Empowered Healing: Unpacking Trauma from Within

Kaliyat Gamba, Shawyna Chase, Kara Guidinger, Chalaina Saine

Purdue University Fort Wayne

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ABSTRACT

Empowered Healing: Unpacking Trauma from Within examines the integration of culturally competent Eye Movement Desensitization and Reprocessing (EMDR) therapy for African American women who have experienced childhood sexual abuse and have a comorbid diagnosis of post-traumatic stress disorder (PTSD) and substance use disorder (SUD). This study highlights the impact of historical oppression faced by African American women, connecting childhood sexual abuse and mental health issues to systemic and generational traumas. Current literature reveals a higher prevalence of childhood sexual abuse among African American women compared to their white counterparts, leading to increased instances of PTSD and SUD. EMDR has been found to be effective in treating these disorders but is most beneficial when cultural considerations are applied to account for the unique experiences of clients. This study identifies the necessity for programs like Empowered Healing, which focuses on culturally informed approaches to mental health support, ensuring clients feel empowered and understood. The proposed study will evaluate the effectiveness of culturally-informed EMDR, Trauma-focused CBT, and supportive talk therapy using a mixed-methods design, incorporating quantitative measures of PTSD (as measured by PCL-5) and substance use (as measured by Brief Craving Scale) and qualitative insights from participant interviews. This research aims to provide a deeper understanding of best practices for treating African American female survivors of childhood sexual abuse, with implications for developing culturally competent therapeutic interventions.

EMPOWERED HEALING

Unpacking Trauma from Within In the United States, 1 in 5 women have been diagnosed with a mental illness (American Psychiatric Association, 2017). Understanding the physiological differences between genders can offer insight into the intricacies of mental illness as it relates to women and how mental health providers can advocate for efficacy in treatment modalities. Studies have shown that because women internalize trauma more than men, they are more susceptible to depression and anxiety (American Psychological Association, 2011). Empirical evidence conveys that women have a higher possibility of receiving a dual diagnosis than men because women are more frequently exposed to high-impact traumas, more vulnerable to developing post-traumatic stress disorder (PTSD), and transition more rapidly from first-time use of substances to problematic substance use (Hien et al., 2020).

Women with both PTSD and substance use disorder (SUD) have been found to experience more severe clinical symptoms than those with one of these disorders (Cohen & Hien, 2006). To further highlight the impact of trauma, most female victims of childhood abuse (physical and sexual) were diagnosed with PTSD. Studies show that African American women have a higher rate of childhood sexual abuse compared to other minorities. A strong correlation between childhood sexual abuse and substance use has been established, most notably connected to alcohol use (Jasinski et al., 2000). This suggests a need for robust treatment modalities that address both PTSD and SUD in African American women.

African American women are at a greater risk of depression and psychological distress due to factors such as lower income levels, educational attainment, and exposure to life event stressors, including trauma, violence, and racial discrimination (Woods-Giscombe et al., 2016). Despite the evidence that highlights African American women's high need, women of ethnic minorities are less likely to receive needed mental health care than white American women. Research has found that 60 percent of African American women experience symptoms of depression, and only 12 percent seek help and/or treatment. One factor that should be considered is the impact of stigma on rates of mental health engagement in the African American community. Mental illness is commonly

viewed as shameful and a weakness that often causes African Americans to conceal their struggles by projecting strength, suppressing emotions and vulnerability, succeeding with minimal support, and prioritizing caregiving over self-care (Woods-Giscombe et al., 2016). Due to this stigma, these individuals seek out support less often, and if they do, they frequently terminate treatment prematurely. In light of these factors, it is evident that further research is necessary to identify alternative treatment options to increase utilization and improve outcomes for African American women.

Intervention Program Overview

The purpose of Empowered Healing is to support African American women between the ages of 18 and 40 years with a history of childhood sexual abuse and a comorbid diagnosis of PTSD and SUD. Empowered Healing works with participants who have previously engaged in mental health services and those who are new to counseling services. This program aims to support participants by acknowledging and addressing barriers to mental health treatment, including the cultural stigma associated with mental illness, misdiagnosis, and disempowerment that African American women often experience in treatment (Kawaii-Bogue et al., 2017). This program highlights these elements and emphasizes empowerment in order to provide African American female clients with the support needed to overcome their mental health struggles.

Program implementation efforts include educating providers about the purpose and goals of the intervention program. This allows providers to identify potential participants who meet diagnostic and program criteria and gain buy-in, highlighting potential benefits for participants. Clients have been internally referred by counselors of community agencies and from outside referral sources. The program is marketed through social media outlets and handouts/fliers that include details of what the program offers. Prospective clients are provided with sufficient information to make informed decisions about participation. Once clients have committed to the program, they complete the necessary intake paperwork, including informed consent and pre-assessment tools, to determine eligibility. Clients engage in weekly 60-minute sessions incorporating culturally aware EMDR, utilizing dual attention, soothing skills, grounding techniques, and emphasizing the Adaptive Information Processing model.

Empowered Healing increases cultural sensitivity while using the modality of Eye Movement Desensitization and Reprocessing (EMDR) treatment. EMDR is a structured form of therapy that utilizes dual attention tasks. In session, the client focuses on a traumatic memory while simultaneously engaging in an external task, the most popular being eye movement and tapping (Jeffries & Davis, 2013). Developed by Francine Shapiro in 1987, EMDR was initially designed as a treatment modality for PTSD. It has since been adapted to be implemented for substance use cases, specifically targeting the same cycle (Perez-Dandieu et al., 2014). As it has gained popularity, it has grown empirical support and is now one of the most researched modalities for addressing trauma. While the use of EMDR with substance use is relatively new, there is evidence to support its effectiveness as a treatment modality.

Despite being confirmed by the American Psychiatric Association and being recognized by the World Health Organization as an effective intervention, EMDR lacks research in terms of its application with diverse populations. This has resulted in "an antiquated one-size-fits-all treatment orientation" (Lipscomb & Ashley, 2021). Recently, there has been a shift in the field of cultural competency and EMDR treatment. As the concept develops further evidence, EMDR has become an option that provides holistic, culturally informed care for African American women. Empowered Healing aims to expand the research on this critical topic, utilizing the empirically supported treatment of EMDR through a culturally competent lens.

Rationale for Program Evaluation

Program evaluations are essential because they ensure that programs have accountability and evidence to support their effectiveness. This helps to monitor and improve a program's quality and effectiveness through research and data (Frye & Hemmer, 2012). The findings can provide insight into what is successful, what areas need improvement, and why. These evaluations help programs sustain ongoing development to ensure intended goals are met. They help explore program effectiveness and evaluate program delivery, resource utilization, and cost-effectiveness of using program resources (Guyadeen & Seasons, 2018). Program evaluations ensure that decision-makers are held accountable for their actions through documentation, research, and the establishment

of clear and measurable goals to assess validity and reliability.

This study is valuable because there is very little research on treatment outcomes for African American women who have a comorbid diagnosis of SUD and PTSD, along with a history of childhood sexual trauma. The lack of research solidifies the importance of this study and the need for evaluation to identify whether or not the results illustrate a decrease in PTSD and/or substance use symptoms. A program evaluation could offer insight and increase awareness of what is lacking and how outcomes could be improved throughout the program. In regard to this specific study, these results can highlight whether a culturally-informed component of EMDR trauma work helps reduce the PTSD and SUD symptoms of African American women who are childhood sexual abuse survivors. This study can help reflect on future research with other minority populations regarding trauma work, following the Empowered Healing program evaluation.

Empirical support is essential for this particular study because there is insufficient evidence to address this issue for this population. This study will inform readers by expanding their knowledge and enhancing their understanding of this population and these mental health concerns. Considering that the research surrounding EMDR with diverse populations is minimal, there must be research surrounding the impact of this intervention with African American women (Lipscomb & Ashley, 2021). With research focused on experiences that impact African American women's wellbeing, readers will gain a better understanding of how interventions, such as culturally competent EMDR, may improve outcomes for African American women diagnosed with PTSD and SUD, specifically following a history of childhood sexual abuse.

Purpose Statement:

The purpose of this study is to determine the effectiveness of culturally competent EMDR compared to Trauma-focused CBT in reducing the severity of post-traumatic stress disorder and substance use disorder among African American women who have a history of childhood sexual abuse. This program proposes that culturally competent EMDR will reduce the severity of PTSD and SUD at a higher rate than Trauma-focused CBT. Once the data is collected, current programs will be adjusted to reflect best practices based on the results. Furthermore, it will provide insight into the effectiveness of these treatments, allowing Empowered Healing to address the gaps in mental health support for African American women.

Evidence has shown that substance use disorders are closely related to both childhood trauma and PTSD (Lotzin et al., 2019). Unfortunately, many communities substance use programs do not focus on addressing childhood trauma and often treat it as a secondary concern. The goal of Empowered Healing is to serve African American women with complex trauma in community substance use treatment programs in a meaningful and culturally sensitive manner. Research has shown that childhood sexual abuse impacts the mental health of African American women, leading to an increased dual diagnosis of post-traumatic stress disorder and substance use disorder, which influences Empowered Healing’s focus on utilizing culturally sensitive EMDR.

LITERATURE REVIEW

This literature review focuses on the merit and research behind utilizing culturally competent Eye Movement Desensitization and Reprocessing (EMDR) with African American women who have a history of childhood sexual abuse (CSA) and a comorbid diagnosis of post-traumatic stress disorder (PTSD) and substance use disorder (SUD). Section I explores the history of oppression that African American women have endured, focusing on how childhood sexual abuse, PTSD, and SUD are connected to systemic and generational traumas that these women experience. Section II focuses on the development and utilization of EMDR, including its history, the use of dual attention tasks, and the concept of Adaptive Information Processing. This section also reviews cultural competency in the therapeutic space and how it can be applied in EMDR treatment sessions.

Section I: Post-Traumatic Stress Disorder and Co-occurring Substance Use Disorder in African American Women

History of Oppressive Systems

Racial disparities in mental health treatment exist and continue to remain a barrier to people of color in the

United States. The origin of this can be traced as far back as slavery, black codes, Jim Crow, and the Civil Rights Movement eras. African Americans have endured generational trauma, inhumane exploitation, and ongoing societal injustices (Burroughs, 2022). There is a consistent mistreatment of African Americans by the medical profession, which has contributed to the gap in equitable and effective physical and mental health care for this population, resulting in the mistrust of the healthcare sector. There have been several examples in history of black patients being used as test subjects for experimental treatments that were based on the belief that black people are strong (Hinton, 2020). This idea has perpetuated the belief that black patients do not need healthcare or are incapable of experiencing emotional distress due to being of an inferior race compared to Euro-whites.

The intersectionality of being a woman and African American presents intricacies that need to be addressed and incorporated into their mental health treatment. Studies have shown that because women internalize trauma more than men, they are more susceptible to depression and anxiety (American Psychological Association, 2011). Further empirical evidence shows that in comparison to other ethnic minority women, the mental health needs of African American women are not adequately met and consequently go undertreated. In addition, African American women experience higher occurrences of misdiagnosis and premature withdrawal from treatment, leading to healthcare disparities (Nelson et al., 2022). Studies indicate that several factors such as education and treatment history should be considered to ensure therapeutic alliance early in treatment (Bauer et al 2022). Furthermore, it has been suggested that low-income African Americans have less accessibility to mental health care and rather seek services via emergency services or primary care. All these factors lead to complex intersectionality in working with this population (Davis et al, 2008). These further illustrates the need to expand knowledge regarding the mental health of African American women.

History of African American Women and Childhood Sexual Abuse

Research has found that 1 in 4 African American girls will be sexually abused before the age of 18 (UJIMA, 2020). In addition, 40% to 60% of African American women report being subjected to involuntary sexual contact by the age of 18. While these statistics reveal a significant issue in the African American community, childhood sexual abuse among African American women and girls still goes undisclosed and underreported. Victims of childhood sexual abuse choose not to disclose for a variety of reasons, including fear of consequences or fears of not being believed (Hanson & Wallis, 2018). African American CSA survivors face specific contextual factors that impact their experience of abuse, willingness to disclose the abuse, and ability to seek support following these traumatic experiences.

To better understand this phenomenon, it is crucial to consider the norms and protective factors ingrained in African American culture related to childhood sexual abuse and the mistrust of systems in place to help. According to research, cultural norms impact whether or not abused children disclose abuse or if their families report child sexual abuse to the authorities. (Brazelton, 2015). Often, the African American community approaches child sexual abuse from a “take care of your own” mentality, seeking no professional help in order to protect the vulnerable and preserve the family. Additional barriers to reporting CSA are related to the broader experiences of mistreatment, discrimination, and stigma by systems, including police, criminal justice systems, and social service agencies that historically have not been supportive or helpful in times of crisis.

Comorbid PTSD and SUD

African American women are at a higher risk of developing post-traumatic stress disorder due to trauma experiences, especially sexual assault (Bauer, 2022; Xu et al., 2024). African American women are more likely to experience gender and race-based discrimination in treatment. Findings indicate that black women with comorbid PTSD and SUD are less likely than the general population and white women to engage in treatment. Several factors, such as stigma, systematic oppression, distrust, and lifetime trauma, have been linked to increased risk in the severity of PTSD symptoms in black women (Mekawi et al., 2021). There is sufficient literature evidence that indicates a link between PTSD and SUD, suggesting that substances are used to self-medicate to alleviate distressing symptoms of PTSD.

PTSD and SUD in African American Women with a History of CSA

Due to the frequency of childhood sexual abuse experiences that are undisclosed and unreported, African

American women survivors often experience severe symptoms of distress without receiving proper mental health treatment and support. Research shows that survivors of CSA experience higher levels of anxiety, depression, dissociation, sexual concerns, and intrusive symptoms (Banyard et al., 2002). These symptoms often result in higher rates of post-traumatic stress disorder diagnosis among survivors of CSA. Although evidence has shown that African American girls experience a high rate of childhood sexual abuse, there is very little research on the resulting diagnosis of PTSD associated with a history of childhood sexual abuse. However, there is evidence that individuals from racially marginalized groups are more likely to experience violent crimes, including sexual assault (Mosely et al., 2021).

Studies show that African American female substance users, compared to the general population, are at a higher risk of experiencing a traumatic event as they are more vulnerable under the influence of substances (Johnson et al., 2006). Nonetheless, empirical evidence further confirms that black females with substance use problems did not seek help or treatment, feeling that the problems were not serious enough (Redmond et al., 2020). Other factors, such as guilt and social stigma about abusing substances, are identified as some barriers that deter black females from treatment-seeking behaviors. There is limited literature on how to help this population improve treatment engagement. This lack of research surrounding this population further illustrates the need for evaluating programs and treatment options that highlight their trauma and experiences through a culturally competent lens.

Sexual abuse is associated with higher rates of mental health issues, such as suicidal ideation and substance use (Mullen et al., 1993). Historically, black women experience sexual assault more often than the general population (Cazad, 2023; Bryant-Davis, 2010). Further research has portrayed the severity of PTSD symptoms in African American survivors compared to white survivors. This stems from the sociocultural context of systematic oppressive notions that sexualize black women and those who question the idea that they are victims of such crimes (Bryant-Davis, 2010). Even though laws in the United States surrounding the rape of black women have changed, the generational trauma of the commodification of this population continues. The comorbidity of PTSD and SUD in African American women with a history of CSA presents unique complexities that need to be taken into account when working with this population. Empowered Healing intends to provide a culturally-informed EMDR treatment model that will incorporate the nuances of the lived experiences of our African American female clients.

Section II: Culturally-Informed EMDR

Developed by Francine Shapiro in 1987, Eye Movement Desensitization and Reprocessing (EMDR) integrates elements of many other therapeutic modalities (Molero-Zafra et al., 2024). Among these modalities are the Psychodynamic, Cognitive-Behavioral, and Person-Centered treatments (Shapiro & Maxfield, 2002). EMDR was originally designed as a treatment option for post-traumatic stress disorder (PTSD), focusing on the past, present, and future at different stages in the treatment process (Lipscomb & Ashley, 2021). Through EMDR, work typically begins with the earliest memory, hypothesizing that this is where the cognition is formed (Shapiro & Maxfield, 2002). The work then moves into the present affect, followed by future goals and aspirations. Unlike other trauma-informed approaches, EMDR leans into free association, encouraging clients to share the first thing that comes to their mind. Since EMDR requires fewer periods of exposure to the negative stimuli, it appears more desirable compared to other trauma-informed approaches by both client and clinician, focusing on the positive aspect of not having the client explain their trauma in-depth (Jeffries & Davis, 2013). Other highly effective treatments for African American clients with PTSD are Cognitive Behavioral and Prolonged Exposure therapy. Further empirical evidence shows that culturally adapted Prolonged Exposure uses race-related trauma themes during sessions which has helped to reduce PTSD symptomology in black clients. (Willaims et al, 2014). Similarly, studies show that culturally adapted CBT could be beneficial to clients from minority ethnic backgrounds as it incorporates core elements that are relevant to ethnic groups (Phiri et al, 2023). We decided to go with EMDR because it has the most significant empirical support when working with persons with PTSD (Abel & O'Brien, 2010). Most importantly, we chose culturally informed EMDR because of its unique perspective on trauma treatment from an anti-oppressive standpoint (Lipscomb & Ashley, 2021).

Over the years, EMDR has grown in popularity alongside Trauma-focused Cognitive Behavioral Therapy (TF-CBT) as the treatment with the most significant empirical support when working with PTSD (Abel & O'Brien,

2010). The World Health Organization has recognized EMDR as an effective and efficient treatment for trauma of any duration (Molero-Zafra et al., 2024). In the 19 controlled outcome studies that have been performed, EMDR has been recognized as an effective form of treatment. Additionally, meta-analyses have found evidence of EMDR being more efficient than other treatments, though these results are not definitive (Shapiro & Maxfield, 2002).

Through research, 14 controlled studies that included civilians have found that there was a reported 40-60% decrease in PTSD symptoms after only a few sessions of EMDR treatment (Shapiro & Maxfield, 2002). Clients reported improved dissociation patterns and a higher perception of their quality of life (Molero-Zafra et al., 2024). Most studies have shown EMDR comparable to TF-CBT, with some revealing more favorable outcomes for EMDR treatment (Shapiro & Maxfield, 2002). Due to this comparison, this program evaluation compares the effects of these two treatment modalities on the African American women population, exploring the effectiveness of different trauma-informed approaches.

Phase Model and Dual-Attention Tasks

EMDR treatment is performed as an eight-phase model. These phases include: phase 1, the intake phase; phase 2, the preparation phase; phase 3, assessment; phase 4, desensitization; Phase 5, reprocessing; phase 6, body scan; phase 7, closure; phase 8, reevaluation. While phases 1 and 2 are done at the beginning of EMDR treatment, phases 3 through 8 occur within each target memory, repeating throughout the entire EMDR process (Molero-Zafra et al., 2024). These phases will be explored further within the Methods section.

The desensitization and reprocessing phases of EMDR rely heavily on the use of dual-attention tasks. A dual-attention task can be in the form of eye movement, tapping, or, in some cases, auditory stimuli heard in each ear. (Molero-Zafra et al., 2024). These tasks are completed in sets where the clinician tracks where the client is between each set. Originally, eye movement was posited as the key component in the EMDR process. However, evidence has suggested that eye movement itself is not supported as the catalyst for change within a client, finding no significant benefit in using eye movement over other dual-attention components (Jeffries & Davis, 2013). Regardless of which dual-attention task is utilized, evidence has suggested that using these tasks enhances information processing, makes distressing images less salient, and allows for adaptation of the client's cognitive functions (Shapiro & Maxfield, 2002). In other words, utilizing concurrent tasks decreases the vividness and emotional intensity of the traumatic memory, making it more tolerable to navigate (Jeffries & Davis, 2013).

Adaptive Information Processing

At the core of EMDR treatment is the hypothesis that every person has a physiological information-processing system that processes and stores new material (Shapiro & Maxfield, 2002). There is a belief that pathology is the result of distressing experiences not being completely processed, meaning that the images, emotions, and sensations are stored in networks. External cues in the present often trigger the stored sensations, resulting in discomfort (Jeffries & Davis, 2013). Adaptive information processing (AIP) is the ability to access an insufficiently processed experience and "adapt" it into a more malleable, tolerable experience (Shapiro & Maxfield, 2002). The goal of adaptive processing is not extinction; instead, the AIP model asks the question "What does this mean to you?" (Lipscomb & Ashley, 2021). By attaching new meaning to traumatic events through AIP, the client can fully process the experiences that were once stored as incomplete.

EMDR Adaptations for Substance Use Disorder

Regarding substance use, research is still emerging as to the efficacy of utilizing EMDR in treatment. Early studies have portrayed positive results, specifically when targeting the "addiction memory" (Abel & O'Brien, 2010). The Substance Abuse and Mental Health Administration recognizes EMDR as a viable treatment modality (Lipscomb & Ashley, 2021). Studies show positive outcomes for clients who have comorbid PTSD and SUD diagnoses (Tapia et al., 2018). Some theorize that the positive outcomes are directly related to the high correlation between SUD and PTSD, meaning that EMDR treatment positively impacts PTSD symptoms, which subsequently positively impacts substance use (Abel & O'Brien, 2010). Current studies indicate better mental health outcomes for clients with a SUD diagnosis after EMDR treatment, though there is limited research as to the effectiveness of utilizing EMDR to specifically reduce substance use cravings (Logsdon et al., 2023).

Cultural Competency

Though there is a substantial amount of empirical evidence supporting the use of EMDR, there are minimal references to diversity, culture, or ethnicity within EMDR research. Due to this lack of research, there are no adaptations suggested for African American clients. This gap in research has resulted in a lack of acknowledgment of the lived experiences of African American clients (Lipscomb & Ashley, 2021). Systemic racism and historical trauma affect how African American clients experience trauma, and failing to explore this vital element results in further marginalization by those affected by oppressive systems (Kawaii-Bogue et al., 2017). There is limited research on the use of cultural competency within the EMDR framework. One major case study in 2021 helped to shed light on the discrepancies between EMDR and its success with African American clients (Lipscomb & Ashley, 2021). Within this study, common themes were found to illuminate the ineffectiveness of EMDR therapy for many African American clients (Ashley & Lipscomb, 2022). Considering that most counselors are trained in Eurocentric methods, these gaps must be consciously bridged in order to provide optimal trauma-informed care for minority clients (Lipscomb & Ashley, 2021).

Studies that address cultural competency in the counseling setting suggest key skills for providing high-quality trauma-informed treatment to African American clients. Researchers articulate that helpers providing trauma treatment are not the same thing as offering trauma-informed treatment from an anti-oppressive standpoint (Lipscomb & Ashley, 2021). One concept that should be considered when approaching treatment from a culturally competent perspective is psychological invisibility. Psychological invisibility occurs when the clinician ignores or fails to address the role of race and ethnicity in the counseling setting. If counselors engage in a "color blind" mentality, they create psychological invisibility for their clients, resulting in shame, confusion, frustration, and disillusionment. Counselors who utilize psychological visibility empower and provide a space for their clients to explore how these issues affect them personally. The use of psychological visibility results in ecological validity, taking into account real-world situations the client is experiencing daily.

Focusing specifically on cultural competency in EMDR, it is encouraged that EMDR therapists spend time in the assessment phase, broaching the topic of race, including racialized experiences as part of the trauma treatment (Ashley & Lipscomb, 2022). During phase 2, clinicians should encourage clients to pull personal resources from culturally relevant sources. To explain further, this means that if a client wants to include their family directly in their treatment, it is encouraged to do so. Allowing the client to pull personal resources from culturally relevant sources creates a more personalized experience for the client (Hartung, 2022).

Another concept related to cultural competence is the idea of positionality. A power imbalance in the counseling room can trigger a traumatic experience for oppressed individuals, as the microcosm of power inequity plays out in the counseling room (Lipscomb & Ashley, 2021). Studies convey that psychoeducation can shift the power dynamic in the counseling room, empowering minority clients in the therapeutic process (Kawaii-Bogue et al., 2017). In therapeutic settings, clients tend to accept counselors who position themselves outside of a hierarchical design. In regard to an EMDR session, a counselor adjusts positionality when they allow a client to control the pacing of the counseling session (Ashley & Lipscomb, 2022).

When working with minority clients, it is imperative to establish safety while dealing with trauma. In the counseling room, safety and trust build an environment that allows for healing and change (Lipscomb & Ashley, 2021). Studies find that many African American clients prefer an African American counselor, believing that the shared experiences create a sense of trust and implicit understanding (Kawaii-Bogue et al., 2017). Cultural humility should always be incorporated into a counselor's experience with clients, particularly counselors of the dominant culture (Lipscomb & Ashley, 2021). Cultural humility is an ever-evolving process of gaining awareness of historical injustices, providing empathy for the client's present situation, and recognizing personal biases and prejudices as they arise. A clinician with cultural humility will never feel as though they have fully arrived as a culturally competent practitioner but will use further information to gain more awareness and understanding of the lived experiences of their clients.

CONCLUSION

African American women have endured years of oppression, discrimination, and generational trauma, leading

to an increase in mental health issues (Burroughs, 2022). The likelihood of African American women experiencing childhood sexual abuse is higher than that of white women, resulting in a higher chance of developing diagnoses of post-traumatic stress disorder and substance use (Banyard, V., et al., 2002). The African American community has endured discrimination and oppression by several different systems, including mental health care, leading to both a higher rate of misdiagnosis and improper treatment planning and avoidance of mental health services altogether (Brazelton, J. F., 2015). Many trauma-informed approaches, including EMDR, have lacked research surrounding their best practices within different ethnicities or cultures (Lipscomb & Ashley, 2021). Some research studies have ventured into exploring culturally competent EMDR within the African American community, focusing on integrating their lived experiences and creating a more personal trauma-informed approach for these women.

EMDR is an empirically proven treatment modality for both post-traumatic stress disorder and substance use disorder. However, its effectiveness when working with African American clients is amplified if viewed through a culturally competent lens. If a clinician utilizes a "one size fits all" approach to EMDR, it results in them being less aware, less in tune, and ultimately less effective (Lipscomb & Ashley, 2021). While the research on culturally competent EMDR therapy is relatively small, generalized research on the cultural competency of mental health clinicians has shown better outcomes for African American clients (Kawaii-Bogue et al., 2017). Culturally competent EMDR is a holistic, individualized way of treating clients, including African American women.

The existing literature illustrates the need for a program such as Empowered Healing that allows African American women to explore their trauma through a safe, culturally sensitive perspective (Lipscomb & Ashley, 2021). The history and statistics depict an increased rate of these women experiencing trauma from a young age, increasing their risk of developing PTSD symptoms (Banyard et al., 2002; UJIMA, 2020). The utilization of substances to cope and the lack of an appropriate trauma-informed approach that incorporates their lived experiences emphasize the fact that these women are not receiving the proper mental health services (Mekawi et al., 2021). Empowered Healing utilizes EMDR as a trauma-informed approach but works through a culturally competent lens. Clinicians ensure they are providing a safe space that empowers these women to bring in their personal experiences instead of a "one size fits all" treatment (Hartung, 2022; Lipscomb & Ashley, 2021). The following section explores the different methods evaluators will utilize to evaluate Empowered Healing's program.

METHODS

Methodological Worldview

A pragmatic worldview focuses on the actions, situations, and consequences of a particular research problem (Creswell & Creswell, 2018). Through a pragmatic lens, researchers focus on a specific research problem, possessing the freedom to choose any methods, approaches, and techniques utilized throughout a study. Pragmatic studies do not focus on applying one particular method, suggesting that mixed methods studies operate through a pragmatic lens as they incorporate quantitative and qualitative approaches for collecting and analyzing data. Researchers using a pragmatic worldview will utilize all approaches to help them understand the research problem. Pragmatic studies focus on the consequences of research and interpretations of the research questions to inform the research problem, highlighting and providing further knowledge to understand a particular phenomenon (Kaushik & Walsh, 2019). A pragmatic worldview is best for the Empowered Healing program evaluation as evaluators are looking to explore a particular research problem, focusing on how certain interventions are contributing to the understanding of best practices about working with African American women who are childhood sexual abuse survivors with a comorbid diagnosis of post-traumatic stress disorder and substance use disorder.

Quantitative Research Questions & Hypotheses

R1: What is the impact of the treatment conditions (culturally-informed EMDR, Trauma-focused CBT, supportive talk therapy) on PTSD (as measured by PCL-5) and substance use (as measured by Brief Craving Scale) among African American female childhood sexual abuse survivors?

Ho: There will be no measurable difference across culturally-informed EMDR, Trauma-focused CBT, and supportive talk therapy related to PTSD and substance use among African American female childhood sexual abuse survivors.

Ha1: Both culturally-informed EMDR and Trauma-focused CBT will have a greater measurable effect on PTSD and substance use symptoms than supportive talk therapy among African American female childhood sexual abuse survivors.

Ha2: Culturally-informed EMDR will have a greater measurable effect on PTSD and substance use symptoms than Trauma-focused CBT among African American female childhood sexual abuse survivors.

Qualitative Research Questions

CRQ: How do African American women in the Empowered Healing program perceive culturally competent EMDR as supportive of their lived experience as trauma survivors?

SQ1: What changes have you experienced in your substance use cravings?

SQ2: How has Empowered Healing impacted how you view your previous traumatic experiences?

SQ3: To what degree do you feel empowered to make choices regarding your mental health?

SQ4: What impact does a culturally sensitive counselor have on your treatment experience?

SQ5: How has Empowered Healing supported your lived experience as an African American woman?

Research Design

The design of this study is a convergent parallel mixed methods design, which collects qualitative and quantitative data (Creswell & Creswell, 2018). The qualitative and quantitative data are collected simultaneously but analyzed separately. This data can then be merged and interpreted together to gain a better understanding of the research question. Quantitative designs test the objective results and relationships among variables, while qualitative designs explore and understand the phenomenon behind a research question. Through a convergent parallel mixed methods study, they utilize both approaches to understand the research question from objective and subjective perspectives.

The quantitative approach of this study is a quasi-experimental design, which incorporates control and experimental groups (Creswell & Creswell, 2018). The control group is utilized as a pre-intervention/baseline group to understand how participants are affected by the experimental conditions (White & Sabarwal, 2014). With this design, the study might have a partial or lack of random assignment of participants to different groups. Researchers have identified stratified sampling as the method that will be used to sample the population. Stratified sampling requires including different characteristics of our choice population. This will ensure a more comprehensive representation of the population in our study. The stratification will be characterized by age, income and educational levels (Creswell & Creswell, 2018).

Regarding the qualitative approach to this study, program evaluators will employ a phenomenological design, which focuses on the lived experiences of each individual in a study about a particular phenomenon (Creswell & Creswell, 2018). In contrast to the quantitative approach, this phenomenological design focuses on subjective data, gathering information and opinions from participants directly. This data is typically gathered through observations and interviews, emphasizing the words “what” or “how” to allow for questions to be open-ended to the participants' personal experiences. Open-ended interviews are normally conducted following a study to gather detailed views from participants to assist in the explanation and understanding of the quantitative results.

Participants

For the program evaluation of Empowered Healing, the participants will be African American women with a

history of childhood sexual abuse and a comorbid diagnosis of post-traumatic stress disorder (PTSD) and substance use disorder (SUD). The evaluation will be conducted in the upper Midwest within a community agency that is focused on establishing support for childhood sexual abuse survivors. Once the strata population has been established, we will calculate the total sample size for the program. The sample size will be 10% of the total population in treatment. This will selection process is typical based on past studies (Creswell & Creswell, 2018). We plan to recruit 45 participants, split into three (3) groups, with fifteen (15) women being assigned to each group. And each group will have two counselors. The sample size would be appropriate for a pilot study and to ensure that each participant receives individual therapy within the 12-week program timeframe. Several studies suggest follow up after 3 months and 6 months (Schafer et al, 2017). We intend doing the same by administering the pre-treatment assessments during the scheduled follow ups to ascertain any symptom reduction in tandem with baseline symptoms.

When considering risks, Empowered Healing has chosen to exclude potential participants who are currently experiencing abuse. This consideration is being made out of an abundance of caution for the well-being of the abused individual so that active abuse can be prioritized and the risk of further traumatization by addressing childhood sexual abuse can be reduced. Researchers are also considering the risks of suicidal clients participating in this program. While research supports EMDR as a modality that can address underlying trauma related to suicidal ideation, Empowered Healing has chosen to exclude participants who are experiencing active suicidal ideation to ensure their safety and reduce the risk of being retraumatized by addressing childhood trauma (Shapiro, 2018).

Treatment Conditions

Supportive Talk Therapy

Once participants have been selected and properly screened, they will be placed into one of three experimental groups. The first group, the control group, will receive individual supportive talk therapy weekly for a 12-week duration. Supportive talk therapy emphasizes relieving emotional distress and symptoms without addressing sources of conflict or attempting to change the personality structure of the client. This therapy highlights reassurance, reeducation, advice, persuasion, re-motivation, and encouragement of desirable behavior. Techniques are rarely used in this style of therapy (APA, 2018).

Trauma-focused Cognitive Behavioral Therapy (TF-CBT)

The second group, experimental group one, will receive individual Trauma-focused Cognitive Behavioral Therapy (TF-CBT) every week for a 12-week duration. TF-CBT shares many characteristics of Cognitive Behavioral Therapy, including using thought records, cognitive restructuring, and focusing on the relationship of thoughts, feelings, and behaviors. It is a counselor-led modality and relies heavily on techniques. A trauma-focused approach differs from traditional CBT in that more time is spent on emotional regulation and soothing skills. These skills can include breathing exercises and mindfulness (Han et al., 2021). Counselors will utilize a TF-CBT manual to incorporate different techniques and interventions with clients in this experimental group (Blanchard, 2004).

Culturally-Informed EMDR

The third group, experimental group two, will participate in individual culturally-informed EMDR treatment weekly for 12 weeks. The recommended number of sessions for EMDR is between 6 and 12 sessions (APA, 2017). However, due to the important culturally-informed aspect of the program, participants will be completing 12 sessions to allow counselors time to engage in the assessment period, providing enough time to focus on incorporating the lived experiences of clients into the trauma work. EMDR is a phase-oriented approach that highlights the importance of resourcing and self-regulation. Resourcing is the process of accessing personal strengths and positive memories. These resources are then "tapped in" for the purpose of self-regulation, both in session and independently. Bilateral sensory stimulation, through eye movement and tapping, is used to desensitize and reprocess negative memories. There are eight phases of EMDR: (1) history taking; (2) preparation and stabilization; (3) assessment; (4-7) desensitization, reprocessing, and closure (these three steps

are repeated for each "target"); (8) reevaluation (Brown, 2020).

Table 1: Procedures in EMDR therapy related to the eight phases, including culturally-informed considerations

Phases	Focus	Activities
1	History taking	● Assessment and conceptualization of the client ○ Include broaching the topic of race and the client's culturally related experiences
2	Preparation and stabilization	● Tools are developed to handle potentially distressing cognitions that may arise: ○ Visualization techniques, mindfulness exercises, and soothing skills ○ Clinician invites the use of culturally-relevant symbols ● When childhood trauma is present, individuals may need to stay in this phase longer ● This phase prioritizes safety in the therapeutic setting before moving on to subsequent phases ● The clinician focuses on empowerment and the psychological visibility of the client ● Clinician is cognizant of positionality within this phase and comes alongside the client as a partner; extra considerations for psychoeducation to help the client feel fully informed
3	Assessment	● Assess for "target" memory or event by documenting Subjective Units of Disturbance (SUD) and Validity of Cognition (VOC) ○ Subjective Units of Disturbance, a scale that gauges the client's current level of distress, based on a 0-10 scale, when focusing on the target memory ○ Validity of Cognition tracks the belief in the alternate positive cognition that the client would like to have ● Clinicians will ask a series of questions about the target memory: ○ including the title of the memory, the image associated with the memory, the negative cognition regarding the memory, and the somatic feeling in the body. ● Alternative positive cognition is identified (VOC) ○ Throughout the VOC process, clinicians will use a scale of 1-7 to gauge how accurate the positive cognition feels to the client ● Clinicians must be mindful of how cultural and/or discriminatory factors may impact this phase
4-7	Desensitization (these three steps are repeated for each 'target')	Phase 4: Processing and employing a dual attention task ● Dual-attention tasks can include eye movement, tapping, and auditory stimulation, among other things ● Clients engage in a set lasting 20-60 seconds, then report to the counselor the last feeling/cognition that accompanied that set

		● The feeling/cognition may be processed briefly before continuing with subsequent sets ● Clinician attends to the client's desired pace and allows the client to take the lead Phase 5: Installing an adaptive belief for the event, occurring after the target memory has been desensitized and the SUD has lowered, preferably to zero ● Dual-attention tasks are also utilized in this phase, often slower, to solidify the positive cognition that the client would like to feel ○ For example, if the negative cognition was "I am worthless," the positive cognition may be "I am worthy of love." ● During this phase, clients are encouraged to slow down and "tap in" to positive cognition Phase 6: Body scan, focusing on the somatic experience ● Attention is placed back on the area of the body that was identified as experiencing the feeling in phase 3, bringing awareness to the changes between phases Phase 7: Closure, mindfulness exercises are utilized at the end of the session to ensure stability after reprocessing takes place
8	Reevaluation	● Reevaluation process occurs at the beginning of the following session. ● Clinician maintains a stance of cultural humility ● It is not uncommon for processing to continue after the sessions ○ Clients may report vivid dreams regarding the target memory. Clients are encouraged to track these instances during this phase
Ashley & Lipscomb, 2022; Hartung, 2022; Lipscomb & Ashley, 2021; Molero-Zafra et al., 2024; Shapiro & Maxfield, 2002		

Instruments

Childhood Trauma Questionnaire (CTQ)

The Childhood Trauma Questionnaire (CTQ) will be utilized as a pre-screening tool to establish whether or not participants meet the criteria for having a history of childhood sexual abuse. According to the Center for Substance Abuse Treatment (2000), the CTQ is a retrospective self-report questionnaire that consists of 28 items that evaluate 5 subscales: physical, sexual, and emotional abuse; physical and emotional neglect. Each question is scored by a point value to determine abuse and neglect exposure: 1 point for the response of never true; 2 points, rarely true; 3 points, sometimes true; 4 points, often true; 5 points, very often true. This scale also includes a minimization/denial scale for detecting underreporting (Bernstein et al., 1998). We plan to pay special attention to the results of the score associated with sexual abuse. The possible scores will show the level of abuse reported: a score of 5 is equivalent to no abuse: 8, low; 12, moderate; 13+, severe. Participants who score an eight or above on the sexual abuse tally will fit the childhood sexual abuse criteria for our program.

Previous results have highlighted the internal consistency, reliability, and validity estimates of the CTQ. These results have demonstrated the internal consistency estimate of the CTQ by utilizing Cronbach's Alpha, concluding that the total scale estimate was .95 (Bernstein et al., 1994). To determine the reliability of the CTQ, they applied a test-retest reliability method and determined that the intraclass correlation for the total CTQ scale was .88. As far as determining the validity of the CTQ, the previous study analyzed the convergent and

discriminant validity of the assessment. Researchers established convergent validity by comparing it against the Childhood Trauma Inventory (CTI), finding that participants' reports of child abuse and neglect on the CTQ were determined to be stable over time and across different instruments as well. When analyzing discriminant validity, researchers concluded that the factors on the CTQ and the total score were unrelated to a participant's verbal intelligence and social desirability.

World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test (WHO-ASSIST)

The World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test (WHO-ASSIST) will be utilized as a pre-test to identify clients with a substance use disorder. This test has been found to be reliable, valid, comprehensive, and inexpensive to administer (Group, 2002). The WHO-ASSIST can be self-administered or administered by a clinician. The test is administered in eight questions, the first indicating any lifetime use of substances. The substances are each listed, and the client can indicate a simple "yes" or "no." Question 2 narrows the timeline of usage to the past three months and indicates a scale from "Never" to "nearly every day" for each substance. Questions 3 through 7 follows in the same format as question 2. The questions cover urges, social/legal/financial/health repercussions of substance use, strains in relationships, and previous attempts to cut back or eliminate use. Question 8 asks if the client has ever used drugs via injection. A clinician then scores the test to assess for a substance use disorder.

Through previous evaluation of validity and reliability estimates of the WHO-ASSIST, the results show that there is high internal consistency reliability, test-retest reliability, and face validity (Group, 2002). To determine the internal consistency reliability, previous results utilized Cronbach's alpha, which highlighted high internal consistency ranging between 0.50 and 0.70 for most results, but the tobacco score depicted a result of 0.37. These results illustrate that for most concepts; the test measures the same construct. The test-retest reliability method depicts the kappa values to range between 0.58 and 0.90, portraying high test-retest reliability among the different items on the assessment. Previous studies have illustrated that there are high face validity results among the WHO-ASSIST, but further studies could highlight the predictive and concurrent validity.

Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-5 (PCL-5)

The Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-5 diagnosis (PCL-5) will be utilized as a pre- and post-assessment given to individuals to assess the severity of PTSD symptoms. PCL-5 is a self-report assessment that is utilized to identify and assess symptoms of PTSD (Sveen et al., 2016). The checklist contains 20 questions divided into four assessment categories: intrusion, avoidance, negative changes in cognition and mood, and changes in avoidance and reactivity. Each statement assesses the severity of symptoms within the past week based on a 5-point Likert scale, ranked from 0-4, 0 being not at all and 5 being extremely bothersome. The range of scores on the assessment is 0-80, with a score of 38 being the cutoff for an individual to be diagnosed with PTSD for our program.

The PCL-5 has shown sufficient internal consistency, reliability, and validity in assessing PTSD in individuals. Concerning the internal consistency estimate of the PCL-5, a Cronbach's Alpha coefficient of .70 is sufficient (Sveen et al., 2016). In a previous study, Cronbach's Alpha was .57-.78 for each subscale measure and .90 for the total scale. A test-retest reliability method was utilized to determine the reliability of the PCL-5 and to understand the reliability of each of the subscales. The test-retest scores illustrated the following: intrusion = .58, avoidance = .49, cognition and mood = .63, arousal and activity =.63, and the total reliability score for the PCL-5 was a .66. The PCL-5 has previously shown construct validity against different assessments, such as the Impact of Event Scale-Revised (IES-R), The Montgomery-Asberg Depression Rating Scale (MADRS), and the Perceived Stress Scale (PSS). The construct validity was determined utilizing Spearman's rho correlation, which demonstrated that the intercorrelations of the PCL-5 are moderate to high, highlighting that the PCL-5 taps into similar constructs as the other assessments.

Brief Craving Scale

The Brief Craving Scale will be administered to each participant every three weeks during treatment to track

progress. The Brief Craving Scale is composed of three questions: (1) "Please rate how strong your desire was to use in the past 24 hours." (2) "Please imagine yourself in the environment in which you previously used drugs or alcohol. If you were in this environment today, what is the likelihood you would use?" (3) "Please rate how strong your urges are for drugs or alcohol when something in the environment reminds you of it." (McHugh et al., 2021) Each question is rated on a scale from 0-9, and the total is added to calculate the level of craving. According to a study done in 2021, this scale is reliable and valid (McHugh et al., 2021). After completing the 12-week program, participants will be asked to complete the Brief Craving Scale and the PCL-5 one final time.

With previous research on the Brief Craving Scale, the internal consistency estimate was determined by McDonald's Omega, which is similar to that of Cronbach's alpha. Using McDonald's Omega, the estimate for the entire sample was .81, which suggests strong internal consistency. When determining reliability, researchers focused on the internal consistency reliability estimates of alcohol and opioid use disorder while also providing the reliability estimates for males and females. The reliability estimates determined were alcohol = .78, opioid use disorder = .80, males = .81, and females = .82. Previously, the Brief Craving Scale has demonstrated concurrent validity with the Obsessive-Compulsive Drinking Scale (OCDS) to assess the alcohol aspect of the scale with estimates ranging between 0.54 to 0.85 (McHugh et al., 2016). The scale has also illustrated predictive validity among future cocaine and prescription opioid use, suggesting that for every 1-point increase on the scale, there is a 17% higher likelihood of future drug use.

Data Collection

Approval by the university's institutional review board (IRB) will be required for this study. Participants will be informed of the purpose of the study and that participation is entirely voluntary. Study analyses will not investigate individual survey responses but will instead analyze the data in aggregate. Participant names will not be used at any stage of data collection. Numeric identifiers will be randomly assigned to each completed survey following data collection to maintain both organizational integrity in the data entry process and participant confidentiality in the data analysis process. Additional procedures will be instituted as necessary to ensure that participant data is kept confidential and secure. All survey data will be entered into a password-protected file and securely stored on a computer in the research supervisor's locked campus office.

Quantitative Procedures

Before participating in the study, participants will be provided an informed consent form to review and sign, acknowledging their understanding of the terms and their rights as participants. The informed consent will allow participants to recognize that their rights will be protected during the data collection process (Creswell & Creswell, 2018). Participants complete the screenings (CTQ & WHO-ASSIST) and the pre-post (PCL-5 & Brief Craving Scale) assessments utilizing the pencil and paper method.

Qualitative Procedures

As the participants move through the treatment groups each week, they are made aware that their consent is voluntary, and they can withdraw from the treatment at any moment during the 12 weeks. Participants will be aware that their sessions are confidential and that following the 12-week sessions, evaluators will conduct an interview to inquire about the process to examine their experiences. To ensure there is documentation of a client's interview, evaluators will utilize audio recordings to record clients' responses in order to transcribe the interview. Each interview will take place at the same mental health agency within the upper Midwest, where treatment groups will be conducted within a confidential counseling space. The interviews are expected to last between 30 and 45 minutes to allow the evaluators to ask the five questions, allocating enough time for any follow-up questions.

Data Analysis

Quantitative

Following data collection, surveys will be scored using the appropriate procedures for the instrument(s). All demographic information and instrument data will be organized using an Excel spreadsheet and entered into

SPSS for statistical analysis. The data will then be analyzed for descriptive statistics such as means, standard deviations, range, confidence intervals, effect sizes, skewness, and kurtosis. Internal consistency estimates will be calculated for the instrument(s) to determine reliability. Data will be assessed for violations of assumptions and missing values.

For the program evaluation of Empowered Healing, evaluators will utilize a multivariate analysis of variance (MANOVA) as the statistical method. A MANOVA test is a statistical method that measures multiple dependent variables (Creswell & Creswell, 2018). The evaluation of the Empowered Healing program consists of two different dependent variable measures: PTSD symptoms and substance use symptoms. A one-way MANOVA is utilized to determine whether or not there are any differences between categorical groups of a single independent variable on two or more dependent variables. (Laerd Statistics, 2018). In the Empowered Healing program evaluation, the single independent variable is treatment conditions, consisting of three different groups (supportive talk therapy, culturally-informed EMDR, and Trauma-focused CBT).

To effectively utilize a one-way MANOVA statistical method, several assumptions need to be met in terms of the variables (Laerd Statistics, 2018). When it comes to the dependent variables, evaluators need to ensure that they can be continuously measured, such as utilizing certain assessments to identify how the dependent variables are affected by the independent variable. In this particular program evaluation, PTSD symptoms and SUD symptoms are being measured by utilizing the PCL-5 and the Brief Craving Scale. Another assumption that needs to be met when conducting a one-way MANOVA statistical method is ensuring that there is only one independent variable that consists of two or more categorical independent groups (Laerd Statistics, 2018). The Empowered Healing program evaluation utilizes treatment conditions as its independent variable with three categorical variables (supportive talk therapy, culturally-informed EMDR, and Trauma-focused CBT). Each categorical variable represents a different treatment condition within the program evaluation that will assess its effect on the two dependent variable measures.

Another assumption must be met, where all observations must be independent, meaning that the same participant cannot be in more than one group. For the Empowered Healing program evaluation, each participant will be randomly assigned to only one of the treatment conditions, ensuring there is no relationship between the participant and the different treatment conditions. One important assumption that needs to be met in order to utilize a one-way MANOVA statistical method is that each program evaluation or study needs to have a sufficient sample size, suggesting that each group needs to have more participants than the number of dependent variables being analyzed (Laerd Statistics, 2018). The use of a stratified sampling will ensure our study satisfies this assumption as we will have more than 2 participants per group. Hence the Empowered Healing program evaluation meets the requirements for the independent and dependent variables to be able to conduct a one-way MANOVA.

Qualitative

Following data collection, surveys will be transcribed using NVivo software and thematically coded using appropriate phenomenological analysis procedures. When focusing on qualitative research, validity is determined based on identifying the accuracy from different standpoints, including the research participants and other outside individuals who review the research (Creswell & Creswell, 2018). To determine the validity of a study, researchers need to identify the trustworthiness of a study and its results, which is analyzed through identifying credibility, transferability, confirmability, and dependability. Trustworthiness ensures the precision and reliability of study findings and interpretations (Ahmed, 2024).

One way to determine credibility is through utilizing a member check, which involves researchers following up with participants regarding the final reports and ensuring that the final result is accurate to what the client is portraying through their answers, allowing them an opportunity to comment on the findings (Creswell & Creswell, 2018). Another way to ensure validity for this program evaluation is to utilize analyst triangulation, which involves using multiple observers rather than a single observer (Pandey & Patnaik, 2014). The advantage of two observers looking at the same qualitative research allows for a reduction in potential bias from a single interpreter (Renz et al., 2018). The Empowered Healing program evaluation will utilize these methods to check the credibility of the findings and ensure they accurately represent the participants' experiences and results

through multiple observers.

Another way to determine the trustworthiness of research is through transferability, which is the degree to which different research findings can be transferred to different contexts or situations (Ahmed, 2024). Transferability can be determined through journaling, where researchers keep detailed notes of their experiences during the research and data collection process. Journaling allows researchers to keep notes that could be important for other researchers to know about what factors are influencing a study at certain times throughout. Journaling can also increase awareness of any biases and reflections that are prevalent during the research process, which also promotes transparency. During this evaluation of Empowered Healing's program, evaluators will utilize journaling to keep detailed notes that indicate their experiences, helping to identify any variables that could affect the research and data collection process.

In addition to the other techniques utilized for maintaining trustworthiness, researchers maintain dependability by documenting their different approaches, techniques utilized throughout the research process, and the different procedures for analyzing the results (Ahmed, 2024). In order to determine dependability, researchers have another individual who is not involved in the research process participate in an inquiry audit. By conducting an inquiry audit, this researcher must describe how they conducted their audit, explaining their decisions throughout the inquiry process. This process provides dependability because it evaluates whether or not the research data supports the conclusions and results of the study. It also allows the research auditor to contribute additional findings to portray stronger research finding and conclusion. Program evaluators will utilize an inquiry audit in Empowered Healing's program evaluation to determine the dependability of research results, ensuring that the research data supports the results.

The final way that this program evaluation can provide additional trustworthiness is through confirmability, referring to the way research findings are presented as unbiased, focusing on objective data (Ahmed, 2024). When confirming the data, most researchers utilize an audit trail, which involves tracking the data process and having outside auditors confirm the data. Data tracking enhances confirmability because it ensures researchers are providing documentation on the processes utilized for checking and rechecking data (Renz et al., 2018). Through data auditing, outside auditors can read the processes utilized during the research process, confirming whether the findings and inferences are logical in terms of the data collection (Cutcliffe & McKenna, 2004). This process allows auditors to assess for any biases during the research process, writing their own independent assessment of the process to allow for a confirmation of a researcher's results. Program evaluators will ensure they are tracking their data collection procedures when conducting the Empowered Healing program evaluation, documenting all processes and procedures to allow an outside auditor to review the data and findings.

Ethical Considerations

It is the responsibility of the Empowered Healing program to ensure that ethical standards are observed to maintain best practices in program implementation and professional practice. The Empowered Healing program and all practitioners associated with it will adhere to the Ethical Standards detailed in the ACA Code of Ethics and uphold the laws and regulations as they pertain to the population of clients. Ethical issues are extensive and must be anticipated at every stage of evaluation (Creswell & Creswell, 2018). The Empowered Healing program intends to look at the stages of evaluation (i.e., initial, treatment, and data stages) to anticipate any ethical issues. For the initial stage, prospective clients will be provided with sufficient information to make informed decisions about participation. The information will also include "the purpose and procedures to be followed…describe any attendant discomforts, risks, benefits, and any limitations to confidentiality" (ACA, 2014).

Throughout the evaluation phases, clients will be reminded that they can withdraw consent to participate at any time. In accordance with Standard E.3.a. Explanation to Clients, an adequate explanation will be given on the nature and purpose of the assessments using terms that the clients understand. Also, in alignment with Standard E.6.a. Appropriateness of Instruments, assessments were selected by carefully considering validity, reliability, and appropriateness. The initial stage also includes screening, which involves selecting those whose needs are compatible with the purpose of Empowered Healing. For this reason, exclusions have been made for victims of active abuse and/or suicidal clients. This is in tandem with Standard A.9.b. Protecting Clients mandates counselors to protect clients from physical, emotional, and psychological trauma. This is buttressed by the

fundamental principle called beneficence, which stipulates working for the good of the client and society by promoting mental well-being (ACA, 2014). The exclusion is necessary to protect participants from potentially being overburdened by extra factors, leading to complexities not addressed by the treatment modality.

For all participants in the treatment phase, it is the primary responsibility of Empowered Healing "to respect the dignity and promote the welfare of clients" (ACA, 2014, Standard A.1a). For experimental group 2 participants, it is imperative to establish safety and build trust by using positionality to empower them. This shift in power dynamics is essential to negate the effects of systemic oppression and improve the efficacy of Empowered Healing. In so doing, the Empowered Healing program will validate the client's lived experience in accordance with Standard E.5.b Cultural Sensitivity, which holds that counselors should be cognizant of "clients' socioeconomic and cultural experiences" and how they relate to clients' presenting problems. No significant ethical issues are anticipated during the Data collection/analysis and storage phase. However, to continue with professional integrity, clients will be reminded of the confidentiality clause that also covers any data acquired and provides clarification for any concerns participants might have about the program (ACA, 2014, Standard G.2.g).

Future Considerations

As earlier mentioned, one resounding limitation of this study was a lack of research on culturally informed EMDR for African American women. We adapted what the available research recommends, however we also acknowledge that there are several areas that need improvement. For instance, the recommended sessions for EMDR are 6 – 12 weeks. This could affect the number of participants that can be involved at a given time except more counselors are involved. In the future, it might be more beneficial for treatment modalities to use group sessions rather than individual sessions to ensure the feasibility of a bigger sample size. Secondly, given that EMDR is a specialized intervention that requires extensive training, culturally competent EMDR is a newer framework and requires further knowledge for best practices in working with minority clients. In view of this, developing an Empowered Healing Practitioner toolkit for this study would be difficult to achieve without the availability of adequate resources and an established train-the-trainer module by culturally sensitive EMDR experts already in the field. In the interim, we believe the procedures detailed in Table 1 (under Treatment Conditions section) will suffice as a guide for practitioners. It is our hope that more studies are carried out to provide essential evidence to the efficacy of EMDR treatment from a cultural lens.

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