Representation, experiences, and insights from racial, ethnic minority and indigenous mental health clinicians:

A scoping review of the literature (1956-2019)

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Author Note

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Abstract

The global export of Western psychology combined with legacies of White supremacy and colonialism have marginalized racial and ethnic minority and indigenous (REMI) mental health providers, to the detriment of the field. We conducted a scoping review to 1) examine the representation of REMI mental health professionals in the published English-language literature through 2019, and 2) provide a narrative review of their training and practice experiences, needs and insights regarding mental health services. We searched PsycINFO-OVID, Medline-PubMed, and CINAHL-EBSCO databases for English-language records through 2019 related to REMI mental health professionals across disciplines. Characteristics of the provider (ethnoracial identity, discipline, country of practice) and the research report (type, method, outlet) were analyzed. Moreover, we conducted a narrative review of key themes and trends by decade. Only 860 reports met inclusion criteria over more than six decades. Most were conducted in the U.S., and the representation of Black, Asian, and Latinx providers mirrored growth in the U.S. population over time. However, indigenous clinicians and those of Arab, Middle Eastern or North African heritage were highly underrepresented. Challenges faced by REMI clinicians– structural racism, race-related stress, cultural conflicts, and pressures to assimilate to Western values– produced a sense of internalized inferiority and cultural dislocation from the healing wisdom of the Global Majority. We recommend that critical consciousness and a global competence perspective guide curricular changes to meet the education and training needs of REMI clinicians in a globalizing world.

Keywords: Scoping review, racial/ethnic minority, mental health, clinician, therapist

Public Significance Statement: Racial-ethnic minority and indigenous mental health clinicians are significantly underrepresented in the mental health literature. Structural racism, cultural conflicts, and pressures to assimilate to Western values produce internalized inferiority and dislocation from the cultural strengths and healing wisdom of the Global Majority. Changes in training and education are needed to leverage the strengths of REMI clinicians in a globalizing world.

Despite the recent increase in REMI[1] providers in the U.S. and other countries of the Global North (Lin et al., 2018; Salsberg et al., 2020), ethnocultural biases are pervasive in professional models of training and education, the production and dissemination of clinical research, and organizational norms and practices (Ho & O'Donovan, 2018; Powell, 2018; Sue, 1999). The global export of Western models of mental health care combined with legacies of White supremacy, colonialism, and imperialism have had adverse impacts for REMI providers of mental health services as well as the clients and communities they serve (APA, 2021; Wood & Patel, 2017). Further, privileging theories and practice models built on WEIRD (Western, Educated, Industrialized, Rich, and Democratic) populations (Henrich et al., 2010) hampers innovation by limiting exposure to diverse perspectives and indigenous healing practices that may advance clinical science and benefit the public (Buchanan et al., 2021).

Although REMI clinicians have long challenged dominant discourses and re-imagined what healing and care might look like (Comas-Díaz, 2005; Fanon, 2008; Martín-Baró, 1994; Poussaint, 1969), scholarship relevant to the needs and experiences of REMI mental health professionals has been marginalized in the field, absent in educational curricula, overlooked by funding agencies, and undercited in the literature (Hoppe et al., 2019; Sue, 1999; Zárate et al., 2017). Fortunately, the tide is shifting. Global Majority scholars and their allies are increasingly calling for decolonizing and anti-oppressive models of research, training, and practice to advance a more critically informed knowledge base to promote mental health equity (Adames et al., 2022; Buchanan et al., 2021; French et al., 2020).

Outsider status offers a powerful vantage point from which to appraise the strengths and

[1] Internationally, the most disadvantaged REMIs in most multicultural societies tend to be people who are non-White. Different terms are used in different contexts to refer to these groups, including 'people of color' and 'BIPOC (Black, Indigenous and People of Color) in the United States, and 'BAME' (Black, Asian, Minority Ethnic) in the United Kingdom. More recently, the term 'People of the Global Majority' is increasingly being adopted to challenge the idea of whiteness as the "norm", and more accurately describe the Black, Brown, Indigenous, and Asian individuals who collectively represent more than 80% of the world's population. In this article, we retain the term REMI to reflect our focus on the effects of minoritized status and racialization within mental health training, education, and practice contexts largely in the Global North, including the ways that such groups navigate oppressive environments to deliver mental health services, especially to REM clients and communities.

weaknesses of prevailing models of care. Tinsely-Jones (2001) wrote more than 20 years ago, “As bicultural representatives, psychologists of color have unique perspectives that can substantively inform psychological theory and practice, as well as enrich the field in general... It is at these overlapping margins of cultures traversed by psychologists of color that new dialogue and creative solutions can be born.” (p. 575). Finally, perhaps because of their first-hand experiences of structural disadvantage, REMI practitioners express a stronger commitment to serve those most marginalized in society (Limb & Organista, 2003). As such, the values and perspectives of REMI practitioners may provide a necessary corrective to the cultural and structural biases that infuse the mental health field.

This study seeks to address the invisibility and marginalization of REMI mental health professionals’ perspectives in education, training, and practice by conducting a scoping review of the global English-language literature published through 2019. We examined published records that included REMI providers of mental health and related services, such as counseling, psychotherapy, psychoanalysis, psychiatry, social work, indigenous healing practices, and other mental health supports whether delivered in institutional (e.g., clinics, schools) or community settings (e.g., churches, reservations). We identified studies in which REMI providers were included as participants or interventionists, in first-person accounts and case studies, and as stimuli in experimental studies. While acknowledging that local sociopolitical contexts and history produce unique dynamics of power and privilege that affect Global Majority providers across practice settings, research suggest that there are common impacts of marginalization, oppression, and colonization that connect experiences of mental health professionals identifying as Black, indigenous or other people of color (BIPOC) in the United States (Goode-Cross & Grim, 2016), with Aboriginal cognitive-behavioral counselors in Australia (Bennett-levy et al., 2014), South Asian social workers in the United Kingdom (Willis et al., 2017), Hindu psychologists in South Africa (Padayachee & Laher, 2014), and immigrant clinicians in Sweden (Eliassi, 2017) and Canada (Salami et al., 2019).

Common experiences of REMI mental health professionals across country contexts include minority stress, internalized oppression, and experiences of systemic racism and marginalization in their educational and work settings (Casas et al., 1980; Hendriks & van Ewijk, 2017; Ramon, 2004). REMI providers also share common sources of resilience and strength, including cultural values, community supports, and engagement in collective action (Bell-Tolliver & Wilkerson, 2011).

Given these shared experiences, we examined all English-language records pertaining to REMI providers of mental health services who were minorities in their country of practice (e.g., Chinese social workers in the U.S. but not in China), with the addition of non-White practitioners in South Africa given its legacy of apartheid and ongoing racial inequality (Kometsi, 2008). While we seek to examine experiences of REMI providers across diverse contexts, the small number of articles from the Global South and restriction to English-language records are key limitations of this review.

Two questions were explored: 1) How have REMI mental health providers been represented in the literature (e.g., growth over time, methodologies, research topics), and 2) What are their training and practice experiences, needs, and insights regarding inclusive mental health practice? Results are used to inform recommendations for revising and expanding the curriculum to foster more inclusive, anti-oppressive, and culturally-centered approaches to mental health training, education, and practice.

Methods

In contrast to systematic reviews, scoping reviews seek to describe the existing literature base and range of evidence available and to represent this evidence by mapping or charting the data without formally assessing the quality of the evidence. Guided by Arksey and O'Malley's (2005) five-step process for conducting scoping reviews and Levac et al.'s (2010) enhancements, we articulated the two broad research questions presented above (Step 1). For Steps 2 (Identifying relevant studies) and 3 (Study selection), we began by operationalizing our core constructs. Preliminary searches revealed inconsistent indexing of subject terms related to "racial or ethnic minority", "indigenous", and "mental health

provider" across research databases over time. In the 1960s for example, the term 'Negro' was used to describe Black Americans, replaced in the 1970s by the term "Black". Consulting with research librarians, we developed a list of maximally inclusive search terms to identify studies that included REMI providers, even if not the focus. To counter biases in search terms related to the mental health professions' global colonial history, we also developed a list of terms to identify providers of indigenous and community mental health care delivered outside the disciplines of psychology, social work, and psychiatry.

Steps 4 (Charting the data) and 5 (Collating, summarizing, and reporting results) involved an iterative process of refining the data to be be extracted, updating the data-charting form, and recoding as needed. Study themes were qualitatively analyzed by decade (Levac et al., 2010). While this study was not preregistered, it complies with the Preferred Reporting Items for Systematic Review and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). Data are available by request.

Eligibility Criteria, Sources, Search Strategy, Screening and Selection Process

Specific inclusion criteria were as follows: (a) REMI mental health providers, trainees, research subjects, supervisors; as stimuli (as in analogue studies); or as authors of first-person accounts or clinical case studies; (b) Minority status in the study or practice setting; (c) Mental health practice focus, e.g., psychiatry; psychoanalysis; clinical, counseling, school psychology; social work; indigenous healing; community mental health; (d) Scope of practice may include counseling/therapy, assessment, medication management, case management, community interventions, indigenous healing, clinical training and supervision; (e) Setting may include healthcare only if the focus is on behavioral or mental health services. Source types included journal articles and book chapters. Document types included literature reviews, case studies, empirical studies (qualitative and quantitative), theoretical articles, first-person accounts; policy reports related to REMI professional groups or workforce diversity.

Articles were excluded for the following criteria: (a) Focus on health care professionals unless

engaged in mental health care; (b) Focus on majority group therapists; (c) Focus on general models of multicultural training unless specific to the training, supervision or professional development of REMI providers; (d) Relevant studies that do not report race/ethnicity of the mental health providers. Excluded source types included newspapers, magazines, and newsletters. Excluded document types included obituaries, awards, policy reports (except those on workforce diversity), introductory articles/chapters for a journal issue or book, dissertations, book reviews, letters.

Database searches were conducted in PsycINFO-OVID, Medline-PubMed (using MeSH terms), and CINAHL-EBSCO Host in 2016 and updated in the winter of 2019. Search terms included 25 synonyms for mental health providers such as *"mental health professional", "psychiatrist", "psychologist", "case managers", "community health workers", "social workers", "clinicians", "counselors",* and *"therapist",* cross-referenced with 87 terms related to race, ethnicity, culture, and immigration[2].

The core research team consisted of a racially diverse group of 5 graduate students and a faculty member in psychology, and an evolving team of 12 undergraduate and master students. Search results were imported to the Covidence software package. Titles and abstracts were screened by at least two members; disagreements were resolved by two additional members. Reports that passed the initial screening proceeded to full-text review by two coders using the Zotero reference management software. Disagreements were resolved in consultation with the full team.

Data Extraction, Charting, and Synthesis of Results

For each report, data extracted included: a) Authors and publication year; b) Source; c) Country; d) REMI heritage(s) of the provider sample; e) Provider type (e.g., psychologist); e) Study type (e.g.,

[2] *Culture; acculturation; cultural deprivation; culture diversity; culture safety; culture values; ethnic groups; Arabs, Cambodians; Chinese; Filipinos; Hmong; Japanese; Koreans; Laotians; Thai; Vietnamese; Blacks; Gypsies; Hispanics; Indigenous people; Eskimos; Native Americans; Racism; Immigrants; Illegal; affirmative action; African culture groups; Alaskan Natives; American Indians; Asians; Client treatment groups; cross cultural collaboration, communication, counseling differences, psychology, treatment; cultural deprivation, sensitivity; disadvantaged; diversity; diversity in the workplace; ethnic identity, values; ethnocentrism; ethnology; expatriates; Hawaii Native; Immigration; Indigenous populations; international psychology, students; Inuit; Latinos/Latinas; Marginalization; Mexican Americans; Microaggressions; minority groups; multicultural counseling, education; multiculturalism; multiracial; Pacific Islander; Patient Selection; prejudice; Race and anthropological, ethnic discrimination, ethnic attitudes, ethnic differences, ethnic groups; ethnic relations; Refugees; Romanians; social discrimination, integration; sociocultural factors; South Asian cultural groups; Southeast Asian cultural groups; Transcultural psychiatry; Indians North American, Central American; Oceanic ancestry group; Jews; Roma; Race relations; continental population groups*

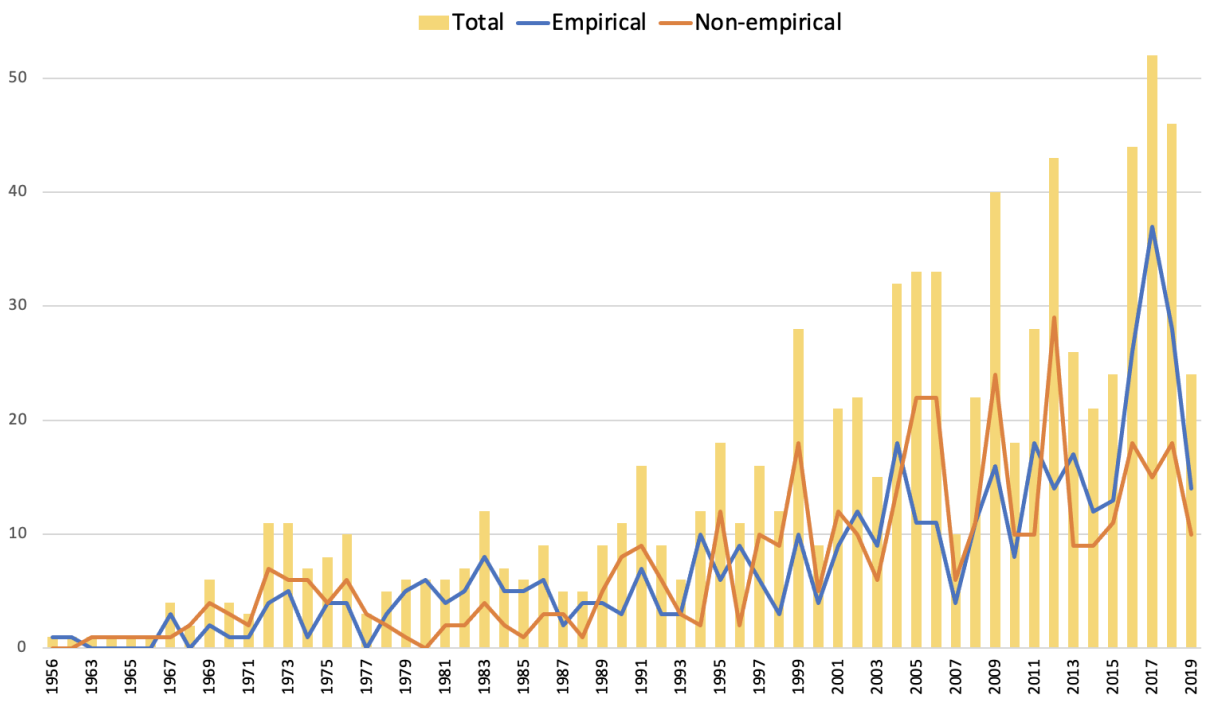
empirical, quantitative); f) Study method (e.g., survey, analogue); g) Study topic (e.g., racial/ethnic matching). Data extraction was conducted initially as a group and then in pairs, once minimum inter-rater reliability was achieved (k=.866-.952), Narrative review of the full-text articles was conducted by 3-4 team members for each decade. Articles were reviewed and coded based on research topics, themes, and trends to summarize the emerging state of knowledge regarding REMI providers over time.

Results

The initial search yielded 29,212 reports, with another 60 located through referrals (see Suppl Figure). Removal of duplicates resulted in 21,333 reports. Of the 4,694 that passed initial screening, 3,834 were excluded during full-text review, resulting in the retention of 860 reports (437 empirical, 423 non-empirical). Reasons for exclusion were a) focus on general health providers, b) focus on general multicultural training, b) provider not a minority in practice context, c) ineligible source type.

Figure 1

Growth in the Literature featuring REMI Mental Health Providers over Time



Representation of REMI Providers by Group, Study Method, Geographic Region, and Discipline

Figures 1 and 2 present the number of records in which REMI providers appeared by decade. The earliest was a 1956 study titled "Graduate education of Negro psychologists" by T.W. Richards, published in the *American Psychologist.* To date, it has been cited only once. Studies featuring REMI providers increased exponentially, with 1 (.1%) published in the 1950s, 17 (2.0%) in the 1960s, 69 (7.9%) in the 1970s, 73 (8.4%) in the 1980s, 139 (16.2%) in the 1990s, 237 (27.6%) in the 2000s, and 328 (37.9%) in the 2010s. Two-thirds (65.5%) were published after 2000. Of the empirical records, 63.4% were quantitative, 32.3% qualitative, and 4.3% mixed-method designs. Survey (k = 137) and interview (k = 116) methods, treatment process and outcome studies (k= 88,) and analogue studies (k= 53) were most common.

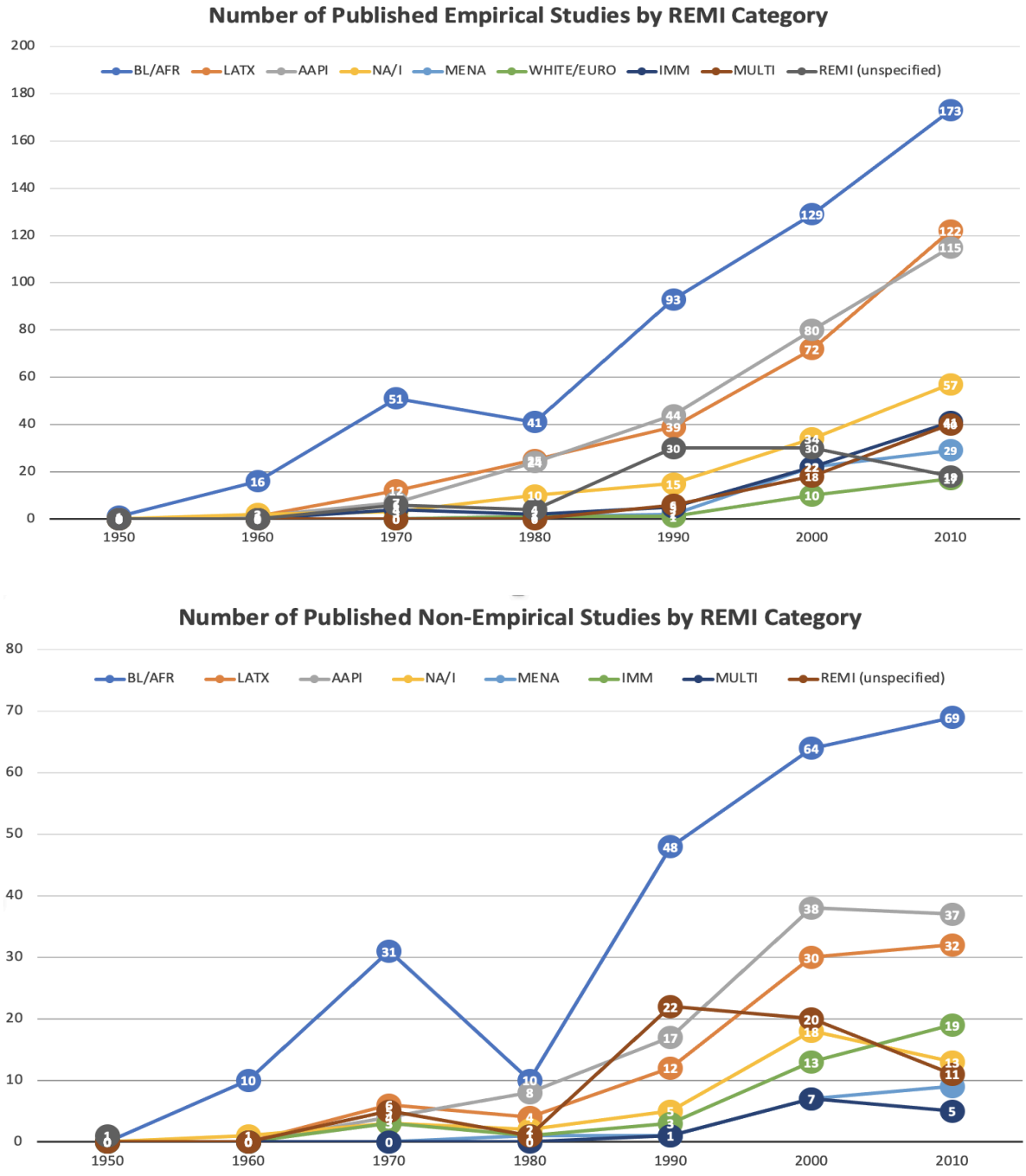
Racial/Ethnic Group Representation

As shown in Figure 2 and Suppl Table 1, Black providers and those of African descent were the most highly represented, present in 58.5% of the 860 reports (62.2% of empirical and 54.8% of non-empirical reports). In the 1960s and 1970s, very few reports included providers from other REMI backgrounds. The 1980s saw a notable increase in reports featuring Asian or Pacific Islander providers[3] (31.5% of the total) and providers of Latinx, Hispanic, Central or South American heritage (31.5%). Providers of native, aboriginal, First Nations, and other indigenous heritage and Arab, Middle Eastern and North African heritage were underrepresented, present in only 14.1% and 6.3% of reports, respectively. Suppl Table 1 reports the specific ethnoracial categories represented. A close look reveals patterns of aggregation and invisibility. Although clinicians of Asian heritage are in nearly one-third of articles, they were typically described in the aggregate ("Asian"), with Southeast Asians (2.6%), Pacific Islanders (1.2%), and Filipinos (0.7%) significantly underrepresented.

[3] Although Pacific Islanders also include some indigenous groups (i.e., Native Hawaiians), we include them here with Asian Americans because published reports often referred to them as a combined category, including Pacific Islanders by name without providing separate frequency counts. These reporting conventions challenge efforts to consistently disaggregate the data. Where there are separate counts available, we also include them in the total Indigenous heritage category (see Supplemental Table 1).

Figure 2

Number of Empirical and Nonempirical Reports by REMI Category by Decade



Note: AAPI= Asian or Pacific Islander heritage; BL/AFR= Black/African heritage; LATX= Latinx, Hispanic, Mexican, Central or South American heritage; MENA= Middle Eastern, North African, Arab heritage; NA/I = Native, Aboriginal, First Nations, other Indigenous heritage; IMM= Immigrant; MULTI= Multiethnic or Multiracial; REMI (unspecified)= referring to REMI providers as a whole

Mental Health Discipline/Provider Type

Suppl Table 2 presents the training background or discipline for the REMI providers in each record. Nearly 1 in 4 records (23.02%) referred generically to REMI "therapists" or "clinicians". Of those designated by discipline, psychology was the most represented (31.16%), followed by counseling (20.47%), social work (16.51%), psychiatry (13.37%), and psychoanalysis (7.67%). Of note, 4.42% referred to REMI clinicians used as stimuli (in analogue studies) or as a response option (as in client preferences studies). Indigenous mental health care workers (1.63%) accounted for a tiny fraction.

Geographic Region

The majority (*n*= 724, 84.2%) of articles focused on REMI providers in the U.S., with another 3.6% in Canada. Of the remaining, 41 (4.8%) articles focused on REMI providers in Europe, 23 (2.7%) in Oceania (e.g., New Zealand, Australia), 21 (2.4%) in the Middle East, 10 (1.2%) in Africa, 4 (.5%) in Asia, 1 (.1%) in Central America, 1 (.1%) in South America, and 7 (0.8%) adopting a global perspective.

Publication Outlets

Of the 860 reports, 148 (17.2%) were book chapters and 712 (82.8%) were articles published in 64 books and 248 journals (see Suppl Table 3). Fourteen journals published 10 or more articles featuring REMI providers (32.6% of all articles). Six of the 14 were counseling psychology journals, 3 had a multicultural focus, 2 were in social work, 2 in general psychology or psychotherapy, 1 in community mental health, and 1 in psychiatry. *Journal of Counseling Psychology* published the highest number (6.3% of all articles), followed by *Journal of Multicultural Counseling & Development* (3.4%).

Narrative Review of Themes by Decade

The 1960s

As the Vietnam War intensified, the 1960s saw the emergence of an anti-establishment counterculture, coalitional politics, and Civil Rights Movement. In 1968, the Association of Black Psychologists (ABPsi) was founded, just months after the assassination of Dr. Martin Luther King, Jr. The

psychiatrist Alvin Poussaint condemned both psychoanalysis and psychiatry for supporting the status quo: “Finally, too many mental health workers incline to help Blacks ‘adapt’ and ‘adjust’ to their situation or otherwise attempt to ‘soothe’ them, at the same time that they do little to eliminate racism in our society--or even in their own hospitals and practices” (Poussaint, 1969, p. 944).

During this period, scholarship on REMI clinicians focused almost exclusively on Black Americans, referred to in the literature as “Negro,” a term dropped from the U.S. Census in 2013. Several articles highlighted their underrepresentation in the field. One study found that from 1920 to 1966, less than 1% of doctorates issued by the top 25 U.S. psychology programs were awarded to Black individuals (Wispe et al., 1969). Nearly half said that race had hindered their professional opportunities. Further, only 27% were members of the APA. One wrote: “I have never been active in the APA, since I have always felt it was part of the white academic club. Besides, ghetto colleges don’t know what it [APA] means, and usually don’t even know what psychology means” (Wispe at al., 1960, p. 149).

Psychoanalytic writings described race as eliciting an unconscious response in White patients, which may impede or catalyze therapy. Resistances, fantasies, and fears in response to Black therapists were attributed to unconscious associations with Blackness that include “darkness,” “death,” “evil”, and “Satan” and “Judas” (Curry, 1964). Conversely, positive regard was associated with stereotypes such as the “mammy” (Grier, 1967) and traits of “sexual potency” and “strength” (Schachter & Butts, 1968).

A few articles examined interracial dynamics using experimental designs. In the most cited article of the 1960s, Banks et al. (1967) found a preference for Black counselors among Black clients, while Womack (1967) found no racial differences in patient comfort with Black or White psychiatrists. Critiquing Eurocentric models of care, Wade et al., (1969) described the Harlem Rehabilitation Center’s anti-establishment approach: “There are many black people who are the Walking Dead, dead in mind and spirit. We intend to bring them back to life and give them their souls” (p. 683).

The 1970s

The 1970s continued to center Black Americans in the mental health professions, while expanding to include those from Asian, Latinx and Indigenous backgrounds. A watershed event was the publication of Dr. Joseph White's (1970) article, "Towards a Black Psychology" in *Ebony,* in which he envisioned a field that would challenge deficit views of Black people and center a Black frame of reference. The broad radicalization of other REMI groups was evident in ethnic and coalitional organizing (e.g., the Third World Liberation Front), which led to the founding of the the National Association for Ethnic Studies in 1972. That same year, the Asian American Psychological Association was created in the San Francisco Bay Area and three years later, the Society of Indian Psychologists was formed in 1975.

The violence of the Tuskegee Syphilis Study, discovered in the early 1970s, deepened medical mistrust among Black Americans and created an ethical imperative to develop Black-centered systems of care. Lawrence (1972) described one program: "There is a black psychiatrist—a rather rare commodity...There are two black social workers who, although trained in white institutions, have been away long enough to now be effective with their black clients. There are a variety of staff members with anywhere from a college education to having completed third grade. But, most important, is the idea that the staff, which is 90 percent black is, for the most part, indigenous to the community" (p. 58).

Whereas professional competence was important, the credibility of Black clinicians was linked to their authentic engagement with community concerns. Banks (1975) wrote, "..in order to authenticate his/her role as a therapist, he/ she should be actively involved in the educational, political, and cultural life of different kinds of blacks….It is not too much to ask that the therapist, in day-to-day living, keep a finger on the pulse of the several black subcultures by visiting barbershops, colleges, churches, bars, and other hangouts and meeting places of black people" (p. 471). Banks also recognized the assimilative pressures to adopt White cultural values and their potential harms: "If the Black therapist has succumbed to white cultural standards and values and becomes a caricature of white middle class respectability, he will bring into the therapeutic encounter his own biases and aspirations, which may

different widely from those of his patient" (p. 471). Shared cultural values and language were also found to be critical for Asian and Hispanic immigrant clients (Atkinson et al., 1978; Furlong et al., 1979). Yet the lack of REMI providers required novel solutions to meet community needs (Lindberg & Wrenn, 1972).

The 1980s

The 1980s saw modest growth in the REMI workforce but little research about issues they were facing. Only 3.1% of APA members identified as REMI, including Blacks (1.2%), Asians (1.0%), Hispanics (0.7%), and American Indians (0.2%) (Russo et al., 1981). Psychiatry was more diverse, with Asian and Hispanic graduates from foreign medical schools comprising 6.8% and 3.4%, respectively, of American Psychiatric Association members (Munoz & Madigan, 1986). Yet, Casas, Furlong, and Castillo (1980) noted that "research with respect to the ethnic minority helping professional is almost totally lacking" (p. 365). Their survey of 71 Black, Hispanic, and Asian counselors found significant stressors including a) "lack of sensitivity of the nonminority staff", b) "expectations that minority counselors can speak for and to all minority problems", and c) "lack of institutional support for minority programs" (p. 367).

Ethnic Matching and Counselor Preference, Treatment Outcome, and Clinical Judgment. More than 40% of records from the 1980s examined whether racial/ethnic matching was preferred by clients and conferred any clinical benefits. Compared to other groups, Black Americans were more likely to prefer racially similar therapists and to terminate from therapy when matched with a White therapist (Terrell & Terrell, 1984). Expanding the focus to Hispanic (Franco & LeVine, 1980), Asian (Lee et al., 1983) and indigenous clients and counselors (Uhlemann et al., 1988) revealed the effects of culture, language, and context on perceptions of therapists. A study of Mexican, Black, Vietnamese, and Filipino American clients found that three "culture-compatibility components" predicted treatment retention: language match, ethnic/racial match, and agency location in ethnic communities (Flaskerud, 1986).
Although matching was weakly associated with treatment outcome, it was found to affect therapy process through clinical judgment processes (Li-Repac, 1980), and in-session behavior (Fry et al., 1980).

Clinical Perspectives on Racialization. The racialization of REMI clinicians was found to shape clinical practice in diverse ways. Black psychologists described themselves as more aware of racial issues in treatment and more able to tailor treatment accordingly, compared to White psychologists (Turner & Armstrong, 1981). Psychoanalytic reports described client devaluation, aggression, and fear towards REMI analysts as well as idealization, identification, and attachment (Mayes & Soth, 1986; Tung, 1981).

The Emergence of Indigenous and Culturally-Affirmative Perspectives. Finally, a vocal minority advocated for a radical re-imagining of clinical practice models that were liberated from racist assumptions (Fullilove et al., 1986), privileged indigenous perspectives, and grounded in culturally-relevant, community-informed services (Arce, 1982; Timpson, 1983). Baldwin (1989) argued that "we Black psychologists, by and large, have functioned in the service of the continued oppression and/or enslavement of Black people rather than in the service of their liberation from Western oppression and positive Black mental health" (p. 67). Afrocentric practice models asserted that the Black cultural values anathema to White society were in fact essential for their adaptation and survival (Jackson, 1983).

The 1990s

While English-language reports on REMI clinicians outside the North American context remained rare, Nicholas (1990) examined the South African context of practice in the waning days of apartheid. He connected the stark underrepresentation of Black psychologists in South Africa (<10% of psychologists in 1989 despite being 79% of the population) to systematic gatekeeping efforts by the two leading psychological associations in South Africa, who, he argued, "have yet to acknowledge their roles, historically, and currently, in perpetuating apartheid (p. 63)".

Early Explorations of Intersectionality. The growing diversity of the US mental health workforce was reflected in articles that explored the effects of ethnocultural similarity and difference on therapy process, including transference and countertransference reactions (Braveheart-Jordan & DeBruyn, 1995;

Comas-Díaz & Jacobsen, 1991). Adopting what would later be referred to as an *intersectional perspective* (Crenshaw, 1989), authors explored how racism intersected with sexism (Chao, 1995), classism (Ferguson & King, 1997) and heteronormativity (Sears, 1990) to affect practice. In her essay "On being an "only" one", Sears (1990) described the responsibilities and expectations she faces as "the only Native American lesbian feminist therapist living in a three-state area" (p. 102).

Mirroring this trend, research on client-therapist matching progressed to integrate identity characteristics beyond ethnicity. Sue et al.'s (1991) landmark study examined the effects of ethnic, gender, and language matching on treatment outcomes in more than 230,000 Asian-American, African-American, Mexican-American, and White outpatients in the Los Angeles County Mental Health system.

Therapy Process and the REMI Clinician. With growing evidence of the benefits (and limits) of ethnic and language matching, scholars dissected the complex dynamics that can arise in diverse dyads. Addressing historical trauma in Native Americans, Braveheart-Jordan and DeBruyn (1995) noted, "Issues of cultural competence apply not only to the non-Native therapist, but to the Native therapist as well. Such is particularly true when a Native therapist is working in a community other than his or her own, especially if the client's tribe had a historically adversarial relationship with one's own tribe. This situation could potentially interfere with the development of the therapeutic relationship" (p. 356). Similarly, Bracero (1998) explored how rigid sex roles and sexism may lead to enactments of *machismo* and *marianismo* dynamics and threaten the alliance in Latina client-Latino therapist dyads.

The 2000s

From 2000-2009, ethnic minorities in the U.S. increased from 30.6% to 35.7% with the largest growth in the Hispanic/Latino population (16.1% in 2009). In 2002, the National Latino Psychological Association was created. The 9/11 attacks and the 2008 election of the first non-White U.S. president, Barack Obama, sparked debates about what it means to be "American". The *narrative turn* in the social

sciences was reflected in an increase in qualitative and narrative reports in this decade.

Increased Visibility of REMI Clinicians of MENA Decent. Studies of REMI clinicians of MENA heritage increased to 22 in the 2000s compared to 3 total in the decades prior. Most were conducted in Israel during the 2nd Intifada, a period of heightened violence in the Israeli-Palestinian conflict. One study of 58 Israeli Arab and Jewish social workers found high levels of stress and tension, and the impossibility of maintaining boundaries between the personal, the professional, and the political (Ramon, 2004). Arab social workers expressed greater frustration and rejection by Jewish social workers.

The terrorist attacks on September 11, 2001 fueled a 500% increase in hate crimes towards Americans of Arab and South Asian descent (Crawford et al., 2021). Yet few reports from this time examined experiences of MENA American clinicians. One exception was Abudabbeh (2008), a Palestinian American Muslim psychologist, who wrote: "As time has passed since 9/11, I seem to have moved closer to my secular Islamic identity … while becoming more strongly attached to my Muslim identity... It is so much a part of who I am to identify with the underprivileged and mistreated that the more my adopted country targeted Islam, the more I had to lift my head high to declare my Islamic identity" (p. 209).

Explorations of Cultural Tensions and Training Needs. Studies of REMI providers, especially immigrant and indigenous providers, identified a core conflict between their more collectivist values and the Western individualism that dominated their clinical training (Akhtar, 2006). A study of Mäori psychiatrists and registrars in New Zealand described the tension between the emphasis in psychiatry training on the "opacity" of the doctor and the Mäori value of whakawhänaungatanga (connectedness), which was crucial to their ability to engage the community. One noted, "'…it was expected. And that was part of who you are and who your whänau [families] are and who your ancestors were ... and people would say ''now we can place you- now we know who you are- now we can get on with the clinical bit'' but if you didn't do the other bit properly first, you never really got to the clinical bit'' (p. 201).

A grounded theory study by Yan (2008) explored cultural tensions experienced by 30 REMI social

workers in Canada. Given their cultural values, roles within systems of power, and experiences of discrimination, the author argued that social workers must be aware of how their socio-organizational positioning can be politicized. Salazar et al.'s (2004) study of counseling educators of color found that the meanings that powerful others attached to their identities affected their level of acceptance or exclusion, the credibility given to their ideas, and the institutional investment and support they received.

A common refrain was that REMI trainees need better preparation and support to navigate the cultural conflicts between their professional training and their cultural identities. The stated goal was not cultural assimilation, but rather affirmation and empowerment to draw on cultural strengths to improve quality of mental health services (Bell-Tolliver & Wilkerson, 2011; Taniguchi, 2005).

The 2010s

The global spread of social media throughout the 2010s contributed to both social justice organizing and increased political polarization. Radical resistance movements, including the Arab Spring and Black Lives Matter, gained popular support for their efforts to expose and dismantle exploitative government and social policies. But by the mid-2010s, there was a growing backlash against the political, economic, and sociocultural changes resulting from globalization. Support for neo-nationalist policies expanded across the US and Europe, signaled by the election of Donald Trump and the passage of Brexit. In the U.S., investments in diversity, equity, and inclusion initiatives in workplaces and educational settings were met with counterresistance efforts from White conservative groups, which brought critical race theory and concepts such as intersectionality and racial microaggressions into the mainstream.

Coping with Racism in Professional Spaces. The modestly expanding literature on REMI mental health professionals confirmed the pervasiveness of racial microaggressions and discrimination across practice contexts (Delapp & Williams, 2015). Turkish and Moroccan social workers in the Netherlands described instances of Islamophobia from clients and colleagues (Hendriks & van Ewijk, 2017). Aboriginal mental health workers in Australia reported difficulties being accepted into the organization, feeling like

their roles were “tokenistic” and that they were less valued (Cosgrave et al., 2017).

Despite both being African American women therapists, Kelly and Greene (2010) noted that differences in their physical appearance and skin tone, client base, and sexual orientation affected the way clients interacted with them. Strategies used to cope with racism in practice settings included having a professional support system, understanding what one’s identities may evoke in clients, using nonreactive questioning to challenge microaggressions, engaging clients in cultural dialogues and race talk, and setting boundaries to prioritize one’s well-being (Guiffrida et al., 2019; Kelly & Greene, 2010).

Centering Black Psychology and Immigrant Perspectives to Counter Eurocentrism and White Supremacy in Clinical Training, Supervision, and Practice. Echoing critiques stretching back now decades, Powell (2018) argued that “the fields of clinical psychology and psychoanalysis are not free of culpability in contributing to America’s fraught racial past in a way that leaves lingering ripples in present society” (p. 1028). Continuing the decolonizing and antiracist traditions of their forebears, Black clinicians increasingly described supplementing their Eurocentric training with African-centered and intersectional frameworks “that assist Black women in discerning their personal struggles from the structural constraints of racism, sexism, classism, and homophobia, thereby moving their life situations from models of pathology to those of wellness” (p. 251-252; Jones & Harris, 2019).

Alongside developments in Black Psychology and intersectionality scholarship, immigrant clinicians described the challenges of negotiating multiple heritage cultures, bilingualism, racism, and xenophobia (Lin & Wiley, 2019; Mendoza et al., 2019). A Japanese American supervisor described her attempts to emulate White male psychologists in positions of power. However, mentoring by female supervisors allowed her to “witness their struggles, their process of self-examination, and more importantly their self-acceptance and confidence in being different” (p. 40, Okubo et al., 2014). They helped her see that her bicultural perspectives “are relevant, valuable, and need to be voiced” (p. 40).

Preparing a Workforce to Meet the Needs of a Globalizing World. Finally, in response to

large-scale migration, studies conducted in North America, Oceania, and Europe identified the need to strengthen workforce capacity to treat culturally and linguistically diverse (CALD) populations. In this context, bilingual and bicultural providers were seen as valuable assets that could improve treatment engagement (Guerrero et al., 2013). Yet, programs failed to provide adequate training to leverage these assets (Ho & O'Donovan, 2018). In an Australian mixed-methods study, multilingual psychologists reported minimal coverage of issues related to CALD populations in the curriculum and few multilingual supervision opportunities. Post-graduation, they learned to provide multilingual services "through trial-and-error" and researching translated tools and terminology on their own (Tan & Denson, 2019).

Recognizing the value of insider knowledge, many studies in the 2010s explored REMI providers' cultural beliefs and attitudes about treatment (e.g., Hartmann & Gone, 2016), in an effort to decolonize the process of intervention design (Nasir et al., 2017). As cultural experts, REMI practitioners helped identify challenges to service delivery in underserved groups, including undocumented immigrants from Mexico (Baranowski & Smith, 2018), Chinese immigrants in New York (Lin et al., 2018), refugees in Alberta, Canada (Salami et al., 2019), and Aboriginal parents in Western Australia (Munns et al., 2018).

Discussion

This scoping review described the representation, experiences, and practices of REMI mental health providers in the published literature across six decades. Given our focus on English-language studies, it was not surprising that the majority were conducted in the U.S., and that growth in the representation of Black, Asian, and Latinx providers mirrored changes in the U.S. population over time. However, the underrepresentation of indigenous clinicians and those of Arab, Middle Eastern or North African heritage remains a crucial gap that requires attention. Further, while multiracial providers were included in 7.4% of records, the samples were typically too small to permit further analysis.

Research and writings featuring REMI providers and perspectives were published primarily in books or journals in counseling psychology, multicultural psychology, and social work. Whereas one-third

were quantitative studies, 18% were qualitative or mixed-methods studies, and 50% were nonempirical, reflecting the field's early-stage emphasis on exploration, description, and theory development. Very few articles were published in the flagship psychology journals, reflecting and likely contributing to the marginalization of REMI provider issues and concerns in the field.

The narrative review of the literature found numerous indications that REMI clinicians are poorly served by the dominant training and practice models across mental health disciplines. Standard approaches have failed to systematically address the contexts of White supremacy, colonization, and Eurocentric, individualistic values that reproduce hierarchies in ways of knowing, requiring that REMI clinicians supplement their training through informal, ad hoc means. Critiques of racism and ethnocentrism in professional training and mental health practice and the call to decolonize mental health practice (although the terminology varied) appeared as early as the 1960s. However, these early writings have been rarely cited, leaving subsequent generations of REMI researchers and providers to re-discover these ideas on their own. Qualitative reports show that these insights are often born out of traumatic interactions with insensitive professors, supervisors, colleagues and clients. They arise out of quiet reflection, through conversations with mentors and chance encounters with research and writings by radical scholars and healers. Those who were able to record these learnings have allowed us to see the connections between our past, our present, and our future. They have laid the foundation for a new curriculum and training approach that integrates these perspectives, bringing them from the margins to the center, to bring our fields of practice into better alignment with social justice values and ethics.

As this scoping review demonstrates, the challenges faced by REMI clinicians– structural racism, race-related stress, cultural conflicts, and pressures to assimilate to Western values– produce a sense of internalized inferiority and dislocation from cultural strengths and healing wisdom of the Global Majority. At the same time, as clinics worldwide are becoming cultural environments of *hyperdiversity* due to increased migration (DelVecchio Good & Hannah, 2015), the cultural knowledge and multilingual

skills of REMI providers are needed now more than ever. Thus, we recommend that decolonizing practices informed by *critical consciousness* and *a global competency perspective* be infused in mental health education and training to expand our capacity to promote healing and liberation for all.

Decolonizing Approaches to Mental Health Training, Education, and Supervision for REMI Clinicians

Recent years have seen a growing number of scholars call for the decolonization of the academy. There is much debate about how to implement change so that it is meaningful rather than tokenistic; in general, those pushing for decolonization argue for root and branch change. This involves the use of anti-oppressive pedagogies that challenge hegemonic forms of instruction, evaluation, and knowledge production as well as a curriculum that centers non-Eurocentric voices and paradigms.

Goodman et al. (2015) listed five areas considered an essential part of the decolonization project within psychology: critical consciousness-raising as a goal of higher education; a curriculum interwoven with multiculturalism and social justice principles; pedagogies and practices that give voice to and empower those who are marginalized, while also cultivating meaningful self-reflection among trainees; community as central rather than peripheral to training; and lastly, political engagement. Cultural competence, they argue, along with notions of health and healing should all be congruent with a client's cultural values and norms. This same logic can be extended to training and supervision so that these arenas are similarly congruent with trainees' cultural backgrounds and perspectives.

The concept of critical consciousness was developed by the Brazilian educator Paulo Friere (1970) and describes a process through which oppressed groups learn to recognize and analyze the systems (e.g., racism, classism, sexism) that produce social inequity, and take action to change them. While the social work profession was first to integrate critical consciousness into its training approaches (see Keefe, 1980), psychology has more recently followed suit (see French et al, 2020). We view critical consciousness for REMI clinicians as a core process that strengthens their capacity to manage the stress and marginalization they face in the profession and become agents of change (Nadal, 2017)

While the concept of global competence has an array of contested meanings in the educational literature (Engel et al., 2019), here we emphasize a general orientation towards cultural pluralism versus cultural assimilation; investment in learning about local, global, and geopolitical issues that may affect our clients and intercultural relations; the capacity to engage in open, appropriate and effective interactions with people from different countries and cultures in all their complexity; and taking action to promote global mental health in an increasingly interconnected world. The construct of global competencies shifts attention to the cultural and linguistic *advantages* that REMI providers have in settings of hyperdiversity, emphasizing the value of bilingual and bicultural health communication skills and the ability to adapt one's practice interventions to CALD populations (Lin & Wiley, 2019).

Institutional, curricular, and supervisory supports are needed to cultivate REMI clinicians' critical consciousness and global competencies, resist pressures to "assimilate to White contexts and White ways of practicing psychotherapy" (Moon & Sandage, 2019), and develop a therapeutic stance that feels *authentic,* liberatory, and grounded in cultural and communal strengths. We offer the following recommendations to better meet the training needs of REMI clinicians in a globalizing world:

Awareness

1. **Provide opportunities for critical reflection and analysis** of oneself and others as shaped by local and global histories and structures of power and domination. Engaging trainees in exploring their family's history may surface messages of internalized inferiority and intergenerational trauma, while nurturing cultural and communal strengths, and fostering a positive cultural identity.
2. **Provide critical, postcolonial and resilience-based models of supervision** to not only challenge Eurocentric frameworks, but also nurture critical consciousness and authenticity so that REMI trainees can bring their whole selves into the supervisory and therapy spaces (Stege et al., 2020).
3. **Create separate spaces for REMI trainees and supervisees** to process their racial traumas, cultural conflicts, and acculturative stress, and find validation and support without needing to cater to

dominant group members' feelings or needs (Moon & Sandage, 2019).

Knowledge

4. **Consult with REMI providers, scholars, and healers for guidance to de-colonize and globalize the training curriculum.** De-center White, Eurocentric perspectives and expand exposure to global, Afro-centered, and indigenous views, theories, practices, and interventions to promote holistic healing.
5. **Expand education and training regarding spirituality and religion,** which is a source of meaning and belonging for many people of the Global Majority, including REMI clinicians (Bell-Tolliver & Wilkerson, 2011). Empower clinicians to integrate cultural and indigenous healing traditions into work with clients who share their backgrounds, as appropriate (O'Keefe et al., 2021).

Skills

6. **Provide education and training in bilingual counseling and supervision** (e.g., language switching, professional terminology) to leverage clinicians' language and cultural communication skills (Kapasi & Melluish, 2015). For providers who are not fluent, provide opportunities to strengthen language skills and learn to work with interpreters to communicate more effectively with CALD populations.
7. **Develop REMI providers' capacity to attune to and analyze cultural conflicts** that may arise between their own culture, the culture of the client, the clinical setting, and the broader country context. Develop skills for repairing cultural ruptures to strengthen the alliance (Chang et al., 2023).
8. **Provide opportunities to critique therapeutic techniques typically aimed at promoting cultural competence for White providers.** Explore how practices such as cultural humility and broaching race and cultural difference may require adaptation for REMI providers in racially similar and dissimilar pairings (Bayne & Branco, 2018; Moon & Sandage, 2019).
9. **Provide training in self-advocacy and critical action** to respond to discrimination, advocate for marginalized clients and communities, and promote equity in systems of care (Nadal, 2017).

References

Abudabbeh, N. (2008). My evolving identity from Arab to Palestinian to Muslim. In M. McGoldrick & K. V. Hardy (Eds.), *Re-visioning family therapy: Race, culture, and gender in clinical practice (2nd ed.)* (p. 204). Guilford Press.

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

Akhtar, S. (2006). Technical challenges faced by the immigrant psychoanalyst. *The Psychoanalytic Quarterly*, *LXXV*(1), 21–43. https://doi.org/10.1002/j.2167-4086.2006.tb00031.x

American Psychological Association [APA] (2021, Oct). *Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S.* https://www.apa.org/about/policy/resolution-racism-apology.pdf

Arce, A. A. (1982). Psychiatric training issues: The Puerto Rican perspective. *The American Journal of Psychiatry*, *139*(4), 461–465.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). Effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology*, *25*(1), 76–83. https://doi.org/10.1037/0022-0167.25.1.76

Baldwin, J. A. (1989). The role of Black psychologists in Black liberation. *The Journal of Black Psychology*, *16*(1), 67–76.

Banks, G., Berenson, B. G., & Carkhuff, R. R. (1967). The effects of counselor race and training upon counseling process with Negro clients in initial interviews. *Journal of Clinical Psychology*, *23*(1), 70–72. https://doi.org/10.1002/1097-4679(196701)23:1<70::aid-jclp2270230120>3.0.co;2-o

Banks, H. C. (1975). The Black person as client and as therapist. *Professional Psychology*, *6*(4), 470–474.

https://doi.org/10.1037/0735-7028.6.4.470

Baranowski, K. A., & Smith, L. (2018). Working with undocumented immigrants from Mexico: Experiences of practitioners in New Mexico and Texas. *Professional Psychology, Research and Practice*, *49*(3), 185–192. https://doi.org/10.1037/pro0000191

Bayne, H. B., & Branco, S. F. (2018). A phenomenological inquiry into counselor of color broaching experiences. *Journal of Counseling & Development*, *96*(1), 75–85. https://doi.org/10.1002/jcad.12179

Bell-Tolliver, L., & Wilkerson, P. (2011). The use of spirituality and kinship as contributors to successful therapy outcomes with African American families. *Journal of Religion & Spirituality in Social Work: Social Thought*, *30*(1), 48–70. https://doi.org/10.1080/15426432.2011.542723

Bennett-levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., Budden, W., & Beale, D. (2014). Can CBT be effective for aboriginal Australians? Perspectives of aboriginal practitioners trained in CBT. *Australian Psychologist*, *49*(1), 1–7. https://doi.org/10.1111/ap.12025

Bracero, W. (1998). Intimidades: Confianza, gender, and hierarchy in the construction of Latino–Latina therapeutic relationships. *Cultural Diversity and Mental Health*, *4*(4), 264–277. https://doi.org/10.1037/1099-9809.4.4.264

Braveheart-Jordan, M., & DeBruyn, L. (1995). So she may walk in balance: Integrating the impact of historical trauma in the treatment of Native American Indian women. In J. Adleman & G. M. Enguídanos (Eds.), *Racism in the lives of women* (pp. 345–367). The Haworth Press, Inc.

Buchanan, N. T., Perez, M., Prinstein, M. J., & Thurston, I. B. (2021). Upending racism in psychological science: Strategies to change how science is conducted, reported, reviewed, and disseminated. *The American Psychologist*, *76*(7), 1097–1112. https://doi.org/10.1037/amp0000905

Casas, J. M., Furlong, M. J., & Castillo, S. (1980). Stress and coping among university counselors: A minority perspective. *Journal of Counseling Psychology*, *27*(4), 364–373. https://doi.org/10.1037/0022-0167.27.4.364

Chang, D. F., Omidi, M., & Dunn, J. J. (2023). Antioppressive approaches to alliance rupture and repair: A critical–cultural–relational model of rupture resolution. In C. F. Eubanks (Ed.), *Rupture and repair in psychotherapy: A critical process for change* (pp. 21–52). American Psychological Association.

Chao, C. M. (1995). A bridge over troubled waters: Being Eurasian in the U.S. of A. In J. Adleman & G. M. Enguídanos (Eds.), *Racism in the lives of women* (pp. 33–43). The Haworth Press, Inc.

Comas-Díaz, L. (2005). Becoming a multicultural psychotherapist: The confluence of culture, ethnicity, and gender. *Journal of Clinical Psychology*, *61*(8), 973–981. https://doi.org/10.1002/jclp.20170

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry*, *61*(3), 392–402. https://doi.org/10.1037/h0079267

Cosgrave, C., Maple, M., & Hussain, R. (2017). Factors affecting job satisfaction of Aboriginal mental health workers working in community mental health in rural and remote New South Wales. *Australian Health Review*, *41*(6), 707–711. https://doi.org/10.1071/AH16128

Crawford, N. C., Graves, L., & Katzenstein, J. (2021, June). *Racial Profiling and Islamophobia*. Brown University, The Costs of War. https://watson.brown.edu/costsofwar/costs/social/rights/profiling

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), 8.

Curry, A. E. (1964). Myth, transference and the Black psychotherapist. *Psychoanalytic Review*, *51*

Delapp, R. C. T., & Williams, M. T. (2015). Professional challenges facing African American psychologists: The presence and impact of racial microaggressions. *The Behavior Therapist*, *38*(4), 101–105.

DelVecchio Good, M.-J., & Hannah, S. D. (2015). “Shattering culture”: Perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry*, *52*(2), 198–221. https://doi.org/10.1177/1363461514557348

Elder, H. (2008). Ko wai ahau? (Who am I?) How cultural identity issues are experienced by Maori psychiatrists and registrars working with children and adolescents. *Australasian Psychiatry*, *16*(3), 200–203. https://doi.org/10.1080/10398560701875199

Eliassi, B. (2017). Conceptions of immigrant integration and racism among social workers in Sweden. *Journal of Progressive Human Services*, *28*(1), 6–35. https://doi.org/10.1080/10428232.2017.1249242

Engel, L. C., Rutkowski, D., & Thompson, G. (2019). Toward an international measure of global competence? A critical look at the PISA 2018 framework. *Globalisation, Societies and Education*, *17*(2), 117–131. https://doi.org/10.1080/14767724.2019.1642183

Fanon, F. (2008). *Black Skin, White Masks*. Grove Press.

Ferguson, S. A., & King, T. C. (1997). There but for the grace of God: Two Black women therapists Explore Privilege. *Women & Therapy*, *20*(1), 5–14. https://doi.org/10.1300/J015v20n01_02

Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, *22*(2), 127. https://doi.org/10.1007/BF00754551

Franco, J. N., & LeVine, E. S. (1980). An analogue study of counselor ethnicity and client preference. *Hispanic Journal of Behavioral Sciences*, *2*(2), 177-183.

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

Friere, P. (1970). *Pedagogy of the Oppressed*. Continuum.

Fry, P. S., Kropf, G., & Coe, K. J. (1980). Effects of counselor and client racial similarity on the counselor's response patterns and skills. *Journal of Counseling Psychology*, *27*(2), 130–137. https://doi.org/10.1037/0022-0167.27.2.130

Fullilove, M. T., Carter, K., & Eversley, R. (1986). Family therapy for Black patients. *The American Journal of*

Social Psychiatry, *6*(1), 62–68.

Furlong, M. J., Atkinson, D. R., & Casas, J. M. (1979). Effects of counselor ethnicity and attitudinal similarity on Chicano students' perceptions of counselor credibility and attractiveness. *Hispanic Journal of Behavioral Sciences*, *1*(1), 41–53.

Goode-Cross, D. T., & Grim, K. A. (2016). "An unspoken level of comfort": Black therapists' experiences working with Black clients. *The Journal of Black Psychology*, *42*(1), 29–53. https://doi.org/10.1177/0095798414552103

Goodman, R. D., Williams, J. M., Chung, R. C.-Y., Talleyrand, R. M., Douglass, A. M., McMahon, H. G., & Bemak, F. (2015). Decolonizing traditional pedagogies and practices in counseling and psychology education: A move towards social justice and action. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing "multicultural" counseling through social justice* (pp. 147–164). Springer New York.

Grier, W. H. (1967). When the therapist is Negro: Some effects on the treatment process. *American Journal of Psychiatry*, *123*(12), 1587–1592. https://doi.org/10.1176/ajp.123.12.1587

Guerrero, E. G., Khachikian, T., Kim, T., Kong, Y., & Vega, W. A. (2013). Spanish language proficiency among providers and Latino clients' engagement in substance abuse treatment. *Addictive Behaviors*, *38*(12), 2893–2897. https://doi.org/10.1016/j.addbeh.2013.08.022

Guiffrida, D., Tansey, M., & Miller, D. (2019). A constructive approach to help counselors work with clients who express discriminatory views. *Journal of Counseling & Development*, *97*(1), 105–112. https://doi.org/10.1002/jcad.12240

Hartmann, W. E., & Gone, J. P. (2016). Psychological-mindedness and American Indian historical trauma: Interviews with service providers from a Great Plains Reservation. *American Journal of Community Psychology*, *57*(1-2), 229–242. https://doi.org/10.1002/ajcp.12036

Hendriks, P., & van Ewijk, H. (2017). To have voice and choice: Turkish and Moroccan Dutch professionals in social work. *International Social Work*, *60*(3), 720–732. https://doi.org/10.1177/0020872816651705

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *The Behavioral and Brain Sciences*, *33*(2-3), 61–83. https://doi.org/10.1017/S0140525X0999152X

Ho, N. K. N., & O'Donovan, A. (2018). An exploration of the experiences of culturally and/or linguistically diverse trainee psychologists in Australian postgraduate programs. *Australian Psychologist*, *53*(6), 493–504. https://doi.org/10.1111/ap.12353

Hoppe, T.A., Litovitz, A., Willis, K.A., Meseroll, R.A., Perkins, M.J., Ian Hutchins, B., Davis, A.F., Lauer, M.S., Valantine, H.A., Anderson, J.M.,… & Santangelo, G.M. (2019). Topic choice contributes to the lower rate of NIH awards to African-American/black scientists. *Science Advances*, *5*(10). https://doi.org/10.1126/sciadv.aaw7238

Jackson, A. M. (1983). Treatment issues for Black patients. *Group Dynamics: Theory, Research, and Practice*, *20*(2), 143–151. https://doi.org/10.1037/h0088485

Jones, L. V., & Harris, M. A. (2019). Developing a Black feminist analysis for mental health practice: From theory to praxis. *Women & Therapy*, *42*(3-4), 251–264. https://doi.org/10.1080/02703149.2019.1622908

Kapasi, Z., & Melluish, S. (2015). Language switching by bilingual therapists and its impact on the therapeutic alliance within psychological therapy with bilingual clients: A systematic review. *International Journal of Culture and Mental Health*, *8*(4), 458–477. https://doi.org/10.1080/17542863.2015.1041994

Keefe, T. (1980). Empathy skill and critical consciousness. *Social Casework*, *61*(7), 387–393.

Kelly, J. F., & Greene, B. (2010). Diversity within African American, female therapists: Variability in clients' expectations and assumptions about the therapist. *Psychotherapy: Theory, Research, Practice, Training*, *47*(2), 186–197. https://doi.org/10.1037/a0019759

Lawrence, L. E. (1972). On the role of the Black mental health professional. *American Journal of Public Health*, *62*(1), 57–59. https://doi.org/10.2105/ajph.62.1.57

Lee, D. Y., Sutton, R., France, M. H., & Uhlemann, M. (1983). Effects of counselor race on perceived

counseling effectiveness. *Journal of Counseling Psychology*, *30*(3), 447–450. https://doi.org/10.1037/0022-0167.30.3.447

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation Science: IS*, *5*, 69. https://doi.org/10.1186/1748-5908-5-69

Limb, G. E., & Organista, K. C. (2003). Comparisons between Caucasian students, students of color, and American Indian students on their views on social work's traditional mission, career motivations, and practice preferences. *Journal of Social Work Education*, *39*(1), 91–109. https://doi.org/10.1080/10437797.2003.10779121

Lin, C.-H., Chiang, P. P., Lux, E. A., & Lin, H.-F. (2018). Immigrant social worker practice: An ecological perspective on strengths and challenges. *Children and Youth Services Review*, *87*, 103–113. https://doi.org/10.1016/j.childyouth.2018.02.020

Lin, C.-H., & Wiley, A. R. (2019). Enhancing the practice of immigrant child welfare social workers in the United States. *International Social Work*, *62*(2), 595–611. https://doi.org/10.1177/0020872817742697

Lindberg, R. E., & Wrenn, C. G. (1972). Minority teachers become minority counselors. *The Personnel and Guidance Journal*, *50*(5), 371–376. https://doi.org/10.1002/j.2164-4918.1972.tb03892.x

Lin, L., Stamm, K., & Christidis, P. (2018). Demographics of the US Psychology Workforce: Findings from the 2007-16 American Community Survey. *American Psychological Association Center for Workforce Studies: Washington, DC, USA*. https://nces.ed.gov/FCSM/pdf/F3_Lin_2018FCSM.pdf

Li-Repac, D. (1980). Cultural influences on clinical perception: A Comparison between Caucasian and Chinese-American therapists. *Journal of Cross-Cultural Psychology*, *11*(3), 327–342. https://doi.org/10.1177/0022022180113006

Martín-Baró, I. (1994). Toward a liberation psychology. *Writings for a Liberation Psychology*, 17–32.

Mayes, S., & Soth, N. (1986). Cross-racial psychotherapy with the borderline patient: Should the patient fire the therapist? *Journal of Contemporary Psychotherapy*, *16*(2), 107–114.

https://doi.org/10.1007/BF00947163

Mendoza, N. S., Lechuga-Peña, S., Lopez, K., & Jackson, K. F. (2019). “Mi’jita, what for?” Exploring bicultural identity of Latina/Chicana faculty and implications for supporting Latinx students in social work. *Affilia*, *34*(2), 259–276. https://doi.org/10.1177/0886109918806278

Moon, S. H., & Sandage, S. J. (2019). Cultural humility for people of color: Critique of current theory and practice. *Journal of Psychology and Theology*, *47*(2), 76–86.

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2018). Aboriginal parent support: A partnership approach. *Journal of Clinical Nursing*, *27*(3-4), e437–e450. https://doi.org/10.1111/jocn.13979

Munoz, R. A., & Madigan, M. (1986). Graduates of foreign medical schools in American psychiatry. *Hospital & Community Psychiatry*, *37*(10), 1021–1024. https://doi.org/10.1176/ps.37.10.1021

Nadal, K. L. (2017). “Let’s get in formation”: On becoming a psychologist–activist in the 21st century. *The American Psychologist*, *72*(9), 935–946. https://doi.org/10.1037/amp0000212

Nasir, B., Kisely, S., Hides, L., Ranmuthugala, G., Brennan-Olsen, S., Nicholson, G. C., Gill, N. S., Hayman, N., Kondalsamy-Chennakesavan, S., & Toombs, M. (2017). An Australian Indigenous community-led suicide intervention skills training program: Community consultation findings. *BMC Psychiatry*, *17*(1), 219. https://doi.org/10.1186/s12888-017-1380-5

Nicholas, L. J. (1990). The response of South African professional psychology associations to apartheid. *Journal of the History of the Behavioral Sciences*, *26*

O’Keefe, V. M., Cwik, M. F., Haroz, E. E., & Barlow, A. (2021). Increasing culturally responsive care and mental health equity with indigenous community mental health workers. *Psychological Services*, *18*(1), 84–92. https://doi.org/10.1037/ser0000358

Okubo, Y., Sneed, R., Sasaki, C., & Duong, H. (2014). Training Asian female students in community mental health: Reflection on our multiple identities as supervisors. *Women & Therapy*, *37*(1-2), 36–45. https://doi.org/10.1080/02703149.2014.850332

Padayachee, P., & Laher, S. (2014). South African Hindu psychologists' perceptions of mental illness. *Journal of Religion and Health*, *53*(2), 424–437. https://doi.org/10.1007/s10943-012-9646-1

Poussaint, A. F. (1969). Racism and psychiatry. *International Journal of Psychiatry*, *8*

Powell, D. R. (2018). Race, African Americans, and psychoanalysis: Collective silence in the therapeutic situation. *Journal of the American Psychoanalytic Association*, *66*(6), 1021–1049. https://doi.org/10.1177/0003065118818447

Ramon, S. (2004). The Impact of the 2nd Intifada on Israeli Arab and Jewish Social workers. *European Journal of Social Work*, *7*(3), 285–303. https://doi.org/10.1080/1369145042000291788

Richards, T.W. (1956). Graduate education of Negro psychologists. *American Psychologist, 11*(7), 326-327.

Russo, N. F., Olmedo, E. L., Stapp, J., & Fulcher, R. (1981). Women and minorities in psychology. *The American Psychologist*, *36*(11), 1315–1363. https://doi.org/10.1037/0003-066X.36.11.1315

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. https://doi.org/10.1111/inm.12512

Salazar, C. F., Herring, R. D., Cameron, S. C., & Nihlen, A. S. (2004). Experiences of counselor educators of color in academe. *Journal of Professional Counseling: Practice, Theory & Research*, *32*(2), 42–57. https://doi.org/10.1080/15566382.2004.12033806

Salsberg, E., Quigley, L., Richwine, C., Sliwa, S., Acquaviva, K., & Wyche, K. (2020). *The social work profession: Findings from three years of surveys of new social workers*. Fitzhugh Mullan Institute for Health Workforce Equity, The George Washington University.

Schachter, J. S., & Butts, H. F. (1968). Transference and countertransference in interracial analyses. *Journal of the American Psychoanalytic Association*, *16*(4), 792–808. https://doi.org/10.1177/000306516801600407

Sears, V. L. (1990). On being an "only" one. In H. Lerman & N. Porter (Eds.), *Feminist ethics in*

psychotherapy (pp. 102–105). Springer.

Stege, A. M. R., Ramírez Stege, A. M., Chin, M. Y., & Graham, S. R. (2020). A critical postcolonial and resilience-based framework of supervision in action. *Training and Education in Professional Psychology*, *14*(4), 316–323. https://doi.org/10.1037/tep0000276

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *The American Psychologist*, *54*(12), 1070–1077. https://doi.org/10.1037/0003-066X.54.12.1070

Sue, S., Fujino, D. C., Hu, L.-T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*(4), 533–540. https://doi.org/10.1037/0022-006X.59.4.533

Taniguchi, N. (2005). From polarization to pluralization: The Japanese sense of self and Bowen theory. In M. Rastogi & E. Wieling (Eds.), *Voices of color: First-person accounts of ethnic minority therapists* (pp. 265–276). Sage Publications.

Tan, L. L., & Denson, L. (2019). Bilingual and multilingual psychologists practising in Australia: An exploratory study of their skills, training needs and experiences. *Australian Psychologist*, *54*(1), 13–25. https://doi.org/10.1111/ap.12355

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. *Journal of Counseling Psychology*, *31*(3), 371–375. https://doi.org/10.1037/0022-0167.31.3.371

Timpson, J. (1983). An indigenous mental health program in remote Northwestern Ontario: Development and training. *Canada's Mental Health*, *31*, 2-10.

Tinsley-Jones, H. A. (2001). Racism in our midst: Listening to psychologists of color. *Professional Psychology, Research and Practice*, *32*(6), 573–580. https://doi.org/10.1037/0735-7028.32.6.573

Tricco, A. C., Lillie, E., Zarin, W., & O'Brien, K. K. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine,* 467-473.

Tung, M. (1981). On being seen as a “Chinese therapist” by a Caucasian child. *The American Journal of Orthopsychiatry*, *51*(4), 654–661. https://doi.org/10.1111/j.1939-0025.1981.tb01412.x

Turner, S., & Armstrong, S. (1981). Cross-racial psychotherapy: What the therapists say. *Group Dynamics*, *18*(3), 375–378. https://doi.org/10.1037/h0088389

Uhlemann, M. R., Lee, D. Y., & France, H. (1988). Counsellor ethnic differences and perceived counselling effectiveness. *International Journal for the Advancement of Counselling*, *11*(4), 247–253. https://doi.org/10.1007/BF00117683

Wade, R., Jordan, G., & Myers, G. (1969). Sociopsychiatric rehabilitation in a Black urban ghetto: 3. The view of the paraprofessional. *The American Journal of Orthopsychiatry*, *39*(4), 677–683. https://doi.org/10.1111/j.1939-0025.1969.tb02461.x

White, J. L. (1970). Toward a Black psychology. *Ebony*, *25*, 44–53.

Willis, R., Pathak, P., Khambhaita, P., & Evandrou, M. (2017). Complexities of cultural difference in social care work in England. In *European Journal of Social Work* (Vol. 20, Issue 5, pp. 685–696). https://doi.org/10.1080/13691457.2016.1255597

Wispe, L., Awkard, J., Hoffman, M., Ash, P., Hicks, L. H., & Porter, J. (1969). The Negro psychologist in America. *The American Psychologist*, *24*(2), 142–150. https://doi.org/10.1037/h0027107

Womack, W. M. (1967). Negro interviewers and White patients. *Archives of General Psychiatry*, *16*(6), 685. https://doi.org/10.1001/archpsyc.1967.01730240041007

Wood, N., & Patel, N. (2017). On addressing “Whiteness” during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291.

Yan, M. (2008). Exploring cultural tensions in cross-cultural social work practice. *Social Work*, *53*(4), 317-328.

Zárate, M. A., Hall, G. N., & Plaut, V. C. (2017). Researchers of color, fame, and impact. *Perspectives on Psychological Science*, *12*(6), 1176–1178. https://doi.org/10.1177/1745691617710511