top-down inhibition over the limbic area. Researchers have shown that people who have PTSD commonly appear to have hyper-activation or in-

creased activity in the amygdala with a combination of hypo-activation in the cortical midline structures, which includes the medial prefrontal cortex, rostral anterior cingulate cortex, and orbitofrontal cortex (Boyd, Lanius, & McKinnon, 2018). It is especially important to discuss the multigenerational aspects of trauma particularly when it affects specific groups of people on a large scale. After the 9/11 World Trade Centre attacks, there was a study by Yehuda and colleagues (2005) investigating the effects on pregnant women who were exposed to this terrorist attack

and had a PTSD diagnosis. A process called glucocorticoid programming appeared to occur where alterations in the pregnant mother’s glucocorticoid response appeared to cause changes in fetal brain development during gestation for the developing child. With regards to the Rwandan genocide, researchers also found evidence for the multigenerational transmission of neurobiological changes. Perroud and colleagues (2014) also studied pregnant women and their offspring. They found several findings: that women who were pregnant while being exposed to the genocide had higher rates of developing PTSD and depression; that mothers who had PTSD had a higher chance of raising children who were more vulnerable to mental health issues once becoming adults; that there was not only this vulnerability which was transferred but also that the offspring would also inherit alterations to the Hypothalamic Pituitary Adrenal Axis (HPA Axis); and that genetic changes occurred in both the traumatized mothers and the unborn children.

And finally, Yehuda and colleagues (2016) also made a landmark study relating to parental exposure to the Holocaust. While building on the previous studies, this was also important because it was the first study to demonstrate that stressors that occurred before conception could also lead to epigenetic changes in both parents and offspring. The researchers also reported seeing an “intergenerational epigenetic priming” effect in the offspring of people who were highly traumatized. Once again, these genetic changes may be long-lasting, and it is unclear how far through the genealogy they can be passed down.

It may now be necessary to discuss some aspects relating to the HPA Axis and its relation to cortisol. Adam and colleagues (2017) discuss that the HPA Axis is primarily responsible for responding to our internal system’s stress/challenges. A primary product of the HPA Axis is the glucocorticoid hormone called cortisol. Sometimes the HPA Axis can respond as it should to stress, or habituate to it, and sometimes it cannot or will not, and thus we introduce allostatic load.

Juster, McEwen, and Lupien (2010) explain that allostatic load represents the wear and tear on our biological systems caused by an imbalance of repeated allostatic responses from stress. It is essential to understand

While racial trauma is not as of this time of writing, a “clinical diagnosis,” the effects of racial trauma are similar to post-traumatic stress disorder (PTSD). Although it is not a diagnosis in its own right, Williams and colleagues (2019) suggest that racial trauma can merit a DSM-5 diagnosis of PTSD in certain conditions, as well as when certain ICD-10 criteria are taken into account.

and colleagues (2019) suggest that racial trauma can merit a DSM-5 diagnosis of PTSD in certain conditions, as well as when certain ICD-10 criteria are taken into account. (https://www.apa.org/pubs/highlights/spotlight/issue-128). PTSD is associated with thought intrusions, avoidance, negative alterations in mood or cognitions, and hypervigilance (American Psychological Association, 2013). From a neurological basis, PTSD is seen as a loss of top-down inhibition over the limbic area. Researchers have shown that people who have PTSD commonly appear to have hyper-activation or in-

and had a PTSD diagnosis. A process called glucocorticoid programming appeared to occur where alterations in the pregnant mother’s glucocorticoid response appeared to cause changes in fetal brain development during gestation for the developing child.

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Five Faces of Oppression with Potential Solutions

1 To oppose cultural imperialism, psychotherapists can make a perspective shift toward decolonization. Recognize that racism is ordinary. Nicker-son (2017) recommends being curious and genuine in trying to understand others. It is imperative to avoid micro-aggressions in therapy. Outside of sessions, challenge the culture of Whiteness and seek cultural consultation when in doubt. Speak up about White Supremacy and acknowledge the impact of racial trauma. Silence is complicity, but being brave enough to name it may be able to change it.

2 To challenge exploitation, seek equity. In therapy sessions, encourage independence by either using the client's resource development cultural imagery, or by identifying community resources to draw strength from. Clients must have resources beyond just the therapist. Avoid gas-lighting or trying to get clients to explain racism. This is not the client's responsibility; it is up to the psychotherapists to do their work. Outside of sessions, acknowledge that there is a history of underpaying or exploiting people of color. Seek to pay equitably for services even when those doing the work come from groups that are different. Additionally, oppose policies that threaten wildlife and our climate. Support the protests of Indigenous people who have always protested policies which exacerbate climate change and the systems which value profit over people.

3 To counter powerlessness, encourage empowerment. In sessions, merely checking for pronouns can make a world of difference for non-binary, gender non-conforming people. Allow space for clients to choose RDI targets from their infinite cultural creativity, avoid imposing our cultural values on them. The other day I had clients who used scenes from the "Black Panther" movie as a source of strength. Another client used a memory from a meal their deceased grandmother used to prepare for them. Encourage people to tap into their culturally relevant sources of strength and celebrate that.

Also, if while reading this article, you may have noticed certain feelings of anger or frustration, invest in your self-

care and therapy. It is not a problem to realize that even clinicians may have ableist beliefs, homophobic tendencies, and racist preoccupations. It is only a problem if psychotherapists ignore them and decide to remain "neutral." Practice what we preach and get well so we can help others to get well. In a system that prioritizes racial oppression and assigns judgments of our complexions against one another, it is an act of resistance to cultivate self-love and acceptance.

4 Instead of marginalization use elevation. Outside of sessions, promote unique voices of colour and encourage all people to have affinity spaces and endorse BIPOC only training spaces. If people are truly marginalized, then permit them to have spaces where they can take center stage. Affinity training spaces for LGBTQ+ groups can get more work done if they do not need to stop every five minutes to explain to cis-gendered, straight people throughout their whole process. And during therapy sessions, remember that in some instances: whatever we don't discuss is what the client won't discuss. Please do your own work so that the client can feel safe to discuss race, gender, and sexuality without needing to manage the feelings of the therapist.

5 And finally instead of violence, embrace compassion. In mindfulness circles a common expression is that the first victim of anger is ourselves. Even if our frustration will be directed toward someone else, we still feel it; our HPA axis does not tell the difference all that well. Those repeated cortisol increases cause us harm. Be compassionate and realize that #BlackLivesMatter is a reasonable argument and recognize where the feelings that relate to political backlash against it are coming from. As best as possible, do not succumb to causing more violence through silencing, microaggression and denial of racism. If we truly do recognize systemic racism, recognize that it is not only in the "other" professions or disciplines. Be courageous, by being self-reflective and antiracist, by working toward the path of building more compassionate therapists, institutions, and a future for everyone.

that regardless of whether a stressor is real or perceived, the body still treats it if it is an actual stressor. It is the over-activation of the stress response systems that causes different systems to overcompensate and collapse onto themselves. Chronic stress impacts our mental and physical health. The chronic, overexposure to stress, and the nervous system's difficulty in managing or habituating, to it is precisely what allostatic load is concerned with.

McEwen (2006) describes the allostatic load model as the following: prolonged secretion of stress hormones, while adaptive during acute scenarios, can end up damaging the brain and the body over time. When we talk about chronic repetitive stresses, different systems in the biological system make efforts to compensate for the imbalances and alter their operating ranges and capabilities, eventually leading to allostatic overload. Allostatic overload is what leads to physiological dysregulation, disease, disorder, and other neurobiological challenges. Generally speaking, allostatic overload causes dysfunction throughout the central nervous system, metabolic system, cardiovascular system, and immune

system. Allostatic overload worsens and jeopardizes physical and mental health across the board.

Chronic stress, which is implicated in PTSD and other disorders, can cause neuronal changes. The hippocampus plays a role in memory and with managing the excitatory response of the HPA Axis. When stress becomes chronic, lasting many months or years, dendrites of the hippocampus begin to atrophy. Neurons in the prefrontal cortex can also atrophy. The amygdala hypertrophies and later degenerates as well. Stress not only makes us sick, it also kills our neurons. Chronic stress alters the volume of the brain, and this has been demonstrated through MRI scans (McEwen, 2006).

PART FOUR: **Critique of Cultural Competence and the Path Toward Antiracism**

Knowing that racial trauma has such a critical impact on our physical, mental, and even neurological health, it is important for psychotherapists to consider how to make a difference. While cultural competence has its strengths, cultural

competence on its own is insufficient for solving the problem of racism. Pon (2009) considers cultural competence as a means of encouraging "new racism." Whereas older conceptions of racism attempted to offer biological pseudoscientific arguments for racial inferiority, cultural competence inadvertently attempts the same by involving culture. Pon criticizes cultural competence in that it fails to examine "whiteness." An example of this is that one can technically be culturally competent about "Black people" or "Indigenous people," but no one can really be said to be culturally competent about "White people."

Pon quotes Sue (2006) explaining that Whiteness is the "default standard ... [f]rom this color standard, racial/ethnic minorities are valued, judged and often found to be lacking, inferior, deviant or abnormal" (p.16). Cultural competence frequently uses stereotypes and represents groups of people as monoliths. While meaning well, it inadvertently uses a process of "othering" and fails to analyze power either in the dynamic between individuals or in the individual who may themselves assert "competence" of a cultural group.



Pon argues that because our helping fields are built on Whiteness, this also means that fields such as social work, counseling, or psychotherapy must examine themselves.

The focus on skill acquisition, lack of self-analysis, and the lack of critical analysis of the power dynamic is meant, as Pon maintains, to preserve “benevolence and innocence” among White clinicians. Western psychotherapists exist in a context where they come from countries that have colonized, exploited, and have been great purveyors of the same multigenerational trauma that they are requisitioned to treat. Cultural competence can then be employed as a means of denying and distancing from the historical realities of oppression that the West has benefitted from. Because cultural competence does not actively

engage with the above, cultural competence potentially reinforces and maintains racism.

Abrams and Moio (2009) describe the need to move from cultural competence toward a critical race informed perspective. Cultural competence often focuses on the individual and does not consider the interlocking systems affecting the individual. Cultural competence also suggests that all races belong under the same “multi-cultural umbrella,” and while cultural sensitivity targets change at the level of our personal beliefs and agency, a model that is based on anti-oppression and critical race theory works toward acknowledging the need for change at the level of the individual.

Clinicians should implement practices that are antiracist. Anti-Racism must follow tenets of mindfulness to

be effective and self-reflective. Mindfulness, as a general concept, can be understood as being aware of events as they come to pass. Being mindful involves identifying with the current moment without being influenced by our past experiences or future expectations. The intended result is to achieve a state where we can experience reality as it is, rather than experiencing a reality that is dictated by our unconscious fears or misconceptions. Kabat-Zinn (2003) describes mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (p.145). Being mindful can be cultivated by an ongoing practice that the clinician makes an effort to maintain. Rather than involuntarily projecting toxic beliefs about others that may pervade our unconscious, mindfulness is seen as a way to mitigate the threat of damaging the therapeutic process.

It is crucial to consider antiracism as a practice rather than being a technique. Despite many misunderstandings of it, mindfulness, was not originally meant to be a mere relax-

This journey involves reflecting on the interlocking systems and being devoted to making a substantive change in the world, not just for the individual client but for the society that both client and therapist are a part of.



10 Main Takeaways

1. In lieu of traditional models, such as cultural competence, move toward active models such as anti-racism to promote social change.
2. Be open to learning about our legacies of trauma. All people are “racialized” (White people included), and all people carry histories of trauma in our bodies.
3. Anti-racism is more of a practice than just a technique. Rather than virtue signaling or skill acquisition, make time for self-reflection and our capacity to be more compassionate.
4. Race is a social construction. It is unscientific but still carries real consequences. Racism is ordinary. While it may be deplorable, it is deeply established in many families, institutions, and communities.
5. We are either racist or antiracist, being non-racist is not possible. (Kendi, 2019)
6. Racial microaggressions (and perceived discrimination) causes real harm to both BIPOC clinicians and clients.
7. Racial trauma is historical, multigenerational, and reinforced through implicit and explicit forms of discrimination and oppression.
8. Allostatic load causes wear and tear on the entire organism. Chronic stress contributes to a state of allostatic overload, which compromises biological systems.
9. In addition to preverbal traumatic events, using EMDR helps to target second-generation traumatic material.
10. We can make a difference in the lives of our clients, but we must start with our institutions, organizations, and ourselves.

ation technique, it was meant to be a practice to eradicate suffering (Hart, 2011). It is this level of commitment that can change systems. Mindfulness is also a self-reflective process where self-analysis is imperative. It is possible to be both mindful and also anti-oppressive. Anti-oppression involves making “cognitive, affective, and action-oriented changes” (Abrams, 2009). Rather than being one step, anti-racism is an evolution of thought, a formative process. This journey involves reflecting on the interlocking

systems and being devoted to making a substantive change in the world, not just for the individual client but for the society that both client and therapist are a part of.

Recommendations for Antiracist EMDR

Nickerson (2017) advocates primarily for a practice of cultural humility when practicing EMDR. We need to recognize that we do not and cannot know all that there is about a given culture or racial group. An ex-

ercise that may cultivate “intercultural competence” has been for clinicians to make their genograms, not for the client, but themselves (Paine, Jankowski, & Sandage, 2016). Not only does this foster a psychotherapist’s capacity for differentiation of self and an awareness of our legacies of suffering which may have been passed down through the bloodline, White clinicians may also come to see themselves as also having a “culture.” One can gain insight when we can see we are all immigrants somewhere down the line, if you’re not already Indigenous, that is.

Nickerson’s (2017) writings on *Cultural Competence and Healing Culturally Based Trauma with EMDR Therapy* sets frameworks and strategies for being more aware of our blind spots and as a means for doing work with people who have suffered from racial trauma. Protocols are identified for addressing multigenerational issues using what he calls “Legacy Attuned EMDR.” He also introduces negative and positive cognitions for collectives, rather than just the individual, and covers means of discussing and reprocessing targets related to racial privilege and oppressive beliefs.

Dr. Maria Aparecida Junqueira Zampieri has previously presented at EMDRIA and other EMDR conferences (2017a, 2017b, 2018). Her theory is multigenerational and suggests that trauma suffered by previous generations appears to be linked to the client’s current PTSD or complex PTSD symptoms. She posits that we must consider the past in the present. She developed the “Safety Platform Protocol” (Inference Exercises and games) for use with EMDR. She is currently developing a randomized study using this novel approach.

Editor's Note: This article was adapted during one of Mr. Archer's presentations the EMDRIA 2020 Virtual Conference: "Racial Trauma, Neurons, and EMDR: The Path Towards an Antiracist Psycho-therapy."

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DAVID ARCHER, MSW, MFT, is an antiracist psychotherapist from Montreal, Canada. In addition to being trained as a clinical social worker, he is also a registered couple and family therapist. Though mindfulness, intersectional feminism, and critical race theory inform his philosophic approach, he works full time in private practice using EMDR, Brainspotting, EFT, and other mind-body strategies which utilize memory re-consolidation. Areas of interest relate to working with individuals who have suffered from PTSD, racial trauma, minority stress, addictions, and eating disorders. Mr. Archer is an ally of LGBTQ, Black, Indigenous, and oppressed people of color around the world.

REFERENCES

- (2017a) *Inference Exercises and Games with EMDR (Security Platform) on a complex OCD case, 2017 EMDRIA Conference.*
- (2017b) *Safety Platform (Inference Exercises and games) with EMDR in early and transgenerational traumas. In: Achievements in psychotherapy III. Brazilian Association of EMDR, 2017.*
- (2018) *Systemic games with EMDR as a strategy of affective regulation for complex trauma. 2018 EMDR Europe Conference*
- Abrams, L. S., & Moio, J. A. (2009). *Critical race theory and the cultural competence dilemma in social work education.* Journal of Social Work Education, 45(2), 245-261.
- Adam, E. K., Heissel, J. A., Zeiders, K. H., Richeson, J. A., Ross, E. C., Ehrlich, K. B., ... & Peck, S. C. (2015). *Developmental histories of perceived racial discrimination and diurnal cortisol profiles in adulthood: A 20-year prospective study.* Psychoneuroendocrinology, 62, 279-291.
- Adam, E. K., Quinn, M. E., Tavernier, R., McQuillan, M. T., Dahlke, K. A., & Gilbert, K. E. (2017). *Diurnal cortisol slopes and mental and physical health outcomes: A systematic review and meta-analysis.* Psychoneuroendocrinology, 83, 25-41.
- Alexander, M., Barbieri, M., & Kiang, M. (2017). *Opioid deaths by race in the United States, 2000-2015.*
- Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). *Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies.* Archives of general psychiatry, 68(7), 724-731.
- Beach, S. R., Hurt, T. R., Fincham, F. D., Franklin, K. J., McNair, L. M., & Stanley, S. M. (2011). *Enhancing marital enrichment through spirituality: Efficacy data for prayer focused relationship enhancement.* Psychology of Religion and Spirituality, 3(3), 201.
- Boyd, J. E., Lanius, R. A., & McKinnon, M. C. (2018). *Mindfulness-based treatments for posttraumatic stress disorder: a review of the treatment literature and neurobiological evidence.* Journal of psychiatry & neuroscience: JPN, 43(1), 7.
- Bor, J., Venkataramani, A. S., Williams, D. R., & Tsai, A. C. (2018). *Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study.* The Lancet, 392(10144), 302-310.
- Capawana, M. R. (2016). *Intimate attractions and sexual misconduct in the therapeutic relationship: Implications for socially just practice.* Cogent Psychology, 3(1), 1194176.
- Dempsey, K., Butler, S. K., & Gaither, L. (2016). *Black churches and mental health professionals: Can this collaboration work?* Journal of Black Studies, 47(1), 73-87.
- Freimuth, V. S., Quinn, S. C., Thomas, S. B., Cole, G., Zook, E., & Duncan, T. (2001). *African Americans' views on research and the Tuskegee Syphilis Study.* Social science & medicine, 52(5), 797-808.
- Gilbert, J. (2006). *Cultural imperialism revisited: Counselling and globalisation.* International Journal of Critical Psychology, 17, 10-28.
- Glance, L. G., Wissler, R., Glantz, C., Osler, T. M., Mukamel, D. B., & Dick, A. W. (2007). *Racial differences in the use of epidural analgesia for labor.* Anesthesiology: The Journal of the American Society of Anesthesiologists, 106(1), 19-25.
- Gordon, K. H., Castro, Y., Sitnikov, L., & Holm-Denoma, J. M. (2010). *Cultural body shape ideals and eating disorder symptoms among White, Latina, and Black college women.* Cultural Diversity and Ethnic Minority Psychology, 16(2), 135.
- Hart, W. (2011). *The art of living: Vipassana meditation as taught by SN Goenka.* Pariyatti.
- Herbenick, D., van Anders, S. M., Brotto, L. A., Chivers, M. L., Jawed-Wessel, S., & Galarza, J. (2019). *Sexual harassment in the field of sexuality research.* Archives of sexual behavior, 48(4), 997-1006.
- Hinton, D. E., & Simon, N. M. (2015). *14 Toward a Cultural Neuroscience of Anxiety Disorders.* Re-Visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health, 343.

- Juster, R. P., McEwen, B. S., & Lupien, S. J. (2010). Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neuroscience & Biobehavioral Reviews*, 35(1), 2-16.
- Kabat-Zinn, J. (2003). *Mindfulness-Based Interventions in Context: Past, Present, and Future*. *Clinical Psychology: Science and Practice*, 10, 144-156.
- Kelly, S., Maynigo, P., Wesley, K., & Durham, J. (2013). *African American communities and family systems: Relevance and challenges*. *Couple and Family Psychology: Research and Practice*, 2(4), 264.
- Kendi, I. X. (2019). How to be an antiracist. *One world*.
- McEwen, B. S. (2006). Protective and damaging effects of stress mediators: central role of the brain. *Dialogues in clinical neuroscience*, 8(4), 367.
- Metzler, M., Merrick, M. T., Klevens, J., Ports, K. A., & Ford, D. C. (2017). *Adverse childhood experiences and life opportunities: Shifting the narrative*. *Children and youth services review*, 72, 141-149.
- Mohamed, C. & Smith, R. (1999). *Race in the therapy relationship*. In M. Lawrence, M. Maguire & J. Campling (Eds.), *Psychotherapy with women: Feminist perspectives* (pp. 134-159). New York: Routledge.
- Nickerson, M. (2017). *Cultural competence and healing culturally based trauma with EMDR therapy: In-novative strategies and protocols*.
- Paine, D. R., Jankowski, P. J., & Sandage, S. J. (2016). *Humility as a predictor of intercultural competence: Mediator effects for differentiation-of-self*. *The Family Journal*, 24(1), 15-22.
- Perroud, N., Rutembesa, E., Paoloni-Giacobino, A., Mutabaruka, J., Mutesa, L., Stenz, L., ... & Karege, E. (2014). *The Tutsi genocide and transgenerational transmission of maternal stress: epigenetics and biology of the HPA axis*. *The World Journal of Biological Psychiatry*, 15(4), 334-345.
- Phelan, J. C., & Link, B. G. (2015). *Is racism a fundamental cause of inequalities in health?*. *Annual Re-view of Sociology*, 41, 311-330.
- Pon, G. (2009). *Cultural competency as new racism: An ontology of forgetting*. *Journal of progressive human services*, 20(1), 59-71.
- Reeves, R., Rodrigue, E., & Kneebone, E. (2016). *Five evils: Multidimensional poverty and race in America*. *Economic Studies at Brookings Report*, 1, 1-22.
- Rutherford, A. (2020). *How to Argue with a Racist: History, Science, Race and Reality*. Hachette UK.
- Shade, L. R., & Jacobson, J. (2015). *Hungry for the job: gender, unpaid internships, and the creative industries*. *The Sociological Review*, 63(S1), 188-205.
- Shapiro, E. (2002). *EMDR as an integrative psychotherapy approach*. Washington, DC: American Psychological Association.
- Sue, D. W. (2006). *The invisible Whiteness of being: Whiteness, white supremacy, white privilege, and racism*. In M. Constantine and D. Wing Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings* (pp. 15-30). New Jersey: John Wiley & Sons.
- Williams, M. T. (2019). *Adverse racial climates in academia: Conceptualization, interventions, and call to action*. *New ideas in Psychology*, 55, 58-67.
- Yehuda, R., Daskalakis, N. P., Bierer, L. M., Bader, H. N., Klengel, T., Holsboer, E., & Binder, E. B. (2016). *Holocaust exposure induced intergenerational effects on FKBP5 methylation*. *Biological psychiatry*, 80(5), 372-380.
- Yehuda, R., Engel, S. M., Brand, S. R., Seckl, J., Marcus, S. M., & Berkowitz, G. S. (2005). *Transgenerational effects of posttraumatic stress disorder in babies of mothers exposed to the World Trade Center at-tacks during pregnancy*. *The Journal of Clinical Endocrinology & Metabolism*, 90(7), 4115-4118.
- Young, I. M. (2014). *Five faces of oppression*. *Rethinking power*, 174-95.

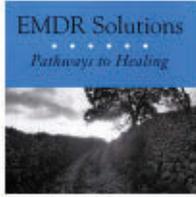
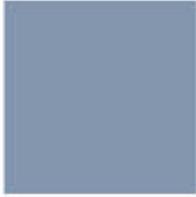
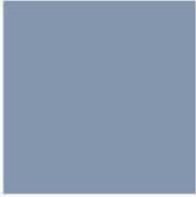
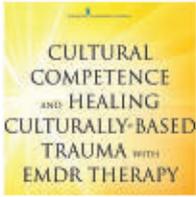
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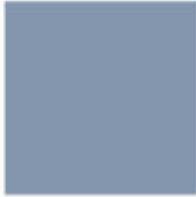
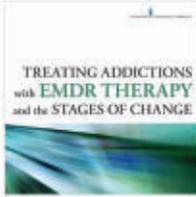
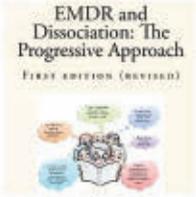
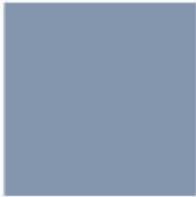
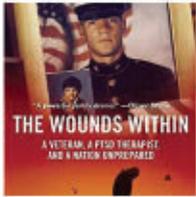
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ADDRESSING RACIALIZED TRAUMA UTILIZING EMDR AND ANTIRACIST PSYCHOTHERAPY PRACTICES

BY WENDY ASHLEY, PSY.D, LCSW & ALLEN LIPSCOMB, PSY.D, LCSW

The year 2020 has brought about a dual pandemic, starting with the COVID-19 outbreak, quarantines, and stay at home orders followed by comprehensive media coverage of the police killings of multiple unarmed Black (The words Black and African American will be used interchangeably in this article to describe the racialized, Black bodied experience.) men and women. The global reaction to this disease/civil unrest dual pandemic has been one of widespread destabilization of physical and mental health (Fiorillo & Gorwood, 2020; Rajkumar, 2020). Psychological distress and fear about the virus and the violence promote anxiety, fear, loneliness, trauma responses, and depression while triggering people with pre-

existing mental health conditions, resulting in relapses of depression, anxiety, and panic attacks (Choi, et al. 2020; Rajkumar, 2020; Tsamakakis et al. 2020). The mental

important to note how race is (or is not) addressed clinically frequently parallels how society is addressing it. For much of America, the racial discourse has elicited discord, diffi-

In the mental health community, we are at the precipice of critical social, psychological, and structural change. More than ever, African American people need allyship, healing, and safety.

health community, which historically has recognized race primarily through ethical standards of cultural competence, has been forced to acknowledge and be accountable for race disparities and racism within psychotherapy spaces. It is

cult conversations, and divisiveness (Sue & Constantine, 2007). However, the savagery of the violent murders by numerous members of law enforcement appears to have a global impact, leading to racial tension, global protests, and exhaus-



tive media coverage (Dukes & Khan, 2017). Racial injustices committed against African American/Black people in the United States are both deplorable and inescapable; thus, it is no longer acceptable for discourse and exploration of race-related trauma to be optional. In the mental health community, we are at the precipice of critical social, psychological, and structural change. More than ever, African American people need allyship, healing, and safety.

Moving from Passivity to Activity

Dr. Ibram X. Kendi (2019) penned a manifesto on being an antiracist, encouraging us to consider the difference between *not racist* and *antiracist*. Kendi (2019) describes antiracist positionality as active, taking steps to identify, challenge, and op-

pose racism individually, institutionally, and structurally. For therapists wanting to shift from the passivity of identification as a *not racist* to an *antiracist* stance, the question is often *how*? When race-related content enters into therapy spaces, clinicians are often left feeling lost and overwhelmed not knowing how to explicitly identify and address race related issues (Sue & Constantine, 2007). Identifying, exploring, and

discussing racism can present discomfort for clinicians and clients, resulting in denial, deflection or avoidance. This can have a tremendous impact on not only the psychological safety of the therapeutic relationship with the client but may also result in misdiagnoses, ineffective treatment planning, and unsuccessful interventions.

For Black clients, psychological mistrust and feeling unsafe with

Many Black clients are reluctant to seek treatment due to mistrust in large medical care facilities and settings, originating from historical experiences of racist, unethical, deceitful, and oppressive treatment services.



treatment providers has historical roots. Many Black clients are reluctant to seek treatment due to mistrust in large medical care facilities and settings, originating from historical experiences of racist, unethical, deceitful, and oppressive treatment services. Systemically, this type of violence has been perpetuated through trans-Atlantic slave trade, abusive detainment, sexual assault, murder, brutality, family separation, forced assimilation, denial of rights and resource access, and mass incarceration of Black people (Pieterse et al., 2012). Therapists providing mental health services to African American clients must understand the historical injustices and the impact of systemic inequities for people of color.

Lived experiences of managing microaggressions, racist interactions, systemic oppression, and graphic media coverage of police lynchings is perceived by many Black and Indigenous

People of Color (BIPOC) as racial trauma. Racial trauma is defined as events of danger related to real or perceived experiences of racial discrimination, which include threats of harm or injury, humiliating or shaming events and witnessing harm to other people of color (Bor, et al, 2018; Carter, 2007; Comas-Diaz, Hall & Neville, 2019). Racial minorities may be more negatively impacted by trauma due to repeated exposure from ongoing individual, interpersonal, institutional, and systemic racism that has transpired throughout history.

Eye Movement Desensitization and Reprocessing (EMDR) is an effective trauma treatment approach. However, despite EMDR's efficacy, there are minimal references to diversity, culture, or intersectionality in EMDR training or research. Without protocol adaptations for African American clients, there is an expectation of an antiquated, *one size fits all* orientation. Culturally relevant treatment with this population includes consideration of the lived experiences and context of Black Americans, acknowledgment of historical trauma and reluctance, stigma and shame regarding help seeking and treatment. Failure to include these racialized concepts obscures the relevance of identity, power, privilege, and inclusion in mental health treatment. In 2020, this is no longer an option if we intend to be effective with clients of color.

Integrating EMDR into Racial Trauma Therapy

Racial trauma is likely to have nuanced, enmeshed connections with more traditional trauma experiences. As a result, EMDR can potentially activate the powerlessness associated with race, trauma, and oppression. Critical consciousness and discourse about the socio-political underpinnings that pervade the treatment process are necessary to ensure that clients re-

Five recommendations for clinicians

1. **Clinicians should actively determine whether they wish to be antiracist in their clinical approach with clients.** Those who identify as non-racist must take into consideration that the passivity that comes with that designation externally appears like collusion with the systems of oppression that maintain racist policies, practices, and structures.
2. **Trust is not automatic.** There are hundreds of years of reasons why Black clients are distrustful of treatment providers. Clinicians must be curious about how their clients self-identify, encourage clients to share their intersectional identities, and talk in therapy about the differences between themselves and clients. Failure to discuss differences in social location can significantly derail the development of a therapeutic rapport.
3. **The experience of racism (whether direct or indirect) has a profound impact on Black individuals in a deeply significant and wounding way.** Frequently, the more intersectional factors of marginalization create additional factors for nuanced wounding. However, clinicians who may not have the same intersectional identity factors may miss the magnitude of the racialized traumatic experience(s). As a result, careful assessment of both traumas and racial traumas are critical.
4. **The clinician must be consistent in how they are showing up as an antiracist therapist.** This must be done throughout the course of EMDR treatment (regardless of protocol phase) and can manifest through race related inquiry, culturally relevant cognitive interweaves, or awareness that successful desensitization may involve a higher subjective units of distress (SUDS) level due to ongoing threats related to racism.
5. **Therapists must maintain awareness of their reactions to race related content.** Managing default response behaviors (specifically, this refers to an internal awareness of where clinicians typically go when race related content is presented and explored) is of the utmost clinical importance. Where clinicians default when uncomfortable halts critical reprocessing content, and ultimately, successful desensitization and reprocessing.

ceiving EMDR are psychologically and emotionally safe—beyond the time they are physically present in therapy spaces. Additionally, African American and other BIPOC clients may benefit from adaptations that support culturally relevant, effective EMDR intervention. Cautious, curious exploration of the clients' intersectional identities, experiences with racism/racialization and therapist transparency (regarding their own identity, power, and privilege) are powerful tools that promote cultural humility and psychological visibility.

There is no universal template in integrating concepts of intersectionality, cultural humility, and privilege in antiracist therapy practice. However, some key adaptations can support clinicians in enhancing their antiracist stance while providing effective EMDR.

REFERENCES

- Bor, J., Venkataramani, A. S., Williams, D. R., & Tsai, A. C. (2018). *Police killings and their spillover effects on the mental health of Black Americans: a population-based, quasi-experimental study*. *The Lancet*, 392(10144), 302-310.
- Carter, R. T. (2007). *Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress*. *Counseling Psychologist*, 35(1), 13-105.
- Choi, K.R., Heilemann, M.V., Fauer, A., & Mead, M. (2020). *A second pandemic: Mental health spillover from the novel Coronavirus (COVID-19)*. *Journal of the American Psychiatric Nurses Association*, 1(4). DOI: 10.1177/1078390320919803.
- Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). *Racial trauma: Theory, research, and healing: Introduction to the special issue*. *American Psychologist*, 74(1), 1.
- Dukes, K. N., & Kahn, K. B. (2017). *What social science research says about police violence against racial and ethnic minorities: Understanding the antecedents and consequences—an introduction*. *Journal of Social Issues*, 73(4), 690-700.
- Fiorillo, A. & Gorwood, P. (2020). *The consequences of the COVID-19 pandemic on mental health and implications for clinical practice*. *European Psychiatry*, 63(1), 1-2.
- Kendi, I. X. (2019). *How to Be an Antiracist*. *One world*.
- Pieterse, A. L., Carter, R. T., Evans, S. A., & Walter, R. A. (2010). *An exploratory examination of the associations among racial and ethnic discrimination, racial climate, and trauma-related symptoms in a college student population*. *Journal of Counseling Psychology*, 57(3), 255-263.
- Rajkumar, R. P. (2020). *COVID-19 and mental health: A review of the existing literature*. *Asian Journal of Psychiatry*, 102066.
- Sue, D. W., & Constantine, M. G. (2007). *Racial microaggressions as instigators of difficult dialogues on race: Implications for student affairs educators and students*. *College Student Affairs Journal*, 26(2), 136-143.
- Tsamakis, K., Rizos, E., Manolis, A. J., Chaidou, S., Kympouropoulos, S., Spartalis, E., Spandidos, D. A., Tsiptsios, D. & Triantafyllis, A. S. (2020). *COVID-19 pandemic and its impact on mental health of healthcare professionals*. *Experimental and Therapeutic Medicine*, 19, 3451-3453.

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SPACEHOGS





SPACEHOGS MAKE A DIFFERENCE

BY CÍO HERNÁNDEZ, PH.D., LMFT, LPCC

I taught human diversity and community mental health for nearly 10 years. One of my assignments was to have people introduce themselves by the cultures with which they associate. They were to provide food, rituals, and traditions that represented their cultures. I always went first in the spirit of fairness and inclusion. Most of my students were white women. Often, in the first class, someone would say, “But, I’m

row box of skin color to the many things that make us different from one another. I hoped that my students would consider it when joining with clients and approaching treatment plans. I had been using a structure for diversity that the Board of Behavioral Sciences used. Over time, I have expanded the acronym to be more inclusive of privilege and space where we find ourselves to, SPACEHOGS. Although there are plenty of categories

Although there are plenty of categories that make us different, this structure just reminds us that we must consider our clients [based on] more than what we can see.

white, I don’t have a culture as you do.” I probed for traditions that their families had for holidays, mealtimes, activities, and more. We all breathed a sigh of relief.

This assignment was the perfect opportunity to expand the traditional biases about diversity from the nar-

row box of skin color to the many things that make us different from one another. I hoped that my students would consider it when joining with clients and approaching treatment plans. I had been using a structure for diversity that the Board of Behavioral Sciences used. Over time, I have expanded the acronym to be more inclusive of privilege and space where we find ourselves to, SPACEHOGS. Although there are plenty of categories

SOCIOECONOMICS Some people are discriminated at both ends of the money spectrum. Still, we also know some stories go with what it takes to achieve or even maintain the middle. This experience may impact where we choose to refer clients and assumptions as to collateral resources that may not seem welcoming to all clients.

PRIVILEGE and profession often go hand in hand as a conduit to social class, but not always. Education, titles, perceived power, the ability to speak the dominant language, relationships with those who have power at different levels, and assumptions made just by looking at someone are essential

Privilege and profession often go hand in hand as a conduit to social class, but not always. Education, titles, perceived power, the ability to speak the dominant language, relationships with those who have power at different levels, and assumptions made just by looking at someone are essential aspects of privilege.

I have had the privilege to walk in neighborhoods of high wealth and the middle class. I have built relationships to be welcome

in low-income communities that may not have historically welcomed people who represented institutions as I have.

SIDEBAR

How EMDR Clinicians Can Prevent Racialized Trauma

1. MAKE IT PERSONAL

Put a loved one's face to Black Lives Matter, like my son's best friend and life brother from kindergarten, Nicholas. His life is important. All lives still matter; it just means that I understand that even though the socioeconomic conditions are the same, it is more likely that Nicholas will have barriers to success, health, safety, and more, just because of the color of his skin.

2. BE WILLING TO BE A BRIDGE

My son-in-law, Lucas, was killed in the line of duty as he chased a Latino man who had stolen a motorcycle. He had no intention of killing someone that day. My husband has also been in law enforcement for over 36 years and openly shares disgust about police brutality. Most all of law enforcement is against police brutality. EMDR clinicians have the educational privilege to be bridges to find solutions that hold community-level trauma and promote solutions to end racism.

3. BRING IT TO YOUR EMDR THERAPY

Ask direct questions to your clients about diversity, -isms trauma, and if they can trust you. This is crucial both if you are perceived as the same ethnicity and if you have different experiences or look different. Please beware of the term colorblindness as it can make clients feel like you do not see them, nor the stories they carry. Harvard Business shares the business case against a colorblind organization, which often tends to have more biased outcomes (<https://hbswk.hbs.edu/item/the-case-against-racial-colorblindness>).

4. BE VULNERABLE

Make mistakes while striving to be culturally humble. Vulnerability is probably the most vital part of this work. I make mistakes with clients all the time. Most of the time, we can walk through the mistakes with kindness, and forgiveness comes quickly. Cultural humility assumes you will be willing to stumble and learn as we grow together. Educate yourself about human diversity areas different than your own. Challenge yourself to bias tests like Harvard's Project Implicit (<https://implicit.harvard.edu/implicit/takeatest.html>) to see areas of potential growth.

5. MAKE IT BIGGER THAN THE THERAPY ROOM

Use tools like the Prevention Institute's Spectrum of Prevention to go from the therapy room to mobilizing communities, fostering networks and coalitions like

SPECTRUM OF PREVENTION

INFLUENCING POLICY & LEGISLATION

CHANGING ORGANIZATIONAL PRACTICES

FOSTERING COALITIONS & NETWORKS

EDUCATING PROVIDERS

PROMOTING COMMUNITY EDUCATION

STRENGTHENING INDIVIDUAL KNOWLEDGE & SKILLS

AGE is a critical diversity indicator that we cannot overlook. In communities where generativity is the dominant value, some people judge those who seem too young and those who seem too old to be able to work as hard as a younger employee. When combined with other diversity categories, age stands out even more. For example, when two young Black or Latino men are together in a park, some people perceive the situation differently from two older white women visiting on the same bench.

CULTURES that we associate with go beyond skin color. These are the people and groups which we are associated whether we choose them

or not. I get to be a part of the educated women of color culture, therapist culture, EMDR culture, mother, and blended family culture. I got to be a part of the HIV culture as a member of the HIV Care Council, an HIV test counselor, and an instructor for *Counseling those Affected by HIV*. I am not HIV+; however, many others in the HIV culture may not have chosen to be a part of the culture if they had not received an HIV+ test.

ETHNICITY is how people choose to identify themselves often by geographic origin but may also be by a set of traditions or history that cannot be assumed. People expect that I am Latina based on my brown

skin and last name, but it may not be obvious that I was born in Texas. I consider myself Tex-Mex, as I was raised bilingually in an area where fluidly interchanging language, is common.

HEALTH and Housing seem separate, and are in some sense; however, access to health care and housing helps us better understand the wealth health gradient, including mental health and well-being. Suppose someone has a diagnosis, disability, or access and functional need. In that case, it can be beneficial to understand how that may impact our treatment planning, or how we might need to modify the standard protocol

EMDRIA's diversity and inclusion committee, changing organizational practices like including race trauma in EMDRIA communications, trainings, vision, hiring, and influencing policy-making that promotes trauma-informed care for all.

6. INCREASE UNIFIED MENTAL HEALTH VOICES

We can maximize EMDRIA's membership, which has members from nearly all U.S. and some international mental health organizations and licensure. Our unified voice puts EMDR clinicians in a unique place to have more strength in advocacy and bridging across membership organizations.

7. REQUIRE EMDR LEVEL I TRAINING IN ALL CLINICAL PROGRAMS

This strategy takes trauma-informed care to the masses. Even if people choose not to continue the training, there will already be an Adaptive Information Processing understanding as clinicians continue to develop their training.

8. ACTIVELY RECRUIT YOUTH OF COLOR INTO MENTAL HEALTH FIELDS AND EMDR

Accessibility to EMDR is challenging for communities of color, especially as clients attempt to find providers they believe may be able to understand their lived experience. Although I believe we all can come from a place of understanding, diversifying EMDR provider membership starts to send a message that EMDR therapy is for everyone and that communities of color are welcome.

9. OFFER MORE ACCESS POINTS TO EMDR/EMDR,

and other trauma-informed approaches at free or low cost, in different languages, and online or in geographically accessible areas. The private practice office or office-based visit is a narrow model that can feel exclusive to those who may need a provider the most. There is plenty of room for innovation to provide larger opportunities for those who may not have access care in traditional ways.

10. KEEP SHOWING UP. DON'T GIVE UP

This work is hard. Ending racism is hard, but not impossible. You will be knocked down. Please do not get disheartened when you think you understand and get put in your place by clients, community, businesses, government, or beyond. You may be the first provider to make it safe to express the reality of the impact of -isms. If you do not get knocked down by institutions, you are likely not showing up loud enough. It has taken me over 20 years to start to move the needle for equity in the organizational systems that I have been able to work and play. Small steps are still considerable strides in the equity arena.

There are so many places EMDR clinicians can make a difference to end -isms, starting with racism. This short structure for diversity and list of things we can do is just a comfortable place to commit to sharing our spaces of privilege with broader audiences.

for EMDR Therapy. I have had many clients with limited vision, motor problems, or are in wheelchairs. We rethink how to engage in bilateral stimulation and adapt EMDR 2.0 protocols to be more accessible to a broader variety of needs. Understanding housing conditions also lets providers know whether there is safety at home, whether the patient can presume confidentiality, or homes are so large clients are isolated from other family members or neglected.

OTHER and opportunity remind us that once we go through the structure, there will always be aspects that make us different from others and areas where some will have access and others will not. The other category is often an area that touches every other category as well. For example, someone who has lost a loved one:

Understanding housing conditions also lets providers know whether there is safety at home, whether the patient can presume confidentiality, or homes are so large clients are isolated from other family members or neglected.

- may not be able to afford a funeral;
- may have death traditions and rituals they follow;
- may change gender roles for those left behind; or
- may challenge assumptions about death when a young person dies.

GENDER, orientation, and expression also include the rules and roles that individuals play in their house-

holds. It may be that siblings play out different roles, depending on the family needs regardless of gender. A clinician cannot assume traditional gender roles and risks being othered if a client does not feel safe to identify outside a heteronormative or gender binary expectation. We can often be more welcoming by changing our intake forms and being careful to ask about pronouns or other identifiers.



SPIRITUALITY includes religion but is not limited to organized structures. It is about how someone makes sense of the world. It could be that someone sees themselves in the context of the environment's power rather than an institution. Whatever the belief, spirituality can be extremely helpful in resourcing, interweaves, and future templating. Someone can bring their faith or beliefs into future templates or into strengths. Spiritual affiliation may also increase happiness and health as Pew Research Center finds. (<https://www.pewforum.org/2019/01/31/religions-relationship-to-happiness-civic-engagement-and-health-around-the-world/>). We also see religious groups continue to be persecuted or discriminated against as well. Suppose someone identifies in a marginalized group or in a group

that has recently had negative media coverage. In that case, it may be relieving when asked about how it has impacted them, or it may be seen as further judgment.

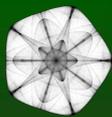
Each of these categories combined offers an overview of client experience to inform an EMDR clinician in better historytaking, understanding targets, resourcing, creating cognitive interweaves, and beyond. This approach is important to address our personal biases about the clients who give us the honor to see them.

Having a structure may also offer other conditions that may have contributed to trauma in our clients. For my white clients who tell me that their mothers sold themselves or sold drugs to put money on the table, I ask how they were kept safe or if they were. I often ask what price they had to pay to succeed in the dominant

culture for wealthy clients of color. Even if they say nothing, at least it is clear that I am trying to understand their story's cultural experiences.

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ROCIO (CIO) HERNÁNDEZ, Ph.D., MFT, LPCC, is a Marriage & Family Therapist in California, Texas, and Hawaii. She specializes in immigration evaluations, violence prevention, and offers EMDR Therapy and LENS Neurofeedback across diversity. She teaches Law & Ethics, Human Diversity, Childhood Trauma, and more. Her systems approach to community capacity building and health equity has been internationally recognized. Cio is the co-founder of the Marin Latino Health Policy Partnership. She served as a Public Information Officer for Marin County Office of Emergency Services. Cio received her doctorate from UC Davis in Health Care Leadership where she studied her app to increase EMDR access.



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ENGAGE IN THE CONVERSATION OF RACE AND RACISM WITH “HOT CHOCOLATE AND CHEESE:” AN IDEA YOU CAN IMPLEMENT

BY VIVIANA URDANETA

Colombians have a tradition of drinking hot chocolate and putting cheese inside it to melt, especially during cold days to warm one's body. It is so delicious that it warms the soul, too. As the cheese melts, you eat it with a spoon. It sounds strange, but it is wonderful.

Every time that I talk about this tradition to friends born in other countries, they look at me with curiosity, with admiration, and sometimes with disgust. Some ask me: “What kind of cheese? What kind of chocolate? Does it have to be hot, or could it be cold? Is it only for cold days, or could it be any day? Can you give me the recipe?” Usually, they would like to try it and ask me if we can do so together. The tradition of hot chocolate and cheese appears so foreign that it raises many questions and opens conversations.

Engaging in Difficult Conversations

I want to engage the conversation about racism with the same curiosity, exploration, and sometimes disgust that we do when we talk about cultural traditions different than ours. I know that racism does not have a positive connotation like hot chocolate and cheese. I know it is not the same. I know racism and hot chocolate and cheese are different. I am not minimizing or glorifying racism. I just want to engage in conversation about this topic not from the perspective of shame and guilt but with an emphasis on commitment, curiosity, and vulnerability.

For people who has grown up experiencing racism, it is so familiar that it is not strange anymore. It is like hot chocolate and cheese in Colombia—extremely common. However, the big difference is that it is not a pleasant

experience. It is never a joke. It is always harmful, independently of the intention of the aggressor. It takes a toll on people. It becomes like a rock inside of your shoe, and you are forced to keep walking with it.

For people who have grown up benefiting from white supremacy, thinking about racism sometimes feels foreign and threatening because they have not been forced to think about it. They are so comfortable with their benefits that their superiority is taken for granted—like it is natural or deserved somehow. Racism does not seem to be part of their world. It appears to be something from the past that changed a long time ago because supposedly: “The law said so. We do not have any slavery or racism today. Everything changed with the civil rights movement, right?” Racism is as strange as the combination of hot

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chocolate and cheese. Is it even possible? Does it still happen? “I thought that it was a matter of the past.”

Talking about race and racism becomes uncomfortable because we have been taught that it is only for “certain people.” It just applies to “some communities.” When we talk about cultural considerations and EMDR therapy, it is usually the last topic, in the last presentation, at the last minute of the conference or the training, if it is even on the agenda. And the conversation about race and EMDR therapy was almost non-existent until recently. Many white people think about racism and say: “That does not apply to me. I am an ally. I am one of the ‘good’ ones. I have many BIPOC friends.” However, “White supremacy is an ideology based upon the belief that white people are superior in many ways to people from other races” (Saad, 2020) and we all, like it or not, live in a white supremacy society where racism and anti-blackness are alive.

Cultivating Nonjudgmental Curiosity

So, how do we engage in the conversation about racism with a similar attitude than we have when we talk about hot chocolate and cheese? How do we cultivate a “nonjudgmental curiosity” about the impacts of racism on us, on our communities, and our jobs? Annalise A. Singh in the “Racial Healing Handbook” (2019), talks about the importance of “non-judgmental curiosity” because “being curious means to question your old ideas, remain open to new ones, and see what best fits you.”

During one of the regular meetings that we have in my job, we discussed a case where the client was talking about some implicit bias and some straightforward anti-blackness comments, and the therapist was strug-

gling to respond. We brainstormed ideas about how to react as therapists, but there was not enough time to talk about it. One of my colleagues (Shanta Jambotkar, LCSW) spoke about having space specifically designed to discuss those personal reactions toward racist comments and their impact on our identities and communities. The

When are we going to take a breath and engage one another differently?

proposal was to have a space to talk about the current situation after the killing of George Floyd and how it left us all questioning when is this anti-blackness going to end? When are we going to take a breath and engage one another differently?

After this, I had a conversation with my supervisor (Tobirus Newby, LCSW) about the Black Lives Matter movement. I asked questions, and he listened and challenged my thoughts about racism and white supremacy. I began to ask those around me their thoughts and experiences about it. Those meetings and my colleagues’ discussions started a personal journey for me, where I began to explore

racism and anti-blackness in my own culture and upbringing. However, it was not only the beginning of a personal journey. It was also a communal experience where we, as a group of colleagues, began to meet and talk about our experiences with race and racism and their impact on us as humans and therapists.

In the first meeting, I shared my desire to talk about racism with the same curiosity that we have when talking about hot chocolate and cheese. Of course, I have already introduced the Colombian tradition to my colleagues. So, before the COVID19 pandemic, it was common to have hot chocolate and cheese as one of the snacks for our meetings. So, we decided to call the group to explore the impact of racism, the Hot Chocolate and Cheese group (HC&C).

Creating a Hot Chocolate and Cheese-Like Group

What is the Hot Chocolate and Cheese Group? It is a group of colleagues that



meet once a month to talk about the impact of racism in themselves and their personal and professional lives. The idea is to explore how our community, our work, and our identities are shaped by implicit bias and anti-blackness. We created shared agreements for space including:

- a nonjudgmental position,
- using I-messages,
- assume best intention,
- be ok with silence,
- request feedback if you would like so,
- and be committed to check-in with one another about the process.

We agreed on what to do if someone experiences microaggressions and decided that participation is completely voluntary. We talked about using “call in and callouts” to call attention to any problematic behavior or intervention. “Call out” means to name instances or patterns of oppressive behaviors or language publicly. “Call in” means to speak privately with an individual who has done wrong to address the behavior (Saad, 2020). We agreed to use questions to prompt and engage in the conversation about racism and to have an open attitude to talk about this topic.

Hope Springs

What is my hope with HC&C group? I hope that we can be vulnerable in community. I hope to explore our internal dialogues about racism and be together in our process of liberation from white supremacy. I hope that we can learn to appreciate diversity and intersectionality. Since the beginning of my journey about anti-racism practices in my personal and professional life, I have begun to analyze the day-to-day things that influence one’s anti-blackness. I have started to educate myself about racism and

I hope that we engage in more individual and community activism with commitment, curiosity, and vulnerability.

notice my reactions. I have chosen to hear the stories of BIPOC and reflect on it. I hope that HC&C helps all its participants and me engage in an active role to be aware and reflect on the pervasiveness of anti-blackness and white supremacy on our personal and professional lives. I hope that we arrive at an understanding that it is ok to be different and that one race is not better than the other because at the end of the day, we are only one human race. I hope that we engage in more individual and community activism with commitment, curiosity, and vulnerability. I hope to talk in the HC&C group about EMDR therapy and practical ways to support people in their journey of healing from racism. I hope to enjoy the savory and the sweetness of a hot chocolate and cheese while we learn together to appreciate difference and unity in the human race. Anyone want to have some hot chocolate and cheese?

REFERENCES

Saad, L. (2020). *Me and White Supremacy*. Naperville, IL. Sourcebooks.

Singh, A. (2019). *The Racial Healing Handbook*. Oakland, CA. New Harbinger Publications, Inc.

About the Author:

VIVIANA URDANETA, LCSW, is an EMDR Certified Therapist and Approved Consultant. She has her private practice and works at the University of California at Berkeley. She specializes in counseling for survivors of trauma, intimate partner violence, and sexual assault. Viviana is from Colombia, South-America and considers herself bilingual and bicultural. Viviana has worked consistently to promote the utilization of EMDR therapy in different settings. Viviana is committed to increase awareness around the challenges and strengths of working with diverse populations and their intersection of identities.

Counselor's Corner

This is a new section in the magazine to bring awareness to vital topics being discussed in our online communities. The answers here are a sampling of replies. To view the entire discussion, create your profile or join one of our 19 online communities or Special Interest Groups (SIGs), please visit www.emdria.org/emdria-community.

Question: I am wondering if anyone who is offering face-to-face sessions has purchased a plexiglass room divider? How has it helped/hindered your sessions? I currently have a HEPA filtration unit, window open, 6 feet apart while sitting, masks on entering and leaving the office. There are some clients who won't feel comfortable with Zoom, so my caseload is now half Doxy, and half face-to-face.

– Trish Garrison, LICSW, ASCH Certified in Clinical Hypnosis, Certified in EMDR

Answers: I have been seeing clients in office for several months now but always with masks. I use clear face masks to allow for the clients to see facial expression, and I also give them the option to wear their own masks, or I give them a clear face mask to wear if desired. I maintain 6 feet of distance along with air purifier equipped to catch COVID size particles. Additionally, I wipe surfaces down with cleaners in between sessions and clients are given the option of wearing gloves if desired (most do not). All are asked to wash their hands upon entering the office and

may also have their temperatures taken if I feel it is needed. I would not feel safe just using the plexiglass because I feel it puts the clients at risk since I would be having a client come and sit in a space that had just been occupied by a prior client who, if not wearing a mask, would be leaving particles potentially in the air for the next person to sit in.

Additionally, I was informed by a COVID-19 researcher that if two people are wearing masks and one is positive, the other person, if they are negative, only has a 1 percent chance of getting infected, whereas if the person who is infected is not wearing a mask the non-infected person's chance of getting infected goes up to 30 percent. As an additional safeguard, I also get tested regularly and so do my clients. They all sign a detailed consent form, so they are

aware of all of the ways in which I am trying to keep them safe. I considered a plexiglass barrier but did not feel that it would be needed and truthfully did not feel it would be as effective as wearing the masks themselves, but I keep it as an option if the rates of COVID-19 go back up significantly. I do not know any medical provider who would ever consider just using a face shield without a mask, so I would not do the same with just a plexiglass. I remain negative for COVID-19 and for antibodies, and I know for a fact I have been exposed to people who have been positive. My partner is a chiropractor, and with the exception of not being able to maintain 6 feet of distance, he has used the same protocols as me and also remains negative, although he sees fewer people than he used to in order to have more time in between for cleaning and getting a break from his mask.

My main challenge is the amount of time I am in a mask daily, so I schedule webcam sessions in between in-person sessions to give myself a break. My clients have been appreciative of all my efforts and have rarely complained. I work using EMDR, SE, DBT, MBIs, Parts



work and psychodrama and specialize in complex trauma and addiction with people with global high intensity activation in their nervous systems and have found that there are those who feel safest in the office and those who prefer webcam. We always weigh the pros and cons first before deciding which option to choose, and we know that we may need to switch up what we are doing or do a hybrid version of in-office and webcam depending on many factors, including if they have traveled, have any symptoms or have been exposed to someone sick, or are worried about the commute. I also use multiple webcam platforms, so I always have a fallback if one system freezes up. Hope this helps.

Carolyn Licht, PHD
NY State Licensed Psychologist

Hello Trish,

I use a plexiglass barrier, and it has helped greatly with older children and adult clients, essentially anyone who stays in one place during the session. It has allowed for sessions without masks and also provides another barrier when there are tears, nose blowing due to tears, tissues etc.....We have sanitizers on either side, along with individually packaged supplies such as markers, paper. Also the pulsars extend the length of the table, and the cords go under the barrier. Overall, a great relief and help for in-person sessions.

Anna Nuedling
EMDR Canada (Membership)
Huntsville ON

EMDR THERAPIST CHALLENGES

Systemic hurdles for EMDR therapists

EARLY LIFE SUPPORTS



- Access to safe stable home environment
- Caregiver able to establish healthy attachment, and encourage learning mindset
- Access to books and learning resources
- Caregiver access to helpful support from family or community
- Community resources like libraries, safe transportation, playgrounds, and healthy food
- Accessibility of school programs and healthcare
- Community expectations of finishing high school or higher education

YOUTH AND TEEN SUPPORTS



- Ability to withstand rigor and style of standardized testing in educational system
- Ability to cope with stress of school AND potential discrimination and bias if BIPOC
- Environment safe enough to learn
- Encouraging teachers and mentors
- Healthy peer relationships
- Encouragement to participate in school

COLLEGE EDUCATION



- Family financial capabilities or supports
- College entrance consideration from institutions often founded in white privilege
- Family, peers and mentor supports
- Ability to develop new relationships in new academic setting
- Personal coping and regulation skills
- Ability to cope with stress of school AND potential discrimination and bias if BIPOC

GRADUATE EDUCATION

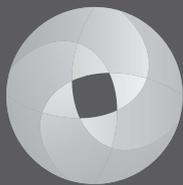
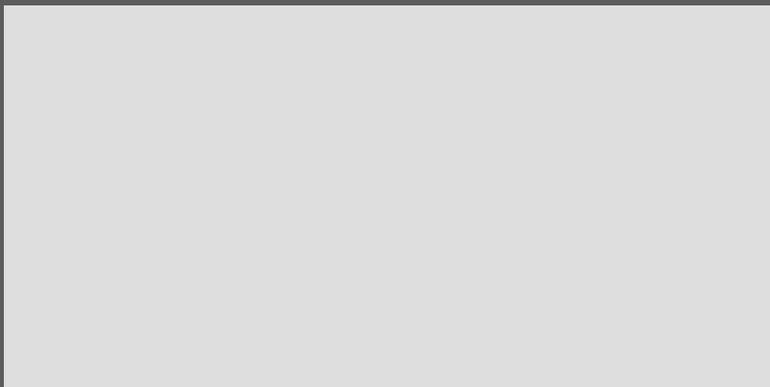


- Ability to undertake financial uncertainty of graduate education process
- Graduate entrance consideration from institutions often founded in white privilege
- Ability to cope with stress of academia AND potential discrimination and bias if BIPOC
- Family, peers and mentor supports
- Personal coping and regulation skills
- Access to information on trauma in program
- Ability to undertake financial uncertainty of licensing process while paying for supervision

PROFESSIONAL LIFE



- Awareness of EMDR therapy
- Choose to pay for EMDR training and consultation
- Hope that trainers, training, and therapy will incorporate lived experience
- Choose to pay for ongoing EMDR support (EMDRIA membership dues or credentials)



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EMDR International Association

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