

ADDRESSING RACIALIZED TRAUMA UTILIZING EMDR AND ANTIRACIST PSYCHOTHERAPY PRACTICES

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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-

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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

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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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