

ORIGINAL ARTICLE



A self-heuristic inquiry: Unpacking the use of “Decolonization” in therapy and mental health care with and for racialized communities

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Abstract

As a registered psychotherapist and art therapist, my clinical training was primarily based on North American clinical approaches influenced by traditional Euro and western-centric clinical theories of human behavior. I completed my training feeling certain that traditional clinical mental health practices were not an appropriate fit for racialized communities and could have negative implications for their healing and well-being. As clinicians, it is our moral obligation to support and enhance the quality of life for marginalized groups. We can do this by challenging our values and knowledge that have been defined and influenced by structures (i.e., education, training, etc.) embedded in these colonial teachings. For this paper, I used a heuristic self-inquiry research method to investigate these concerns. I interviewed other racialized psychotherapists practicing in Turtle Island (currently mostly occupied by the political entities of Canada and the United States) with the aim to learn how and if decolonization can be used in therapy practice. With this research, I (1) identified a gap in care for racialized communities, (2) questioned if or how a decolonizing approach to care should be considered, (3) explored my discomfort with practitioners in the field that claim their position on decolonizing therapy, practice, and approaches, and lastly (4) propose other ways of knowing that can inform new ways of practicing therapy. The results of this research helped to problematize the language and use of *decolonizing* therapeutic practices while learning about other concepts that may be relevant yet distinct, such as principles of coloniality/decoloniality. Those of us, therapists or researchers, wanting to disrupt the current practice of therapy need to work together, share knowledge, and challenge each other, so that we can transform the way we practice as psychotherapists. This paper is my contribution to this conversation.

KEYWORDS

clinical training, community-based learning, decolonization versus decoloniality, mental health, racialized communities, therapy practices

Highlights

- I interviewed racialized psychotherapists to learn how and if decolonization can be used in therapy.
- Traditional psychology can lead to ineffective mental health care for racialized communities.
- I propose other ways of knowing that can inform new therapy practices for racialized communities.

INTRODUCTION

As a registered psychotherapist and art therapist, my clinical training was primarily based on North American clinical approaches influenced by traditional eurocentric

clinical theories of human behavior. I completed my training with unanswered questions, and I felt certain that traditional clinical mental health practices presented in my western-centric psychotherapy training would not be an appropriate fit for racialized communities and *risked*

negative implications for their healing and well-being. My questions include: Can North American clinical interventions be effective for understanding the stories and experiences of racialized communities? Why aren't culturally responsive forms of healing more central in North American clinical training? What forms of healing exist that might resonate and provide healing for racialized clients? and How can we ensure that we do not further harm racialized clients by pathologizing and diagnosing them (a common practice in the euro-western biomedical model)? Aligning with the AJCP special issue, this research unpacks the effects of ongoing racism on the health and well-being of racialized communities. Through this research, we invite community psychologists working in mental health and therapeutic spaces to critically examine their current practices, while working to re-imagine mental health supports that are more culturally and racially appropriate in their respective contexts.

Prompted by many questions, I embarked on a self-reflective practice. I used a *self-heuristic research method* that involved interviewing four racialized psychotherapists with the aim to learn how and if critical theories, such as decolonization, can be used in therapy practice. After completing my analysis, I moved away from the term *decolonizing* therapy and find myself instead aligning with Indigenous and racialized scholars who are critical of decolonization as a concept being applied in these settings. This pivot led me to examine other theories and knowledge-holders such as decoloniality and psychological concepts developed by Frantz Fanon. Heuristic inquiry allows for this personal exploration through self-searching and dialog—and results in an authentic way of being (Moustakas, 1990). My intention from this research is to be a psychotherapist who more authentically connects with who I am, challenges my own knowledge, all while refusing to conform to ideologies and practices that are harmful for racialized communities.

RESEARCH AIM

The aim of this research is to embark on a critical self-reflection process of my psychotherapy practice to understand how I can shift toward a transformative approach. The goal was to challenge aspects of my clinical training and identify principles of reflection for myself and other clinicians who want to understand what is meant by *decolonizing therapy*. Initially, I was specifically drawn to the practice and process of decolonization and how it can be applied within the context of mental health care. Thus, my research question was: *as a Psychotherapist and Art Therapist, how can a critical self-reflective process and dialogue with other therapists assist with understanding a “decolonizing” therapeutic practice?*

I used a heuristic self-inquiry research method that focused on gaining a new sense of knowing and perspective as a psychotherapist. This process was done by connecting with other psychotherapists practicing in Turtle Island (currently mostly occupied by the political entities [or states] of Canada and the United States) and who have positioned themselves as using alternative approaches to care. Such approaches include tenets from social justice, Black-feminist psychology, and collective liberation. During my interviews, I learned that regardless of specifying the approach as “decolonizing therapy,” the common objective is to decenter western and Eurocentric approaches. Further, several of the therapists that I interviewed mentioned Tuck and Yang's (2012) article titled, *decolonizing is not a metaphor*, as the reason to move away from naming it as “decolonizing therapy.” A point referenced by the interviewees is based on Tuck and Yang's (2012) explanation that the term decolonization should not be used until there is a repatriation of Indigenous land. Further, the authors argue that many discussion, presentations, course content of decolonizing methods, spaces, thinking ... and so forth. do not mention “Indigenous peoples, our/their struggles for the recognition of our/their sovereignty, or the contributions of Indigenous intellectuals and activists to theories and frameworks of decolonization” (Tuck & Yang, 2012, pp. 2–3). Further, they claim that “until stolen land is relinquished, critical consciousness (free your mind/reducing internal colonization) does not translate into action that disrupts settler colonialism” (Tuck & Yang, 2012, p. 19). Due to the near complete project that is colonialism, even this conception of land repatriation as reconciliation risks leaving people behind. This issue is more complex than what we can or have represented in this paper, however, we can look to both Indigenous and Black scholars who are writing of these complexities to further understand the impact of colonization that has resulted in harm and violence toward Black and Indigenous communities and the process of reclamation and restoration (Amadahy & Lawrence, 2009; Tuck & Yang, 2012; Wilson & James, 2018).

Contrary to Tuck and Yang's articulation of decolonization, many scholars and clinicians have written about decolonizing psychology and mental health (Horn, 2020; McDowell & Hernández, 2010; Mullan, 2020). In my discussions with the therapists, they expressed that instead of using decolonization, they referenced other approaches, such as social justice, abolition and transformation therapy, and collective liberation.

Several questions from my interviews with the therapists prompted additional questions: What does *decolonization* mean? Who can use the term? Why are there such a range of voices, for instance, scholars, activists, writers, clinicians, speaking about the praxis of decolonization? Are there other terminologies that should be/are being considered? For instance,

coloniality/decoloniality, de-colonial thinking, liberation, abolition or Indigenizing? Further, I wonder if and how decolonization can be applied within the mental health field and specifically in therapy? If so, what implications does “decolonizing therapy” have on the field? I explored these questions by including the voices of Indigenous scholars who speak about what decolonization means to them, then explored the concepts of decoloniality/coloniality and another critical approach, Fanonian Psychology.

SOCIAL POSITION AS A RESEARCHER

I (the first author and voice of this paper) am a cis-female, Canadian-born South Asian, of Indian ancestry, where both my parents were born. Born and raised in Ontario, I grew up with other Southeast Asian families and fluently speak English and understand Hindi-Punjabi. Growing up, I never experienced a sense of belonging, as a first-generation Indian/South-Asian-Canadian, and experienced insecurities of not truly feeling a part of any one cultural identity. With a Master's degree in Art Therapy and a Master's degree in Counseling Psychology, I have worked in the not-for-profit youth mental health sector for almost a decade. I have witnessed cultural disparity and inequity issues across mental health service providers, training materials, and service delivery interventions.

I (the second author), am a White, settler born, cis-female community psychologist and the faculty mentor for this research. Also born and raised in Ontario, I grew up in a visibly homogenous community, that I only later learned was the result of Indigenous erasure and structures of racism. I see my own political consciousness through educative rather than lived experience and am grateful for the writings and mentorship of community psychologists who are actively laying the foundation for a decolonial turn in the field opening spaces for papers such as this one—namely Christopher Sonn, Urmitapa Dutta, and Dominique Thomas.

WESTERN PSYCHOLOGY INFORMING THERAPY PRACTICE

How does western psychology inform a clinical space?

Western psychology is based on knowledge taken from dominant European views, which has heavily influenced North American scholars throughout time and shaped how we teach and practice psychology today (Horn, 2020; Reynolds, 2012; Wever, 2015). An intention of those promoting western psychology is to bring to the forefront ways of building theory and offering practical guides for

clinical-practitioners (Horn, 2020; McDowell & Hernández, 2010), however, it may not support the mental health needs of racially diverse communities. A clinician is trained to take an individualistic approach and told that western psychology defines the “truth” of addressing mental health in the counseling space. This creates an imbalance of power by diminishing nonwestern values (Horn, 2020; Mahoney & Kiraly-Alvarez, 2019), which can translate into harm and violence against marginalized communities (McDowell & Hernández, 2010). Unfortunately, the reality for therapists in North America is that we are navigating the effects of capitalism, which defines where a therapist works and who can afford therapy (i.e., middle-upper class White clients) (McDowell & Hernández, 2010). This leads to clinicians being confined in the way they choose to practice and limits the accessibility for racialized clients.

How can western psychology impact racialized communities?

To make matters worse, marginalized and racialized clients are often told they are living with an internal psychological disorder (Wever, 2015), which is most often linked to the effects of systemic and structural oppression (Liu & Modir, 2020). Western psychology focuses on pathologizing and diagnosing individuals, which can impact how they see themselves (Horn, 2020; Reynolds, 2012; Wever, 2015) as they are being defined, labeled, and ultimately controlled by a healthcare system. Most often, tracing the presenting issues of our clients and their experiences are linked to broader structural harm such as unemployment, being victims of abuse, or being marginalized by a dominant group (Campbell et al., 2001), yet therapeutic intervention (s) focuses on the individual-level. For instance, clients will internalize how they view themselves as “not being enough or not feeling worthy,” which most often is a symptom of systemic harm, violence, or oppression. For this reason, health activism that identifies the negative impact of invisible power, can be a critical piece to address structural inequities and practices (Horn, 2020). I initially positioned decolonizing psychotherapy as a push back against the imperial knowledge that is pervasive in North American psychology, which I have shared above as being harmful and limiting. However, later in my analysis, it became clear that using the term “decolonizing therapy” continues to potentially perpetuate colonial harm.

RESEARCH METHOD

Self-heuristic inquiry

The research method used was a self-heuristic inquiry and supported by an interpretivism and transformative paradigm. With interpretive research, I acknowledge the “existence of multiple knowledges.... and that different

researchers bring different perspectives to the same issue” (Rehman & Alharthi, 2016, p. 55). Further, the integration of a transformative paradigm enables the recognition of “inequalities and injustices” (Mertens, 2007, p. 212) that occur particularly within mental health.

A heuristic inquiry is based on the Greek word *heuriskin*, “meaning to discover or find” (Moustakas, 1990, p. 2). I was drawn to selecting heuristic inquiry as it takes the researcher on a personal journey of reflecting inward and is known to be process-oriented, culturally embedded, introspective, reflexive, relational, and participatory (Sultan, 2018). A critical self-reflection process can access deeper understanding that is necessary to shift and transform a clinician’s perspective (Mezirow, 1991). A critical reflection can also lead to an improved practice, particularly with transforming the therapeutic relationship and encouraging the client’s personal growth (Tufekcioglu & Muran, 2015).

Selecting heuristic inquiry

Initially, it was challenging to find a nonwestern methodology that was applicable to this process. Datta (2018) explained that a researcher focused on decolonization does not need to reject all western methods and theories, as they can be adaptable and benefit communities. In particular, the self-heuristic approach has been adapted by Indigenous scholars, including Kahakalau (2004), who described that using Indigenous heuristic action research can be altered until they are created for and from an Indigenous perspective. Thus, one of the draws of selecting heuristic inquiry was the adaptability and flexibility of the process. I used the six phases of heuristic inquiry, including *initial engagement, immersion, incubation, illumination, explication, and creative synthesis* (Moustakas, 1990) to explain how each of these stages informed my process and critical response toward my research focus—if and how “*decolonization*” can be practiced and used in therapy with racialized communities.

RESEARCH FINDINGS

Phase 1: Initial engagement

In the first phase of *initial engagement*, “vague and formless wanderings are characteristics” (p. 47), and there is an overwhelming sensation of finding meaning as the understanding of the concepts for the researcher grows while acknowledging the scope of the problem (Douglass & Moustakas, 1985). This process involves looking within and through persistent self-reflection, as the researcher inquires: “how and where this theme is relevant and what ways it might be shifted to reveal its components most effectively” (p. 47). My “initial

engagement” experience was the result of feeling overwhelmed with uncertainty after completing two graduate degrees to become a therapist and questioning if what I knew could be helpful for racialized communities in addressing their mental health needs. As a result, I pursued a PhD in Community Psychology (CP) to learn ways of providing a more connected and transformative approach to care. As suggested in this phase, “the task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal compelling implications” (Moustakas, 1990, p. 27). I have been working in the field of mental health for almost a decade, and I continue to hold a persistent interest in learning ways of providing more effective care for racialized communities.

Why is this work important?

Research has shown that ethnocentric models (applying one culture as a frame of reference to judge other cultures) do not work with racialized communities, (Bhatt et al., 2013; Heidi et al., 2011; Sue, 2004), but there is limited research on how to deconstruct the current practices of North American clinical care to one that is more effective for racialized communities. Other critiques of North American psychology have included German Critical Psychology, which can be seen as a “backlash against American psychology” (p. 1), yet is grounded in understanding power structures/social injustices and has focused on creating theoretical tools that have more relevance and meaning to local cultures (Teo, 2013; Tolman, 2013). This remains limiting in supporting racialized communities, as it continues to emerge from mainly White scholars with eurocentric perspectives and does not include decolonizing principles, such as interrupting colonial power dynamics, holding non-Indigenous scholars responsible, and “involving individual and institutional progression from conscientization to action” (Mitchell et al., 2018, p. 351). It has been clear for a while that aspects of western psychology may not apply to racialized communities—which led to Phase 2 of my research journey, *immersion*.

Phase 2: Immersion

In Phase 2, the “immersion process enables the researcher to come to be on intimate terms with the question—to live it and grow in knowledge and understanding of it” (Moustakas, 1990, p. 27). As part of the *immersion* phase, “through persistent and self-reflection, the researcher inquires as to where and how the theme is relevant and in what ways it might be shifted to reveal its components most effectively” (Douglass & Moustakas, 1985, p. 47). In my training, I had learned

clinical theories, case studies, interventions, and assessments that were predominantly from eurocentric and western perspectives and developed by White male clinicians. For this reason, I started to search and read about therapists and mental health professionals who are “decolonizing” the mental health space and therapeutic practice.

Decolonizing mental health and psychotherapy practices

A starting point of a decolonizing approach is the possibility of an alternative and transformative space that challenges hegemonic practices (McDowell & Hernández, 2010). A decolonizing approach to practice brings forward the historical violence of colonialism and eurocentric values/norms that have constructed the beliefs and practices of marginalized communities, while challenging whose knowledge is valid (Horn, 2020; Lara, 2008; Lewis et al., 2018). At the same time, a decolonizing approach to care or alternative forms of therapy/healing can face critique and resistance from traditional theorists and practitioners as it poses a threat against the status quo of the patriarchy, eurocentrism, and so forth (Lara, 2008), making it challenging for clinicians to implement new ways of practice and transform the therapeutic space. It is suggested that a decolonizing view should push clinicians to look up the power hierarchy and acknowledge where inequalities are embedded in the systems and structures that privilege the few at the expense of many disenfranchised communities (Goodman & Gorski, 2015). To challenge the status quo, therapists should take an active role by engaging in the process of advocacy, activism, and social justice action (Goodman, 2015).

Another facet of decolonizing psychology is critical consciousness raising; a tool to share the effects of white supremacy on the hearts and minds of communities of color as it highlights the construct of oppression and demands social justice and change (Shin, 2015). As shared by Shin (2015), researchers and clinicians should view themselves as collaborative partners, “seeking to liberate both themselves and others from colonial constraints” (p. 18). Further, a therapist should not claim to use a “multicultural” perspective but then look the other way when it gets too “political”; this response continues to allow white supremacy to own and occupy the dominant narrative (Conwill, 2015; Mingo et al., 2021). This is clearly demonstrated by the works of Frantz Fanon, a Black decolonial Psychiatrist (Fanon, 2007) whose work has been discredited, erased, critiqued, and often misunderstood (Jamison, 2010) as he was critiquing Eurocentric hegemonic therapeutic practices and pushing toward a more culturally relevant approach to mental health care (Sikuade, 2012) for Black Diasporic people.

These authors are highlighting critical points of reflection in regard to aspects of western psychology

that can be deemed harmful and ways to mitigate this harm. At this stage of the inquiry, I was intrigued by how naming practices as a “decolonizing therapist” could support me in being an activist or advocate who can utilize power analysis or social justice principles. Further questioning, how do we learn to develop this critical consciousness within ourselves, as clinicians, before working with clients? How do we take the rich theoretical knowledge from scholars and practitioners and translate it into an accessible practice that better supports racialized clients? It is these questions that initiated an exploration of this topic area and are shared in the subsequent phases of the heuristic research method.

Phase 3: Incubation

“Incubation is the process in which the researcher retreats from the intense, concentrated focus of the question” (Moustakas, 1990, p. 26). During this phase, meanings are being developed to help form the researcher’s question (Moustakas, 1990). I spent years in training and practice with an ongoing sense of dissatisfaction with how I was trained and the disconnected approach to care for racialized communities. I consider my incubation period as being nonlinear, a known point in the heuristic inquiry process (Moustakas, 1990); meaning I have been in the incubation phase at several different points throughout my clinical practice.

Connection to CP

My intent of engaging in research within the field of CP is to steer away from traditional-clinical teachings and move toward prioritizing community needs, allowing research to be a catalyst for real change. Thus far, my experience of participating in the CP field has provided the opportunity to read and learn about critical theories and engage in critical dialog about community praxis that can lead to social transformation. With this research, I am able to take my knowledge rooted in critical analysis and better understand how it translates into therapeutic practice. This phase provided an opportunity to focus and sort through, review, and reorganize new ways of being, seeing, and understanding concepts that I had never considered in my practice nor was taught in my clinical training. Further, it was only during my experience in Phase 4, *illumination*, that I started to question and challenge why we name or use terminology, such as to “decolonize the mind” or “decolonizing therapy.”

Phase 4: Illumination

This phase occurs once the direction and themes are identified, and the researcher then thinks about data

collection (Douglass & Moustakas, 1985). According to Moustakas (1990),

the process of illumination is one that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition. The illumination as such is a breakthrough into conscious awareness of qualities and clustering of qualities into themes inherent in the question (p. 2).

My data collection process involved interviewing four racialized (non-Indigenous) psychotherapists who are practicing in Turtle Island (currently mostly occupied by the political entities [or states] of Canada and the United States) who present themselves as critical thinkers and/or referenced critical theories in their therapeutic practice. This research project received research ethics board approval from Wilfrid Laurier University, and each participant consented to their real names being identified in research dissemination. In Phase 5, I developed themes based on our conversations.

Phase 5: Explication

As shared by Moustakas (1990),

the purpose of the explication phase is to examine fully what has awakened in consciousness, in order to understand its various layers of meaning ... the entire process of explication requires that researchers attend to their own awarenesses, feelings, thoughts, beliefs, and judgments as a prelude to the understanding that is derived from conversations and dialogues with others (p. 31).

In this phase, I identified several themes that were presented across the conversations that helped with unpacking my research question. Some of the themes are: 1. *Naming Decolonization in Therapy*, 2. *Training Experience*, 3. *Community-Based Learning*, and 4. *Creating Spaces for Racialized Folks*. Below, is a summation of the themes.

Theme 1: Naming decolonization in therapy

A presenting theme across the interviews was on the participant's understanding of decolonization and their approach to naming decolonizing therapy (or not) within the context of therapy. Ji-Youn Kim who is located in so-called Vancouver in the lands of the Musqueam Squamish and Tsleil-Waututh nation described,

I have seen it used as a metaphor so much without unpacking what colonialism really is and the particular manifestations of it. In focusing on myself being in so-called Canada and focusing on the settler colonialism here, I generally use the term justice-oriented.

Many of the interviewees referenced the Tuck and Yang (2012) article, *Decolonization is not a Metaphor* as the reason for not using decolonization within the context of therapy. Tuck and Yang (2012) oppose decolonization being placed onto existing colonial theoretical frameworks of social justice, as that becomes yet another form of colonial appropriation. Many clinicians referenced other frameworks and theories used in practice, including social justice, feminist psychology, intersectionality, anti-oppression, liberation psychology, and abolition therapy. It was evident that many of these theories were not taught during their clinical training experience.

Theme 2: Clinical training experience

As shared by Foucault (1980), the creation of truth is based on a set of rules which separate true and false and the outcomes of power are attached to truth. During the training of a therapist, only select therapeutic methods are taught and become accepted as approaches suitable for therapeutic practice. Thus, clinicians in training are learning to practice as a therapist in an educational system and become carriers of truth that holds power. Ji-Youn described what she learned from her clinical training as “what not to do”. Similarly, Melody Li, who is located on the land of the Tonkawa tribe, also known as Austin, Texas, explained that they went through the process of “unlearning” in their graduate studies and was fortunate to have a woman of color supervisor that allowed more “expansive conversations.” More specifically, Melody shared that

To become a therapist we have to jump through a lot of hoops. We have to jump through school hoops, licensing, and there's a certain level of compliance that is required in order to jump through these hoops ... the image in my mind is kind of like carnival animals and there isn't really a lot of choice and so emerging from that I had to work to shed a lot of that compliance and to ask critical questions.... is this really helping and who is it helping and who is this benefiting? So, the unlearning work definitely happens in the community and not within an institution.

Others expressed that their experience of clinical training did not speak to the lived experiences of their communities, which led to this process of *unlearning*. Psychologist Mariana Plata described unlearning as “the process through which we break down the origins of our thoughts, attitudes, behaviors, feelings, and biases” (Plata, 2020). Many of the interviewees named the need to seek a more connected and relevant approach to care.

Theme 3: Community-based learning

Community-based learning, is a process that allows students or community members to learn through community engagement (Shumer, 1994). Most participants spoke about deepening their knowledge by working with folks in the community. Virginia Jahyu, an expressive arts therapist and facilitator using social justice frameworks for 12 years articulated the following,

I would say that my deepest learnings and what I identify as my personal wisdom comes from places that are not it's not institutional education. It is the vulnerable relationships that I engage in—my supervisors and peers and it is my people that I connect with ... a lot of the work that informs my practice today also comes from community organizing ... I've been involved with a lot of different movements.

Community-based learning has been a key element in the process of unlearning what is taught in clinical training, and to learn ways of being collaborative with the community and engaging in critical discourse to improve care for racialized communities.

Theme 4: Healing spaces for racialized folks

It is known that western and Eurocentric views and ideologies have been harmful and instrumental in developing social constructs of race and classism (Quijano, 2007). Unfortunately, these social constructs of race and class are not generally unpacked in clinical training, which increases the chance of these topics not being carefully discussed in therapy. Hiba Khatkhat, who has been working in mental health for 14 years, explained that “not acknowledging experiences of race and the impacts of structural powers can be harmful and traumatic for the client.” Further, Melody expressed that, “there has not been nearly enough repair of harm that psychology has caused Indigenous and Black communities, as well as LGBTQ folks, disability folks, which explains why BIPOC folks do not want to seek support ... and a way to support BIPOC communities is to offer resources that allow them to survive this

culture.” The space we, as therapists, collaboratively create with racialized folks is imperative. The therapy space allows racialized folks to process their experiences without being dismissed, feel validated while disrupting the dominant narrative, and seek ways to liberate and heal.

In this phase of *explication*, I processed and expressed what I was discovering—a time of new insight, new understanding, and new meaning (Moustakas, 1990). Each therapist provided critical perspectives and insights during our conversations surrounding care for racialized communities. This included the potential harm of using “decolonizing” in their practice as non-Indigenous therapists while referencing community and social justice-oriented approaches. At this point, I decided to advance my knowledge of the topics of colonialism/decolonization versus coloniality/decoloniality and introduce myself to Frantz Fanon, which I explored next.

Phase 6: Creative synthesis

The sixth phase is *creative synthesis*, in which the fragments and components are placed together based on the journey of meaning and discovery (Douglass & Moustakas, 1985). My journey of meaning continued with reading more about decolonization, coloniality, and decoloniality. Moustakas (1990) described that the data collected does not become a generalized summary, rather a new reality of how a researcher views the work. At this point, I can so comfortably express that I, as a researcher and therapist, do not feel comfortable with referring to “decolonizing” the therapeutic practice and view it as futile as a non-Indigenous clinician. This phase of the research has broadened my knowledge of decolonization, while considering other critical social theories as a possible next move.

Is the term decolonization being co-opted? Yes

In 2018, a panel of Indigenous Elders and scholars were interviewed on the Canadian Broadcast Channel (CBC), titled “What does decolonization mean? Our Panel Debates the Buzzword.” The speakers included Anishinaabe Elder Chickadee Richard, Indigenous scholar, Niigaan Sinclair, a professor at the University of Manitoba, and Dallas Hunt who is Nehiyaw from Swan River First Nation in Alberta and teaches at the University of Manitoba. The panel was facilitated by Lenard Monkman, who is Anishinaabe from Lake Manitoba First Nation, Treaty 2 territory and who is an associate producer with CBC Indigenous. The discussion began with asking the panelists what decolonization means to them. Richard shared that decolonization is a broad concept that started in the 1980s that recognized how institutions and everyday

society, which includes colonial aspects and mentality, have been violent and harmful against Indigenous pedagogy, voices, and communities (as cited by Monkman, 2018). Richard shared that we live in a system that continues to work against Indigenous communities and that Canada is not being honest about the harm caused (as cited by Monkman, 2018). Similarly, other scholars have named the risk of co-optation and appropriation of decolonization theories (Cruz, 2008). Wallace (2013) argued “one of the ways neo imperialism and internal colonialism are actualized and expanded is through research and knowledge production that negates Indigenous peoples’ knowledges, experiences and self governance” (p. 34). Further, acts of colonialism have, and continue to promote anti-Indigenous presence and white mainstream supremacy (Monkman, 2018). Decolonization is then used to describe the “injection” of Indigenous voices in spaces that have been inherently violent through colonialism (as cited by Monkman, 2018).

Colonialism, settler colonialism, and Indigenization

The panelists continued with a discussion of the differences between the term's colonialism, settler colonialism, and Indigenization. Colonization happened at contact while settler colonialism is described as societal structures being put in place such as legal ordering and policies, (i.e., The Indian Act), as a way of control and power over Indigenous communities (as cited by Monkman, 2018). Settler colonialism manifests within institutional spaces such as academic settings, where Indigenous histories, peoples, and cultures are repressed (as cited by Monkman, 2018). Sinclair shared that the term decolonization is used by institutions to claim transformational change by, for example, involving more Indigenous people and knowledge, however, it leads to the term being co-opted as it does not actually create any change inside the institutions (as cited by Monkman, 2018). Based on the term decolonization being co-opted, Sinclair prefers the term Indigenizing instead, as Indigenization is about “building our own institutions with Indigenous voices at the centre” (as cited by Monkman, 2018). The varying constructs and definitions shared by the Indigenous folks assist with challenging my original question of this research paper and critically asking the mental health field why we are using the term without acknowledging Indigenous peoples, the historical context of colonialism and the effects it has on Indigenous communities today. Co-opting and using decolonization as a metaphor recenters whiteness, and extends innocence to the settler (Tuck & Yang, 2012). I argue that the tenets and principles of decolonizing psychology, mental health, or therapy should instead consider the implications and use of other critical theories, such as coloniality/decoloniality.

Coloniality/decoloniality

Many scholars have written about the meaning and discourse of modernity/coloniality/decoloniality and reference known figures in the field, including Peruvian sociologist Anibal Quijano, Porotician Philosopher and Historian Nelson Maldonado-Torres, and Argentine professor Walter Dignolo (Gaztambide-Fernández, 2014; W. D. Mignolo, 2007). Coloniality and decoloniality refer to a matrix of power that has been created by the process of colonialism and decolonization with ties to European and Western civilization/Western modernity (Maldonado-Torres, 2016). In addition, decoloniality is being further theorized within a CP context (Beals et al., 2021).

Colonial matrix of power

The majority of people living in North America or Europe consider their countries modern, forward-thinking and superior to other countries in the world, which equates to constituting and producing coloniality (Maldonado-Torres, 2016). Thus, decolonization does not remove coloniality as it remains a direct result of colonialism (Ndlovu-Gatsheni, 2013) which can be further explained through the colonial matrix of power. The colonial matrix of power can be described in four interconnected domains including (1) control of economy (i.e., land appropriation, control of natural resources), (2) control of authority (e.g., army, government, religion), control of gender and sexuality (e.g., family, education), and control of subjectivity and knowledge (i.e., education, epistemology) (W. D. Mignolo, 2007). W. D. Mignolo (2007) describes the coloniality of power as the “darker side of modernity and global reach of imperial capitalism” (p. 17). According to Gaztambide-Fernández (2014), there is coloniality without colonialism, as it is alive and well in countries that were not colonized, making it a “global crisis.” Further, the harm of coloniality continues as a process of internalization, on an individual and collective level, brought on by structural systems of power that remain intact today (Carolissen & Duckett, 2018). Decoloniality emerges out of the idea that our world is not sustained by a colonial matrix of power and that we must engage and acknowledge other epistemologies that support balance (Ndlovu-Gatsheni, 2013).

What is decoloniality?

According to Maldonado-Torres (2016), decoloniality “is a direct challenge to the temporal, spatial, and subjective axis of the modern/colonial world and its institutions, including the university and the state” (p. 4). Decoloniality aims to delink colonial relations related to knowledge production and framing of identity while leaning on the collective and historical memory of people impacted by coloniality (Carolissen & Duckett, 2018;

W. Mignolo & Hoffmann, 2017). There are three concepts of decoloniality, which include the “coloniality of power” as described above, the second is “coloniality of knowledge,” and lastly “coloniality of being.” Coloniality of knowledge, adapted by Quijano, questions who produce knowledge and for what purpose while Maldonado-Torres shares that coloniality of being responds to the effects of coloniality in lived experiences rather than just the mind (Maldonado-Torres, 2007; W. D. Mignolo, 2007; Ndlovu-Gatsheni, 2013).

Further, decoloniality is analytic and built on perspective; it is the effort to rehumanize the world by dismantling hierarchies of differences and promoting counter-movements related to discourse, knowledge, creativity, and practices that seek to abolish coloniality (Maldonado-Torres, 2016; W. Mignolo & Hoffmann, 2017). Importantly, Maldonado-Torres (2016) describes that the analysis of decoloniality is not simple as there are a vast number of experiences, knowledge, and histories, making it challenging to capture the principles of decoloniality in a single definition. The expansiveness of decoloniality principles allows for the opportunity to have richer and more critical dialog that surrounds the protest of decolonization (Maldonado-Torres, 2016). It is clear that colonialism/decouolonization is uniquely different from coloniality/decouoloniality, they build on each other and yet are distinct (Fernández et al., 2021)

Examining coloniality/decouoloniality in therapy

The practice of decoloniality is to recognize that coloniality of knowledge and being consists of imperial knowledge that represses the marginalized that have and continue to be impacted by the colonial matrix of power (W. D. Mignolo, 2007). As practitioners, scholars, writers, and critical thinkers, we should understand our options of moving through the colonial matrix. First, we begin with locating ourselves in the colonial matrix of power and acknowledge that we are all in it—so we need to stop being an observer (W. Mignolo & Hoffmann, 2017). Subsequently, we must realize the options we have within the colonial matrix of power, such as the ideological, political, or ethical views you hold (W. Mignolo & Hoffmann, 2017). Lastly, W. D. Mignolo (2007) emphasizes that we should feel empowered to select a position within the colonial matrix of power while ensuring that it does not make you feel superior to others. The colonial matrix of power can be a constructive and reflective exercise that can be utilized within clinical training, facilitated among peers, and used in therapy. These teachings are similar to what is shared above under “decouolonizing mental health and psychotherapy,” however, it centers coloniality/decouoloniality.

I refer here to Carolissen and Duckett's (2018) list of 10 key markers of teaching decoloniality, which they gathered from a literature review process. These markers

can function as a framework for approaching decolonial practices in therapeutic training, teachings, and praxis.

- (1) disrupting privileging of Euro-American/Western epistemologies; (2) reframing pathologized accounts of marginalized peoples; (3) reclaiming and reframing erasure of histories; (4) deconstructing colonial discourse, inserting counter-narratives; (5) Foregrounding Indigeneity and Indigenous knowledge in curriculum; (6) Foregrounding politics of knowledge production: Inserting embodied author identities and positionalities such as race, ethnicity, and gender; (7) Foregrounding politics of knowledge production: Highlighting power relationships inherent in positionalities and identities in institutional structures and cultures; (8) activism central to the pedagogical continuum, inside and outside classroom; (9) pedagogical tools employed as catalysts for critical reflexivity; and (10) drawing on ecologies of knowledge, appropriate to context (p. 244).

These 10 key points focus on reclaiming the harm experienced, disrupts/abolishes harmful practices, centers Indigenous knowledge, and speaks to the impacts of coloniality while moving toward a decolonial praxis. Further, clinical training can integrate these 10 principles as they encourage critical discourse and dialog that will inform and shape the therapeutic practice and ultimately lead to providing a more connected approach to care for communities of color.

Decolonial teachings in mental health practices decentralize the Euro-western epistemology and look at historical implications, especially those who have been omitted, and focus on counter-narratives of marginalized communities (Figuerola-Vásquez, 2020). Quijano (2007) describes that a symptom of coloniality is the “eurocentricity” of colonial domination that led to “racial” criteria and social classification. In response, to liberate from the racial classification is “the freedom of all peoples to choose, individually or collectively, such relations: a freedom to choose between various cultural orientations, and, above all, the freedom to produce, criticize, change, and exchange culture and society” (Quijano, 2007, p. 178). Understanding the experience of race and class in therapy can assist with liberating self from systems that cause the internalization of cognitive distortions and views of self, for instance, “feeling less than or not good enough.” Further, decoloniality becomes a practice of liberation from western and European constructs that have created divide and domination through power hierarchies. Much of this work on racial constructs and the implications of internalization should be credited to Frantz Fanon.

Unfortunately, Frantz Fanon was never referenced or mentioned in any of my clinical training and I only learned about his work while learning about critical theories. Moustakas (1990) described that the self-heuristic practice has no official end, and by Phase 6, the researcher can be left with more questions that lead to new pathways of discovery. It was critical to end my process with this subsequent section, as I see it as a “new path”; engaging with the teachings of Frantz Fanon.

Frantz Fanon and mental health

Frantz Fanon, a well-known psychiatrist, writer, and activist, identified that mental illness and racial discrimination were forms of alienation and dehumanization, and that colonization was a trigger for mental pathology, injustice and power relationships (Robertson & Walter, 2009; Sikuade, 2012). Fanon was one of the first psychiatrists to name the need for an integrative and culturally appropriate approach to care with an emphasis on race, culture, and creed (Sikuade, 2012). Fanon's focus was on decolonization in Africa and the African Diaspora, writing from his lived experiences, he expressed the importance of forefronting the lived experiences of oppressed people's while being independent from European ideologies, such as the standardization of psychological theories (Fairchild, 1994; Jamison, 2010). Fanon was not convinced by European theorists or the universal applicability of psychological ideas, rather he was critical of hegemonic phenomenon and generalizations (Jamison, 2010; Robertson & Walter, 2009). For instance, as cited by Jamison, Fanon was clear on his views of European psychoanalysis and shared that:

whenever I have read a psychoanalytic work, discussed with my professors, or talked with European patients, I have been struck by the disparity between the corresponding schemas and the reality that the Negro presents. It has led me to the conclusion that there is a dialectical substitution when one goes from the psychology of the white man to that of the black. (Fanon, 1967, pp. 150–151).

This disparity gap was named and challenged by Fanon, which led to him developing his own views and approach based on his experiences and clinical work.

Fanonian psychology

In Fanon's book, *Wretched of the Earth*, Fanon shares case studies that highlight the continuation of colonial harm, such as through superordinate/subordinate role relationships (clinician vs client), and harmful labeling of criminality and personal pathologies (Fanon, 2007). Fanon would incorporate traditional cultural practices in his work as a way to blend precolonial knowledge in a

colonial context (Jamison, 2010; Robertson & Walter, 2009), as opposed to the approach by European colonists who used Indigenous culture as a way to control and manipulate (Jamison, 2010). Adams (1970) shared that for Fanon, “there was no question of inducing *adjustment* to a vicious social system” (p. 811). Meaning, that the burden should not be placed on the client to “adjust,” while living in a system that causes their mental illness. Further, Robertson and Walter (2009) described a Fanonian approach as not controlling or manipulating cultures into Western frameworks but rather questioning concepts of power, justice, and sociocultural factors to understand clients. Unfortunately, Jamison (2010) demonstrates that psychological literature about people of African descent and Fanonian psychology goes unnoticed and are misunderstood when studied from a eurocentric perspective. Fanon's teachings need to be more extensively and intentionally shared within training, educational, and action-oriented spaces—especially within the psychotherapy profession.

DISCUSSION

In reflection, I come back to my intended research question, *as a Psychotherapist and Art Therapist, how can a critical self-reflective process and engaging in dialogue with racialized therapists assist with decolonizing a therapeutic practice?* It is clear that I can no longer answer this question and that I no longer align with the idea of decolonizing therapy practice unless we are speaking about Indigenous sovereignty and reclaiming of relationships and land. It was through my conversations with peers and learning about the meaning of decolonization and decoloniality/coloniality that solidified my resistance to answering this research question. In learning about Fanon, I have expanded my own knowledge of the impact of colonialism, particularly with African communities. Fanon named the effects of colonialism as a trigger to the individualization of mental health illness and race discrimination, while he sought culturally appropriate care. Based on my findings, the direction of my research changed, and I used tenets of self-heuristic inquiry to follow my intuition and gain new meaning in my work as a therapist.

To recap, my journey in this process started with (1) identifying a gap in care and understanding how to better support racialized communities, which led to (2) questioning, if and how a decolonizing approach to care can be considered and then (3) being critical of what I was learning and sitting with the discomfort that I was questioning practitioners in the field that claim a position on decolonizing therapy, practice and approaches, and then lastly (4) proposing other ways of knowing that can inform or suggest new ways of practicing therapy.

This research process has also become a call to action, particularly for scholars to work with clinicians

and communities to critically understand (1) why we are not differentiating between decoloniality and decolonization, particularly in the therapeutic space; and (2) how we can continue to center the voices of Indigenous folks while ensuring their experiences are not co-opted through mis-use of language. As shared in this paper, Indigenous peoples are voicing their concerns with the misuse, appropriation, and co-optation of “decolonizing” practices and processes. As non-Indigenous practitioners, I have to wonder why we are not listening to these concerns. I can only conclude that we need a movement toward shifting and re-imagining the therapeutic space to ensure the therapeutic responses are aligned with community needs.

RECOMMENDATIONS FOR THE PSYCHOTHERAPY PROFESSION

I provide the following recommendations for the mental health and psychotherapy field:

Ask critical questions

Ask, and ask again, when using terminology, what does it mean? What is its history? Participate in critical dialog with peers, read articles, and spend time unpacking your knowledge. One can start their own peer group, to discuss, reflect, and challenge our understanding of this work.

Engage in critical social theories

Do a search of critical social theories and learn about scholars, activists, writers who have already unpacked a lot of these issues as they relate to mental health/clinical practices. Look globally. For instance, disability studies, critical race theory, or intersectionality would provide additional layers of engagement. A single model or theory can be limiting and harmful to diverse communities, as it cannot reflect the vast experiences of individuals and communities.

Be collaborative and community-focused

Find ways to directly work with and learn from communities to inform how healing spaces can be shaped best for their community. The production of knowledge and truth regarding mental health needs should not explicitly be generated by clinicians and researchers. There needs to be a process before engaging in therapy to work with the community in understanding their needs.

Know your history

Learn about the history of psychology and how it has impacted racialized communities. Be open, prepared, and critical of the knowledge you hold and that decenters the experiences of marginalized communities.

These recommendations should be a critical requirement in training clinicians.

LIMITATIONS

The key limitations faced during this research process included the number and type of participants involved in this process, the selected research method, and the lack of theoretical inclusion from other racialized scholars. I interviewed four participants and thus gathering additional perspectives may have helped to further analyze the use or misuse of decolonizing therapy. In addition, having the opportunity to speak with an Indigenous and a Black therapist may have provided a critical perspective into navigating therapeutic care through their lived experiences and work as a therapist. Also, I selected a research method that was developed by an American clinical psychologist who happens to be a White male. Though as shared, this method has been utilized by Indigenous scholars, suggesting its adaptability for different communities and cultures. Next, most of my literature was from Black, South American, and Indigenous scholars, which was intentional, however, it may have benefited from including theoretical considerations from other racialized scholars, such as South Asian or Asian theorists. I want to acknowledge and commend the contributions of my peers/interviewees, as some identify as Asian and are doing critical mental health work within their own communities.

CONCLUSION

I am not here to discredit the critical work of scholars who are pushing an agenda that disrupts the hegemonic norm that continues to pathologize and individualize marginalized groups. The current teachings in the field, though potentially under the wrong umbrella term, are solid, sound, and important to reference. At the same time, the academic space is known to co-opt language that misrepresents the experiences of marginalized groups. My research works to unpack the understanding of *decolonization* and how it has been framed as a theory or practice in mental health and therapy. Referencing the voices of Indigenous folks and as written by Tuck and Yang (2012), using terminology inappropriately becomes a “settler move to innocence” that perpetuates ongoing harm and does not address the root problem, such as redistribution of land or making fundamental changes required within systems (Monkman, 2018).

As a researcher and psychotherapist, engaging in this narrative reflection process has confirmed my reasons to step away and refrain from referencing decolonizing therapeutic practices while continuing to learn about other concepts that may be relevant yet distinct, such as principles of coloniality/decoloniality or Fanonian Psychology. Thus, I agree with my colleagues and peers in the field who are advancing the idea that “decolonizing mental health” has become a metaphor. Those of us, therapists or researchers, wanting to disrupt the current practice of therapy need to continue to work together, share knowledge, and challenge each other, so that we can work toward transforming the way we practice as psychotherapists.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

ETHICS STATEMENT

This study was approved by Wilfrid Laurier University Research Ethics Board (REB# 6786).

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