Chapter 1[1]

Sensorimotor Psychotherapy in Context: Sociocultural Perspectives

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Not everything that is faced can be changed, but nothing can be changed until it is faced.

James Baldwin

For the master's tools will never dismantle the master's house.

Audre Lorde

Racism, sexism, ableism, homo- and transphobia, ageism, fatphobia are algorithms created by humans' struggle to make peace with the body. A radical self-love world is a world free from the systems of oppression that make it difficult and sometimes deadly to live in our bodies.

Sonya Renee Taylor

Contemporary psychotherapy as we understand it was first developed in the 19th century by people of European Christian and Jewish ancestry, designed to treat people of that society. Most other psychotherapeutic modalities established over the past century followed a similar trajectory of development, and Sensorimotor Psychotherapy is no exception. This method, a body-based treatment approach that values the "somatic narrative" (the story told by facial expressions, posture, gesture, movement, and eye gaze) as a viable avenue of therapeutic change, was created in the United States in the mid to late 20th century. It implicitly contains the values and bias of white culture and has not been systematically adapted to address the unique perspectives of people of color and marginalized ethnic populations, nor of other historically marginalized groups (e.g., those with disabilities, the elderly, LGBTQ+, and so forth). "Whiteness" has a complex meaning as it is both a category of racialized identification and a social construction. Best described as "a constellation of processes and practices rather than as a discrete entity (i.e. skin color alone)" (DiAngelo, 2011, p. 56), whiteness allocates power to those considered white, shaping every aspect of our social, cultural, educational, political, and economic institutions. In psychology, the predominance of whiteness and related Eurocentric/Western views throughout the history of psychology research and practice has resulted in an exclusion of diverse perspectives that do not meet the prevailing criteria for health. More recently, the distinct mental health needs of marginalized

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people have been a frequent topic of exploration in psychology; however, the impact of mainstream psychology values and white supremacist and heteropatriarchal ideologies on marginalized populations remain relatively underexamined both clinically and theoretically.

The purpose of this chapter is to expand the current conceptualization of Sensorimotor Psychotherapy to increase the reader's knowledge of this legacy and to bring awareness to the influence of culture, racism, and biases toward those we perceive to be unlike ourselves. We hope to inspire practitioners to develop a deeper sensitivity to these issues as well as a commitment to ongoing learning within a contextual sociocultural and anti-oppression lens. The chapter is organized around the model pioneered by Sue, Arredondo, and McDavis (1992) that delineates three essential components of a more equitable, inclusive, and culturally sensitive therapeutic orientation: knowledge, awareness, and skill.

Increasing Knowledge and Understanding

In this section, we consider a few of the Eurocentric and Western paradigms that inform Sensorimotor Psychotherapy, introducing some of the culture-bound values and their impact on contemporary clinical practice. We believe that examining these values and paradigms will clarify some of the projections and misunderstandings commonly imposed on those for whom these models were not developed.

Contributions and Limitations of Western Developmental Models

Western Eurocentric models in general prioritize the use of empirical data and natural science methodology to understand social phenomena. These European ideologies were exported to other areas of the world through imperialism and colonization, and were presented as intellectually superior to alternative ways of living (Said, 1978). This reflects a belief in the dominance of reason and a devaluation of intuitive and emotional perception as well as the body that has its roots in the Cartesian dualism of mind and body. One way this belief may manifest is that people who use complicated arguments and language might be perceived as more knowledgeable and trustworthy, while those whose reasoning is based on emotions, intuition, or a felt sense in the body may be dismissed as subjective. Additionally, this kind of Westernized thinking prioritizes individual rights over collective rights and competition over collaboration, and thus seeks to advance an individual's own status and needs rather than those of the group as a whole.

Many researchers, theorists, and clinicians have highlighted the problems of maintaining such a stance. Boykin, Franklin, and Yates (1979) pointed out the inherent biases that exist in all forms of research, which are especially problematic when the outcomes of the research are presented as objective and universal. Nobles (1986) coined the phrase "conceptual incarceration" to describe the generalization and indiscriminate application of these partial ideas and biases to all individuals and groups of people. The acronym WASP (Western academic scientific psychology) is used to identify theories and scientific

approaches that draw upon research based on a rather limited percentage of the people in the world (Berry et al., 1997). However, despite criticism of its bias and limited applicability, the scientific method and quantitative measurement are consistently valued over emotional insight, direct experience, or other forms of sensory-based or qualitative "knowing," which has contributed to a lack of data about alternative ways of knowing.

Elements of this Western scientific methodology and its assumed universality are evident in many developmental models in psychology. With individualism at its very foundation, these models frame human development as a process of maturing into a self-contained individual with agency and autonomy. Western psychology relies upon a sharp distinction between the self and nonself, that is, a dualistic understanding of self as independent from context (Schachter, 2005). In such models, optimal development centers around individualistic and relationally independent orientations (that prioritize the well-being of the individual over the group), while implicitly or explicitly dismissing collectivist and interdependent orientations (that prioritize the well-being of the group over the individual) as inferior or lacking. Successful individuation—described as the achievement of a separate and distinct sense of self—is touted as the direction and telos of human development and a necessary foundation for psychological wellness, vitality, and health across the life span. In contrast, models founded in ecological theory are increasingly gaining influence and represent an alternative to mainstream individualistic models (Harrell & Gallardo, 2008). These models highlight the multiple contextual and community influences and interactions that impact and shape the child's development, from the most immediate environment of the child to larger sociocultural elements (Harrell & Gallardo, 2008).

Attachment theory is drawn from traditional Western scientific models, but highlights the relational and interdependent aspects of human development. This model, with its focus on the quality of early childhood relationships, has dramatically changed the field of psychology and continues to dominate prevailing perspectives on child development. Innovative in his time, John Bowlby emphasized the importance of early caregiver-child interactions as critical for healthy development, thus challenging Freudian concepts of infant development and the individualistic nature of other models. This emphasis on relationship represented a paradigm shift, as Sroufe and Siegel (2019, para. 1) state:

> By divorcing human attachment from the drive-reduction notions of Freudian theory, Bowlby laid the foundation for a shift from seeing people as individuals somehow standing apart from their social environment to a more fine-tuned grasp of just how deeply relational human nature is.

The contributions of attachment theory have profoundly impacted psychotherapy practice. However, although attachment theory has been extensively examined across cultures, research remains limited, and cultural elements that contribute to attachment outcomes are not apparent (Agishtein & Brumbaugh, 2013).

Bowlby stated that infants were biologically wired to develop a singular relationship with the caregiver. Because attachment is thought to be rooted in biology, it is assumed to be universal across cultures. However, while the survival need for relationship itself is universal, establishing a primary attachment with one particular caregiver is not. Additionally, attachment

research often bypasses critical cultural factors relevant to caregiving practices. These include diverse family and community structures, socioeconomic status, family culture and kinship structure, ethnicity, education levels, mental health issues, medical care access, and so forth, all of which strongly influence both the child's development and caregiver availability (Cassidy et al., 2013). Applying generally culture-bound conceptions of family structure of the industrial world (nuclear family, fewer children per family, late first pregnancy, high education, relative financial stability, and so forth), which represent a limited portion of the entire global population, to all cultures fails to account for sociocultural variety. In Keller's (2018, p. 11414) words, "The claim of universality for attachment theory, qualifying one particular view as best for all children in the world is in stark contrast to the actual ecosocial diversity."

Ainsworth's Strange Situation research expanded attachment theory by focusing on the behavior of children when their mothers left them alone with strangers and then returned (Ainsworth & Bell, 1970). Although some of her research was conducted in countries outside of Europe, Western theoretical premises were used as the contrasting baseline norm. Such premises are biased toward ideals of autonomy and individuation of the self, prioritizing a parental style of sensitivity that requires the caregiver to be available and attuned to the signals of the child, and values child behaviors such as social competence and the idea of a secure base connected to one caregiver (Rothbaum et al., 2000). In contrast, infants in non-Western farming societies learn to comply with the directives of multiple caregivers who view an infant not as an independent agent who deserves attuned ministering to their signals (a Western view) but as a "calm, unexpressive, quiet, and harmoniously well-integrated communal agent" (Keller, 2018, p. 4). When judged by the Western standard of sensitivity, caregiver practices adaptive in such cultures are viewed as emotionally distant, harsh, and unresponsive to the child's immediate needs, and parents can be considered inadequate (Morelli et al., 2018). Furthermore, in collectivist cultures, children are not seen as having rights over their caregivers, and "the notion of separating the rights of children from the family or community circle would be deeply and structurally—indeed, ethically—problematic" (Morelli et al., 2018, p. 6).

Bowlby wrote that "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (1951, p. 13). According to attachment theory, failure to form a one-on-one attachment bond with a caregiver, or the disruption of this dyad, is considered detrimental to the development of secure attachment in a nearly deterministic manner, while at the same time stranger anxiety is considered normal. The Strange Situation research showed differences in children's responses to both separation and reunion with the mother, leading to the categorizations of secure, insecure avoidant, and insecure ambivalent; later, a fourth category was added, disorganized/disoriented (Main & Solomon, 1986, 1990). ReleVant for technologically advanced cultures, these views do not always take into account the predominant child-rearing practices in non-Western, non-technological communities, and to risk classifying children of these communities with disregard for sociocultural norms and meanings neglects critical factors.

For instance, ethnographic studies in sub-Saharan Africa show that communities in which child-rearing tasks are distributed among many people also produce well-adapted, securely attached children who lack an anxiety response when separated from their biological caregiver and do not experience fear of strangers (Gottlieb, 2004; Otto & Keller, 2014). In another example, among the Efe of Zaire, newborns are cared for by various women, and at six weeks of age are in the company of their birth mother less than with other people, yet grow up to be well-adjusted adults (Tronick et al., 1992). Similarly, Otto's (2008) and Otto and Keller's (2014) research on northwest Cameroonian Nso practices confirms that fostering a child's bonds to older siblings also produces well-adjusted children. In these more collectivist cultures, applying the concepts of attachment theory that reflect an individualist, independent cultural orientation can be misleading. Not surprisingly, most cross-cultural research on attachment patterns systematically finds a higher percentage of securely attached children in Western developed countries (Keller, 2018), although so-called "insecure" patterns are often shown to be adaptive when contextualized. Additionally, Tronick (2007) has noted that infants display different attachment patterns with different caregivers, yet this complexity is not commonly acknowledged. The prevailing view is that a child develops one attachment pattern that remains stable throughout adulthood (Mikulincer & Shaver, 2007). Moreover, it is not only possible to develop different attachment patterns with different people, but also to "earn" secure attachment as an adult (Main, 2000). Both these potentials—to develop different attachment patterns and earn secure attachment—challenge the deterministic nature of attachment patterns in early childhood.

Attachment theory as it is often applied provides an example of how the unexamined use of psychotherapy practices based solely in Western models increases the possibility of misunderstandings, misattunements, and mistreatment of persons, communities, and cultures that do not seek to approximate such standards or those that have been historically defined as "other" by the privileged culture. For example, relational patterns common to extended family systems and collectivistic cultures could be misconstrued as enmeshed and thus evidence of pathology (Kağitçibaşi, 1990). A therapist with an individualistic orientation might view the physical proximity between a mother and child in a more collectivist Asian culture "as symbiotic and overdependent" (Pallaro, 1997, p. 229). A parent from India living in a European country who lifts a hand to their child and firmly demands that the child cease what they are doing—normal parenting practice in Indian culture—may be assessed as abusive by Western social services (Keller, 2018). When clients do not meet Western ideals of relationship or developmental trajectories toward autonomy and independence (e.g., demonstrate less interest in productivity or prefer a relaxed time orientation over a fixed or future time orientation), they may run the risk of being perceived by therapists as underachieving, hostile, lazy, resistant, or generally not committed to therapy. Conversely, a client from an individualistic culture could be perceived by a therapist whose culture is collectivist as selfish or egotistical for strongly asserting their right to personal gratification or achievement. When both therapist and client value an individualistic cultural orientation, qualities such as dependence on others, a desire to blend in, and disinterest in one's unique expression may be faulted or seen as undesirable.

In sum, as Tronick states, "Western models of childrearing and development are extremely limited and narrow" (2007, p. 12). We mental health professionals can challenge claims of universality and expand our lens to include collectivist or even hybrid developmental models. And although attachment theory continues to be valuable, we also need to include the perspective that an adaptive attachment pattern depends on context (Keller, 2013) and congruence with the belief system of the community (Tronick, 2007).

Trauma Theory and Models in Western Societies

The effect and impact of trauma, defined as a threat to safety that elicits instinctive defensive responses and dysregulated arousal (Ogden et al., 2006), is strongly influenced by cultural norms, values, and perspectives. Culture shapes not only whether certain events are experienced as traumatic, but also how an individual makes meaning of those events. For example, the greater the significance of an event to the person and community and/or the level of disruption of cultural practices due to the event (SAMHSA, 2014), the greater the impact. However, in Western psychology, post-traumatic stress disorder (PTSD) is generally identified as a universal phenomenon observed cross-culturally (Figueira et al., 2007; Foa et al., 2009) and thus provides the frame for most of the common understandings of trauma. Although the neural substrates of PTSD are well documented, "there is very little empirical work investigating the impact of culture on these systems" (Liddell & Jobson, 2016, p. 1). Thus, differences in "idioms of distress," a term introduced by Nichter (1982, 2010) in reference to "socially and culturally resonant means of experiencing and expressing distress in local worlds" (Nichter, 2010, p. 405), and alternative explanations for symptoms considered to be related to PTSD by the Western world are areas that requires more exploration and expansion (Jacob, 2019; Kaiser & Jo Weaver, 2019).

Trauma literature often omits the influence of historical trauma, which is defined as "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003; Brave Heart & DeBruyn, 1998, p. 7). Over the centuries, groups of people have been discriminated against, terrorized, and at times decimated based on one or more of their social identities. The generational aspect of this form of trauma has been described by other authors as transgenerational, intergenerational, cross-generational, and multigenerational. Historical trauma can be found in "numerous colonized indigenous groups throughout the world, as well as … many other cultural groups and communities that share a history of oppression, victimization, or massive group trauma exposure" (Mohatt et al., 2014, p. 2). These include the historical trauma of African Americans, described as "post-traumatic slave syndrome" (DeGruy, 2017); the trauma of Native Americans, described as a "soul wound" (Duran et al., 1998); and the experience of descendants of Holocaust survivors around the world (Kellermann, 2001).

Historical trauma (and racialized trauma in particular) is an intrinsic dynamic in any country where there is a political and social cleavage between groups that hold power (e.g., national citizens) versus those who do not (e.g., immigrants). A close

examination of the history of the United States reveals a pervasive ideology of white dominance that led to the genocide of Native Americans, the African slave trade, Jim Crow, Japanese internment camps, and the current immigration detention centers, to name a few. The racialized dominance inherent in these actions and policies became further entrenched as this ideology was transformed into normative political, economic, social, and cultural practice and embedded in the very psyche of the United States. Although often covert, such as in the predominance of Western ideas of health and healing and how pathology is defined, racism also presents itself in more overt forms such as in the disproportionate number of Black and Brown people incarcerated or in deliberate discriminatory hiring practices (Alexander, 2020; Quillian et al., 2017). The ideology of white racial dominance is thus institutionalized as normative and natural, and the structural adVantages of this privileged group become invisible so that whiteness remains a self-perpetuating cultural structure (Frankenberg, 1993; Lietz, 2015). In psychology, for example, dominance is maintained through policies and practices that privilege white people, which contributes to the lack of diversity among psychiatrists, doctors, and mental health professionals in relation to the population as a whole (Roberts, et al, 2020). Furthermore, racial/ethnic marginalized people and those of lower socioeconomic status have a reduced probability of accessing state-of-the-art psychotherapy from well-trained therapists, receiving the needed number of sessions, reaping the benefit of interventions most applicable to their difficulties, or securing timely treatment (Harrell & Sloan-Pena, 2006).

Racialized trauma and the trauma of systemic oppression are closely related. Systemic or structural oppression refers to the ways in which institutional practices and policies interact to keep specific groups of people at a disadvantage, reducing their options for the future and sometimes even their very survival. It is widespread, with devastating outcomes for those groups, for example when girls are denied education, immigrants are denied work, Blacks are incarcerated at many times the rate of whites for similar crimes, or when institutionalized Islamophobia justifies violence and even war. Both trauma and oppression are perpetrated not only in overt ways but also in subtle and often intractable ways by people who would not consider themselves oppressors or racists. The impact of this individual and systemic oppression affects a multitude of groups, including women, Blacks, Chicanos, Latinx, Arabs, Asians, Native Americans, immigrants, refugees, Jews, lesbian, gay, bisexual, transgender, and gender nonconforming individuals, older people, working-class people, those with larger bodies, and the physically and/or mentally disabled, to name a few. Currently, are seeing manifestations and results of systemic oppression in the coronavirus pandemic that disproportionately affects vulnerable, marginalized, and food-insecure communities who have less access to resources such as shelter, health care, less financial backup to support them during shelter-at-home mandates, and less availability of online options (technology, Wi-Fi, etc.). Concomitantly this global pandemic is fueling fear, breeding misinformation, and spreading racist scapegoating and accusations in statements such as, “The Chinese are to blame for this,” or calling it the “Chinese virus.” Still other racist theories are circulating that hold Jews responsible for this pandemic as well.

The varied and nuanced responses to the multitudes of traumas and oppressions, such as those outlined above, may be judged as pathological without understanding their cultural implications or their relationship to oppression and racialized trauma.

As Harrell and Sloan-Pena state, “The ideology of racism has been embedded in psychological theory and research since its inception and continues to influence what is considered normal or abnormal, healthy or maladaptive, functional or dysfunctional” (2006, p. 396). For example, a tendency to view overactive instinctive survival defenses that are elicited in the face of threat (cry-for-help, fight, flight, freeze, feigned death) as needing to be fixed or treated discounts the possibility that these defenses might be vital and crucial strategies necessary to survival in hostile environments. Emotional numbing and behavioral inhibition, common reactions when confronted with discrimination (Sanders Thompson, 2006), can be adaptive responses when the targeted person perceives that challenging the perpetrators would lead to a negative outcome (Sue et al., 2019). In another example, toughness and its associated qualities (e.g., difficulties with being vulnerable, armoring of the body) might be interpreted as negative or as something to be softened, when an individual may need this protection when confronted with racism or other unsafe situations.

In sum, because institutionalized practices that privilege white cultural groups against people of color and ethnic groups are usually present in society, it is critical for psychotherapists working with traumatized individuals and communities to understand the dynamics of each sociocultural context and the impact on psychotherapy practice. Awareness of the different idioms of distress, as well as the legacies of racialized trauma, oppression, and historical violence, is essential when addressing individual or community presentations of trauma-related dysregulation.

Western Perspectives on the Body and Nonverbal Communication

Western perspectives on mind-body dualism tend to dominate how we see and experience the body itself. Descartes crystallized the idea of division between the body and the mind by proposing that the body is an instrument without consciousness, a concept that gave birth to modern science and medicine (Mehta, 2011). This view has largely carried through to the present day in the Western viewpoint that the body and the mind are distinct and can be studied and treated separately. The body is usually perceived as lesser than the mind, driven by passion instead of intellect, and considered an enemy to control because it challenges cognitive objective logic by the subjectivity of the senses (Aposhyan, 1999). This perspective has contributed to the development of specialized fields and professions that address problems of the mind and the body as separate from one another.

However, although it is not yet mainstream, an emergent recognition of the mutual interdependence between the body and the mind has started to appear in approaches such as integrative medicine and many models of psychotherapy, including Sensorimotor Psychotherapy. Despite these shifts toward holism, the cultural impacts of mind-body dualism continue to affect perspectives on the body itself. For example, the body is often viewed as something to be controlled, shamed, and objectified. This is apparent in the popular fixation with molding and enhancing bodies through fitness, dieting, and surgery (Hanckock et al., 2000). Norms of what is acceptable and attractive in terms of the body itself as it relates to color, size, ability, age, shape, proportion, posture, stance, and symmetry primarily reflect Western heteropatriarchal values (Hanckock et al., 2000). These idealized Western/European standards of beauty, such as being thin, fair, and blonde, as well as appropriate physical behaviors

and how the body is to be adorned, are then imposed upon various cultures and races. Within the confines of these standards, "the body that acts and appears different becomes a marked pariah and disrupter of the social order" (Thompson, 1997, p. 254, in Caldwell, 2013). People whose bodies do not conform to the norms of beauty, color, presentation, and the like will also tend to be seen with more suspicion and biases, even if unconsciously.

The influence of these values is also evident in norms related to which bodies are to be controlled or policed. For instance, one of the myths of "white-body supremacy" (the privileging and elevating of white bodies above all others) is based on the belief that Black bodies are strong and, if not subdued or enslaved, must otherwise be controlled and punished (Menakem, 2017). In contrast, white bodies are seen as more fragile (DiAngelo, 2011), a version of the puritan Victorian ideal of "angels" that need protection by the police.

Culture and context also shape nonverbal patterns of body posture, movement, expression, and nonverbal communication (Birdwhistell, 2010; Hall & Hall, 1959; Knapp, 2006). Physical behaviors of dominance and subordination are learned through countless social interactions over time, and these become procedural habits. Johnson asserts, "asymmetrical interactions are a hallmark of the nonverbal exchanges between individuals from dominant/subordinate social groups" (2015, p. 83). Privilege/oppression dynamics are reinforced through these learned procedures of nonverbal communication (including movement, posture, boundary actions, use of space, gestures, and expression), all of which are used (consciously or nonconsciously) to maintain societal norms and power dynamics (Henley, 1977; Henley & Freeman, 1995; Johnson, 2015; Johnson et al., 2018).

Reviews of research in Western cultures confirm that status—determined by different relationships of various factors (such as race, gender, class, economic status, occupational rank, age, and so forth) "is a powerful organizer of proxemic behavior" (Gillespie & Leffler, 1983, p. 141). For example, implicit conventional rules of personal space in Western European culture prescribe that people of the dominant culture are permitted to take up more interpersonal space through expansive postures and movements. Dominance can also be demonstrated by less formality, more variety, flexibility, and ease in gesture and posture, while oppression is indicated by the opposite (Johnson, 2015; Johnson et al., 2018). Eye contact as well serves to modulate and manage social interactions, including power and oppression dynamics. For example, prolonged, direct eye contact is a signal of dominance and often aggression in animals, including humans (Ellyson & Dovidio, 1985). Similarly, the use of touch can reflect power/oppression dynamics. Since physical contact indicates more intimate access to another person, a person deemed to have lower status learns to refrain from touching a person deemed to have higher status, while the person with higher status is permitted to initiate and informally touch the other person (Henley & Freeman, 1995). This is also observed in patriarchal, heteronormative, and gender-binary cultures to reinforce male dominance (Borden & Homleid, 1978), even taking into account cultural differences in touch behaviors (DiBiase & Gunnoe, 2004). However, in "societies where gender roles are less defined," the use of touch for dominance is less clear across the gender category (DiBiase & Gunnoe, 2004, p. 59).

The power of nonverbal language lies in its repetitive nature, which becomes automatic and procedural over time, and thus harder to identify (Johnson, 2015; Johnson et al., 2018; Ogden, Minton & Pain, 2006). The body's language is especially significant when we consider that the impact of nonverbal communication has been shown to be four times stronger than that of verbal language when both are used simultaneously (Argyle et al., 1970). In this sense, seemingly ordinary social gestures replicate and perpetuate histories of cultural domination and subordination.

Awareness of the biases toward the body as well as attention to the nonverbal perpetuation of dominance and submission are often lacking in mental health. As psychotherapists and counselors, we need to account for culture and oppression dynamics and how these are re-enacted through both verbal and nonverbal expressions in the therapy interaction. When they are ignored, the most well-intentioned approaches can, and often do, negatively impact therapeutic formulation, assessment, intervention, and, ultimately, progress.

Assessment and Treatment Considerations

Despite the progress made by including cultural formulations in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), its main taxonomy of pathology is based on research that privileges the Western and Eurocentric value systems as previously outlined. These cultural formulations are lacking in the *International Classification of Disease* (*ICD-11*) (Paniagua, 2018), although some argue that "the more flexible language of the *ICD-11* diagnostic guidelines is intended to increase clinical utility by allowing for cultural variations in presentation as well as contextual and health-system factors that may affect diagnostic practice" (Clark et al., 2017, p. 84). Still, because the classifications of diseases were developed with individualistic and Western values in mind, when people are evaluated against these standards, their unique conditions, challenges, and alternative explanations of symptoms can be lost. This has resulted in a history of, at best, inaccurate psychological assessments and diagnoses for individuals and communities that do not align with such standards and, at worst, legitimized the perpetration of physical and/or psychological violence against those individuals and communities (Barrera & Jordan, 2011; Cosgrove, 2005; Hammack et al., 2013; Kirschner, 2013; Szasz, 1971). Similarly problematic is the fact that even when there is an increasing effort to develop more culturally appropriate methods (i.e., assessments, treatments, theoretical orientations, etc) in mental health, research continues to show disparities in access, diagnosis, and quality of treatment (Snowden, 2003).

Mental health practitioners' decision making about diagnosis and treatment is influenced by their internal bias and prejudices (Escobar, 2012; Snowden, 2003) as well as cultural misunderstandings of symptoms (Snowden, 2003), which can result in either an "overdiagnostic bias" or an "underdiagnostic bias" (López, 1989). Harrell and Sloan-Pena clarify, "Clinicians may overpathologize racial/ethnic [marginalized] clients or interpret behavior as deviant when a client is not understood within a cultural context. Alternatively, clinicians may also underpathologize racial/ethnic [marginalized] clients and label a problem

behavior as 'cultural' in an attempt to not be perceived as racist" (2006, p. 401). Overpathologizing is well documented in disparities in diagnosing the African American population in the last two decades: for example, African Americans are overdiagnosed with schizophrenia disorders, while research shows less diagnosis of affective disorders (Snowden, 2003). These disparities between privileged and marginalized groups are likely to be present in any country where marginalized groups do not fit the predominant standards of wellness.

Sidhu explains that applying Western models indiscriminately is "a forceful, oppressive endeavor [that] replicates colonization, where Eastern [and other non-Western] ways of healing are disregarded and Western theories are seen as the 'true' ways of healing" (2017, p. 13). Ancient, traditional, and folk healing and alternative forms of diagnosis and treatment of psychological disturbance have been largely neglected and even devalued by dominant conceptualizations of psychotherapy (Sidhu, 2017). This exclusionary focus leaves psychology bereft of a truly nuanced understanding of both the diversity of the human experience and the multiple approaches to healing. Recognizing this ethnocentrism in Western psychology requires us to learn from other ways of thinking about illness and from different practices for assessing and healing beyond hospitals or medical interventions (Christopher et al., 2014). These can include, among others, reiki, curanderismo, rootworkers, Ayurvedic therapies, traditional Chinese medicine therapies, and group practices such as spiritual rituals and ceremonies, like drumming circles, and so forth.

In terms of diagnosis, many cultures formulate explanations of symptoms that are different from those of the *DSM-5*. For example, hearing voices is viewed in certain cultures as the emergence of the person's spiritual giftedness, the need for increased protection of personal energy, or as ancestral communication (ValaVanis et al., 2019). Symptoms of dissociative identity disorder, associated in the West with severe trauma, might be accepted in other cultures as an indication of being inhabited by spirits or ancestors (Kirmayer, 1996). Thus, in Afro-Caribbean countries and in many Latin American countries, a person may more readily seek the guidance of a curandero, spiritual diviner, or native healer for a perceived mental health issue than a doctor or psychotherapist.

To increase the utility and effectiveness of Western paradigms of psychotherapy, we need to question when they are applicable, and also to include other sources and approaches to understand wellness, pathology, and healing as conceptualized and practiced by different cultures and subcultures. This is delicate territory, since this dialogue can often lead to appropriation of these practices by those without adequate knowledge of and deference to the ancestral and/or spiritual underpinnings of such practices. For example, "mindfulness" is a commonly utilized term in the field, including Sensorimotor Psychotherapy, but it is often used without recognition of the historical and cultural background of its roots in Eastern practices and spirituality (cf. Chapter 4, this volume). The nuanced variations that occur when these practices are applied in a different cultural context or used to promote particular goals is rarely acknowledged. Such cultural appropriation can reinforce the devaluation of other cultures, maintain privilege/oppression dynamics, and sometimes serve to increase the profit of people in power who commodify cultural

artifacts. As mentioned above, one way to address this issue is to cultivate a thoughtful approach to when and how we use contributions originating in other cultures, and to give credit to these sources, while studying and analyzing what changes in meaning occur when we import these practices into our own cultural context. For example, we can acknowledge that mindfulness, in a Western conceptualization, serves a different purpose when applied to psychotherapy than it does in the original contexts. Without such thoughtfulness, we collude with the inherent oppression and colonialism that exists in cultural appropriation.

In sum, mainstream mental health models that inform current evidence-based methods in psychotherapy are founded in Western understandings of illness and health while practices from other cultures are typically undervalued by the dominant culture. Therapists need to consider that much can be learned from unpacking culturally bound assumptions and starting a dialogue with alternative ways of understanding symptoms and pathways to well-being.

Deepening Awareness and Sensitivity

In this section, we move from theoretical understanding into personal awareness of our bias and how it operates in mind and body. All of us assess the external world according to preconceptions that arise from the norms and customs of the groups to which we belong and from associations we have formed that are reinforced by the dominant culture. These preconceptions obscure understanding of the sociocultural phenomena of privilege and oppression, and also structure and constrict our capacity to form equitable relationships with those we perceive as different. Understanding how introjected values impact our prejudices and behaviors toward our clients begins with awareness of their historical context and the conditionings of explicit and implicit bias. We will explore how to cultivate cultural sensitivity and humility, accept the inevitability of implicit bias, and suggest strategies to increase awareness of our own bias.

Understanding Explicit and Implicit Bias

Bias—defined here as the attitudes, stereotypes, and prejudices we hold toward our own groups of reference and toward groups of people that we perceive as different from ours—can be explicit or implicit. Explicit bias includes conscious opinions and belief systems. Although we may not reveal these to others, they are reflected in our internal thought processes, emotions, and somatic responses. Behaviors based on explicit prejudices vary from more extreme forms of hate and violence to more subtle forms of nonverbal acrimony, animosity, harassment, and discrimination. Explicit biases are often modified to appear more socially acceptable when social norms reinforce values of equality and justice (Perception Institute, 2019). However, expressions of explicit bias increase when there are few social norms in place to restrict prejudice, or when people in power model or endorse such expressions, hence validating previously hidden prejudices of the general population. In contrast, implicit bias encompasses the values, opinions, attitudes, stereotypes, and prejudices we hold toward both our own groups and toward groups of people

different from our own that are outside of our awareness, governed by processes that are reflexive and automatic. They can also be described as shortcut assessments that are triggered subcortically, without reflection, to facilitate immediate judgments of people and situations. Hence, implicit bias includes all that "we don't know that we don't know" and "what we don't think that we think."

Bias arises partly because the brain is wired to maximize both efficiency and survival through association and categorization. Before we develop language and narratives about the self, we begin to classify stimuli at a basic level. Even in utero, we learn to categorize prosody and cadence of movement as familiar or unfamiliar, and act accordingly as we physically orient toward safety cues and away from threat cues. Once born, categorization continues: For instance, babies have an innate preference for particular facial traits and learn quickly to recognize the traits of their main caregivers, including the characteristics of their own race or ethnicity (Bobula, 2011; Dunham et al., 2008). However, when infants are exposed to diverse racial groups, they do not show patterns of preference toward their own racial or ethnic group or against others (Dunham et al., 2008).

Categorizing stimuli is elaborated throughout development by imitating others while exploring and adapting to one's specific sociocultural environment. As we mature, we steadily absorb information from a variety of sources: direct interactions with and observations of others, overheard conversations among adults and peers, education both formal and informal, music lyrics, books, news, movies, TV, and, more recently, the internet and social media. Our brains continually compare present-moment sensory stimulation from the environment to this stored information, facilitating lightning-quick unconscious and biased associations upon which we may act without realizing our prejudice. Thus, learned associations and categorizations become procedural and are subsequently applied reflexively and universally regardless of context. This leads to automatic projections between groups that we perceive as "us" versus groups that we perceive as "others" (Tajfel & Forgas, 1981). So, although procedural learning supports survival and belonging, it can also constrain receptivity to new information (Ogden et al., 2006; Tronick 2007), and in this sense can support and perpetuate bias.

Reshamwala's (2016) short film on bias and race clarifies how we form mental shortcuts that we may not agree with consciously but nevertheless act upon unwittingly. He describes the associations we unconsciously make as pairings typical in a given culture, such as peanut butter being paired with jelly in the United States. All cultural assumptions, but particularly those of the dominant culture, influence our non-conscious perspectives of our own groups and of other groups. In a seminal study, Bertrand and Mullainathan (2004) altered résumés to reflect typically white and typically Black-sounding names and emailed them to potential employers who had explicitly expressed the intention to increase the diversity of their personnel. Despite this conscious intention, potential employers were 50% more likely to respond to those résumés that had a white-sounding male name. Also noteworthy was that employers responded more frequently to résumés with white-sounding names who were rated as average than to résumés with Black-sounding names who were rated as "highly skilled." There are numerous additional studies

that also demonstrate that job applicants with ethnic-sounding names working in English-speaking countries like the United States, United Kingdom, and Canada are not hired as much as those with English-sounding names, a phenomenon that has not changed in the last four decades (Quillian et al., 2017). Such bias does not only apply to race and ethnicity. Moss-Racusin, Dovidio, Brescoll, Graham, and Handelsman (2012), who used male and female names for identical student application materials for a laboratory management assignment, found that faculty of both genders rated males as more competent, and offered males both a higher salary and more opportunities for mentoring than female applicants. Although this study only examined binary categories of gender, its results highlight social biases around gender dynamics, in this case in a patriarchal culture.

As these studies reveal, implicit bias operates outside of our awareness and can contradict our explicit attitudes and beliefs, even when negative bias is toward the group to which one belongs. These attitudes and beliefs are reinforced by popular culture, language, the media, social networks, technology, and the like, which often support Western Eurocentric ideas and promulgate them globally, to the exclusion of other perspectives. Disturbingly, the reinforcement of these stereotypes and associations through media and social structures perpetuates systemic oppression, white supremacy, and racism. Some common inaccurate and offensive associations are African American men/violent; Asian/compliant; poor people/lazy; migrants/troublemakers; women/incompetent in business; blonde women/intellectually inferior; Arabs and Muslims/terrorists; gay men/feminine; lesbian/masculine; overweight/unhealthy; disabled/less intelligent; Native American/alcoholic; homeless people/drug addicts; and sadly there are many more. None of us are immune from the cultural conditioning that ingrains such associations in our unconscious, and even with a conscious belief in equality and fair treatment for all people, implicit attitudes and practices of discrimination toward specific groups of people, including one's own, can still occur.

Identifying Microaggression, Denial, and Vulnerability to Bias

Biased associations can lead to microaggressions, defined as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group" (Sue, 2010, p. 5). Microaggressions are common occurrences when people who belong to different races, cultures, or religions interact, and are regularly inflicted on groups such as women, LGBTQ+ community members, those with disabilities, the elderly, people with more body fat, and immigrants, but also occur between interethnic groups as well (Sue et al., 2007). Like the studies above show, those who inflict microaggressions are usually unaware that their communications are offensive (Sue et al., 2007). It is important to highlight that microaggressions prevail because the cultural conditioning that drives them upholds and perpetuates "social inequalities and hierarchies that are desirable to the in-group at the expense of the out-group" (Williams, 2019, Defining Microaggressions section). However, because members of the dominant culture are conditioned to avoid recognizing racial and ethnic inequities (Phillips & Lowery, 2018), and because they are not typically the targets of the effects of prejudice and bias, their own and others' microaggressions often remain unnoticed. In addition to all these reasons, microaggressions are more likely to take place

when there is a power imbalance, such as in the therapist/client dyad (Sue 2010; Williams, 2019); hence, it is imperative that therapists examine their own biases and how they might play out in the therapy hour.

Denial of bias is common among us all, often occurring where we hold a place of privilege, which renders our bias hidden. Our desire for social acceptability and a need to protect an egalitarian self-image can often lead to this denial. For instance, we may readily identify racism and prejudice in society but fail to recognize racialized implicit biases within ourselves, both because they occur outside of our conscious awareness, and because ignorance of bias maintains congruence with how we want to see ourselves as well as how we want others to see us. When we have tendencies toward explicit bias, our desire to avoid disapproval from others, preserve a positive image of ourselves, and uphold anti-racist, anti-oppression attitudes would have us edit or modify our behavior to be more acceptable. However, when bias is implicit and thus unconscious, we are unable to recognize the need to modify our behavior. Therefore, regardless of our explicit values and good intentions toward others (including our clients), implicit bias can lead to inadvertent microaggressions.

Acting upon implicit bias is particularly prevalent when we have not addressed our internalized privilege or oppression, or become aware of our biases. We can begin to notice implicit bias as a sense of general discomfort or "feelings of anxiety and uneasiness" toward people of different groups (Dovidio & Gaertner, 2004, p. 42). These feelings may also manifest somatically as sweaty palms, longer or shorter eye contact, more blinking, frozen smiles, or unconscious efforts to bypass difference through denial, fixation, or overcompensation. For example, in a dyad between a white therapist and a client of color, denial of color (colorblindness) might lead the therapist to invalidate the client's experience of being a person of color by saying, "I don't see color; I just see you as a person." Or a therapist may demonstrate a fixation on difference when identities are not shared, and continue to misgender a client who is gender expansive. Finally, a therapist's attempt to speak with the vocal intonations, verbal patterns, and/or other phrases stereotypically associated with the oppressed or targeted group may also signal discomfort or attempts to cover up discomfort (e.g., a heterosexual therapist who uses idioms associated with gay and queer culture like " "tea," and "hunty," whose origins are from Black and Latinx LGBTQ+ culture). It should be noted that overemphasizing positive qualities can also be microaggressions, as in telling a refugee, "With all you have endured, I'm sure you can deal with this problem too." As with any interpersonal process, these expressions may also be bidirectional and happen from therapist to client and from client to therapist and across variations of difference.

The tendency to employ the mental shortcuts of stereotyped categories is intensified in stressful situations, when access to cortical processes might be more limited and the brain relies on speed over accuracy. Based on our personal and cultural backgrounds and societal messaging, these quick judgments may be predicated on subtle and not so subtle physiological responses to threat, regardless of whether the threat comes from a truly unsafe situation or is assumed to do so. In other words, implicit bias and stereotyping are more active when our arousal is approaching a state of hyper- or hypoarousal. We are also more susceptible to implicit bias when making decisions quickly or without sufficient information, for instance, in rapid action-reaction

encounters between law enforcement and Black individuals (Menakem, 2017). However, with intention, we can become aware of our tendencies and develop strategies to mitigate denial and work to reduce their negative impact.

Strategies to Challenge Bias

Understanding bias is facilitated by examining the concepts of social location and intersectionality. Social location refers to each of the groups people belong to, defined by such factors as race, socioeconomic status, gender, age, religion, sexual orientation, ability, education, language, geographic location, immigration status, and the like. Social location answers the questions, "who am I? and who are my people?" (Kirk & Okazawa-Rey, 2013), giving rise to a sense of group membership. While some of these locations may be more visible, such as race, many are not, such as gender, sexual orientation, class, and some disabilities. Some social locations are stable, and some develop and change over a life span. Intersectionality, a term introduced by Crenshaw (1989), describes the process and dynamic by which these social locations interact and come together at any given time and how they are acted upon by the forces of domination and oppression. Considering intersectionality helps us look beyond a single identity of who a person is and instead understand the person as a complex tapestry of identities that have an intersecting impact on the entirety of a person's experience. For instance, a person's male privilege is mitigated by being undocumented, working class, and disabled. Similarly, a working-class person will hold greater privilege when cisgender, heterosexual, and white.

As therapists, our task is to continually work toward understanding our own social locations and the roots of our own identity that is informed by the sociopolitical history of the groups to which we belong and the power and privilege these groups hold. For instance, if we benefit from white privilege, it would be helpful to understand the construction of whiteness and white supremacy, or if we identify as cisgender, to become curious about all the privileges we hold and the ways intersex, transgender, and gender-non-conforming individuals have been oppressed throughout history. We can read and get acquainted with the literature of our own history from a critical standpoint, connect with other people of our own group that can support us in awakening to these privileges, and explore how to use them consciously to decrease inequality. Identifying when our social locations indicate positions of subordination or subjugation and exploring the ways in which oppression, historical and current, impacts us, is also helpful. For example, the social locations of a highly educated, Latino, 35-year-old heterosexual man with documented status, or of a white, wealthy, physically disabled lesbian woman whose first language is English include elements of both privilege and oppression. Examining our privileged locations, we learn to recognize the invisibility of our own implicit bias and how this invisibility has benefited those that share similar social locations, while placing others with dissimilar locations at a disadvantage.

A critical first step is to consider our early learning about differences, including races, ethnicities, cultures, and social groups. In our own self-examination, we have found it valuable to reflect on questions such as these: When did you first become aware that there were different races or cultures? What early messages (verbal and nonverbal) did you receive from those around

you about yourself and people different from you? How did those around you respond to those they perceived as other? In your upbringing, was there homogeneity or diversity around various social locations? How were differences acknowledged? Were they valued or ignored, respected or judged, minimized or celebrated? What of these early learnings remain with you and what have you changed? It is also helpful to consider the associations you learned in relation to social locations, particularly considering the locations of your clients and how they differ from yours. There are always differences between a therapist and client who share the same location that may be overlooked, as well as other similarities that can be invisible at the beginning. Terms such as "Asian," "Latinx," "African," or "European" are commonly used to categorize groups of people but overlook the abundant diversity to be found within each of these cultural groups. Being curious about differences between ethnicities and identifying individual differences in people of the same culture can help counteract our own stereotypes and associations.

Pondering our tendencies—what we avoid, what challenges us, what we are reactive to, what we minimize—with regard to race, culture, gender, age, and any other differences between us and our clients is essential. Asking ourselves questions like, "Would I prefer a male (or white, physically fit, English-speaking, able-bodied, or heterosexual) doctor, mentor, or client?" can reveal implicit bias. Examining "affinity" bias (Ross, 2017), a subtle form of prejudice that eludes recognition, can elucidate how our perceptions of similarity between ourselves and our clients may influence our approach and even the outcome of therapy. We can identify affinity bias by considering which clients we resonate with the most, and why. What aspects of a client do we feel particularly resonant with and empathic toward (or not)? How do those aspects that we are resonant with relate to our own social locations? How can we sustain an inquiry into our biases and not bypass them or subsume them under the rubric of countertransference?

As important as knowing our own social location is knowing the history and cultural background of our clients. We all need to educate ourselves about other cultures, being aware that the media is full of biases and prejudices toward marginalized groups. We can learn from original and multiple sources, and also expand our "social context" by "increasing intergroup contact" (Stewart & Payne, 2008, p. 13). A note of caution: Even though it is often helpful to learn directly from people who identify with marginalized social locations, we need to be mindful that doing so may be burdensome to that person.

As therapists, we can aspire to hold an intersectional understanding of the identity of our clients and ourselves and how these intersecting identities interface and show up in the therapy room at different times during treatment. At the same time, from our localized awareness we need to accept the limits of our own knowledge and understanding of others' experiences, bodies, individuals, families, cultures, and communities that are not our own. We strive to cultivate an open mind and attitude of curiosity and self-inquiry that allows new and sometimes dissonant information to affect us and impact our actions.

Mindful Awareness of Biases

Through the use of mindfulness—the ability to notice our present-moment internal experience—we aim to become aware of and challenge both the implicit assumptions of superiority/shame of our privileged identities, and of the internalized shame/oppression of our marginalized identities, at somatic, emotional, and cognitive levels. Ng and Purser (2015, para. 11) state, "If mindfulness teaches us anything, it is the importance of redirecting our attention *continuously* to *repeatedly* to question how forces of conditioning are shaping unacknowledged habitual reactive patterns." The willingness to be tenaciously aware of our own feelings, physical responses, and thoughts that emerge when we meet someone we perceive as different can be a vital teacher in dismantling our own implicit bias. If our heart rate increases, or we notice tension in the belly or in another part of the body, or if we become aware of certain body sensations, micromovements, or impulses, we can reflect on their meaning and how these somatic responses might echo implicit bias and stereotypes. We can examine the emotional response and the reflexive thoughts that emerge in response to difference. Do we feel anxious, critical, or afraid? What are the automatic thoughts and assumptions that emerge in our minds?

As we become mindfully aware of our internal reactions, we can hypothesize what microaggressions we might be prone to enact and actively work toward counteracting them. For example, if we were to lead a workshop on mental health stigma for a group of unsheltered homeless people in an economically impoverished part of town and notice our shoulders tightening, our breath becoming shallow, and tingling in our belly as we approach the location of the event, we can examine the associations. For example, we might be correlating these groups of people with violence and crime. It follows that we may then be inclined to microaggress in particular ways, such as exhibiting surprise, through words or facial expression, upon finding out the workshop participants have families or higher levels of education than we had assumed.

Learning to tolerate discomfort helps us increase our capacity to stay with experiences that are new and unknown. This is especially true for our privileged social locations that give us a sense of safety, and yet we often have little tolerance for discomfort when these locations are named or highlighted by others in the context of discussing oppression. A common example of this occurs when a person is sharing an experience of oppression and this sharing elicits uncontained emotions from a person holding a place of privilege due to their own guilt, which in turn can divert the focus away from the original sharing. In the therapeutic context, an aware therapist versed in an understanding of these dynamics will be able to regulate and contain their reactions to stimuli that elicit strong emotion or arousal.

Dismantling internalized ideas of privilege or oppression might require actively identifying counter-experiences of our own stereotypes or what Stewart and Payne (2008) call "implementation intentions," that is, intentionally and repeatedly finding examples of individuals we know or public figures that counteract our own biases toward that specific community. By doing so, we are deliberately considering "the diversity within social groups and especially the many examples of group members who

disconfirm the stereotype" (Blair et al., 2001, p. 838). As the authors highlight, this active strategy has been proven to mitigate the intensity and presence of implicit bias (Blair et al., 2001) more than awareness alone (Bobula, 2011).

Through a concerted effort to be mindful of our reactions to difference, we learn to identify the internal signals of our learned associations and stereotypes, our triggers, and our propensities for microaggressions. After noticing them, the next step is to inhibit these automatic reactions through finding ways to regulate ourselves appropriately and alter our behavior. A good dose of compassion for one's own learning process and growing edges helps us lean gently into the discomfort, and to seek like-minded others for support and challenge. Dismantling internalized privilege and healing from oppression can only occur in the context of a larger container of a supportive and intentional community that helps us grow. We naturally have a tendency to surround ourselves with those that look like us and think like us. Even though we might need kin spaces for resourcing, it is important to actively and authentically increase our exposure to different ways of thinking, feeling, being, and moving to challenge our own assumptions.

Bias and the Body

The body is central in Sensorimotor Psychotherapy; thus it is critical to recognize our bias and preconceived notions toward the body, some of which are described in the first section of this chapter. At this point it should be clear that our own ideas of what constitutes both physical health and desirable physical presentation and movement habits are historically, culturally, and socially constructed. At the same time, the meaning we make from posture and movement is also a result of idiosyncratic and family influences embedded in a community-specific culture (Moore & Yamamoto, 2012). At the most fundamental level, what we feel, see, and recognize in others' nonverbal communication is filtered through what we have personally experienced. We have more familiarity and feel more comfort with the movements and other nonverbal cues of our group of reference. When we recognize familiarity in movement patterns and expression, we experience an increased felt sense of security and resonance; on the contrary, when movements and patterns are not familiar, we may experience a sense of threat.

Naturally, our sense of safety and familiarity affects the way we read other people's movements and somatic expressions, which can lead to misinterpretation when working with people from diverse backgrounds and locations (Caldwell, 2013). For instance, if the therapist assumes a client feels angry or aggressive due to their stiff or armored body posture (when the person is feeling safe) or assumes a client is lying due to a lack of eye contact (when the person is being truthful), the therapeutic relationship could be adversely impacted. Eye contact behaviors are used often when illustrating cultural differences because duration and direction of eye contact is highly influenced by cultural norms, and what is considered respectful or not (Burgoon et al., 2010). Similarly, different cultures have different norms for degree of personal space and amount, placement, and duration related to touch (Burgoon et al., 2010). Movement tendencies, such as more sway in the hips or expressive gestures with the hands, are not common in some cultures, hence, they might be considered "uncontained," "dysregulated," "histrionic," or overly

sexualized. Attaching inaccurate meaning to physical characteristics and idiosyncratic movements can be especially salient with clients that are on the autism spectrum, neurodivergent, or otherwise physically atypical.

As therapists, we can seek to become increasingly aware of our perspectives and prejudice toward "different" bodies (race, size, attractiveness, age, ability, etc.) and movements (including nonverbal communication). The more cultural, ethnic, or racial disparity between people, the higher the probability of "body prejudice" (Moore & Yamamoto, 2012): Each of us will be prone to interpret the other person's movement, gesture, posture, and so forth from their own lens, and judge these somatic expressions quickly and unconsciously. We can learn to recognize our own physical reactions to the bodies and movement habits of others and also identify the cognitive descriptors of that prejudice (e.g., "dangerous" or "fragile" bodies). In this way, we become aware of inclinations to label or interpret certain body shapes, colors, movements, gestures, postures, or expressions as pathological, restricted, maladaptive, or conversely optimal, positive, and healthy, with the understanding that as therapists we can only know what is adaptive or not as we explore these patterns with the client in front of us.

Implicit Bias, Transference, and Countertransference

Perceived and actual difference evokes powerful and often unconscious emotions and physical actions that lead to transference, countertransference, and enactments in the therapist-client relationship. Becoming aware of the body-to-body conversation occurring in the therapy space (touch, proximity, initiation/reaction, eye contact, etc.) that perpetuates privilege/oppression dynamics is a first step in uncovering them. We can be mindful of our own body language and what it might be communicating moment by moment. As we notice our client's reactions to our nonverbal expressions and consider what our body language might be communicating, we learn about the undercurrents and habits of our posture and movements, in reciprocal interaction with the posture and movements of our clients. It is important to understand that the person who holds privilege (the therapist) will be likely to demonstrate power nonverbally. Examples include touching first (as in offering a handshake), having more relaxed movements, initiating movement or verbal talk, greater use of space, greater allowance for expression, and initiation of direct gaze (Johnson, 2009, 2015; Burgoon et al., 2010). The therapist-client dynamic is asymmetrical with respect to power and privilege, where the therapist is always, due to their role as therapist, in a position of power in relation to their clients. Exploration of the nuances of this asymmetry in the clinical encounter is often deemed unimportant, discouraged, and even overlooked. However, the therapist's mindful awareness of their power and privilege, and how they express it verbally and nonverbally, can foster trust and strengthen the therapeutic alliance. Conversely, lack of awareness and unconscious misuse of power and privilege can lead to significant or even irreparable damage to the therapeutic relationship.

As Comas-Díaz and Jacobsen (1991) explain, enactments and relational processes between the therapist and the client are influenced by both projections of each person's sociocultural reality onto the other and the discomfort or disorientation that each feels in the presence of difference. The authors identify several common dynamics that occur when the therapist and the

client do not share social locations. For instance, either party can be overly compliant or overly friendly to avoid being stereotyped, which can manifest in trying to be a good client or good therapist. If the therapist experiences feelings of anxiety or nervousness, they may find themselves seeking approval, trying to please, or avoiding conflict with the client, or even utilizing the therapeutic relationship in an attempt to prove that they are not racist (Harrell & Sloan-Pena, 2006). We therapists may deny discussion of a client's disability and other locations from the conviction that all clients should be treated equally, from guilt about our own ableism or other privileges we hold, or from fear of exposing our own privilege. Transference can manifest in myriad complex ways. For example, a client of color working with a white therapist may demonstrate "overcompliance and deferring to the therapist, behaviors that are intended to disprove racial stereotypes, [or] hostility toward the therapist" (Harrell & Sloan-Pena, 2006, p. 401). Moreover, marginalized clients who have internalized the racism of society may be apt to disconnect from their own group or seek approval from their white therapist (Harrell & Sloan-Pena, 2006).

Emotions such as guilt and shame, pity, mistrust, suspicion, or even ambivalence toward the therapeutic process can also be part of these dynamics. For example, a documented immigrant therapist experienced guilt over their own status while working with an undocumented client grieving about not being able to travel back to their country for their parent's funeral, which resulted in the therapist unconsciously trying to find similarities to bond with the client and inadvertently overlooking the client's need to work on grief and separation.

When therapist and client share some of the same marginalized sociocultural locations, there may be "a risk of overidentification, a need to rescue, protect, or join with the client in an 'us against them' orientation" (Harrell & Sloan-Pena, 2006, p. 401). Comas-Díaz and Jacobsen (1991) also describe such dynamics, including the therapist's idealization by the client as a perfect parent or savior, an "overidentification" between therapist and client, or feelings of anger or frustration toward the success of the therapist or the client if they share some locations but differ in socioeconomic status. Internalized oppression and racism might also play a role if the therapist has not explored it, which can lead to pressuring the client toward increased effort, such as to focus on individual success for the sake of improving the status of the group that both belong to. In another example, a Black therapist from a working-class or low-income background may experience a form of survivor's guilt about having achieved higher social status when working with a Black client from a similar background. This guilt may cause the therapist to unconsciously focus treatment toward the client's achievement of individual success. Bias is inevitable among mental health professionals. As therapists, it is essential that we identify and reflect on our own bias, cultivate humility and non-defensiveness, and maintain an attitude of beginner's mind since this work is never complete. Learning to accept and welcome the unknown, especially when being confronted or challenged, can help in being compassionate with ourselves. In the next section, we encourage an inner posture of openness and humility to the ways our clinical encounters with clients are nuanced by their (and our) histories of privilege, oppression, and resilience.

Therapeutic Action

After reviewing some of the culturally bound assumptions inherent to Western psychology and examining the implications of our personal biases, we have now arrived at the skills that support and strengthen our socioculturally attuned therapeutic practice. In this section, we will explore the significance of cultural humility and radical openness to mitigate the influence of implicit bias and the dynamics of privilege/oppression on our work as therapists. Our emphasis in this chapter is not on perfect practice but on therapeutic action that is grounded in mindful awareness of the effects of many histories of privilege/oppression and resilience present in both the client and the therapist.

Radical Openness and Cultural Humility

The U.S. civil rights movement of the 1950s and 1960s demanded respect for diversity and attention to racial inequality, and was fundamental to the development of the first multicultural competency model in the 1980s (Sue et al., 1982). As stated by Chiarenza, the competency approach often assumes that cultural proficiency and expertise can be "taught, learned, trained, and achieved," (2012, p. 69) leading to greater efficacy in clinical practice. However, Hart (2017, para. 2) writes, "Such [competency] training inherently promotes a defended, prepared manner of addressing difference and otherness, with all their attendant anxieties and defenses, and this represents a major lost opportunity for personal reflections and deeper engagement." He proposes instead an attitude of "radical openness," which entails an ongoing effort "to notice, question, and relinquish presumptions about oneself and the other" (para. 6). Radical openness, like cultural humility (Hook, Davis, et al., 2013; Hook, Owen, et al., 2013; Tervalon & Murray-Garcia, 1998) is conceptualized as a lifelong process emphasizing self-reflection and personal critique. This requires us to realize that we are products of our sociocultural context, accept that we have internalized their biases, recognize the inevitability that we will at times act upon them, and continually examine our own reactions to and actions toward our clients. Hart advises therapists to engage "a stance of openness to the unknown, the unfamiliar, even the frightening, in our clients and in ourselves" (2017, para. 18). Therapeutic action—what we do in clinical practice—emerges from an attitude of radical openness and cultural humility.

Radical openness and cultural humility build the therapist's trustworthiness and credibility. We become trustworthy in our clients' eyes when we recognize the impact of sociocultural and sociopolitical elements on our clients, are willing and able to stay present to issues of oppression and racism, and confront our own bias. As credibility is earned, the client experiences a growing sense of safety in bringing personal and cross-cultural challenges forward. Credibility is fostered by the predictability of the relational dynamics and our demonstration of consistency, goodwill, and care, as well as attention to the specific and concrete needs of the marginalized aspects of our clients (Dilbeck, 2014). We can assume that there will be many moments in cross-cultural and cross-ethnic therapeutic dyads in which therapist and client will not share values and points of view. Embodying radical openness requires us to remain curious about the complexity of these differences and how our own biases play out in our

bodies, emotions, and thoughts, as well as about what we might be missing in understanding the interplay of privilege/oppression. All of these may include recognizing, challenging, and at times discussing our own locations and prejudices with our clients. In this way, we become increasingly capable of staying in the relational process during challenge and conflict, instead of focusing on competence, skills, and interventions.

As the therapeutic relationship develops—when credibility with the therapist has been sufficiently established and when the client seems receptive—explicit exploration of the historical and sociocultural context of the client's presenting issues might help to destigmatize pathology as a solely personal deficit. Whether or not the client takes up the therapist's invitation to explore these contexts, when the therapist is able to name these issues, it opens the door for future discussion and signals their relevance to the presenting problem for the client. As therapists, we hold these considerations in our personal consciousness and case formulation regardless of whether we are actively or explicitly working with these issues with the client. We can reflect upon them ourselves, discuss them in supervision, and consider the impact of those factors with other helping providers.

Regardless of intention, without awareness of the dynamics of privilege and oppression therapists may be unskillful or overzealous in exploring sociocultural issues with their clients. It is also possible for a therapist to become fearful of intervening more assertively. Either extreme may be more likely when the therapist holds multiple positionalities of marginalization in contrast to a client's privileged social locations. We strive to recognize our own capacities and stage of development of this awareness along with those of our client in navigating these issues and seek consultation. Culturally informed supervision, especially group supervision, whether it is with peers or led by a mentor, will help us continue to develop skills, learn about our own responses to these issues, and gain insight into the specific intersectionalities between ourselves and our clients. Harrell stresses that supervisors should be selected based on their having "engaged in, and continu[ing] to engage in, the process of examining [their] own race narratives, including racial identity, racism, privilege, interracial encounters and relationships, and beliefs about race and racial groups" (2014, p. 24).

Most importantly, we must track carefully for clients' responses to our interventions, realizing that all clients, but perhaps especially marginalized clients because of the dynamics of privilege/oppression, might conceal their negative responses due to fear of backlash or rejection, or due to conditioned deference to authority (Vasquez, 2007). Negative responses are usually revealed through the body, in facial expressions, tension, or movements, rather than words. As we notice the indicators that may signal an adverse reaction, we share our observations, ask for more information, and adjust our approach in the moment. It is important that we refrain from pushing our own agendas, and particularly that we avoid campaigning for discussions on oppression and injustice when this is not the client's main purpose for therapy. But we can consistently hold an anti-oppression lens in our awareness, use it to broaden our understanding of the client's presenting issues, and discuss it when appropriate. Delineating culturally relevant practical skills and interventions is complex and nuanced. Although power dynamics and identities are always present in the therapy room, when and whether to address these dynamics depend on timing, context,

content, and the client's focus and goals, in addition to the client's receptivity and the therapist's credibility. Moreover, specific interventions, both verbal and physical, require great sensitivity and skill. Drawing on Sensorimotor Psychotherapy, the next section explores a few elements of the dynamics of therapeutic action, common pitfalls, and culturally releVant intervention, all within the context of the therapeutic relationship.

Sensorimotor Psychotherapy Skills

It is paramount for the clinician to track the impact of their interventions on the client. Tracking is the skill of noticing changes in the body—in movement, gesture, posture, facial expression, tension, or relaxation. Physical signs of emotions (moist eyes, changes in facial expression or voice tone) and the beliefs that emerge, like the words, "I'm failure" or "I'm not good enough," are accompanied by physical indicators such as looking down at the floor. The Sensorimotor Psychotherapist especially tracks the physical changes that correspond to emotions, thoughts, and narrative. These changes in the body often go unnoticed by the client unless the therapist verbally names them with a contact statement that is intended to demonstrate understanding of the client's experience and convey our curiosity about these physical signs (Kurtz, 1990; Ogden et al., 2006).

For example, when Ejikeme, a male originally from Ghana now living in Western Europe, spoke of the difficulty navigating the culture of his new home to his female therapist, she noticed that his shoulders rounded, his posture slumped, and he looked down. Such physical signs can reflect the legacy of trauma, oppression, and relational stress; other such signals can include hyperarousal, held breath, constriction, collapsed chest and shoulders, or trembling, tension, stillness, or blank expression. Holding these hypotheses in our awareness, the Sensorimotor Psychotherapist does not immediately move to interpreting the client's movement, which would mainly be informed by the therapist's location, but introduces these movements into the client's awareness by contacting what is observed. The contact statements his therapist used—"As you say those words, it seems as if your posture changes. …It looks like your head comes down too, huh?"—offered Ejikeme the chance to disconfirm or elaborate the accuracy of the contact statements. This intervention is enhanced by using qualifiers such as "seems like," or "maybe," which convey the tentative nature of the observation and invite the client to modify or correct it. The opportunity to revise the therapist's statements can expose inaccurate interpretations and projections, and is an important invitation for marginalized clients who may not be accustomed to those in authority soliciting their input.

In this instance, Ejikeme nodded in response but said he wanted to continue discussing the problems he was facing. The therapist followed his lead without challenging why he was not interested in exploring the physical indicators. It is important to note that Sensorimotor Psychotherapy, as a relationally focused method, is collaborative and seeks to follow the client's agenda and interest. Instead of labeling a client as resistant or guarded when they reject a suggestion, the therapist recognizes that the client has good reasons for their stance, which in and of itself increases trust in the relationship. Physical signs of trust, openness, or well-being might include a deep, regular breath, a more relaxed or upright posture, or more spontaneous movement and less

tension (Ogden et al., 2006). For example, when exploring Ejikeme's resources for the purpose of stabilization, the therapist asked about what was meaningful to him about his culture—the songs he grew up with, his family and the village where he lived as a boy—and he told her the story his elders had taught him: When he was born, he was put outside in nature because his family thought he was dead. Upon hearing the distant roar of a lion, his parents saw that he was breathing, which in their tradition showed how strong he was. As Ejikeme told the story, his shoulders squared, his head lifted, and his spine lengthened upward. His therapist tracked and named the changes in his body, and Ejikeme responded with a big smile and said that he felt proud. This time he resonated with what the therapist had tracked and contacted, and thus the therapist suggested that maybe they could stay with this experience of pride and how his body responded, to which Ejikeme enthusiastically agreed. This intervention of framing is used to collaboratively narrow the focus of exploration at any given moment in the session, in this case to Ejikeme's pride and posture (Ogden, 2014).

Mindfulness, as used in Sensorimotor Psychotherapy, is relationally focused, used to help clients become aware of their internal organization of experience by becoming aware of the five basic building blocks of present experience that make up their internal landscape: thoughts, emotions, internally generated sensory perceptions, movements, and sensations (cf. Chapter 4, this volume). The efficacy of mindfulness interventions is supported by directing the client's attention toward one or more of the building blocks that are thought to be instrumental in meeting therapeutic goals, called "directed mindfulness" (Ogden, 2007, 2009). In the above example, the therapist directed Ejikeme's mindful attention toward the pride and changes in his body when he remembered the story his elders told him with questions like, "Are there images that come up when you remember this story?" (himself as a happy boy, feeling the hot sun of his homeland) and "Are there movements that go with this sense of pride?" (a slight lifting of the arms outward) and "What words might go with this movement?" ("I feel strong!")

The positive feeling, posture, and movement, which were empowering for Ejikeme, were applied in imagination to the difficult situations he faced in navigating the challenges of an unfamiliar culture, specifically an upcoming job interview that evoked anxiety. Ejikeme's therapist asked him, "If you imagine your job interview and at the same time, sense this strength and pride, and let your spine lengthen, and say the words, 'I am strong,' what happens?" Therapeutic experiments in Sensorimotor Psychotherapy are prefaced by phrases such as, "What happens when…?" or "What do you notice when…?" These mindful directives instruct clients to notice the changes in their building blocks in relation to a stimulus, in this case embodying the resource while imagining a challenge. Therapist and client can experiment with words (e.g., saying "no," or "I am strong!") and movements (e.g., reaching out or lifting the spine) that challenge habitual patterns, or engage a pattern to discover more about it (e.g., using Ejikeme's habit of lowering his head as the stimulus led to sensing the part of him that felt anxious and incompetent). When Ejikeme embodied his resource, he reported feeling a little more confidence and a little less anxiety, and both he and the therapist noted the significance of his expressing his strength and pride physically in the presence of a therapist of a different ethnicity. He decided to practice this resource—to lift his chin, lengthen his spine, and recall the sense of pride and strength—as

he struggled to navigate the complexities of speaking a new language while trying to secure work. Note that the dance of tracking, contacting, framing, asking mindfulness questions, and conducting experiments always occurs in collaboration with the client, and the client's responses determine the next intervention and direction of the session.

Our task as therapists is complex as we must simultaneously attend to the client, to the content, to the process of the therapy dynamics, and to our own reactions. We track our own bodies for signs of implicit bias, which are highly individual but may include tightening, held breath, pulling back, averting or narrowing the eyes, and so forth. We are mindful as well of our own emotional responses (e.g., aversion, blame, or annoyance) and stereotypical judgmental thoughts (e.g., "You're not trying hard enough" or "Your people all have alcohol problems") that reflect our bias toward the client's group. We are also mindful of how we use our bodies to assert dominance or to act from a position of privilege and how that is impacting the client, or, on the other hand, how our bodies react if the client is enacting a similar dynamic with the therapist. Thus, our ability to track ourselves and use our own mindful awareness reveals critical, often unconscious, indicators of bias, useful information to be explored in the ongoing process of challenging our conditioning.

Opportunities for Exploration

Bryant-Davis states, "Initiating process and being aware of process themes that emerge related to discrimination, migration, language, skin color, gender, sexual orientation, religion, spirituality, age, identity, roles, responsibilities, stigma, and cultural strengths need to be a part of both assessment and intervention" (2019, p. 6). However, therapists often neglect to address these issues, perhaps by failing to pick up on signals, changing the subject, or lacking empathetic contact (Comas-Díaz, 2006). Paying attention to timing and the client's receptivity, we might inquire about family roles, spirituality and religion, migration history, beliefs, values, ancestors, documentation status, intergenerational connections, acculturation, or connection with the client's own culture, as well as ideas of health and healing. In tracking clients' responses to these discussions, simple contact statements, such as, "It must be difficult leaving your homeland, huh?" or "Seems like the values of this culture are quite different from your own," can convey the therapist's interest and understanding of the client's experience, and open the door to exploring these themes. As always, tracking your client's response to any intervention, including contact statements, is critical. If your client's facial expression indicates a lack of receptivity, or if they shift topics, the therapist follows the client's lead and internally notes this shift, while continuing to track for future opportunities for exploration of these issues as trust and credibility deepen. Framing the effects of oppression on beliefs, body, values, life path, and so forth (e.g., "Maybe we can stay with how this struggle to fit in impacts you physically") can open doors to deepen the exploration. Additionally, therapists can surmise that clients from historically marginalized groups have likely experienced multiple forms of discrimination, bias, and misunderstanding. Finding opportunities to bring these encounters forward, including those with other helping professionals, can build trust and credibility and provide a chance to process the effects of oppression while building resources to navigate future encounters from a place of

empowerment. The inquiry can include asking about prior relationships with therapists, social services, medical professionals, teachers, or other authorities.

Moreover, people affected by historical trauma may experience reminders of the past in the present time. For example, Williams states that African Americans "have a cultural memory of things that have happened to us going all the way back to slavery—knowing all of that, and then hearing things in the media about unarmed Black men being shot or Black people being killed in a place of worship. These are traumatic for us many times because we have all of this cultural knowledge already" (2014, para. 7). Keeping historical trauma in mind, and taking opportunities to name, discuss, and explore it (while at the same time assessing client receptivity as well as our own credibility and skill) can help place current symptoms and experience in a broader context, and provide opportunities to build resources. For example, when Reyhan (a female Iranian daughter of highly skilled refugees that migrated to Sweden after the Iranian revolution in 1979) mentioned that she had to work harder than anyone else in her workplace to advance professionally, her therapist wondered aloud if this reflected the plight of many immigrants and the effect of anti-Islamic sentiment, to which Reyhan vehemently responded in the affirmative. Through Sensorimotor Psychotherapy, she and her therapist went on to explore how this extra pressure affected her self-esteem, posture, movements, and even her health. This validation allowed the client to soften her own self-judgment and identify the introjected racism that she had experienced at work. By naming this, the client's muscle tension relaxed, and she was able to express her grief about the world's injustices with the support of her therapist.

As previously discussed, the therapist aspires to cultivate an intersectional understanding of social location, and to welcome the tapestry of identities that clients bring to the therapy hour. Everyone holds multiple identities, and trauma "is exacerbated by intersectionality because persons live with multiple oppressed statuses such as African American Muslim women, Jewish transgender men, undocumented Latinas who are differently abled, and homeless Asian American gender-nonconforming adolescents" (Bryant-Davis, 2019, p. 6). Examining intersections such as these and, when appropriate, acknowledging possible privileged identities reveals both strengths and vulnerabilities. We can track and contact the impact of different marginalized identities on the client, including the impact on the body. For instance, we might explore the physical cost (somatic adaptations, physical pains, illness, movement adaptations, and so forth) and invite clients to describe their physical organization in response to different contexts they navigate in their daily life. We might also explore the impact of privileged identities, like higher socioeconomic status, male gender identity, or slim physical appearance, on the body.

Kimberly was an African American female therapist living in the western United States. When her white female therapist asked what she noticed about herself in different contexts, Kimberly spoke about the discrepancies in her body movement and relational capacity when she was at work (at a mental health agency with mostly white people), versus when she was at home with her family. She noticed that she restricted the movement in her body at the workplace, feeling like she needed to" follow authority" and curtail spontaneity, while being "overly friendly" and hyperalert at the same time. These feelings were

familiar to her, and she said that they were mostly present when she was in white settings and specifically in front of white male clients in her practice. Therapist and client named Kimberly's feelings related to the oppression she experienced both as a Black person and as a woman. Her therapist asked her to notice, as an experiment, what happened when she imagined being in her clinical practice, and Kimberly reported that her body was more rigid, with truncated movements, and she did not feel confident, had thoughts of wanting to be liked, and felt overly compliant. In contrast, when her therapist asked her to imagine being in her community, she felt more confident, playful, and spontaneous in her movements, and reported an impulse to reach out and connect with others. Part of Kimberly's work in therapy was to recognize and acknowledge the burden on her body when she was in a predominantly white environment, and to identify resources to support her well-being while navigating in a white-dominant cultural context. She placed a picture of her family in her office to remind her of her community and used the somatic resource of a small reaching movement when she felt tense at work. This movement was imperceptible to Kimberly's clients but significant to her, as it connected her to the confidence she felt in reaching out to her community. Exploring different social locations creates an opportunity to examine the privilege/oppression dynamics that exist in society and in the therapeutic relationship, and to acknowledge and develop resources to mitigate the continual invalidation, discrimination, and trauma that marginalized clients experience as connected to the themes of the therapy. One of the goals in Sensorimotor Psychotherapy is to increase this awareness, while at the same time developing the somatic, emotional, and cognitive tools to support resilience.

In treatment, at different times, some of the client's identities and locations will move to the background while others will become more salient, depending on the content the client is bringing forward, which will modify what is played out in the therapeutic relationship. For instance, when exploring relational conflicts with a lesbian client, the heterosexual location of her female therapist created a different dynamic in the therapy room than when discussing the client's documented status with the same therapist (also an immigrant), or when bringing forward the client's Mexican culture in contrast with the Spanish background of the therapist. In the first case of different locations (lesbian and heterosexual), the client's eyes looked to the floor, her body tightened and pulled back, and there was more silence between sentences. Where explorations pertained to similar locations (both had documented immigrant status), the client was smiling, had a softer body posture and a more relaxed stance, often nodding to the therapist, and the verbal exchanges flowed smoothly. When talking about her Mexican background, the client shrank slightly in her body and avoided eye contact with the therapist while stating, "You speak such a nice Spanish," referencing the differences in accent and signaling an introjected prejudice. The dance between these locations can be fluid and ever changing and requires awareness of the landscape that emerges at any given moment and the somatic switches that occur depending on which identities are more salient. Attending and studying these changing dynamics increases awareness around how the client (and therapist) carries their multiple identities both within and outside of the therapy room.

It might also be relevant for a therapist who holds privileged identities (e.g., male, heterosexual, white, able bodied, or higher socioeconomic status, and so forth) to share their own process of learning about oppression and sociocultural complexity

with their client, including their own strengths and limitations. This can model humility in addressing these issues, and open the opportunity for conversations on these topics with the client throughout the therapy. It is important that this conversation is not for the benefit of the therapist but for the therapy itself, and in support of the therapeutic relationship. In Sensorimotor Psychotherapy, tracking the client's response and brief contact statements ("I see that you're nodding, and it seems your breath deepened when I talk of this" or "What I'm saying doesn't seem to resonate with you…") guide interventions; disclosure can be expanded if it is received with interest by the client, or abandoned if otherwise received.

The Window of Tolerance and Embodiment of Resources

Verbalizing and listening to experiences of oppression can be triggering for clients from both historically marginalized and historically privileged social locations. In Sensorimotor Psychotherapy, a potentially useful way to conceptualize triggers and signs of dysregulation is to consider the "window of tolerance," a term coined by Siegel (1999), described as an optimal zone within which stimuli can be processed (Ogden & Minton, 2000; Ogden et al., 2006). Triggers can cause arousal to enter the hyperarousal or hypoarousal zones, within which integrative capacity is compromised. Through practice and attention to internal signals, we can increase our capacity to regulate and be present to these potentially dysregulating experiences and conversations. As we converse about identities and privilege/oppression dynamics, we can start tracking the signs of regulated and dysregulated arousal in ourselves and in our clients. When the arousal of either the client or therapist threatens to exceed the boundaries of the window of tolerance, progressing toward the hyper- or hypoarousal zones, the primary task becomes to support the return of arousal to the window by using interventions that help to regulate. Since dysregulation is first and foremost a bodily response, somatic resources (breath, centering, grounding, movement, alignment, self-touch, and so forth) and attending to boundaries and space can be useful.

Many trauma-focused approaches are designed to resolve the effects of past trauma and regulate symptoms of dysregulated arousal that emerge in the face of threat but persist long after the trauma is over and the surroundings are now safe. However, people from marginalized groups may suffer continuous oppression in various forms in their current lives, so the threat is never really over. For this reason, although the trauma of oppression will often induce typical PTSD symptoms, historical trauma, the trauma of racism and marginalization, and "intersectional oppression" are not equivalent to PTSD (Bryant-Davis, 2019). In cases such as this, it is important for therapists to acknowledge and process the effects of trauma, as well as to develop resources to increase resilience and navigate the impact of ongoing oppression. For example, Ejikeme experienced anger when he talked about the systemic oppression and discrimination he faced after migrating to western Europe. As he spoke of his anger, his arousal escalated. He reported his energy rising, and he expressed fear of acting upon his aggressive impulses, which he sensed in the tension of his jaw and arms. When his therapist said that his anger made sense in this context of ongoing oppression, Ejikeme felt validated, but repeated that it frightened him. With his therapist's help, he learned to track the internal signs of anger as his

arousal threatened to escalate into a hyperarousal zone, and regulate it by putting his hands in his armpits. Lengthening his spine, lifting his chin, and speaking the words, "This is not fair. I don't deserve this treatment," connected him to his resource of pride and helped him maintain arousal within a window of tolerance.

When therapist and client do not share similar social locations, but especially when they are at different levels of cultural and identity awareness development, the ability to tolerate conversations about privilege and oppression may vary considerably. For instance, it is not unusual for white people to have a lower capacity to engage in conversations about racial privilege because, as they occupy a historically privileged location, white people do not need to contend with the stress of racism, prejudice, and discrimination that people of color manage on a daily basis. When these conversations are introduced and white privilege is explicitly named, white people often become defensive. This defensiveness has been referred to as *white fragility*, a term describing the behavioral responses to race stress that "function to reinstate white racial equilibrium" (DiAngelo, 2011, p. 54). Fragility is not limited to whiteness and applies to the defensive behaviors of any person embodying a *privileged* identity, meaning one can demonstrate *male* fragility, *cisgender* fragility, *heterosexual* fragility, *able-bodied* fragility, and so forth. The susceptibility to fragility highlights the importance for members of the privileged groups to explore their own identity and bias, and increase their understanding of the dynamics of privilege and oppression in order to widen their own windows, build their capacity, and skillfully address these topics in therapy nondefensively and with humility. Conversations about power, privilege, oppression, and identity will likely trigger dysregulation, especially when we are in the infancy of our development toward knowing how to engage in these conversations. Referencing the window of tolerance as it relates to conversations about racism and oppression might provide an additional map to facilitate the navigation of these discussions. The challenge is to both resource ourselves as clinicians and support the client in resourcing themselves to stay connected during these conversations. We will need to learn how to hang out at the regulatory boundaries of the window of tolerance and navigate the conflicts, differences, and enactments that may emerge (cf. Chapter 11, this volume). As Menakem (2017) points out, therapeutic practice becomes one of accepting discomfort, being less disturbed in unknown territory, and increasing our capacity to bring curiosity and gentleness to ourselves and to our clients.

The Therapist Role: Beyond Western Perspectives

Bryant-Davis (2019, p. 4) points out that therapists may tend to "define the person through their trauma while overlooking the strengths, resources, culture, and sociopolitical identity of the survivor." Being attentive to indicators of clients' resources, whether they be existing or missing, internal (within the self) or external (within the environment), can provide opportunities to develop and embody resilience (Ogden et al., 2006; Ogden & Fisher, 2015). As Denham (2008) states, the contextualization of historical trauma can also be framed with the "transmission of resilience strategies" within the community. Therapists can inquire about the resources inherent in the client's culture, such as traditions, spiritual or religious elements, food, celebrations, songs,

art, and so on. For example, a middle-aged Puerto Rican immigrant client living in New York sat straighter and her face lit up as she spoke of her church and singing in the choir. Her therapist noted her expression, contacted it, and framed it by saying, "This seems really important to you! Let's explore it a bit, shall we?" The client readily accepted the therapist's invitation to explore her experience at church and in choir. The therapist listened with curiosity and warmth as the client shared details about her church, her participation in this community, and the songs she sang in the choir. As the client spoke, the therapist tracked and commented on the client's affect and somatic responses in the moment: "I can sense your happiness as you share about that song" and "As you say that, your hands come together as if to clap." The client followed up by sharing how clapping was a vehicle for audience participation when the choir sang, and it brought her great joy to see her fellow parishioners enjoying the choir and her singing. As she talked about her joy, her chest expanded, and her breathing deepened. Together, the therapist and client identified these physical changes as somatic resources that the client could easily embody and use throughout her day to remind her of her beloved church community and her love for singing.

Current treatment guidelines, which emphasize evidence-based treatment, may fail to pay enough attention to cultural elements; therapists must cultivate "respect for the client and their culture, recognizing that cultures have therapeutic pathways despite the lack of empirical validation for their contribution" (Bryant-Davis, 2019, p. 5). Some cultural resources and healing practices, such as ritual, songs, dance, and drumming, existed long before the field of psychotherapy itself but have not been acknowledged by contemporary Western standards. These cultural elements can be identified and developed into powerful healing resources. Julieta, originally from Chile but living in western Europe at the time of her therapy, was of both Indigenous and Spanish heritage. In therapy, she learned that the pattern of collapse in her spine and shallow breathing was related to submitting to others. Julieta discovered that she had internalized the historical abuse of the Spanish conquistadors by oppressing and silencing the Indigenous part of her. Impacted by the historical trauma of her ancestry, her challenge was to integrate these two parts of herself. She stated that the Indigenous part of her was grounded in nature, and with help from her therapist she remembered the beloved araucaria tree, a symbol of strength and resilience for the Indigenous people of central and southern Chile for centuries. Remembering this tree, Julieta found that her body became less collapsed, and her chest became fuller with a deep breath. She said as the Indigenous part of her drew upon the strength of the tree, she felt less vulnerable to being dominated. The therapist invited Julieta to imagine a recent moment when she had felt dominated, and her posture immediately began to slump. But when she recalled that moment, and simultaneously visualized the tree and its strength, she could maintain her more erect posture, fuller chest, and deeper breathing. In this way, Julieta moved from a triggering experience (recalling feeling dominated and sensing the tendency to collapse) to a resource (visualizing the tree and embodying a more upright posture, fuller chest, deeper breath). This movement from collapsed posture to the resource of upright posture helped to bring her two sides into a more equal relationship, healing some of the effects of transgenerational trauma.

Additionally, historically marginalized people may have needs beyond those of mental health due to the sociopolitical, structural, and financial consequences of oppression that the therapist may need to address. To support meeting these needs, the therapist can develop a referral network of other services and providers that are socioculturally sensitive, for instance, medical doctors and psychiatrists that are aware of trauma's impact on the body, or agencies that can support clients' access to important resources and connect them with community, such as clothing, food, and housing. At the same time, the therapist might need to utilize their professional position to advocate with and for the client in schools, workplaces, and courts. For example, Sofia, a 54-year-old client originally from Central America living in the United States, spoke broken English and suffered from a work-related injury and PTSD from her husband's suicide. Sofia minimized the pain she was in from her workplace injury and referred to her PTSD symptoms as personal deficits, indicating that she had failed to create a better life for herself and her daughter in the United States. She wanted to appear happy and content in her new country, especially with authorities like doctors, and was not able to obtain disability benefits. Therefore, she needed advocacy to make sure that her doctors understood the severity of her symptoms so she could receive benefits. As her therapist filled out the disability application, she explained what she was writing and why, asking Sofia for input and feedback. When the application was complete, the therapist brought awareness to the relationship as a resource by asking, "What happens when you sense that we did this together?" Sofia brought her hand up to her heart, which her therapist mirrored. Sofia said, "Yes, you are here," patting her heart. Advocacy not only met a real need of Sofia's but also strengthened the therapeutic relationship, and helped Sofia find a somatic resource of connection with her therapist (patting her heart).

Therapists might also need to address and adjust the therapy setting to meet the client's needs; for instance, examining accessibility of therapy offices (including more local venues or online therapy if the client has internet access), addressing transportation needs, child-care coverage, work schedule unpredictability, financial constraints, religious limitations, and so forth. The capacity of the therapist to be flexible and open to adjusting the counseling setting to increase access to mental health care for marginalized populations is an important anti-oppression policy toward increasing equity. Client needs and the expanding role of the therapist can conflict with traditional Western approaches to psychotherapy that tend to establish a clear boundary between professional disciplines, within which advocacy and case management tasks are not traditionally considered in the scope of psychotherapy practice (Comas-Díaz, 2006). These multiple roles that the therapist might need to fulfill also increase the necessity of discussions with the client, supervisors, and consultants as the dance between the different and nuanced dual relationships is negotiated.

Microaggressions in the Therapy Room

Because we cannot escape implicit bias, we are vulnerable to committing microaggressions of all kinds in the therapy hour, both verbal and nonverbal. These may be subtle, through what we contact, emphasize, or fail to acknowledge, and are often based on

our own values and biases. For example, we may coach clients to increase their independence and autonomy, not considering that the client's culture is collectivist. We may make biased assumptions ("Did you grow up with a single mom?" for an African American client, or "Since you're Jewish you're probably good with money") or assume similarities ("I understand racism because I have a friend who is a person of color"). We may become silent or avoidant in the face of triggers, as when a white therapist's guilt is triggered as his African American client brings up feelings anxiety and stress from media coverage of excessive violence directed toward Black people.

Our bias, disapproval, and judgment will typically be revealed first on a physical level, and often without our awareness. Our facial expression may be the first indicator: furrowing brows (when a client discloses that they are transgender), a surprised expression (when an immigrant client from South America reports that she is highly educated), a neutral expression (when a client reports the horror of suffering political torture), or a slight frown (when a client reports an experience of discrimination). Our biases and those of our clients will also be revealed in the tension and expression of the body, such as visibly tensing and pulling back (when a gay client is sharing feelings about a sexual encounter or when a gay therapist discloses their sexual orientation to the client), looking down and away (when a client asks for needed advocacy), shrugging one's shoulders and shaking one's head (when a genderqueer client requests use of the pronoun "they" or when the therapist discloses the same thing to a cisgender client) or leaning forward and speaking with a patronizing attitude and prosody (to a disabled adult client). It is important that we therapists understand when and how our bodies commit microaggressions or when they are committed against us as therapists, and what the somatic cues of each are. The more we know about our physical tendencies and how our own body responds, the more we can address how we express our own implicit bias nonverbally.

Jacy was a young Native American man who had been raised on a reservation in the United States. During therapy, his white female therapist became aware of two microaggressions that she had committed. Jacy struggled with alcohol, and she made the comment that she understood the connection between alcoholism and being Native American. Jacy grew silent, and the session stalled. In supervision, the therapist realized that her statement had failed to acknowledge the impact of historical trauma upon his people and instead categorized Jacy's difficulty in terms of stereotypes about his culture. In the next session, she acknowledged this and apologized, thus enhancing her own credibility, and Jacy was visibly relieved (his shoulders relaxed, and he smiled). His therapist's willingness to take responsibility for her own bias initiated a conversation about other microaggressions Jacy experienced on a regular basis. In another incident much later in therapy, Jacy expressed doubts that he could succeed in college, and his therapist said, "Oh, you're so smart, I'm sure you'll do fine." This time she tracked Jacy's subtle disappointed facial expression and squinting eyes, and he again grew silent. Vasquez (2007, p. 880) points out that marginalized people "experience slights and offenses so regularly that there is a tendency for them to 'edit' their responses on a regular basis. That reality, combined with cultural values, may … inhibit negative reactions." Therapists must take extra care to track for signals of negative reactions to their interventions and provide opportunities to discover their source. In this case, the

therapist made a contact statement ("That didn't quite resonate, did it?"). Jacy shook his head but remained silent. The therapist continued with contact statements and thinking out loud ("It seems that what I said didn't sit well with you"; "Maybe it wasn't quite accurate") and asked Jacy to tell her more about his fear. Jacy's face began to relax, and he said he felt he would have to work twice as hard as anyone else to succeed in college, and he did not know if he could meet that challenge. His therapist then recognized that the statement she had made was a microaggression that reflected meritocracy: the myth that all people have equal opportunity, which ignores the effects of systemic oppression that puts marginalized groups at a disadvantage. Again, she apologized, and again the relationship was strengthened as Jacy felt seen and understood. In both instances, the therapist tracked not only Jacy's body but also her own physical reactions, noticing that her arousal increased, her breath quickened, and her body tensed. She also noticed an impulse to rescue the client and felt guilt about the genocide of Native Americans perpetrated by settler colonialism and the implications of that for her own location as a white woman.

Bias can also be demonstrated by the client. A therapist from a marginalized culture whose client is from the privileged culture may be the target of microaggressions. For example, a white male client of a female immigrant therapist for whom English was a second language showed his bias by challenging her knowledge and competence. Negatively assessing another based on their "foreign" accent is a common form of discrimination (Fuertes et al., 2012). In the face of a microaggression like this, the therapist will need to regulate and ground themselves to be able to name the impact in a way that does not shame the client, and initiate a process of repair, taking into consideration the strength and nature of the therapeutic relationship. In this case, the therapist commented that she understood that the client wanted to receive good care and that he could be scared about that not being that case, which helped the client relax and feel validated. The therapist asked if he was afraid of that because of her accent, and if he wanted to discuss both his assumptions and the qualifications of the therapist openly.

Clients may also express racism, stereotypes, or biases toward other marginalized groups. This can present a dilemma for therapists, who may feel conflicted between refraining from challenging the client's perspective in favor of honoring a core belief of the client's culture; risking damaging the therapeutic relationship by discussing the remark; or going against their own social justice values by not bringing attention to it. For example, Joe, a white, middle-aged, low-income male client, came to therapy to address PTSD from his years of deployment in the Vietnam War, after having served prison time for aggravated assault. In therapy, Joe made hostile racist remarks about the African American men he encountered while incarcerated, calling them violent and stupid. This presented an opportunity to address his dysregulated anger and hyperarousal associated with PTSD, which was also fueled by racism. The therapist has several options at this point, depending on the client and the therapeutic relationship, such as framing ("Let's stay with this perception for a moment") to explore the roots of the client's racism by asking questions like those suggested in the second section of this chapter (e.g., "Do you remember when you first learned about other races?" "What were the attitudes of your family or hometown?" "What personal experiences have you had?"). This line of questioning can help both clients and therapists understand the roots of the biased attitudes, thus reducing judgment and

mitigating possible shame the client might feel if directly confronted. The client eventually recognized that he felt closer to the white inmates than to the Black men, due to the similar stories they shared, and that the unfamiliar group had been an outlet for his dysregulated anger. Self-disclosure about the therapist's own bias combined with psychoeducation about oppression and systemic racism can also open the door to a conversation in a nonshaming manner. A third option from a Sensorimotor Psychotherapy perspective would be to work with the memory, in this case, of being with African American men in prison. The client reported that the most triggering incident was a brawl before he went to prison, in which he attacked a group of Black men in a parking lot and received a knife slash on his arm. Client and therapist worked to process the memory, after which the client was able to identify how he had provoked the incident himself, as he sought high intensity and risk before prison, and how he had targeted those against whom he was biased and who happened to be in his immediate proximity.

As always, therapists should also be mindful of their own reactions to the client on somatic, emotional, and cognitive levels, perhaps explore these in supervision, and examine their own motivations and values in relation to the client's prejudicial expressions. Additionally, a therapist always has the option to refer the client if the clash of values and the microaggressions are intense enough that it would compromise the therapeutic work.

Pitfalls and Vulnerabilities

Therapists are vulnerable to a variety of pitfalls in the therapeutic dyad. As mentioned, we may fail to track the signals that our clients are not ready or do not wish to explore sociocultural elements, or we ask too many personal questions, including inquiring about emotional states, expressions of affect, and body language or posture before developing the relationship and building credibility (Comas-Díaz, 2006). And although it is important to learn about a client's cultural background, we are vulnerable to indiscriminately applying this knowledge and making assumptions without being aware of the client's unique or divergent experience. Furthermore, misunderstandings and miscommunications are common when we work with marginalized clients who are not fluent in the privileged culture's language.

We may rely too heavily on our training in Eurocentric approaches and miss opportunities to draw on non-Western healing methods. We may emphasize evidence-based practices, which may or may not work well with diverse groups, considering the paucity of research conducted with these groups (Comas-Díaz, 2006). We may tend to adapt the language of neuroscience indiscriminately in psychoeducation or conceptualization, not understanding that those who developed most of that research often belong to privileged locations within the dominant culture, so it is skewed and biased toward those identities. We may fail to consider alternative explanations of health that might be more releVant to the client. For example, current neuroscience research and literature assume too quickly that reactions to threat or unsafe situations are biologically ingrained, without taking into account that they are also socially primed or conditioned. Language can also be used insensitively in ways that discount or demean a particular group. For example, the words "primitive" or "animal" are racist terms when used in

reference to people of color, but are often used as nomenclature for innate subcortical defenses that instinctively emerge when we are threatened. Another example is referencing skin color to refer to changes in the autonomic nervous system. One of the signs of hypoarousal is commonly described as blanching or becoming pale; however, people with darker skin tones rarely demonstrate observable blanching. Recognition of these biases in medical and psychological research is critical when offering the client psychoeducation, as well as when the therapist tracks and contacts the client's body.

As we introduced earlier in the chapter, therapists are also at risk of attributing meaning to the body language of their clients without understanding differences in nonverbal communication of the client's culture. For example, a client's preference for increased proximity (a characteristic of their culture) might be interpreted as indicative of insufficient boundaries. A therapist may explore eye contact as a proximity-seeking, attachment-related action with a client whose cultural norms eschew direct eye contact with authority figures. A client who speaks loudly and expressively may be misread as dysregulated or angry, or a client who speaks softly might be interpreted as weak or lacking confidence. An Asian client whose body was pulled in (described as "hiding") was thought by the therapist to have familial issues with safety, when this was not the case; the client's physical pattern was developed in reaction to the lack of safety in the face of ongoing systemic oppression as a person of color. A client who hailed from Italy, an expressive culture, who gestured widely was thought by his therapist to be dysregulated and lacking self-control. A Latinx client who touched her therapist on the arm upon greeting was thought to have inappropriate boundaries, when frequent physical contact is accepted in their culture. It is important to understand the nonverbal communication norms of the culture of our clients and to initiate open discussions about them in a body-oriented therapy like Sensorimotor Psychotherapy to mitigate the tendency to prematurely make meaning of nonverbal cues.

One can never avoid all these pitfalls, and therapy itself is never a one-size-fits-all endeavor. Therapists must constantly track the effects of their interventions and adjust, and learn what is appropriate for each client. Vasquez points out that "some culturally diverse clients may be unsettled with the egalitarian and nondirective interaction styles of some therapists. Others may be put off by an authoritarian stance" (2007, p. 5). For example, an open-ended and more equal relationship that includes self-disclosure and participation in community endeavors on the part of the therapist may be appropriate for some clients, while others may prefer a therapist who has a more directive stance, assertively takes charge of the sessions, does not self-disclose, and does not expand their boundaries to include community. Some culturally diverse clients may prefer more silence, less questioning, or more small talk, while others may prefer a faster pace, less small talk, and more focused questioning that pertains to specific goals. Thus, it is important for therapists to cultivate variability in style. With careful tracking of the client's response and appropriate adjustments in the Sensorimotor Psychotherapy skills of contacting, framing, directed mindfulness questions, and experiments, clinical practice can be adapted in the moment to meet the client in a culturally sensitive manner.

Conclusion

To review, Eurocentric Western approaches to psychotherapy (including developmental models and trauma theory), as well as many perspectives of the body, were primarily developed according to individualistic and privileged Western paradigms. These models of psychological health have generally excluded other cultural understandings and in particular the wisdom of Indigenous and marginalized people. Knowledge of the applicability and releVance of these models for collectivistic cultures and more generally for individuals and communities with different models of consciousness, psychology, and personality is limited. Integration and adaptation of culturally sensitive approaches to understanding presentation of illnesses and therapeutic interventions remains at the margins of psychological theory and practice, which can impact the effectiveness of treatment with persons that do not conform with the norm.

We have seen that our identities, values, and other lenses through which we assess and interact with the world are embedded in the historical, sociopolitical, and cultural context of the group(s) to which we belong. This embeddedness is the result of our brain's adaptability to context and, with all its benefits, makes us vulnerable to cultural conditioning, hence to prejudices and biases. This inevitability can be held with compassion and humility, as well as curiosity toward examining our own cultural background, and how it informs our cognitive, emotional, and physical reactions to ourselves and others. From the first contact, to assessments of our clients, to the therapeutic relationship, to the interventions we put forth, implicit bias affects every aspect of therapy. Trying to suppress our biases or deny their existence only reinforces them, while continuing to impact our interpretations of the world and other people, including our clients, implicitly (Blair et al., 2001). Challenging our bias requires an active interrogation of the associations that inform our way of perceiving others, to compassionately recognize how these may not align with our beliefs, to be curious about how they show up in our lives and in the therapy room, and to actively work to counteract them. Additionally, our responsibility as therapists is to educate ourselves with regard to the impact of privilege/oppression dynamics and to develop the skill to address these dynamics in therapy. Therapists need to engage in a lifelong process of self-reflection and growth (Hook, Davis, et al., 2013; Hook, Owen, et al., 2013). This ongoing aspirational process cannot be sustained without a commitment to the journey of inquiry. What we can gain along this path goes far beyond knowledge; it includes a felt sense of the lived experience of these explorations, in connection with others, deepening our embodied resonance with our fellow human beings.

References

Agishtein, P., & Brumbaugh, C. (2013). Cultural variation in adult attachment: The impact of ethnicity, collectivism, and country of origin. *Journal of Social, Evolutionary, and Cultural Psychology, 7*(384). https://doi.org/10.1037/h0099181

Ainsworth, M. D., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*, 49–67.

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Alexander, M. (2020). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York: New Press.

Aposhyan, S. (1999). *Natural intelligence: Body-mind integration and human development*. Baltimore, MD: Williams and Wilkins.

Argyle, M., Salter, V., Nicholson, H., Williams, M., & Burgess, P. (1970). The communication of inferior and superior attitudes by verbal and non-verbal signals. *British Journal of Social and Clinical Psychology, 9*(3), 222–231. https://doi.org/10.1111/j.2044-8260.1970.tb00668.x

Barrera, I., & Jordan, C. (2011). Potentially harmful practices: Using the DSM with people of color. *Social Work in Mental Health, 9*(4), 272–286. https://doi.org/10.1080/15332985.2011.554306

Berry, J. W., Poortinga, Y. H., & Pandey, J. (Eds.). (1997). *Handbook of cross-cultural psychology* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Bertrand, M., & Mullainathan, S. (2004). Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor market discrimination. *American Economic Review*, *94*(4), 991–1013.

Birdwhistell, R. L. (2010). *Kinesics and context: Essays on body motion communication*. Philadelphia: University of PennsylVania Press.

Blair, I. V., Ma, J. E., & Lenton, A. P. (2001). Imagining stereotypes away: The moderation of implicit stereotypes through mental imagery. *Journal of Personality and Social Psychology, 81*(5), 828–841. http://dx.doi.org/10.1037/0022-3514.81.5.828

Bobula, K. A. (2011). *This is your brain on bias… or, the neuroscience on bias* [Faculty Lecture Series]. Developing Brains: Ideas for Parenting and Education, Clark College, Vancouver, Washington.

Borden, R. J., & Homleid, G. M. (1978). Handedness and lateral positioning in heterosexual couples: Are men still strong arming women? *Sex Roles, 4*, 67–73.

Bowlby, J. (1951). *Maternal care and mental health*. Geneva: World Health Organization Monograph (Serial No. 2).

Bowlby, J. (1982). *Attachment* (2nd ed., Vol. 1). New York: Basic Books.

Boykin, A. W., Franklin, A. J., & Yates, J. F. (1979). Work notes on empirical research. In A.W. Boykin, A. J. Anderson, & J. F. Yates (Eds.), *Research directions of black psychologists* (pp. 1–17). New York: Russell Sage Foundation.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, no. 2, 60–82.

Braveheart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. Journal of psychoactive drugs, 35(1), 7-13

Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. *Psychotherapy, 56*(3), 400–408. http://dx.doi.org/10.1037/pst0000241

Caldwell, C. (2013). Diversity issues in movement observation and assessment. *American Journal of Dance Therapy, 35*, 183–200.

Cassidy, J., Jones. J. D., & Shaver, P. R. (2013). Contributions of attachment theory and research: A framework for future research, translation, and policy. *Developmental Psychopathology, 25*(4, Pt. 2), 1415–1434. https://doi.org/10.1017/S0954579413000692

Chiarenza, A. (2012). Developments in the concept of "cultural competence." In D. Ingleby, A. Chiarenza, W. Devillé, & I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (pp. 66-81). Antwerp: Garant.

Christopher, J. C., Wendt, D. C., Marecek, J., & Goodman, D. M. (2014). Critical cultural awareness: Contributions to a globalizing psychology. *American Psychologist, 69*(7), 645–655. https://doi.org/10.1037/a0036851

Clark, L. A., Cuthbert, B., Lewis-Fernández, R., Narrow, W. E., & Reed, G. M. (2017). Three approaches to understanding and classifying mental disorder: ICD-11, DSM-5, and the National Institute of Mental Health's Research Domain Criteria (RDoC). *Psychological Science in the Public Interest*, *18*(2), 72–145. https://doi.org/10.1177/1529100617727266

Comas-Díaz, L. (2006). Cultural variation in the therapeutic relationship. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 81–105). Washington, DC: American Psychological Association. https://doi.org/10.1037/11423-004

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*(3), 392–402.

Cosgrove, L. (2005). When labels mask oppression: Implications for teaching psychiatric taxonomy to mental health counselors. *Journal of Mental Health Counseling, 27*(4), 283–296. https://doi.org/10.17744/mehc.27.4.9eqrq789bllq1dd2

Crenshaw, K. (1989). "Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), Article 8. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

DeGruy, J. (2017). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Milwaukie, OR: Uptone Press.

Denham, A. R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry, 45*(3), 391–414.

DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy*, *3*(3), 54–70.

DiBiase, R., & Gunnoe, J. (2004). Gender and culture differences in touching behavior. *Journal of Social Psychology*, *144*(1), 49–62. https://doi-org.naropa.idm.oclc.org/10.3200/SOCP.144.1.49-62

Dilbeck, K. E. (2014). Vicarious and source credibility: A cross cultural explanation. *Theses and Dissertations*, 589. https://dc.uwm.edu/etd/589

Dovidio, J. F., & Gaertner, S. L. (2004). Aversive racism. In M. P. Zanna (Ed.), *AdVances in experimental social psychology* (Vol. 36, pp. 1–52). New York: Elsevier Academic Press. https://doi.org/10.1016/S0065-2601(04)36001-6

Dunham, Y., Baron, A. S., & Banaji, M. R. (2008). The development of implicit intergroup cognition. *Trends in Cognitive Sciences, 12*, 248–253. https://doi.org/10.1016/j.tics.208.04.006

Duran, E., Duran, B., Heart, B., & Horse-Davis, Y. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341–354). New York: Springer US.

Ellyson, S. L., & Dovidio, J. F. (1985). Power, dominance, and nonverbal behavior: Basic concepts and issues. In S. L. Ellyson & J. F. Dovidio (Eds.), *Power, dominance, and nonverbal behavior* (pp. 1–27). New York: Springer-Verlag.

Figueira, I., Luz, M., Braga, R. J., Cabizuca, M., Coutinho, E. S. F., & Mendlowicz, M. (2007). The increasing internationalization of mainstream posttraumatic stress disorder research: A bibliometric study. *Journal of Traumatic Stress, 20*(1), 89–95.

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (2nd ed.). New York: Guilford.

Frankenberg, R. (1993). *White women, race matters: The social construction of whiteness*. Minneapolis: University of Minnesota Press.

Fuertes, J. N., Gottdiener, W. H., Martin, H., Gilbert, T. C., & Giles, H. (2012). A meta-analysis of the effects of speakers' accents on interpersonal evaluations. *European Journal of Social Psychology*, *42*, 120–133.

Gillespie, D. L., & Leffler, A. (1983). Theories of nonverbal behavior: A critical review of proxemics research. *Sociological Theory, 1*, 120–154. https://doi.org/10.2307/202049

Gottlieb, A. (2004). *The afterlife is where we come from: The culture of infancy in West Africa*. Chicago: University of Chicago Press.

Hall, E. T., & Hall, T. (1959). *The silent language* (Vol. 948). New York: Anchor.

Hammack, P. L., Mayers, L., & Windell, E. P. (2013). Narrative, psychology and the politics of sexual identity in the United States: From "sickness" to "species" to "subject." *Psychology and Sexuality*, *4*(3), 219–243.

Hanckock, P., Hughes, B., Jagger, E., Paterson, K., Russell, R., Tulle-Winton, E., & Tyler, M. (2000). *The body, culture and society: An introduction*. Philadelphia: Open University Press.

Harrell, S., & Gallardo, M. (2008). Sociopolitical and community dynamics in the development of a multicultural worldview. In J. K. Asamen, M. L. Ellis, & G. L. Berry (Eds.), *The SAGE handbook of child development, multiculturalism, and media* (pp. 113–128). Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781412982771.n8

Harrell, S. P. (2014). Compassionate confrontation and empathic exploration: The integration of race-related narratives in clinical supervision. In C. A. Falender, E. P. Shafranske, & C. J. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach* (pp. 83–110). Washington, DC: American Psychological Association. https://doi.org/10.1037/14370-004

Harrell, S. P., & Sloan-Pena, G. (2006). Racism and discrimination. In Y. Jackson (Ed.), *Encyclopedia of multicultural psychology* (pp. 396–402). Thousand Oaks, CA: Sage.

Hart, A. (2017). From multicultural competence to radical openness: A psychoanalytic engagement of otherness. *American Psychoanalyst*, *51*(1). https://apsa.org/apsaa-publications/vol51no1-TOC/html/vol51no1_09.xhtml

Henley, N., & Freeman, J. (1995). *The sexual politics of interpersonal behavior in women: A feminist perspective*. London: Mayfield.

Henley, N. M. (1977). *Body politics: Power, sex, and nonverbal communication*. Englewood Cliffs, NJ: Prentice-Hall.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*, 353–366. https://doi.org/10.1037/a0032595

Hook, J. N., Owen, D. E., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility of therapists is associated with stronger working alliance and better psychotherapy outcomes. *Clinician's Research Digest: Adult Populations, 31*(9), 5.

Jacob, K. S. (2019). Idioms of distress, mental symptoms, syndromes, disorders and transdiagnostic approaches. *Asian Journal of Psychiatry, 46*, 7–8. https://doi.org/10.1016/j.ajp.2019.09.018

Johnson, R. (2009). Oppression embodied: Exploring the intersections of somatic psychology, trauma, and oppression. *USPB Journal, 8*(1), 19–31.

Johnson, R. (2015). Grasping and transforming the embodied experience of oppression. *International Body Psychotherapy Journal, 14*(1), 80–95.

Johnson, R., Leighton, L., & Caldwell, C. (2018). The embodied experience of microaggressions: Implications for clinical practice. *Journal of Multicultural Counseling and Development, 46*(3), 156–170.

Kağitçibaşi, Ç. (1990). Family and socialization in cross-cultural perspective: A model of change. In J. Berman (Ed.), *Nebraska Symposium on Motivation, 1989* (pp. 135–200). Lincoln: University of Nebraska Press.

Kaiser, B. N., & Jo Weaver, L. (2019). Culture-bound syndromes, idioms of distress, and cultural concepts of distress: New directions for an old concept in psychological anthropology. *Transcultural Psychiatry*, *56*(4), 589–598. https://doi.org/10.1177/1363461519862708

Keller, H. (2013). Attachment and culture. *Journal of Cross-Cultural Psychology*, *44*(2), 175–194. https://doi.org/10.1177/0022022112472253

Keller, H. (2018). Universality claim of attachment theory: Children's socioemotional development across cultures. *PNAS, 115*(45), 11414–11419.

Kellermann, N. (2001). Transmission of Holocaust trauma: An integrative view. *Psychiatry Interpersonal and Biological Processes*, *64*(3), 256–267.

Kirmayer, L. J. (1996). Confusion of the senses: Implications of ethnocultural variations in somatoform and dissociative disorders for PTSD. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 131–163). Washington, DC: American Psychological Association.

Kirschner, S. R. (2013). Diagnosis and its discontents: Critical perspectives on psychiatric nosology and the *DSM*. *Feminism and Psychology, 23*(1), 10–28.

Knapp, M. (2006). An historical overview of nonverbal research. In V. Manusov & M. L. Patterson (Eds.), *The SAGE handbook of nonverbal communication* (pp. 3–20). Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781412976152.n1

Liddell, B. J., & Jobson, L. (2016). The impact of cultural differences in self-representation on the neural substrates of posttraumatic stress disorder. *European Journal of Psychotraumatology, 7*. https://doi.org/10.3402/ejpt.v7.30464

Lietz, M. (2015). Whiteness and white identity development. http://cultureandyouth.org/racism/articles-racism/whiteness-white-identity-development

López, S. R. (1989). Client variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychology Bulletin, 106*(2), 184–203.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95–124). New York: Ablex.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. *Attachment in the Preschool Years: Theory, Research, and Intervention, 1*, 121–160.

Mehta, N. (2011). Mind-body dualism: A critique from a health perspective. *Mens Sana Monographs*, *9*(1), 202–209. https://doi.org/10.4103/0973-1229.77436

Menakem, R. (2017). *My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies*. Las Vegas, NV: Central Recovery Press.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York: Guilford.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Kramer Tebes, J. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science Medicine, 106*, 128–136.

Moore, C. L., & Yamamoto, K. (2012). *Beyond words: Movement observation and analysis* (2nd ed.). New York: Routledge.

Morelli, G., Quinn, N., Chaudhary, N., Vicedo, M., Rosabal-Coto, M., Keller, H., Murray, M., Gottlieb, A., Scheidecker, G., & Takada, A. (2018). Ethical challenges of parenting interventions in low- to middle-income countries. *Journal of Cross-Cultural Psychology, 49*, 5–24. https://doi.org/10.1177/0022022117746241

Moss-Racusin, C. A., Dovidio, J. F., Brescoll, V. L., Graham, M. J., & Handelsman, J. (2012). Science faculty's subtle gender biases favor male students. *Proceedings of the National Academy of Sciences, 109*(41), 16474–16479. https://www.pnas.org/content/109/41/16474.abstract

Ng, E., & Purser, R. (2015). White privilege and the mindfulness movement. Buddhist Peace Fellowship: Buddhism and Social Justice. http://www.buddhistpeacefellowship.org/white-privilege-the-mindfulness-movement/

Nichter, Mark. (1982). Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India. Culture, medicine and psychiatry. 5. 379-408. 10.1007/BF00054782.

Nichter, M. (2010). Idioms of distress revisited. *Culture, Medicine and Psychiatry*, *34*, 401–416. https://doi.org/10.1007/s11013-010-9179-6

Nichter, Mark. (1982). Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India. Culture, medicine and psychiatry. 5. 379-408. 10.1007/BF00054782.

Nobles, W. (1986). *African psychology: Toward its reclamation, reascension and revitalization*. Oakland, CA: Black Family Institute.

Otto, H. (2008). *Culture-specific attachment strategies in the Cameroonian Nso: Cultural solutions to a universal developmental task* [Unpublished doctoral dissertation]. Osnabrück, Germany.

Otto, H., & Keller, H. (Eds.). (2014). *Different faces of attachment*. Cambridge, UK: Cambridge University Press.

Pallaro, P. (1997). Culture, self and body-self: Dance/movement therapy with Asian Americans. *Arts in Psychotherapy, 24*(3), 227–241.

Paniagua, F. A. (2018). ICD-10 versus *DSM-5* on cultural Issues. *SAGE Open*. https://doi.org/10.1177/2158244018756165

Perception Institute. (2019). *Transforming perception: Black men and boys* [Executive summary]. https://perception.org/research/explicit-bias/

Phillips, L. T., & Lowery, B. S. (2018). Herd invisibility: The psychology of racial privilege. *Current Directions in Psychological Science, 27*(3), 156–162.

Quillian, L., Pager, D., Hexel, O., & Midtbøen, A. H. (2017). Meta-analysis of field experiments shows no change in racial discrimination in hiring over time. *Proceedings of the National Academy of Sciences, 114*(41), 10870–10875.

Reshamwala, S. (2016). *Peanut butter, jelly, and racism* [Video]. *New York Times.* https://www.nytimes.com/video/us/100000004818663/peanut-butter-jelly-and-racism.html

Ross, H. (2017). Exploring unconscious bias. https://culturalawareness.com/wp-content/uploads/2017/03

Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist*, *55*(10), 1093.

Said, E. (1978). Orientalism: Western concepts of the orient. New York: Pantheon.

SAMHSA. (2014). *Trauma-informed care in behavioral health services.* Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sanders Thompson, V. L. (2006). Coping responses and the experience of discrimination. *Journal of Applied Social Psychology, 36*(5), 1198–1214.

Schachter, E. P. (2005). Context and identity formation: A theoretical analysis and a case study. *Journal of Adolescent Research, 20*(3), 375–395. https://doi.org/10.1177/0743558405275172

Sidhu, G. (2017). The application of Western models of psychotherapy by Indian psychotherapists in India: A grounded theory. *Dissertations and Theses*, 377. http://aura.antioch.edu/etds/377

Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*, *93*(2), 239–243. https://doi.org/10.2105/ajph.93.2.239

Sroufe, L. A., & Siegel, D. (2011, March/April). The verdict is in. *Psychotherapy Networker*, pp. 34–39, 52–53. https://www.drdansiegel.com/uploads/1271-the-verdict-is-in.pdf

Stewart, B. D., & Payne, B. K. (2008). Bringing automatic stereotyping under control: Implementation intentions as efficient means of thought control. *Personality and Social Psychology Bulletin, 34*, 1332–1345.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*(2), 64–88.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *Counseling Psychologist, 10*, 45–52. https://doi.org/10.1177/0011000082102008

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different.* New York: Wiley.

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counselling the culturally diverse: Theory and practice*. New York: Wiley.

Szasz, T. S. (1971). The sane slave: An historical note on the use of medical diagnosis as justificatory rhetoric. *American Journal of Psychotherapy*, *25*(2), 228–239.

Tajfel, H., & Forgas, J. P. (2000). Social categorization: Cognitions, values and groups. In C. Stangor (Ed.), *Stereotypes and prejudice: Essential readings* (pp. 49–63). Ann Arbor, MI: Taylor and Francis.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. New York: Norton.

Tronick, E. Z., Morelli, G. A., & Ivey, P. K. (1992). The Efe forager infant and toddler's pattern of social relationships: Multiple and simultaneous. *Developmental Psychology, 28*(4), 568.

ValaVanis, S., Thompson, C., & Murray, C. D. (2019). Positive aspects of voice-hearing: A qualitative metasynthesis. *Mental Health, Religion and Culture*, *22*(2), 208–225. https://doi-org.naropa.idm.oclc.org/10.1080/13674676.2019.1601171

Vasquez, M. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8), 875–885. https://doi.org/10.1037/0003-066X.62.8.878

Williams, M. (2014). A conversation on racial disparities in MH treatment. New York Association of Psychiatric Rehabilitation Services. https://www.nyaprs.org/e-news-bulletins/2015/a-conversation-on-racial-disparities-in-mh-treatment

Williams, M. (2019). Microaggressions: Clarification, evidence, and impact. *PsychArchives*. https://doi.org/10.23668/psycharchives.2506

Agishtein, P., & Brumbaugh, C. (2013). Cultural variation in adult attachment: The impact of ethnicity, collectivism, and country of origin. *Journal of Social, Evolutionary, and Cultural Psychology, 7*(384). https://doi.org/10.1037/h0099181

Ainsworth, M. D., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*, 49–67.

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Alexander, M. (2020). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York: New Press.

Aposhyan, S. (1999). *Natural intelligence: Body-mind integration and human development*. Baltimore, MD: Williams and Wilkins.

Argyle, M., Salter, V., Nicholson, H., Williams, M., & Burgess, P. (1970). The communication of inferior and superior attitudes by verbal and non-verbal signals. *British Journal of Social and Clinical Psychology, 9*(3), 222–231. https://doi.org/10.1111/j.2044-8260.1970.tb00668.x

Barrera, I., & Jordan, C. (2011). Potentially harmful practices: Using the DSM with people of color. *Social Work in Mental Health, 9*(4), 272–286. https://doi.org/10.1080/15332985.2011.554306

Berry, J. W., Poortinga, Y. H., & Pandey, J. (Eds.). (1997). *Handbook of cross-cultural psychology* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Bertrand, M., & Mullainathan, S. (2004). Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor market discrimination. *American Economic Review*, *94*(4), 991–1013.

Birdwhistell, R. L. (2010). *Kinesics and context: Essays on body motion communication*. Philadelphia: University of PennsylVania Press.

Blair, I. V., Ma, J. E., & Lenton, A. P. (2001). Imagining stereotypes away: The moderation of implicit stereotypes through mental imagery. *Journal of Personality and Social Psychology, 81*(5), 828–841. http://dx.doi.org/10.1037/0022-3514.81.5.828

Bobula, K. A. (2011). *This is your brain on bias… or, the neuroscience on bias* [Faculty Lecture Series]. Developing Brains: Ideas for Parenting and Education, Clark College, Vancouver, Washington.

Borden, R. J., & Homleid, G. M. (1978). Handedness and lateral positioning in heterosexual couples: Are men still strong arming women? *Sex Roles, 4*, 67–73.

Bowlby, J. (1951). *Maternal care and mental health*. Geneva: World Health Organization Monograph (Serial No. 2).

Bowlby, J. (1982). *Attachment* (2nd ed., Vol. 1). New York: Basic Books.

Boykin, A. W., Franklin, A. J., & Yates, J. F. (1979). Work notes on empirical research. In A.W. Boykin, A. J. Anderson, & J. F. Yates (Eds.), *Research directions of black psychologists* (pp. 1–17). New York: Russell Sage Foundation.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, no. 2, 60–82.

Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. *Psychotherapy, 56*(3), 400–408. http://dx.doi.org/10.1037/pst0000241

Burgoon, J.K., Guerrero, L., & Floyd, K. (2016). *Nonverbal communication*. New York: Routledge

Caldwell, C. (2013). Diversity issues in movement observation and assessment. *American Journal of Dance Therapy, 35*, 183–200.

Cassidy, J., Jones. J. D., & Shaver, P. R. (2013). Contributions of attachment theory and research: A framework for future research, translation, and policy. *Developmental Psychopathology, 25*(4, Pt. 2), 1415–1434. https://doi.org/10.1017/S0954579413000692

Chiarenza, A. (2012). Developments in the concept of "cultural competence." In D. Ingleby, A. Chiarenza, W. Devillé, & I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (pp. 66-81). Antwerp: Garant.

Christopher, J. C., Wendt, D. C., Marecek, J., & Goodman, D. M. (2014). Critical cultural awareness: Contributions to a globalizing psychology. *American Psychologist, 69*(7), 645–655. https://doi.org/10.1037/a0036851

Clark, L. A., Cuthbert, B., Lewis-Fernández, R., Narrow, W. E., & Reed, G. M. (2017). Three approaches to understanding and classifying mental disorder: ICD-11, DSM-5, and the National Institute of Mental Health's Research Domain Criteria (RDoC). *Psychological Science in the Public Interest*, *18*(2), 72–145. https://doi.org/10.1177/1529100617727266

Comas-Díaz, L. (2006). Cultural variation in the therapeutic relationship. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 81–105). Washington, DC: American Psychological Association. https://doi.org/10.1037/11423-004

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*(3), 392–402.

Cosgrove, L. (2005). When labels mask oppression: Implications for teaching psychiatric taxonomy to mental health counselors. *Journal of Mental Health Counseling, 27*(4), 283–296. https://doi.org/10.17744/mehc.27.4.9eqrq789bllq1dd2

Crenshaw, K. (1989). "Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), Article 8. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

DeGruy, J. (2017). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Milwaukie, OR: Uptone Press.

Denham, A. R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry, 45*(3), 391–414.

DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy*, *3*(3), 54–70.

DiBiase, R., & Gunnoe, J. (2004). Gender and culture differences in touching behavior. *Journal of Social Psychology*, *144*(1), 49–62. https://doi-org.naropa.idm.oclc.org/10.3200/SOCP.144.1.49-62

Dilbeck, K. E. (2014). Vicarious and source credibility: A cross cultural explanation. *Theses and Dissertations*, 589. https://dc.uwm.edu/etd/589

Dovidio, J. F., & Gaertner, S. L. (2004). Aversive racism. In M. P. Zanna (Ed.), *AdVances in experimental social psychology* (Vol. 36, pp. 1–52). New York: Elsevier Academic Press. https://doi.org/10.1016/S0065-2601(04)36001-6

Dunham, Y., Baron, A. S., & Banaji, M. R. (2008). The development of implicit intergroup cognition. *Trends in Cognitive Sciences, 12*, 248–253. https://doi.org/10.1016/j.tics.208.04.006

Duran, E., Duran, B., Heart, B., & Horse-Davis, Y. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341–354). New York: Springer US.

Ellyson, S. L., & Dovidio, J. F. (1985). Power, dominance, and nonverbal behavior: Basic concepts and issues. In S. L. Ellyson & J. F. Dovidio (Eds.), *Power, dominance, and nonverbal behavior* (pp. 1–27). New York: Springer-Verlag.

Escobar, J. I. (2012). Diagnostic bias: racial and cultural issues. *Psychiatric Services* 63(9): 847. doi: 10.1176/appi.ps.20120p847

Figueira, I., Luz, M., Braga, R. J., Cabizuca, M., Coutinho, E. S. F., & Mendlowicz, M. (2007). The increasing internationalization of mainstream posttraumatic stress disorder research: A bibliometric study. *Journal of Traumatic Stress, 20*(1), 89–95.

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (2nd ed.). New York: Guilford.

Frankenberg, R. (1993). *White women, race matters: The social construction of whiteness*. Minneapolis: University of Minnesota Press.

Fuertes, J. N., Gottdiener, W. H., Martin, H., Gilbert, T. C., & Giles, H. (2012). A meta-analysis of the effects of speakers' accents on interpersonal evaluations. *European Journal of Social Psychology*, *42*, 120–133.

Gillespie, D. L., & Leffler, A. (1983). Theories of nonverbal behavior: A critical review of proxemics research. *Sociological Theory, 1*, 120–154. https://doi.org/10.2307/202049

Gottlieb, A. (2004). *The afterlife is where we come from: The culture of infancy in West Africa*. Chicago: University of Chicago Press.

Hall, E. T., & Hall, T. (1959). *The silent language* (Vol. 948). New York: Anchor.

Hammack, P. L., Mayers, L., & Windell, E. P. (2013). Narrative, psychology and the politics of sexual identity in the United States: From "sickness" to "species" to "subject." *Psychology and Sexuality*, *4*(3), 219–243.

Hanckock, P., Hughes, B., Jagger, E., Paterson, K., Russell, R., Tulle-Winton, E., & Tyler, M. (2000). *The body, culture and society: An introduction*. Philadelphia: Open University Press.

Harrell, S., & Gallardo, M. (2008). Sociopolitical and community dynamics in the development of a multicultural worldview. In J. K. Asamen, M. L. Ellis, & G. L. Berry (Eds.), *The SAGE handbook of child development, multiculturalism, and media* (pp. 113–128). Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781412982771.n8

Harrell, S. P. (2014). Compassionate confrontation and empathic exploration: The integration of race-related narratives in clinical supervision. In C. A. Falender, E. P. Shafranske, & C. J. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach* (pp. 83–110). Washington, DC: American Psychological Association. https://doi.org/10.1037/14370-004

Harrell, S. P., & Sloan-Pena, G. (2006). Racism and discrimination. In Y. Jackson (Ed.), *Encyclopedia of multicultural psychology* (pp. 396–402). Thousand Oaks, CA: Sage.

Hart, A. (2017). From multicultural competence to radical openness: A psychoanalytic engagement of otherness. *American Psychoanalyst*, *51*(1). https://apsa.org/apsaa-publications/vol51no1-TOC/html/vol51no1_09.xhtml

Henley, N., & Freeman, J. (1995). *The sexual politics of interpersonal behavior in women: A feminist perspective*. London: Mayfield.

Henley, N. M. (1977). *Body politics: Power, sex, and nonverbal communication*. Englewood Cliffs, NJ: Prentice-Hall.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*, 353–366. https://doi.org/10.1037/a0032595

Hook, J. N., Owen, D. E., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility of therapists is associated with stronger working alliance and better psychotherapy outcomes. *Clinician's Research Digest: Adult Populations, 31*(9), 5.

Jacob, K. S. (2019). Idioms of distress, mental symptoms, syndromes, disorders and transdiagnostic approaches. *Asian Journal of Psychiatry, 46*, 7–8. https://doi.org/10.1016/j.ajp.2019.09.018

Johnson, R. (2009). Oppression embodied: Exploring the intersections of somatic psychology, trauma, and oppression. *USPB Journal, 8*(1), 19–31.

Johnson, R. (2015). Grasping and transforming the embodied experience of oppression. *International Body Psychotherapy Journal, 14*(1), 80–95.

Johnson, R., Leighton, L., & Caldwell, C. (2018). The embodied experience of microaggressions: Implications for clinical practice. *Journal of Multicultural Counseling and Development, 46*(3), 156–170.

Kağitçibaşi, Ç. (1990). Family and socialization in cross-cultural perspective: A model of change. In J. Berman (Ed.), *Nebraska Symposium on Motivation, 1989* (pp. 135–200). Lincoln: University of Nebraska Press.

Kaiser, B. N., & Jo Weaver, L. (2019). Culture-bound syndromes, idioms of distress, and cultural concepts of distress: New directions for an old concept in psychological anthropology. *Transcultural Psychiatry*, *56*(4), 589–598. https://doi.org/10.1177/1363461519862708

Keller, H. (2013). Attachment and culture. *Journal of Cross-Cultural Psychology*, *44*(2), 175–194. https://doi.org/10.1177/0022022112472253

Keller, H. (2018). Universality claim of attachment theory: Children's socioemotional development across cultures. *PNAS, 115*(45), 11414–11419.

Kellermann, N. (2001). Transmission of Holocaust trauma: An integrative view. *Psychiatry Interpersonal and Biological Processes*, *64*(3), 256–267.

Kirk, G., & Okazawa-Rey, M. (2013). *Women's lives: Multicultural perspectives* (6th ed.). New York, NY: McGraw-Hill.

Kirmayer, L. J. (1996). Confusion of the senses: Implications of ethnocultural variations in somatoform and dissociative disorders for PTSD. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 131–163). Washington, DC: American Psychological Association.

Kirschner, S. R. (2013). Diagnosis and its discontents: Critical perspectives on psychiatric nosology and the *DSM*. *Feminism and Psychology, 23*(1), 10–28.

Knapp, M. (2006). An historical overview of nonverbal research. In V. Manusov & M. L. Patterson (Eds.), *The SAGE handbook of nonverbal communication* (pp. 3–20). Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781412976152.n1

Kurtz, R. (1990). *Body-centered psychotherapy: The Hakomi method: The integrated use of mindfulness, nonviolence, and the body*. Mendocino, CA: LifeRhythm Books.

Liddell, B. J., & Jobson, L. (2016). The impact of cultural differences in self-representation on the neural substrates of posttraumatic stress disorder. *European Journal of Psychotraumatology, 7*. https://doi.org/10.3402/ejpt.v7.30464

Lietz, M. (2015). Whiteness and white identity development. http://cultureandyouth.org/racism/articles-racism/whiteness-white-identity-development

López, S. R. (1989). Client variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychology Bulletin, 106*(2), 184–203.

Main, M. (2000). The organized categories of infant, child, and adult attachment: Flexible vs. inflexible attention under attachment-related stress, Journal of the American Psychoanalytic Association, 48(4), 1055-1096, p.1094.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95–124). New York: Ablex.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. *Attachment in the Preschool Years: Theory, Research, and Intervention, 1*, 121–160.

Mehta, N. (2011). Mind-body dualism: A critique from a health perspective. *Mens Sana Monographs*, *9*(1), 202–209. https://doi.org/10.4103/0973-1229.77436

Menakem, R. (2017). *My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies*. Las Vegas, NV: Central Recovery Press.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York: Guilford.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Kramer Tebes, J. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science Medicine, 106*, 128–136.

Moore, C. L., & Yamamoto, K. (2012). *Beyond words: Movement observation and analysis* (2nd ed.). New York: Routledge.

Morelli, G., Quinn, N., Chaudhary, N., Vicedo, M., Rosabal-Coto, M., Keller, H., Murray, M., Gottlieb, A., Scheidecker, G., & Takada, A. (2018). Ethical challenges of parenting interventions in low- to middle-income countries. *Journal of Cross-Cultural Psychology, 49*, 5–24. https://doi.org/10.1177/0022022117746241

Moss-Racusin, C. A., Dovidio, J. F., Brescoll, V. L., Graham, M. J., & Handelsman, J. (2012). Science faculty's subtle gender biases favor male students. *Proceedings of the National Academy of Sciences, 109*(41), 16474–16479. https://www.pnas.org/content/109/41/16474.abstract

Ng, E., & Purser, R. (2015). White privilege and the mindfulness movement. Buddhist Peace Fellowship: Buddhism and Social Justice. http://www.buddhistpeacefellowship.org/white-privilege-the-mindfulness-movement/

Nichter, M. (2010). Idioms of distress revisited. *Culture, Medicine and Psychiatry*, *34*, 401–416. https://doi.org/10.1007/s11013-010-9179-6

Nobles, W. (1986). *African psychology: Toward its reclamation, reascension and revitalization*. Oakland, CA: Black Family Institute.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy.* New York, NY: Norton.

Ogden, P. (2007, March). *Beyond words: A clinical map for using mindfulness of the body and the organization of experience in trauma treatment*. Paper presented at Mindfulness and Psychotherapy Conference, Los Angeles: UCLA/Lifespan Learning Institute.

Ogden, P. (2009). Emotion, mindfulness, and movement: Expanding the regulatory boundaries of the window of affect tolerance. In D. Fosha, D. Siegel, & M. Solomon (Eds.), *The healing power of emotion: Affective neuroscience & clinical practice* (pp. 204–231). New York: W. W. Norton & Company.

Ogden, P. (2014). Beyond Conversation in Sensorimotor Psychotherapy: Embedded Relational Mindfulness In V. M. Follette, D. Rozelle, J. W. Hopper, D. I. Rome, and J. Briere (Eds), *Contemplative methods in trauma treatment: Integrating mindfulness and other approaches.* New York: The Guilford Press.

Ogden, P. (2020). The different impact of trauma and relational stress on physiology, posture, and movement: Implications for treatment. *European Journal of Trauma & Dissociation*, 100172.

Otto, H. (2008). *Culture-specific attachment strategies in the Cameroonian Nso: Cultural solutions to a universal developmental task* [Unpublished doctoral dissertation]. Osnabrück, Germany.

Ogden, P. & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. New York: W. W. Norton & Company.

Otto, H., & Keller, H. (Eds.). (2014). *Different faces of attachment*. Cambridge, UK: Cambridge University Press.

Pallaro, P. (1997). Culture, self and body-self: Dance/movement therapy with Asian Americans. *Arts in Psychotherapy, 24*(3), 227–241.

Paniagua, F. A. (2018). ICD-10 versus *DSM-5* on cultural Issues. *SAGE Open*. https://doi.org/10.1177/2158244018756165

Perception Institute. (2019). *Transforming perception: Black men and boys* [Executive summary]. https://perception.org/research/explicit-bias/

Phillips, L. T., & Lowery, B. S. (2018). Herd invisibility: The psychology of racial privilege. *Current Directions in Psychological Science, 27*(3), 156–162.

Quillian, L., Pager, D., Hexel, O., & Midtbøen, A. H. (2017). Meta-analysis of field experiments shows no change in racial discrimination in hiring over time. *Proceedings of the National Academy of Sciences, 114*(41), 10870–10875.

Reshamwala, S. (2016). *Peanut butter, jelly, and racism* [Video]. *New York Times.* https://www.nytimes.com/video/us/100000004818663/peanut-butter-jelly-and-racism.html

Roberts, S. O., Bareket-Shavit, C., Dollins, F. A., Goldie, P. D., & Mortenson, E. (2020). Racial inequality in psychological research: Trends of the past and recommendations for the future. Perspectives on psychological science, 1745691620927709.

Ross, H. (2017). Exploring unconscious bias. https://culturalawareness.com/wp-content/uploads/2017/03

Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist*, *55*(10), 1093.

Said, E. (1978). Orientalism: Western concepts of the orient. New York: Pantheon.

SAMHSA. (2014). *Trauma-informed care in behavioral health services.* Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sanders Thompson, V. L. (2006). Coping responses and the experience of discrimination. *Journal of Applied Social Psychology, 36*(5), 1198–1214.

Schachter, E. P. (2005). Context and identity formation: A theoretical analysis and a case study. *Journal of Adolescent Research, 20*(3), 375–395. https://doi.org/10.1177/0743558405275172

Sidhu, G. (2017). The application of Western models of psychotherapy by Indian psychotherapists in India: A grounded theory. *Dissertations and Theses*, 377. http://aura.antioch.edu/etds/377

Siegel, D. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford Press.

Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*, *93*(2), 239–243. https://doi.org/10.2105/ajph.93.2.239

Sroufe, L. A., & Siegel, D. (2011, March/April). The verdict is in. *Psychotherapy Networker*, pp. 34–39, 52–53. https://www.drdansiegel.com/uploads/1271-the-verdict-is-in.pdf

Stewart, B. D., & Payne, B. K. (2008). Bringing automatic stereotyping under control: Implementation intentions as efficient means of thought control. *Personality and Social Psychology Bulletin, 34*, 1332–1345.

Sue, D.W. (2010). Microaggressions in everyday life: Race, gender, and sexual orientation. Hoboken, NJ: Wiley.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*(2), 64–88.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *Counseling Psychologist, 10*, 45–52. https://doi.org/10.1177/0011000082102008

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different.* New York: Wiley.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counselling the culturally diverse: Theory and practice*. New York: Wiley.

Szasz, T. S. (1971). The sane slave: An historical note on the use of medical diagnosis as justificatory rhetoric. *American Journal of Psychotherapy*, *25*(2), 228–239.

Tajfel, H., & Forgas, J. P. (2000). Social categorization: Cognitions, values and groups. In C. Stangor (Ed.), *Stereotypes and prejudice: Essential readings* (pp. 49–63). Ann Arbor, MI: Taylor and Francis.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. New York: Norton.

Tronick, E. Z., Morelli, G. A., & Ivey, P. K. (1992). The Efe forager infant and toddler's pattern of social relationships: Multiple and simultaneous. *Developmental Psychology, 28*(4), 568.

ValaVanis, S., Thompson, C., & Murray, C. D. (2019). Positive aspects of voice-hearing: A qualitative metasynthesis. *Mental Health, Religion and Culture*, *22*(2), 208–225. https://doi-org.naropa.idm.oclc.org/10.1080/13674676.2019.1601171

Vasquez, M. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8), 875–885. https://doi.org/10.1037/0003-066X.62.8.878

Williams, M. (2014). A conversation on racial disparities in MH treatment. New York Association of Psychiatric Rehabilitation Services. https://www.nyaprs.org/e-news-bulletins/2015/a-conversation-on-racial-disparities-in-mh-treatment

Williams, M. (2019). Microaggressions: Clarification, evidence, and impact. *PsychArchives*. https://doi.org/10.23668/psycharchives.2506