

Treating the Trauma of Racial Systemic Oppression:

A Scoping Review and Thematic Analysis

by

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B.A., University of California, Northridge, 1994

M.A., Pacifica Graduate Institute, 2006

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We acknowledge and respect the Ləkʷəŋən (Songhees and Xʷsepsəm/ Esquimalt) Peoples on whose territory the university stands, and the Ləkʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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### **Abstract**

This research study sought to answer the question: How does the recent literature examine treating the chronic trauma of racial systemic oppression within the individual therapy hour? A scoping review and thematic analysis of 34 articles was conducted, per the Arksey and O'Malley (2005) and PRISMA-SR protocols. The analysis found that there are three categories of philosophy in the selected literature: Western, Adapted Western, and Decolonized. These categories agree that racial systemic oppression is psychologically traumatic, that it must be addressed via anti-racist approaches, and that the therapist must have done significant reflexive work to unlearn racist beliefs that are inherent in society. The three categories differ in how they go about implementing anti-racist approaches. Western and Adapted Western approaches are rooted in evidence-based Western therapy practices and add varying degrees of anti-racist or culturally adapted elements to this base. The Decolonized approach completely decenters the Western perspective and replaces it with the healing traditions of the culture of the person seeking help. All the articles agreed that while these concepts are theoretically sound, they lack research to determine their effectiveness. More research needs to be done, specifically via a decolonizing research methodology, to avoid continuing the cycle of Western systemic oppression.

## Table of Contents

<b>Abstract.....</b>	<b>iii</b>
<b>Table of Contents.....</b>	<b>iv</b>
<b>List of Tables.....</b>	<b>vi</b>
<b>List of Figures.....</b>	<b>vii</b>
<b>Acknowledgements .....</b>	<b>viii</b>
<b>Chapter One. Introduction.....</b>	<b>1</b>
1.1 Primary Researcher Positionality Statement .....	3
<b>Chapter Two. Literature Review .....</b>	<b>5</b>
2.1 Systemic Oppression .....	5
2.1.1 <i>Defining Concepts and Terms</i> .....	5
2.1.2 <i>Colonialism</i> .....	8
2.1.3 <i>Decolonization and Post-Colonial Perspectives</i> .....	10
2.1.4 <i>Why Is This Research Important?</i> .....	12
2.2 Psychological Trauma .....	15
2.2.1 <i>What Is It?</i> .....	15
2.2.2 <i>Trauma Diagnoses</i> .....	16
2.2.3 <i>Why Is It Important?</i> .....	18
2.2.4 <i>Racism is Traumatic</i> .....	19
2.3 Treatment of the Chronic Trauma of Racial Systemic Oppression .....	22
2.3.1 <i>Overview of Trauma Treatment and Goals</i> .....	22
2.3.2 <i>The State of Treating Chronic Racial Trauma Before May 2020</i> .....	23
2.3.3 <i>The State of Treating Chronic Racial Trauma Since May 2020</i> .....	27
2.3.4 <i>Psychotherapy and Social Work</i> .....	29
<b>Chapter Three. Methods and Analysis Plan .....</b>	<b>32</b>
3.1 Philosophical Paradigm .....	33
3.2 Scoping Review Methodology.....	35
3.2.1 <i>Arksey and O’Malley’s Methodology for Scoping Reviews</i> .....	36
3.3 Search Strategy and Eligibility Criteria .....	39
3.4 Article Selection Process .....	42
3.5 Eligibility Criteria .....	43
3.6 Data Extraction, Analysis and Appraisal.....	44

3.7 Trustworthiness .....	47
3.8 Ethical Considerations .....	47
<b>Chapter Four. Research Findings.....</b>	<b>48</b>
4.1 Accounting of Articles .....	48
4.2 Categories Based on Theoretical Underpinnings .....	53
4.3 Global Article Findings.....	61
4.4 Measurement Tools to Assess the Impact of Racial Trauma .....	61
4.5 Author Positionality .....	63
4.6 Empirical Studies .....	63
4.7 Proposed Frameworks and Models.....	68
4.8 Thematic Analysis .....	72
4.8.1 <i>What Causes Harm</i> .....	72
4.8.2 <i>What Facilitates Healing From Systemic and Racial Oppression?</i> .....	75
4.8.3 <i>Therapist Role and Responsibilities</i> .....	80
<b>Chapter Five. Discussion .....</b>	<b>87</b>
5.1 Summary of Findings.....	87
5.1.1 <i>Key Findings</i> .....	87
5.1.2 <i>Three Major Themes Emerged</i> .....	88
5.1.3 <i>Consistency and Agreement in the Literature</i> .....	89
5.1.4 <i>Contradictions or Debates in the Literature</i> .....	89
5.1.5 <i>Gaps Identified</i> .....	92
5.2 My Professional Reflections .....	94
5.2.1 <i>My Opinions on the Three Categories</i> .....	95
5.2.2 <i>How I Can Apply the Findings in Clinical Practice</i> .....	98
5.3 Implications and Future Directions.....	99
5.3.1 <i>Training</i> .....	100
5.3.2 <i>Future Research</i> .....	101
5.4 Strengths and Limitations .....	102
<b>Chapter Six. Conclusion.....</b>	<b>104</b>
<b>Funding .....</b>	<b>105</b>
<b>Competing Interests .....</b>	<b>105</b>
<b>References .....</b>	<b>106</b>

**List of Tables**

Table 1 <i>The Five Stages of Creating a Scoping Review</i> .....	37
Table 2 <i>Inclusion and Exclusion Criteria</i> .....	44
Table 3 <i>Complete Dataset</i> .....	50
Table 4 <i>Summary of Categories</i> .....	57
Table 5 <i>Validated Measures of Racial Trauma</i> .....	62
Table 6 <i>Empirical Studies: Methodology, Sample sizes, and Findings</i> .....	65
Table 7 <i>Frameworks and Models</i> .....	69

**List of Figures**

Figure 1 <i>The Relationship Between the Various Forms of Oppression</i> .....	8
Figure 2 <i>Search and Eligibility Results</i> .....	43
Figure 3 <i>Decolonial and Liberation Pathways for Trauma Restoration</i> .....	78

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## Chapter One. Introduction

The trauma of racial systemic oppression is rampant in North America, yet psychotherapists are ill-equipped to treat this type of trauma (Bryant, 2024; Miola et al., 2025). I was inspired to do this research after witnessing the Black Lives Matter movement in the United States, in reaction to the murder of George Floyd in May 2020. As a therapist, I realized that I was not trained to treat the chronic trauma of racial systemic oppression. If any one of the Black protestors had come into my office seeking help for the trauma of their years of anger and grief over the seemingly unending murders of innocent Black people at the hands of police officers and White vigilantes (e.g., Trevon Martin, George Floyd, Breonna Taylor, Ahmaud Arbery, Eric Garner, etc.), I would not have known how to treat their trauma; much less help them address the larger political system that perpetuates it. In the summer of 2020, when I began looking for guidance on treating the trauma of racism, I found that to date mainstream Western psychology had little to offer. The diagnostic criteria for posttraumatic stress disorder (PTSD) did not acknowledge racial trauma, systemic oppression, nor present-day trauma on either an individual or collective level. Without a proper diagnosis, there was little guidance for treatment (Benuto et al., 2020).

Therapists tended to address a cluster of individual disorders, such as depression, anxiety and substance abuse, rather than the bigger problem of debilitating systemic oppression. Treatment attempted to address symptoms of trauma without regard to the context of the sociopolitical environment that the client inhabited (Bryant, 2024). Further, the goal of treatment was to merely reduce symptoms and increase functioning or productivity. It patched people up, then sent them back into the fray to be reinjured. Something seemed to be missing.

While there were multiple approaches to trauma treatment, it felt problematic that these approaches were typically geared towards single event traumas that had occurred in the past. They focused on contrasting present-day safety with past trauma. The message, ‘the threat is over, and you are safe now’ is essential to these treatment approaches. However, in the chronic trauma of systemic oppression, the event is not over, it is ongoing and thus the person is not safe. The challenge is to heal a wound while the person is still being wounded. What is a therapist to do with the client sitting in front of them in the psychotherapy hour?

This dilemma is the essential point of this research. In 2020, my research into the treatment of racial trauma yielded no satisfying results. Since then, there has been more discussion and literature on the subject of racial trauma. Now, five years after the catalytic event, I am revisiting the dilemma in the form of a scoping review to see what has developed in the field. The research question driving this inquiry is: How does the recent literature examine treating the trauma of racial systemic oppression within the context of individual counseling? The target audience is mental health professionals seeking guidance on how to support people struggling with the chronic trauma of racial systemic oppression and academics hoping to identify potential areas for future research.

I chose to make this research a scoping review because I wanted to see a broad picture of the literature emerging on this topic. Preliminary research revealed that there were numerous articles on this topic and many asserted that their approach was the best, yet the approaches differed significantly. For example, some had a more traditional Western approach while others called for decolonization of psychology and psychotherapy. Thus, to answer the burning question that ignited this project, I realized that instead of searching for a singular answer, I needed to see

the full spectrum of positions on the topic. From this broad, informed perspective, future research could be focused on a more specific question and answer.

My research aims to survey and thematically summarize this recent body of work (2020-2025) on treating the trauma of racism. It specifically examines how these emerging concepts can be applied at an individual level. This is important because the practice of psychology is still dominated by individual counseling sessions. Mental health professionals need guidance on how to adapt the treatment of racial trauma to the individual therapy hour. My research question is: How does the recent literature examine treating the chronic trauma of racial systemic oppression within the individual therapy hour? This research is relevant to therapists, other mental health professionals, and policy makers who are addressing how to treat the epidemic of trauma stemming from racial systemic oppression.

### **1.1 Primary Researcher Positionality Statement**

In the interests of transparency and socio-political context, I feel it is important to share my positionality. I am a female, White, middle-class, psychotherapist, licensed in California, Oregon, Washington, and British Columbia with 15 years' experience in private practice and specializing in trauma treatment. My primary counseling training was in depth psychology, with emphasis on Jungian and humanistic theories and approaches to psychotherapy. My training emphasized a decolonized and multi-cultural perspective on psychology and counseling, in addition to a traditional Western approach that prepared me for licensing. My subsequent training in trauma treatment includes Eye Movement Desensitization and Reprocessing (EMDR), somatic processing, and the psychedelic ketamine used in clinical settings. In the context of the larger

field of mental health professionals, my training is both Western and non-traditional. My licensure and business practice are Western. I chose to pursue non-traditional treatment modalities because I find the Western treatments limiting and sometimes ineffective.

## **Chapter Two. Literature Review**

Now that the context, catalyst, and research question has been established (How does the recent literature examine treating the chronic trauma of racial systemic oppression within the individual therapy hour?), I will present a review of the literature to further establish the fundamental components of treating the trauma of systemic oppression in psychotherapy. This literature review will define and summarize systemic oppression, psychological trauma, and the history of treating systemic trauma to set the stage for the research and findings.

### **2.1 Systemic Oppression**

#### **2.1.1 Defining Concepts and Terms**

Oppression is a severe power imbalance that privileges one group while dominating one or more other groups (Asumah & Nagel, 2014). It can be caused by explicit tyrannical power intent on overt dominance such as colonialism, fascist political power, and patriarchy. But, as Iris Marion Young states, it can also be the result of systemic constraints that are “embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules” (Asumah & Nagel, 2014, p. 5). Iris Marion Young posited the mechanisms of oppression can be categorized into five groups—“the five faces of oppression”: exploitation, marginalization, powerlessness, cultural imperialism, and violence (Asumah & Nagel, 2014). Oppression is deeply unjust and detrimental to the oppressed because it devalues human worth and potential based on categories such as race, gender, socioeconomic class, and ethnicity (Stanley & Atari-Khan, 2024).

Systemic oppression is a logical continuation of the general concept of oppression. The systemic aspect is an intentional pattern of domination that advantages one group while

disadvantaging others. Power, or lack of it, is created and maintained through a network of institutions, policies, laws, and cultural and social norms (Braveman et al., 2022; M.T. Williams et al., 2023). The primary drivers of systemic oppression are racism, neoliberalism, and patriarchy (Shaia et al., 2019). Systemic oppression manifests in layers of society via institutional, cultural, interpersonal, and individual systems (Braveman et al., 2022; Miola et al., 2025). This complex, systemic network creates self-perpetuating reinforcement that ensures that it is long-lasting and difficult to disrupt. While the division of power is often based on racial groupings, it can also be applied to other forms of social categories such as gender, sexual orientation, and caste systems that include multiple races within a subjugated caste level. Kimberlé Crenshaw coined the term ‘intersectionality’ to describe the co-occurrence or overlap of oppressed categories—for example, being a Black woman (Crenshaw, 1989). People who are part of these intersectional social categories often face greater discrimination and struggle than those for whom only one category applies.

Institutional or structural oppression is a sub-category of systemic oppression. In this research the terms institutional and structural oppression will be used synonymously. Structural oppression is systemic oppression manifested on the societal levels of laws, government institutions, political systems, religion, education, economy, health care and social interactions (Braveman et al., 2022; M. T. Williams et al., 2023). Examples are: racial red-lining practices that separate neighborhoods by race; segregation in education; discriminatory health care; financial oppression via biased criteria for access to financial tools; and the general lack of access to health and wealth promoting resources based on bias and discrimination.

Racial oppression is another sub-category of systemic oppression. In this case the systemic, structural oppression is organized around the concept of race (Miola et al., 2025; Shaia et al., 2019). In this research the terms racial oppression, racial systemic oppression, and racial structural oppression will be used synonymously to describe oppression based on race and ethnicity. There are many examples of racial systemic oppression in the history of North America, for example, genocide against Indigenous peoples, Indigenous residential schools (Truth and Reconciliation Commission of Canada, 2015), enslaving African people, the Chinese Exclusion Act of 1882 in the United States (Britannica, 2025a), the Japanese internment camps during World War II in both the United States and Canada (Robinson, 2024; National Archives, 2024), mass deportations of Mexicans from the United States (Hester, 2020), post-9/11 Islamophobia (The Pluralism Project, 2013), South Asian targeting and anti-Asian violence during the COVID-19 pandemic (Ruiz et al., 2023), and generalized racialized violence, discrimination, and exploitation by the dominant White culture against people of color.

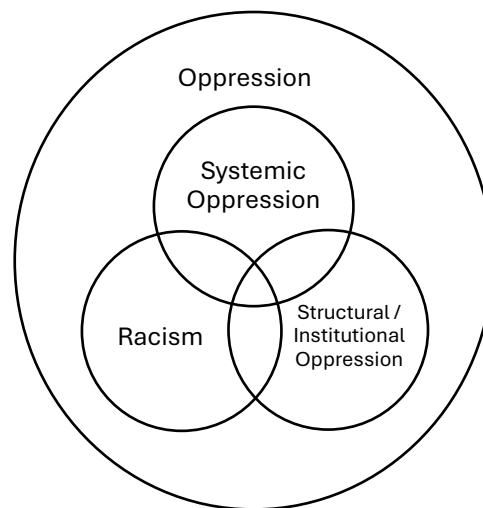
Racism at the community and interpersonal levels is often manifested as physical and psychological violence via both large, overt acts and small, covert acts (Caulley, 2020). For example, acts of racism can include direct physical violence, overt discrimination, and exclusion. They also include microaggressions that are more subtle and sometimes even well-intentioned but nonetheless harmful. Examples of microaggressions include racial slurs, 'jokes' that are hurtful, subtle demeaning behavior, stereotyping, and asking people of different cultures to conform to the dominant culture for the comfort of the people within the dominant culture (Caulley, 2020). Acts of racism, whether they be on the systemic, structural, or interpersonal

scale, are psychologically and emotionally detrimental because they cause chronic stress and anxiety, depression, isolation, and internalized oppression (Caulley, 2020).

Figure 1 illustrates the relationship between these terms. The generalized concept of oppression contains the interlocking sub-categories of systemic, institutional/structural, and racial oppression.

### **Figure 1**

*The Relationship Between the Various Forms of Oppression*



#### **2.1.2 Colonialism**

Colonialism is a clear example of the full spectrum of systemic oppression. Colonialism occurs when one group, often an external nation, invades, occupies and oppresses another group or territory. The result is destruction of the self-governance, identity, and culture of the occupied people as well as resource extraction from the land and exploitation of the people to serve the colonial power (Kohn & Reddy, 2024). History is filled with examples of colonialism, such as the British empire colonizing much of the globe from the 16<sup>th</sup> to 20<sup>th</sup> centuries (Britannica, 2025b).

Within North America the colonization of Indigenous peoples by European settlers, beginning in the late 1400s, is relevant to this study (Hele, 2023). North American colonization also included kidnapping Africans from their homelands in Africa and exporting them to North America as enslaved people (National Archives, 2016). This North American colonization, and the subsequent trauma inflicted on the colonized people, is at the heart of this research, which focuses on populations of North America.

Colonialism is driven by the desire to acquire more wealth and power by conquering other people and territories. It is often morally justified by the colonizer claiming religious or racial superiority and thus righteousness in their actions (Kohn & Reddy, 2024). Extreme power imbalance, through hierarchical dominance, is at the core of colonialism. This domination is rationalized through ideology that dehumanizes the oppressed, labels them as 'others,' and views them as inherently less valuable humans. This is often based on racial labels, though it can also include gender, religion, political affiliation, sexual orientation or any other difference that the oppressor chooses to use. This ideology allows for cruel exploitation of human beings who serve the colonizer. To ensure that this exploitation is not challenged, they create cultural assimilation and structural oppression via language, religion, governance, laws, and institutions that fracture and destroy the oppressed cultures while reinforcing the rule of the colonizer (Hele, 2023; Kohn & Reddy, 2024).

Colonialism is destructive to the oppressed on many levels. This research will focus on the psychological impact of colonialism. One level of the destruction is the psychological trauma of the physical violence used to establish dominance, such as genocide, enslavement, destruction of communities and families, and being removed from land that has life-sustaining

resources to land that is barren (The Office of the High Commissioner for Human Rights, n.d.).

Another level is the psychological violence of rendering humans powerless and unable to protect themselves emotionally from on-going threat and harm (Fanon & Philcox, 2004, 2008; Matheson et al., 2022). The essence of psychological trauma is powerlessness. Colonization is specifically designed to render one group of people physically, intellectually, and psychologically powerless. It is psychological warfare designed to break heart, mind, and spirit so that the oppressed has only enough strength to serve the oppressor but not enough strength to fight back (Fanon & Philcox, 2004, 2008; Matheson et al., 2022). Thus, for the colonized, the psychological legacy of disconnection from ancestral cultural resources, fractured identity, internalized inferiority, learned helplessness, shame, anger, and grief can reverberate for generations after the initial colonization because it is reinforced by the new culture of dominance and subjugation (Adames et al., 2023; Matheson et al., 2022). This research seeks to learn how the psychotherapy hour can be used to facilitate healing this trauma.

### **2.1.3 Decolonization and Post-Colonial Perspectives**

Decolonization is the process of dismantling the structure, systems, and ideologies of the colonizer and restoring autonomy and culture to the oppressed groups. It seeks to correct the power imbalance between colonizer and oppressed by giving more power to the oppressed in all aspects of society, government, and institutions (The Oxford Review, n.d.).

A few of the seminal contributors to decolonization theory include Frantz Fanon, Ignacio Martín-Baró, and Paulo Freire. Frantz Fanon is considered the founding father of decolonization theory. His classic works *Black skin, White masks* (1952) and *The wretched of the earth* (1961) established the concept of colonialism as psychological domination causing internalized

oppression and the need for collective resistance to decolonize the mind and reclaim cultural identity (Kohn & Reddy, 2024). Ignacio Martín-Baró developed liberation psychology in Latin America as a result of dictatorships in Central America (1960s-1990s). He critiqued Western psychology for being complicit in oppression and called for collective action towards empowerment and justice for the oppressed (Lykes, 2021). Paulo Freire's work, *Pedagogy of the oppressed* (1970), introduced the concept of critical consciousness and the necessity to empower people and community through participatory action, and dialogue (Dotts, n.d.).

Because colonization is as much psychological and emotional as it is physical and structural, this research will address the psychological aspects of decolonization as one approach to treating the trauma of racial systemic oppression (Fanon & Philcox, 2004, 2008). Psychological decolonization is rooted in critical consciousness, which allows the oppressed people to reframe their struggle as the result of a system designed to dominate them, rather than personal failings (Comas-Díaz et al., 2024). This shift allows for an increased sense of personal agency; this sense of power is essential to treating trauma because trauma is rooted in feeling powerless. Psychological decolonization also includes reclaiming cultural identity and community connection, restoring language and epistemology, healing internalized racism and the resulting shame, restoring spirituality, forming alliances with other groups, and processing the grief and anger caused by the brutality of colonization (Comas-Díaz et al., 2024).

It is also relevant to this research to note the history of resistance to colonization in North America by looking at examples from Indigenous and Black cultures. Resistance can be framed as both literal war against the invading groups and decolonization against the institutional, societal, cultural, and psychological aspects of colonization (Kohn & Reddy, 2024). Resistance

and decolonization have existed for as long as colonization has. In North America, Indigenous resistance against European colonizers such as the Pueblo Rebellion (1680) (Britannica, 2025c), the modern movement to establish Indigenous sovereignty such as the American Indian Movement (1968-present) (American Indian Movement, n.d.), and the Truth and Reconciliation Commission Report and Calls to Action (2008-2015) have worked to push back against colonial rule and re-establish Indigenous sovereignty, governance, culture, land stewardship, and spirituality. Ongoing resistance has also been strong in the Black communities of North America, from physical revolts and networks against slavery (e.g., slave rebellions and the Underground Railroad) (Miller, 2022), to the Great Migration of Black people after the American Civil War (Harvard University, n.d.), to the American Civil Rights Movement (Library of Congress, n.d.). Most recently, the Black Lives Matters movement (2013 to present) has become the face of modern Black decolonial and anti-racist movements in the United States and Canada (Black Lives Matter, 2024; Library of Congress, n.d.). This is important to this research because resistance is an important part of the history, culture, and identity of oppressed people. Understanding the history of fighting back is as important as the history of oppression itself.

#### ***2.1.4 Why Is This Research Important?***

Systematic oppression has a detrimental impact on all aspects of quality of life for the oppressed because it directly affects the social determinants of health (SDH). SDH are the non-medical influential factors that affect health such as “housing and environment, education, food insecurity, working conditions, economic power, social inclusion and discrimination, and access to health services” (World Health Organization, n.d.). Numerous studies link poor social determinants of health with poverty, physical and

mental illness (World Health Organization, n.d.). Social determinants of health can be more influential on health than lifestyle and medical history, accounting for “between 30-55% of health outcomes” (World Health Organization, n.d.).

This research is based on the understanding that systemic oppression negatively impacts *mental health*. Studies show unequivocally that systemic oppression leads to poor mental health (M. T. Williams et al., 2023). The consequences include high rates of depression, anxiety, trauma, substance abuse and addiction, eating disorders, poor relationships between parents, children, whole families, and the community at large (Cénat, 2023; French et al., 2020; Sevillano et al., 2022; M. T. Williams et al., 2023). The cumulative effect of this is debilitating to the oppressed individual and their communities. People with intersectional exposure to systemic oppression have even higher rates of mental health problems (Adames et al., 2023; Cénat, 2023; Millner et al., 2021; Sevillano et al., 2022; Shaia et al., 2019). Not only does systemic oppression lead to poor health, the experience of being subjected to long-term systemic oppression is itself a form of trauma (Cénat, 2023; French et al., 2020; Sevillano et al., 2022; M. T. Williams et al., 2023). Yet, traditional Western concepts of trauma do not acknowledge it (Adames et al., 2023; Cénat, 2023; Millner et al., 2021; Sevillano et al., 2022).

Braveman et al. (2022), in their analysis of how systemic racism affects health equity, provide four ways in which racial systemic oppression manifests and harms health. First, by politically disenfranchising and disempowering people:

Lack of political power produces lack of access to key resources and opportunities needed to be healthy, such as clean water, pollution-free neighborhoods, well-resourced schools, affordable housing, and access to medical care. When people are prevented from voting or when their votes count less, they cannot get elected representatives to act on their behalf. (Braveman et al., 2022, p. 175)

Second, economic disadvantage via racially discriminatory practices creates obstacles to financial stability and power and cuts-off access to financial opportunities (Braveman et al., 2022; Miola et al., 2025).

Segregation systematically limits their incomes and wealth—for example, through lack of access to good jobs and by facilitating unfair lending practices such as redlining, which have been major obstacles to home ownership and accumulating wealth. Segregation also constrains the next generation’s employment, and hence their economic opportunities—for example, through poorly resourced schools. Lower levels of income, wealth, and education among people of color have repeatedly been shown to be major contributors to racial or ethnic disparities in health. (Braveman et al., 2022, p. 175)

Third, systemic oppression negatively affects health by constraining people of color to living within unhealthy environments and impeding access to health-promoting environments (Braveman et al., 2022; Bryant-Davis, 2023; Miola et al., 2025). For example, lack of financial power constrains disadvantaged people to living in areas with “air pollution, toxic waste, mold in substandard housing, or other environmental hazards”

while limiting access to resources and opportunities that promote health and wealth, such as education and medical care (Braveman et al., 2022, p. 5).

Fourth, the chronic stress caused by racial systemic oppression, regardless of level of income, leads to higher risk for chronic disease and mental health problems (Braveman et al., 2022; Bryant-Davis, 2023; Miola et al., 2025).

Awareness of race-based unfair treatment of others in one's group could be stressful even if a given individual has not personally experienced an overtly discriminatory incident. It could lead to chronic anxiety and worry about whether personal incidents will occur and, potentially, because it reflects social exclusion, hatred or lack of respect for one's racial or ethnic group. Interpersonal racism could undermine one's self-esteem—an important indirect influence on health.

(Braveman et al., 2022, p. 5)

Despite the impact of systemic racism on health and mental health, relatively little research has been done to determine how best to treat the damage to mental health caused by systemic oppression (Adames et al., 2023; American Psychological Association [APA], 2021).

## **2.2 Psychological Trauma**

### **2.2.1 What Is It?**

Trauma occurs when one feels terror or powerless to protect oneself from a real or perceived threat to life, bodily harm, and psychological integrity. Trauma can be caused by numerous events including natural disaster, violent crime, sexual assault, accidents, war, death

of a loved one, interpersonal physical and emotional violence, severe neglect, and chronic oppression. Trauma can be caused by both directly experiencing these events and witnessing others being harmed (Smith et al., 2024). Traumatic events can be categorized as either single episode events or chronic events (Brown et al., 2025).

Traumatic life events are common. Nearly 75% of Canadians report experiencing at least one traumatic event (Smith et al., 2024, p. 1). "Traumatic stressors, as opposed to daily stressors, can create intense feelings of fear, horror, and powerlessness, disrupting the nervous systems, affecting regulation, sense of self, and even relational capacities" (Brown, 2008, Bryant-Davis & Tummala-Narra, 2020, Rogel et al., 2020, as cited in Bryant, 2024). Psychological trauma is a normal response to an overwhelming event because people need time and support to process loss and injury. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*, a trauma response is not diagnosed as pathological until it significantly impairs functioning for at least one month (American Psychiatric Association, 2022).

### **2.2.2 Trauma Diagnoses**

Trauma is sometimes equated with the PTSD diagnosis. This is, however, incorrect and misleading. In Western psychology, there are three levels of diagnosis for trauma responses: adjustment disorder, acute stress disorder, and post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2022). Adjustment disorder, the least severe, is diagnosed when the precipitating event does not meet criteria for post-traumatic stress disorder and the symptoms do not last more than six months. Acute stress disorder is diagnosed when the traumatic event meets criteria for post-traumatic stress disorder and the trauma symptoms impair functioning for

up to one month after the event. PTSD is diagnosed when the symptoms impair functioning for more than one month. In 2013, the DSM-5-TR expanded the PTSD diagnosis to include some symptoms often associated with complex PTSD (C-PTSD), such as negative self-blame, persistent negative mood, irritability, and self-destructive behavior, acknowledging the compounding effect of experiencing multiple traumas or on-going trauma (American Psychiatric Association, 2022).

Although traumatic events are common and trauma response is normal, the rates of formal diagnosis of trauma response are relatively low. For example, the American Psychiatric Association states in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-5-TR):

In two U.S. national epidemiological studies, lifetime DSM-5 PTSD prevalence estimates ranged from 6.1% to 8.3%, and the national 12-month DSM-5 prevalence estimate was 4.7% in both studies. National lifetime DSM-IV PTSD estimates from World Mental Health Surveys in 24 countries varied substantially among countries, income country groups, and WHO regions but was 3.9% overall. In conflict affected populations worldwide, the point prevalence of PTSD with functional impairment is 11% after adjustment for age differences across studies. (American Psychiatric Association, 2022, p. 308).

Differentiating a trauma response from the PTSD diagnosis is important because the criteria for the diagnosis of PTSD are relatively narrow compared to the broad range of feelings and dysfunctions that result from trauma (Miola et al., 2025; M. T. Williams et al., 2023). Further,

only diagnosable trauma reactions are measured and counted, if at all. Nonetheless, all traumatic events create psychological distress to varying degrees and durations. The cumulative effect of this distress can severely impact a person's quality of life. This means that the experience and consequences of trauma are often underestimated in statistical reporting, but nonetheless deeply affect the quality of life of trauma survivors (Cénat, 2023; Miola et al., 2025; M. T. Williams et al., 2023).

However, most literature considers PTSD and either chronic or complex PTSD diagnoses because research is often done using the more severe diagnoses and thus there is more literature available. Symptoms and consequences associated with PTSD have been tied to experiences of chronic racism: “intrusive and distressing thoughts, memories, or flashbacks related to the traumatic event; avoidance of situations, people, or activities that remind one of the traumatic event; irritability, sleep difficulties, or hypervigilance; feelings of guilt, shame, or fear; substance use; strains on relationships; and suicidal thoughts and behaviors” (Smith et al., 2024, p. 1). When people live with these symptoms over long periods of time, their overall functioning and quality of life are greatly reduced.

### ***2.2.3 Why Is It Important?***

Exposure to trauma results in “increased risk for depression, anxiety, eating disorders, PTSD, dissociation, anger, distrust, self-harming behavior, aggression, suicide, revictimization, somatic complaints, difficulty focusing and concentrating, and poor physical health consequences” (Bryant, 2024, p. 685). Trauma also creates long-term nervous system dysregulation which in turn impacts one's sense of self and ability to relate to others (Bryant,

2024). The more traumatic events a person experiences, the greater their likelihood of developing mental health problems. This effect is further magnified if the trauma happens early in life (Shaia et al., 2019, p. 242).

#### **2.2.4 Racism is Traumatic**

Racial systemic oppression is “socially engineered trauma” (Shaia et al., 2019, p. 241). As stated above, trauma can be experienced by direct exposure to a real or perceived threat of harm or by witnessing others suffer a threat or harm. Being directly subjected to racism or watching one’s loved ones and community struggle with this oppression is traumatic. Racial trauma is both individual and collective (Comas-Díaz et al., 2019).

It is important to note that racism is not a single event type of trauma. It is chronic or complex trauma. “The trauma of racism is sometimes called racist incident-based trauma, racial trauma, ancestral trauma, historical trauma, intergenerational trauma, collective trauma, and collective grief” (Bryant, 2024, p. 687). According to Brown et al. (2025, p. 247), “Historical traumas (such as slavery, colonization, and the Holocaust) may live in the body and nervous system (Menakem, 2021) becoming intergenerational traumas through their epigenetic, neurobiological, and psychological impact on subsequent generations (Yehuda & Lehrner, 2018).” Yet, according to Cénat (2023), racial trauma is different from other forms of chronic or complex trauma. Cénat (2023) states that racial trauma is more severe than a typical definition of PTSD because of “its cumulative nature; the constant and inevitable concern surrounding interpersonal, institutional, and systemic racism; and developmental hindrance” (p. 678). Cénat (2023) further asserts that “racial trauma differs from complex trauma in three fundamental ways: its origin, constancy beyond childhood, and internalization” (p. 678). Racial trauma

impacts Black, Indigenous, and People of Color (BIPOC) individuals over their lives, and is additionally shown to cause symptoms associated with PTSD, depression, and anxiety (Cénat, 2023).

Aside from the obvious trauma of being dominated by physical violence, racism is deeply dehumanizing. Racial systemic oppression uses psychological tactics such as self-righteous ideologies, 'othering' or declaring other groups as 'less than' the dominant group, and intentional destruction of cultural and community bonds to break the minds and spirits of the oppressed (Dotts, n.d.; Kohn & Reddy, 2024). It strips a human of dignity and inherent worth by reducing them to an object to be used by the dominant group to further their agenda. This is psychologically and emotionally traumatizing to individuals, families, communities, and cultures. According to Bryant-Davis and Ocampo (2005):

In short, racist incidents perpetrated at the individual level by an overtly racist perpetrator that involve verbal, physical, or some other type of abuse or assault fit the standard definition of trauma. In fact, these incidents would be traumatic regardless of the motivation (racist or otherwise). (p. 574)

Because these assaults are chronic throughout the lifespan of a BIPOC person, the result is a "racial hypervigilance that surrounds the lives of racialized people and threatens their psychological integrity" (Cénat, 2023, p. 679).

One example of a common, chronic, dehumanizing assault is microaggression (Cénat, 2023). Sue et al. (2007) describe racial microaggressions as follows:

Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color. Perpetrators of microaggressions are often unaware that they engage in such communications when they interact with racial/ethnic minorities. (p. 271)

Microaggressions are detrimental because their pervasive nature requires constant hypervigilance that leaves one exhausted and thus vulnerable to further assault, including internalized racism resulting from repeated negative messaging (Bryant-Davis & Ocampo, 2005). Bryant-Davis and Ocampo (2005) suggest evaluating the micro-level aggressions using three criteria. First is quantity and repetition of events (Bryant-Davis & Ocampo, 2005; Cénat, 2023). Second is the relationship between the perpetrator and the victim; being assaulted by a formerly trusted person adds insult and betrayal to the injury (Bryant-Davis & Ocampo, 2005; Cénat, 2023). Third is the element of public humiliation, which can manifest as the absence of the support of others, the effect of which is an increase in severity (Bryant-Davis & Ocampo, 2005; Cénat, 2023).

Trauma due to racial systemic oppression has severe effects on mental health, physical health and all other measures of quality of life. According to Brown et al. (2025), “Historical trauma has an intergenerational impact on nervous system functioning, and systemic oppression impacts regulation and ANS [autonomic nervous system] functioning as part of the daily context of the individual’s life” (p. 251). This means that one person’s experience of trauma can have an epigenetic effect that changes their physical functioning in a way that can be genetically passed to future generations, making the next generation more susceptible to poor mental and physical

health. Thus, racial systemic trauma is not only present from cradle to grave but also handicaps future generations (Comas-Díaz et al., 2019).

## **2.3 Treatment of the Chronic Trauma of Racial Systemic Oppression**

### **2.3.1 Overview of Trauma Treatment and Goals**

The overarching goal of Western-based trauma treatment is to reduce the emotional and psychological suffering caused by trauma and to restore productive functioning in daily life and relationships (Holmes et al., 2024; Millner et al., 2021). Non-Western or decolonized approaches, however, aim to create post-traumatic growth, encourage meaning making, restore relationships and enhance rich community connection (Adames et al., 2023; Bryant, 2024; Millner et al., 2021). Whereas Western approaches tend to focus on cognitive function, non-Western approaches tend to be more holistic, incorporating body, mind, spirit, and environment. An extract from Brown et al. (2025, p. 252):

In line with an understanding of the impact of trauma on brain, mind, and body, there are two primary avenues for intervention: 1) top-down and 2) bottom-up approaches. “Top-down” intervention approaches tend to rely on cognitive and interpersonal talk-based approaches that focus on cognitions, relational connections, and awareness of one’s internal experiences while processing traumatic memories (van der Kolk, 2015). In contrast, “bottom-up” approaches engage more primitive regions of the brain, regions that are dysregulated (e.g., helplessness, fear, rage) through bodily and sensory experiences that involve interpersonal rhythms, movement, and breathing (Malchiodi, 2020; Perry, 2009; Perry & Winfrey, 2021; van der Kolk, 2015).

Ideally, trauma treatment will have a combination of top-down and bottom-up approaches. Because trauma injures both body and mind, the healing must include both aspects.

According to Brown et al. (2025), top-down approaches "tend to rely on cognitively-mediated strategies, such as cognitive behavioral therapy or interpersonal psychotherapy which are focused on changing how we think" (p. 252). These can include talk therapy, re-exposure, cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), eye movement desensitization and reprocessing (EMDR), acceptance and commitment therapy (ACT), narrative therapy and psychedelics.

Brown et al. (2025, p. 252) explain further: "Whereas bottom-up approaches (e.g., yoga, expressive arts therapy) center on strategies focused on the underlying causes of dysregulation to help clients cope with raw emotions and defensive reactions (Malchiodi, 2020; National Institute for the Clinical Application of Behavioral Medicine, n.d.)." These can include medication, mindfulness, somatic techniques, and techniques based on polyvagal theory.

Because my research study was inspired by the murder of George Floyd in May 2020 and the subsequent Black Lives Matter movement, I will frame my review of treatments for the trauma of racial systemic oppression as before and after May 2020.

### ***2.3.2 The State of Treating Chronic Racial Trauma Before May 2020***

Prior to May 2020, the effects of racism were typically "examined economically, legally, and medically" but less often psychologically (Bryant-Davis, 2007, p. 141; Miola et al., 2025). There was a lack of clarity around whether to use the diagnosis of PTSD for racial trauma because

the previous definitions of trauma were based on a specific event and physical harm (Bryant-Davis, 2007). But systemic racism is ongoing, does not always result in direct physical harm and thus did not fit the narrow definition. Further, to pathologize a normal response to abusive treatment via formal diagnosis could lead to victim blaming (Bryant-Davis, 2007). Nonetheless, it was acknowledged that the psychological and emotional consequences of racial oppression mirror the definitions of trauma. Bryant-Davis (2007) explains:

Race-based traumatic stressors have the potential to affect victims cognitively, affectively, somatically, relationally, behaviorally, and spiritually (Bryant-Davis & Ocampo, 2005). Cognitive effects may include difficulty concentrating, remembering, and focusing. Affective effects may include numbness, depression, anxiety, grief, and anger. Somatic complaints may include migraines, nausea, and body aches. Relationally, victims may demonstrate distrust of members of the dominant group or, in cases of internalized racism, distrust of members of their racial group. Behaviorally, victims may begin to self-medicate through substance misuse or other self-harming activities. Spiritually, victims may question their faith in God, humanity, or both. (p. 139)

While there was no clear definition of racial trauma and how it related to the diagnosis of PTSD, it was acknowledged that a new way of thinking and vocabulary needed to be invented to address both the trauma and its treatment (Bryant-Davis, 2007).

In terms of treating current and chronic trauma, in 2020, the response in the field of psychology was typically limited to the concept of resilience and coping skills (Wilcox, 2023). While resilience is an essential aspect of psychological health, focusing solely on resilience and

ignoring the source of the pain one is enduring can become pathological in itself. According to Shaia et al. (2019):

Focusing on grit and resilience also manifests as exceptionalism, as there will always be some clients who can achieve success in the face of structural barriers. Unfortunately, many other clients facing systemic intergenerational trauma caused by oppression will experience significant impairment. With the odds stacked against them, the fact that they are unable to rise above their situation should not be considered a fault or weakness.

(p. 240)

Without this larger awareness of systemic oppression, encouraging a client to rise above can be misleading and further disempower them by making them seem a failure in their efforts to persevere, when in fact the game was rigged for them to fail (French et al., 2020; Millner et al., 2021; Miola et al., 2025).

Western psychology, based in White culture's reverence for rugged individualism, has a long tradition of conceptualizing mental health as an individual issue (Bryant-Davis, 2019; Chu et al., 2025; Wilcox, 2023). In 2020, mainstream trauma treatment was largely individualistic. It focused on what the individual should do to optimize their quality of life (Bryant-Davis, 2019). This rugged individualism rarely acknowledges how the external environment affects the individual for better or worse (Bryant, 2024). Shaia et al. (2019) explain that frameworks in use by psychotherapists prior to 2020 were inadequate, "focusing on individual psychopathology while ignoring the forces of social oppression and inequality that disproportionately predispose some groups in society to traumatic experiences." Western psychology failed to acknowledge non-

Western, non-White cultural influences, needs, and resources for people of color, and thus lacked relevance and efficacy (Comas-Díaz et al., 2019).

Up to 2020, the concepts of cultural sensitivity and cultural competence encouraged therapists to be aware of stereotypes, avoid using them, and to instead see the client as an *individual*; but this did not address the impact of discrimination nor did it offer suggestions for treating these complex issues (Benuto et al., 2020, p. 2). Therapists were taught that cultural stereotypes were bad, but not that cultures could be a source of strength and healing. Thus, Western psychology isolated oppressed people and celebrated them if they could rise above systemic oppression and blamed them if they could not.

Thema Bryant-Davis, a Black, female psychologist was elected President of the American Psychological Association in 2023. She has served as the representative of the American Psychological Association to the United Nations, and directs the Culture and Trauma Research Laboratory at Pepperdine University in California. Thema has become a leading voice confronting the lack of treatment for the trauma of racism (Dr. Thema, 2021). In her critique of Western psychology's lack of consideration of cultural influence on assessing and treating trauma in people of color, Bryant-Davis (2019) called for trauma treatment models to "integrate the sociopolitical and sociocultural realities and resources of the survivor" (Bryant-Davis, 2019, p. 400). Bryant-Davis integrated the concept of intersectionality, to be applied to understanding and treating the trauma of racism and thus acknowledged the complexity of the problem (Bryant-Davis, 2019, p. 400). Bryant-Davis (2019) had the following to say:

Marginalized community members are more likely to experience interpersonal trauma, to develop severe PTSD, and to face barriers to safety, justice, and mental health services; the neglect of these populations in the PTSD guidelines contributes to the cultural incompetence found in the field. (p. 401)

In August 2019, nine months before George Floyd was murdered, Bryant-Davis (2019) stated:

The cultural erasure in the current Treatment of American Psychological Association PTSD Guideline (2017) ... adds to the call for multicultural psychologists, liberation psychologists, feminist psychologists, queer psychologists, and community psychologists to continue doing the sacred work of decolonizing psychology through the creation of space for the voices, experiences, needs, strengths, and treatment of diverse populations. (p. 401)

Thema Bryant-Davis's election to the role of President of the American Psychological Association in November 2023 was an indication that the field of psychology was attempting a shift from the status quo to a new way of addressing the trauma of racial systemic oppression. These changes will be explored below.

### ***2.3.3 The State of Treating Chronic Racial Trauma Since May 2020***

The murder of George Floyd and the subsequent Black Lives Matter protests became a watershed moment in the field of psychology. Like me, many other mental health professionals voiced frustration about Western psychology's lack of acknowledgement and guidance on the epidemic of racial trauma. This allowed existing research on racial trauma, that had previously

been shunned by the mainstream, to come forward and be centered in the discussion. In October 2021, the American Psychological Association (APA) issued this formal apology:

The American Psychological Association failed in its role leading the discipline of psychology, was complicit in contributing to systemic inequities, and hurt many through racism, racial discrimination, and denigration of people of color, thereby falling short on its mission to benefit society and improve lives. APA is profoundly sorry, accepts responsibility for, and owns the actions and inactions of APA itself, the discipline of psychology, and individual psychologists who stood as leaders for the organization and field. (APA, 2021, p. 1)

This period of change also spurred new research on how to treat the trauma of racism. Several scholarly articles were written on this subject from 2020 to 2025. The preliminary research for this project found more than 80 articles addressing treating racial trauma. Like Bryant-Davis calling for decolonizing psychology in 2019, the new research calls for decolonizing trauma therapy from Western-centric values and learning from liberation psychology, Black psychology, and Indigenous resilience how to incorporate community resources and participation in resistance against oppression as a therapeutic intervention (Bryant, 2024).

Decolonization psychology is an effort to de-center White Western values and customs and replace them with those of other cultures. Instead of having one system that is based on White, Western patriarchy, there could be multiple models that are customized to each culture's values, beliefs, and customs (Adames et al., 2023; Bryant, 2024; French et al., 2020; Gone, 2021; Millner et al., 2021). These approaches tend to be holistic in nature, meaning they include mind, body, spirit, and environmental factors into their concept of health, illness, and treatment. This

perspective emphasizes the foundational importance of culture, community and relationships over individualism. Culture, community and relationships are seen as essential sources of strength (Adames et al., 2023; Bryant, 2024; French et al., 2020; Gone, 2021; Millner et al., 2021). While decolonization psychology approaches may utilize Western counseling interventions, these will be adapted and secondary to the decolonized perspective which prioritizes community, culture and local knowledge systems.

Decolonization psychology is often paired with liberation psychology because these two philosophies complement each other (Bryant, 2024). Liberation psychology began as socio-political movement in response to oppressive government regimes. It emphasizes community cohesiveness to support the people and culture while also using the unified force to resist the oppression via political means. Liberation psychology has been adapted to be used in community and individual psychology as a way of framing resistance to oppressive forces in the environment.

Decolonization psychology and social work are closely related, as both have an important role to play in uplifting and empowering marginalized communities. Here I explore the literature on the similarities and differences between psychotherapy and social work; and explain how social work will be addressed in the discussion.

#### ***2.3.4 Psychotherapy and Social Work***

Like psychotherapy, social work is a profession dedicated to helping people. Social work is an important aspect of the overall community of mental health care and thus was included in the search terms during data gathering. It is important to note that psychotherapy and social work

are similar, but different in important ways. The role of social work, differentiated from individual psychotherapy, will be explored in the discussion section of this document.

Psychotherapy is rooted in the disciplines of psychology and psychiatry and is introverted by nature. It focuses primarily on the autonomous individual and intrapsychic processes, but it can also work for small-scale relationships such as couples or family therapy. Psychotherapists are trained in psychological assessment, psychopathology, and psychotherapy methodology (Read, n.d.). Psychotherapists primarily work in private practice and clinics but may also work in hospitals or schools. Psychotherapy utilizes insight, emotional intelligence, self-awareness and behavior change (Read, n.d.). The goal of psychotherapy is to reduce symptoms and improve functioning.

Social work is rooted in the study of society, social justice, and community resources (Canadian Association of Social Workers, 2020) and is extroverted by nature. Social work sees the person as part of a social, cultural, and political ecosystem. Social workers are trained in counseling, systems theory, policy, case management and community practice. Social workers primarily work within institutions or organizations such as community agencies, non-profits, hospitals, schools, but may also have private counseling practices (Canadian Association of Social Workers, 2020). Social work utilizes empowerment, advocacy, resource utilization, and system reform to support both the individual and community. The goal of social work is to empower the person by connecting them to community resources, and improving the community through programs, advocacy, and policy change (Canadian Association of Social Workers, 2020).

Now that the literature review has established the concepts of systemic oppression, psychological trauma, racial oppression as a form of trauma, and the historical treatment of racial trauma, it is time to set the stage for the methodology behind how this research project attempted to answer the question: How does the recent literature examine treating the chronic trauma of racial systemic oppression within the individual therapy hour?

### Chapter Three. Methodology

I chose to make this research a scoping review because I wanted to see a broad picture of the literature emerging on this topic. Preliminary research revealed that there were numerous articles on this topic and many asserted that their approach was the best, yet the approaches differed significantly. For example, some had a more traditional Western approach while others called for decolonization of psychotherapy. Thus, to answer the burning question that ignited this project, I realized that instead of searching for a singular answer, I needed to see the full spectrum of positions on the topic. From this broad, informed perspective, future research could be focused on a more specific question and answer.

This research was conducted as a scoping review and a thematic analysis because the goal of the research was to assess what has been published on the topic between June 2020 and May 2025 and to summarize the key themes. The philosophical paradigm adopted for this study was classical pragmatism. The overall research methodology was guided by Arksey and O'Malley's (2005) framework for a systematic scoping review, considering Levac et al.'s (2010) revisions. The PRISMA Scoping Review (PRISMA-ScR) protocol (Page et al., 2021; Tricco et al., 2018) guided the data collection, evaluation, inclusion and exclusion screening. The thematic analysis was guided by Levac et al.'s (2010) modified version of the Arksey and O'Malley (2005) methodology and the tenets of classical pragmatism. The research team consisted of myself (the first author) and two secondary reviewers.

### 3.1 Philosophical Paradigm

The philosophical paradigm underpinning this research was pragmatism. “Pragmatism is a philosophical tradition that originated in the United States around 1870. The most important pragmatists, known as classical pragmatists, were Charles Sanders Peirce, William James, and John Dewey” (University of Nottingham, n.d.). The core tenet of pragmatism is practical consequences—it asks ‘what works?’ It values practical consequences, human experience, pluralism, growth and inquiry. It does not seek a final answer with certainty. Rather, it fully acknowledges that knowledge is fallible and needs to evolve as new information or relationships emerge because knowledge is contextual and contingent. In both the research design and analysis of findings, this research emphasized what was relevant, actionable and rooted in pragmatic real-world context to answer the research question. Pragmatism’s concept of relevance is connected to humanism; it “Advocates human rights and individual freedom; An enquiry should bring relief and benefit the condition of man” (University of Nottingham, n.d.).

As a research philosophy, pragmatism avoids the dualism of qualitative vs quantitative or empirical vs interpretive. Instead, it allows space for all and chooses which tool to use based on what best helps answer this research question at this time and in this context. It values usefulness over universality and thus application over abstraction or theory (University of Nottingham, n.d.).

Pragmatism does not dictate methodology. It is deeply rooted in pluralism and thus invites and adapts to many methodologies.

A pragmatic study focuses on an individual decision maker within an actual real-world situation. The process of undertaking a pragmatic study is first to identify a problem and view it within its broadest context. This leads to research inquiry, which seeks to better understand and ultimately solve the problem. (University of Nottingham, n.d.).

Because it is pluralistic, according to the University of Nottingham (n.d.):

A pragmatic piece of research may involve multiple methods .... However, it has to be noted that pragmatists do not have to use multiple methods; rather they use methods or combination of methods pragmatically in order to advance a specific piece of research in the best possible manner.

Because pragmatism is action oriented and is always asking ‘what works?’, “Pragmatic studies are inductive, moving from a complex problem to a general theory of understanding in order to improve a given situation.” (University of Nottingham, n.d.).

While it is considered a useful approach when little is known about a phenomenon, there are criticisms of pragmatic research inquiry: “However, most of the concerns about the approach arise from its lack of a strong theoretical or methodological basis that can leave its findings and interpretations open to question or contradiction”(University of Nottingham, n.d.). This research project sought to address this potential limitation by using a scoping review methodology based on Arksey and O’Malley’s (2005) process and Levac et al.’s (2010) revisions to the original stages and guidance for a thematic analysis. This, combined with the PRISMA-ScR protocol for study selection, provided a sturdy methodology to complement pragmatism’s inherent flexibility.

Pragmatism was a good philosophical fit for this research project because the nature of psychotherapy is that it seeks practical consequences, growth and inquiry. Similarly, pragmatism is connected to humanism, as is psychotherapy. The aim of the research question was to learn from the literature how to make therapy more effective and pragmatic for the treatment of racial trauma. The research methodology, described below, like therapy itself, sought to cast a wide net to find what is useful in a variety of contexts. In pragmatic research and pragmatic therapy, the method is not as important as the outcome. It seeks a path to many good outcomes, not a singular correct answer.

### **3.2 Scoping Review Methodology**

I chose to design this research as a scoping review because I wanted to assess the breadth of new research on this topic and summarize the findings. According to Colquhoun et al. (2014):

A scoping review or scoping study is a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge. (p. 1294)

As noted in the literature review, the field of psychology has evolved on the topic of the trauma of racism since George Floyd's murder in May 2020, the APA apology on racism in 2021, and the election of Thema Bryant-Davis as President of the APA in 2023. The intention of this scoping review was to cast a wide net to evaluate any emerging developments that could be directly applied to trauma treatment within the real-world context of individual therapy. Because

chronic trauma caused by systemic racial oppression is a complex topic, the intention was not to find a specific answer to the complex question. Rather, I intended to assess developments in the field and to create a thematic summary of those developments. This would allow me, or other clinicians or researchers, to determine the next step of research or training suited to their unique needs.

### ***3.2.1 Arksey and O'Malley's Methodology for Scoping Reviews***

The overall research methodology was guided by Arksey and O'Malley's (2005) framework for a systematic scoping review. Arksey and O'Malley state that scoping reviews have four purposes: 1. To examine the extent, range, and nature of research activity; 2. To determine the value for undertaking a full systematic review; 3. To summarize and disseminate research findings; and 4. To identify research gaps in the existing literature (Levac et al., 2010, p. 2). This research project sought to align with the first and third purposes and reveal gaps in existing literature.

Arksey and O'Malley (2005, p. 22) outlined five primary stages of creating a scoping review: 1. identifying the research question; 2. identifying relevant studies; 3. study selection; 4. charting the data; and 5. collating, summarizing and reporting the results. Since Arksey and O'Malley first published their methodology in 2005, other researchers have revised the process for clarification and adaptation to accommodate research requiring more flexibility in thematic analysis and data summarization. Levac et al. (2010) critiqued Arksey and O'Malley's (2005) scoping review methodology and proposed revisions to each of the five stages in the basic model. Most relevant to this research proposal are the revisions Levac et al. (2010) made to stages four and five, which address charting and summarizing the dataset. Taken together, the revisions to

these steps allow for a richer thematic analysis that leads to a knowledge synthesis of the dataset. This is summarized in Table 1 below.

**Table 1**

*The Five Stages of Creating a Scoping Review*

<b>Arksey and O'Malley Stages</b>	<b>Levac et al.'s Recommendations</b>
1. Identify the research question	Design the research question to include the focus, purpose and rationale of the study (Levac et al., 2010).
2. Identify relevant studies	The scope of the study should be guided by the research question and purpose of the study. Ensure the research team has the expertise to conduct the study. When limiting the scope is necessary, acknowledge and justify the limits (Levac et al., 2010).
3. Study selection	This should be an iterative process with ongoing discussion amongst the team and at least two reviewers evaluating the abstracts and full articles (Levac et al., 2010).
4. Charting the data	“The research team should collectively develop the data charting form and determine which variables to extract in order to answer the research question” (Levac et al., 2010, p. 4). The charting should be iterative. “Two authors should independently extract data from the first five to ten included studies using the data-charting form and meet to determine whether their approach to data extraction is consistent with the research question and purpose” (Levac et al., 2010, p. 4).
5. Collating, summarizing, and reporting the results	“Researchers should break this stage into three distinct steps: 1a. Analysis (including descriptive numerical summary analysis and qualitative thematic analysis); 1b. Reporting the results and producing the outcome that refers to the overall purpose or research question; 1c. Consider the meaning of the findings as they relate to the overall study purpose; discuss implications for future research, practice and policy” (Levac et al., 2010, p. 4).

This evolution in the scoping review methodology works well with the pragmatism philosophy because it allows for focus on how the data reveals what works in real-world situations. It also provides flexibility via the iterative process of refinement and exploration. This aligns with the pragmatism value of method and knowledge influencing each other to evolve knowledge, always with an emphasis on practical, actionable insights (Levac et al., 2010; Morgan, 2014).

I will now address how this project complied with each of the five primary stages of the scoping review methodology named above. First, the research question was formulated: *How does the recent literature examine treating the chronic trauma of racial systemic oppression within the context of individual therapy?* The research question was specifically designed for a scoping review because it asked what the recent literature did to better understand the topic and attempted to be inclusive while maintaining the pragmatic focus of the context of individual therapy. Second was identifying relevant studies. This was accomplished using the data search strategy described below. Third was study selection. This was guided by the PRISMA (ScR) article selection and screening process, also described below. Fourth, was charting the data; and fifth was collating and summarizing the results of the scoping review. These will be discussed in the analysis and appraisal section below.

The PRISMA-ScR protocol (PRISMA, 2021) guided data collection; evaluation; inclusion and exclusion screening; and data charting. According to Page et al. (2021), “The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) statement, published in 2009, was designed to help systematic reviewers transparently report why the review was done, what the

authors did, and what they found.” The PRISMA standards have been adopted across multiple disciplines and hundreds of academic journals (Page et al., 2021). The PRISMA scoping review protocol was created in 2018 and comprises 20 essential and two optional items for a scoping review (PRISMA, 2020a). This research will include the 20 essential elements. Step 12 of the PRISMA-ScR protocol calls for a critical appraisal of the articles. Because this is both optional and in conflict with Arksey and O’Malley’s (2005) stance on not conducting quality appraisal, it will not be included.

### **3.3 Search Strategy and Eligibility Criteria**

The search strategy included five databases (PsychINFO, PsychArticles, Web of Science, Google Scholar, Medline), using customized search strings for each database. PsychINFO was used because it is curated by the American Psychological Association and includes articles, books, book chapters, and dissertations (University of Victoria, n.d.-d). PsychArticles was used because it combines the American Psychological Association and Canadian Psychological Association collections of full-text, peer-reviewed scholarly articles (University of Victoria, n.d.-c). Google Scholar and Web of Science were used because they offer access to a network of databases covering a broad range of related subjects, including gray literature (University of Victoria, n.d.-a, n.d.-e). Medline was used because it is a rich repository of psychological research (University of Victoria, n.d.-b).

I consulted with three University of Victoria librarians to develop effective search strings for each database. The four core elements of the search terms—the therapy hour, trauma, racial,

and systemic—were created after analysis of materials from the literature review and other related research to determine the most common key words in the field of treating racial trauma.

For the **PsychArticles** database, the following search string was used:

Element 1: (“Therapy hour”) “psychotherapy” OR “social work” OR “counselling”

Element 2: (“Trauma”) Trauma OR PTSD OR “post-traumatic stress disorder” OR “multi-systemic trauma”

Element 3: (“Racial”) “Rac\*” OR “people of color”

Element 4: (“Systemic”) “Systemic” OR “chronic”

(“psychotherapy” OR “social work” OR “counselling”) AND (Trauma OR PTSD OR “post-traumatic stress disorder” OR “multi-systemic trauma”) AND (“Rac\*” OR “people of color”) AND (“Systemic” OR “chronic”)

For the **PsychINFO** database, the following search string was used:

Element 1: psychotherapy OR therapy OR counsel\* OR intervention OR treatment or

"social work\*" or "social services" OR DE "Cognitive Behavior Therapy" OR DE

"Counseling" OR DE "Intervention" OR DE "Treatment" OR DE "Mental Health Services"

OR DE "Social Services"

Element 2: trauma or ptsd or "post-traumatic stress disorder" or "traumatic event" or

"trauma history" or "multi-systemic trauma" OR DE "Posttraumatic Stress Disorder"

Element 3: racism or discrimination or prejudice or "racial bias" OR DE "racism" OR DE

"discrimination" OR DE "prejudice" OR DE "racial bias" OR DE "Systemic racism" OR DE

"people of color"

Element 4: systemic OR institutional OR chronic

For the database **Google Scholar**, the following search string was used:

"psychotherapy" OR "social work" OR "counselling" trauma OR PTSD OR "post-traumatic stress disorder" OR "multi-systemic trauma" "racial trauma" OR "people of color"  
 "systemic oppression" OR "chronic trauma"  
 date range 2020-2025

For the **Web of Science** database, the following search string was used:

ALL=((“psychotherapy” OR “social work” OR “counselling”) AND (Trauma OR PTSD OR “post-traumatic stress disorder” OR “multi-systemic trauma”) AND (“Rac\*” OR “people of color”) AND (“Systemic” OR “chronic”))

For the **Medline** (EBSCO) database, the following search string was used:

Element 1: psychotherapy OR counsel\* OR intervention OR treatment or "social work\*" or "social services" OR MH "psychotherapy" OR MH "Counseling" OR MH "Psychosocial Intervention" OR MH "Mental Health Services" OR MH "Social Work"

Element 2: trauma or ptsd or "post-traumatic stress disorder" or "traumatic event" or "trauma history" or "multi-systemic trauma" OR MH "Stress Disorders, Post-Traumatic"

Element 3: racism or discrimination or prejudice or "racial bias" OR MH "racism" OR MH "discrimination, racism" OR MH "systemic racism" OR MH "racial bias" OR "ethnic and racial minorities"

Element 4: systemic OR institutional

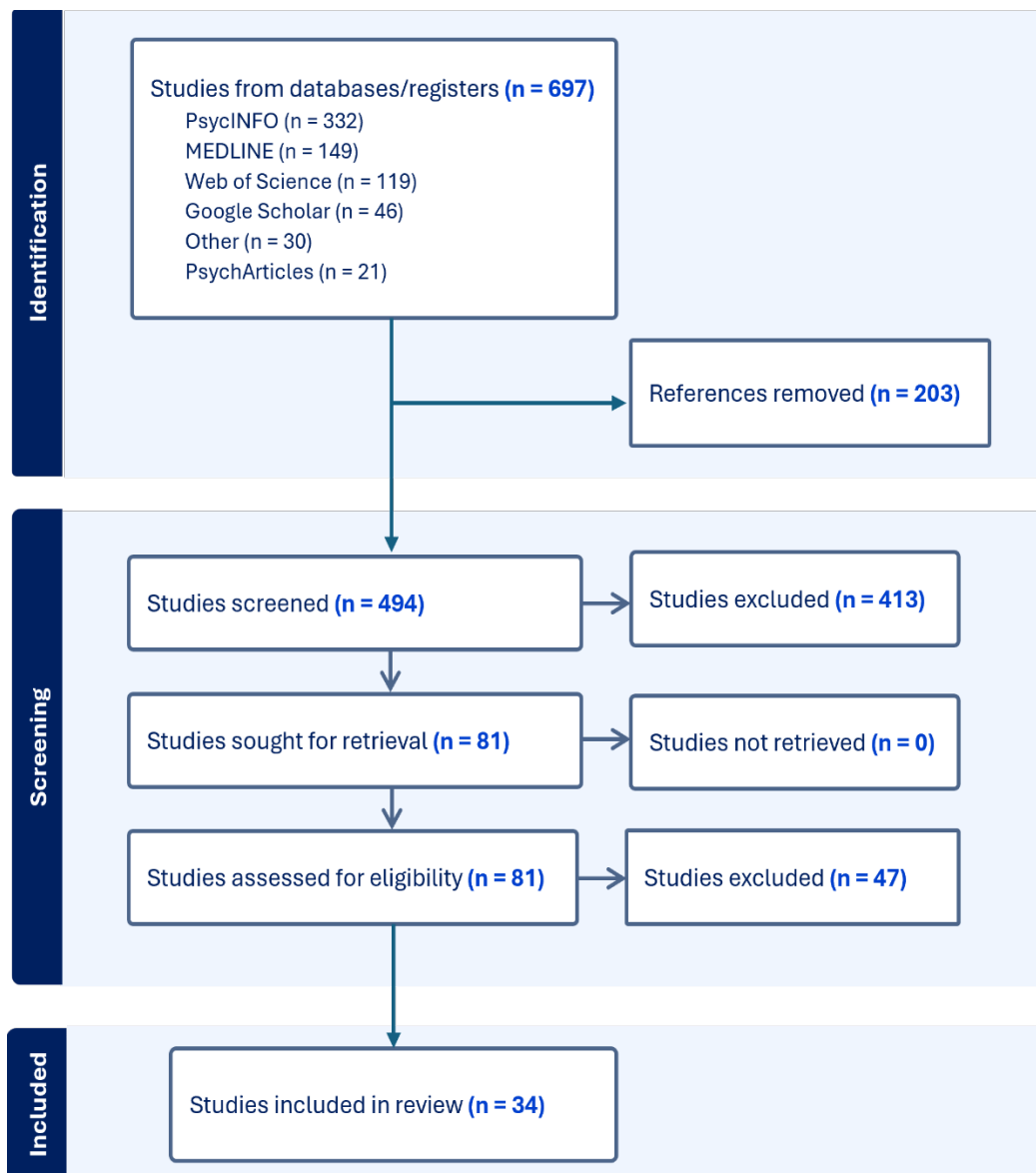
In addition to these broad searches, three articles that were not included in the search results but that I knew would complement the literature were added to the dataset. An article by French et al. (2020) was added because it had been cited by multiple articles and thus seemed to be seminal. Articles by Sevillano et al. (2022) and Wilbur and Gone (2023) were added to include an Indigenous perspective—these had been found during the literature review research. All three articles met the inclusion criteria.

### **3.4 Article Selection Process**

The searches across the five databases yielded a grand total of 697 references imported for screening as 697 studies. Of these 697 articles, 203 duplicates were identified by Covidence (a web-based platform used to screen studies) and removed. This left 494 studies screened at the title and abstract level.

The first round of screening of the 494 studies was conducted using the Covidence software. The review of titles and abstracts per criteria will be described below. I, together with the second reviewer, reviewed all the articles and we came to a greater than 90% agreement on inclusion and exclusion. Differences were discussed before a final decision was made.

The second round of screening was a full-text review. We (first author and second reviewer) reviewed ten (out of the 81) articles per the inclusion and exclusion criteria, and discussed the results. Once we reached a 100% agreement rate, I continued to the remaining 71 eligible articles. Ultimately, 34 articles were selected for the final dataset (Figure 2).

**Figure 2***Search and Eligibility Results***3.5 Eligibility Criteria**

The following inclusion and exclusion criteria were used when screening articles at each stage to determine inclusion or exclusion (Table 2). The software Covidence was used to gather and filter the potential articles.

**Table 2***Inclusion and Exclusion Criteria*

<b>Include</b>	<b>Exclude</b>
Articles that fit the search criteria: therapy for the chronic trauma of racism and systemic oppression.	Articles that do not have a focus on therapy for the chronic trauma of racism and systemic oppression.
Published between June 2020 – May 2025.	Published outside of the date range
Addresses racial systemic oppression occurring within North America only.	Subject is outside of North America
Interventions that can be applied in the individual counseling hour.	Interventions that cannot be pragmatically applied in the individual counseling hour
Articles about decolonizing therapy, in the context of treating the trauma of racial systemic oppression in individual therapy.	Articles about the general theory of decolonizing therapy and thus do not focus on the pragmatic aspect
Western literature, including gray literature, and non-western literature	
All types of study designs or articles are included.	
English language only.	
Full text availability only.	
Articles, theses, dissertations, gray literature, book chapters.	Entire books, films, or podcasts

**3.6 Data Extraction, Analysis and Appraisal**

The data analysis was carried out solely by myself as primary researcher and was divided into two sections: a basic scoping review of quantity and types of information in the dataset per Arksey and O'Malley (2005) and PRISMA-SR guidelines; and a thematic analysis per Levac et al.'s (2010) theories.

The analysis and appraisal work was guided by Levac et al.'s (2010) modifications of the Arksey and O'Malley (2005) process. This began with charting the data (the fourth stage of the scoping review process). In the original Arksey and O'Malley (2005) methodology, this meant producing a table that summarizes basic data points of each article in the dataset, such as author(s), year of publication, study location, study populations, aims of the study, methodology and findings (Arksey & O'Malley, 2005). However, this basic data charting does not include any interpretation of relationships, causality nor meaning-making amongst the articles.

In their 2005 paper, Arksey and O'Malley (2005) acknowledge their methodology has limitations that include: "a lack of appraisal of the quality of the evidence, the need to balance the breadth of the dataset with the depth of the data, and a lack of synthesis of the evidence" (p. 30). Thus, a deeper content analysis was conducted based on Levac et al.'s (2010) recommendations. It entailed noting themes in alignment with the tenets of pragmatism, such as knowledge of what works in the real world, the broad view of influential factors, and actionable insights.

The initial Arksey and O'Malley (2005) accounting summary had multiple sub-themes including research methodology, article types, populations studied, aims and findings, therapeutic treatment models, author positionality, proposed frameworks and models, and an overarching categorization of Western, Adapted Western, Decolonial therapeutic approaches that was used to further evaluate these articles.

The fifth stage of the scoping review was collating and summarizing the results. Like the fourth stage in the original Arksey and O'Malley (2005) method, this is a straightforward narrative

of the numerical analysis of topics and a relatively shallow summary of the findings because it does not attempt to synthesize the findings into themes of meaning within the dataset (Arksey & O'Malley, 2005, p. 27). "Consequently, scoping studies [can only] provide a narrative or descriptive account of available research" (Arksey & O'Malley, 2005, p. 30). However, the Levac et al. (2010) revision to the scoping review process calls for "Consider[ing] the meaning of the findings as they relate to the overall study purpose; discuss implications for future research, practice and policy" (p. 4).

I conducted a thematic analysis through an iterative process of reviewing the dataset and key findings. In practice, this meant sorting, organizing, noting patterns, noting gaps, and grouping similar themes. The result was a summary that was in alignment with pragmatism tenets by using a plurality of data about real-world experience in effectively treating the chronic trauma of racial systemic oppression in the context of individual therapy. Per the fallibility tenet of pragmatism, it did not suggest a definitive answer, but rather presented knowledge to date, based on experience of what works per the dataset. This provides the reader with consolidated data that can act as a stepping stone in their own research on the topic.

To help develop and compare themes, the software research tool, NVivo, was used to facilitate organizing and documenting the themes emerging across the final 34 articles. I read all 34 articles and coded them. I did not begin with a code book but rather allowed themes to emerge naturally and inferentially. A secondary reviewer reviewed three full-length articles and reviewed my codes. The results of this review were discussed and codes such as antiracist, cultural competence, structural competence, decolonization, proposed models, interventions, clinician self-awareness, and culturally appropriate treatment emerged as common codes. The second

reviewer verified the coding of the first reviewer (myself) and thus the resulting themes were not altered from this review.

The results of the thematic analysis were organized into three themes. These themes are a product of combining the pragmatist perspective on the research question with the content emerging from the dataset. The resulting three themes are a pragmatic analysis of the pragmatic questions: what harms; what helps; and what is the therapist's role?

### **3.7 Trustworthiness**

The trustworthiness of this research relied on the credibility of the methodology and findings. This was achieved by triangulation, audit review, and peer review. The data selection used multiple data sources for triangulation. An audit trail was created via the PRISMA-ScR process, and the documentation of methodology changes in stages four and five as noted above. The research utilized Covidence and NVivo research software tools to facilitate organizing and documenting the data. Peer review during research design, and a team approach to reviewing articles for inclusion/exclusion and thematic analysis of the dataset reduced the likelihood of bias or oversight. In stages three, four and five, the second researcher reviewed only a subset of the data to provide peer review on the article selections and thematic analysis.

### **3.8 Ethical Considerations**

Ethical approval was not required for this study because it was secondary research that analyzed and summarized primary research.

## **Chapter Four. Research Findings**

In this chapter I will present a summary of the literature from multiple perspectives in the style of a scoping review. First, I will present an account of the types of articles, research methodologies used, and populations studied. Next, I will organize the dataset into categories based on similar theoretical underpinnings. These three categories are central to the analysis of the literature. From this categorical perspective I will summarize the aims, findings, and therapeutic models of each category, as well as their commonalities. Following the findings, I will summarize the new frameworks and models proposed in the literature. Finally, there will be a summary of empirical studies, trauma measurement tools, and author positionality.

### **4.1 Accounting of Articles**

The search protocol yielded 34 articles in the final dataset. All articles were published between 2020 and 2025 and related to North America. Geographically, 27 were American, four were Canadian, and three were Canadian and American collaborations.

Among the 34 articles, eight were critical analyses of the topic, eleven were theoretical and proposed a new treatment framework or model, five were theoretical supported by case studies, three were theoretical and proposed new conceptual frameworks, five were literature reviews, among which four were systematic reviews. Three were based on interviews, analyzed using thematic analysis, and two were cross-sectional surveys. Some articles have been counted in more than one category.

Twelve articles focused on Black Americans; within this group two specified females of color and Black women, two specified Black men, one specified Black racial justice activists, one specified Black college students, and the others generalized the Black American population.

Eleven articles used generalized categorical terms such as BIPOC, marginalized, people of color, individuals affected by racism, racialized people, racial and ethnic groups targeted for oppression, minority youth, and children and adolescents of color. Three articles focused on youth. Two articles focused on generalized Asian Americans. Two articles focused on Indigenous populations. One article addressed a generalized Latinx population.

Table 3 shows the full dataset of articles. Note that the article ID number (#) will be used in the analysis to refer to specific articles.

**Table 3***Complete Dataset*

<b>ID #</b>	<b>Author, Year, Country</b>	<b>Research Methods &amp; Article Type</b>	<b>Population</b>	<b>Treatment Category</b>
1	Adames et al., 2023, US	Review, Theory / Theoretical, Case Study	BIPOC	Decolonized
2	Akubuiro et al., 2023, US	Review, Theory / Theoretical, Case Study	Low SEC minority youth	Western
3	Avruch & Shaia, 2022, US	Review, Theory / Theoretical	Marginalized populations	Adapted Western
4	Brown et al., 2025, US	Review, Theory / Theoretical, Case Study	Socially and economically marginalized populations from low-resourced communities	Western
5	Bryant, 2024, US	Review, Theory / Theoretical	Marginalized survivors	Adapted Western
6	Bryant-Davis and Moore-Lobban, 2020, US	Review, Theory / Theoretical	Black Americans	Decolonized
7	Bryant-Davis, 2023, US	Review, Theory / Theoretical	Women, girls, non-binary people of color	Decolonized
8	Cénat, 2023, Canada	Review, Theory / Theoretical, Propose New Model	BIPOC in Western societies	Adapted Western
9	Cénat et al., 2024, Canada	Review, Theory / Theoretical, Proposed Model	Racialized people	Adapted Western
10	Chu et al., 2025, US	Cross-sectional survey / Empirical	Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) adults	Adapted Western
11	French et al., 2020, US	Review, Theory / Theoretical, Proposed framework	People of Color and Indigenous individuals (POCI)	Decolonized

12	Gingles, 2022, US	Review, Theory / Theoretical, Propose New Model	Black Americans	Adapted Western
13	Gregory & Tucker Edmonds, 2023, US	Focus group / Focus Group Interviews	Black American men	Adapted Western
14	Holmes et al., 2024, US and Canada	Review, Theory / Literature Review, Propose New Protocol	Individuals affected by racism	Western
15	McNeil-Young et al., 2023, US	IPA interviews / Interpretive phenomenological analysis	Black racial justice activists	Adapted Western
16	Mekawi et al., 2022, US	Cross-sectional survey / Survey	lower-socioeconomic-status (SES) Black adults	Western
17	Millner et al., 2021, US	Review, Theory / Theoretical, Propose New Model	Asian American communities	Decolonized
18	Miola et al., 2025, US	Review, Theory / Theoretical, Historical	Black Americans	Adapted Western
19	Nortey & Downtin, 2024, US	Review, Theory / Theoretical, Case Study	Black women in US	Decolonized
20	Ortega-Williams et al., 2021, US	Review, Theory / Theoretical, Proposed framework	Racial and ethnic groups targeted for oppression	Adapted Western
21	Ortega-Williams et al., 2024, US	Review, Theory / Theoretical, Proposed framework	Black people of the African diaspora, specifically in North America	Adapted Western
22	Sanders et al., 2024, US	Review, Theory / Theoretical, Proposed framework	Black men	Adapted Western
23	Sarmiento Hernández & Kia-Keating, 2024, US	Systematic review / Literature Review	Latinx communities in the United States	Adapted Western
24	Schaechter et al., 2025, US	Systematic review / Literature Review	Marginalized youth	Adapted Western

25	Sevillano et al., 2022, US	Systematic review / Literature Review	Indigenous peoples in the United States	Adapted Western
26	Stanley & Atari-Khan, 2024, US	Systematic review / Literature Review, Content Analysis	People of color in the United States	Adapted Western
27	Wilbur & Gone, 2023, Canada and US	Interviews and thematic analysis	Canadian Northern Algonquian First Nations	Adapted Western
28	Wilcox, 2023, US	Review, Theory / Theoretical	Black community	Adapted Western
29	M. T. Williams et al., 2023, Canada and US	Review, Theory / Theoretical, Proposed Model	People of color	Adapted Western
30	T. R. Williams et al., 2022, Canada	Review, Theory / Theoretical	CBT Therapists	Adapted Western
31	M. T. Williams et al., 2021, Canada	Review, Theory / Theoretical	People of color	Adapted Western
32	T. R. Williams et al., 2022, US	Review, Theory / Theoretical	Black Americans	Adapted Western
33	T.R. Williams et al., 2022, US	Review, Theory / Theoretical, Case Study	Black college students	Adapted Western
34	Yuen et al., 2024, US	Review, Theory / Theoretical, Case Study	Children and Adolescents of Color (CAoC)	Western

## 4.2 Categories Based on Theoretical Underpinnings

The theoretical underpinnings behind the selected articles have been grouped into three categories: Western, Adapted Western, and Decolonized. They represent a spectrum of concepts ranging from traditional Western thought on one end and Decolonized concepts on the opposite end; Adapted Western concepts lie in the middle between these two. The Western and Decolonized category names are based on the well-established concepts of traditional Western and Decolonization philosophies. The term 'Adapted Western' was coined for this research project because it indicates that this category is based on Western concepts but has been adapted to be anti-racist or culturally adapted. Five articles were categorized as Western, 23 as Adapted Western, and six as Decolonized. These categories were connected to the pragmatic theoretical framework of this research as shown in the literature review. They were also informed by my experience as a psychotherapist and thus summarize the complex content in a way that supports a pragmatic clinical perspective. Because this is a scoping review, the analysis is understood to be reductive and this categorization was an attempt to broadly reflect what the literature stated without commentary or value judgements. A deeper critical analysis of the content was outside the scope of this research.

**Western category:** In the selected literature, Western concepts tended to be presented in two ways: either supportive of or critical of using Western methods to treat the trauma of systemic oppression. There were more articles criticizing Western approaches than supporting them. Models and frameworks that align with this category include cognitive behavioral therapy, behavioral analytics, motivational interviewing, diagnosis, and psychiatric care (Akubuiro et al., 2023; Brown et al., 2025; Holmes et al., 2024; Mekawi et al., 2022; Yuen et al., 2024). There were

five articles that were in favor of the existing Western models, often citing the history of empirical validation of these treatments as the basis for their reasoning for applying it to this trauma. The articles using these Western models acknowledged a need to include an element of antiracist awareness and practices (Akubuiro et al., 2023; Brown et al., 2025; Cénat et al., 2024; Mekawi et al., 2022).

**Adapted Western category:** In the selected literature, Adapted Western concepts were typically framed as a hybrid approach that added the awareness of racial and systemic oppression, and antiracism values, to existing Western mental health treatments. The term ‘antiracist’ occurred frequently in this category with a call for antiracist perspectives to be applied to Western treatment. For example, combining generalized antiracist perspectives and practices with cognitive behavioral therapy, motivational interviewing, posttraumatic growth, behavior analytics, mindfulness, and acceptance and commitment therapy (Cénat et al., 2024; McNeil-Young et al., 2023; Ortega-Williams et al., 2021). Within these adapted perspectives there were two sub-categories: those that saw this adaptation as a pragmatic negotiation between the ideal of a decolonized approach and the rigidity of a system entrenched in Western ways (Gingles, 2022; Mekawi et al., 2022); and those that seemed to indicate that adding culturally-adapted elements to the Western approach was sufficient (Cénat et al., 2024; Holmes et al., 2024; Sanders et al., 2024; Stanley & Atari-Khan, 2024). This second sub-category, which prioritized systemic and racial competence, but did not go as far as to include decolonization concepts, tended to be invested in evidence-based treatment and thus prioritized empirical evidence in their rationale to stay rooted in the Western camp (Cénat et al., 2024; Holmes et al., 2024; Mekawi et al., 2022).

The literature stated that the adaptive approach required the therapist to be reflexively engaged in self-awareness of their beliefs and feelings around racism, internalized racist concepts, and to actively engage in changing themselves to be fit to provide treatment for people of color. It required a commitment to growth toward the goal of antiracist values and actions (Adames et al., 2023; Bryant, 2024; Bryant-Davis, 2023; French et al., 2020; Millner et al., 2021; Wilcox, 2023; T. R. Williams et al., 2024).

This reflexivity related partially to how the antiracist perspective was attained. The literature stated that the other essential elements to an antiracist perspective was that therapists must have cultural and structural competence. Meaning, they must educate themselves in how different cultures understand and engage with all aspects of life. Similarly, a therapist must have systemic competence, which means that they must be aware of the reality of systemic oppression, the various ways it manifests, and the negative impact it has on communities and individuals (Adames et al., 2023; Bryant, 2024; Bryant-Davis, 2023; French et al., 2020; Millner et al., 2021; Wilcox, 2023; T. R. Williams et al., 2024).

**Decolonized category:** In the selected literature, there was a collection of six articles that called for a decolonized approach to the treatment of racial and systemic trauma (Bryant-Davis, 2023; Chu et al., 2025; French et al., 2020; Millner et al., 2021). As defined by the literature, decolonization is an effort to de-center White Western values and customs and replace them with those of other cultures. Instead of having one system that is based on White, Western patriarchy, there could be multiple models that are customized to each culture's values, beliefs, and customs (Adames et al., 2023; Bryant, 2024; French et al., 2020; Gone, 2021; Millner et al., 2021). The literature showed that these approaches tended to be holistic in nature.

Meaning they include mind, body, spirit, and environmental factors into their concept of health, illness, and treatment. The articles highlighted that the decolonized perspective emphasizes the foundational importance of culture, community and relationships over individualism. Culture, community and relationships were seen as essential sources of strength (Adames et al., 2023; Bryant, 2024; French et al., 2020; Gone, 2021; Millner et al., 2021). While decolonized approaches may utilize Western counseling interventions, these would be secondary to the decolonized perspective. Similarly, while decolonization is often paired with liberation psychology because these two philosophies complement each other, there is not a requirement for them to be paired (Bryant, 2024).

The literature showed that, because decolonization directly confronts systemic oppression which is the cause of many ills, it requires therapists to be fully committed to prioritizing a decolonized perspective over Western approaches (Adames et al., 2023; Bryant, 2024; Wilcox, 2023; M. T. Williams et al., 2022; Yuen et al., 2024). Practicing a Decolonized approach includes engaging in interventions that support decolonized and culturally-specific values and customs, and encouraging the client to engage in resistance to the oppressive forces at both an individual and collective level (Wilbur & Gone, 2023; Wilcox, 2023; M. T. Williams et al., 2022). Table 4 shows the common traits of each category.

**Table 4***Summary of Categories*

<b>Western</b>	
<b>Core characteristics</b>	<ul style="list-style-type: none"> <li>• Based on an individualistic perspective of life.</li> <li>• Prioritizes cognitive function over emotions and relationships.</li> <li>• Emotional and psychological challenges are conceptualized as pathology.</li> <li>• Hierarchical nature of relationships and internal processes.</li> <li>• Limited effectiveness and often criticized as problematic for people of color.</li> </ul>
<b>Research aims from this dataset</b>	<ul style="list-style-type: none"> <li>• Correct misdiagnosis in treatment with Black people via awareness of bias.</li> <li>• Apply polyvagal theory.</li> <li>• Strengthen therapeutic rapport.</li> <li>• Use evidence-based coping skills and resilience, both passive and active styles, to cope with racial trauma.</li> </ul>
<b>Key findings in this dataset</b>	<ul style="list-style-type: none"> <li>• The detrimental impact of systemic oppression must be acknowledged and accounted for in treatment.</li> <li>• Therapist cultural competence, humility, and antiracist personal growth is important.</li> <li>• Somatic regulation is essential to trauma treatment.</li> <li>• Empirically supported coping skills are helpful but not enough.</li> <li>• Active coping skills are more effective than passive coping skills.</li> <li>• More research is needed to study the effectiveness of these treatments.</li> </ul>
<b>Therapeutic models</b>	<ul style="list-style-type: none"> <li>• Diagnosis</li> <li>• Somatic regulation (polyvagal theory)</li> <li>• Therapeutic alliance</li> <li>• Critical consciousness theory</li> <li>• Antiracist perspectives</li> <li>• Evidence-based coping skills</li> </ul>

	<ul style="list-style-type: none"> <li>• Psychiatric care</li> </ul>
<b>Relevant articles</b>	5 articles in this category, by ID#: 2, 4, 14, 16, 34.
<b>Adapted Western</b>	
<b>Core characteristics</b>	<ul style="list-style-type: none"> <li>• Recognizes systemic oppression as a significant source of stress or trauma.</li> <li>• Promotes antiracist goals in the individual therapist, the field of psychology, and in society.</li> <li>• Encourages therapists to have systemic and cultural competence.</li> <li>• Requires clinician self-awareness of feelings and beliefs around racism.</li> <li>• Combines these perspectives with existing Western treatment models such as: cognitive behavioral therapy, posttraumatic growth, acceptance and commitment therapy, motivational interviewing counseling, behavior analytics, polyvagal theory, and mindfulness.</li> </ul>
<b>Research aims from this dataset</b>	<ul style="list-style-type: none"> <li>• Seek to culturally adapt existing Western treatments.</li> <li>• Propose new frameworks and treatment models that center systemic, racial, and cultural competence.</li> <li>• Seek to redefine the diagnostic criteria of trauma (PTSD) to include racial trauma experiences.</li> <li>• Study the effectiveness of cultural adaptations to existing treatment.</li> </ul>
<b>Key findings in this dataset</b>	<ul style="list-style-type: none"> <li>• Therapists must do reflexive work to identify and own their relationship with racial issues.</li> <li>• Therapists must develop antiracist values and behaviors.</li> <li>• Therapist's structural (institutions, systemic) and cultural competence is essential to treatment.</li> <li>• Structural and racial oppression must be addressed directly in treatment because it increases critical consciousness of oppression.</li> <li>• Cultural adaptation is generally better than no adaptation but is also limited and could cause harm. Decolonization may be better.</li> <li>• There are multiple tools for assessment and treatment of racial trauma.</li> <li>• More research is needed to study the effectiveness of these treatments.</li> </ul>
<b>Therapeutic</b>	<ul style="list-style-type: none"> <li>• Motivating interviewing counseling and SHARP</li> </ul>

<b>models</b>	<ul style="list-style-type: none"> <li>• Complex racial trauma (CoRT)</li> <li>• Critical race theory (CRT)</li> <li>• Critical consciousness theory</li> <li>• Antiracist practices</li> <li>• Historical trauma framework</li> <li>• Culturally adapted interventions</li> <li>• Structural competency</li> <li>• Cultural competency</li> <li>• Race-informed trauma treatment</li> </ul>
<b>Relevant articles</b>	23 articles in this category, by ID #: 3, 5, 8-10, 12, 13, 15, 18, 20-33.
<b>Decolonized</b>	
<b>Core characteristics</b>	<ul style="list-style-type: none"> <li>• Relationship and community-based.</li> <li>• Tends to be holistic by equally incorporating mind, body, soul, and environment.</li> <li>• Tends to be strengths-based focusing on assessing and supporting individual and community.</li> <li>• Community-centered</li> <li>• Prioritizes relationships</li> <li>• Advocates for individual and collective active resistance to oppressive forces.</li> </ul>
<b>Research aims from this dataset</b>	<ul style="list-style-type: none"> <li>• Advocate for fundamental shifts towards decolonized and liberation psychology approaches</li> <li>• Implement the radical healing model (French et al., 2020).</li> <li>• Promote intergenerational healing.</li> <li>• Develop culture-specific counseling models.</li> </ul>
<b>Key findings in this dataset</b>	<ul style="list-style-type: none"> <li>• The radical healing framework is effective.</li> <li>• Culture as medicine is effective.</li> <li>• These elements are important to healing from racial trauma: critical consciousness, radical hope, strength and resistance, cultural authenticity and self-knowledge, and collectivism.</li> </ul>

	<ul style="list-style-type: none"> <li>• Using Western treatments can be harmful to people already traumatized by colonization and systemic oppression.</li> <li>• Therapists need to be committed to a decolonized value system and interventions.</li> <li>• Community and culture support are more effective than individual treatment.</li> <li>• More research is needed to study the effectiveness of these treatments.</li> </ul>
<b>Therapeutic models</b>	<ul style="list-style-type: none"> <li>• Radical healing</li> <li>• Decolonization and liberation psychology</li> <li>• Womanist psychology</li> <li>• Black psychology</li> <li>• Social justice</li> <li>• Black feminist psychology</li> <li>• Intergenerational healing and well-being</li> </ul>
<b>Relevant articles</b>	6 articles in this category, by ID#: 1, 6, 7, 11, 17, 18.

### **4.3 Global Article Findings**

Table 4 above summarizes the findings of the data, organized according to the three categories I have introduced. In addition to these three categories, it is important to note common concepts that appeared across nearly all the articles. These included: acknowledgement of racial systemic oppression that is paramount to treating the trauma it creates (N=32); the therapist must embody antiracist perspectives and practices (N=32); all therapists need a trauma-informed approach when addressing racial issues (N=32); and more research is needed on the topic of systemic and racial trauma and the effectiveness of treatments (N=34).

### **4.4 Measurement Tools to Assess the Impact of Racial Trauma**

As noted in the literature review, a significant issue in treating racial trauma is that it does not meet the PTSD diagnostic criteria per the DSM-5. The selected literature states that there are a wide variety of validated measurement scales that assess the emotional and psychological impact of racial trauma. Twelve of the 34 articles specifically used or suggested the use of the instruments to assess for racial trauma, despite it not meeting criteria for the PTSD diagnosis (Cénat, 2023; Chu et al., 2025; Gingles, 2022; Holmes et al., 2024; Mekawi et al., 2022; Miola et al., 2025; Ortega-Williams et al., 2021; Sanders et al., 2024; Schaechter et al., 2025; Sevillano et al., 2022; M. T. Williams et al., 2021; T. R. Williams et al., 2022). The instruments most commonly referred to in the literature are the Race-Based Traumatic Stress Symptom Scale (RBTSSS) and the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS). Holmes et al. (2024) summarized the most common tools (Table 5).

**Table 5***Validated Measures of Racial Trauma*

<b>Measure</b>	<b>Purpose</b>
UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS)	Assesses the various types of racism experienced by clients with a checklist to determine if they were collectively traumatizing based on the DSM-5 posttraumatic stress disorder criteria.
Racial Trauma Scale (RTS)	Measures the impact of racial trauma on an individual's psychological well-being.
Trauma Symptoms of Discrimination Scale (TSDS)	Assesses trauma symptoms of anxiety specifically associated with experiences of discrimination.
Race-Based Traumatic Stress Symptom Scale, short form (RBTSSS-SF)	Measures race-based traumatic stress symptoms and their impact on mental health in a concise format.
Race-Based Traumatic Stress Symptom Scale (RBTSSS)	Assesses key areas of race-based traumatic stress symptoms requiring intervention using self-report and interview formats; consists of seven subscales.
Oppression-Based Traumatic Stress Inventory (OBTSI)	Assesses experiences of oppression and resulting posttraumatic stress symptoms based on DSM-5 criteria.

*Note.* Adapted from "Racial stress, racial trauma, and evidence-based strategies for coping and empowerment," by S.C. Holmes, M. Zare, A. M. Haeny, and M. T. Williams, 2024, *Annual Review of Clinical Psychology*, 20(1), p. 79 (<https://doi.org/10.1146/annurev-clinpsy-081122-020235>).

#### **4.5 Author Positionality**

Author positionality is important because it provides transparency and thus credibility to research. It is particularly relevant in this research because the nature of systemic oppression is that it silences certain voices while amplifying others. Thus, knowing the positionality of a research author potentially lends insight into their perspective or expertise from lived experience. Of the 34 articles in this dataset, 22 articles had no positionality statement. Twelve of the articles had positionality statements. Within these 12 articles the positionality statements on intersectional aspects of identity can be summarized as follows: 12 Black females; 11 cisgender females; three heterosexual females; three queer females; two White females; two American Indians; two by professional status only; and one each of the following descriptors: cisgender male, White male, biracial female, Latinx female, Indigenous Mexican, African American, Puerto Rican, Indigenous Taiwanese, Black male, Arab American female, biracial American Indian, and White Vietnamese with a disability in a lower socioeconomic status (Gingles, 2022; Gregory & Tucker Edmonds, 2023; McNeil-Young et al., 2023; Miola et al., 2025; Nortey & Dowtin, 2024; Ortega-Williams et al., 2021, 2024; Sarmiento Hernández & Kia-Keating, 2024; Stanley & Atari-Khan, 2024; Wilbur & Gone, 2023; Wilcox, 2023; M. T. Williams et al., 2022).

#### **4.6 Empirical Studies**

While most of the articles in the dataset were critical reviews without specified methodologies, nine articles engaged in empirical enquiry. Table 6 summarizes the methodology, sample sizes, and findings of the empirical studies. As mentioned above, four used systematic reviews, two used interviews (one through IPA and one through thematic analysis approaches), one used a focus group and two used cross-sectional surveys. The cross-sectional surveys

explored the associations between racial trauma and racial healing in AANHPIs (Chu et al., 2025) and the effectiveness of active versus passive coping styles in Black Americans (Mekawi et al., 2022). The focus group interview (Gregory & Tucker Edmonds, 2023) explored injustice during the period of the COVID pandemic and Black Lives Matter movement from the perspective of Black American men and drew implications for clinical interventions from it. The two interviews explored how Black activists used story telling for Black survivance (McNeil-Young et al., 2023) and how the clients and staff of a Canadian First Nations behavioral health treatment program perceived the usefulness of therapy services (Gameon & Skewes, 2020). The full group of empirical studies included all three categories—Western, Adapted Western, and Decolonized—with seven of the nine being Adapted Western.

**Table 6***Empirical Studies: Methodology, Sample sizes, and Findings*

#	Author	Western / Adapted / Decolonized	Methods	Population & Sample size	Therapeutic approach?	Findings (Direct Quotes)
10	Chu et al., 2025	Decolonized	Cross-sectional survey	436 Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) adults	Radical Healing	“Findings suggest the importance of promoting radical healing through programs and interventions to support AANHPIs in healing from racial trauma” (Chu et al., 2025, p. 1).
13	Gregory & Tucker Edmonds, 2023	Adapted	Focus Group Interviews	20 Black American men	Cognitive behavioral therapy	“From a CT intervention perspective, the five emerging themes can be directly translated into cognitive-behavioral principles regarding therapeutic rapport, cultural adaptation, emphasis on positivity, and collaborative empiricism when working with BA men” (Gregory & Tucker Edmonds, 2023, p. 1).
15	McNeil-Young, et al., 2023	Adapted	Interpretive phenomenological analysis Interviews	12 Black racial justice activists	Story telling / narrative	“This study therefore provides important and practical information about how Black people and the counseling psychologists who aim to serve them can utilize storying survival to resist and heal from ABR [anti-black racism]” (McNeil-Young et al., 2023, p. 276).

16	Mekawi et al., 2022	Western	Cross-sectional survey	401 lower-socioeconomic-status (SES) Black adults	Critical consciousness theory	“These results suggest that for Black Americans, coping with racism actively (vs. passively) may buffer the association between racial discrimination and psychological symptom severity” (Mekawi et al., 2022, p. 38)
23	Sarmiento Hernández & Kia-Keating, 2024	Adapted	Systemic Review / Literature Review	Latinx communities in the United States	Mindfulness-based interventions	“Findings suggest that MBIs are feasible and acceptable for Latinx individuals; however, barriers to use need to be addressed” (Sarmiento Hernández & Kia-Keating, 2024, p. 269).
24	Schaechter et al., 2025	Adapted	Systemic Review / Literature Review	Marginalized youth  12 Culturally adapted EBI treatments	Culturally adapted interventions	“The current literature is promising yet inconclusive about the benefits of adapted treatments over standard protocol” (Schaechter et al., 2025, p. 1).
25	Sevillano et al., 2022	Adapted	Systemic Review / Literature Review	Indigenous peoples in the United States  5 Studies, N=608	4-part group intervention, Holistic System of Care HSOC	“Due to the limited number of studies, and the heterogeneity of research findings and the methodological limitations suffered by included studies, no definite conclusions about mental health interventions that address HT [historical trauma] can be drawn” (Sevillano et al., 2022, p. 127).

26	Stanley & Atari-Khan, 2024	Adapted	Systemic Review / Literature Review, Content Analysis	People of color in the United States 54 articles	Resilience	“We argue for the need to shift our understanding of resilience away from individual processes to focus on group and communal ways of healing, as a means of aligning with our values as counseling psychologists and working to disrupt systems of oppression” (Stanley and Atari-Khan, 2024, p. 509).
27	Wilbur & Gone, 2023	Adapted	Thematic analysis of interviews	Canadian Northern Algonquian First Nations 32 interviews	10-week, holistic healing program with integration of Indigenous culture and Western treatment,	“targeted goals of therapy and specific qualities of counselors were important in facilitating a positive therapy experience for clients. Decolonizing therapy may impact positive change for Indigenous Canadians” (Wilbur & Gone, 2023, p. 1143).

#### 4.7 Proposed Frameworks and Models

In this dataset, 11 of the 34 articles proposed a new framework or model for working with the trauma of systemic oppression (Table 7).

**Frameworks** suggest a conceptual perspective that emphasizes a particular set of values or considerations. Frameworks are theoretical, while models are oriented towards actionable implementation of ideas or behaviors. In the dataset, all eight articles that proposed frameworks highlighted the need to recognize the history and current day systemic oppression that shapes every aspect of the lives of people of color. Five of the frameworks aligned with Adapted Western concepts (Cénat, 2023; Gingles, 2022; Ortega-Williams et al., 2021, 2024; Sanders et al., 2024) and three utilized decolonized concepts (Adames et al., 2023; French et al., 2020; Millner et al., 2021).

**Therapeutic models** combine conceptual frameworks with pragmatic clinical interventions. There were three models proposed in this dataset, all of which were Adapted Western approaches (Avruch & Shaia, 2022; Cénat et al., 2024; M. T. Williams et al., 2023).

**Table 7***Frameworks and Models*

#	Author	Proposed Model or Framework	Western / Adapted / Decolonized	Population	Therapeutic Approach and Components (Direct Quotes)
1	Adames et al., 2023	Framework: Keeping radical healing in mind therapeutic approach	Decolonized	BIPOC	“Psychotherapists are encouraged to conceptualize interventions for BIPOC clients using PRH [psychology of radical healing] to support clients to internalize, develop, and nurture (a) critical consciousness, (b) cultural authenticity and self-knowledge, (c) radical hope and envisioning possibilities, (d) collectivism, and (e) strength and resistance. To better meet the needs of BIPOC clients, the stance requires clinicians to develop their critical consciousness of systemic racism and interlocking forms of oppression” (Adames et al., 2023, p. 39).
3	Avruch & Shaia, 2022	Model: Motivational interviewing and SHARP	Adapted Western	Marginalized populations	Motivational interviewing and structural competence (SHARP). “The resulting hybrid, Macro MI, offers tools to join with clients to assess the impact of structural oppression on individual problems, as well as to envision solutions that include macro systems change” (Avruch & Shaia, 2022, p. 176).
8	Cénat, 2023	Framework: Critical race theory and complex racial trauma (CoRT)	Adapted Western	BIPOC in Western societies	"This article presents evidence for complex racial trauma (CoRT), a theoretical framework of CoRT, and guidelines for its assessment and treatment. Avenues for future research, intervention, and training are also presented" (Cénat, 2023, p. 675).

9	Cénat et al., 2024	Model: Antiracist CBT Framework	Adapted Western	Racialized people	“The proposed guidelines aim to transform CBT practice, increase confidence of racialized individuals in mental health care, and ultimately decolonize CBT interventions” (Cénat et al., 2024, p. 1).
11	French et al., 2020	Framework: Radical Healing	Decolonized	POCI	“Advancing beyond individual-level approaches to coping with racial trauma, we call for a new multisystemic psychological framework of radical healing for People of Color and Indigenous individuals. Radical healing involves critical consciousness, radical hope, strength and resistance, cultural authenticity and self-knowledge, and collectivism” (French et al., 2020, p. 15).
12	Gingles, 2022	Framework: Utilizing acceptance and commitment therapy (ACT), and behavioral analytics	Adapted Western	Black Americans	“A behavioral model to promote Black psychological liberation, infusing preestablished frameworks of Black psychology and cultural healing practices with acceptance and commitment therapy. The model addresses behaviors observed within systemic and internalized racism” (Gingles, 2022, p. 1050).
17	Millner et al., 2021	Framework: Postcolonial perspective that centers Asian experiences	Decolonized	Asian American communities	“Provides a road map to decolonize and reconstruct the existing mental health practice framework through a social justice lens of postcolonialism. Centering Asian collectivistic values, (re) integrating religious and spiritual traditions, and elevating recovery, resilience, and resistance are discussed as ways to enhance clinical practice with Asian American communities” (Millner et al., 2021, p. 333).

20	Ortega-Williams et al., 2021	Framework: Historical Trauma and Posttraumatic Growth	Adapted Western	Racial and ethnic groups targeted for oppression	“HT-PTG conceptualizes the mass group-level domains of growth, informed by HT and PTG frameworks. In this view, the individual-focus of PTG is reconceptualized as a dynamic interplay between the personal and collective, as well as the contemporary and historical, extending beyond the current lifespan” (Ortega-Williams et al., 2021, p. 227).
21	Ortega-Williams et al., 2024	Framework: Posttraumatic growth, intergenerational healing and well-being	Adapted Western	Black people of the African diaspora, in North America	“This conceptual article advances the idea of intergenerational healing and well-being, in the context of anti-Black racism and historical trauma among Black people, extending theorized pathways to posttraumatic growth” (Ortega-Williams et al., 2021, p. 1171).
22	Sanders et al., 2024	Framework: CRT and CoRT	Adapted Western	Black men	"The authors propose a conceptual framework incorporating historical trauma, discrimination, and traumatic stress reactions, emphasizing the need for cultural competence and humility," when diagnosing the mental health of black men. (Sanders et al., 2024, p. 721).
29	Williams et al., 2023	Model: Healing Racial Trauma protocol	Adapted Western	People of color	“This article describes the essential components of treatment for racial stress and trauma from a cognitive-behavioral perspective, called the Healing Racial Trauma protocol” (M. T. Williams et al., 2023, p. 565).

## 4.8 Thematic Analysis

I identified three broad themes from the dataset that help highlight how these papers view the topic. The three themes are: what causes harm; what facilitates healing; and what is the therapist's responsibility in treatment?

### 4.8.1 What Causes Harm

The literature indicated that there are two major factors that inflict harm on BIPOC people: the ubiquitous existence of systemic and racial oppression; and the deeply entrenched denial of it. Individually and collectively the articles in this dataset acknowledged that this entrenched oppression is “socially-engineered trauma” (Avruch & Shaia, 2022, p. 178) with traumatic effects on the physical and mental health of the oppressed (Adames et al., 2023; French et al., 2020; Miola et al., 2025). It is also understood that these effects are passed down through generations via epigenetic changes, destruction of culture and community, internalized racism, restricted opportunity for improving quality of life, and general degradation in all areas of the social determinants of health (Cénat, 2023; Miola et al., 2025). Across the literature in this dataset the long history systemic oppression was often referred to using terms such as ‘colonization,’ ‘neocolonialism,’ ‘historical trauma,’ and ‘intergenerational trauma’ (Miola et al., 2025; Sevillano et al., 2022). In short, this literature pointed to the fact that the long-term crisis of systemic oppression as a source of trauma for BIPOC individuals, families, communities, and cultures is a well-established fact (French et al., 2020; Miola et al., 2025; M. T. Williams et al., 2023).

However, this literature also acknowledged that the *denial* of this ubiquitous oppression is another form of injury, oppression and trauma atop the injury of the initial oppression itself. This is because denying the toxicity of the environment shifts the blame away from the true source of

the problem and onto the person suffering. When therapists collude with this blame shift, they risk repeating cycles of subjugation, discrimination and racist stereotypes that falsely claim that certain races are inferior as proven by their tendency to suffer or be less successful than White people (APA, 2021; Millner et al., 2021; Miola et al., 2025).

The literature of this dataset showed that the underlying structures that support the denial of systemic oppression can be reductively generalized into two areas. First, given that the research is set in North America, White Western values and norms dominate the fabric of society. The concept of rugged individualism is a core tenet in this epistemology (Chu et al., 2025; Wilcox, 2023). Second, is that the dominant culture, historically established by colonizers, does not empathize with the oppressed nor hold itself accountable for the damage it has done to the oppressed (Bryant, 2024; Wilcox, 2023; M. T. Williams et al., 2023). Thus, the existence of the glaring crisis is generally ignored or normalized via racist narratives (Miola et al., 2025; M. T. Williams et al., 2023). This leaves the individual to bear blame, shame, and guilt for not being able to individually rise above challenges through rugged determination and hard work. Blaming the individual for failing to overcome a system that is rigged against them makes the crisis worse. It sets up a recurring cycle of oppression both internally in the individual and externally in society, keeping individual and cultures trapped in generations of oppression (Miola et al., 2025). This is why the articles in the Adapted Western and Decolonized categories place strong emphasis on acknowledging the oppression system as the problem, and not pathologizing the person suffering within the system. Bryant (2024) sums this up as follows:

When trauma psychologists neglect to ask about the trauma of oppression, they set up the likelihood that this trauma will be overlooked for the totality of the therapeutic

process (Bryant-Davis, 2019). This avoidance of such a crucial, pervasive issue may contribute to the premature therapy dropout rate of people of color (Comas-Díaz & Torres Rivera, 2020). In other words, instead of seeing persons of the global majority as resistant to care, the reality may be that our intervention protocols are resistant to the care of marginalized populations (Bryant-Davis, 2023). (p. 687)

Most relevant to this research is the fact that the field of psychology itself has been complicit in this oppression and denial of the oppression (APA, 2021; Bryant, 2024). This fact is central to the research question of this project. How can a therapist embedded in the field of Western psychology help a person that is suffering from the trauma caused by the same system of oppression? As explored in the categorized findings above, recent developments show efforts to change the practice of psychology via new frameworks or models that range from generalized awareness of systemic oppression, to antiracist adaptations of Western treatments, to fully decolonizing trauma treatment and rebuilding per the wisdom and needs of individual cultures.

Despite the fact that the DSM-5 does not allow for racial trauma in the diagnostic criteria of PTSD (Adames et al., 2023; APA, 2021; Chu et al., 2025; M. T. Williams et al., 2021) and that systemic oppression is both rampant and ignored, there are measurement tools that help clinicians assess and validate the experience of and damage caused by racial trauma. This is important because it gives voice and measurement to experiences that are typically not acknowledged. The six most common trauma tools were summarized in Table 5 above (Holmes et al., 2024).

This naturally segues to the second major theme from this body of literature: what supports healing from systemic trauma?

#### ***4.8.2 What Facilitates Healing From Systemic and Racial Oppression?***

The selected literature explored multiple ways to facilitate the healing from this oppression. First and foremost, was to fully acknowledge the existence of oppression. The articles from the Adapted Western and Decolonized categories—29 of the 34 articles in the dataset—clearly call for this. From this starting point, there are multiple paths to support the individuals and communities impacted by oppression.

According to the articles, acknowledging the existence of oppression creates critical consciousness. “Critical consciousness is seen as a prerequisite for liberation from oppression” (French et al., 2020, p. 25). This is powerful because “one must reflect on sociopolitical realities, deeply questioning and discerning for oneself (although often with others) how and why power relations are structured and maintained, in order to begin the process of radical healing” (French et al., 2020, p. 25). One way this reflection facilitates healing is that it takes the individual out of an isolating microcosm of reality and places them within the larger field of community and contact with others who are dealing with the same issues. As Adames et al. (2023) state, “resisting self-blame for racism and oppression is also healing” (p. 41). Breaking the isolation of individualism and seeing clearly how the sociopolitical systems operate (Miola et al., 2025) frees one from the never-ending cycle of self-blame and thus allows them to put their energy into more effective ways of coping and healing. For example, the entire fields of critical race theory, intersectionality, and liberation psychology can now be accessed by the person or

communities that were once locked in self-blame, as the articles from the Decolonized category show.

Connected to the concept of critical consciousness is a debate within the literature about the role of resilience. Western perspectives tend to see resilience and coping skills as positive behaviors that reduce suffering (Cénat et al., 2024; Holmes et al., 2024; Stanley & Atari-Khan, 2024). The articles within the Adapted Western and Decolonized categories argue that while basic resilience is a necessary life skill, it is too often used as a thinly veiled attempt to keep the status quo of systemic oppression in place and blame the victim for lacking coping skills. As Williams et al. (2023) explain:

People of color are already resilient enough. The issue is that no one can be continuously resilient in the face of ongoing abuse, and therefore treatment must also include components aimed at protecting the client from unnecessary racist acts and reducing racism in their lives. (p. 4)

The latter argument underpins the fact that psychology should be used to help people thrive, not merely survive (Adames et al., 2023; Bryant, 2024; Bryant-Davis, 2023; Bryant-Davis & Moore-Lobban, 2020; Chu et al., 2025; French et al., 2020; Nortey & Downtin, 2024; Stanley & Atari-Khan, 2024).

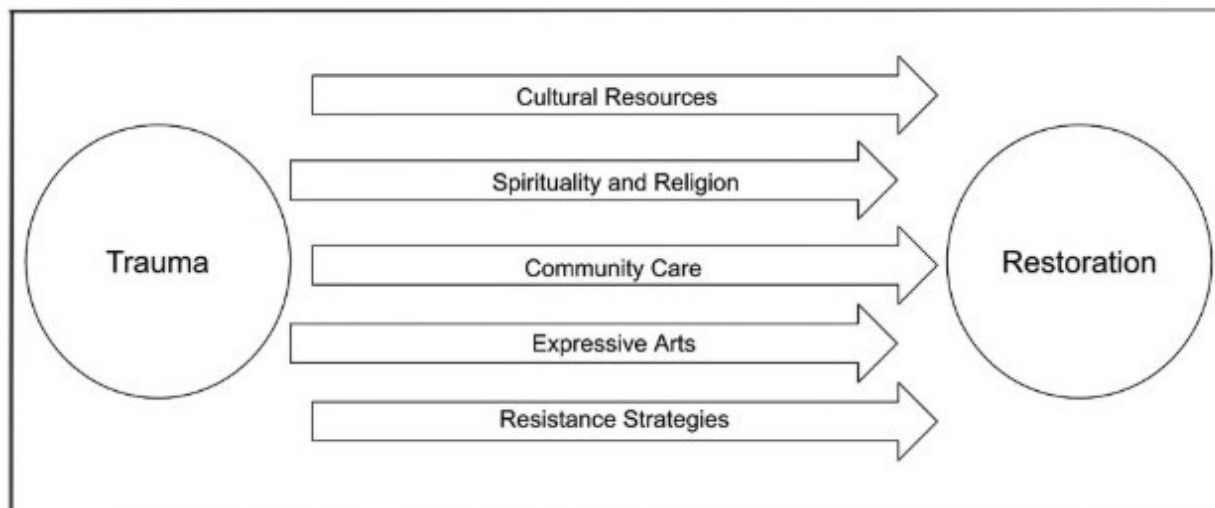
Another approach to healing is to prioritize culture. The literature categorized within the Decolonized category aligned with the position that “culture is medicine” (Bryant, 2024, p. 689). When authentic cultural wisdom, expression, and connection to community is restored, healing occurs. In the categorized findings above, we see culture applied in

varying degrees from awareness and antiracist goals layered upon Western treatments (the Adapted Western perspective), to fully decolonized approaches (Bryant, 2024).

Overall, this aligns with the articles' conclusions, whereby authors suggested that the more culturally competent care is applied to treatment, the better the outcome (Adames et al., 2023; Bryant, 2024; Millner et al., 2021; Nortey & Downtin, 2024; Ortega-Williams et al., 2021, 2024; Sevillano et al., 2022). This is not to say that Western treatment techniques are fully discarded, but rather they are secondary to the healing traditions of each culture, which need to be made primary. Accordingly, Western treatments can be used as tools for treatment, if the culturally centered approach chooses to incorporate them.

Two seminal views on culture-based healing emerged from the literature: the combination of decolonialism and liberation psychology; and the framework of radical healing. Although many authors speak to these concepts, two authors stand-out: Thema Bryant-Davis for her work in applying decolonialism and liberation psychology (Bryant, 2024; Bryant-Davis, 2023; Bryant-Davis & Moore-Lobban, 2020); and Bryana French for her radical healing framework (French et al., 2020). These authors and concepts were additionally frequently cited by other authors in this dataset.

As defined by the literature in the dataset, the components of the decolonial and liberation psychology approach are: cultural resources, spirituality and religion, community care, expressive arts, and resistance strategies (Bryant, 2024). Figure 3 illustrates this concept.

**Figure 3***Decolonial and Liberation Pathways for Trauma Restoration*

*Note.* From "Lessons from decolonial and liberation psychologies for the field of trauma psychology," by T. Bryant, 2024, *American Psychologist*, 79(5), p. 688 (<https://doi.org/10.1037/amp0001393>).

In addition to Bryant-Davis' foundation, other authors in this literature review expanded on the decolonial approach to include a strengths-based approach, allowing for autonomous cultural expression, that can be utilized at the individual or community level, and sees community as the fabric of society (Adames et al., 2023; Chu et al., 2025; Millner et al., 2021; Nortey & Downtin, 2024). The theory is that the more fully embodied and vigorously these components are enacted, the more restorative it is for the oppressed. In this model, trauma treatment is embedded in the culture and thus calls for community-based healing (Adames et al., 2023; Chu et al., 2025; Millner et al., 2021).

French et al. (2020) define the radical healing framework as “moving beyond individual-level approaches to coping with racial trauma” (p. 14). It is built on “existing frameworks rooted in social justice education and activism and describes a form of healing and transformation that integrates elements of liberation psychology, Black psychology, ethno-political psychology, and intersectionality theory” (French et al., 2020, p. 14). The core components of the radical healing framework are: “(a) collectivism; (b) critical consciousness; (c) radical hope; (d) strength and resistance; and (e) cultural authenticity and self-knowledge” (French et al., 2020, p. 14). Radical healing begins with critical consciousness of the systemic nature of oppression. Radical hope sees the possibility of effective resistance to oppression via strength rooted in community and cultural authenticity. Strength and resistance are expressed through living joyfully, even within a systemic oppression. Collectivism, or healing and strength within community, holds it all together. The articles in this dataset that incorporated concepts from the radical healing framework include Adames et al. (2023), Chu et al. (2025), McNeil-Young et al. (2023), Stanley and Atari-Khan (2024), and Wilcox (2023).

Despite strong support for a decolonized and liberation approach, many of the selected articles called for more research to be done on the effectiveness of cultural healing practices to substantiate the claims (Avruch & Shaia, 2022; Gameon & Skewes, 2020; Gingles, 2022; Millner et al., 2021; Miola et al., 2025; Ortega-Williams et al., 2021). Nonetheless, the literature made it clear that treating the trauma inflicted by Western colonization with more forms of Western colonization (i.e., traditional Western psychology)

was likely to be more harmful than helpful (Adames et al., 2023; Bryant, 2024; Chu et al., 2025; Miola et al., 2025; Wilbur & Gone, 2023; Wilcox, 2023).

#### **4.8.3 Therapist Role and Responsibilities**

The third theme that emerged from the literature was that of the therapist's responsibility in the treatment of systemic and racial trauma. It is not surprising that this theme followed the pattern of the first two themes: what causes harm and what helps. Here, the therapist was called upon to be actively engaged in self-development, to do less harm, and help more. Most of the articles *insisted* that all mental health professionals must commit to the long-term inner work of exploring the racist beliefs that they have absorbed in Western culture and replace those beliefs with principles of social justice, and structural and cultural competencies.

A significant impediment to this goal of less harm and more help is the fact that most therapists in the U.S. are White. According to Benuto et al. (2019), 80% of therapists in the U.S. are White and many graduated before therapists were required to undergo multicultural training in their programs, and some are graduating without such training currently (M. T. Williams et al., 2023, p. 580). Because the field of Western psychology has been implicit in structural oppression and racism for hundreds of years (Bryant, 2024; Miola et al., 2025; Wilcox, 2023), a therapist that has been trained within this system must commit to developing their own critical consciousness of their positionality in the larger field and in relationship to an individual BIPOC client seeking their professional help (Avruch & Shaia, 2022; Cénat et al., 2024; Wilcox, 2023). As Avruch and Shaia (2022) explain:

Service delivery models which fail to reckon with the influence of macro structures on individual development and functioning now appear incomplete at best, and unethical at worst. The data speak too clearly: there is no longer any “neutral” space for clinicians to occupy. (p. 178)

Most articles in the dataset called for therapists to become antiracist in their beliefs and actions. However, they acknowledged that this is a big task. As Monnica Williams, whose article is categorized as Adapted Western, states, it is not a passive stance or “simply deciding to treat all people fairly” (M. T. Williams et al., 2022, p. 9). Rather, “It requires a life-time philosophy of humility, acknowledging personal privileges, confronting acts as well as systems of racial discrimination, and working to change personal racial biases” (M. T. Williams et al., 2022, p. 9). Further, actively being antiracist means being a racial justice ally. Williams defines this as follows: “Racial justice allies display behaviours such as identifying and decentering Whiteness, empowering people of colour, and confronting uncomfortable or shameful race-based topics through ongoing education, and engaging in reciprocal vulnerability and accountability” (M. T. Williams et al., 2022, p. 10). Williams goes on to define antiracist behavior to include the concepts of meaningful action, expectations of long-term effort, connection to BIPOC communities, and accountability (M. T. Williams et al., 2022). All of the articles in the Adapted Western and Decolonized categories, and some of the articles in the Western category, echoed these concepts.

For a therapist to be reflexive and commit to long-term change requires humility (Avruch & Shaia, 2022; Cénat et al., 2024; Wilcox, 2023; M. T. Williams et al., 2022).

Humility is also essential for a therapist to effectively work with BIPOC people. As Miola et al. (2025) explain:

It is well established that the therapeutic relationship is primary with regards to positive outcomes in psychotherapeutic treatment across a variety of patient presenting problems (Stubbe, 2018; Vasquez, 2007). Thus, after knowing this history [of racism in psychology], we invite readers to provide radical presence to the individual stories of Black clients, demonstrate a recognition of power difference, invite mutual authenticity, and ultimately create relationships of trust and accountability. (p. 10)

Chen et al. (2024) add, “The practice of cultural humility involves showing a desire to learn from others; to examine one’s own identities, biases, and power within therapeutic relationships; and to maintain respect and openness to new cultural information” (p. 16). Beyond having an open mind and empathic ear for the experience of people from other cultures, the therapist must have the strength to sit with the discomfort of recognizing their own White privilege in relation to a systemically oppressed person. As T. R. Williams et al. (2024) explain:

Clinicians must be cognizant of how power and privilege manifest in the conceptualization and treatment of trauma and operate from an anti-racist stance (e.g., the racialized experiences are not negated, ignored or intellectualized) (Bryant-Davis & Ocampo, 2006). Clinicians need to be comfortable sitting with the discomfort and pain of witnessing the impacts of oppression (Comas-Díaz, 2016; French et al., 2020). (p. 5)

Furthermore, understanding the power dynamics of White privilege and oppression leads to structural competence. Nearly all the Adapted Western and Decolonized articles stated that therapists must have structural competence to be safe and effective in working with racial trauma. Avruch and Shaia (2022) define structural competence as follows:

This term describes clinical practice at “the intersection of individual and sociosystemic dynamics” (Gaztambide, 2019, p. 2028). Structurally competent approaches to therapy reflect the contributions of feminist therapy (e.g., Relational-Cultural Therapy), multicultural counseling, and theories of intersectionality. There are four primary rationales for structural competence. First, it can enhance rapport between worker and client: by demonstrating an appreciation for how the social, cultural and historical contexts have contributed to the problem at hand, the provider reassures the client that she does not judge the client as exclusively to blame for experiencing the problem (Worthington & Atkinson, 1996). Second, macro frameworks can offer clinicians access to important areas of clinical inquiry. Third, helping clients to contextualize their individual experiences within macro systems can open the door for clients to join movements seeking to change those systems. Finally, structural competence allows service providers themselves to contribute to systems change by facilitating the entry of clients into social justice movements. (p. 177)

Accordingly, if the therapist does not see and understand the larger sociopolitical context that the client lives within, they cannot effectively help them with the trauma that the environment causes. Not seeing this denigrates the client-therapist relationship. This is critical because a strong therapeutic rapport is necessary to do trauma work, especially when the trauma itself is rooted in toxic relationship dynamics.

The articles also described cultural competence. Twenty-four of the 34 articles in the dataset referred to its importance. Cultural competence is like structural competence, but focuses on the unique culture that the client lives in. Instead of looking at power dynamics at the systemic level, it seeks to understand how power and relationships work at the cultural level. Chu et al. (2025) pose the question, how does this culture define itself, operate daily, hold together, and repair ruptures? This is important for therapeutic work because it gives the therapist insight into the social context in which the client developed a sense of self and relationship to others and the world around them (Nortey & Downtin, 2024). It is a fundamental part of their psychological operating system. Knowing how the culture attends to relationship ruptures or others forms of psychological or emotional harm is also important for understanding the underlying concepts of health, illness, and healing (Ortega-Williams et al., 2024; M. T. Williams et al., 2021). According to these articles, treatment will progress better if the therapist works with the flow of the client's culture rather than against it. Adames et al. (2023) expand on this:

To illustrate, a meta-analysis conducted by Cabral and Smith (2011) examined ethnic and racial matching among Asian American, African American, Latinx, and European American clients and therapists on three

variables, including (a) preference for an ethnic and racial matched therapist, (b) client perception of racially or ethnically matched and unmatched therapists, and (c) the therapeutic outcome in racially and ethnically matched and unmatched treatment. The results indicated that BIPOC clients prefer a therapist of their own race and that those matched with a therapist of the same ethnic and racial background stayed in treatment longer. However, ethnic and racial matching between the therapists and the client did not account for better treatment outcomes (Cabral & Smith, 2011; Smith & Trimble, 2016); instead, what accounts for a better outcome is the therapists' cultural competence and responsiveness to clients' social demographics including their ascribed race. Working from this clinical stance requires therapists to understand the impact of their racial socialization on their clinical work with BIPOC clients and develop an antiracist identity. (p. 40)

This demonstrates that cultural competence and culturally-attuned empathy was seen by many of these authors as even more powerful than ethnic and racial matching. According to these papers, people need to be fully seen and understood to heal—especially when the wound was caused by being made invisible and deemed unworthy.

To summarize the findings of this research, the 34 articles of the dataset were grouped into three categories based on their theoretical underpinnings. The

categories of Western, Adapted Western, and Decolonized became the basis to analyze the content of the articles from multiple perspectives. Next, the thematic analysis noted three key themes across the articles: what causes harm, what helps healing, and the therapists' responsibility in the treatment. This exploration of content supported the philosophical and practical application of pragmatism by allowing multiple approaches and perspectives to reveal what works.

## Chapter Five. Discussion

This scoping review set out to answer the question: How does the recent literature examine treating the trauma of racial systemic oppression within the context of individual counseling? Using Arksey and O'Malley's (2005) and Levac et al.'s (2010) frameworks, I mapped the literature on the treatment of racial trauma over the last five years (2020-2025). This was important because, up until 2020, the field lacked guidance on how to recognize, diagnosis, and treat this form of trauma.

### 5.1 Summary of Findings

#### 5.1.1 Key Findings

That a collection of 34 articles on the topic of treating the trauma of racial systemic oppression exists, is important. As noted in the literature review above, until the murder of George Floyd in 2020, the literature in psychology marginalized treating racial trauma (Benuto et al., 2020; Comas-Díaz et al., 2019). It was not until this watershed moment that the American Psychological Association issued its formal apology for the long history of racism within the field of psychology in 2021 (APA, 2021). This acknowledgement of racial systemic oppression is vital because, as noted in the findings, the denial of the systemic oppression is as damaging as the oppression itself. Open recognition of the problem allows for the development of critical consciousness and thus for the trauma of racial systemic oppression to be widely addressed in the field of psychology for the first time.

The review identified 34 studies published between 2020-2025, spanning a variety of article types, methodologies, and populations studied. Most of the articles utilized qualitative

methodologies and critical reviews in their work. Twenty-five of the 34 were literature reviews with critical theory analysis, four were systematic reviews, three were based on interviews, and two were cross-sectional surveys. While most of the articles in the dataset were purely critical or theoretical in nature, 11 articles engaged in empirical measurements of the subject matter.

The findings revealed that the selected articles could be grouped into three broad theoretically-aligned categories: Western, Adapted Western, and Decolonized approaches to treating the trauma of systemic and racial oppression. This represents a wide spectrum of perspectives. The trajectory of the body of literature was away from the Western perspective and towards the Decolonized view. It has not yet arrived at a Decolonized position so lies in the middle ground called Adapted Western.

### ***5.1.2 Three Major Themes Emerged***

The three major themes noted in the thematic analysis above are: what causes harm; what helps the healing; and what is the therapist's role.

1. What causes harm: The literature showed that two major causes of harm to BIPOC people is the ubiquitous nature of systemic oppression and the denial of it.
2. What helps to heal from racial trauma: The selected literature revealed that what facilitates healing is naming the systemic oppression, breaking the confinement of rugged individualism, and connecting with community to reframe the problem to hold the corrupt system accountable, not the victim.
3. The therapist's role in the treatment: The literature stated that the therapist has an ethical responsibility to do reflexive work to identify their relationship with issues around

race and privilege (power) to avoid continuing harmful racial discrimination and stereotypes with their clients. Therapists are challenged to develop antiracist values and behaviors and to become structurally and culturally competent.

### **5.1.3 Consistency and Agreement in the Literature**

The 34 articles were nearly unanimous on a few issues. These included an acknowledgement that traditional Western approaches are insufficient and harmful (N=32); a critical consciousness of systemic and racial oppression is paramount to treating the trauma it creates (N=32); the therapist must embody antiracist perspectives and practices (N=32); all therapists need a trauma-informed approach when addressing racial issues (N=32); and more research is needed on racial trauma and the effectiveness of proposed treatments (N=34).

### **5.1.4 Contradictions or Debates in the Literature**

While there was near unanimous agreement that traditional Western psychology and approaches to trauma treatment were not effective for treating racial trauma, there was a lot of contradiction, and little debate, about the best alternative approach.

The contradictions lay in the diversity of approaches for alternative perspectives, frameworks, and treatments. What was striking was that each article strongly advocated their perspective but there was little or no cross-reference to other perspectives. It was as though there were 34 silos of thought that did not know about each other. The sense of contradiction came from a lack of cohesion rather than a critique of the others. It is like the parable of the five blind men describing an elephant. Each one is accurate, but none of them sees the total picture.

Perhaps this exploratory phase is to be expected in a field that is in the process of change, per the American Psychological Association's 2021 apology for its long history of racism (APA, 2021); and after the major social disruptions of COVID-19, George Floyd's murder, and the Black Lives Matter movement and protests. It may indeed be too soon to have robust debate and critique, much less a widely accepted approach. However, the research trajectory is moving away from an uncritical Western perspective, and is presently in the Adapted Western category (23 of the 34 articles were in this category), with the Decolonization group pushing the edge of the envelope and pulling the field in that direction.

The literature had a thread of debate, or disagreement, on the topic of resilience. As noted above, the articles did not debate with each other, rather there was a collection of critiques on the topic. The Stanley & Atari-Khan (2024) article from the data set gives an overview of the concept of resilience in counseling psychology literature. Stanley & Atari-Khan (2024) conducted a content review of 54 articles on the broad subject resilience from two flagship counseling psychology journals from 1997-2024. Their study revealed that resilience was first written about in 1995 and found that "although people of color are often groups of focus in resilience research, the concept of resilience was created by predominately White, American, cisgender researchers who sampled predominately White populations" (Stanley & Atari-Khan, 2024, p. 509). This creates doubt as to whether the concept of resilience, as defined by Western psychology, accurately reflects the lived experience of marginalized people (Stanley & Atari-Khan, 2024). Their research found that resilience was overwhelmingly constructed as an individual's responsibility to "overcome larger forces of oppression and succeed in life. And of they if the person is unsuccessful, they are to blame for their "poor choices" (Stanley & Atari-Kahn, 2024, p.

510). This sentiment was present even when the research papers within their data set explicitly examined hardships such as systemic oppression, anti-immigration laws, racism, and gender discrimination (Stanley & Atari-Kahn, 2024). Their conclusion of this study stated,

When working with people of color in the United States, applying resilience in the way harmfully places the responsibility on the person to overcome oppression. ... We argue for the need to shift our understanding of resilience away from individual processes to focus on group and communal ways of healing, as a means of aligning with our values as counseling psychologists and working to disrupt systems of oppression (Stanley & Atari-Kahn, 2024, p. 509).

The articles within this scoping review agree with Stanley & Atari-Kahn. Some, often from the Decolonized category, argued that encouraging resilience in people suffering systemic oppression is merely a tool to maintain the status quo when we should be dismantling the oppressive symptom instead (French et al., 2020; Stanley & Atari-Khan, 2024; Wilbur & Gone, 2023; M. T. Williams et al., 2023). Others, from the Adapted Western category, stated that while changing the system is indeed necessary, that change will take a long time to implement and people need coping skills to survive the pain inflicted by the system in the meantime (Brown et al., 2025; Bryant-Davis, 2023; Cénat, 2023; Cénat et al., 2024; Chu et al., 2025; Miola et al., 2025; M. T. Williams et al., 2021). These positions could be reframed as whether resilience should be the end goal of treatment or a tool that allows a person to persist in resisting and changing the system that oppresses them. The Western and Adapted Western groups tend to see resilience as the end goal, while the Decolonization group sees resilience as a tool, or a source of fuel, to stay in the fight to dismantle the colonized system. The Western and Adapted Western

groups echo the tradition of psychotherapy focused on the individual and intrapsychic processes, whereas the Decolonization group is savvy to social systems and social justice and is therefore more aligned with the social work perspective (Bryant, 2024; Canadian Association of Social Workers, 2020). Given this, both perspectives of the debate have elements that are accurate; traditional psychotherapy is limited to developing strong coping skills, whereas Decolonization aims for systemic change.

### ***5.1.5 Gaps Identified***

The dataset revealed important gaps in the field. These gaps can be summarized in three topics: lack of research on effectiveness; absence of some cultures in the search results; and lack of clear guidance for the clinical practitioner.

The most obvious gap is the lack of empirical evidence. As noted above, the 34 articles unanimously called for more research on treatment efficacy. Another significant gap was the absence or lack of certain populations of historically oppressed people. For example, the original searches of five substantial databases yielded little or no results for Indigenous populations. Likewise, there was only one article on the Jewish population, which did not meet the inclusion criteria, so that perspective is not counted here. There were two articles addressing the Asian population and only one on Latinx. This is not to say that there is no literature on these subjects, but that these populations have such little representation in a search designed to be as inclusive as possible, which in itself indicates potential gaps. Similarly, many of the articles addressed very broad categories of the population, such as BIPOC or “oppressed” people, or “racialized” people, or “people of color” rather than more specific populations. This is important because the

literature indicates, albeit via preliminary results, that the more culturally specific a treatment is, the more effective it can be.

There is an implicit gap in the literature which reflects the systemic racism present in the field of psychology itself. That is, the field of psychology has systemically oppressed BIPOC voices through blatant racism (APA, 2021). In its 2021 formal apology to people of color for perpetuating racial systemic oppression, the American Psychological Association acknowledged that it has been complicit in oppressive racism since the mid-19<sup>th</sup> century (p. 1). It goes on to acknowledge that “psychology has minimized and marginalized psychologists from communities of color and their contributions to the field” (APA, 2021, p. 2). Further, a lack of funding and support for faculty of color and “perpetuating multiple barriers” (APA, 2021, p. 3) for students of color to enroll in and complete graduate programs in psychology. Because of this long-term systemic oppression, there is an absence of BIPOC perspective, voice, and scholarship in the field, and on this topic specifically. This is problematic because this expertise is essential to developing culturally appropriate forms of treatment.

Finally, although there were 34 articles with well-argued perspectives, there was a lack of clarity on how a therapist could proceed in implementing the concepts, or under what circumstances to apply the different concepts. Ideas on how to close these gaps will be addressed in the Implications and Future Directions section below.

## 5.2 My Professional Reflections

Throughout this scoping review I have tried to maintain an objective perspective on the data within the literature and faithfully report my findings. In this section, I will temporarily depart from the objective perspective and share my personal and professional perspective on the research findings.

As noted in the positionality statement above, I am the primary researcher and a psychotherapist in private practice. My burning question about how to treat people suffering from the chronic trauma of racial systemic oppression was the driving force behind this research. I am a female, White, middle-class, psychotherapist, licensed in California, Oregon, Washington, and British Columbia with 15 years in private practice and specializing in trauma treatment. My primary counseling training was in depth psychology, with emphasis on Jungian and humanistic theories and approaches to psychotherapy. My training emphasized a decolonized and multi-cultural perspective on psychology and counseling, in addition to the traditional Western approach that prepared me for state licensing. My training in Jungian depth psychology was both non-traditional and deeply Western. My subsequent training in trauma treatment, which includes eye movement desensitization and reprocessing (EMDR), somatic processing, and the psychedelic Ketamine used in clinical settings provided more emphasis on non-Western perspectives. However, my practice must operate within a rigid Western health system with payment dictated by insurance companies. My politics are feminist, left, liberal (by the U.S. definition of liberal). Although I have significant experience in private practice, I have little experience in community mental health. As I gain experience in this field, I develop greater

appreciation for the role of community mental health. Perhaps the most significant lesson from this research was becoming aware of how much I do not know.

### **5.2.1 My Opinions on the Three Categories**

During the research process, I found that my heart aligns with the Decolonized group, but my head aligns with the Adapted Western category because it presents, for me, the most pragmatic option at this time. I found myself frustrated with the rigidity of the Western group. If the world could be changed quickly, I would want to see the field centered in the Decolonized perspective because I appreciate the richness and diversity of wisdom across many cultures and I want to see an end to the destruction and oppression caused by Western colonization. However, we live in a Western colonized world and the current global shift in politics towards the far-right seems to indicate that it will be this way for some time. Of course, the left must continue to resist and advocate for social justice and large-scale systemic change. But, in the meantime, we as psychotherapists must pragmatically do our best with what we have to work with. I believe that the Adapted Western approach is insufficient but currently accept that this is the best option for *my* practice because it aligns with the legal and business requirements I practice under. I see that other could thrive using a Decolonized approach, and that the Western approach still has limited utility; however, I believe it is becoming increasingly antiquated and ineffective.

The Adapted Western approach to treating the trauma of racial oppression was the bulk of the research identified. Of the 34 articles in this dataset, 23 of them held an Adapted Western perspective. Western and Decolonized were the outliers with five and six articles each. I believe this is the case because many therapists are like me, White,

Western-based practitioners who are trying to operate a business in a model that demands adherence to Western values, while also providing effective treatment, that requires stretching towards the non-traditional options offered by the decolonized perspective. We are straddling two worlds, doing the best we can to pragmatically satisfy both. In the business of psychotherapy, the insurance companies and their concept of managed care, means that the client-therapist relationship includes satisfying an insurance company's demand that treatment methods be proven effective and in as few sessions as possible (Marczyk & Wertheimer, 2001). The effectiveness of treatment is based on evidenced-based treatments (Marczyk & Wertheimer, 2021), which are narrowly defined by Western epistemology in an inherently racist system of science (APA, 2021). Beyond satisfying the insurance company to receive payment, the therapist must also consider practicing evidence-based treatment to defend themselves from potential malpractice suits (Marczyk & Wertheimer, 2001). So, although there is a compelling argument for a Decolonized approach, a therapist will not be paid for this work and likely could not defend themselves against a malpractice suit if they used it. So, in the context of a capitalistic health care system, the Adapted Western approach is the best the health care system will allow. Although this is insufficient, the anti-racist adaptations improve it and thus make it better than going back to a traditional Western approach; and we cannot yet fully occupy the Decolonized perspective because we are so inherently Western. There is tension in this in-between space and thus there is a lack of agreement on what to do. White, Western therapists can earn their way into a Decolonized approach, but they must first commit to a long process of deprogramming themselves from Western values and epistemology via

reflexivity, immersion in other cultures, and internalizing anti-racism perspectives. This is a long-term project, and it is reasonable to expect that relatively few White, Western therapists will make the transition fully enough to be highly effective in the Decolonized approach. However, many can be great allies along the way.

The traditional Western approach represents the past and the Decolonized approach is the future; albeit slow in coming. I believe that the Decolonized approach is better than the Western approach because it is not bound by the artificial limitations of Western epistemology such as rugged individualism, patriarchy, Christianity, over-emphasis on science and pathology, prioritizing cognition over body and soul, prioritizing profit over the health of the ecosystem. Psychology's long history in racist oppression is also severely problematic. The Decolonized approach holistically values mind, body, spirit and nature, it is committed to social justice, prioritizes relationships and community, and is strength-based. It is inherently more nurturing and healing than the Western approach and thus more likely to be effective in treating trauma. The Western approach to psychiatry, pathology, behaviorism, intrapsychic insight, and cognition still has utility in the field of psychology, but it should no longer dominate and is more detrimental than effective in trauma treatment. The Western approach is also appropriate for clients that are deeply Western and thus not open to Adapted Western or Decolonized modalities. The Decolonized approach may seem new to Western therapists, but there is an established history of its effectiveness in Indigenous survivance in North America (Wilbur & Gone, 2023), the liberation psychology from Latin America (Cook et al., 2023; Duran, 2019), the

Truth and Reconciliation of South Africa (Apartheid Museum, n.d.), and satyagraha and civil disobedience movements in India (Nangia, 2025) .

### ***5.2.2 How I Can Apply the Findings in Clinical Practice***

Before conducting this research, I believed that therapists had an important role to play in helping people heal from racial trauma. After completing the research, I no longer believe this. I think racial trauma is best treated by social workers in a community mental health setting. This is because social work is rooted in systemic competency, community engagement, and has skill in working with individual level trauma. These ingredients are aligned with what the Decolonized group calls for. Social work has been doing this for at least 100 years. It is the psychotherapists that are new on the community scene and just starting to learn the ropes. I think that trauma work should be led by the culture that is impacted by the trauma of systemic oppression. The field of social work is already designed to support that. Because psychotherapy is inherently individualistic and not engaged in social systems, it cannot go much further than developing strong coping skills to deal with chronic trauma. Metaphorically, if we were discussing a person ill with cancer, a therapist could be supportive in their feelings about the disease and treatment, but they could not treat the disease itself. I think this is like therapy and the trauma of racial systemic oppression. Deeper healing needs to come from community-based resistance and engagement.

Therapists can play a supporting role by taking directions from community groups and social workers. Therapists that have done anti-racist reflexive work, and that are trained in trauma treatment, can help by offering individuals general trauma support and coping skills. The individual therapeutic hour can offer psychoeducation around critical consciousness and critical race theory to stop blaming the person for external systemic problems they are caught in. Therapy can

also facilitate processing feelings and beliefs about the problem of oppression; and it can help repair damage to essential relationships caused by the trauma of racism. I believe the best type of coping skills for trauma are somatic, such as Vagus nerve-based work, because it is rooted in the common ground of anatomy and thus cuts through cultural differences that occur in modalities based in cognition or emotional expression. Perhaps, most importantly, a therapist can help by connecting the individual to their community resources, so they are no longer working on a collective problem in isolation.

I will apply this learning in my private practice by becoming more engaged in community mental health. This will require leaving the bubble of isolation that comes with being a therapist and connecting with community organizations so that I can both refer my clients to appropriate cultural resources, but also make myself of service to support these resources when they have needs that are better served by a therapist than a social worker. I will also apply my learning by continuing my reflexive anti-racist work. Because I know that I have good intentions, I would like to believe that I do not have racist ideas or exhibit racist behavior. However, this work requires humility and honest acknowledgement that I was raised in a Western racist society, and I thus have unconscious ideas that are rooted in racism. I need to stay disciplined in identifying, uprooting, and replacing these Western ideas with decolonized understanding.

### **5.3 Implications and Future Directions**

Building on the summary and professional reflections above, I will now explore the implications and future directions for this field of research.

### **5.3.1 Training**

The literature clearly shows that current clinical practice needs to move towards being as antiracist as possible and adopting a decolonized perspective. Continuing traditional Western psychology practices without embracing antiracist changes is both harmful and unethical. Psychotherapists already in practice, and those currently in training, need a more inclusive, decolonized education that will help create the structural and cultural competences that the literature states are missing from traditional Western approaches. Unfortunately, the literature shows that the past and current states of therapist training are deeply rooted in traditional Western perspectives and thus lack knowledge of and empathy for the lived experiences of BIPOC people within an inherently racist society (Brown et al., 2025; French et al., 2020; M. T. Williams et al., 2022). This means that therapists, both established and new, need new training on these important issues.

My recommendations for improving training are based on the lessons learned from three themes that emerged from this scoping review. First, we must identify the structural oppression and racism and the harm they cause. Second, we must break the lock of Western cultural and structural norms by supporting cultures and communities from the grassroots levels and challenging the institutional status quo at all levels. Third, we must require therapists to do their own reflexive work around issues related to race, power, culture, and the inherent colonization within Western psychology. The scoping review literature makes suggestions on how to do this (Brown et al., 2025; Bryant-Davis, 2023; Cénat et al., 2024; French et al., 2020; Wilcox, 2023; M. T. Williams et al., 2022). However, rather than reinvent the training wheel, perhaps the best approach will be to break the isolation silo of psychotherapy and partner with the larger mental

health community by learning from the field of social work. Social workers are trained to see the big picture of person-in-environment and then determine how to support the individual within that environment. They study systems, power structures, institutions, and how to empower individuals and communities via culturally appropriate advocacy, resource utilization, and systems reform (Canadian Association of Social Workers, 2020). If therapists studied this existing curriculum, and then partnered with social work in the field, they could make great strides in understanding systemic, cultural, racial dynamics that both the client and therapist live within. This could make therapists more effective and ethical in working with BIPOC people.

### **5.3.2 Future Research**

This scoping review is the tip of the iceberg in this field of study. As discussed above, although these 34 articles were grouped into three thematic categories, there was a striking disconnect between the articles. The scoping review brought 34 different perspectives into one review and organized them into a coherent landscape. From here, there is ample opportunity to explore many themes within the field. There are two major areas for future research: specific BIPOC cultures (e.g., Asian, Latinx, Indigenous, Black, and Jewish populations) and the effectiveness of Adapted Western and Decolonized treatments. It would also be important for the field to have respectful critical debate between the proposed frameworks and treatments to encourage dialogue, collaboration, and critical reflection as part of an evolution in treatment. Given the results of the initial research on the harmful effects of forcing Western approaches in mental health, future research should be undertaken using Decolonized research methodologies that prioritize and center the cultural values and healing traditions of each population.

## 5.4 Strengths and Limitations

This research project had both strengths and limitations. The primary strength of this research is that it was broad and inclusive. Also, the research methodology—a scoping review with a thematic analysis—focused on the content of the articles with no emphasis on the researcher’s opinions. That having been said, it is acknowledged that no researcher can be fully objective. There were three significant limitations in this scoping review.

First, as noted above, some populations were missing or less visible in the literature. This may have been because of limitations in search terms used or strict adherence to the scope of the project. Near the end of the project, it was noted that different synonymous terms, such as ‘historical trauma,’ might have yielded more Indigenous scholarship, as historical trauma is a term commonly used in that field. The absence of Indigenous literature was noted in the initial search results and compensated for by hand-selecting articles known to the author. It was additionally noted above that there was a shortage of Latinx and Asian perspectives and no Jewish perspectives in the dataset despite these cultures having significant histories of systemic oppression and racism. The initial search results did yield articles in these domains, but they did not fit the inclusion criteria and thus were not included in the final dataset. Future researchers may want to explore these perspectives because, even if they do not focus on the therapeutic hour, they may provide additional insights. Similarly, there is an absence of articles from the psychoanalytic perspective because they were too theoretical to meet the inclusion criteria.

Second, the coding phase of the project was impacted by a lack of resources. The original plan was to have a second reviewer engaged in both the article selection and coding process from the beginning. However, two team members slated to do this work were affected by

unforeseeable life events that prevented them from fully participating. One secondary reviewer fully participated in the article selection phase. Another secondary reviewer was added at the end of the analysis phase to review codes and themes created by the primary researcher. However, while their input was valuable it did not alter the outcome of the analysis. It did, however, confirm the findings of the primary researcher.

Third, the primary researcher conducted the bulk of the thematic analysis because of logistical limitations of resources and time. Undoubtedly, having more researchers, with a wide variety of lived experiences, which is typically done in published reviews, would have enriched the selection of articles and the thematic analysis. Thus, the results are inherently biased by the primary researcher's lived experience as a White, Western woman and practicing psychotherapist.

Future research projects could learn from these challenges by including resources outside of articles (e.g., books, podcasts, videos, etc.) in the literature review and developing a larger and more diverse team of researchers. Further, utilizing a decolonized research methodology may have yielded different results.

## Chapter Six. Conclusion

This scoping review has contributed to the field of psychotherapy by gathering and reviewing recent literature on the topic of treating the trauma of racial systemic oppression. It identified and clarified three categories of treatment approaches—Western, Adapted Western, and Decolonized—and summarized what the selected literature says about what causes harm, what helps to heal, and the therapist’s role. It set the stage for future research on the topics of specific BIPOC culture healing practices and the effectiveness of a wide variety of non-Western approaches. Overall, the review demonstrated that the best way to treat the trauma of systemic racism is to move away from a traditional Western approach of individualized trauma treatment towards a decolonized approach that centers around reconnecting people with culture and community. Specifically, a community that is systemically liberated, just, and equitable, not oppressive, because we cannot reasonably hope to solve a problem with the same thinking that caused the problem in the first place.

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The author declares that she has no competing interests.

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