ABSTRACT

Title of Dissertation: DECOLONIZING IN INDIVIDUAL PSYCHOTHERAPY: A QUALITATIVE EXPLORATION

Priya Bansal, Doctor of Philosophy, 2024

Dissertation directed by: Professor Clara E. Hill, Ph.D.
Department of Psychology

We interviewed 12 therapists experienced in practicing decolonizing about their understanding of decolonizing and its relevance to therapy, as well as how they implemented this approach with at least one client. Interviews were analyzed using Consensual Qualitative Research (CQR) and revealed that colonial paradigms had negative individual, relational, and societal impacts; therapists used a range of interventions aligned with decolonizing, including interventions to help clients gain insight about the systemic context of psychological problems and to facilitate client resistance of colonial ideologies; sociocultural identity interactions between therapist and client considerably shaped the therapy work; therapists encountered conceptual, practical, and systemic barriers to decolonizing practice; and clients experienced improvements across intrapersonal and interpersonal functioning. Implications for practice and research are discussed.

DECOLONIZING IN INDIVIDUAL PSYCHOTHERAPY: A QUALITATIVE EXPLORATION

by

Priya Bansal

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Advisory Committee:
Professor Clara E. Hill, Ph.D., Chair
Professor Jioni A. Lewis, Ph.D.
Professor Delida Sanchez, Ph.D.
Professor Richard Q. Shin, Ph.D.
Professor Cixin Wang, Ph.D.

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Decolonizing in Individual Psychotherapy: A Qualitative Exploration

The dynamic of power and resistance, particularly in relation to colonialism, is interwoven throughout world history. Today, with clear demonstrations of colonial destruction in Ukraine and Palestine (Muhire, 2024), legacies of white supremacy exemplified in political unrest and gun violence (Glick, 2023), and global impacts of colonial practices such as exacerbated climate change (Bhambra & Newell, 2023), efforts to resist the impacts of colonialism are becoming increasingly salient.

Decolonizing involves an attempt to undo harm done by colonizing (Gone, 2020). Some scholars preserve the term's original connection to reinstating Indigenous sovereignty over their land (Hartmann et al., 2019; Tuck & Yang, 2012), whereas others describe it as a broader shift in attitude and action focused on undoing colonial harm by recentering Indigenous ideas and epistemologies (Sium et al., 2012).

Colonialism involves the establishment and maintenance of control over a territory and its people by a foreign power (Adams et al., 2015; Fanon, 1963). The best example of colonialism in the United States is the genocide against Indigenous people and theft of their land. Other examples include the labor trade system, which dehumanized and commodified minoritized people; and gentrification, which overtook communities and rerouted capital gain from minority-owned businesses to the privileged oppressors. These systems created still-existing social inequalities and continue to drive societal inclinations toward urgency, productivity, commodification, and control.

Even an attempt to define (e.g., capture, contain, restrict) decolonizing can be considered a colonial act (Machado de Oliveira, 2021). The institution of research as it currently stands tends to require rigidity in the form of definitions, statistics, and evidence (Gone, 2020); as I

write this dissertation, I am continually mindful of how this project and my (our) interpretations are in some ways manifestations of these colonial patterns. In other ways, where I can and presently have the skills and knowledge to do so, I hope to disrupt some of the typical colonial patterns seen in research institutions and in the field of counseling psychology.

In this dissertation, I explore how therapists engage in decolonizing within their clinical practices. As an emerging clinician myself, I am struck by the knowledge of how the field of counseling in the United States has historically followed colonial thought and has perpetuated colonial harm aligning with that described above. For instance, Tate et al. (2015) described how the counseling field has historically situated a privileged minority (white, cisgender, heterosexual men) as experts who defined mental health and wellness to their standards and "dictated the frame through which counseling competence should be defined and researched" (p. 43). Based on this foundation, psychologists historically enabled and justified violence through eugenics, invisibilizing Indigenous belief structures around wellness, and establishing a system that has been "complicit with the overarching maintenance of Western domination of social, psychological, and scientific thought" (p. 44). Clinicians today grapple with challenges associated with being part of a colonial system while also striving to stop and undo colonial harm (Machado de Oliveira, 2021; Mullan, 2023; Rober & Seltzer, 2010; Singh et al., 2020).

My Positionality Within the Colonial Landscape

Several times over the course of this project, I have asked myself—and have been asked by others—why I am doing this work. Questions I have grappled with include: is it my place to be studying decolonizing, given that I am not an Indigenous person? Is a university system, with its historic rejection of Indigenous values and worldviews (Louie et al., 2017), an appropriate setting for this work? Truthfully, I think the answers to these questions embody more complexity

than yes or no. My reasons for doing this work have evolved along my journey of learning about decolonizing in psychotherapy (see Appendix A).

I see this dissertation as part of my personal and professional journey toward healing. I do not aim to become an "expert" on decolonizing, nor do I believe that is possible. Instead, I aim to respectfully use my positionality (as a researcher, clinician, and student in the system of academia) to highlight voices that have historically been erased in the field of counseling psychology. In this work, I will try to remain authentic to my position and be honest about the many things I do not know. I aim to expand my (our) curiosity rather than arrive at conclusions—and to describe rather than define—how therapists who are on their decolonizing journeys are currently practicing.

Review of Decolonizing Psychotherapy

Much of the literature describing decolonial philosophies about psychological suffering and healing is theoretical and clinical in nature rather than involving empirical tests of assertions. Theoreticians have primarily identified problems with non-decolonial approaches to therapy (e.g., Gorski & Goodman's critique of multicultural therapy) and described ideals that decolonial psychotherapy should fulfill such as addressing issues of power, systems of oppression, internalized inferiority, and psychological harm (Gone, 2008; Robcis, 2020). Although several scholars have produced guidelines for practicing decolonial psychotherapy (French et al., 2020; Marsella, 2015a; Millner et al., 2021; Singh et al., 2020), there is a scarcity of concrete examples illustrating how these guidelines are applied in clinical practice. Similarly, nonempirical case examples (Adames et al., 2022, Fay, 2016), although certainly beneficial, do little to provide a comprehensive picture of decolonial psychotherapy in practice.

Theoretical Underpinnings

One foundation for decolonial psychotherapy is liberation psychology, which emphasizes that systems of oppression reflect colonial patterns and cause harm. Liberation psychologists believe that that healing comes from the emancipation of oppressed people, and that this emancipation comes from resistance (Adames et al., 2022). According to this philosophy, helping people develop a conscious awareness and memory of their historical oppression facilitates the deconstruction of oppressive schemas that perpetuate psychological harm and allows for the construction of liberated schemas (Comas-Díaz, 2020; Moane, 2003). According to Comas-Díaz, clinicians who practice liberation psychotherapy "believe that the purpose of psychotherapy is to change people, so that they can change the world" (p. 170). Thus, even in work with individual people, liberation psychotherapists focus on creating change on a broader, systemic level.

Understanding Suffering. When traditional Western theorists consider what it means to be well or not to suffer, they often do so from an individualistic perspective and pathologize ways of being that fall outside of this perspective, which may lead to misinterpretations of unfamiliar experiences as suffering (Duran & Duran, 2000; Fadiman, 1998; Gamby et al., 2021). For example, Fadiman (1998) described the story of a Hmong family in California whose refusal to medically treat their daughter's epilepsy (due to their belief that it was a spiritual gift) was misinterpreted by social workers as child abuse; contrary to their expectations, the daughter's health rapidly deteriorated when she was removed from her family environment and stabilized only after she was returned. Furthermore, decades of research on psychological diagnoses in the United States has found racial disparities between Whites and racial minorities in the diagnoses of serious mental illness and psychotic disorders, with racial minorities being diagnosed more frequently (Atdjian & Vega, 2005; Doyen, 2021; Liang et al., 2016). Critics have described these

diagnostic disparities as potentially reflective of mental health clinicians' ignorance of systemic and environmental influences on psychological experiences (Atdjian & Vega, 2005; Doyen, 2021; Suite et al., 2007). Specifically, Atdjian and Vega noted that African Americans tend to score higher than average on DSM subscales of mistrust and paranoia, which can result in the misdiagnosis of psychotic disorders. They noted, however, that the history of political and systemic dehumanization of African Americans, slavery, and the use of African Americans for medical experimentation could easily explain their mistrust of the health system.

Scholars suggest that decolonial philosophies of suffering redefine illness outside of Western standards of diagnosis such as the DSM to avoid missing or misinterpreting elements of psychological suffering (Duran & Duran, 2000; Dupuis-Rossi, 2021; Gone, 2008, 2021; Liang et al., 2016; Rimke & Brock, 2012). For instance, Liang et al. recommended that clinicians consider how their conceptualizations of psychological suffering differs from that of their patients—whose understanding of their problems typically does not involve the DSM—and adjust their conceptualizations accordingly. They noted that illness is a sociocultural construct because "the labeling, perception, meaning, consequences, and communication of illness are dependent upon sociocultural beliefs about illness" (p. 1932). Thus, the factors that clinicians emphasize when conceptualizing illness (e.g., symptoms, treatment) often differ from what patients emphasize (e.g., context, consequences). The authors provided an example of taijin kyofusho (TKS), a syndrome in Japanese culture that resembles social anxiety disorder (SAD) but develops out of fear of disrupting social harmony rather than fear of embarrassing the self.

Duran and Duran (2000) recommended that clinicians educate themselves about ways that life experiences might be defined and described outside of the Western lens. For example, time in Western culture is a linear construct; when we think of life events, we remember them

sequentially in terms of when they occurred. In many Indigenous communities, however, time is a non-linear spatial construct with an emphasis on where something happened rather than when (Duran & Duran, 2000).

Case Conceptualization. Decolonial case conceptualizers emphasize the impact of oppression on psychological problems and identify how oppressive patterns may be replicated in the psychotherapeutic treatment process (Adams et al., 2015; Millner et al., 2021). For instance, Millner and colleagues suggested that traditional Western diagnostic practices "lack consideration for the history and context of mental distress" (p. 335). They argued that a decolonial conceptualization of psychological problems involves remembering the lasting impacts of the history of psychological science being used to establish the superiority of white, affluent heterosexual, cisgender men over others, such as internalized inferiority (Schwalbe et al., 2000) and cultural mistrust of the medical system.

Scholars have also suggested that the Western tendency to distinguish between mind, body, and spirit and to conceptualize and treat ailments separately (e.g., with psychotherapy, physical medicine, and religious/spiritual healing, respectively) reflects colonial principles of dividing and conquering (Brady, 2018; Lezama, 2018). Therefore, clinicians who practice decolonization in psychotherapy advocate integrating the mind, body, and spirit in case conceptualization (Beech, 2021; Hodge et al., 2009; Smeja, 2019).

Some decolonial therapists break free from traditional Western descriptions of psychopathology (Fay, 2016). For instance, Fay described the case of a Māori patient in a psychiatric clinic in New Zealand who was under the care of a team consisting of Pākehā (non-Māori, often descendants of settler colonialists) individuals. The patient struggled with substance abuse, but Fay refrained from pathologizing the substance abuse, citing that doing so might

recreate a colonial/oppressive dynamic by forcing a Pākehā perspective onto the patient. Instead, Fay understood that the patient's ancestral history of colonization, displacement, and insecurity was being recreated in her body as the feeling of being a ghost. The patient was feeling unable to occupy her own body to the fullest extent, much like Māori people were unable to occupy their land to the fullest extent after colonization. Fay conceptualized that the patient was using substances as a means to feel more connected to her body, demonstrating the decolonial principles of integrating mind, body, and spirit (Hodge et al., 2009) and being open to alternative perspectives on existence (Dupuis-Rossi, 2021; Gone, 2020).

Empirical Research on Decolonizing Psychotherapy

Many of the suggested therapeutic techniques are similar to those commonly used in extant Western frameworks of psychotherapy (e.g., developing the therapeutic relationship and alliance, Fellner, 2016; equalizing power dynamics in the therapeutic relationship, Beech, 2021; and narrative storytelling, Smeja, 2019). The distinction between these two, however, is that decolonial knowledge and intentions drive the use of all interventions in decolonial psychotherapy (Hodge et al., 2009; Smeja, 2019), whereas Western philosophies have driven the development of traditional Western psychotherapies.

Smeja (2019) used collaborative narrative inquiry (CNI, Arvay, 2003) to investigate how narrative therapy aligns with decolonial principles. They believed that narrative therapy could be decolonial when the intention behind using narrative techniques is to shift the power dynamic to focus on the client as the narrator and expert. When storytelling is used as an investigation of alternate dimensions of life (e.g., dreams) and to have conversations about systems and systemic oppression, it further fits a definition of decolonial therapy.

Relatedly, in a qualitative interview-based study, Fellner (2016) found that decolonial therapists used the pacing of and distance within the therapeutic relationship as mechanisms of healing. Specifically, the method used for this study was informed by several Indigenous values (e.g., love, faith, compassion) and knowledge-seeking methods (e.g., storytelling, reflection exercises). Fellner used individual and paired interviews and a talking circle with 16 therapists as well as the author's practical clinical experience working with Indigenous clients. Therapists in this study suggested that following the client's lead regarding how quickly the therapeutic relationship developed helped shift the clinician's role to one of being a witness to the clients' humanity and spirituality. This shift promoted decolonization in therapy because it equalized the power dynamic by reducing the psychological, spiritual, and emotional distance between therapist and client.

Similarly, Hodge et al. (2009) described how traditional Western therapeutic techniques, specifically cognitive techniques, can play a role in decolonial psychotherapy. They suggested that a key aspect of decolonial psychotherapeutic treatment is the integration of body, spirit, mind, and context (e.g., environment) and indicated that cognitive techniques could weave across all four of these dimensions. For instance, cognitive techniques could include physical health planning (e.g., sleep and exercise plans) to address the body, dream work to address the spirit, and memory recall and narrative storytelling to address the mind and context (e.g., exploring clients' narratives about family, culture and traditions).

Research shows that clinicians who practice decolonial therapy consider the environment and space in which the therapy takes place (Beech, 2021; Smeja, 2019). For instance, Beech (2021) conducted interpretive qualitative research (Merriam, 2002) with 9 non-Indigenous therapists who worked with Indigenous clients. Beech found that therapists endorsed collecting

and displaying Indigenous books and art or playing Indigenous music to bring a sense of comfort and familiarity for their clients and facilitate conversations in therapy (e.g., one therapist gave an example of how a piece of art reminded a client of their childhood and served as a starting point for sharing a memory). Therapists in Smeja's (2019) study described how a traditional office structure (in which the client enters the clinician's space in order to engage in therapy) could instill feelings of discomfort and apprehension in clients by reminding them of institutional spaces that have historically caused colonial harm, such as prisons. These therapists sometimes met with clients in clients' homes or neutral places such as parks. They suggested that awareness of the impact of space and willingness to adjust were important elements of practicing decolonization in their work.

Extant research indicates that many therapists also promote decolonization by participating in extra-therapeutic decolonial work (Beech, 2021; Fellner, 2016; Smeja, 2019). For instance, therapists interviewed in interpretive qualitative research by Beech (2021) and collaborative narrative inquiry by Smeja (2019) pursued education about colonialism and decolonization, routinely spent time reflecting on their personal biases and internalized racist or colonial attitudes, and participated in social justice advocacy (e.g., through volunteering). Decolonial therapists working with Indigenous clients spent extra-therapeutic time participating on licensing boards to help make mental health services more accessible and appropriate for Indigenous clients as well as utilizing social media platforms to engage in discourse about Indigenous rights and decolonization (Beech, 2021).

One limitation to the existing literature in this area is researchers have not investigated how therapists use decolonial therapeutic approaches with specific clients in terms of case conceptualization, treatment, and evaluation of outcomes. Furthermore, theorists who included

nonempirical case examples limited these illustrations to either case conceptualization or treatment (Adames et al, 2022; Fay, 2016). The piecemeal information in the current literature limits our understanding about the details of decolonial therapeutic work.

Second, the research studies in which therapists reflected on their work with clients involved non-Indigenous therapists working with Indigenous clients (Beech, 2021; Smeja, 2019). Given that there are other important populations to study (Gorski & Goodman, 2015; Singh et al., 2020), additional research is needed to investigate the characteristics of decolonial approaches with diverse therapists and clients.

Purpose of the Present Study

Though there is an abundance of recommendations and guidelines for clinicians looking to ground their work in decolonial philosophies, current literature is lacking in research exploring what this actually entails in practice. Thus, the purpose of the present study was to investigate how psychotherapists use decolonizing in their practices.

Because this is a relatively new approach to psychotherapy, I used qualitative methodology involving interviewing psychotherapists who believe in and practice decolonizing in therapy. Specifically, I used consensual qualitative research (CQR, Hill & Knox, 2021) because it is an inductive approach grounded in constructivism and based on the beliefs that there is no absolute truth and that knowledge is constructed (Morrow et al., 2012). Other qualitative methodologies, such as participatory action research (PAR; Kidd & Kral, 2005) and grounded theory research (Fassinger, 2005) could also have been appropriate for exploring decolonizing in individual psychotherapy.

CQR is a rigorous methodology that involves a team of judges, allowing for multiple perspectives to ensure a greater understanding of the data. The methodology involves bracketing

the original research questions and interview questions during data analysis and focusing purely on the raw data. Results emerge from the data, as opposed to an approach that uses data to confirm or disconfirm established hypotheses. This methodology aligns with my belief that it is most faithful to the data not to preemptively structure the analysis. It is also in alignment with decolonizing, which values openness to new conceptualizations of practice. I believe preemptively structuring the data analysis would contradict the open and exploratory nature of CQR, dilute the richness of results, and obscure new conceptualizations of practice which are at the core of decolonizing. CQR was additionally appropriate for the present study because the research questions were exploratory in nature. I had no expectation that a particular theory would be created through this study. Rather, the purpose of this study was to describe rather than to predict. Finally, the topic of interest in the present study is decolonization, which inherently values narrative and constructivism (Smeja, 2019).

My initial exploratory questions for the present study (recognizing that these questions could change based on the data collected) were:

1. How do decolonial therapists conceptualize psychological problems?
2. How do therapists implement decolonial therapeutic approaches with their clients?
3. How do decolonial therapists assess the effectiveness of psychotherapy?
4. What facilitated the development of therapists' decolonial therapeutic approaches?
5. What barriers did therapists encounter in developing their decolonial therapeutic approaches?

Method

Design

The data for the present study involved qualitative analyses of in-depth interviews with 12 currently practicing, licensed psychotherapists and counselors in the United States and Canada who endorsed decolonizing in their practice. All interviews were conducted and recorded via Zoom and transcribed. Data were analyzed by a team of trained judges using CQR.

Participants

Therapist Interviewees

The study sample was 12 licensed therapists/counselors in the United States and Canada who were seeing clients at the time of the interview. The therapists reported that they actively decolonized their work and could discuss a case example of how they practiced decolonizing with an adult client in individual psychotherapy.

Participants were between 30 to 59 years of age (M = 40, SD = 7.25) and represented a variety of racial identities (in alphabetical order): 1 Afro-Latine, 1 Asian, 1 Asian American, 1 Asian American/Canadian, 1 Asian Indian, 1 Black, 1 ethnic Chinese from Vietnam, 1 Iranian, 1 Métis, 1 second-generation South Asian American, and 2 White. Seven participants identified as cisgender women, 2 were genderqueer and/or non-binary, 2 were cisgender men, and 1 identified as transmasculine. In terms of sexual orientation, 6 participants identified as queer, 3 as heterosexual, 2 as fluid, and 1 as queer/pansexual/bisexual. Their religious identities included (in alphabetical order) Agnostic (1), Atheist (1), Buddhist (1), Catholic (1), Eclectic (1), Jewish (1), Pagan (1), Indigenous Spiritual (1), and Spiritual (3); one participant chose not to disclose religious identity. On a socioeconomic scale of 1 (*low*) to 10 (*high*), participants rated themselves between 5 to 8 (M = 7, SD = 0.86). Seven participants were master's-level clinicians, and 5 were

doctoral-level clinicians, in licensed practice from a range of 5 months to 22 years post-degree conferral. On the Theoretical Orientation Profile scale (TOPS-R; Worthington & Dillon, 2003), participants identified themselves as primarily Multicultural (M = 8.28, SD = 2.46), followed by Feminist (M = 7.72, SD = 2.73), Humanistic or Existential (M = 6.42, SD = 2.85), Psychoanalytic or Psychodynamic (M = 5.64, SD = 2.97), Family Systems (M = 5.33, SD = 2.35), and Cognitive Behavioral (M = 3.00, SD = 2.37).

Clients as Described by Therapist Interviewees

Clients were between 24 to 38 years of age (M = 30, SD = 4.15) and represented a variety of racial identities (in alphabetical order): 3 Asian, 1 Asian American, 1 Filipinx, 1 Filipinx Canadian, 2 Indigenous and First Nations, 2 Latinx, 1 Multiracial, and 1 South Asian. 5 clients identified as female, 4 identified as genderqueer, nonbinary, or Qariwarmi, 2 were male, 1 identified as trans, and 1 was questioning and exploring gender. In terms of sexual orientation, therapists described that 7 clients identified as queer, 2 as heterosexual, 1 as heterosexual "ish," 1 as lesbian, and 1 as questioning. Therapists described clients' religious identities as (in alphabetical order): Animist (1), Atheist (1), Buddhist (1), Christian (2), Indigenous Spiritual (1), Secular (2), and Spiritual (2); two therapists did not disclose their clients' religious identities. On a socioeconomic scale of 1 (*low*) to 10 (*high*), therapists described their clients as between 2 to 7 (M = 5, SD = 1.38).

Interviewer

I, a second-generation Indian American, bisexual, cisgender woman, advanced doctoral student in counseling psychology, conducted and transcribed all of the interviews. I am familiar with CQR (Hill, 2012) and have prior experience participating on CQR research teams.

Research Team

The research team initially consisted of 5 people in addition to myself as the lead investigator: a Multiracial (Pakistani and White), bisexual and asexual, cisgender woman who was an advanced doctoral student in counseling psychology; a Chinese American, bisexual, cisgender woman who was a licensed psychologist; a White, lesbian, transgender woman who was a doctoral student in physics; an Indian American, heterosexual, cisgender woman who was an advanced doctoral student in school psychology; and a Multiracial (Indigenous and Black), heterosexual, cisgender woman who was an undergraduate student in public health. Over the course of data analysis, two team members ceased participation (one graduate student withdrew from the team after establishment of the initial domain list, and the undergraduate student withdrew after the domain list was finalized). The auditor and primary advisor for the present study was a licensed and currently practicing 74-year-old counseling psychologist who identified as moderately liberal, was not a decolonizing therapist, and who had extensive experience with qualitative research in addition to being a co-creator of the CQR methodology.

Biases and Expectations of the Research Team

I am a doctoral candidate in counseling psychology with over five years of primarily psychodynamic clinical training and practical experience. I have engaged in considerable reflection about decolonization in counseling psychology. I believe that elements of Western models of psychotherapy can perpetuate harmful patterns of oppression that stem from colonialism and White supremacy and am interested in how individual psychotherapy can be practiced in an anti-oppressive way. For this study, I anticipated that therapists who had been trained in the United States and who endorsed decolonizing their practice would have engaged in a similar journey of recognizing oppressive patterns in their original training and would have become intentional about decolonizing their work through initiating change in their practice. I

expected therapists to have clear definitions about decolonizing and how they implemented it in therapy. I approached this study with the hope that I would learn from the clinicians I interviewed and thus be able to develop my own practice around decolonizing principles moving forward.

All team members expressed interest and enthusiasm for the topic. Most did not have extensive experience or knowledge of decolonizing, but indicated that their personal values aligned with their broad understanding of decolonizing. One person had personal and community experience with decolonizing efforts that had not extended to their academic and professional work at the time of the study. All team members indicated that multiculturalism and social justice were important to them. The team discussed that it may be important to align with decolonizing and social justice values in order to most accurately and authentically code the data, given that all participants heavily aligned with decolonizing values and actively practiced it in their profession. However, the team also discussed how having strong hopes for learning about decolonizing through the study might emerge as bias in the coding; thus, the team members agreed to critically discuss all coding decisions.

The team also discussed the impact of power dynamics on team relationships and coding outcomes. Three team members were not experienced in the field of counseling and thus expressed apprehension around being able to participate in the coding process. Team members varied in age and educational experience, so discussion included an exploration of how themes of respect, admiration, and a hierarchy of knowledge might manifest in the team dynamic. I acknowledged that as team leader, first author, and a generally passionate person, I needed to maintain mindfulness of how my words might influence or persuade other team members. Transparent discussion around power dynamics before embarking on coding allowed team

members to establish a method of checking and balancing each other through in-depth discussions to reach consensus on all coding decisions. Throughout data analysis, team members encouraged each other to vocalize their thoughts, particularly disagreements, to facilitate thoughtful and fruitful discussions.

Data Collection

Screening Questionnaire

A screening questionnaire was developed by the lead investigator to assess participants' eligibility and willingness to discuss their decolonizing therapy practice. Questions included (eligibility criteria indicated in parentheses): age (over 18), licensure status (licensed at whichever level they were practicing), currently practicing individual therapy with adults (yes), use of a decolonizing approach with clients (yes), and willingness to discuss work with a client whom they saw for at least six months and who was either an ongoing or recent (i.e., within the last two years) client at the time of the study (yes).

Demographic Form

A demographic questionnaire asked therapists for information about their educational background, clinical background, age, gender, racial and ethnic identity, religious identity, sexual orientation, and socioeconomic status. Interviewees were also asked to provide this same demographic information about the client they planned to discuss during the interview.

Theoretical Orientation Profile Scale – Revised

The Theoretical Orientation Profile Scale – Revised (TOPS-R; Worthington & Dillon, 2003) was used to assess therapists' theoretical orientation. Participants responded to 18 items on a 10-point Likert scale ranging from 1 (*never*) to 10 (*always*), which corresponded with the "extend to which [they] identify with, conceptualize from, and utilize techniques" associated

with six dominant theoretical orientations: Psychoanalytic or Psychodynamic, Humanistic or Existential, Cognitive Behavioral, Family Systems, Feminist, and Multicultural. See Appendix C for specific scale items.

Interview Protocol

I developed a semi-structured interview protocol with standardized questions as well as follow-up questions and probes (e.g., "Tell me more about…;" "Can you expand on…"). I also conducted two pilot interviews, revising the protocol after feedback from each interviewee. The protocol was then reviewed by my advisor (also serving as auditor for this study) as well as the dissertation committee, and revised based on their feedback.

The interview protocol began with an introduction of myself, the interviewer, including a description of my familial and sociocultural background, my interest in decolonizing and in conducting this research, and my journey to learning about and commitment to undoing colonial harm. This personal disclosure was provided based on feedback from pilot interviewees that they needed such information to trust the interviewer. I then provided a definition of decolonial philosophies to contextualize the conversation. Interviewees were then asked to describe their theoretical orientation and philosophy around decolonization in psychotherapy as well as their journey of developing their practice using their decolonial philosophy of therapy. Next, interviewees were asked to think of the client with whom they had used their decolonial approach (and whose demographic information they had provided in the survey) and describe (a) their decolonial case conceptualization of the client, (b) their implementation of a decolonizing therapeutic approach with this client, (c) observable indications of their decolonial therapeutic approach with this client, and (d) a description of how they determined the success of their decolonizing therapeutic approach with this client. (See Appendix D for the interview protocol).

Ethical Considerations

Approval was granted by the Institutional Review Board at the University of Maryland prior to data collection. Code numbers were used for all cases. Research team members were asked to recuse themselves from working with any case if they knew the therapist or client. All team members indicated no conflicts of interest throughout the study.

Participant Recruitment

Therapists were recruited for participation in this study via email. I first reached out to clinicians who had been outspoken (e.g., on social media platforms, at academic conferences, on academic listservs, and on their websites) about decolonization in psychotherapy and who were known for their anti-oppressive practices in order to ensure that their individual psychotherapy practices would likely fit the eligibility requirements of the present study (specifically, that the therapists practiced decolonizing psychotherapy). Although a broad definition of decolonizing psychotherapy was provided during recruitment (see Appendix E), part of the purpose of the present study was to investigate how practicing therapists conceptualized decolonization in psychotherapy—thus, this method of identifying therapists who practice decolonizing or anti-oppressive psychotherapy was necessary to initiate recruitment.

Personalized recruitment emails to therapists (see Appendix E) included brief descriptions of the study purpose and procedure, eligibility requirements (e.g., that the person is licensed as either a psychologist, counselor, or social worker, is currently seeing clients for individual psychotherapy, and practices decolonized psychotherapy), and the interview protocol so that therapists could reflect on the topic and recall work with a specific client. Therapists who met the eligibility requirements and who expressed interest in participating in this research by responding to the recruitment email received a follow-up email containing a link to the online

consent form and demographics form. Upon completion of these forms, I contacted therapists to schedule a 90 to 120-minute interview using a video or audio platform. After completion of the study procedures, I encouraged therapists to share the recruitment email with other eligible therapists who may have been interested in this research or to recommend such therapists in their networks whom I could contact for recruitment. Interviewees were largely enthusiastic about the study and often recommended participants before I asked.

In total, 104 therapists were contacted via recruitment email. 23 people completed the screening questionnaire to determine eligibility; 2 surveys were abandoned and 2 did not pass eligibility criteria. Of the 19 therapists contacted for interviews, 13 of them participated in the study. 12 interviews were included in the study; after considerable discussion amongst myself (the interviewer), the coding team, and the auditor, one interview was ultimately dropped from analysis because the interviewee only reported practicing decolonizing therapy with a small percentage of their clients, stated uncertainty about how to describe decolonizing therapy, and had substantially unclear answers to interview questions.

Interviews

The 90 to 120-minute interviews were completed using a video platform and were audio-recorded. At the beginning of the study, participants were informed of confidentiality procedures and possible risks associated with the study. Participants were reminded that they could skip any questions or end the interview at any time. No participants chose to skip questions or end the interview before completing the interview protocol.

Transcriptions

All interviews were transcribed by the primary researcher. All identifying information was removed from transcripts and replaced with general terms (e.g., “[City]”) where appropriate.

Minimal encouragers and utterances (e.g., “um,” “ah,”) were removed. Places in the interview where participants did not complete a thought or sentence were marked as “[trails off].” Final transcripts were emailed to participants for review to confirm accuracy.

Data Analysis

Data analysis followed the recommended CQR procedure (Hill & Knox, 2021). In alignment with their recommendations, we bracketed both the research questions and interview protocol questions during data analysis in order to focus on what emerged organically from the data and mitigate potential bias from any a priori expectations that could overshadow the richness of the data.

Domains. Data analysis began with the process of creating domains (i.e., identifying broad topics) in the data. Three interview transcripts were selected for each member of the research team to independently review and identify main topics to develop an initial domain list. The team met weekly to discuss and modify the list of topics until consensus was reached about the overarching domains. Throughout this process, domains were added, changed, or removed based on the evolving discussion. Upon reaching consensus, the domain list was reviewed by the auditor and revised based on her feedback.

The research team then coded three additional transcripts using the revised domain list; coding involved assigning all “chunks” of data (i.e., meaningful sets of words) from each transcript to one or more domains. The domain list was modified and thoroughly reviewed and audited as needed throughout the process of reviewing and coding the transcripts. Previously-coded transcripts were re-coded upon modification of the domain list as needed. Any data that did not fit into established domains was coded as “other” and reexamined at multiple later points in the study, such as after all domains were coded, during construction of core ideas, and during

and after the cross-analysis. All codes were reviewed by the auditor, who gave feedback and suggestions if she disagreed with any team decisions. Upon receiving feedback, the team reviewed the auditor's notes and revised codes using the consensus process.

A consensus version of each case, where the raw data had been assigned to domains (including line numbers for where the raw data was in the transcript), was created by the first author and reviewed by the team.

Constructing Core Ideas. The consensus version of each coded transcript was used to construct core ideas. In this step, each chunk of raw data under each domain was paraphrased to "capture the essence" of the participant's words in a clear and concise manner (Hill, 2012, p. 111). The full research team worked together to construct core ideas for the three transcripts for which domaining was done: team members rotated to read aloud one chunk of data, and members discussed to consensus a fitting core idea paraphrase for each chunk. Core ideas were added to the consensus version of each transcript next to the raw data. The remainder of the cases were coded in the combined next step.

Combined Domain/Core Ideas. The team divided into groups of 3 to code the remaining transcripts for both domains and core ideas; each group included the first author. For each assigned transcript, group members rotated and read aloud a section of the raw data. Group members consensually constructed the core idea and discussed appropriate domain(s). Consensus versions were created for all coded transcripts and sent to the auditor for feedback. Upon receiving feedback, groups met and revised codes using the consensus process.

Conducting Cross-Analysis. After all transcripts were coded into domains and core ideas and consensus versions were finalized for all cases, a master file was created with all core ideas across transcripts organized together under their respective domains. Raw data was deleted

from the master file, leaving only the therapist code numbers and transcript line numbers for reference. Similar to the process of creating the initial domain list, the research team members independently examined all of the core ideas listed under each domain (starting with the easiest domains) and identified common themes across cases. The team then met to work toward consensus about fitting categories and subcategories for each domain.

The team once again divided into groups with each group including the first author; groups assigned each core idea to an appropriate category (or categories) within its domain. For any discrepancies among the research team or when consensus was difficult, team members revisited the raw data to clarify meaning and to help minimize researcher bias. The cross-analysis for each domain was provided to the auditor for feedback; as before, the groups discussed the recommended revisions and consensually decided how to incorporate feedback into the final document.

Throughout the data analysis process and at the end, team members reflected on their initial expectations, biases (see earlier section on Biases and Expectations of the Research Team), and reactions to study findings. Team members also discussed how their understanding of and perspective on decolonizing in therapy shifted throughout the process. In general, team members were appreciative of the knowledge gained over the course of the study. Throughout coding, they found themselves reflecting on decolonizing principles in their personal and professional lives. They expanded their existing understanding of social justice to include decolonizing, and one team member developed a specific passion for decolonizing in their advocacy work. Team members who were clinicians started using methods of decolonial case conceptualization (e.g., contextualizing mental health concerns like perfectionism/imposter syndrome in systems of oppression like capitalism) and implementation (e.g., somatic

techniques) with their clients. One team member reported experiencing dissonance between their desire to practice decolonizing therapy and their actual ability to do so due to barriers within their institution. All team members reported feeling relatively unsurprised by the general results of the study.

Finally, the manuscript was sent to all study participants to ensure confidentiality was appropriately maintained and to solicit feedback about study findings.

Trustworthiness of Data. Morrow et al. (2012) outlined four criteria for assessing the trustworthiness of a research study and its data: social validity, subjectivity and reflexivity, adequacy of data, and adequacy of interpretation. The present study clearly meets the social validity criteria of trustworthiness; the timeliness of the study fits with the movement of the counseling field toward anti-oppressive practices and the lack of empirical research investigating these practices in detail. The research team addressed subjectivity and reflexivity by keeping journals throughout the research process to track their biases, expectations, and reactions to the research. The information gathered in these journals was referenced during consensus discussions in each step of data analysis in order to maintain transparency about the perspective each team member is bringing to the discussion. The study met the recommendation of Hill (2012) to recruit 12 to 15 participants to achieve adequacy of data and see consistency in results (p. 74). Finally, adequacy of interpretation was achieved through the multi-step and systematic data analysis process involving a research team with multiple perspectives, in-depth discussion to reach consensus, and an auditor.

Results

Because we set aside the original research questions and interview questions during data analysis to avoid biasing the results, results are organized by emergent domains rather than in

accordance with the original questions (see Appendix F). We discuss these findings in the context of the original research questions in the Discussion section.

We used guidelines established by Hill & Knox (2021) to calculate the frequencies of all the categories and subcategories within domains. Categories and subcategories that included core ideas from 11 to 12 participants were termed *general,* from 7 to 10 participants *typical*, and from at least 2 up to 7 participants *variant*. Categories with only one participant were placed into an "Other" category, or existing categories were revised to accommodate straggler core ideas. When we report results, we provide actual quotes from the interviews, with ellipses (. . .) used when words were deleted to save space. We discuss results in a descending order of the frequency with which they were endorsed.

Domain 1: Problems with Colonial Paradigms

Participants described problems with colonial paradigms that motivated their engagement in decolonizing psychotherapy. They discussed problems at the individual, relational, and societal levels, and ways that therapists perpetuate colonial ideas in their practices.

Individuals are Negatively Impacted by Internalization of Colonial Values

Participants typically believed that experiences of disembodiment and disconnection at the individual level stem from internalization of colonial ideologies of perfectionism, urgency, and productivity. These ideas create a rigid understanding of an ideal way of being. PD said it,

> restricts our vision to this very narrow box of this lifetime and what that's supposed to look like. And it's supposed to look like getting an education, and getting a job, and wealth accumulation, and property ownership.

PB noted that these rigid expectations have led to a loss of curiosity and self-exploration, particularly for people with historically oppressed identities,

> There's this linear expectation of ourselves as people, that we just plug and chug this information and produce this thing. And I think about the ways that people who have historically been oppressed have taken that value into their bodies and have, in order to be safe, stomped out the possibility of exploration for themselves. So that they're always upholding their value in this external structure that they're living in.

Participants described how experiences of disembodiment and disconnection were associated with clients' presenting concerns in therapy. PQ said, "it's the sense of what's often called 'imposter syndrome' or 'perfectionism' or 'people pleasing,' it's viewed as these sort of psychological terms, but I think those are colonial." Furthermore, therapists described how clients' association of self-worth with external colonial systems led to problems with functioning. For instance, PB shared that presenting concerns including "not getting the grades that I want or that I should be getting," or "not getting the job that I want," or "not getting the recognition at the job," and "not able to sleep," or "sleeping too much," or "suicidal" were because clients felt they were "not meeting some of those standards" set by colonial ideologies.

Therapists believed that people with privileged identities are also harmed by their internalization of colonial values. For PE,

> Working with people with privilege, whatever that may be, is also really important, because if they are not connected to it and they don't understand their role in all of this, they continue to perpetuate harm. And they [are] also harming themselves by having to cut off and dissociate from the parts of themselves that are being the oppressors.

Finally, therapists described how internalization of colonial values and experiences of disembodiment and disconnection follow a cyclical pattern where each fuels the other. For PE,

> All of the systems of oppression that are connected to colonization tell us to be disconnected from our bodies. And it's only in our disconnection from our bodies that we can keep existing in these structures and keep perpetuating and being a part of.

Relationships Are Damaged by the Influence of Colonial Ideologies

Participants typically discussed negative impacts of colonialism on relationships, including interpersonal isolation, devaluation of community connection, and the perpetuation of relational hierarchies and power dynamics. For example, PC believed that isolation is a colonial tactic and that "There's something about having to be isolated in some way in order to 'fix yourself' that doesn't quite work in a decolonial model. I think it's about how we connect to the people in our lives."

Therapists also discussed the manifestation of hierarchies between people who have historically benefitted from colonialism and those who have historically experienced oppression. For instance, PQ shared,

> The people in [Country] that benefitted from colonialism become disconnected from the people that didn't. That happened in [Country] and a lot of other places: you divide up a country and then you create conflict. Divide and conquer is an old strategy, and it happens geopolitically, but it also happens internally.

Similarly, therapists discussed how hierarchies and power dynamics rooted in colonial ideologies can manifest in and damage the therapeutic relationship. PL described mainstream psychotherapy as "coming from that colonial paradigm of domination, of oppression, of pathologizing . . . the hierarchical relationship, this expert-client dynamic, even the language."

PP discussed the negative relational impact of the therapist "savior complex" facilitated by colonial ideologies in mainstream psychotherapy,

> We find ourselves in environments that are very competitive, very individualistic, we're thinking about ourselves, and I think therapists have a really noble profession but we take that too much to heart and mind, and that's when the savior complex comes in, like: we're the one, we're the only one. And that is a huge disservice to the people that we're trying to help, because we're assuming we're more knowledgeable than them, that we know their stories more than they do, versus waiting for them to tell us and for us to learn from them.

Finally, therapists discussed the cyclical nature of how interpersonal disconnection facilitates the perpetuation of colonial ideologies. For instance, PD shared,

> Our superiority and separation is what allows us to exploit others, whether it's other people or the planet . . . it's easier to do harm when we feel separate and we feel superior . . . the supremacy and separateness are intrinsic to violence.

Colonial Violence and Oppressive Ideologies are Woven into the Fabric of Society

Participants typically discussed colonial problems at the societal level, such as genocide, land theft, and oppression of Indigenous language and traditions. In addition, they mentioned how our existence (including goods and comforts we use in daily life) is grounded in violence and oppression of others. PP described the pervasive nature of colonialism in our everyday lives,

> To even imagine a world where we're rid of colonization is really difficult because it's so seeped into everything that we do. The fact that we're sitting in front of a computer, the fact that we're in these academic institutions, all of these things that we do, is colonization.

Relatedly, PD described how the way violence is interwoven into society is often kept hidden from the general consciousness, “So much of our lives in modernity, especially in the global

north, are based on colonial entitlements, and I think colonialism and modernity want us to not see that, want that all to be invisible to us."

Participants discussed how the normalization of colonial ideologies in society has led to societal dismissal and disavowal of Indigenous and non-colonial ways of knowing, being, and doing. PL noted the irony behind multicultural therapy efforts to critically consider how, when, and if to use non-Eurocentric healing practices in therapy, while Eurocentric therapy practices are normalized to the extent of no longer being considered cultural,

> One of the parallels that I often draw is that nobody hesitates about bringing in Eurosettler culture, right? People will always ask questions about "Well, are we sure we should bring this in, what if they don't practice this, what if that's not part of who they are?" Nobody asks that about dominating Eurosettler colonial, except for people that are doing decolonizing work.

Clinicians Perpetuate Colonial Ideologies in Therapy

Generally, participants described that they had internalized colonial ideologies during their clinical training and had to unlearn these attitudes and behaviors in their decolonizing practice. For instance, PE shared that her "training was psychodynamic, and so that's a very blank slate, more objective or seemingly objective. There's different values I was taught as a therapist. And compared to that, I'm transparent, I'm open, I share of myself."

Participants discussed how the societal tendency to invisibilize colonial influences can manifest in therapy as clinician failure to name systemic issues as the context for clients' presenting concerns. PN stated that this failure can lead to pathologization and other forms of misrepresentation of client narratives and experiences,

> There's this quote that has really, really stuck with me . . . the goal of therapy shouldn't be to help people conform to oppressive systems. And I was like, you're fucking right! It shouldn't be. And sometimes that's what, up until that point, I felt like I was doing, I was helping people navigate these systems, helping them process their anxiety and their depression (which were really manifestations of racism and xenophobia, or transphobia, depending on who I was working with), helping them process these things so that they could armor back up and go back out into the world that was killing them.

PL illustrated how clinicians who practice mainstream psychotherapy can perpetuate colonial ideologies in how they conceptualize intergenerational trauma,

> We often hear a lot about intergenerational trauma. That's everybody's favorite story because that's the colonized story. And it's a story that tells us as Indigenous people that we're fucked up. The whole concept of intergenerational trauma, when it's taken at that face value, is that we are fucked up. And people do take that on as "I'm doomed, I'm fucked, what am I going to do? I can't do anything, I have this trauma."

Given the many ways clinicians perpetuate colonial ideologies in therapy, participants believed that if therapists are not practicing decolonizing, they are causing harm. PD thought that mainstream therapy is

> Patching people up so they can keep functioning in this system that is oppressive, instead of dismantling the systems . . . If I don't want to perpetuate colonialism, then I have to work on bringing on decolonial thinking into my work as a therapist.

Domain 2: How Therapists Practice Decolonizing Psychotherapy

In this section, we present several ways participants described practicing decolonizing therapy with specific clients.

Develop or Repair the Therapeutic Relationship

There was one typical and one general subcategory under this general category related to the therapeutic relationship. In the first, therapists disclose thoughts, feelings, experiences, and personal healing practices to develop or repair the therapeutic relationship with their clients. In her work with one client, PB noted that she had similar

> identities as this person that [the client was] having a conflict with, and it was around identity and the performance of those identities, and I think it was a nice relational moment to work through for us. And it wasn't deep, it wasn't excruciatingly painful or anything, but I do think just having the nuance of being able to name those differences, "how might you be reacting to me when I have a very similar identity to this person in the way that they're performing that identity for you? Having to process it with me?"

PI described disclosing about how her own embodied reactions to hearing clients' stories helped develop build the therapeutic relationship,

> If they've shared something with me that has really greatly impacted me, I can say "Whoa, I just want us to, I wonder if we can pause for a moment, because I noticed that when you said that, I felt my chest swell, I felt a lump in my throat, I felt, and I wonder if we can be with it for a moment, because I'm noticing that my body is feeling it, and I wonder how is it for you?"

PL recalled an example of a time when she facilitated healing by sharing her own knowledge and healing practices with a person outside of her cultural heritage,

> We got a call from medical about this person who was experiencing a severe panic attack and they were immobilized . . . I invited this person in, and he was African American with no Indigenous ancestry whatsoever, and the first thing I offered him was a smudge.

> And I said "This is part of our culture, this is something we use that can help, is this something that you would like to try?" And he said, "Sure." . . . And he smudged, and I'm not kidding you, calmed him right down . . . He was like "That was so powerful!"

In the second subcategory, therapists generally address power dynamics and foster client agency. PI practiced rebalancing power in therapy by naming how power dynamics are related to societal oppression, by acknowledging the reality of how her sociocultural identities and related privileges would position her to miss certain aspects of clients' experiences, and by expressing her desire and willingness to discuss these moments of "missing" in therapy by saying,

> "Holding my identity as a cis woman and recognizing that you are a trans person, that I'm going to miss you. And there will be times where I can't possibly know what that's like. And, I want to, I want to better understand. And so can I retry, can I strive, will you allow me to, can you give me the opportunity? And if I miss you, can we come back to it and check in as to, I want to know what I did that may have missed you."

PL addressed power dynamics by describing her role as that of a supporter who helped clients engage in their own decolonizing practice by asking for consent for therapeutic activities, encouraging clients to voice their boundaries in therapy, by requesting feedback about the therapy process, and by ignoring referral files in favor asking for clients' own narratives because the information in referral files is "all colonial crap, just to be quite blunt."

Facilitate New Conceptualizations

Within the general category, there were two general, four typical, and two variant subcategories depicting how therapists facilitate new understandings.

Help Clients Internalize New Decolonial Ideologies. Participants generally helped clients recognize that they have internalized harmful colonial ideologies and identify new ways

of knowing, being, and doing. PK helped a client name colonial messaging around success and stigma against mental health treatment (e.g., “You’ve got to pull yourself up by your bootstraps . . . and silently suffer . . . continue to work and be productive”), which had been passed down through generations of her family. As a result of undoing these colonial narratives, the client went to see a doctor for prescribed medication, which helped them heal by alleviating symptoms that inhibited therapeutic exploration. Ultimately, the client chose to stop the medication, which was a free choice rather than one influenced by internalized colonial narratives.

PL described her practice of reframing trauma stories as survivance stories,

> The way that we are taught to tell or receive trauma stories from a Western, Eurosettler, colonial perspective is like "Oh my god, you poor thing." It's very patronizing. It's very much like "Oh my god, that's so awful that happened to you," and it turns the person into a victim and it takes away their power, because it's almost like, "You have been crushed by this thing." Whereas when we look at our survivance stories, we acknowledge the ways that we persist through that, and we have words that speak to that in our languages.

Facilitate Insight About Psychological Suffering Being Caused by Systemic Oppression. Participants generally helped clients recontextualize their presenting concerns and experiences of suffering as a result of systemic oppression to remove inappropriate self-blame, shame, hopelessness, and harmful effects. PB said, “I would, with this client specifically, use words like oppression, anti-Blackness, antiracist, homophobic . . . sort of like “Okay, these are things we are dealing with in the world, they're not just housed within yourself.” PI’s work with one client involved an effort to, “get to know her family's immigrant story, their history. French has also colonized Vietnam, and so we make sure to make a lot of space to name how that has impacted her family, how immigration has impacted her family.”

Help Clients Understand Their Ancestral History. Participants typically named how psychological suffering is associated with people having been uprooted and disconnected from their ancestral histories. PN helped an Indigenous client understand their ancestral history,

> When colonization was happening, to fit in, [the ancestors] hid some of their traditional ways of knowing and healing and would only do it in secrecy. And most of them converted to Catholicism; and even the word "converted" is (laughs), it's forced conversion to Catholicism out of survival. And that from that moment on, there were these fear- and survival-based decisions to assimilate and fit in so that they wouldn't be detected as much as possible. And through some of these points of critical decision-making, where people, out of survival and fear and coercion and persecution, did what they could to survive, generations later, that impact is felt.

Participants also described helping non-Indigenous clients reflect on their experiences of settler privileges and understand the roots of these experiences in their ancestral histories of immigration. For instance, PD said, “we talk a lot about [my client’s] experience as a settler, as an immigrant, as a woman of color who ‘passes.’”

Facilitate Insight About How Sociocultural Identities Shape Experiences. Participants typically invited discussion in sessions about how sociocultural identities shape clients’ psychological and relational experiences. PS shared,

> When somebody is describing the particular ways they are suffering, I am kind of mentally placing that in location and relationship to colonial structures and systems of structural violence and oppression, how has patriarchy shaped and influenced how this person might be experiencing this particular thing, what is this person's relationship to

> class or to migration status or to gender and gender-policing, and how might those be a piece of their experience of the struggle they're describing.

PI gave an example of when she explicitly pointed out to a client,

> when she's comparing herself to a coworker who is a White, cis male, and she is a woman of color. And so, unintentionally, she is not able to see that there is a power dynamic here. So, the naming, for me as a therapist, is to point that out, to say, "Well that is an unfair set of expectations that we're placing upon ourself, because this person has a tremendously disproportionate amount of privilege, and people will respond to him in a different way than they may respond to you, unfortunately.

Use the Therapeutic Relationship to Understand Relational Dynamics. Participants typically used the therapeutic relationship as a model for facilitating insight about the client's relational dynamics. PP helped her client reflect on how sociocultural identities can facilitate or hinder their relational intimacy,

> I invited [the client] to ask me any questions, any thoughts she had, any relationships she had with people who shared similar identities with me. And then I did the same; I asked her questions, I shared what my experience has been like and what kinds of barriers we might experience when working together.

PK described attuning to and helping clients become aware of their emotional needs in relationships by using her knowledge of attachment to facilitate corrective emotional experiences. She shared with a client, "I'm here in therapy with you, I'm impacted by your presence. You are also impacted by my presence, my attuneness, my focus, my loving kindness."

Provide Psychoeducation About Decolonizing Therapy. Participants typically educated their clients about decolonizing therapy. PL offered psychoeducation as part of gaining

consent for engaging in cultural healing practices such as smudging. PK shared Resmaa Menakem's books with a client to make more explicit connections between the client's presenting concerns and her ancestral history. PE recommended books about how and why rest is needed to break the White supremacist cycle of work, burnout, depression, and anxiety.

Disclose Thoughts, Feelings, Experiences, and Healing Practices to Facilitate Client Insight. Participants variantly self-disclosed to facilitate client insight about psychological patterns and systemic oppression. PI said,

> One of the ways that has allowed for her [the client] and I to connect is for me to share some of my own journey, and how the need to people-please, the need to meet other people's needs has been her adaptive and superpower parts of herself that have, it's a survival aspect.

PK disclosed to highlight the shared and communal nature of her client's immigrant experiences to foster a corrective experience of not being "othered" as a person of color. PK told the client, "That really resonates with me," or "that really resonates with my immigrant experience," "you're not alone," "that's an experience that myself and other folks that I've talked to who have immigrant backgrounds [relate to]." PK believed that the mutual connection facilitated the client's reconceptualization of the things their ancestors had done to survive colonialism as "protective, not defective."

Depathologize Psychological Experiences. Participants variantly depathologized clients' psychological experiences by focusing on strengths and survival narratives and by reconceptualizing psychological symptoms as relationships with spirits and ancestors rather than as individual deficits. PP worked with clients "in a more holistic framework, so that you're not just seeing them as their deficits or symptoms . . . Who else is sitting on their shoulders or

standing behind them? What were their stories of healing?" Recalling one client who had been diagnosed with "alcohol[ism], anxiety, and depression," PL said,

> Alcohol is something that she has come to develop a relationship with that helps her to not have to feel the deep pain of the traumas that she's experienced. This, over time, has developed into an abusive relationship where she is being harmed by the alcohol and by the spirit of that alcohol. Within natural law, reciprocity is very important, and so one of the things when people are using alcohol or drugs to help medicate themselves, to help ease the pain that they're experiencing that feels too much for them to deal with or to face, is often they are not engaging with those drugs or alcohol in reciprocity. So, in the ways that I've been taught, when we go pick medicines, or when we harvest foods, we offer tobacco, we always offer something in exchange, because that's part of natural law, is that reciprocity piece, that if I'm asking for something, if I'm taking something, I must offer something in return. Often when people get into these relationships with drugs or alcohol, they're not putting those offerings out, and so what will happen, because they are not offering something for what they're asking for, is the spirit of that substance, you know, the spirit of alcohol, or whatever drug it may be, starts to take from them.

Help Clients Resist Impacts of Colonialism by Facilitating Connection and Reconnection

Under this general category, there were three typical and one variant subcategories.

Use Somatic Interventions. Participants typically implemented somatic and body-based interventions with clients to facilitate connection with the body. For PC,

> [The client was] talking about a frustration they were having with their partner at the time. They kind of did something like this [shakes fist with knuckles down]. I invited them to think about "what happens when your fist is like that? What is this doing?" And

> part of that, for them, they were like "well I'm kind of protecting myself. And I'm also feeling frustrated." And I was like, "okay, let's think about the shape, and if you're open to it, can we experiment with this shape? So, what happens if you open your hand?" [opens hand] "Or what happens if your fist is the other way?" [closes fist and turns knuckles up] "What does that feel like?"

PE used somatic work to help a client practice boundary-setting,

> We might do boundary work where she's standing on one end of the office, I'm standing on one end, and I'm walking towards her, and I want her to say "Stop" when I get to a place where she just wants me to stop. And then we examine, “What was it in your body that knew you wanted me to stop?" And then we do that again, "Now I want you to say "Stop" louder, and with your hands up, like with more assertion. "How does that feel in your body?" "What came up for you to have to do that, and for me to listen to it?"

Incorporate Clients' Cultural Healing Practices and Ancestral Teachings.

Participants typically invited clients to bring their own cultural healing practices and ancestral teachings into the therapy work. Regarding their work with a client who explored cultural death and grieving practices, PN said,

> Last year actually was the first year they ever raised an altar and engaged in that practice, and now this year helping them think through that again and explore it. So a concrete example was: last year, really helping the client think through it and think through how, and if at all, there was community near them that they could go to, to do it in community. And they did find community, and they were able to create their own altar at home and then have a community altar, and then they brought the pictures into session—we could talk about it and process it.

PS helped clients identify ancestral teachings and practices,

> I'll often ask questions about what are ways in which your particular kind of resistance to this colonial violence comes to you through your family and your community, where did these decolonial practices come from historically . . . especially for those of us who are not White, usually—who are not White and cis, especially, and heterosexual—that somewhere in our histories, we have teachings and histories of decolonial struggle, and that that history can be a really useful resource in equipping us to understand the ways in which we resist now, and in finding ways to leave us equipped even more to resist whatever kind of colonial violence we're encountering.

Help Clients Develop Relationships with the Land. Participants typically helped clients resist the impacts of colonialism by developing relationships with the land they occupy and that their ancestors historically occupied. PD said, “I'm talking more with clients about what is the land that we're on? What is your connection with your land and lineage? Where are your ancestors from?” PJ encouraged clients to reflect on the relationships they have with the land and environment around them; with one client, PJ did “a lot of attachment work with the sun, and they're in deep relationship with a creek near their house, and so how do they check in on the creek. And the decisions that they make, how does the creek feel about that.”

Help Clients Connect with Alternate Versions of Themselves and Others Through Parts-of-Self Work. Participants variantly helped clients engage with imagined aspects of themselves. PK recalled,

> We've done a lot of naming of the intergenerational trauma, we've done a lot of looking at her parents' immigration history and giving her a chance to sit with those stories in a different way and be curious about younger mom and younger dad. And do some parts

> work with that. So, like younger dad meeting your young self and how some of those habits, how did those habits become transferred? Then having a choice, do we want to continue in this way, is there a different way that we want to be in the present.

PQ guided his client through a two-chair exercise that involved separating themselves from the part of them that represented internalized colonial trauma. He said, "So then, now, we're two: instead of the person being absorbed in the trauma, it's I'm here in a dialogue with what I view as an internal representative, an internal visualization that encapsules a familial, personal and colonial trauma."

Expand Beyond Individual Therapy

To correct for limitations of individual talk therapy with regard to addressing client concerns, participants generally tried to open the therapy space to community and family members, as well as connect clients with external healing practices. For PB,

> I will tell clients that if they're interested in doing this work, it didn't begin here and it doesn't end here. The therapy, once a week model of talking about it, isn't going to quite get to everything, which is why I'll bring some of those embodied or ancestral practices into the room if that is okay with the client. And if not, I will always send them resources that might feel relevant or that might resonate with them so that they can explore it at their own leisure and in their own timing.

For PE, "bringing in family as needed, especially for folks who come from more collectivistic cultures where bringing in family into the work, or family members, can be really helpful."

Participants practiced from the perspective that healing experience from therapy also expanded beyond the individual. For PN, therapy was "a gradual process that involves our

physical, spiritual, emotional, bodies and energies, and then is across time . . . it [healing] ripples out to other members of community, to ancestors, and hopefully to future generations to come."

Having a willingness to expand beyond their own knowledge of healing practices was an important part of participants' decolonizing practices. PP described practicing humility by maintaining the perspective that other types of healing and other practitioners might be a better fit for her clients than talk therapy. She reflected,

> It is kind of adopting this humility of realizing, okay, my approach and my therapy might not be the best fit for this client; am I willing to go beyond and explore who I know in this community that can help them better. And that's not just another therapist: it could be somebody from their community or another type of healer that feels like a better fit.

Embody a Decolonizing Philosophy and Attitude

There were two typical and two variant subcategories within this general category.

Therapists Are Intentional and Mindful of Language Usage. Participants typically described language as a powerful tool that could be used to facilitate decolonial healing. For example, PL suggested that "client" and "therapist" labels perpetuate harmful power dynamics,

> The people who are coming to me for help, who I do not call clients because that, again, is part of colonialism, and part of decolonizing is removing that language. There's a couple of words that I've been taught to use: one is manitou, spirit, acknowledging that person as a spirit, and I am a spirit, we are all manitou, and being connected in that way, and another one that was shared with me, which is okay too, is okehokew, which is Cree for guest, so this person is a guest, and we are there kind of hosting them.

Therapists also shifted their language to de-pathologize client experiences. PP used "human language" rather than diagnostic language to help clients understand diagnoses beyond

their associated labels. PS tailored his language to name the colonial and structural context of clients' suffering based on what they believed would resonate with the client,

> What I say is a lot more contextual, not so much to which size of wrench I have pulled out of my toolkit based on the shape of the problem, but more about what will land, what is useful common language between me and the client. But the orientation and the understanding is always filtered through this decolonial understanding.

Practice Intention Over Intervention. Participants typically described their implementation of decolonizing therapy as unstandardized and rooted their practice in decolonizing intentions and values. For PP, "decolonization is about intention: what is your intention behind an act." PS said that therapeutic interventions grounded in decolonizing philosophy and intention would not be objectively recognizable as if they were from a manual, "it makes it seem like somehow it's supposed to be hidden, and that's not what I mean, but just that the importance isn't the techniques." Similarly, PJ cited Vanessa Andreotti's metaphor that decolonizing is

> More like we're in such volatile, uncertain, chaotic, ambiguous times that we're just all trying to have a raft. And maybe my raft bumps into your raft . . . But then we'll disconnect . . . this isn't a franchise; she's not trying to create a centralized decolonization dot com.

Participants suggested that decolonizing intentions are informed by values of love, humility, patience, kindness, and consistency. PL brought these values into therapy by "fully respecting [the client], fully honoring her, listening to her. I wasn't imposing a "Oh, we need to reduce your drinking" . . . I'm being with the person in front of me as they're showing up with me."

Facilitate a Slow and Non-Linear Therapy Process. Participants typically implemented a slow and steady approach to therapy, describing it as a lifelong journey without an expected or possible end. PC said that the practice of decolonizing therapy is a "slow process" that involves time to build connection and develop trust. For PL, decolonizing is

> An ongoing process and it will always be an ongoing process, because there will never be a 'final decolonization' . . . [that] would imply a full return to the way that things were pre-colonialism . . . So decolonization is not possible, at all. The best we can do is engage in decolonizing, as much as we are able to.

Use Interventions from Established Therapy Models That Fit Their Decolonizing Approach. Participants variantly implemented interventions rooted in mainstream or established therapy models when the values and intentions aligned with decolonizing. PK incorporated skills from CBT and DBT into early therapy sessions to help clients alleviate debilitating symptoms (e.g., of anxiety or depression) so that they could engage in deeper decolonizing work. PP said,

> My philosophy isn't to reject everything that Western psychotherapy has to offer. It's not like an "or," so it's either CBT or decolonizing framework . . . It's really about, let's start off with this decolonizing framework, and then if some interventions from CBT or somatic therapy make sense, then they can come along to that party.

Credit Their Sources of Knowledge About Decolonizing. Participants typically credited the knowledge holders, mentors, resources, and trainings that shaped their knowledge and practice of decolonizing. A table of these credits can be found in Appendix H.

Engage in Self-Care and Maintain Connections with Professional Community and Mentors

Participants variantly indicated that an important component of their decolonizing therapy work was engaging in self-care and seeking mentorship and consultation from community and peers. For PC,

> Part of it is caring for myself, and part of it is reaching out to other people to care for me . . . having those other voices help resource me, as well. I think it's part of my decolonial approach to resourcing myself, because I think there's so much talk about self-care, and at the same time, there's no way for me to do this job by myself. I think from a traditional, White supremacist, capitalist point of view, that's a failing on my part. And on the other hand, it takes a village. So, I'm going to let the village in.

Domain 3: The Influence of Sociocultural Identities on Decolonizing Therapy Practice

Participants reflected on how their sociocultural identities, those of their clients, and the match between themselves and the client shaped their decolonizing therapy work.

Therapist Sociocultural Identities Shape Their Decolonizing Therapy Work

Therapists generally described ways in which their own sociocultural identities were central to shaping their practice of decolonizing therapy. There were two typical subcategories under this general category.

Therapist's Experiences Shape Their Understanding of and Connection with Clients. Participants typically discussed how their histories and sociocultural locations offered them insights about how their clients may carry and experience impacts of colonial trauma. PS said, "a key piece of how I think about this work described as decolonial therapy is that it is making visible our social locations and histories of those social locations for clients, and it kind of has to be, for me." PS used his sociocultural identities to facilitate exploration of clients' experiences, "I can ask a question by locating myself and being like how is that relative to your

experience, or how does that fit, and then they can locate themselves." Similarly, PK recalled how her own experiences as a person grounded in collectivist culture and as a child of immigrants deepened her work with a client, contrasting this with the client's previous work with a White therapist from an individualist culture.

For some therapists, experiences related to their own sociocultural identities were a barrier to understanding and connecting with clients. For instance, due to their difficult familial history, PC felt disconnected from their racial identity and cultural knowledge. Thus, PC encountered difficulty with clients who had a similar racial identity because of expectations these clients sometimes held for PC to understand cultural traditions,

> In some ways, the racial piece feels complicated, because I feel not as connected to that part . . . there's a lot there around not knowing a whole lot about traditional stuff, or people in session expecting me to know something that I don't know.

Clients Seek Out Therapist Because of Sociocultural Identities and Values. Participants typically shared experiences of clients seeking services from them due to their stated and visible sociocultural identities and values. PB said,

> I try to be pretty transparent around some of my values, or the work around decolonization, in whatever publication I put out about myself on my website or Psychology Today. And I think that folks for the most part gravitate to that when they're asking some of those similar questions themselves.

Similarly, PI shared,

> Oftentimes when [clients] reach out, they mention that is an aspect of why they were drawn to me in the first place. I think I share a lot of my identities on my website, I share a little bit in terms of my own healing journey, and I think that is what draws them to

> wanting to work with me. And so a lot of our identities are very similar and backgrounds are similar.

Client Sociocultural Identities Shape How Therapists Work with Them

Therapists were generally responsive to clients' sociocultural identities in their practice of decolonizing therapy. There was one typical and one variant subcategory.

Therapists Were More Explicit About Decolonizing Therapy with Clients Who Were Knowledgeable About Colonialism and Willing to Engage in Decolonizing. Therapists typically attuned the level of explicitness with which they referenced systems of oppression in sessions to better facilitate healing to fit client readiness. PD said,

> On the one hand, I really look at somebody's readiness and what they're talking about in therapy. But on the other hand, I actually think I'm practicing more this way with everyone . . . it makes me think of the racial identity models that we've all been exposed to, and that when someone is in a particular place, certain kinds of interventions are going to work better than others. And I think the same is true with decolonial work. I notice that there are certain clients who I'm really talking with them about it . . . And then there are other clients who are, maybe I'll just give them this one little homeopathic drop and see how it affects their system.

Relatedly, PP thought that decolonizing therapy is

> About meeting people where they're at. Because people are going to come to us that come from different backgrounds and different levels of connection or disconnection from their communities, from their ancestors. So, it is really about, this person sitting in front of me, do they have strong roots that they're aware of and conscious of, are they

> going to be willing to work with me within this framework completely, or do I need to start off with a framework that makes more sense to them.

Some Client Identities Motivated Therapists to Critically Examine Power Dynamics. Participants variantly engaged in critical examination of interpersonal power dynamics based on their clients' sociocultural locations. For instance, PC thought that mandatory reporting and the systemic structure of therapy is particularly important for clients who are inherently distrustful of medical systems due to historical trauma. Working with these clients made PC intensely aware of their role in the medical system and motivated them to find creative, non-systemic solutions to ethical dilemmas,

> Some of my clients . . . don't trust medical systems, and have histories with them that have been traumatic. And so I think there's also something about their own personal histories around that and relationship to systems that I think makes me aware, as a gatekeeper of the systems, how much I'm leaning on that system and how much I'm feeding them back into that system, and how to think about non-system ways to approach their needs.

Match Shapes Decolonizing Therapy Work

Participants generally discussed how the level of sociocultural match between therapist and client shaped their decolonizing work. There were two typical subcategories.

Shared Identities or Values Between Therapist and Client Make Decolonizing Work Easier. Participants typically believed that having shared sociocultural identities and values helped facilitate decolonizing therapy with their clients. For instance, PE said, "It's easy to do this work with somebody who thinks in very similar ways." She described feeling "free" to use self-disclosure to explore "[setting] boundaries in culturally congruent ways" with clients who

shared her East Asian, collectivistic cultural background. PI similarly recalled how shared identities facilitated interpersonal connection and healing for one client,

> We share the immigrant experience. We share the proximity in terms of our family having navigated war, and we also share a healing journey that is very similar in terms of how our internalized oppression have been formed and our identities have been formed by these oppressions.

Lack of Shared Identities or Values Between Therapist and Client Makes Decolonizing Work Harder. Differences in sociocultural identities or values typically made decolonizing therapy more difficult for some therapists with their clients. For instance, PS described that he could not use his own sociocultural experiences as "shortcuts" to help understand and connect with clients who did not share his sociocultural locations; instead, he helped clients with different identities explore their relationships with colonial structures by asking cautious and curious questions. When he worked with a queer client, PS (a heterosexual therapist) said,

> That isn't an identity location that I share, and so that's a piece where, when we encounter pieces that are more directly connected to queerness and homophobia and how that lives (and also how that lives in their particular community of origin), that gets to be a place where I get to approach with more curiosity and tentativeness.

PI (a therapist of color) reflected on the differences between her work with POC and White clients:

> The focus has been so much around oppression that I don't name the privilege for my White clients as much as I would like. And I think that is because of the dynamic between myself and my White clients, that I perhaps am not tuned into until now. And

> that, I would say, would be something that I want to be able to step into more in this approach, in decolonizing my practice.

Some participants discussed challenges that therapists of color experienced specifically regarding practicing decolonizing therapy with White clients. Participants spoke about having feelings of discomfort and lack of personal emotional safety. PC said,

> I've had a couple of White trans clients who specifically sought out me as a clinician of color, and I've been turning that around in my mind in so many ways. I think there's something about acceptance there, and wanting to be seen for who they are, and the sense that because of my experiences, I will be able to do that. And yet, there's also this weird dynamic of—you want a Brown person to serve you, basically [laughs uncomfortably].

Through the interview process, PN gained insight about how their own identities as a queer and nonbinary person of color impact how safe they feel practicing decolonizing therapy with White clients. PN stated they exclusively practice therapy with POC clients,

> I'm very aware that there's a part of me that is hesitant—not because I don't think it's necessary, I just don't know if I have the capacity to do that work with White folks exclusively . . . that may even be one of the reasons why, whether consciously or unconsciously, I've only been working with Black and Brown, Indigenous folks the last few years.

Domain 4: Challenges in Practicing Decolonizing Therapy

Participants discussed barriers and challenges that made it more difficult for them to engage in decolonizing therapy practice.

Lack of Clarity About How to Practice Decolonizing

Participants typically felt unclear about the practice of decolonizing therapy due to limited guidance, support, mentorship, and resources. PD said,

> I feel like what I'm going to be left with after our conversation and where I feel like I'm running into a wall in myself is what it looks like, intervention. And how it's not just conceptualization, but what I'm doing with someone in the room. I feel like that's where I'm going to really want to look next, and I'm just realizing in our exchange that that's not as materialized as I thought it was.

Although her graduate training included conceptual and theoretical discussions about social justice, guidance about practical implementation was limited. PI said,

> My wish and hope is that there could be a bigger, broader community of therapists who are doing this, that there could be a lot more support and dialogue and spaces of learning institutions that are implementing practices, teaching.

Therapists are Cautious About Claiming to Be a Decolonizing Therapist

Therapists variantly lacked confidence about using the label "decolonizing" to describe themselves and their work (note that only non-Indigenous therapists mentioned this). For instance, PS was mindful of how some Indigenous scholars have advocated for the term "decolonizing" to be used exclusively to describe land-back movements,

> My therapy is not about talking to settlers and . . . getting them to return colonial territories . . . back to Indigenous governance. It's seeking to do a bunch of other things, it's informed for me by a lot of decolonial struggle and writing and thought, but it's not doing that thing that I think I'm hearing some Indigenous voices that I respect saying we want to be really focused on. It's not doing that thing of actually returning land. And so I

> want to be careful to distinguish broader justice-seeking work from this project of decolonization, and so that makes me kind of tentative.

Therapists Fear Violating Professional Ethical Standards if They Practice Decolonizing Therapy

Participants were variantly concerned that because decolonizing is a form of resistance, upholding decolonizing values in their practice may go against established professional and ethical standards of counseling. PP grappled with how clinicians may shift into a self-serving rather than decolonizing focus out of fear of getting in trouble with the licensing board,

> It seems like people are just so scared about being sued, so let me just kind of ask the right questions to do this risk assessment so that I don't get sued, so I can report it and record it in the right way.

Some therapists believed there is a mismatch between their moral obligations to maintain client safety and ethical obligations to notify authorities of safety concerns. For PE,

> When a client is suicidal, and they don't come in, we want to do a welfare check. That's just kind of what we would do if we think they are in danger or they might be suicidal. But if you have a Black client and you know that puts them at risk, that there have been welfare checks that have led to the murders of Black people, how do I do that [while] acknowledging that?

Power Dynamics Are a Barrier to Practicing Decolonizing Therapy

Participants variantly struggled with the dissonance between inherent power dynamics in therapy and the decolonizing value of shifting away from hierarchical relationships. PB questioned whether she was imposing her decolonizing beliefs about health and wellness onto her clients, which would be antithetical to decolonizing, “Is it sort of a values expectation that

I'm starting to place on the work that I do myself, or even on my own clients' wellness, or my definition of their health?"

In contrast, PE believed that it could be harmful to dismiss the power and hierarchy that is present in a therapeutic dynamic,

> I think part of the work is knowing that I have power. I think that's the other thing that a lot of newer therapists struggle with, which can become disempowering, is to disown one's power. And that's actually when sometimes traps can happen where you actually perpetrate something not knowing that you hold the power that you do.

Colonial Foundations of Society Are a Barrier to Practicing Decolonizing Therapy

Participants variantly encountered challenges in upholding their decolonizing values due to living in a society that has historically been shaped by colonial ideologies. PN wondered, "How do I actively decolonize my . . . practices, while working within a system that is deeply colonial and racist and embedded with many systems of oppression." Similarly, PQ said, "There's challenges of being within a healthcare system that I don't particularly like in this country . . . it's also therapy, it's also a business, and also you have to make money."

Therapists Struggle to Balance Decolonizing Values with Standardized Therapeutic Approaches

Participants variantly struggled with using familiar therapeutic approaches despite being aware that the foundations of these approaches are in colonial ideologies. PK described that she uses

> a narrative approach, that I'm not the expert, the client is the expert in their life. So that really resonates with me. And I recognize that narrative therapy is really White, male

> centric. So, for me, [the challenge is] recognizing that and also finding this particular nugget very useful, and really useful for [clients] to hear.

Similarly, PN thought it was important

> to recognize that I do still have a theory, that I do think comes from a colonial mindset and perspective. So, I do identify as a Gestalt therapist, and I say that knowing that Fritz Perls and Laura Perls were White folks who were in South Africa for some time and did some work there, and there's lots of examples of colonization in South Africa. And then they moved over to what we call the United States and did a lot of work in New York and California, where again they brought this quote-unquote "wisdom" and framework and theory into the Western world.

Domain 5: Outcomes of Successful Decolonizing Therapy

In this section, we describe clinical changes that therapists noticed as a result of their decolonizing therapy practice.

Improvements in Client Intrapersonal Functioning

Participants generally saw improvements in clients' intrapersonal functioning. There were one general and three variant subcategories in this section.

Increased Self-Empowerment. Participants stated that clients generally began to take ownership of their strengths and lean into their ability to liberate and heal themselves. PS said that he aims for clients to

> feel a bit more solid in themselves about their resistance to whatever has been attacking or harming them . . . I hope that people feel a bit more equipped to do whatever small piece they can in resisting this broad system of colonization and all of these intersecting systems of structural violence. That they leave our conversation with a bit more of a fire

> in their belly about actively resisting and dismantling some of these systems of structural violence that we've been suffering under for such a long time, in different ways, depending on our histories and locations.

PC described that their client

> feels really invested in their own experience, and to me, that feels like success. It's not about them being dependent on me; I feel like the roles are really clear. They really are the leader in this, and I'm almost like a consultant in their own self-study.

Increased Systemic Understanding. Participants variantly noted that their clients developed a greater understanding of how their suffering was contextualized in systemic oppression. PD described that one of her clients had

> externalized some of her understanding of her struggles . . . she used to be kind of blanketly despairing and hopeless and down on herself for feeling so bad, for having so much anxiety and so much depression and so many PTSD symptoms. And I think she now has a different conceptualization of where that comes from. I think she has sharper critical thinking skills, she's more able to spot and identify where some of her attitudes and thoughts come from. I think she's begun to step aside from grind culture a little bit.

Increased Empathy for Self and Ancestors. Participants suggested that clients variantly developed empathy for themselves and their ancestors as a result of understanding the systemic context of their suffering. PQ noticed that his clients

> start to have empathy of, oh, it must have been so hard for my dad and for that whole generation of people—they were in that survival and of course, if you're trying to survive those environments, of course they disconnected. And there starts to be more empathy

> around, now that I'm here, I can see how painful it is to be there, and how much pain my ancestors must have experienced.

Decrease in Symptoms. Clients variantly decreased psychological symptoms; for PE, "Symptoms are decreasing, like their distress is decreasing." Therapists variantly thought this symptom decrease was associated with increasing clients' capacity for distress. For PJ, healing looked like "an aliveness, or a larger window of tolerance." PL similarly described healing as

> a shift in people's relationship with their difficulties. That seeing over time that they develop a different relationship with the triggers that come up, with whatever it would be labeled—anxiety, depression, trauma—however they understand it, that they come to a place where they are better able to be in relationship with it. To allow it to be there, to be curious about it, and to be able to tap into the medicine of it.

Improvements in Client Interpersonal Functioning

Clients variantly experienced improvements in their interpersonal functioning and relationships. PD shared that one client is

> in a really loving relationship for the first time. Up until now she's been in relationships that really recapitulated some of this [oppression], that were neglectful and made her feel bad about herself, and people weren't really available to her.

PC described noticing their client "reaching out to family that they've had conflict with. They're curious about what things could look like, coming from a place of possibility or abundance. To me, that's where I see progress."

Positive Impacts on Therapists

Participants variantly felt positive personal impacts of practicing decolonizing therapy with their clients. For PN,

> [The client was] taking antidepressants and anxiety medication after having experienced the sudden death of their partner at that time. And coming . . . into the space of wanting to grieve in a different way, and not wanting to be afraid of their grief. And that really encouraged me to lean into my own experiences of grief and my own beliefs around the death and dying process to support the client in this deeper exploration. And after months of work and really supporting the client in no longer taking this very pathologizing view of their pain and grief as something that needed to be medicated . . . that encouraged me to also unlearn some of those things for myself as we were exploring them together.

Therapists Use Non-Standardized Forms of Assessing Success and Outcomes

Participants variantly did not use standard or typical methods of assessing the outcomes of their decolonizing therapy practices. Some also avoided using terms and concepts like "success" and "outcomes." PL commented,

> It's such a colonial question about "What's the criteria for success?" So let me think, because I just think about it in a different way. Honestly, it's really just a matter of checking in with that person. Like I said, this cannot come from me.

PJ said, "There is a vibe [laughs] I know it's not really quantifiable. But I think there is a vibe that something is flowing, is clicking, that that would be successful."

Domain 6: How Therapists Practice Decolonizing in Their Non-Professional Lives

This domain was not directly associated with questions on the interview protocol but rather emerged organically through the interview process.

Practice Critical Self-Reflection

Participants variantly described engaging in critical self-reflection. PK described a recent conversation with her sibling about the prevalence of impatience and urgency in their family, and how these values are “rooted in misogyny,”

> Having done my own therapy work around that, that's where it comes from. So, it's not even a philosophy, it's really embodied practice. For my survival in a way that I'm not, like Resmaa says, "weathered and withered" by colonialism, I have to name these things, and I have to live with these things decentered.

PE questioned, “Am I doing it enough? Are there parts where I'm still upholding colonized ways of practicing or thinking? And, of course, I am. I think it's gonna be a lifelong process to decolonize ourselves.”

Engage in Community-Building and Social Justice Advocacy

Participants variantly discussed their engagement in social justice advocacy outside of their decolonizing therapy practices. For PJ, decolonizing was

> taking the next step on the tightrope between desperate hope and desperate hopelessness. And [knowing] that what holds that . . . is intellectual rigor on the one side . . . the other side of the tightrope is the relational rigor. And the relational rigor is, that's Duwamish Solidarity Group, that's working with [mentor] and the Living Room Collective (politicized therapists), and it's so hard. It's, like, really painful.

Actively Disinvest from Colonization in Daily Life

Participants variantly discussed areas of their life where they disinvest from the influence of colonialism. For instance, PD thought of her “personal process of decolonizing” as

> taking away those veils and those shrouds and really looking at where everything comes from and the violence that everything is based on. For me, I've been in study for a

> number of years now about everything from the food I eat, to where my clothes are made, to what electric cars really are about and utilize, and it's everything!

In addition to personally disinvesting from colonial practices, PN described teaching others similar practices and values,

> I just did a workshop with a few students here at the university around reconnecting to our ancestral medicine, and one of the students that was facilitating with me was like "oh, we should get some sage sticks," and was like, "here, I found a bunch on Amazon," and I was like "oh, no," [laughs] I was like, "I won't buy my smudge sticks from Amazon." They were like "really?" I was like "yes, and especially White sage." So, inviting a conversation around why not and what it means and what is the harm, from what I know, knowing that I don't know all of the harm that it causes. And then saying, "However, I do create my own smudge sticks, and this is how," so then sharing with the student the importance of harvesting your own herbs that you can use on a smudge stick.

Discussion

In this research, I proposed five research questions: (a) How do decolonial therapists conceptualize psychological problems? (b) How do therapists implement decolonial therapeutic approaches with their clients? (c) How do decolonial therapists assess the effectiveness of psychotherapy? (d) What facilitated the development of therapists' decolonial therapeutic approaches? (e) What barriers did therapists encounter in developing their decolonial therapeutic approaches? In this section, we discuss the results in the context of each original research question. We also identify findings that emerged outside of the original research questions and identify implications for future research, practice, and training. See Appendix G for the organization of the results in table format.

Research Question A: How Do Decolonial Therapists Conceptualize Psychological Problems?

Overall, participants did not directly answer this research question even though it was posed in the interview protocol. Instead, they discussed problems with colonial paradigms (domain 1) on the individual, relational, and societal levels and described how these colonial paradigms serve as a context for mental health concerns. In addition, their case conceptualizations were generally evidenced in their therapeutic work by helping clients shift away from colonial conceptualizations of mental health and facilitating new conceptualizations of psychological experiences (see domain 2: "how therapists practice decolonizing psychotherapy"). From these data, we surmised that therapists conceptualized mental health concerns in terms of systemic oppression stemming from colonialism. More specifically, they intentionally shifted away from mainstream understandings of mental illness, which tend to focus on deficits within the individual (Adames et al., 2022), and toward a holistic understanding that psychological experiences reflect historical and intergenerational reactions to survival within colonial systems. The relevant categories and subcategories from domains 1 and 2 (with associated domain noted in parentheses) will be discussed here as they inform our understanding of how decolonial therapists conceptualize psychological problems.

Problems with Colonial Paradigms

Individuals Are Negatively Impacted by Internalization of Colonial Values. In alignment with authors describing decolonizing, liberation, and ethnopoliticism (Comas-Díaz, 2007; Menakem, 2017; Mullan, 2023), nearly all participants suggested that pervasive colonial paradigms are responsible for psychological problems. In extant literature, adoption of colonial values is considered to be a result of experiencing colonial trauma or surviving under colonial

oppression; Duran (2006) referred to this as internalized oppression. Participants typically understood colonialism as a core traumatic wound (Menakem, 2017; Mullan, 2023) and believed that clients' current presenting concerns could be traced back to internalization of colonial trauma. For instance, they described productivity and perfectionism as capitalistic values that, when internalized and perceived as an individual's own values, created psychological problems such as anxiety (e.g., persistent feelings of urgency and worry) and imposter syndrome. Duran similarly conceptualized that internalization of colonial trauma created psychological problems by wounding the soul and emphasized the importance of grounding our understanding of the problems we are treating in the context of the historical oppression that created them.

Relationships Are Damaged by the Influence of Colonial Ideologies. Participants typically believed that colonial ideologies like individualism and associated colonial tactics such as isolation was damaging to relationships. Similarly, other authors have described individualism as a core tenet of the psychotherapy profession that perpetuates harm (Rhodes & Langtiw, 2018) due to its alignment with colonial divide-and-conquer tactics (Millner et al., 2021); historically, colonists strategically isolated individuals and small groups and overpowered them as a means to eventually oppress entire communities (Hall, 2015; Legault, 2022).

Relatedly, participants typically believed that power-based colonial ideologies damage relationships by creating artificial hierarchies in which colonial ideas, values, and identities have a privileged status. In alignment with scholars like Kivel (2004), participants believed that isolation and superiority contribute to the prevalence of current psychological problems by fueling the cycle of colonial oppression. Kivel (2004) and Blackwell (2003) wrote about how people engage in psychological separation between the parts of themselves that align with colonialism (superior) and the parts of them that are oppressed (inferior), and that harm is

perpetuated when people reenact this separation relationally by viewing others as inferior to them.

Colonial Violence and Ideologies Are Woven into the Fabric of Society. Participants typically discussed how colonialism is embedded into the foundations of modern-day society (Wolfe, 2006), making colonial ideologies sometimes difficult to identify, let alone counteract. Similarly, Machado de Oliveira (2021) wrote that colonialism and society have become almost indistinguishable in many ways, and the invisibility of oppression makes it difficult to challenge; this creates persistent cycles of oppression and contributes to problems with functioning. Participants discussed the erasure of Indigenous ways of knowing, being, and doing; Wolfe (2006) used the word "genocide" to describe the colonial project, stating that "settler colonialism destroys to replace" (p. 388). On a smaller scale, participants described colonialism within the field of psychotherapy as the normalization of Eurocentric therapy practices such that other culturally-based or non-Eurocentric practices are described using qualifiers; this creates a divide that aligns with colonial practices of division and control (Rimke & Brock, 2012).

How Therapists Practice Decolonizing Psychotherapy

Facilitate New Conceptualizations. Although participants generally discussed their conceptualizations of psychological problems in the context of how they helped clients develop new conceptualizations of mental health, examining their facilitation of this mental shift provided insight into how they conceptualized psychological problems. Relevant subcategories are discussed here.

Help Clients Internalize New Decolonial Ideologies. Participants generally helped clients replace their internalized colonial conceptualizations of mental health concerns with new understandings of the underpinnings of psychological problems. In some ways, with regard to

this research question, the results in this category mirrored those discussed in the above sections: participants developed their conceptualizations of psychological concerns by facilitating client insight about how concerns are rooted in problems with colonial paradigms (e.g., internalized trauma). Other participants resisted pathologizing psychological experiences as a manifestation of trauma; although their conceptualization remained that colonialism was the root of psychological concerns, they focused on connecting clients' current concerns to intergenerationally repeated patterns of strength and survival. They believed the current sources of clients' pain have been shaped by habits ancestors developed to survive in oppressive conditions. This mental shift from a narrative of trauma to a narrative of strength aligns with Vizenor's (1994) concept of survivance, an Indigenous counternarrative and argument that viewing people as traumatized maintains their powerlessness and contributes to oppression by keeping them victimized. Thus, in addition to conceptualizing psychological problems as rooted in systemic oppression, participants employed a perspective of strength and resilience.

Depathologize Psychological Experiences. Some participants reconceptualized psychological problems as manifestations of relationships with spirits and ancestors. Similarly to other non-Eurocentric understandings previously described in literature (Fadiman, 1997; Nagai, 2013; Van Duijl et al., 2014), participants believed that psychological symptoms like anxiety, depression, and dissociation were messages from ancestors meant to guide clients to reestablish harmony between their spirit, body, mind, and environment (Hodge et al., 2009).

Research Question B: How Do Therapists Implement Decolonial Therapeutic Approaches with Their Clients?

Some categories of implementation loosely followed Hill's (2020) psychotherapy framework of exploration, insight, and action, which incorporate knowledge from mainstream

theoretical approaches such as client-centered, psychodynamic, and cognitive-behavioral therapies, with an emphasis on insight (e.g., facilitating new conceptualizations) and action (e.g., helping clients engage in resistance of colonial impacts). Participants also, however, used interventions more unique and explicitly aligned with decolonizing motivations (e.g., helping clients develop or repair their connections with the land (Mullan, 2023).

Develop or Repair the Therapeutic Relationship

Participants generally approached decolonizing therapy relationally, which involved disclosing thoughts, feelings, experiences, and personal healing practices with clients when appropriate. Scholars have previously described decolonizing as a collective, collaborative, and relational healing framework (Fellner, 2016; Hodge et al., 2009; Mullan, 2023). Participants' views on disclosure aligned with Togashi's (2020) discussion of the importance of sincerity in relationships. Togashi suggested that therapists strike a balance between a mainstream blank-slate approach (which compromises the sincerity of the human being), and an overly personal approach (which compromises the sincerity of the professional).

Participants also generally addressed power dynamics in the therapeutic dynamic and fostered client agency in their own healing journeys. They shifted from a hierarchical understanding of a healing relationship to seeing themselves as companions along clients' healing journeys. They encouraged clients to take the lead in therapy given that that they are the experts on their lives, and they provided space for clients to connect with their strengths and power, as have other decolonial therapists (Duran, 2006; Fellner, 2016). Suzuki (2019) wrote that systemic oppression can be reenacted in individual relationships, and advocated for shifting from a hierarchical helping relationship to a more equal one as a way of resisting this pattern.

Facilitate New Conceptualizations

Help Clients Internalize New Decolonial Ideologies. Participants generally helped clients internalize decolonial ideologies. Similarly, Machado de Oliveira (2021) theorized that letting go of colonial habits and adopting new decolonial habits is necessary for the sustainability of decolonizing movements. In addition, participants typically helped clients replace self-blame with a new systemic understanding of psychological problems in which clients understood systemic oppression (rather than individual deficits) to be root of psychological concerns. Some participants believed that conceptualizing psychological problems through a narrative of systemic trauma was a colonial habit that prevented healing by keeping people stuck in victimhood; thus, similar to Vizenor (1994), they helped clients replace their internalized trauma narratives with non-victimizing survival narratives.

Facilitate Insight About Psychological Suffering Being Caused by Systemic Oppression. In alignment with Indigenous scholars (Dupuis-Rossi, 2021; Machado de Oliveira, 2021), Black feminist scholars (Crenshaw, 1991; hooks, 2010), and radical healing scholars (Adames et al., 2022; Comas-Díaz, 2020; French et al., 2020), participants generally facilitated the development of clients' critical consciousness by contextualizing psychological suffering in terms of historical systemic oppression (as noted above). They helped clients gain an understanding of how individual psychological problems develop over time and reflect generations of psychosocial patterns that developed as a direct reaction to colonial harm. In this way, participants helped clients shift out of an individualistic and self-blaming perspective on their mental health concerns, which scholars have previously associated with increased psychological distress (Adames et al., 2022; French et al., 2020).

Help Clients Understand Their Ancestral History. To counteract patterns of intergenerational disconnection, forgetting, and erasure of ancestral histories that they believed

were a result of centuries of colonial rule, participants typically helped clients develop deeper understandings of their ancestral histories. Scholars in extant literature have argued that erasure of ancestral history through forgetting has historically been a form of survival under colonial oppression (Byrd, 2011; Hartman, 2007). Thus, engaging in remembering exercises with clients as a way of reconnecting with their ancestral histories was an important part of participants' practices of decolonizing therapy. This practice was important even with clients who did not have historical memories or knowledge about their ancestral histories given that clients could imagine from their bodily experiences how their ancestors lived.

Facilitate Insight About How Sociocultural Identities Shape Experiences. Participants typically facilitated insight about how clients' sociocultural locations within the context of systemic oppression may have shaped their experiences over time. Parallel to participants' efforts to contextualize mental health concerns in systemic oppression to help clients shift away from self-blame (see section above), participants noted that clients who experienced minoritization sometimes conceptualized their experiences in such a way that they overlooked the influence of sociocultural identities and instead internalized self-blame. In alignment with guidelines established by authors in extant literature (French et al., 2020; Millner et al., 2021), participants raised client's critical consciousness by naming the relevance and role of sociocultural dynamics in their minoritized experiences.

Use the Therapeutic Relationship to Understand Relational Dynamics. Similar to current relational psychoanalytic perspectives about the therapeutic relationship (e.g., Rogers, 1995; Safran & Muran, 2000), participants typically used the therapeutic relationship to understand relational dynamics. They thus viewed the therapeutic relationship as a microcosm of broader interpersonal patterns and a means of exploring past relational experiences that may

impact present interactions (McWilliams, 2004). Furthermore, they used the therapeutic dynamic to help clients gain insight about their emotional needs within relationships (Safran & Muran, 2020) to facilitate connection and community building, which they conceptualized as important to decolonial healing (Millner et al., 2021).

Provide Psychoeducation About Decolonizing Therapy. Providing psychoeducation about the systemic sources of psychological pain, as well as about decolonizing therapy and particular healing practices, was a typical element of decolonizing. Psychoeducation in general has been established in extant literature as a treatment modality in and of itself, cited as effective for symptom alleviation and treatment retention (Lukens & McFarlane, 2006). Regarding healing from systemic injustice-based harm such as racialized microaggressions, psychoeducation has been shown to help increase validation of psycho-emotional experiences, raise critical consciousness, and dismantle displaced self-blame (Wong & Jackson, 2023). Psychoeducation in trauma treatment has been recommended for contextualizing symptoms by increasing understanding and normalization of common reactions to trauma, as well as promoting healing by emphasizing resilience and coping (Ben-Cheikh, 2022). Since psychological impacts of colonialism are considered traumatic wounds (Mullan, 2023), it makes sense that participants would incorporate this type of psychoeducation into their practices.

Use Self-Disclosure to Facilitate Client Insight. Some participants used self-disclosure to facilitate client insight about psychological patterns and impacts of systemic oppression. Researchers have previously suggested that therapists' strategic use of self-disclosure can extend beyond merely establishing rapport to actively facilitating client insight. For instance, Knox et al. (1997) highlighted how therapists' self-disclosures prompted clients to explore previously unexamined aspects of their lives, leading to heightened self-awareness and deeper

understanding. Furthermore, Garrison et al. (2023) found in their qualitative study that BIPOC female group therapists utilized self-disclosure to model authenticity, transparency, and awareness of systemic oppression.

Depathologize Psychological Experiences. A few participants discussed their depathologized conceptualizations of psychological experiences with their clients. As described earlier, participants viewed symptoms as messages from spirits and ancestors highlighting imbalances across dimensions of spirit, body, mind, and/or environment in clients' lives (Hodge et al., 2009). In therapy, they helped clients understand how these imbalances may have occurred; for instance, similar to Duran (2006), one participant facilitated a client's new conceptualization of "alcoholism" as a replacement of their spirit by the spirit of alcohol. In this example, the participant encouraged the client to both call their own spirit back to their body and reestablish a respectful, balanced relationship with the spirit of alcohol.

Help Clients Resist Impacts of Colonialism by Facilitating Connection and Reconnection

Use Somatic Interventions. Typically, participants used somatic interventions, a practice they attributed to the decolonizing literature. More specifically, Menakem (2017) described the use of somatic techniques to facilitate healing from intergenerational trauma wounds. Participants thus helped clients feel how their bodies carried intergenerational trauma (e.g., helping a client explore how emotional reactions to boundary-setting manifested in their body).

Similarly, other writers have described the disconnection between mind, body, and spirit as a manifestation of colonial trauma and emphasized reintegration as a somatic practice (Mark & Lyons, 2010; Mullan, 2023). Comas-Díaz (2020) said that "healing requires harmony between body, mind, and spirit" (p. 174). Our participants used somatic work to facilitate reintegration of body, mind, and spirit in a way that aligned with other frameworks, such addressing exiled parts

in internal family systems therapy (Schwartz & Sweezy, 2019) and splitting in object relations therapy (Hamilton, 1990) to help clients reintegrate these parts of self.

Incorporate Clients' Cultural Healing Practices and Ancestral Teachings. Participants typically incorporated clients' cultural healing practices and ancestral teachings into their individual therapy work. They encouraged clients to bring items into the therapeutic space (e.g., bringing in photos of ancestors for an ancestral altar; engaging in beadwork during therapy). They also asked questions to help clients reflect on ancestral memories and stories to counteract colonial erasure of Indigenous ancestral histories (Comas-Díaz, 2020; Gone, 2010, 2020).

Although participants in our study were intentional in their practices of incorporating clients' healing traditions in therapy, they also encountered challenges in balancing their decolonizing values within the Western therapeutic frame (see Question 5 below). Similarly, Gone (2012, 2020) cautioned that although traditional healing practices are important for healing, incorporating them into "contemporary" (Western) psychotherapy practices is complex. Centering on American Indigenous healing practices in particular, Gone described divergencies between contemporary and traditional frameworks in terms of the secular-sacred (i.e., traditional healing practices that emphasize religion, spirit, and ceremony may not integrate neatly into Western conceptualizations of treatment); rational-mystical (i.e., traditional philosophy that healing involves elements of magic or intangible power may be at odds with Western philosophy); and technical-relational (i.e., traditional healing practices that rely on relationships and community may not integrate neatly into Western individualistic therapy paradigms).

Help Clients Develop Relationships with the Land. Participants typically helped clients heal through connecting with the land. Some participants helped clients connect with the

earth, sun, water, trees, and other beings, aligning with Fay's (2016) belief that positive relationships with nature and the cosmos are vital to psycho-spiritual wellbeing. Others helped clients grapple with their participation in colonial relationships with the land (e.g., helping non-Indigenous clients understand the nuances of how their ancestors' participation in immigration reflected both a reaction to and a perpetuation of colonization, Astolfo & Allsopp, 2023). Similarly, decolonial theorists have suggested that land is vital for psychological wellbeing (Dudgeon et al., 2017; Fellner, 2016; Mark & Lyons, 2010; Mitchell & Dossey, 2018). Because colonialism originally prevailed through land theft, land-based wounds continue to be an anchor of colonial harm through reduced Reservation acreage, erasure of Indigenous people, and segregation and criminalization (Tuck & Yang, 2012).

Not all participants, however, mentioned using land-based healing practices in their work. Similarly, extant literature is mixed with regard to the appropriateness of land-based psychological healing practices in decolonizing work. Decolonial scholars who have advocated for restricting decolonizing terminology to refer to land-back movements (Hartmann et al., 2019; Tuck & Yang, 2012) have criticized other uses of the label as problematic and distracting from the goals of the movement. Other scholars, by contrast, have posited that bringing decolonizing into mental health work expands, rather than dilutes, the movement. Mullan (2023) wrote that the "emotional component" of decolonizing is a necessary part of the framework, stating that "Without the emotional component, in addition to the return of the land, the movements have a danger of staying a theory or the action of a small select few" (p. 318).

Help Clients Engage in Parts-of-Self Work. Participants sometimes utilized parts-of-self work, rooted in Internal Family Systems (IFS) theory (Schwartz, 1995), to help clients achieve a more holistic and integrated sense of self. Schwartz described that on an individual

level, people perceive themselves in terms of parts and try to "exile" parts of themselves they perceive as repulsive, weak, or shameful (p. 28). On a societal or systemic level, Schwartz described that similar practices of exile occur interpersonally where certain sociocultural groups are made to feel inferior in a hierarchical system. Our participants aligned with prior researchers who have bridged these concepts by suggesting that people internalize oppressive messaging about certain sociocultural identities or ways of being that are typically exiled in society, and "exile" the parts of them that align with the oppressed identities or values in an effort to experience less systemic oppression (Schwalbe et al., 2000; Smith, 2022).

Expand Beyond Individual Therapy

Participants generally expanded their practice of decolonizing psychotherapy beyond the confines of mainstream individual psychotherapy, believing that decolonial healing cannot occur in isolation. Practitioners invited family, community members, and ancestors into the therapy sessions. They suggested the healing process for their individual client would have a "ripple effect" across their communities. They also developed relationships with other clinicians, healers, shamans, and elders and facilitated referrals to help clients connect with healing practices outside of mainstream individual therapy. Similarly, other scholars (Fellney, 2016; Lewis et al., 2018; Rhodes & Langtiw, 2018) have advocated for community-based approaches to mental health treatment to address psychological problems stemming from colonialism.

Embody a Decolonizing Philosophy and Attitude

Therapists Are Intentional and Mindful of Language Usage. Participants typically asserted that language is an important part of decolonizing. For instance, participants disliked using diagnostic language (Dupuis-Rossi, 2021), and some critiqued using the term "client," as

others have previously critiqued “patient” or “consumer,” to describe the people they helped (Costa et al., 2019).

Participants typically aligned with narrative scholars like Kamya (2007) in their belief that language is not neutral but rather is central to shaping our reality; therefore, anti-oppressive and decolonizing language must be intentionally used throughout decolonizing practice. Decolonizing theorists believe that language has historically been used as a tool of colonial oppression to erase Indigenous histories and languages (Simpson, 2011; wa Thiong'o, 1986) and perpetuate sociocultural hierarchies (Jeewa & Bhima, 2021; Kivel, 2017). Language has been used to wield power over minoritized sociocultural communities. Some scholars even critique the use of the word “minoritized” as it centers and normalizes colonization—perhaps “non-colonizer” or “non-settler” would be more aligned with these critiques (Machado de Oliveira, 2021; Mullan, 2023). Scholars have also critiqued the pathologizing language used to describe Western mainstream conceptualizations of psychological suffering as disorders and deficits (Goodman et al., 2015; Vera & Speight, 2003).

Practice Intention Over Intervention. Some participants advocated that a decolonizing framework is more relevant for practice than a focus on specific interventions, describing intentionality as the key that makes an intervention decolonizing. More specifically, they were informed by their understanding of colonialism as an anchor for a far-reaching web of systemic oppression, including patriarchy, heterosexism, racism, and capitalism. Similarly, some scholars have advocated for embracing theoretical frameworks rather than interventions as guidelines for practice (Marsella, 2015a; Singh et al., 2020).

Other participants, by contrast, described their implementation of decolonizing therapy as a mix of established and unique interventions. For instance, like Smeja’s (2019) study exploring

the use of narrative therapy techniques in decolonizing practice, participants often used interventions that were directly from or reminiscent of other established frameworks of psychotherapy, including Gestalt, psychodynamic, narrative, client-centered, and several others. Similarly, Hodge (2009) suggested that having a decolonizing intention means using a decolonial framework to understand when it is appropriate to use mainstream (Western) or non-mainstream (non-Eurocentric) psychotherapy interventions.

Facilitate a Slow and Non-Linear Therapy Process. Typically, participants described decolonizing as a slow and lifelong journey. Rather than conceptualizing healing as a cessation of suffering, they grounded their practice in the belief that healing comes from engagement in the ongoing process of decolonizing. Similarly, decolonizing scholars (e.g., Adams et al., 2015; Desai, 2018; Dupuis-Rossi, 2021) have described decolonial healing as an ongoing journey rather than a destination or goal.

Regarding the process of healing, participants typically aligned with Indigenous scholars who have described healing as a slow process (Duran, 2006; Mitchell, 2018) and drawn distinctions between Eurocentric and colonial tendencies towards urgency and Indigenous healing values of slowing down and trusting the process of reestablishing harmony between one's mind, body, spirit, and environment (Hodge et al., 2019).

Use Interventions from Established Therapy Models That Fit Their Decolonizing Approach. Some participants used interventions from established therapy models that aligned with their underlying decolonial philosophies. They felt that even though manualized treatment models often contradict decolonizing principles (Fellner, 2016; Gone, 2021), some behavioral interventions such as mindfulness could facilitate healing when grounded within a decolonizing framework (Singh et al., 2020). Indeed, scholars have noted how interventions such as

mindfulness originated in non-colonial cultures and were coopted by Western psychology (Purser, 2019); thus, these interventions may inherently align with decolonizing values.

Credit Their Sources of Knowledge About Decolonizing. Participants typically gave credit to their sources of knowledge about decolonizing; throughout the interviews, they credited their sources and did not claim their knowledge or practices of decolonizing as purely their own. These participants believed that giving credit reflected decolonial principles by counteracting colonial paradigm of co-opting knowledge (Laenui, 2000; Tate et al., 2015). A table of credits can be found in Appendix H.

Engage in Self-Care and Maintain Connections with Professional Community and Mentors

Some participants mentioned that they engaged in self-care to replenish their energy and emotional capacity. Just as participants believed it was not appropriate or possible for decolonial healing to happen in isolation (Lewis et al., 2018; Rhodes & Langtiw, 2018), they felt that decolonizing practice also required community for care and sustainability. Similarly, scholars have discussed the importance of "helping the helper" and the dangers of overlooking the emotional needs of the clinician (Rothschild, 2006).

Research Question C: How Do Therapists Assess the Effectiveness of Psychotherapy?

Participants reacted with surprise to the interview question about they evaluated the effectiveness of their approach. They were not happy about how mainstream approaches uphold colonial ideologies such as measurement and definition (Machado de Oliveira, 2021). Indeed, they sometimes used non-standardized forms of assessing success and outcomes, such as privileging informal client feedback as a primary source of assessing effectiveness (Miller & Duncan, 2000) and instead provided examples of various types of change they have noticed in their clients as a result of decolonizing therapy. Since participants typically discussed having a

lack of guidance about how to practice decolonizing, it is possible they were unsure of how to assess outcomes. Having a greater sense of clarity about the practice of decolonizing may have led to more descriptive discussions of outcome evaluation.

Improvements in Client Intrapersonal Functioning

Participants generally reported improvements in their clients' intrapersonal functioning, primarily in terms of increased self-empowerment and agency, investment in their own healing, more active engagement in therapy, and recognition of their strengths and healing power. These findings align with Gorski and Goodman (2015), who posited that people inherently have strengths and psychological "gifts" that facilitate healing. Within this category, participants noted increases in clients' understanding of the relationships between systemic oppression and mental health concerns, as well as increased self- and ancestral empathy. These findings align with case examples in Adames et al. (2022) and Fay (2016), whose reported outcomes included reduced self-blame, increased self-empathy and self-empowerment, and increased knowledge and understanding of ancestral history.

Decreased symptoms were infrequently mentioned, which aligns with the decolonial critique alleging that this focus distracts from the core systemic problems underlying mental health concerns and contributes to the perpetuation of systemic oppression (Purser, 2019; Mullan, 2023). Our participants seemed to align with this ideology and focused instead on other indicators of effectiveness in their practices.

Improvements in Client Interpersonal Functioning

Some participants also noted that clients engaged in healthier interpersonal relationships and developed deeper connections with their families and communities after decolonial psychotherapy. Researchers have previously identified the development of stronger relationships

as an expected part of decolonial healing (Fay, 2016; Fellner, 2016). Specifically, Fellner, along with other scholars (Duran, 2006; Gone, 2010) suggested that decolonial healing is deeply rooted in community.

Positive Impacts on Therapists

Finally, participants were attuned to positive impacts they experienced for themselves as outcomes of their decolonizing practice. Specifically, they were inspired by their clients to challenge how they had internalized colonial ideologies in their own lives, such as in death, grieving, and ceremonial practices. Extant research has shown that therapists take lessons from their clients and from the therapeutic work (Hatcher, 2012; Stahl et al., 2009). For instance, Hatcher et al. found in their qualitative study that therapist outcomes as a result of psychotherapy practice included increases in their patience, humility, flexibility, and resilience in both their professional and personal lives. Because decolonizing therapy is rooted in the philosophy that relationships are central to healing and that healing is not an isolated practice (Hodge et al., 2009; Walker, 2008), it makes sense that decolonial therapists would also be impacted by the therapeutic work.

Research Question D: What Facilitated the Development of Therapists' Decolonial Therapeutic Approaches?

Participants did not directly answer this question. Instead, they described how the problems they noticed with colonial paradigms (domain 1), particularly in how these paradigms manifest in mainstream psychotherapy frameworks, motivated them to start practicing decolonizing. They also shared various sources of support and knowledge that helped shape their decolonizing practices. Although the act of giving credit to knowledge-holders is considered in and of itself to be a resistance against colonial behaviors of stealing knowledge (Laenui, 2000;

Tate et al., 2015) and was coded as such in domain 2, participants also described these sources of knowledge as facilitators of their development as decolonizing therapists.

Problems with Colonial Paradigms

Clinicians Perpetuate Colonial Ideologies in Therapy. Participants were aware of the pervasiveness of colonial paradigms in psychotherapy practices and discussed how non-decolonial clinicians perpetuate colonial harm in therapy. Given that participants agreed with the premise that the foundations of Western mainstream psychotherapy frameworks are White supremacy and colonialism (e.g., Tate et al., 2015), it is not surprising that they believed that their mainstream clinical training contributed to their internalization of colonial ideologies. Like Purser (2019), many participants noted that the emphasis of mainstream psychotherapy frameworks on symptom alleviation contributes to the maintenance of larger systemic problems through ignorance. Aligning with these perspectives, participants were motivated to develop decolonial therapy practices due to their desire to stop perpetuating harm.

Embodying a Decolonizing Philosophy and Attitude

Crediting Sources of Knowledge About Decolonizing. Participants typically cited receiving support from mentors and peers, engaging in coursework, and pursuing resources to help inform their knowledge of decolonizing and shape their therapeutic practice. Prior research has also indicated that therapists do not develop their practices on their own and that continued engagement in decolonizing pedagogy and didactics is a common facilitator of the development of their decolonizing practices (Beech, 2021; Smeja, 2019). Notably, participants cited sources and mentors across a spectrum of sociocultural locations and schools of thought. The idea that decolonizing practice can be informed by other schools of thought, and vice versa, is supported by extant literature (Comas-Díaz, 2020; Duran, 2006).

Research Question E: What Barriers Did Therapists Encounter in Developing Their Decolonial Therapeutic Approaches?

Participants described ongoing challenges they encountered in developing and maintaining their decolonizing therapy practices (domain 4). They also described problems with colonial paradigms in clinical work (domain 1) and challenges associated with the influence sociocultural identities on the decolonizing work (domain 3).

Challenges in Practicing Decolonizing Therapy

Lack of Clarity About How to Practice Decolonizing. Participants typically described not being clear about how to practice decolonizing therapy. Some participants realized over the course of the interview that their understanding of decolonizing therapy was less clear or less established than they had previously anticipated. Participants typically cited not having access to education and mentorship about decolonizing throughout their graduate studies and wished for a larger, more accessible community of decolonizing therapists to help shape their practices. Similarly, in Bergkamp et al.'s (2023) grounded theory study of how psychologists address social privilege in their practice, participants expressed having a lack of education on issues of social privilege and decolonizing.

Caution About Claiming to Be a Decolonizing Therapist. Some participants were cautious about their descriptions of themselves as decolonizing therapists even though they believed their therapy practices aligned with decolonizing motivations and values. Extant literature appears mixed with regard to guidelines for calling oneself a decolonizing therapist. Some scholars have advocated for preserving the original meaning of "decolonizing" to refer specifically to undoing land theft; they have criticized the application of the term to psychological healing (Hartmann et al., 2019; Tuck & Yang, 2012). These scholars have

criticized the confusion created when decolonizing terminology is used to describe other anti-oppressive frameworks. Notably, Tuck and Yang stated that people who "hybridize decolonial thought with Western critical traditions" uniquely perpetuate colonial ideologies by feigning superiority to both Indigenous and Western scholars (p. 16).

Fear of Violating Professional Standards. Participants sometimes cited fear of violating professional ethical standards as an inhibitor of fully practicing decolonizing therapy. They worried that they could put their licenses at risk, which could in turn risk their ability to legally engage in therapy. Similarly, scholars have discussed challenges associated with fighting a system while living within it (Blackwell, 2003; Machado de Oliveira, 2021; Rober & Seltzer, 2010). For instance, it is difficult to unlearn methods of practice that are commonly considered, even by licensing bodies, to be the standards of the counseling field (Rober & Seltzer, 2010; Singh et al., 2020). Furthermore, departure from historically dominant approaches requires sustained effort and may trigger internal experiences of intense discomfort, chaos, uncertainty, and guilt (Blackwell, 2003; Machado de Oliveira, 2021). Speaking more directly to the systemic challenges of practicing in alignment with decolonizing values, Kivel (2004) described the "constant struggle between those practitioners who are trying to undermine the rigid hierarchies of our society and the managers and administrators who are trying to maintain them" (p. 7). To my knowledge, there is no literature exploring the relationship between professional ethics codes and therapists' willingness to practice outside of established Western psychotherapy frameworks.

Power Dynamics Are a Barrier to Decolonizing Practice. Power dynamics inherent in the counseling profession (PettyJohn et al., 2021) were somewhat challenging for participants to navigate. Some participants had difficulty balancing hierarchical therapist-client power dynamics with decolonizing values of equalizing power dynamics (Beech, 2021), while others reflected on

potential harms of not acknowledging differences in power between therapist and client (Blitz, 2006). Similarly, scholars have also indicated that focusing on power dynamics is central to decolonizing (Marsella, 2015a; Millner et al., 2021).

Colonial Foundations of Society Are a Barrier to Decolonizing Practice. Participants struggled with maintaining their decolonizing therapy practices within the larger system of society due to its foundations in colonial ideologies. They worried, for instance, about the structure of therapy as a career and the role of finances in their practices; on one hand, an income source is necessary for survival within a capitalistic system. On the other, they felt that charging for sessions aligned with capitalistic values and could challenge their commitment to decolonizing. Regarding this internal conflict, Mullan (2023) wrote about how the capitalistic foundations of society can bleed into how therapists choose to structure their practices, and called for decolonizing therapists to "remember that colonial capitalism banks on our obsession with money and "making it" (p. 4).

Challenges with Decolonizing Values and Standard Therapy Approaches. Some participants grappled with using mainstream therapeutic approaches, even when the approaches could be aligned with decolonizing values, due to their foundations in colonial paradigms. For instance, one participant experienced internal dissonance between their use of Gestalt therapy techniques and their belief that the establishment of Gestalt therapy as a practice was a colonial enactment of commodifying Indigenous practices. Similarly, Purser (2019) critiqued the commodification of mindfulness in the behavioral health industry. Blackwell (2003) suggested that feelings like guilt associated with the arising inner conflict from becoming aware of colonial harm can be a barrier to engaging in decolonizing practice; because humans tend to avoid feeling

guilty, we may tend to avoid confronting knowledge that triggers these feelings and instead continue to practice in ignorance.

Problems with Colonial Paradigms

Clinicians Perpetuate Colonial Ideologies in Therapy. Participants identified several ways that clinicians perpetuate colonial ideologies in therapy, including maintaining a relational hierarchy by facilitating an expert-consumer dynamic with clients (Beech, 2021; Rhodes & Langtiw, 2018) and encouraging clients to conform to oppressive systems (Kivel, 2004). The pervasiveness of these ideologies in the mainstream psychotherapy profession reflects the temptation to colonize identified by scholars in extant literature (Blackwell, 2003; Machado de Oliveira, 2021; Rober & Seltzer, 2010). Blackwell described this temptation as a result of avoiding guilt triggered by clinicians' awareness of how their profession is complicit in colonial oppression. Rober and Seltzer described the temptation as a fantasy to be a fixer of problems; an arrogant view of the role of therapist as savior (Beech, 2021) which the authors believed is uphold and taught in mainstream frameworks. Thus, temptations to continue perpetuating colonial ideologies in therapy can be a barrier to decolonizing practice even when the knowledge of how clinicians are complicit in colonial violence is a motivator for decolonizing.

Influence of Sociocultural Identities on Decolonizing Therapy Practice

Challenges Based on a Mismatch of Values and Identities. Participants typically reported that a lack of shared sociocultural identities or a mismatch between therapist and client in terms of sociocultural experiences and values contributed to challenges in practicing decolonizing therapy. Participants in our study also struggled with staying true to their decolonizing approach and respecting clients' values when clients were less passionate, knowledgeable, or willing to engage with decolonizing therapy. They practiced value bracketing

(McWhorter, 2019) and noted that imposing their values onto clients could reenact a pattern of systemic oppression (Keeling & Piercy, 2007). Similarly, scholars have suggested that mismatched sociocultural identities may require more intentionality from clinicians with regard to navigating power differentials in the therapy dynamic (Bergkamp et al., 2023; Frey, 2013).

A smaller subset of participants in our study, all Black, Indigenous, and People of Color (BIPOC) therapists, described the psycho-emotional costs of practicing decolonizing therapy with White clients given the complex power dynamics. Thus, some of these therapists worked only with BIPOC clients and referred White clients to White therapists who they believed were better positioned in terms of sociocultural location to facilitate their systemic healing. Similarly, Bergkamp et al. (2023) discussed the psycho-emotional cost BIPOC clinicians experience when working with White clients.

Other Findings Not Fully Covered by Research Questions

Influence of Sociocultural Identities on Decolonizing Therapy Practice

Although we did not have a research question about sociocultural identities, we included questions on our interview protocol based on the literature indicating that sociocultural identities are central to anti-oppressive, liberatory, and decolonial work (results placed in domain 3). Participants generally believed that sociocultural identities of both therapist and client, as well as the level of match between their sociocultural locations, influenced their decolonizing work.

Therapist Sociocultural Identities Shape Their Decolonizing Therapy Work.

Therapist's Experiences Shape Their Understanding of and Connection with Clients.

Participants typically used their own experiences grounded in their sociocultural backgrounds to inform their case conceptualizations and interventions with clients (thus leading to some overlap between this domain and domain 2). For instance, when appropriate, participants generally

disclosed identities they shared with clients or with clients' social networks to develop the therapeutic relationship; they also typically facilitated insight about how sociocultural identities shape the client's experiences and relational dynamics. Similarly, other scholars have written about how therapists' sociocultural backgrounds inform the questions they ask, the information they give, and their self-disclosures (PettyJohn et al., 2021).

The term countertransference has been used in the psychodynamic literature to refer to the influence of therapists' reactions on the therapy relationship (Parth et al., 2017). Scholars have argued sociocultural identities are the context within which countertransference emerges (Bonovitz, 2005; Comas-Díaz & Jacobsen, 1991). Although countertransference has been viewed as a hinderance to effective therapeutic work (Bernstein, 2001; Comas-Díaz & Jacobsen, 1991), research has shown that awareness and management of countertransference can facilitate therapeutic healing (Hayes et al., 2018). Participants in our study had an easier or harder time connecting with clients depending on how they managed their reactions to their sociocultural identities that became salient in the therapy work. Thus, their experiences with how sociocultural locations informed their work align with the concepts of cultural and ethnocultural countertransference (Bonovitz, 2005; Comas-Díaz & Jacobsen, 1991).

Clients Seek Out Therapist Because of Sociocultural Identities and Values. Participants typically felt that their clients sought their services because of their visible or stated sociocultural identities, values, and decolonizing approaches to therapy. Researchers have similarly noted that clients consider demographic variables, level of therapist self-disclosure in their biographies, and perceived personality and value match when selecting a therapist, and that clients' assessments of therapeutic fit continue throughout their engagement in therapy (Ellis et al., 2018; Hollander-Goldfein et al., 1989; Kaufman et al., 1997; Spalter, 2014). For example, Spalter found that

clients engage in considerable research to find information about therapists and even seek opinions from people within their communities when selecting a provider, indicating that clients form preferences based on information they find about clinicians. Ellis et al. found that for Black clients, racial identity match with the therapist was an important facilitator of their desire to seek services. Kaufman et al. found that queer-spectrum clients considered therapist sexual orientation and gender match to be important, to varying degrees, to their selection of a provider.

Client Sociocultural Identities Shape How Therapists Work with Them.

Therapists Were More Explicit About Decolonizing Therapy with Some Clients.

Participants were typically more explicit about using decolonizing language and naming systems of oppression with clients who were knowledgeable about colonialism and who demonstrated a willingness to engage in decolonizing. Specifically, they believed that client readiness was an important factor in determining whether explicitly discussing systemic oppression and decolonizing would be facilitative to healing or whether it could be hindering due to being too removed from a client's awareness. Similarly, authors have described that interventions to facilitate identity development need to match the client's stage of development (Helms, 2004; Umaña-Taylor, 2018). Furthermore, researchers have previously found that psychotherapy treatment modalities that match clients' culturally-based understandings of pathology and healing are more effective than modalities that are not as reflective of clients' conceptualizations (Xu & Tracey, 2016).

Some Client Identities Motivated Therapists to Critically Examine Power Dynamics.

Participants believed that a person's sociocultural identities inform therapists about how clients' ancestors were historically impacted by colonialism, how those impacts manifest in their current lives, and what decolonial healing would look like for them (Menakem, 2017; Mullan, 2023).

These beliefs shaped their work by informing their critical examination of power dynamics; therapists were cautious not to recreate systemic oppression in therapy, and BIPOC therapists were particularly mindful of the complex power dynamics created when working with racially non-minoritized clients (see also earlier section on challenges based on a mismatch of values and identities). The importance of clinician engagement in critical self-examination of their sociocultural location and the impact of this self-examination on the therapy work has been discussed in extant literature (Fisher-Borne et al., 2015; French et al., 2020; Tummala-Narra, 2014).

Match Shapes Decolonizing Therapy Work.

Shared Identities or Values Made Decolonizing Therapy Easier. Participants typically felt that having shared sociocultural identities or values with their clients facilitated their decolonizing work. For instance, similar to findings by Garrison et al. (2013), participants thought that their self-disclosures to develop the therapeutic relationship or to build insight were especially impactful for clients who shared elements of their sociocultural backgrounds. Participants also typically felt that clients sought them out based on their perceived sociocultural or value match (see earlier section). Prior research supports that similarities of worldview and sociocultural identity between therapist and client are preferred by clients (Ertl et al., 2019).

Lack of Shared Identities or Values Made Decolonizing Therapy Harder. Participants typically believed that a sociocultural or value mismatch between therapist and client was a barrier to effective decolonizing therapy. These results were discussed thoroughly in the previous section (see Question E).

Our Observations About Sociocultural Identities. Through the data analysis process, we noticed that participants' sociocultural locations affected how they engaged in decolonizing

therapy. Although we did not have enough data to draw conclusions, we noted that all of the participants who mentioned feeling cautious about using the decolonizing label were non-Indigenous. Furthermore, we noted that all participants read books and took courses by Indigenous therapists and scholars, engaged in clinical and peer supervision, and learned from mentors about decolonizing, whereas Indigenous participants additionally cited elders within their communities and discussed their own ancestral healing practices as examples of their decolonizing work.

Engagement in Extra-Therapeutic Decolonizing

Although not a specific question in our interview protocol, participants spoke about how they practiced decolonizing in their lives outside of clinical work (domain 6); thus, this domain emerged organically through the data analysis process. Some participants described engaging in critical self-reflection about their own ancestral histories and context within systemic oppression; engaging in social justice advocacy work such as contributing to land-back movements to return Indigenous sovereignty to their lands; and disinvesting from colonization in daily life such as by harvesting their own herbs for use in healing practices (e.g., smudging) instead of buying them from large consumerist stores that harm the environment with production. These practices aligned with findings that clinicians practice decolonizing both within and outside of the therapy room (Beech, 2021; Fellner, 2016; Smeja, 2019).

Reflections on Fit of Findings to Initial Research Questions

Based on the CQR methodology we used in this research (Hill & Knox, 2021), we bracketed and set aside the initial research questions and interview protocol during data analysis. This allowed us to see the raw data with fresh eyes and be open to themes that emerged from within the data itself, as unbiased as possible by a priori expectations. Thus, our results did not

completely and cleanly overlap with the initial research questions. Most of our initial questions were adequately addressed by a combination of domains and categories; however, questions c and d were not addressed as sufficiently.

We initially expected that question 11 on the interview protocol (see Appendix D), which asked participants about criteria they use to determine the success of their approach, would address question c. However, participants often appeared surprised by the question and had difficulty answering it. Nearly all participants mentioned noting increases in client agency and self-empowerment, but all other types of improvement were only discussed by a few participants. Many participants instead discussed problems with colonial paradigms, and some named the concepts of "success" and "criteria" as reflective of colonial ideologies. Thus, it is possible that a change in the language used to assess this question may have elicited more illustrative results about how therapists determine if their decolonizing approach facilitates healing.

We also expected that responses to question 4 on the interview protocol (see Appendix D), which asked participants about their journeys to incorporating decolonizing philosophies into their work, would address question d. Surprisingly, participants more often associated their motivation to develop their decolonizing practice with having an awareness of problems with colonial paradigms rather than with positive facilitators. Although most participants gave credit to several sources of knowledge and support that helped shape their practices, we were not able to gain a substantial understanding of what facilitated participants' choices to engage with these resources. In hindsight, a more specific question about facilitators may have helped glean a deeper understanding of why therapists choose to learn and practice decolonizing.

Conclusions

Our understanding of what decolonizing therapy remains fluid after this study. There seems to be considerable overlap between decolonizing and other established movements such as liberation and ethnopoliticism; it could be said that the practice of decolonizing is a form of liberation, or vice versa (Duran, 2006). Indeed, scholars across areas of study in psychology cite each other's work as theoretical foundations for their respective frameworks. For instance, Adames et al. (2022) published a table listing a variety of different theoretical frameworks and scholars that informed the development of their model of radical healing in psychotherapy. Comas-Díaz (2020) cited decolonizing movements as informative of liberation psychology. French et al. (2020) similarly reviewed several schools of thought that informed the development of their psychological framework of radical healing. Similarly, scholars have noted that decolonizing is "a messy, dynamic, and a contradictory process" (Sium et al., 2012, p. II). Some have posited that labels and definitions are examples of colonial ideologies (Machado de Oliveira, 2021); thus, seeking to define decolonizing (for instance, by cleanly distinguishing it from other movements) could be considered a colonial reenactment.

Results of this study suggest that decolonizing is not a culturally-based framework of psychotherapy. Rather than a roadmap of how to practice psychotherapy with particular cultural subgroups, decolonizing is a multifaceted practice that is unique for each person who practices it. We believe that all practitioners can practice decolonizing therapy regardless of their sociocultural backgrounds, and that elements of the practice will differ based on the intersectional identities of those involved in the therapeutic dynamic. Therefore, it follows that authentically and effectively practicing decolonizing would require practitioners to become aware of their own ancestral history and sociocultural locations.

Given the discourse in extant literature about the role of land in decolonizing healing practices (see above section on land-based healing), we believe land-based healing practices are an important and unique component of decolonizing therapy. In addition, a less tangible distinction we make between decolonizing therapy and other schools of thought is that decolonizing knowledge, philosophy, and intention drive and shape the practice. Similar to Rogers' (2007) facilitative conditions, decolonizing therapy is a holistic way of being, not a set of interventions. By drawing these basic distinctions, we respect the overlap between decolonizing and other liberatory movements while also acknowledging the unique importance of decolonizing practice.

Based on our findings, we believe that therapeutic practice that is not decolonizing is in danger of perpetuating colonial harm. Scholars in extant literature have already posited that multicultural counseling and psychology movements can reproduce systemic colonial harm when they are not grounded in decolonizing knowledge and intentions (Gorski & Goodman, 2015; Singh et al., 2020; Smith, 2015). Indeed, perpetuating colonial harm is easy and natural, whereas it takes effort and intention to undo centuries of embedded colonial habits (Machado de Oliveira, 2021). Thus, practicing decolonizing therapy must be a lifelong and intentional journey of undoing rather than causing harm.

Finally, one critical question that emerged for us over the course of conducting this study is: can individual therapy be decolonizing? Based on the findings in this study, particularly that nearly all participants engaged in some sort of expanded practice beyond individual therapy (see above sections on Beyond Individual Therapy and Engagement in Extra-Therapeutic Decolonizing), we believe individual therapy can be decolonizing, but only if there are considerable efforts to not keep the therapeutic work contained in the mainstream structure of

individual therapy. Restricting or limiting the practice or healing effects of therapy—either by not engaging in discussions of intergenerational family histories and concerns, by not inviting family and ancestors into the therapy space, and/or by not connecting clients to external sources of knowledge and healing—could be a reenactment of colonial paradigms (e.g., divide and conquer, hierarchy of power, withholding access to resources).

Limitations

We did not limit our sample in terms of sociocultural location, clinical degree (beyond the requirement of being a licensed mental health practitioner able to discuss work with a client seen for at least six months), or populations served. Thus, our sample was relatively heterogeneous in terms of identities and experiences. Although we determined that a person's sociocultural location is central to shaping their practice of decolonizing therapy, we were unable to draw specific conclusions about any identity groups given the limited numbers.

We did not interview clients in the current study; thus, our findings are limited to therapists' perspectives about characteristics of decolonizing therapy. Additionally, therapists were asked to reflect on "successful" examples of their decolonizing therapy work, likely limiting our understanding of situations in which decolonizing practice may be less facilitative of psychological healing.

The interview-based approach to data collection meant our data was limited to what therapists verbally reported during the interviews. It is therefore possible that more of the participants would have endorsed some of the themes had they thought of them. For instance, although seven participants noted that they used land-based healing practices in their work, it is possible that others also used these practices without mentioning them during the interview.

In CQR, participants are involved in the data collection phase, but not the data analysis or writing phase of the research. Thus, some context and richness may have been missing from the data that could have been gained through more involvement by participants throughout all phases of research, as is done in other qualitative methodologies such as community-based partnership research (Israel et al. 1998). Collaboration with participants throughout all phases of the research could have represented further alignment with decolonizing and critical action values (Feldman, 2023). Notably, recruitment and retention of participants for the present study was challenging, with only 12 completed interviews of 104 outreach attempts. Thus, future research involving more comprehensive collaboration should expect a greater and more flexible time commitment than was feasible for the present study.

The research team was primarily composed of graduate and undergraduate students, whereas different results might have been obtained had the team consisted of experienced decolonizing therapists. In addition, two members had to drop out of the study after certain phases of coding due to scheduling conflicts. Although we did our best to mitigate possible effects of losing team members (for instance, no members dropped out in the middle of coding a transcript or domain), it is possible that shifting team dynamics ultimately had some effect on how we coded the data. To account for this, we engaged in self-reflection about our reactions to the findings, as well as our biases and expectations, throughout the coding process.

Finally, this qualitative research study is descriptive rather than experimental; thus, we are unable to draw conclusions about the causality of the findings, although we can report on whether participants viewed things as causal. For instance, we cannot infer that the outcomes therapists discussed were due to their implementation of decolonizing therapy, although therapists attributed changes as due to therapy.

Implications

Practice and Training

Clinicians seeking to develop a decolonizing therapy practice should be open to the idea that the practice will likely involve a foundational shift in their framework of psychotherapy if they were trained using mainstream Western psychotherapy models. Despite all of their training about how to be helpers (e.g., interventions and skill-building) and about the legality and ethics of the counseling profession, our participants suggested that having a solid understanding of the colonial context of psychological suffering and a lifelong commitment to undoing colonial harm were key components of decolonizing practice. Thus, we believe developing this practice will involve a critical examination of how white supremacist and colonial values manifest in mainstream psychotherapy frameworks and contribute to the pervasiveness of colonial harm in society, as well as a commitment to unlearning these harmful colonial ways of knowing, being, and doing that we clinicians have historically internalized.

We suggest that part of this shift involves expanding our conceptualization of psychological experiences to include systemic context in addition to individual context. Decolonial healing emphasizes liberation and long-term systemic change rather than stopping at symptom management or reduction within unchanged oppressive systems (Gone, 2021; Mullan, 2023). Thus, instead of understanding mental health concerns solely through the lens of pathology, we encourage decolonizing clinicians to consider how mental health concerns may reflect internalized colonial ideologies and/or historical reactions to colonialism and its many branches (e.g., patriarchy, heterosexism, racism, capitalism). Similarly, regarding training, we encourage clinicians to divest from the promotion of diagnostic assessment as the ultimate tool

within which to understand mental health problems, and to prioritize teaching how to incorporate systemic frameworks into case conceptualization.

We believe a foundational shift in psychotherapy framework would be most sustainable if supported by a foundational shift in the standards of ethical practice currently upheld by the counseling field. Scholars have historically and repeatedly critiqued the standards of ethical practice developed by the American Psychological Association as insufficient for and sometimes even conflicting with the practices and values of non-Western cultures (Gelberg et al., 2018). The challenges our participants discussed encountering in their practice of decolonizing therapy suggests there is currently clear tension between the field and practice of counseling as clinicians expand outside of Eurocentric psychotherapy frameworks. As clinicians continue to radicalize their practices and challenge the oppressive history of the field, we encourage the field to shift its established professional guidelines in the same direction.

We encourage clinicians to be mindful of how their sociocultural identities shape their engagement in decolonizing therapy. In general, we agree that everyone has a responsibility to decolonize because non-decolonial work can actually perpetuate harm (Ratts et al., 2016; Smith, 2015; Vera & Speight, 2003). We also believe that everyone has historically been impacted by colonialism in some way and that everyone can benefit and heal from decolonizing regardless of sociocultural background (Anzaldúa, 2012; Machado de Oliveira, 2021). However, our findings suggested that the process of decolonizing may look different based on a person's sociocultural location. We encourage therapists to reflect on how their sociocultural backgrounds and experiences inform their historical ancestral knowledge about colonialism, where they seek knowledge about decolonizing, their role and responsibility to decolonize as a settler or non-settler on the land they live on, and how much space they occupy in the decolonizing discourse.

Training in this area could include the use of exercises such as the Social Identity Wheel (Intergroup Relations Center, Arizona State University) and reflection questions about personal identity and ancestral history (Amin & Bansal, 2022).

Our results suggest that recognizing and integrating land-based healing practices is an important part of a decolonizing therapy approach. Land-based healing acknowledges the intrinsic connection between individuals and the land, recognizing nature as a source of wisdom, resilience, and healing (Dudgeon et al., 2017; Mark & Lyons, 2010; Mitchell & Dossey, 2018). Moreover, it offers an opportunity to challenge the historical dominance of Western epistemologies and make room for Indigenous ways of knowing, being, and doing, thus promoting a more inclusive and culturally respectful approach to mental health care (Mullan, 2023). Clinical training could focus on developing clinicians' abilities to incorporate these practices into therapy by providing psychoeducation about how consumerism damages our connections with land, engaging in rituals and ceremonies to heal connections with land, facilitating nature-based therapy, and encouraging land-back advocacy efforts.

Finally, we found that expanding beyond the confines of individual therapy and into community-based healing is also an important characteristic of decolonizing therapy practice. We suggest that by establishing a network of healers within the community, therapists can tap into a diverse range of perspectives, techniques, and cultural traditions that may not be accessible through traditional therapeutic modalities alone (Lewis et al., 2018; Rhodes & Langtiw, 2018). This network can include Indigenous healers, traditional medicine practitioners, community organizers, and cultural leaders who bring unique insights and approaches to the healing process. Engaging in community-based healing not only acknowledges the collective nature of trauma and resilience but also empowers individuals to draw strength from their cultural heritage and

community support systems. This shift from primarily individualistic healing to healing that involves community reflects a commitment to decolonizing therapy that prioritizes cultural humility, collective empowerment, and social justice (Singh et al., 2020).

Research

There are several implications for future research based on our study. First, I learned that conducting qualitative research specifically about decolonizing required more self-disclosure from me as the interviewer than I had originally anticipated. Referred to in extant literature on qualitative research as "situating" the researcher, I found that it was important for me to disclose my own sociocultural location and relevant information during participant recruitment and prior to commencing the interview for participants to be willing to engage in the interview process. Some participants expressed that they were only interested in participating in the study after learning about me, my own reflections, and my motivations for engaging in this research (see Appendix A). Future researchers should be similarly intentional about engaging in self-reflection and disclosing their sociocultural locations and motivations with potential participants.

Second, we learned in our study that clinicians' sociocultural identities shape how they practice decolonizing therapy; however, we did not have enough data representative of any particular group (e.g., Indigenous, BIPOC) to draw specific conclusions about how practices may look different based on sociocultural location. Future researchers could more intentionally explore the practice of decolonizing therapy among particular sociocultural groups to develop a greater understanding of how sociocultural location is important in shaping the practice.

We also learned that client sociocultural identities shape the practice of decolonizing therapy, but did not explore client perspectives on decolonizing in the present study. Future researchers could conduct similar studies exploring clients' experiences of decolonizing

psychotherapy, or dyad-based studies (e.g., Coutinho et al., 2011) to explore both the therapist and client experiences of decolonizing within a therapeutic pair.

Fourth, in reflecting on their practices of decolonizing therapy, our participants expressed that they were fearful of violating professional and ethical standards if they fully practiced decolonizing. To our knowledge, there is no literature specifically exploring the relationship between decolonizing or liberatory mental health practices and ethical or professional repercussions. Due to the possibly sensitive nature of the topic, it is conceivable that this concern may be underreported both in the current study and in extant literature. More intentional research exploring this topic could help elucidate the prevalence of this concern for clinicians, as well as nuances of how they manage these challenges.

Finally, the incorporation of land-based healing practices in therapy also emerged as an interesting finding in our study that was controversial due to conflicting extant discourse about the appropriateness of applying decolonizing to psychotherapy versus preserving its original meaning of restoring Indigenous land and sovereignty. Future researchers could expand these findings further by exploring therapists' perspectives on land-back movements and asking more specific questions about how therapists incorporate land into their healing practices.

Appendix A

Reflections on My Positionality Within the Colonial Landscape

Initially, I approached this research as I have been taught by my institutions: as an observer seeking answers to depersonalized and nomothetic questions, in order to achieve some kind of mastery over the subject matter and to receive a degree. It is a colonial mindset to take knowledge from knowledge-holders, decontextualize it, and use it for my personal gain as an academic and clinician. I have been lucky along this journey to have been met by elders and knowledge-holders who have resisted my colonial mindset, challenged me, questioned me, and guided me. As I reflected further on the "why" of this study, I became keenly aware of how disconnected I was from my self and roots. Despite having had many dialogues about the impacts of colonialism and the need for social justice action across professional spaces, I had neglected to ground myself in how colonialism impacted me and my ancestors—I had removed myself from the conversation and attempted to make my individuality irrelevant. In turn, I created distance from my personal underlying motivations for pursuing knowledge about decolonizing psychotherapy and manifested colonial harm in my research practices by situating myself as a disconnected, mostly unidentified, taker of knowledge. Upon being encouraged to do so by an Indigenous therapist who received my original scripted contact email, I took a step back from the work and reflected on who I am and the space I occupy.

I am not indigenous to the land I live on. My ancestors are indigenous to India, where they fought and survived through colonial rule until Independence in 1947. In our blood, we carry stories of colonial resistance and displacement. My grandparents and parents went on to become settlers on Turtle Island (colonial name: North America), and have occupied plots of land within the territory of the Onondaga of the Haudenosaunee Confederacy, which is called

"New York, United States." I have lived on land within the territories of the Kaskaskia, Meskwaki, myaamia, Oceti Sakowin, Ho-Chunk, Kickapoo, and Piscataway First Nations Peoples.

I notice tension and resistance in my body when I think about being a settler here and my complacency in perpetuating colonialism. As I imagine myself in my future career and role in this world, I want to commit myself to non-complacency and actively engage in decolonizing myself and my practice. I want to know and respect the people whose land I live on and I want to actively undo the established colonial patterns that I and generations of my family have been living with. I believe that decolonizing practice will allow me to heal my own intergenerational wounds, and I hope to be able to help facilitate the healing of personal and intergenerational wounds for others.

Appendix B

Extended Literature Review

Understanding Decolonizing

Theoretical frameworks of decolonizing emerge from critical examinations of historical and sociopolitical processes that have perpetuated colonial power structures and have marginalized Indigenous knowledge and worldviews (Robcis, 2020). Decolonizing can be described as a paradigm shift that encourages a broad reevaluation of dominant narratives and challenges the imposition of Western ideologies on diverse societies across dimensions of culture, economy, and politics. In this section, I explore decolonial theory in each of these areas, examine how they undercurrent psychological wellbeing, and discuss their relevance to the field of psychotherapy.

My discussions of decolonizing will be holistic in nature because the foundations of decolonizing psychotherapy exist in theories and movements that are not exclusive to the field; however, it is beyond the scope of this work to provide a comprehensive and untethered overview of decolonizing. Thus, I will tie my discussions of decolonizing theories and movements to their relevance to the field of psychotherapy.

Terminologies and Overlapping Schools of Thought

Several overlapping schools of thought exist to describe values and perspectives aligned with the paradigm shift I have referred to as decolonizing. These include transdisciplinary ideologies like anticolonialism, which describes taking an active stance against colonialism (Hartmann et al., 2019), and postcolonialism, which is the consideration of a world beyond colonization (Millner et al., 2021).

Related frameworks such as liberation (Adams et al., 2015; Comas-Díaz, 2020), ethnopoliticism (Comas-Díaz, 2007), and cultural humility (Bogle et al., 2021; Fisher-Borne et al., 2015) have heavily informed psychotherapy and related fields such as education and policy. Liberation movements have been pushed forward by Black feminist scholars such as bell hooks, Kimberlé Crenshaw, Angela Davis, and Audre Lorde, whose insightful analyses have illuminated the intersectionality of oppression. They have advocated for resistance to oppression through means such as radical self-care, love, and rest, which have historically been impugned by Western mainstream society. Comas-Díaz (2007) describes ethnopoliticism as a practice of holding colonization responsible for harm and striving for the sociopolitical and psychological liberation of people of color through the "development of critical consciousness and sociopolitical action" (p. 92). Fisher-Borne et al. (2015) expand the Hook et al. (2013) cultural humility framework to emphasize acknowledgement of and accountability for social inequities that may be perpetuated at an individual level (e.g., within the therapeutic dynamic) and at a systemic level (e.g., within the mental health organization or system). All of these ideologies are unified by underlying themes of promoting healing through understanding and challenging oppression.

Elsewhere, this paradigm shift has been described as a return to what was previously stolen; for instance, Mullan (2023) described decolonizing as a return to land, culture, and ancestral knowledge that were stripped away by acts of colonialism. One idea of return is similar to radical healing practices (French et al., 2020) discussed in liberation movements where an emphasis is placed on reclaiming lost, stolen, discarded, and oppressed ways of being. Menakem (2017) described the practice of reclaiming the self by restoring connections to the knowledge, wisdom, and healing power of the body. Both Mullan and Menakem stated that colonialism and

related branches of oppression are core traumatic wounds, that disconnection from our bodies and wisdom is a manifestation of this trauma, and that practicing returning to ourselves is an act of resistance and healing. Other scholars focused on the idea of return outside of the context of the body; for instance, Tuck and Yang (2012) discussed their core decolonizing focus of returning stolen land to Indigenous people. Like Mullan (2023), Machado de Oliveira (2021), and others, Tuck and Yang described decolonizing as unsettling, uncomfortable, and effortful; however, they maintained that despite the existence of several similar and overlapping anti-oppressive frameworks, “decolonization does not have a synonym” (p. 3) and must center efforts to restore Indigenous sovereignty.

The paradigm shift has also been described as an act of letting go; for instance, Machado de Oliveira (2021) described “hospicing” coloniality, or preparing for and fostering the death of colonial ideology and its associated modern ways of life—including mainstream Western systems of education, career/capitalism, healthcare, mental healthcare, and more. Machado de Oliveira advocated for critically examining and letting go of colonial desires (“comfort, convenience, consumption, certainty, control, and coherence,” p. 42) and stated that relying on ways of life built using colonial frameworks will stand as a barrier to liberation and healing.

Overall, decolonizing is aligned with diverse movements championed by Indigenous and Black feminist scholars. This multifaceted approach promotes healing by challenging oppression, reclaiming stolen knowledge and ways of life, and actively dismantling colonial ideologies. Scholars like Machado de Oliveira advocated for "hospicing" coloniality and emphasized the need to let go of oppressive structures for true liberation and healing. Decolonizing requires a nuanced understanding, active resistance, and a willingness to shed oppressive frameworks for a more equitable future.

Decolonizing, Culture, and Language

Influenced by postcolonial theory, decolonialists seek to dismantle the enduring legacies of colonization by acknowledging its impact on culture, identity, and systems of knowledge. In his pivotal work, "Orientalism," Said (1978) dismantled the Eurocentric representations of the East and exposed the power dynamics inherent in the creation of knowledge. Said revealed how Western discourse has historically constructed the "other," specifically in the context of how the Eastern world is perceived in modern-day. In "My Grandmother's Hands," Resmaa Menakem (2017) also discussed how colonial ideology shapes our understanding and perception of culture. Anchored in the theory that colonization is a form of trauma, Menakem stated:

> After months or years, unhealed trauma can appear to become part of someone's personality. Over even longer periods of time, as it is passed on and gets compounded through other bodies in a household, it can become a family norm. And if it gets transmitted and compounded through multiple families and generations, it can start to look like culture. But it isn't culture. It's a traumatic retention that has lost its context over time. (p. 39)

Both Said and Menakem underscored the need to deconstruct these entrenched narratives of culture, norms, and trauma to liberate cultural identity from the grip of oppressive colonial stereotypes. This deconstruction is central to understanding how cultural identities are fashioned in response to and in resistance against colonial dominance.

Language is a powerful carrier of culture and thus plays a critical role in the process of decolonizing, acting both as a reflection of how colonial harm has taken place and a tool to challenge and reshape established narratives that perpetuate colonial ideologies (Kivel, 2017). In "Decolonising the Mind," Ngũgĩ wa Thiong'o (1986) underscored how language is intricately

tied to culture and argued that colonial powers have historically used language as a tool of subjugation, imposing European languages and erasing Indigenous ones in the process. Similarly, in "Dancing on Our Turtle's Back," Leanne Betasamosake Simpson (2011) discussed how colonial policies—particularly those related to education—have had profound and often detrimental effects on the languages of Indigenous communities. Focusing on the Nishnaabeg (Anishinaabe) people's experiences, Simpson explored how the imposition of Western educational systems and residential schools played a significant role in the erasure and suppression of Indigenous languages by creating policies that disconnected Indigenous children from their languages as part of a broader attempt to assimilate them into Eurocentric cultural norms. Simpson described numerous intergenerational consequences of these policies which have led to a decline in the fluency and usage of Indigenous languages within Indigenous communities. Thiong'o and Simpson both emphasized the importance of reclaiming Indigenous languages in literature and life as a means of decolonizing.

Other scholars discussed the importance of critically examining and changing the language we use as a means of shifting away from Eurocentric and colonial paradigms because even our simple, everyday language is steeped in colonial ideologies (Machado de Oliveira, 2021; Mullan, 2023). For instance, U.S. History courses often describe land as "discovered" or "found," which erases Indigenous history, centers Eurocentric and settler experiences, and situates indigeneity outside of the norm (i.e., in the margins). Scholars like Machado de Oliveira and Mullan highlighted how even language that is regularly used across the counseling field and even across anti-oppressive movements, such as referring to certain communities as "marginalized," centers colonization as the focal experience and norms privileged sociocultural identities.

Although it is important to name rather than bury historical oppression (Crenshaw, 1991), decolonialists also invite critical discourse about the impact of centering experiences of marginalization over resilience (Vizenor, 1994). In “Manifest Manners: Postindian Warriors of Survivance,” Vizenor (1994) explored the idea of “survivance” as a counternarrative to the story that Indigenous people are victims of trauma. He stated that situating Indigenous people as victims creates prevailing, false stereotypes of Indigenous people as helpless and powerless, and erases their true stories of survival and resilience. He argued that by painting Indigenous people as powerless victims of colonial trauma, the standard narrative of colonialism serves to maintain an oppressive hierarchy of power in society; instead, the language of survivance—which focuses on Indigenous people’s active resistance, resilience, and survival through colonial genocidal efforts—represents a shift away from the standard narrative in an effort to break the pattern of oppression through language and storytelling.

bell hooks is another prominent scholar who has written about the use of language as a form of empowerment and resistance in the context of Black feminism. In “Talking Back: Thinking Feminist, Thinking Black” (1989), she encouraged historically minoritized individuals to "talk back" to systems of oppression by urging them to reclaim their voices, challenge dominant narratives, and actively engage in dialogue. hooks specifically emphasized the importance of speaking out against racism, sexism, and other branches of colonial ideology (Mullan, 2023). Similarly, across her life and career, Audre Lorde (1984, 2017) emphasized the power of language and the need for historically marginalized individuals to articulate their experiences as a form of resistance and empowerment.

Colonialism has a strong legacy in the field of psychology, which was historically built on a foundation informed by eugenics and normalized the experiences of a Western, educated,

industrialized, rich, and democratic (WEIRD) population (Adams et al., 2015; Desai, 2018; Henrich et al., 2010; Mullan, 2023). Mullan (2023) underscored how language has been weaponized in the psychology field to perpetuate oppression against people with historically minoritized identities, such as BIPOC and LGBTQIA+ communities, through means such as diagnosis and pathologization of cultural experiences (e.g., prayer ceremonies, death and mourning rituals, and more). Thus, decolonizing psychotherapy requires a shift of the broader culture of the field, including engaging in critical examination of the historical roots of the field, decentering Eurocentric ways of being and knowing, and changing our language and understanding of healing.

Decolonizing, Economics, and Capitalism

Colonialism has profoundly shaped the economic systems and structures that drive modern U.S. society. Decolonization seeks to challenge existing economic power structures and critically examine their impacts on individual and community dynamics (Quijano, 2000). Quijano (2000) discussed how colonialism established a global division of labor, marked by a hierarchy where certain communities benefit from materials and labor produced by others, that has endured and deepened over time. Dunbar-Ortiz (2014) further described how the removal and displacement of Indigenous communities due to settler colonialism profoundly impacted Indigenous economic livelihoods because their connection to the land was closely tied to their sustenance, economic practices, and cultural identities. Specifically, the imposition of settler colonial private property and capitalist systems disrupted Indigenous communal land tenure and economic practices and created economic inequities that continue to disproportionately concentrate wealth among people with settler identities and persistently disadvantage Indigenous and BPOC communities (Dunbar-Ortiz, 2014; Quijano, 2000; Villanueva, 2018).

The introduction of capitalist ideologies through settler colonialism also established social patterns that persist in society today. For example, the urgency to accumulate wealth, achieve success, and maximize productivity has become deeply ingrained in the cultural fabric, influencing not only economic practices but also individual and community dynamics. In "A Brief History of Neoliberalism," David Harvey (2005) discussed how the capitalist values of urgency and productivity manifest in the relentless pursuit of economic growth and success, often at the expense of social and environmental considerations. Harvey stated that this urgency has fueled exploitative practices, contributing to the perpetuation of economic inequalities inherited from the colonial era as well as the maintenance of systemic barriers that hinder the economic advancement and wellbeing of historically minoritized communities. Moreover, perfectionistic values upheld by capitalist ideals reinforce a competitive ethos, creating a societal expectation of constant improvement and achievement. This perfectionist mindset can also exacerbate existing inequalities, as those who face systemic barriers often find it challenging to meet the unrealistic standards set by a system rooted in colonial legacies (hooks, 1987; Lorde, 1984).

Economic systems rooted in colonialism and capitalism shape the methodologies, priorities, and overarching dynamics of the counseling field. For instance, capitalist values such as individualism and profit-driven motives can influence therapeutic practices by potentially prioritizing symptom alleviation over systemic change. In "McMindfulness: How Mindfulness Became the New Capitalist Spirituality," Purser (2019) critiqued the commercialization of mindfulness and argued that the practice has been co-opted to serve corporate motives of maintaining a hierarchy of power and pinning the responsibility of change on individuals rather than corporations or systems. Purser and Loy (2013) described how the commodification of

mindfulness, which decontextualizes and severs the practice from its roots, diverts attention away from broad societal issues through depoliticizing and individualizing the practice. Moloney (2013) similarly suggested that modern talk therapy, driven by colonial and capitalist values systems, seeks to "persuade us that our troubles stem not from the world in which we live, but from our lack of insight into ourselves and from our failure to take responsibility for what we think, feel and do" (p. 1). He claimed that the profit-driven business model that currently informs the mental health system in the U.S. actually deprioritizes the mental health and wellbeing of the populations it serves by prioritizing the survival of the system. Thus, decolonizing the field of psychotherapy is not possible as long as the goals of the field align with capitalist values of exponential growth, accumulation of wealth and business, and encouraging consumerism (Villanueva, 2018).

Counseling professionals must navigate the complexities of post-colonial mental health, acknowledging the intersecting socioeconomic dimensions that shape client experiences while advocating for holistic approaches that challenge and transform the systemic inequalities perpetuated by colonial legacies. This is a difficult task, because counseling professionals are also human beings who are equally as impacted and forced to survive within systems shaped by colonial ideologies. An analogy: how do you notice pee in the ocean when you are a fish? What do you do about the pee once you have noticed it?

Doherty (2012) explored the ethics of engaging in profit-making as practitioners of mental health. Using qualitative methods, she learned that counselors sometimes experience tensions arising from charging session fees; counselors in the study reported that these tensions were related to capitalism-driven insecurities about the value of their work, as well as to the misalignment between the act of charging fees and their personal morals of providing equitable

and accessible mental health services. Other scholars have also described challenges and barriers to consistently practicing decolonizing in the mental health field. For instance, Duran and Duran (2000) described how training under Western philosophies and living in a Eurocentric society—therefore having limited, if any, exposure to Indigenous and non-Eurocentric worldviews—may adversely impact even well-intentioned clinicians' abilities to practice decolonizing psychotherapy by hindering these alternative worldviews from even breaching clinician's conscious awareness. Blackwell (2003) suggested that even when clinicians are aware of other ways of being and knowing, they may inadvertently block themselves from wholeheartedly engaging in liberation and decolonizing efforts due to rising feelings of guilt associated with this awareness.

Just because it is difficult to see the pee in the water, or because you still have to swim in it after you become aware of it, or because you are contributing to it, does not warrant ignorance. Scholars have repeatedly posited that decolonizing is uncomfortable, unsettling, and difficult to tolerate; it involves feelings of grief, guilt, shame, helplessness, exasperation, and anger; it is exhausting and slow; it is powerful (Gorski & Goodman, 2015; Machado de Oliveira, 2021; Mullan, 2023; Singh et al., 2020; Tuck & Yang, 2012). This is all part of true and authentic decolonizing work.

Decolonizing, Politics, and Law

I often consider whether it is possible to exist in the world today without being political. Given that modern society reflects the aftermath and lingering effects of colonialism, scholars have posited that any act, including inaction, is political (Chayinska et al., 2017; McConnell & t'Hart, 2014). This perspective has taken various shapes; for instance, in her posthumously published work, Audre Lorde (2017) emphasized that silence is complicity and that failure to act

or speak out against oppression is an endorsement and perpetuation of oppression (Johnson, 2022). Similarly, in "The Personal is Political," Carol Hanisch (1970) stated that personal experiences are inherently political and that addressing personal issues is crucial for broader societal change. Angela Davis (1981) expanded this perspective by suggesting the personal is not only political but is deeply entwined with structures of power and oppression; Davis contended that individuals cannot disentangle their personal experiences from the larger social and political frameworks that shape their lives. Finally, scholars like Chayinska et al. (2017) and McConnell & t'Hart (2014) argued that even seemingly apolitical choices contribute to the existing power structures shaped by historical events like colonialism.

The assertion that any act or inaction holds inherent political implications underscores the idea that neutrality is an illusion. This concept is in direct conflict with mainstream psychotherapeutic theories that often encourage the separation of personal and political spheres. Mainstream psychotherapeutic paradigms have historically emphasized the individual's psychological well-being without explicit consideration of broader societal contexts (Wampold & Imel, 2015). Some clinicians advocate for therapist neutrality and caution against overtly political engagement and discussion in therapy (Pope & Vasquez, 2016). Pope and Vasquez described the potential harm that can arise when therapists express strong political views, stating this may compromise the therapeutic alliance and create an environment where clients feel hesitant to share their authentic experiences. Importantly, some contemporary theorists recognize the limitations and potential drawbacks of therapist neutrality, especially in contexts where issues of social justice and systemic oppression are prevalent. For instance, Prilleltensky and Nelson (2002) advocated for a paradigm shift explicitly acknowledging that individuals are embedded in larger systems and that their well-being is intricately connected to their broader

societal contexts. Scholars who call for decolonizing psychotherapy generally encourage clinicians to develop a multidimensional systemic perspective on oppression by recognizing both societal (e.g., socioeconomic inequalities, discrepancies in access to healthcare, racial injustice) and individual (e.g., interpersonal power dynamics) patterns of oppression. Additionally, they encourage clinicians to understand the psychological impact of oppression and work to liberate clients from oppressive patterns where possible, for instance by explicitly addressing issues of power in psychotherapy (Marsella, 2015a; Millner et al., 2021; Singh et al., 2020) and discussing the sociopolitical correlates of mental health concerns with clients (Comas-Díaz, 2007; French et al., 2020).

Although clinicians are shifting to more anti-oppressive and decolonizing frameworks of therapy, the requirement of operating within regulated legal, ethical, and healthcare systems poses barriers for therapists who aim to practice freely in this way. Traditional licensing frameworks often emphasize standardized, Eurocentric approaches to mental health, which may not fully account for the diverse cultural contexts and healing practices that characterize decolonizing perspectives. For example, Marsella (2015b) posited that the American Psychological Association (APA) and its framework of sound psychological practice were formulated using colonial ideologies and continue to perpetuate a narrow, colonial view of what constitutes legally and ethically acceptable clinical work. Marsella specifically cited individualism as a core colonial value that drives the APA's framework of acceptable practice: "The individual is the focus of behavior. Determinants of behavior reside in the individual's brain/mind, and interventions must be at this level rather than the broader societal context" (p. 149). Thus, clinicians whose conceptualizations of mental health concerns clearly fall outside of this framework may risk facing licensing repercussions.

Practitioners committed to enhancing the accessibility of mental health services often face the challenge of navigating a system that is not inherently conducive to decolonizing and anti-oppressive practices. For instance, those who participate in the health insurance system are required to align themselves with manualized treatments and utilize diagnostic tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) to ensure healthcare coverage or cost reimbursement for their clients (Sadler, 2013). Paradoxically, while these clinicians recognize the limitations of traditional systems, they also acknowledge that structures such as the health insurance system remain the primary avenue through which socioeconomically disadvantaged populations have access to mental health services (Fullen et al., 2019). Thus, clinicians navigate a delicate balance of introducing decolonizing principles into established frameworks without compromising the accessibility of services for those who need them the most. The tension between the desire to reform mental health practices and the practical necessity of working within existing structures highlights the need for systemic changes. As professionals navigate this complex terrain, advocacy for reforms that promote decolonization within mental health services becomes not only a professional imperative but a moral one, ensuring that all individuals have equitable access to culturally competent and anti-oppressive mental health care.

Decolonizing and Related Movements in Psychotherapy

Though well behind its sister fields of community psychology and social work, counseling psychology has begun to embrace and explore decolonial philosophies as grounding frameworks of healing in psychotherapy (Adams et al., 2015; Gone, 2020). This change has come about because traditional Western models of psychotherapy were historically inadequate for meeting the needs of people with marginalized identities (Desai, 2018). Scholars have

suggested that psychotherapy that does not take an actively anti-oppressive stance can instead perpetuate harmful oppressive patterns (Ratts et al., 2016; Smith, 2015; Vera & Speight, 2003).

Psychotherapy has evolved over the years to include cultural awareness, multicultural competence (Sue, 1998), and cultural humility (Hook et al., 2013). Decolonial psychotherapy is part of a spectrum of efforts to move away from or expand traditional psychotherapy frameworks to address the psychological impacts of oppression (French et al., 2020; Marsella, 2015a; Millner et al., 2021; Singh et al., 2020; Smith, 2015). In this extended literature review, I provide an overview of multicultural psychotherapy and clarify how decolonial psychotherapy differs from it. I then describe the theoretical underpinnings of decolonial psychotherapy and the extant empirical research that examines what the practice of decolonial therapy entails. Finally, I describe challenges that therapists may encounter when developing a decolonial therapy practice.

Multicultural Psychotherapy

Multicultural psychotherapy emerged out of recognition that psychotherapy frameworks that historically targeted the needs of affluent, cisgender, white men were limited in their relevance and appropriateness for marginalized populations (Desai, 2018). In practice, multicultural psychotherapy has taken many forms including adapting Western frameworks to be more culturally relevant (e.g., Husain & Hodge, 2016) and integrating traditional and nontraditional interventions (e.g., Korman & Saizar, 2018). Despite these important steps in recognizing and addressing the shortcomings of traditional Western therapeutic frameworks, proponents of decolonization have posited that multicultural psychotherapy as presently exists is still limited in addressing wellness in underserved communities because it does not always consider the role of historical systemic injustice on psychological problems (Desai, 2018; Gamby et al., 2021; Rieken & Gelo, 2015).

Adaptations of Western Therapeutic Frameworks

Adaptations of traditional models of psychotherapy have been explored across theoretical orientations. For example, Husain and Hodge (2016) modified cognitive behavioral therapy to better serve Muslim populations. They described how clinicians can help clients to replace harmful schemas with more constructive self-statements. Giving an example of how a traditional cognitive behavioral therapist might reframe a schema related to unbearable frustration in a way that highlights a client's individual ability to tolerate hardship, Husain and Hodge pointed out that this individualistic perspective may be incongruent with Muslim values and thus would likely be less effective for Muslim clients. Instead, the authors suggest adapting self-statements to center terminology drawn from Islam. In the given example, authors reframe the harmful schema by emphasizing that people build resilience under the guidance of Allah; they also used "we" instead of "I" to semantically move away from the traditional individualistic reframe.

Tummala-Narra (2019) described considerations for working broadly with immigrants and refugees using psychodynamic psychotherapy. She expanded on the core concepts of transference and countertransference in psychodynamic psychotherapeutic work with immigrant and refugee clients. She noted that the therapists' and clients' sociocultural histories play an important role in informing their therapeutic dynamic. Specifically, social, political, economic, and racial dynamics are particularly salient for immigrant and refugee clients. They may internalize oppressive dynamics they experience systemically and expect similar dynamics within the therapeutic dyad, or they may seek alliance within the therapist against oppression they experience outside of the therapeutic relationship. The therapist may similarly have preconceived ideas of clients' cultural contexts based on the abundance of literature describing cultural differences between groups. For instance, Tummala-Narra indicated that a therapist who

has read that people from Asian cultures prefer direct forms of interaction with authority figures may practice this kind of engagement with Asian clients with the intention of communicating cultural sensitivity. Psychodynamic therapists who are aware of cultural differences may be likely to experience countertransferences stemming from the discomfort and anxiety as well as curiosity and excitement associated with them. For example, a clinician who has read about the importance of addressing racial identity differences in the therapy room may experience more sensitivity to the potential role of racial identity in their client's narrative even when it is not the main focus of discussion. These approaches could lead to problems if they are presumptive and rigid. It is therefore important for clinicians to manage their countertransferences by maintaining conscious openness to being surprised by immigrant and refugee clients.

In another example of expanding traditionally Western therapeutic frameworks to be more multicultural, Kallivayalil (2010) used narrative therapeutic techniques grounded in feminist philosophy to understand the experiences of South Asian women survivors of domestic violence. Her adaptation of the narrative framework included using her knowledge of cultural values (such as karma and past life experiences) to contextualize the participants' words. Similarly, her adaptation of the feminist framework included creating space for the intersectionality of South Asian women's identities and understanding how the South Asian culture could uniquely shape their narratives. Kallivayalil explored challenges and benefits to using feminist narrative therapeutic techniques with South Asian women and investigated how domestic violence-related mental health concerns could be better conceptualized for this population.

Several emerging themes from the survivors' narratives were reconceptualized by the author using the intersectional cultural context of South Asian women. Reconceptualization

primarily appeared to involve a clear shift from an individualistic to a collectivistic understanding of narratives. For instance, Kallivayalil found that South Asian women survivors of domestic violence blame themselves for the abuse they experienced. This self-blame differed from traditional notions of self-blame in domestic violence situations where survivors often blame their own character or behavior; participants described more collectivistic self-blame related to values and beliefs upheld by the South Asian cultural group (e.g., belief in arranged marriage, strict gender roles, and servitude of a South Asian woman toward her husband and in-laws). Another emerging theme that was clearly reconceptualized using cultural context was betrayal. Although betrayal of trust is universal in experiences of domestic violence, Kallivayalil suggested that the cultural context of arranged marriage and immigration—where many women leave their families of origin to travel abroad with their new spouse—made the betrayal experienced by South Asian women survivors more acute and multifaceted. Overall, cultural context is an important framework for accurately understanding mental health experiences of multicultural populations.

"Validating" Non-Traditional Therapeutic Techniques Using Western Frameworks

In the United States, non-Western sciences and interventions are societally viewed as invalid at worst and "alternative" at best to more traditional Western practices. For example, mindfulness-based approaches are healing practices that were not considered seriously until they were appropriated by Western society (Korman & Saizar, 2018). One major problem with such appropriation is that it often happens in a piecemeal approach and erases the less-standardizable spiritual underpinnings of nontraditional interventions (Farb, 2014; Korman & Saizar, 2018). The implication that Western science can consider which aspects of Eastern practices are scientifically valid and which are not—and subsequently incorporate some of their aspects but

not others into clinical work—is reflective of colonial practices of invasion and stealing (Ishikawa, 2018). Furthermore, this type of appropriation supports capitalist ideology: the erasure of nuance and spirituality in favor of easily marketable interventions commodifies healing and prioritizes mass outreach and capital gain (Scherer & Waistell, 2017). Therefore, although it could be argued that a positive outcome of validating nontraditional healing practices using Western frameworks is their increased utilization in mainstream psychotherapy, there is harm in that non-Western cultures are used, marginalized, and erased under the hierarchy of Western superiority.

Theory of Decolonial Psychotherapy

Some common themes that emerge in the literature on decolonial psychological healing also exist in other frameworks of therapy such as humanistic (Rogers, 1995), feminist (Enns, 1997), and multicultural therapies. One major example is the practice of equalizing power dynamics between therapist and client such as by following the client's lead in their own healing process (Fay, 2016; Smeja, 2019; Dupuis-Rossi, 2021; Singh et al., 2020). Decolonial and some multicultural theories also align in their emphasis on critical consciousness (Adames et al., 2022; Comas-Díaz, 2011); scholars of decolonization suggest that specifically acknowledging colonial harm and creating awareness of how colonial violence leads to psychological harm is an important mechanism of creating change and healing (Moane, 2003; Dupuis-Rossi, 2021).

Radical Healing. Some researchers have described decolonial healing as radical healing, though in slightly different ways (Adames et al., 2022; French et al., 2020; Suzuki et al., 2019; Ginwright, 2015). According to French et al. (2020), radical healing occurs at the center of the spectrum between oppression and liberation. The authors argue that focusing exclusively on oppression could fuel feelings of despair and exclusive focus on liberation (e.g., only dreaming

of the future when one is liberated) could facilitate a disconnection from the current reality. Thus, radical healing according to these authors involves tolerating existence in both spaces of resisting oppression and moving toward liberation.

Adames et al. (2022) described radical healing in terms of engagement with both internal and external processes of resistance. Specifically, this type of radical healing involves resisting external oppression and resisting internal self-blame for the oppression. These authors also described five pillars which they believe are essential for the radical healing process. The first pillar is critical consciousness; as described above, raising critical consciousness involves cultivating conscious awareness of how systemic oppression perpetuates colonial harm. The second pillar, cultural authenticity and self-knowledge, emphasizes regaining self, community, and cultural identity outside of what has been defined by colonial oppression. Promoting radical hope and envisioning possibilities in the third pillar, including the importance of positive, strengths-based conceptualizations of healing. The fourth pillar, collectivism, recognizes the power of community to cultivate love, hope, and healing. Though individual psychotherapy primarily works outside of groups and communities, collectivism can be addressed through witnessing a client's narrative story (Smeja, 2019) or making referrals to connect clients with community healing practices in addition to individual work (Beech, 2021). The fifth pillar in the radical healing framework is strength and resistance, which refers to a resolve to live a happy life despite the painful awareness that may emerge through other pillars such as critical consciousness.

Other descriptions of radical healing describe healing across the dimensions of individual, collective, and structural or institutional (Ginwright, 2015; Suzuki et al., 2019). Healing addresses how power dynamics in interpersonal relationships can replicate systemic

oppression on an individual level, promotes community and togetherness as a mechanism of resisting oppression, and has a broader goal of transforming policies and systems that are believed to be major underlying causes of harm (Suzuki, 2019). Ginwright (2015) promotes that because individual and collective harm caused by systemic oppression is inherently political, healing must also be political. The author also describes radical healing as a healing justice framework, citing the #BlackLivesMatter movement as an example of this type of healing. Radical healing from this perspective involves restoration of power and energy, resistance against "hegemonic notions of justice" (p. 40), and reclamation of a liberated, reimagined future.

Travel and Movement. Desai (2018) describes a decolonial framework of psychological healing centered on the philosophy that decolonization is a continual process and a journey rather than a destination or an achievement. This framework emphasizes both healing psychological effects and addressing the causes (i.e., systemic oppression) of these effects in part by challenging traditional notions of evidence-based intervention and embracing multicultural frameworks of science in psychotherapy. The author described a number of different types of "travel" associated with decolonial healing across dimensions similar to those described previously in the reviews of liberation psychology and radical healing. For instance, Desai reviewed the importance of the relational journey: healing emerges from the *process* of developing a strong and trusting therapeutic relationship where it is safe to engage with the pain of navigating systems of oppression. Decolonial journeys also occur on the societal and institutional levels, where clinicians step out of the therapy room to engage with the surrounding community and gain and understanding of the client's world. Finally, disciplinary decolonial journeys involve continual efforts by clinicians to expand and adapt their clinical training to embrace social justice movements; these journeys also include efforts to reduce the gap between

the therapy room and the rest of the world. For instance, clinicians may continue their practice of decolonization by engaging in social justice advocacy supplementary to their work in individual therapy (Beech, 2021; Smeja, 2019).

According to Desai (2018), decolonial therapists recognize that colonialism is a universal problem and fosters unity against colonial harm; therapists who follow this framework aim to find commonality across global and cross-cultural anti-colonial movements. It also denounces how our current systems are informed by colonialism and power and works toward building systems that are informed by justice, liberation, and peace. Systemic injustice is counteracted by facilitating and preserving community love and relational/interpersonal love, and there is a focus on cultivating and emphasizing the strengths of oppressed people. Finally, decolonial therapy validates Indigenous traditions and practices. Careful not to exploit or appropriate in a manner that would be reflective of colonialism, decolonial therapy instead focuses on collaborating with and respecting Indigenous knowledge and science.

Nonempirical Case Illustrations

Examples of what decolonial case conceptualization and psychological healing look like in clinical practice is scarce; however, some publications offering non-empirical case examples do exist. Adames et al. (2022) described radical healing psychotherapy between Brenda, a 32-year-old, African American, cisgender woman client with a rigid self-image of strength and resilience and her AfroLatinx male therapist. The therapist embodied the critical consciousness principle of radical healing by connecting the client's discussion in the therapy room to societal issues and naming in multiple ways how systemic oppression could be a source of her distress. The therapist also helped Brenda to resist self-blame by appropriately situating her expressed hopelessness in societal and systemic oppression, and helped her to emotionally experience hope

for the future by drawing focus to her visions of future possibilities. By helping Brenda to recognize people in her life who model resilience and strength, the therapist also helped Brenda feel the strength of her community and feel the salience of her cultural identities.

Fay (2016) reviewed a case conceptualization of Lucy, a 36-year-old Māori patient in a psychiatric clinic under the care of a mental healthcare team consisting of Pākehā (non-Māori, often descendants of settler colonialists) individuals. The author begins by naming the layered and nuanced oppression involved in Lucy being deemed incompetent to care for herself and her child within a colonial society where mental healthcare involves the threat of removing civil liberties in an uncanny resemblance to colonial patterns. Where the clinical team believed that Lucy needed to stop her substance use and comply with treatments in order to be deemed psychologically well and be granted freedom, Lucy disagreed with her diagnosis and viewed her substance use as unrelated to her psychiatric symptoms. Fay described that "Lucy reports feeling like a ghost much of the time. Cannabis helps her to feel more real…" (p. 3). Fay (2016) conceptualized Lucy along three dimensions: individual identity, parent-child relationships, and Māori-Pākehā relationships. First, Fay suggested that Lucy was suffering from loss and disconnection from her individual, human identity. Fay posited that Lucy's "psychotic moments" (p. 8) were a demonstration of resistance to colonial power: disassociation from herself was a way of refusing to experience the pain of oppression she otherwise experienced in society. Thus, decolonial treatment could focus on helping Lucy develop her self-identity through a supportive therapeutic stance that models acceptance of who and where she is. Regarding parent-child dynamics, Fay posited that Lucy's difficult upbringing in an unsafe world resulted in her overidentification with children who are alone (i.e., who she perceives to be neglected). Her history of police accusations of harassing children and her related distress could be an illustration

of her impulse to act on this overidentification. Decolonial treatment could focus on helping Lucy to engage with her own inner child in order to increase her self-empathy and relieve the pressure she feels to act outwardly toward other children (Fay, 2016). Regarding relational dynamics between Māori and Pākehā individuals, Fay emphasized the power differentials between Lucy and her treatment team and acknowledged the loss of cultural traditions—including the value and role of community in healing—perpetuated by strictly individualistic inpatient psychiatric care facilities. Fay stated that "a decolonized health service would prioritize active partnership with extended family systems" (p. 11).

Millner et al. (2021) shared a number of brief case examples to illustrate different concepts within their proposed framework of decolonial psychotherapy with Asian American clients. Specifically, they claimed that decolonizing psychotherapy with Asian American clients requires adopting a broad postcolonial perspective and actively reconstructing an "Asian-centric framework" of therapy (p. 337). Adopting a postcolonial perspective includes reflecting on positionality, power dynamics, and the ways that mental health fields have historically perpetuated harm and facilitated distrust. The case examples were treatment-focused and provided brief insights into therapist interventions to build an Asian-centric framework, which reflects values of centering collectivism, integrating religion and spirituality, and facilitating resistance, resilience, and recovery from the impacts of systemic oppression. For instance, Millner et al. described the case of an Iranian American woman with a Zoroastrian and Muslim background who was navigating the coming out process regarding her queer identity. The therapist worked with the client to understand how her mother's traumatic history of living through British colonialism and the Iranian Revolution influenced her views on homosexuality. Together, the client and therapist explored the client's connection to her Iranian identity; the

therapist helped empower the client by working with her to learn about Iranian leaders who had resisted systemic oppression such as the ban on homosexuality. Finally, the therapist and client worked through her coming out process, which was grounded in their knowledge of love, attraction, and resilience in Iranian culture.

Other examples of therapist interventions included naming important values, creating space to discuss family dynamics, directly inquiring about religion and spirituality, exploring intersectionality of identities, providing psychoeducation about shortcomings of traditional psychotherapies, and focusing on building up community connections. Although the case examples do demonstrate elements of the decolonial framework described by these authors, it is difficult to ascertain what in particular makes these interventions decolonial. An argument could be made that similar interventions are also used in traditional psychotherapies.

These theoretical case illustrations provide some insight into decolonial approaches in psychotherapy, but it is notable that Adames et al. (2022) focused primarily on therapeutic interventions and Fay (2016) focused primarily on case conceptualization. Millner et al. (2021) focused on illustrations of particular interventions, but did not provide case examples of either more comprehensive treatment work or case conceptualization. There is a need for additional work consolidating case conceptualization and treatment in order for clinicians to gain a more holistic understanding of what decolonial approaches in therapy look like. Furthermore, the case examples reviewed here were not empirical in nature; extant empirical research on decolonial approaches in therapy is reviewed in the next section.

Distinctions Between Multicultural Psychotherapy and Decolonial Psychotherapy

Decolonial psychotherapy is distinct from multicultural psychotherapy because some of its elements (e.g., the philosophy that psychological suffering and healing are tied to colonial

history) go beyond multicultural pedagogy (Gamby et al, 2021; Gorski & Goodman, 2015). Currently, multicultural psychotherapy is widely practiced under established guidelines that encourage clinicians to increase their awareness and knowledge of cultural differences in mental health as well as skills for working with clients from other cultures (Desai, 2018; Ratts et al., 2016; Sue et al., 1992). Clinicians who practice multicultural psychotherapy do so out of recognition that traditional Western models of psychotherapy were originally primarily centered around the experiences of a Western, educated, industrialized, rich, and democratic (WEIRD) population (Adams et al., 2015; Henrich et al., 2010; Desai, 2018). These clinicians believe that therapy frameworks that reflect such an insular foundational perspective are problematic because their relevance and appropriateness for marginalized or non-WEIRD populations is limited (Desai, 2018).

In practice, multicultural psychotherapy has taken many forms including adapting traditional Western models of therapy for minoritized populations (Hwang, 2006), integrating Western and non-Western models of psychological healing (Gamby et al., 2021), and appropriating piecemeal elements of non-Western healing practices such as mindfulness (Scherer & Waistell, 2017). These approaches have been shown to be effective in reducing the gap in mental health service utilization and treatment efficacy for people with marginalized identities (Hall & Ibaraki, 2016; Hussain & Hodge, 2016).

Some elements of decolonization (e.g., understanding the importance of culture and acknowledging how cultural identities influence life experiences like discrimination) may already be part of the way at least some clinicians teach and practice multicultural psychotherapy. For instance, Smeja (2019) blurred the line between multicultural and decolonial psychotherapies by investigating how elements of narrative therapy—a framework stemming

from a multicultural foundation—could represent a form of decolonization. However, other clinicians and scholars have critiqued multicultural psychotherapy as falling short of decolonial ideals (Gorski & Goodman, 2015; Goodman et al., 2015; Singh et al., 2020). Gorski and Goodman (2015) attest that a major shortcoming of multicultural psychotherapy is in its focus on cultural differences. Specifically, they indicate that focusing on culture when conceptualizing mental health problems can minimize systemic oppression (e.g., racism, heterosexism) by reducing it to a cultural phenomenon when it is actually a problem of power and society. They further argue that failure to appropriately name power and society (rather than culture) as sources of oppression means that multicultural psychotherapy does not address issues of psychological harm as well as it could.

Some scholars believe that multicultural psychotherapy approaches may not be appropriate for certain minoritized populations because they stem from and incorporate Western frameworks of psychotherapy. For instance, studies with Indigenous people in the United States show that they experience Western clinical approaches as methods of "ethnic cleansing" and conversion therapy (Gone, 2008). Specifically, Indigenous knowledge and healing practices are eradicated and Indigenous people are made to convert to Western conceptualizations of healing under Western frameworks of psychotherapy (Duran & Duran, 2000; Gone, 2008). It is therefore imperative to explore alternative frameworks of psychotherapy that may be more appropriate and effective particularly for Indigenous groups.

Empirical Research Illustrating Decolonial Philosophies in Individual Psychotherapy

Decolonization in psychotherapy has been investigated empirically primarily using qualitative research methodologies. Many of the research findings appear to consist primarily of general philosophies, attitudes, or perspectives rather than specific case illustrations of

decolonized psychotherapy in practice (Beech, 2021; Fellner, 2016). In addition, a number of studies specifically explore decolonization in therapy settings with Indigenous clients; often, these studies involve therapists who are not Indigenous. For example, Beech (2021) conducted a research study investigating how nine non-Indigenous counseling professionals "decolonized and Indigenized their practice" in their work with Indigenous clients (p. 3). Participants were all female, licensed mental health professionals (social workers, psychologists, and counselors); two were People of Color—no further elaboration on how they identified—and seven were White. Beech defined decolonization as requiring acknowledgement of systems of oppression and advocacy for social justice; thus, their research questions spanned from inquiring how therapists incorporate decolonization into their practices to specifically asking how they acknowledge systems of oppression and engage in advocacy work.

Using thematic analysis, Beech (2021) found several themes in the data, one of which was decolonization with several sub-themes. Decolonizing psychotherapy involved equalizing power dynamics by asking questions that communicated that the therapist was not the all-knowing expert, was open to unexpected or non-traditional ways of being (existing) or coping, and followed clients' leads for experiencing and expressing emotion. Interventions were described as open and flexible; for example, silence is used to create space for clients to explore, and questions stemming from a narrative perspective were used to understand clients' histories, present concerns, and visions for the future. Beech suggested that decolonization psychotherapy is holistic in that it spans across physical, emotional, and spiritual dimensions and may incorporate Indigenous artifacts to create a familiar space for clients. Beech also emphasized that therapists are mindful of their limits by making appropriate referrals enabling clients to utilize non-Western healing practices outside of the therapists' own professional training. In terms of

attitudes and engagement, Beech found that therapists who practice decolonization routinely checked their personal biases and internalized racist or colonial attitudes, continually learned about decolonial philosophies and unlearned their internalized colonial patterns, and were actively involved in social justice advocacy outside of the therapeutic space. These findings generally align with the previously described guidelines for decolonizing psychotherapy. However, this research provides little insight into case conceptualization or outcome assessment. Due to the nature of the study and broad scope of the research questions, therapists answered interview questions about decolonization in therapy generally instead of describing particular cases in-depth. While interviewers did ask therapists to provide clinical examples to support their answers, these examples did not provide enough evidence to draw significant conclusions about decolonial case conceptualization, treatment, or outcomes.

Smeja (2019) also studied therapeutic practices of non-Indigenous therapists working with Indigenous clients. This research study was a collaborative narrative inquiry of two non-Indigenous mental health practitioners who described how their practices with Indigenous clients reflected decolonial philosophies. Smeja specifically recruited participants who practiced narrative therapy and explored how narrative therapy does and does not fit into a decolonial approach to psychotherapy. Data was collected through pre-interview conversations followed by loosely structured interviews that aligned with guidelines for narrative therapy and Indigenous research practices. Results suggested that several elements of the narrative style fit within a decolonial philosophy. For example, participants indicated that narrative therapy is not just a technique but a philosophy which upholds all aspects of storytelling, including those that do not fit into traditional prescriptions of science, as important for knowledge-building. According to this perspective, healing through storytelling involves curious inquiry, a shift in the power

dynamic to focus on the client as the narrator and expert, investigation of dreams, and conversations about systems and systemic oppression. To practice decolonial narrative therapy, participants also endorsed using narrative therapy to focus on body, spirit, and environment. Somatic narrative therapy involved learning from the body, experiencing in the body, and healing in the body; narrative focus on spirituality involved dream work, out-of-body work and experiencing. Creating a safe environment using this decolonial approach involved meeting people outside of institutional or clinical spaces, such as in their homes or in parks, as well as adjusting the traditional clinical face-to-face setup to instead sit side-by-side or conduct a walking session. They also emphasized the importance of developing a strong therapeutic alliance, since the relationship dynamic is an integral foundation to storytelling. Participants suggested that clinicians acknowledge without challenging when clients address how clinicians may be limited in their ability to appreciate clients' experiences of oppression, particularly because clinicians themselves are inherently part of a bureaucratic and ultimately oppressive system. Finally, like Beech (2021), Smeja found that decolonial narrative therapy involves increasing conscious knowledge of colonial harm and engaging in the process of unlearning habitual colonial practices. Unfortunately, the interview questions did not directly address what the participating therapists did in their work with clients that reflected their decolonial philosophies. Although the information gained from this research supports the idea that elements of narrative therapy make it a decolonial approach, further empirical elaboration is needed to understand what decolonial approaches look like in the therapy room.

Fellner (2016) also explored decolonial psychological healing with Indigenous clients. In particular, Fellner investigated limitations of mental health service provision in serving the Indigenous community and transformations that are needed in the field in order to better serve

the community. Both the research topic and methodology were grounded in decolonial philosophy: the foundational framework echoed nonempirical calls for decolonizing psychotherapy given the limitations that Western psychotherapists do not operate from a decolonial perspective. Fellner recruited 16 self-identified Indigenous mental health professionals who worked with Indigenous clients. Data was collected through individual and paired interviews as well as a talking circle with the participants. Fellner approached data analysis from an Indigenous meaning-making perspective, which views meaning-making as a continuous process that occurs even throughout data collection; reflexivity and change based on things that are learned throughout the process are integral to this approach.

Even though Fellner (2016) engaged in an intentional departure from Western frameworks of research methodology and meaning-making, the themes that emerged broadly aligned with how decolonial psychotherapy has been described in other empirical and nonempirical work. For instance, practitioners in Fellner's study stressed the importance of learning from clients, being open to change, and adapting their own clinical perceptions of suffering and healing in validation of Indigenous conceptualizations of them. In particular, practitioners described centering Indigenous conceptualizations of wellness in therapeutic work by allowing an expanded and fluid definition of a good life to inform therapeutic goals. They also described love as foundational to psychological healing and emphasized clinicians' responsibilities to reduce psychological, spiritual, and emotional distance between therapist and client. Practitioners discussed following clients' leads with regard to pacing of the therapeutic work and relationship. By reducing distance in these ways, described elsewhere as equalizing the power dynamic, the clinician's role becomes one of being a witness to the clients' humanity and spirituality and the goal becomes to facilitate healing through prioritizing the development of the

therapeutic relationship. In addition, participants suggested that building and maintaining a client's sense of belonging, security, and safety is a substantial method of psychological healing—perhaps because colonialism destroys belongingness and safety. Similar to findings in Beech (2021), participants in Fellner's study suggested that decolonial therapy touches health across psychological, physical, and spiritual dimensions. Furthermore, they believed that all dimensions of health as well as life and death are connected to the earth and land; therefore, decolonial therapy with Indigenous clients should work restore the connection between people and land as a method of healing. Finally, Fellner's findings align with Beech in the description of decolonial practice as a continual process: therapists who practice decolonization in psychotherapy have a responsibility to dedicate themselves to learning about colonial harm and unlearning pervasive and harmful colonial patterns.

The results from Fellner's (2016) research clearly reflect well and provide empirical support for how decolonial psychotherapy has been described in theory and in other research. However, this study did not explore what practitioners actually do in their work with clients; instead, the purpose of this research was to give voice to what Indigenous mental health practitioners see as shortcomings of the field as well as areas and mechanisms for growth in decolonial mental health service provision. Additional research is needed to bridge the gap between potential and real decolonial psychotherapy.

Barriers Therapists May Encounter in Decolonizing Psychotherapy

It is beyond the scope of this literature review to describe the ways that even well-intentioned therapists perpetuate colonial harm in the therapy room. However, I briefly review the literature on ways therapists may struggle to adopt decolonial philosophies in an effort to contextualize my interest in what therapists do in practice that reflects these philosophies.

Blackwell (2003) spoke about how guilt presents a barrier to working towards true equalization of people and power. In line with United States literature on white guilt about the racial hierarchy (Turner, 2018), there is an element of guilt involved for the privileged party in a dynamic relationship (Blackwell, 2003). Conscious awareness of colonial harm and its associated guilt may make transference issues in psychotherapy more salient; therapists may avoid topics of systemic oppression (Blackwell, 2003) or feel pulled to overcompensate by being sensitive to their own feelings associated with colonial dynamics over issues that are alive in the therapy room for the client (Thomas, 2013). The appeal of avoidance to evade the discomfort of guilt may present a serious barrier preventing therapists from incorporating decolonial principles in psychotherapeutic practice.

A related barrier that therapists may encounter in practicing decolonial psychotherapy is the human tendency towards ease, rest, and comfort. Decolonization has been described as a philosophy that requires active resistance against colonial ideologies and a continuous choice of action over inaction (Almeida et al, 2007). It is easier to continue practicing the way we have historically practiced psychotherapy than it is to effortfully learn about how our practices must change—and take steps to change them—to reduce harm and facilitate decolonial healing.

The avoidance of change is enabled by the ideology that traditional Western frameworks of psychotherapy—despite how they may perpetuate colonial harms—are the superior and correct way to practice psychotherapy. Critical consciousness theorists (e.g., Adams et al., 2015) highlight how ways of knowing in the scientific community are placed on a hierarchy that resembles colonialism: with the colonizer's way of knowing at the top and given more validity than the rest. Furthermore, researchers suggest that therapists trained in Western philosophies are often unaware of how life experiences might be defined and described outside of the Western

lens. For instance, time in Western culture is a linear construct; when we think of life events, we remember them sequentially in terms of when they occurred. In many Indigenous communities, however, time is a non-linear spatial construct with an emphasis on where something happened rather than when (Duran & Duran, 2000). Given that Western ways of thinking are generally considered "correct," Duran and Duran (2000) argued that other conceptualizations of life constructs often fail to even breach clinician's conscious awareness. This may create a divide between therapists and clients of marginalized communities before therapists can even begin to demonstrate curiosity and openness to client experiences—a skill often identified as central to decolonial psychotherapeutic practice (Fellner, 2016; Smeja, 2019).

The barriers of ignorance and avoidance of discomfort may be another reason why decolonial psychotherapy practice is scarcely described in the extant literature. Still, scholars have called for clinicians to increase their awareness of the shortcomings of multicultural psychotherapy, the importance of social justice and decolonization, and barriers they may encounter in bridging this gap (Gorski & Goodman, 2015; Singh et al., 2020).

In sum, some clinicians have begun to address mental health problems by integrating individual and systemic understandings of oppression, marginalization, and colonialism into how they conceptualize mental health problems and treatment (Blackwell, 2003; Gone, 2021). I attest that the scarcity of extant literature that describes the actual practice of decolonization in individual psychotherapy is not appropriately reflective of the significance of this practice in the field of counseling. The present study will address this research gap by qualitatively exploring how therapists practice decolonization in case conceptualization, treatment, and outcome assessment. Furthermore, this study will assess facilitators and barriers that therapists faced in

decolonizing their practices. My hope is that insights gained through this research will help demystify decolonization for other therapists who may be considering this approach.

Appendix C

Theoretical Orientation Profile Scale - Revised

The following items have been devised to assess the extent to which you identify with, conceptualize from, and utilize techniques consistent with several theoretical schools of counseling and psychotherapy.

1. I identify myself to others as Psychoanalytic or Psychodynamic in orientation.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

2. I conceptualize client problems from a Psychoanalytic or Psychodynamic perspective.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

3. I utilize Psychoanalytic or Psychodynamic therapy techniques.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

4. I identify myself to others as Humanistic or Existential in orientation.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

5. I conceptualize client problems from a Humanistic or Existential perspective.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

6. I utilize Humanistic or Existential therapy techniques.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

7. I identify myself to others as Cognitive or Behavioral in orientation.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

8. I conceptualize client problems from a Cognitive or Behavioral perspective.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

9. I utilize Cognitive or Behavioral therapy techniques.
   Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
   1 2 3 4 5 6 7 8 9 10

10. I identify myself to others as Family Systems in orientation.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely

1 2 3 4 5 6 7 8 9 10

11. I conceptualize client problems from a Family Systems perspective.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

12. I utilize Family Systems therapy techniques.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

13. I identify myself to others as Feminist in orientation.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

14. I conceptualize client problems from a Feminist perspective.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

15. I utilize Feminist therapy techniques.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

16. I identify myself to others as Multicultural in orientation.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

17. I conceptualize client problems from a Multicultural perspective.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

18. I utilize Multicultural therapy techniques.
    Not at all |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Completely
    1 2 3 4 5 6 7 8 9 10

Completed items within each theoretical school are summed and averaged. Items not rated are dropped. Scores on each of the six subscales range from 1 to 10 and provide an indication of the extent to which respondents adhere to each specific theoretical orientation. There are no reverse scored items.

Note: This instrument was created by Worthington & Dillon (2003).

Appendix D

Interview Protocol

Thank you for your willingness to speak with me today! In this interview, I will ask questions about your journey to practicing using a decolonial approach and I will ask you to describe what this work looked like with one of your clients.

1. How do you define decolonization?
2. Describe your therapeutic philosophy around decolonization.
3. Why is having a decolonial philosophy important in therapy?

Please think about your practice in general.

4. How did you come to incorporate a decolonial philosophy in your therapy work?
5. How do you decide when and with whom to use a decolonial approach in therapy?
6. How do your sociocultural identities inform your decolonial therapy work?

Now, please think about a client with whom you've used this decolonial approach in therapy successfully.

7. How do you conceptualize this client using your decolonial philosophy?
8. Describe how you've implemented your decolonial approach in your work with this client.
9. Please discuss how your and your client's sociocultural identities shaped your decolonial work with this client.
10. If we were observing a session of yours with this client, what indications would we have that you were using a decolonial approach?
11. What are your criteria for determining if your decolonial approach was successful with this client?

Thank you so much for talking with me about your decolonial approach in therapy.

12. Is there anything else you can tell me about decolonization in individual therapy that we haven't yet talked about?

Appendix E

Recruitment Email

Subject: Invitation to Participate: Qualitative Research Exploring Decolonization in Individual Psychotherapy

Dear Therapist,

Are you a licensed therapist who practices individual psychotherapy using a decolonial approach? Have you developed your psychotherapy practice around the philosophy that psychological harm can be facilitated by repeated patterns of colonial harm? If so, you may be someone I can learn from in my qualitative research study on this topic!

I am a doctoral candidate in the University of Maryland's Counseling Psychology program, and I am currently interviewing therapists for my dissertation study investigating decolonial approaches to individual psychotherapy. Here is some context for who I am, my perspective, and my interest in this topic:

> *I am not an Indigenous person, and I have been grappling with the extensive harm and cycle of harm that people perpetuate through colonialism. My parents and ancestors were harmed by colonialism in India, and then my parents went on to settle on the great Turtle Island and become oppressors in that way. I have been taught to identify as "second generation Indian American," which I am understanding is also harmful and perpetuative language. I share parts of my identity with colonial oppressors (coming from an immigrant family, identifying as cisgender, benefiting from my family's engagement in wealth-building) and also experience marginalization (sexism because I am a woman, racism because I am Indian, and heterosexism because I am bisexual). I am trying to understand how to practice respect and journey toward liberation while existing in a society whose framework is systemic oppression.*

I'm reaching out in hopes that you might be willing to describe how you practice decolonization in your therapy work in an interview with me. You would have the choice of completing this interview over a phone or video call and it would last between 1-2 hours.
The study eligibility requirements are that all therapists:

> (a) are 18 years or older,
> (b) are licensed therapists,
> (c) have a self-identified specialization in working with clients in individual psychotherapy using a decolonial approach, and
> (d) are able to talk about one client with whom they are currently still in therapy or ended therapy within the last two years, whom they saw for at least six months, and with whom they used a decolonial psychotherapeutic approach.

The interview protocol is attached for you to review. If you are interested in participating in this study, please complete this eligibility and background survey:

https://umdsurvey.umd.edu/jfe/form/SV_eJoMpUCTtTq3vX8.

This survey is expected to take no more than 10 minutes to complete.

If you are eligible for the study, I will email you to schedule an interview. Verbal consent will be obtained at the start of the interview and consent can be withdrawn at any time; you may also choose to skip any question you prefer not to answer. Data for the interview will be collected via audio recording, so consent for audio recording is required for participation in this study.

I would also appreciate your consideration in forwarding this email or my contact information to any therapists in your professional network who might be interested in this study. I can be contacted at pbansal@umd.edu.

Thank you for considering contributing to this important area of research!

Sincerely,

Priya Bansal, Doctoral Candidate in Counseling Psychology; University of Maryland

Clara E. Hill, PhD, Advisor

Appendix F

Table 1. Categories and subcategories within domains for decolonizing individual therapy

Domain/Category/Subcategories	Frequency
Domain 1: Problems with colonial paradigms	
Individuals are negatively impacted by internalization of colonial values	T (10)
Relationships are damaged by the influence of colonial ideologies	T (10)
Colonial violence and oppressive ideologies are woven into the fabric of society	T (8)
Clinicians perpetuate colonial ideologies in therapy	G (11)
Domain 2: How therapists practice decolonizing psychotherapy	
Develop or repair the therapeutic relationship	G (11)
Disclose thoughts, feelings, experiences, and personal healing practices	T (10)
Address power dynamics and foster client agency	G (11)
Facilitate new conceptualizations	G (12)
Help clients internalize new decolonial ideologies	G (12)
Facilitate insight about psychological suffering being caused by systemic oppression	G (11)
Help clients understand their ancestral history	T (10)
Facilitate insight about how sociocultural identities shape experiences	T (8)
Use the therapeutic relationship to understand relational dynamics	T (8)
Provide psychoeducation about decolonizing therapy	T (7)
Disclose thoughts, feelings, experiences, and healing practices to facilitate client insight	V (5)
Depathologize psychological experiences	V (4)
Help clients resist impacts of colonialism by facilitating connection and reconnection	G (12)
Use somatic interventions	T (10)
Incorporate clients' cultural healing practices and ancestral teachings	T (8)
Help clients develop relationships with the land	T (7)
Help clients connect with alternate versions of themselves and others through parts-of-self work	V (3)
Expand beyond individual therapy	G (11)
Embody a decolonizing philosophy and attitude	G (12)
Therapists are intentional and mindful of language usage	T (10)
Practice intention over intervention	T (8)
Facilitate a slow and non-linear therapy process	T (9)
Use interventions from established therapy models that fit their decolonizing approach	V (4)
Credit their sources of knowledge about decolonizing	T (10)

Engage in self-care and maintain connections with professional community and mentors	V (6)
Domain 3: The influence of sociocultural identities on decolonizing therapy practice	
Therapist sociocultural identities shape their decolonizing therapy work	G (11)
Therapist's experiences shape their understanding of and connection with clients	T (10)
Clients seek out therapist because of sociocultural identities and values	T (7)
Client sociocultural identities shape how therapists work with them	G (11)
Therapists were more explicit about decolonizing therapy with clients who were knowledgeable about colonialism and willing to engage in decolonizing	T (9)
Some client identities motivated therapists to critically examine power dynamics	V (6)
Match shapes decolonizing therapy work	G (11)
Shared identities or values between therapist and client make decolonizing work easier	T (9)
Lack of shared identities or values between therapist and client makes decolonizing work harder	T (10)
Domain 4: Challenges in practicing decolonizing therapy	
Lack of clarity about how to practice decolonizing	T (7)
Therapists are cautious about claiming to be a decolonizing therapist	V (5)
Therapists fear violating professional ethical standards if they practice decolonizing therapy	V (5)
Power dynamics are a barrier to practicing decolonizing therapy	V (4)
Colonial foundations of society are a barrier to practicing decolonizing therapy	V (4)
Therapists struggle to balance decolonizing values with standardized therapeutic approaches	V (4)
Domain 5: Outcomes of successful decolonizing therapy	
Improvements in client intrapersonal functioning	G (12)
Increased self-empowerment	G (11)
Increased systemic understanding	V (6)
Increased empathy for self and ancestors	V (4)
Decrease in symptoms	V (6)
Improvements in client interpersonal functioning	V (6)
Positive impacts on therapists	V (5)
Therapists use non-standardized forms of assessing success and outcomes	V (6)

Domain 6: How therapists practice decolonizing in their non-professional lives	
Engage in community-building and social justice advocacy	V (5)
Actively disinvest from colonization in daily life	V (3)
Practice critical self-reflection	V (5)

Note: *N* = 12. G = general (11-12), T = typical (7-10), V = variant (2-6).

Appendix G

Table 2. Initial Research Questions with Corresponding Results

Initial Research Question	Domain	Category	Subcategory
Question A: How do decolonial therapists conceptualize psychological problems?	1	1, 2, 3	n/a
	2	2	1, 8
Question B: How do therapists implement decolonial therapeutic approaches with their clients?	2	all	all
Question C: How do decolonial therapists assess the effectiveness of psychotherapy?	5	all	all
Question D: What facilitated the development of therapists' decolonial therapeutic approaches?	1	4	n/a
	2	5	5
Question E: What barriers did therapists encounter in developing their decolonial therapeutic approaches?	4	all	n/a
	1	4	n/a
	3	3	2
Other findings not fully covered by research questions	3	all	all
	6	all	n/a

Note: Indicated numbers for domain/category/subcategory correspond with the order of these items in Table 1 (see Appendix F).

Appendix H

Table 3. Sources of knowledge credited by participants for shaping their decolonizing practice

Name	Type
Tema Okun	Individual
Resmaa Menakem	Individual
Gesturing Toward Decolonial Futures	Group
Facing Human Wrongs	Course
Vanessa Andreotti/Vanessa Machado de Oliveira	Individual
Hospicing Modernity	Book
Jennifer Mullan	Individual
Tada Hazoumi	Individual
Ritual as Justice School	Course
Generative Somatics	Group
Audre Lorde	Individual
Sister Outsider	Book
Mattilda Bernstein Sycamore	Individual
Tuck & Yang (2012)	Individuals
Decolonization is not a Metaphor	Article
Leticia Nieto	Individual
Black feminists	Community
Larry Yang	Individual
Nadine Burke	Individual
The Deepest Well	Book
Shirley Turcotte	Individual
Eugene Gendlin	Individual
Gerald Vizenor	Individual
Canadian Psychological Association	Organization
Psychology's Response to the Truth and Reconciliation Commission of Canada's Report	Apology
Joseph Gone	Individual
Eduardo Duran	Individual
Blackfoot, Stoney Nakoda, Tsuu T'ina, Anishinaabe, and Dakota people	Communities
Toni Morrison	Individual
The Origin of Others	Book
Lifeforce	Conference
Healers outside of licensed psychotherapy community	Community
Elders	Individuals
Kim TallBear	Individual

Indigenous communities	Communities

References

Adams, G., Dobles, I., Gómez, L. H., Kurtiş, T., & Molina, L. E. (2015). Decolonizing Psychological Science: Introduction to the Special Thematic Section. *Journal of Social and Political Psychology, 3*(1), 213-238. https://doi.org/10.5964/jspp.v3i1.564

Adames, H. Y., Chavez-Dueñas, N. Y., Lewis, J. A., Neville, H. A., French, B. H., Chen, G. A., & Mosley, D. V. (2022). Radical healing in psychotherapy: Addressing the wounds of racism-related stress and trauma. *Psychotherapy*. Advance online publication. https://doi.org/10.1037/pst0000435

Almeida, R., Dolan-Del Vecchio, K., & Parker, L. (2007). Foundation concepts for social justice-based therapy: Critical consciousness, accountability, and empowerment. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 175–206). Lawrence Erlbaum Associates Publishers.

Amin, S. & Bansal, P. (2022). *Understanding the Asian Indian Diaspora and Mental Health: Liberation from Western Frameworks*. Cognella.

Anzaldúa, G. (2012). *Borderlands/La Frontera: The New Mestiza*. Aunt Lute Books.

Arvay, M.J. (2003). Doing reflexivity: A collaborative, narrative approach. In: Finlay, L. and & Gough. B. (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences*. Oxford: Blackwell, 163-175.

Astolfo, G., Allsopp, H. (2023). The coloniality of migration and integration: continuing the discussion. *Comparative Migration Studies, 11*(19). https://doi.org/10.1186/s40878-023-00343-2

Atdjian, S., & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: implications for psychiatrists. *Psychiatric services (Washington, D.C.), 56*(12), 1600–1602. https://doi.org/10.1176/appi.ps.56.12.1600

Beech, L. T. (2021). *"I'm Not the Expert": Ways Mental Health Providers Decolonize Their Practice* [doctoral dissertation, University of Saskatchewan]. Harvest.

Bergkamp, J., O'Leary Sloan, M., Krizizke, J., Lash, M., Trantel, N., Vaught, J., Fulmer, T., Waite, I., Martin, A. M., Scheiderer, C., & Olson, L. (2023). Pathways to the therapist paragon: a decolonial grounded theory. *Frontiers in psychology, 14*, 1185762. https://doi.org/10.3389/fpsyg.2023.1185762

Bernstein, D. M. (2001). Therapist-Patient Relations and Ethnic Transference. In W. S. Tseng & Streltzer, J. (Eds.), *Culture and psychotherapy: A guide to clinical practice.* American Psychiatric Press.

Bhambra, G. K., & Newell, P. (2023). More than a metaphor: 'climate colonialism' in perspective. *Global Social Challenges Journal, 2*(2), 179-187. Retrieved Jun 16, 2024, from https://doi.org/10.1332/EIEM6688

Blackwell, D. (2003). Colonialism and Globalization: A Group-Analytic Perspective. *Group Analysis, 36*(4), 445-463. https://doi.org/10.1177/0533316403364002

Blitz, L. V. (2006). Owning whiteness: The reinvention of self and practice. *Journal of Emotional Abuse, 6*(2-3), 241-263.

Bogle, A., Rhodes, P., & Hunt, C. (2021). Cultural humility and decolonial practice: narratives of therapists' lives. *Clinical Psychologist, 25*(1), 36-43. https://doi.org/10.1080/13284207.2021.1924655

Bonovitz, C. (2005) Locating Culture in the Psychic Field, *Contemporary Psychoanalysis, 41*(1), 55-75. DOI: 10.1080/00107530.2005.10745848

Brady, J. (2018). (Re)Claiming Spirituality as Anti-Colonial Resistance and Decolonial Praxis: An Africana-Feminist Discussion on Spirituality and Indigenous Knowledges in Education. In G. J. Sefa Dei & C. Jaimungal (Eds.), *Indigeneity and Decolonial Resistance: Alternatives to Colonial Thinking and Practice*. Myers Education Press.

Byrd, J. A. (2011). *The Transit of Empire: Indigenous Critiques of Colonialism*. University of Minnesota Press.

Chayinska, M., Minescu, A., & McGarty, C. (2017). Political solidarity through action (and inaction): how international relations changed intracultural perceptions in Ukraine. *Group Processes And Intergroup Relations, 20*(3), 396-408. https://doi.org/10.1177/1368430216682354

Comas-Diaz, L. (2007). Ethnopolitical psychology: Healing and transformation. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 91–118). Lawrence Erlbaum Associates Publishers.

Comas-Díaz, L. (2011). Multicultural approaches to psychotherapy. In J. C. Norcross, G. R. VandenBos, & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (pp. 243–267). American Psychological Association. https://doi.org/10.1037/12353-008

Comas-Díaz, L. (2020). Liberation psychotherapy. In L. Comas-Díaz & E. Torres Rivera (Eds.), *Liberation psychology: Theory, method, practice, and social justice* (pp. 169–185). American Psychological Association. https://doi.org/10.1037/0000198-010

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

Costa, D. S. J., Mercieca-Bebber, R., Tesson, S., Seidler, Z., & Lopez, A. L. (2019). Patient, client, consumer, survivor or other alternatives? A scoping review of preferred terms for labelling individuals who access healthcare across settings. *BMJ open, 9*(3), e025166. https://doi.org/10.1136/bmjopen-2018-025166

Coutinho, J., Ribeiro, E., Hill, C., & Safran, J. (2011). Therapists' and clients' experiences of alliance ruptures: A qualitative study. *Psychotherapy Research, 21*(5), 525-540.

Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Davis, A. (1981). *Women, Race, and Class*. Random House.

Desai, M. (2018). *Travel and Movement in Clinical Psychology: The World Outside the Clinic*. Palgrave Macmillan UK.

Doherty, S. P. (2012). *Money in therapy: Private practitioners' experiences and perceptions of charging for counselling: A qualitative study*. [Master's thesis, University of Chester, United Kingdom].

Doyen, P. (2021). The Overdiagnosis of Bipolar Disorder Within Marginalized Communities: A Call to Action. *Columbia Social Work Review, 19*(1), 80–99. https://doi.org/10.52214/cswr.v19i1.7388

Dudgeon, P., Bray, A., D'Costa, B., & Walker, R. (2017). Decolonising psychology: Validating social and emotional wellbeing. *Australian Psychologist, 52*(4), 316–325. https://doi.org/10.1111/ap.12294

Dunbar-Ortiz, R. (2015). *An indigenous peoples' history of the United States*. Beacon Press.

Dupuis-Rossi, R. (2021). The Violence of Colonization and the Importance of Decolonizing Therapeutic Relationship: The Role of Helper in Centering Indigenous Wisdom. *International Journal of Indigenous Health. 16*(1). 10.32799/ijih.v16i1.33223.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other native peoples*. Teachers College Press.

Duran, B. and E. Duran (2000). "Applied postcolonial clinical and research strategies." In Battiste, M. (Ed.), *Reclaiming indigenous voice and vision*. Vancouver, UBC Press. pp 86-100.

Ellis, D. M., Guastello, A. D., Anderson, P. L., & McNamara, J. P. (2019). How racially concordant therapists and culturally responsive online profiles impact treatment-seeking among Black and White Americans. *Practice Innovations, 4*(2), 75.

Enns, C. Z. (1997). *Feminist theories and feminist psychotherapies: Origins, themes, and variations*. Harrington Park Press/The Haworth Press.

Ertl, M. M., Mann-Saumier, M., Martin, R. A., Graves, D. F., & Altarriba, J. (2019). The impossibility of client–therapist "match": Implications and future directions for multicultural competency. *Journal of Mental Health Counseling, 41*(4), 312-326.

Fadiman, A. (1998). *Spirit catches you and you fall down*. Farrar, Straus & Giroux.

Fanon, F. (1963). *The wretched of the earth*. Grove Press.

Farb, N. (2014). From Retreat Center to Clinic to Boardroom? Perils and Promises of the Modern Mindfulness Movement. *Religions, 5*(4), 1062–1086. https://doi.org/10.3390/rel5041062

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*, 156–166. doi:10.1037/0022-0167.52.2.156

Fay, J. (2016). Decolonising mental health services one prejudice at a time: psychological, sociological, ecological, and cultural considerations. *Settler Colonial Studies, 8*(1), 47–59. https://doi.org/10.1080/2201473X.2016.1199828

Feldman, A. (2023). Participatory and critical action research. *Educational Action Research, 31*(4), 611–619. https://doi.org/10.1080/09650792.2023.2252212

Fellner, K. D. (2016). *Returning to our medicines: decolonizing and indigenizing mental health services to better serve Indigenous communities in urban spaces.* [Doctoral dissertation, University of British Columbia]. UBC Theses and Dissertations.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

French, B. H., Lewis, J. A., Mosley, D. V., Adames, H. Y., Chavez-Dueñas, N. Y., Chen, G. A., & Neville, H. A. (2020). Toward a psychological framework of radical healing in communities of color. *The Counseling Psychologist, 48*(1), 14–46. https://doi.org/10.1177/0011000019843506

Frey, L. L. (2013). Relational-cultural therapy: Theory, research, and application to counseling competencies. *Professional Psychology: Research and Practice, 44*(3), 177-185. DOI: 10.1037/a0033121

Fullen, M. C., Wiley, J. D., & Morgan, A. A. (2019). The Medicare mental health coverage gap: How licensed professional counselors navigate Medicare-ineligible provider status. *The Professional Counselor, 9*(4), 310–323. https://doi.org/10.15241/mcf.9.4.310

Gamby, K., Burns, D., & Forristal, K. (2021). Wellness Decolonized: The History of Wellness and Recommendations for the Counseling Field. *Journal of Mental Health Counseling, 43*(3), 228-245. 10.l7744/mehc.43.3.05

Garrison, Y. L., Jiao, T., Vaz, S., Shah, S., Reeves, D., Murphy, S., Lin, C.-L. R., & Pak, S. (2023). A qualitative study of women of color group psychotherapists: The wellspring of collective healing. *Journal of Counseling Psychology, 70*(1), 1–15. https://doi-org.proxy-um.researchport.umd.edu/10.1037/cou0000643

Gelberg, S. O., Poteet, M. A., Moore, D. D., & Coyhis, D. (Eds.). (2018). *Radical psychology: Multicultural and social justice decolonization initiatives*. Lexington Books/Rowman & Littlefield.

Ginwright, S. (2015). Radically Healing Black Lives: A Love Note to Justice. *New Directions for Student Leadership*, 33-44. 10.1002/yd.20151.

Glick, S. (2023). I am the 'evil other'(and so are you): healing historic divisions that breed public mass gun violence in the US. Compare: *A Journal of Comparative and International Education, 53*(5), 767-782.

Gone, J. P. (2008). Introduction: Mental health discourse as Western cultural proselytization. *Ethos, 36*(3), 310-315.

Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist, 38*(2), 166–235. https://doi.org/10.1177/0011000008330831

Gone, J. P. (2020). Decolonization as methodological innovation in counseling psychology: Method, power, and process in reclaiming American Indian therapeutic traditions. *Journal of Counseling Psychology, 68*(3), 259–270. https://doi.org/10.1037/cou0000500

Gone J. P. (2021). The (post)colonial predicament in community mental health services for American Indians: Explorations in alter-Native psy-ence. *The American psychologist, 76*(9), 1514–1525. https://doi.org/10.1037/amp0000906

Gorski, P. C. & Goodman, R. D. (2015). Introduction: Toward a Decolonized Multicultural Counseling and Psychology. In R. D. Goodman & P. C. Gorski (Eds), *Decolonizing "Multicultural" Counseling through Social Justice* (pp. 1-10). Springer Science+Business Media, LLC.

Hall, G. C. N., & Ibaraki, A. Y. (2016). Multicultural issues in cognitive-behavioral therapy: Cultural adaptations and goodness of fit. In C. M. Nezu & A. M. Nezu (Eds.), *The Oxford handbook of cognitive and behavioral therapies* (pp. 465–481). Oxford University Press.

Hall, R. J. (2015). Divide and conquer: Privatizing Indigenous land ownership as capital accumulation. *Studies in Political Economy, 96*(1), 23-46.

Hamilton, N. G. (1990). *Self and others: Object relations theory in practice*. Rowman & Littlefield Publishers, Inc.

Hanisch, C. (1970). The personal is political. *Notes From the Second Year: Women's Liberation*, 76-78. https://idn.duke.edu/ark:/87924/r33x35

Hartman, S. (2007). *Lose Your Mother: A Journey Along the Atlantic Slave Route*. Farrar, Straus and Giroux.

Hartmann, W. E., Wendt, D. C., Burrage, R. L., Pomerville, A., & Gone, J. P. (2019). American Indian historical trauma: Anticolonial prescriptions for healing, resilience, and survivance. *American Psychologist, 74*(1), 6–19. https://doi.org/10.1037/amp0000326

Harvey, D. (2005). *A Brief History of Neoliberalism*. Oxford University Press.

Hatcher, S. L., Kipper-Smith, A., Waddell, M., Uhe, M., West, J. S., Boothe, J. H., ... & Gingras, P. (2012). What Therapists Learn from Psychotherapy Clients: Effects on Personal and Professional Lives. *Qualitative Report, 17*(95), 1-21.

Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy, 55*(4), 496.

Helms, J. E. (2004). Racial identity development and its impact in the classroom. *Special Diversity Issue, 4*.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world?. *The Behavioral and brain sciences, 33*(2-3), 61–135. https://doi.org/10.1017/S0140525X0999152X

Hill, C. E. (Ed.). (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena*. American Psychological Association.

Hill, C. E. (2020). *Helping skills: Facilitating exploration, insight, and action* (5th ed.). American Psychological Association.

Hill, C. E., & Knox, S. (2021). *Essentials of consensual qualitative research*. American Psychological Association. https://doi.org/10.1037/0000215-000

Hodge, D. R., Limb, G. E., & Cross, T. L. (2009). Moving from colonization toward balance and harmony: a Native American perspective on wellness. *Social work, 54*(3), 211–219. https://doi.org/10.1093/sw/54.3.211

Hollander-Goldfein, B., Fosshage, J. L., & Bahr, J. M. (1989). Determinants of patients' choice of therapist. *Psychotherapy: Theory, Research, Practice, Training, 26*(4), 448–461. https://doi.org/10.1037/h0085463

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.

hooks, b. (1989). *Talking back: thinking feminist, thinking black*. Boston, Mass., South End Press.

hooks, b. (2010). *Teaching Critical Thinking: Practical Wisdom*. Routledge.

hooks, b. (2014). *Ain't I a Woman: Black Women and Feminism*. Pluto Press.

Husain, A., & Hodge, D. R. (2016). Islamically modified cognitive behavioral therapy: Enhancing outcomes by increasing the cultural congruence of cognitive behavioral therapy self-statements. *International Social Work, 59*(3), 393-405. https://doi.org/10.1177/0020872816629193

Hwang, W. (2006). The Psychotherapy Adaptation and Modification Framework: Application to Asian Americans. *The American psychologist, 61*, 702-15. 10.1037/0003-066X.61.7.702.

Intergroup Relations Center. (n.d.). *Social Identity Wheel: Voices of Discovery*. Arizona State University.

Ishikawa, M. (2018). Mindfulness in Western Contexts Perpetuates Oppressive Realities for Minority Cultures: The Consequences of Cultural Appropriation. *SFU Educational Review, 11*(1). https://doi.org/10.21810/sfuer.v11i1.757

Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. *Annu Rev Public Health, 19*(0163-7525):173–202.

Jeewa, T. R., & Bhima, J. (2021). Discriminatory Language: A Remnant of Colonial Oppression. *Constitutional Court Review, 11*(1), 1-17.

Johnson, T. J. (2022). "Your Silence Will Not Protect You": Using Words and Action in the Fight Against Racism. *Pediatrics, 149*(2), 1-4. https://doi.org/10.1542/peds.2021-052115

Jordan, J. V. (2018). *Relational–cultural therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000063-000

Kallivayalil, D. (2010). Narratives of Suffering of South Asian Immigrant Survivors of Domestic Violence. *Violence Against Women, 16*(7), 789–811. https://doi.org/10.1177/1077801210374209

Kamya, H. (2007). Narrative Practice and Culture. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 207-220). Lawrence Erlbaum Associates Publishers.

Kaufman, J. S., Carlozzi, A. F., Boswell, D. L., Barnes, L. L., Wheller-scruggs, K., & Levy, P. A. (1997). Factors influencing therapist selection among gays, lesbians and bisexuals. *Counselling Psychology Quarterly, 10*(3), 287-297.

Keeling, M. L. & Piercy, F. P. (2007). A careful balance: Multinational perspectives on culture, gender, and power in marriage and family therapy practice. *Journal of Marital and Family Therapy,* 33(4), 443–463.

Kidd, S. A., & Kral, M. J. (2005). Practicing participatory action research. *Journal of Counseling Psychology, 52*, 187–195. doi:10.1037/0022-0167.52.2.187

Kivel, P. (2017). *Uprooting Racism: How White People Can Work for Racial Justice* (4th ed.). New Society Publishers.

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44*(3), 274–283. https://doi.org/10.1037/0022-0167.44.3.274

Korman, G. P. & Saizar, M. M. (2018). A qualitative study on cognitive behavioral therapist. The appropriation of Eastern practices or the practice of mindfulness? In M. M. Saizar & Bordes, M. (Eds.), *Alternative Therapies in Latin America: Policies, Practices and Beliefs*. Nova Publishers.

Laenui, P. (2000). Processes of decolonization. In Battiste, M. (Ed.), *Reclaiming indigenous voice and vision* (pp. 150–160). University of British Columbia Press.

Legault, G. (2022). From (re) ordering to reconciliation: early settler colonial divide and conquer policies in Canada. *Journal of indigenous social development, 11*(2), 44-66.

Lewis, M. E., Hartwell, E. E., & Myhra, L. L. (2018). Decolonizing mental health services for indigenous clients: A training program for mental health professionals. *American Journal of Community Psychology, 62*(3-4), 330–339. https://doi.org/10.1002/ajcp.12288

Lezama, C. R. (2018). Decolonial Latinx Feminist Spiritual Practices in Processes of Decolonization. In G. J. Sefa Dei & C. Jaimungal (Eds.), *Indigeneity and Decolonial Resistance: Alternatives to Colonial Thinking and Practice*. Myers Education Press.

Liang, J., Matheson, B. E., & Douglas, J. M. (2016). Mental Health Diagnostic Considerations in Racial/Ethnic Minority Youth. *Journal of child and family studies, 25*(6), 1926–1940. https://doi.org/10.1007/s10826-015-0351-z

Lorde, A. (1984). *Sister outsider: Essays and speeches*. Crossing Press.

Lorde, A. (2017). *Your Silence Will Not Protect You*. Silver Press.

Louie, Dustin & Poitras Pratt, Yvonne & Hanson, Aubrey & Ottmann, Jacqueline. (2017). Applying Indigenizing Principles of Decolonizing Methodologies in University Classrooms. *Canadian Journal of Higher Education, 47*, 16-33. DOI: 10.7202/1043236ar

Lukens, E. P., & McFarlane, W. R. (2006). Psychoeducation as evidence-based practice. *Foundations of evidence-based social work practice, 291*, 151-160.

Machado de Oliveira, V. (2022). *Hospicing Modernity*. North Atlantic Books.

Mark, G. T., & Lyons, A. C. (2010). Māori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine, 70*(11), 1756–1764. https://doi.org/10.1016/j.socscimed.2010.02.001

Marsella, A. J. (2015a). Decolonization of Mind and Behavior: A Responsibility of Professional Counselors. In R. D. Goodman & P. C. Gorski (Eds), *Decolonizing "Multicultural" Counseling through Social Justice* (pp. vii–x). Springer Science+Business Media, LLC.

Marsella, A. J. (2015b). Trends, Changes, Challenges in North American (Eurocentric) Psychology: Rethinking Assumptions, Practices, and Organization in Socio-Political Contexts. *Journal for Social Action in Counseling & Psychology, 7*(1), 143–152. https://doi.org/10.33043/JSACP.7.1.143-152

McConnell, A. & t'Hart, M. (2014). Public Policy as Inaction: The Politics of Doing Nothing. *SSRN Electronic Journal*, http://dx.doi.org/10.2139/ssrn.2500010

McWhorter, M. R. (2019). Balancing value bracketing with the integration of moral values in psychotherapy: Evaluation of a clinical practice from the perspective of catholic moral theology. *Linacre Q, 86*(2-3), 207–224. DOI: 10.1177/0024363919856810

McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. Guilford Press.

Menakem, R. (2017). *My grandmother's hands*. Central Recovery Press.

Merriam, S. B. (2002). *Qualitative research in practice: Examples for discussion and analysis*. Jossey-Bass.

Messer, S. B., & McWilliams, N. (2007). Insight in Psychodynamic Therapy: Theory and Assessment. In L. G. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 9–29). American Psychological Association. https://doi.org/10.1037/11532-001

Miller, S. D., & Duncan, B. L. (2000). Paradigm lost: From model-driven to client-directed, outcome-informed clinical work. *Journal of Systemic Therapies, 19*(1), 20–34. https://doi.org/10.1521/jsyt.2000.19.1.20

Millner, U. C., Maru, M., Ismail, A., & Chakrabarti, U. (2021). Decolonizing mental health practice: Reconstructing an Asian-centric framework through a social justice lens. *Asian American Journal of Psychology, 12*(4), 333–345. https://doi.org/10.1037/aap0000268

Mitchell, S. L., & Dossey, L. (2018). *Sacred instructions: indigenous wisdom for living spirit-based chang*e. North Atlantic Books.

Moane G. (2003). Bridging the personal and the political: practices for a liberation psychology. *American journal of community psychology, 31*(1-2), 91–101. https://doi.org/10.1023/a:1023026704576

Moloney, P. (2013). *The Therapy Industry: The Irresistible Rise of the Talking Cure, and Why It Doesn't Work*. Pluto Press. https://doi.org/10.2307/j.ctt183p0xg

Morales-Doyle, D. (2017). Justice-centered science pedagogy: A catalyst for academic achievement and social transformation. *Sci Ed., 101*, 1034-1060. https://doi-org.proxy-um.researchport.umd.edu/10.1002/sce.21305

Morrow, S. L., Castañeda-Sound, C. L., & Abrams, E. M. (2012). Counseling psychology research methods: Qualitative approaches. In N. A. Fouad, J. A. Carter, & L. M. Subich (Eds.), *APA handbooks in psychology®. APA handbook of counseling psychology, Vol. 1. Theories, research, and methods* (p. 93–117). American Psychological Association. https://doi.org/10.1037/13754-004

Muhire, H. (2024). Colonial violence and the dangerous passivity of Western intellectuals on Palestine. *Justice, Power and Resistance, 7*(1), 86-98. Retrieved Jun 16, 2024, from https://doi.org/10.1332/26352338Y2024D000000010

Mullan, J. (2023). *Decolonizing Therapy: Oppression, Historical Trauma, and Politicizing Your Practice*. Norton Professional Books.

Nagai, C. (2013). Responding to culturally based spiritual experiences in clinical practice from East Asian perspectives. *Mental Health, Religion & Culture, 16*(8), 797-812.

Parth, K., Datz, F., Seidman, C., & Löffler-Stastka, H. (2017). Transference and countertransference: A review. *Bulletin of the Menninger Clinic, 81*(2), 167-211.

PettyJohn, M. E., Tseng, C. F., & Blow, A. J. (2020). Therapeutic utility of discussing therapist/client intersectionality in treatment: When and how?. *Family process, 59*(2), 313-327.

Pope, K. S., & Vasquez, M. J. T. (2016). *Ethics in psychotherapy and counseling: A practical guide*. John Wiley & Sons.

Prilleltensky I. & Nelson G. B. (2002). *Doing psychology critically: making a difference in diverse settings*. Palgrave Macmillan.

Purser, R. (2019). *McMindfulness: How Mindfulness Became the New Capitalist Spirituality*. Repeater Books.

Purser, R. & Loy, D. (2013). *Beyond McMindfulness*. HuffPost. https://www.huffpost.com/entry/beyond-mcmindfulness_b_3519289

Quijano, A. (2000). Coloniality of Power and Eurocentrism in Latin America. *International Sociology, 15*(2), 215-232. https://doi.org/10.1177/0268580900015002005

Ratts, M.J., Singh, A.A., Nassar-McMillan, S., Butler, S.K. and McCullough, J.R. (2016), Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession. *Journal of Multicultural Counseling and Development, 44*, 28-48. https://doi.org/10.1002/jmcd.12035

Rhodes, P. & Langtiw, C. (2018). Why clinical psychology needs to engage in community-based approaches to mental health: Why we need community-based approaches to clinical psychology. *Australian Psychologist, 53*. DOI: 10.1111/ap.12347.

Rieken, B., & Gelo, O. C. G. (2015). The philosophy of psychotherapy science: Mainstream and alternative views. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations, process, and outcome* (pp. 67-92). Springer-Verlag Publishing/Springer Nature. https://doi.org/10.1007/978-3-7091-1382-0_4

Rimke, H., & Brock, D. (2012). The culture of therapy: Psychocentrism in everyday life. In M. Thomas, R. Raby & D. Brock (Eds.), *Power and everyday practices* (pp. 182-202). Toronto: Nelson

Robcis C. (2020). Frantz Fanon, Institutional Psychotherapy, and the Decolonization of Psychiatry. *Journal of the history of ideas, 81*(2), 303–325. https://doi.org/10.1353/jhi.2020.0009

Rober, P., & Seltzer, M. (2010). Avoiding colonizer positions in the therapy room: Some ideas about the challenges of dealing with the dialectic of misery and resources in families. *Family Process, 49*(1), 123–137. https://doi.org/10.1111/j.1545-5300.2010.01312.x

Rogers, C. R. (1995). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.

Rogers, C. R. (2007). The basic conditions of the facilitative therapeutic relationship. In M. Cooper, M. O'Hara, P. F. Schmid, & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp. 1–5). Palgrave Macmillan/Springer Nature.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. W W Norton & Co.

Sadler, J. Z. (2013). Considering the economy of DSM alternatives. In J. Paris & J. Phillips (Eds.), *Making the DSM-5: Concepts and controversies* (pp. 21–38). Springer Science + Business Media. https://doi.org/10.1007/978-1-4614-6504-1_2

Said, E. (1978). *Orientalism*. Pantheon Books.

Scherer, B. and Waistell, J. (2017) Incorporating mindfulness: questioning capitalism. *Journal of Management, Spirituality and Religion*. pp. 1-18. ISSN 1942-258X.

Schwalbe, M., Godwin, S., Holden, D., Schrock, D., Thompson, S., & Wolkomir, M. (2000). Generic Processes in the Reproduction of Inequality: An Interactionist Analysis. *Social Forces, 79*(2), 419–452. https://doi.org/10.2307/2675505

Schwartz, R. C. (1995). *Internal Family Systems Therapy*. Guilford Press.

Schwartz, R. C., & Sweezy, M. (2019). *Internal family systems therapy*. Guilford Publications.

Simpson, L. *Dancing On Our Turtle's Back: Stories of Nishnaabeg Re-creation, Resurgence and a New Emergence*. Arbeiter Ring Pub.

Singh, A. A., Appling, B., & Trepal, H. (2020). Using the multicultural and social justice counseling competencies to decolonize counseling practice: The important roles of theory, power, and action. *Journal of Counseling & Development, 98*(3), 261–271. https://doi.org/10.1002/jcad.12321

Sium, A., Desai, C., & Ritskes, E. (2012). Towards the 'tangible unknown': Decolonization and the Indigenous future. *Decolonization: Indigeneity, Education, & Society, 1*(1), I-XIII

Smeja, K. (2019). *Weaving Narrative Therapy into a Decolonizing Approach to Counselling: A Collaborative Narrative Exploration of Indigenous Healing in Canada* (Publication No. etd20454). [Master's thesis, Simon Fraser University]. Summit – Institutional Repository.

Smith, L. C. (2015). Queering multicultural competence in counseling. In R. D. Goodman & P. Gorski (Eds.), *Decolonizing "multicultural" counseling through social justice* (pp. 23–39). New York, NY: Springer

Spalter, D. (2014). *How clients choose their psychotherapist: influences on selecting and staying with a therapist* (Doctoral dissertation, Middlesex University/Metanoia Institute).

Stahl, J. V., Hill, C. E., Jacobs, T, Kleinman, S., Isenberg, D., & Stern, A. (2009). When the shoe is on the other foot: A qualitative study of intern-level trainees' perceived learning from clients. *Psychotherapy: Theory, Research, Practice, Training, 46*, 376-389. doi.org/10.1037/a0017000

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American psychologist, 53*(4), 440.

Suite, D. H., La Bril, R., Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association, 99*(8), 879–885.

Surmitis, K. A., Fox, J., & Gutierrez, D. (2018). Meditation and appropriation: Best practices for counselors who utilize meditation. *Counseling and Values, 63*(1), 4–16. https://doi.org/10.1002/cvj.12069

Suzuki, L. A., O'Shaughnessy, T. A., Roysircar, G., Ponterotto, J. G., & Carter, R. T. (2019). Counseling Psychology and the Amelioration of Oppression: Translating Our Knowledge Into Action. *The Counseling Psychologist, 47*(6), 826-872. https://doi.org/10.1177/0011000019888763

Tate, K. A., Rivera, E. T., & Edwards, L. M. (2015). Colonialism and multicultural counseling competence research: A liberatory analysis. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing "multicultural" counseling through social justice* (pp. 41–54). Springer Science + Business Media. https://doi.org/10.1007/978-1-4939-1283-4_4

Thomas, L. K. (2013). Empires of mind: Colonial history and its implications for counselling and psychotherapy. *Psychodynamic Practice, 19*(2), 117–128. https://doi.org/10.1080/14753634.2013.778484

Togashi, K. (2020). *The Psychoanalytic Zero: A Decolonizing Study of Therapeutic Dialogues*. Routledge.

Tuck, E., & Yang, K. W. (2012). Decolonization is not a metaphor. *Decolonization: Indigeneity, Education, & Society, 1*(1), 1–40.

Tummala-Narra, P. (2014). Cultural competence as a core emphasis of psychoanalytic psychotherapy. *Psychoanalytic Psychology. Advance online publication*. http://dx.doi.org/10.1037/a0034041

Tummala-Narra, P. (2019). Working with immigrants and refugees in psychodynamic psychotherapy. In D. Kealy & J. S. Ogrodniczuk (Eds.), *Contemporary psychodynamic psychotherapy: Evolving clinical practice* (pp. 281–294). Elsevier Academic Press. https://doi.org/10.1016/B978-0-12-813373-6.00019-2

Turner, D. (2018). 'You Shall Not Replace Us!' White supremacy, psychotherapy and decolonisation. *Journal of Critical Psychology, Counselling and Psychotherapy, 18*(1), 1-12.

Umaña-Taylor, A. J. (2018). Intervening in cultural development: The case of ethnic–racial identity. *Development and Psychopathology, 30*(5), 1907–1922. doi:10.1017/S0954579418000974

wa Thiong'o, N. (1986). *Decolonizing the Mind: The Politics of Language in African Literature*. James Currey.

Walker, M. (2008). How therapy helps when the culture hurts. *Women & Therapy, 31*(2-4), 87-105.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of Genocide Research, 8*(4), 387–409. https://doi.org/10.1080/14623520601056240

Wong, K. L., & Jackson, M. A. (2023). Psychoeducational and healing experiences with microaggressions of college-educated Black and Indigenous people of color. *Qualitative Psychology, 10*(2), 208–226. https://doi.org/10.1037/qup0000246

Worthington, R. L., & Dillon, F. R. (2003). The Theoretical Orientation Profile Scale-Revised: A validation study. *Measurement and Evaluation in Counseling and Development, 36*(2), 95-105.

Van Duijl, M., Kleijn, W., & de Jong, J. (2014). Unravelling the spirits' message: A study of help-seeking steps and explanatory models among patients suffering from spirit possession in Uganda. *International Journal of Mental Health Systems, 8*, 1-13.

Vera, E. M., & Speight, S. L. (2003). Multicultural Competence, Social Justice, and Counseling Psychology: Expanding Our Roles. *The Counseling Psychologist, 31*(3), 253-272. https://doi.org/10.1177/0011000003031003001

Villanueva, E. (2018). *Decolonizing wealth: Indigenous wisdom to heal divides and restore balance* (First edition.). Berrett-Koehler Publishers, Inc.

Vizenor, G. (1994). *Manifest Manners: Postindian Warriors of Survivance*. Wesleyan University Press.

Xu, H., & Tracey, T. J. (2016). Cultural congruence with psychotherapy efficacy: A network meta-analytic examination in China. *Journal of counseling psychology, 63*(3), 359–365. https://doi.org/10.1037/cou0000145