Exploring Disparities Experienced by Black, Indigenous, People of Colour When Accessing Health-Related Services

by

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Abstract

Black, Indigenous, People of Colour (BIPOC) experience disproportionate disparities when they access colonial Canadian health and mental healthcare services. The colonial Canadian healthcare system contains systemic barriers throughout various institutional levels that perpetuate harm to BIPOC populations that are trying to access supports. Due to systemic inequities, many of these disparities and the extent of harm are under researched. To bridge this research gap, this capstone will through a literature review, explore inequities experienced by BIPOC populations when accessing colonial Canadian health-related services and expand on where some of these disparities originate from. It provides an in-depth review of the implications that cognitive behaviour therapy (CBT) has when utilized by psychotherapists without cultural sensitivity practices and awareness of inequities experienced by BIPOC populations. Furthermore, this capstone will explore potential ways to reduce and address these institutional disparities. Through systemic change at various levels from education of health-related professionals at the university level to the available cultural sensitivity training for healthcare professionals and holding larger institutions accountable for ensuring culturally safe practices there could be a reduction in disparities for BIPOC populations when accessing colonial healthcare services.

Keywords: BIPOC, cognitive behaviour therapy (CBT), cultural sensitivity, disparities, healthcare.

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Dedication

For my children, Cadence, Margaret, and Cedar.

May Cadence and Margaret see a world where they belong. My hope is that work like this shapes a world worthy of their brightness.

For Cedar, who did not get a chance to experience a full life, but who we carry every day.

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Chapter One: Introduction

In society we so often experience the 'Us' vs 'Them' mentality. It is so pervasive that it can spread from our social lives to our professional lives and can have a profound impact on people. This mentality has caused inequities within healthcare and mental healthcare settings. As recently as 2020 in the province of British Columbia (BC) a comprehensive review, led by Mary-Ellen Turpel-Lafond, regarding systemic racism towards Indigenous peoples throughout the medical system, was ordered by BC Health Minister Adrian Dix. The order was the result of an alleged 'Price is Right' game that some BC emergency department staff were playing regarding assumed alcohol levels for Indigenous patients (Turpel-Lafond et al., 2021). According to Turpel-Lafond et al. (2021) a BC survey indicated that a staggering 73% of Indigenous people had some kind of unsafe feeling while accessing healthcare services in BC. Turpel-Lafond's findings are not isolated to the discrimination of Indigenous peoples but expands more broadly to other ethnic minorities throughout various areas of the colonial Canadian and BC healthcare and mental healthcare systems.

The Canadian Mental Health Association (CMHA) Ontario indicated that freedom from discrimination and violence is one of most important social determinants of mental health for Canadians in Ontario (n.d.). They indicate that discrimination occurs when people are treated differently or excluded based on their "race, ethnicity, gender, sexual orientation, and/or disability" (CMHA, n.d.). CMHA Ontario indicates that those experiencing discrimination and violence have adverse experiences when they access health-related services. They further indicate that people facing these disparities have further negative mental health outcomes. Furthermore, as part of their ways to move forward, CMHA Ontario call on their provincial

government to promote inclusion, increase economic resources for those experiencing barriers, and create freedom from discrimination and violence.

It seems apparent that there are barriers for certain marginalized populations when they access Canadian medical services. Many components of the Canadian medical system are not designed to accommodate Black, Indigenous, People of Colour (BIPOC). Several aspects of the system itself are even structured to oppress these populations. It is present in the way that legislation, facility policies, social norms, and cultural representation are instituted throughout our health and mental healthcare facilities (Cooper Brathwaite et al., 2023). The social stratification of racialized peoples is embedded throughout all levels of government, healthcare, education, workplaces, and daily life and have been there for centuries (James, 2023). These systemic forms of oppression increase the disparities for BIPOC individuals as they access health-related facilities and supports. These systems often perpetuate the very issues that BIPOC individuals are seeking support for.

Purpose Statement

This paper will explore disparities that Black, Indigenous, People of Colour experience when they access Canadian health and mental healthcare services. It aims to provide an overview of the colonial Canadian health and mental healthcare system and how it affects those trying to access it. There will be a more in-depth focus on the British Columbia health services system. In addition, there will be a particular focus on whether there are disproportionate inequities for BIPOC individuals in accessing these services. Potential ways to reduce these disparities will also be explored.

Contributions to the Field and Significance

Though research has been expanding on disparities for BIPOC individuals as they access health-related services, the research does remain rather sparce. This capstone will explore how the available literature and expand on potential ways to reduce disparities for BIPOC populations accessing colonial Canadian health-related services. Since mental health services are deeply intertwined with our overall healthcare system it is necessary to explore disparities within the broader colonial Canadian health field. The intended audience for this research is counsellors, mental health professionals, healthcare professionals, policy makers, and anyone who works in a helping profession. It is intended to be informational and a potential resource for the intended audience.

Data Collection and Method of Analysis

Research for this paper will be done in the way of a systematic qualitative literature review of existing literature surrounding similar areas of healthcare, mental healthcare, disparities, and BIPOC populations. The majority of the reviewed literature will be accessed through computerized databases such as EBSCO and Google Scholar.

Topic Overview

In a concerted effort to reduce research bias, I initially specifically searched for articles using the keywords “disparities” and “accessing health care” without the additional assorted BIPOC keywords throughout any articles’ abstracts. For a vast majority of article results, they still had some variation of ethnic underpinnings. In an article by Leahy et al. (2021) they describe certain disparities for cancer patients when accessing mental healthcare. They indicate that a consistent barrier to cancer patients is the general stigma surrounding mental health. Furthermore, they mentioned that people with significant mental health difficulties (SMHD) and cancer have even greater challenges accessing care. SMHD include those with schizophrenia,

bipolar disorder, addictions, and other severe forms of psychological disorders. Part of their struggles come from the bias that many clinicians carry, which prevents these individuals from getting appropriate mental health treatments and even prevents cancer screenings. This disparity in diagnostic tests is higher than their counterparts without some kind of mental health struggle. Furthermore, Leahy et al. indicate that many clinicians admit to expecting that patients of all ethnicities within the SMHD category are unlikely to understand and follow treatment plans, thus creating additional barriers to their overall wellbeing and prognosis. These stigmas not only adversely affect these patient's mental health outcomes, but their overall physical wellbeing and likelihood of positive outcomes while having cancer.

Income and gender are social determinants of health and often dictate whether an individual experiences inequalities in accessing health-related services. Duhn et al. (2024) indicate that women and people with low income both face social discrimination and have less opportunity for economic gain. Furthermore, Duhn et al. (2024) indicate that these populations are less likely to be involved in government policy and decision making, thus perpetuating their problems without effective solutions. They also indicate that women are more likely to experience domestic violence, and the stigma surrounding this topic prevents them from accessing support. Furthermore, gender roles often pressure women into being the primary caregivers for children, and/or ageing or ill parents and loved ones, which can limit their time availability to access health-related services. Since there are institutionalised gender biases and limitations, women are also less likely to access career advancement and pay increases (Smith-Carrier et al., 2021). Furthermore, if women take on a caregiving role, this can limit their career even further (Duhn et al., 2024). These limitations further restrict their income and make accessibility of health-related services even more challenging.

An additional barrier that arises for people with significant health diagnosis, such as cancer, is the challenge of accessing all the services necessary for the person. Leahy et al. (2021) indicate that cancer patients suffer the additional challenge of physical location. For example, their physical cancer treatments occur in one facility and their mental health supports are in another. This obstacle is intensified when the cancer patient is limited in mobility and resources while accessing in-person treatments. This barrier of accessibility and the heavy weight of various medical appointments stretches to other people with significant ailments as Rix et al. (2013) indicate for hemodialysis patients. These facility and time barriers are shared amongst people of all ethnicities and not limited to those within the BIPOC communities.

If there are so many barriers that exist for people of all ethnicities when accessing health related services, then why is it important that we discuss and research the disparities specifically for the BIPOC population? The key reason is that these disparities are disproportionately present for BIPOC individuals. Furthermore, they experience additional inequities not just when accessing these services, but also in daily life. For example, though Duhn et al. (2024) focused their research on low-income women, they specifically mention that women of colour are more likely to experience financial instability and additional systemic barriers. Furthermore, Wright (2024) indicates that minoritized ethnoracial groups experience poorer mental health because of discrimination and higher adverse outcomes when accessing healthcare related services.

Intersectionality

A significant impact for BIPOC individuals and their overall experiences in accessing health-related services is that they also have additional oppressed identities that can further these disparities. Kimberlé Crenshaw (1991) described having multiple oppressed identities as intersectionality. Oppressed identities can include, but are not limited to, being a woman, gender

diverse, neurodiverse, having a disability, being queer, one's racial identity, experiencing housing instability, and having low-income. Crenshaw indicates that people with intersectionalities experience several overlapping and simultaneous systemic oppressive systems. Garg et al. (2023) indicate that these compounded intersectionalities increase the difficulty in accessing medical care as well as increasing adverse outcomes for those facing systemic inequities.

Expanding on intersectionality and disparities accessing health-related services, we see additional challenges for the neurodivergent BIPOC populations. Groen et al. (2023) indicates that people with autism face additional stigma and bias not just in accessing health services, but in everyday life. As Groen et al. (2023) indicate autistic women are often under diagnosed because of their ability to camouflage and fit into the social norm more effectively than their male-identifying counterparts. This creates further barriers to care and everyday life for those individuals. When we examine the intersectionality of neurodiverse BIPOC individuals we see that there are even greater disparities than their White counterparts. Benevides et al. (2024) indicate that BIPOC autistic individuals are underrepresented in research assessment for their mental health outcomes. In addition, they indicate the need for culturally competent policies and practice standards (Benevides et al., 2024). Neurodivergent BIPOC individuals experience higher than average systemic barriers including poverty and geographical barriers to accessing effective mental healthcare (Benevides et al., 2024).

Self-Positioning Statement

I approach this paper carrying *all my relations*. This is a phrase that I grew up hearing, it was explained to me as being how we are all connected with one another and how we share things for the betterment of ourselves, our communities, and the land. I recently explored an

Indigenous early childhood resource program through the University of British Columbia who opened their instruction with a description of *all my relations*. They described *all my relations* as carrying "principles of holism, reciprocity and responsibility [being] embedded within this concept, constantly guiding Indigenous interactions in the world" (Hare, 2024, para. 2). I have carried this phrase for as long as I can remember, it was only recently that I realized that it impacts my approach to academia. I write this capstone not just for myself and my master's degree, but for the betterment of my clients, my peers, my loved ones, my ancestors, my children, my future. But I also write this for betterment of strangers, for people I have yet to meet, for my community, and for the land. My hope is that this work touches someone else and gives them either a morsel or an entire upheaval of their approach to their work and their lives.

I approach this paper being a cis-gender woman with both Indigenous and European decent. Auger et al. (2021) beautifully expresses the complexities that Métis peoples face walking between their two worlds of Indigenous and European ancestry. It demonstrates the complexities of being the mixed-race of your Indigenous ancestors and their oppressors. This concept of walking between two worlds has resonated with me. I simultaneously navigate the intergenerational traumas and systemic oppression that Indigenous peoples face while also carrying some of the privilege that having lighter skin presents.

Belonging to the BIPOC community, while also being white presenting, I have the unique perspective of witnessing people act differently in front of me depending on whether they think I am White or Indigenous. I have far too many examples of people being covertly racist about different populations and then once they realize I am Indigenous they often look ashamed or change their narrative. Coates (2011) describes covert racism as hidden or private racism, which commonly occurs behind closed doors or in private settings. I have experienced this when

people think I share their mindset based on the colour of my skin. I also experience racism in a different way because I often do not look Indigenous enough for some people who do not know me or what family I am from. Some Indigeous people will say rude things about White people in front of me either because they think I am only White or because they know I am Indigenous.

I also have the added perspective of previously being a nurse within colonial Canada. Previously, I worked in the field for just under five years before leaving for a plethora of reasons. During my nursing training and work experience I directly witnessed perpetuated behaviours of covert racism from my colleagues. For example, I have experienced people being covertly racist about the San'yas Indigenous Cultural Safety Training Program, which has the primary goal of "uprooting anti-Indigenous racism and promoting cultural safety for Indigenous people" throughout Canada that was required at the time of my employment at my local hospital (San'yas, 2025, para. 2). When I disagreed with her opinion, she changed her narrative and then asked if I was also Indigenous. This was one instance of covert racism that I experienced when working as a nurse, other microaggressions were committed throughout my time there, often around the nurse's station during shift change. When I read excerpts from Turpel-Lafond's comprehensive review of the systemic racism throughout the BC healthcare system, it did not come as a surprise to me at all. I have also been alienated as a healthcare patient because of my heritage and have observed the distress that the healthcare system puts on my family members. I approach this paper having witnessed my former colleagues expressing oppressive behaviours towards BIPOC patients and my loved ones.

As a non-practicing nurse of BC, I have both witnessed, was complicit, and perpetuated some of the disparities I discuss in this paper. When I was a practicing nurse I worked in a local hospital where I was responsible for responding to Code Whites. A Code White is an emergency

situation where aggression is involved (Government of British Columbia, 2011). Hospital staff are trained in Code White protocols and have the ability to call a Code White when they believe there is a person who is at risk for harming themselves or others. I have witnessed the 'othering' and distancing that society and our medical system puts on people with mental health struggles. Miller (2016) writes a quote about healthcare workers interacting with people living with schizophrenia that truly resonated with me "the presentation of a mind 'degenerated' into meaningless babble is frightening for most of us to behold, and [we seek to distance ourselves] from such a situation" (p. 76). I feel that this reflects an 'othering' perspective that I delve into in a later section. It also reflects my own previous experience of having to navigate a challenging field. Nurse and healthcare safety is so important, and it is a dangerous job, which is why there is a Code White protocol at all. However, I feel like when I reflect on this work, I recognize how divisively the healthcare field is structured.

We can see how the BC healthcare system views people in vulnerable states of mind, losing sight of the person beneath the symptoms, and instead separating them to justify the various protocols and actions taken to distance 'ourselves' from 'them'. Healthcare workers have whole arsenals on how to navigate these Codes from take-down training, restraints, isolation rooms, and medical protocols that sedate people. Sometimes after forced medical intervention, they can be unconscious for longer than expected. Colloquially being unconscious for longer than expected was referred to as being "snowed' in the hospital setting. This was a term used when someone was given too many as needed/pro re nata (PRN) antipsychotic medications. Though I did not administer these medications in these situations, I was complicit with the actions.

When I worked as a nurse there were specific critical care indicators that were used as a guide for staff to know some information about a patient quickly. A common indicator was the Aggressive Violent Behaviour (AVB), which is also identified with a purple dot on a room (Fraser Health, 2021). Since healthcare workers are allowed to label patients as having an AVB indicator at their discretion there is little regulation around the misuse or potentially disproportionate usage on BIPOC individuals. I tried to locate sources surrounding this point of misuse or overuse of the AVB label on BIPOC populations, but could not locate anything specific, which may serve my previous point about BIPOC populations being under researched in health-related fields. This certainly warrants potential future investigation considering common narratives and previous anti-racism investigations within BC's healthcare field. However, the In Plain Sight data report does highlight that some "healthcare workers stereotyped Indigenous peoples as being …violent or frightening, dirty, thieving, …" (Government of British Columbia, 2020, p. 76). In addition, Kassam et al. (2024) describe that healthcare workers view Black people as "being perceived as more agitated, paranoid, and aggressive", which can add to the likelihood that they are given PRN medications unnecessarily (p.1). Though I didn't label someone with an AVB based on their ethnicity, I once again worked in a system with people who may have. I approach this paper acknowledging that I worked in a system that perpetuated these disparities, and I may have unconsciously done some of them myself. My hope is that I do not perpetuate them further as a psychotherapist and that I can be part of a bigger systemic change.

As I approach this paper to be a better psychotherapist, and person, I also have the lens and desire to be a better researcher. Throughout this process one of the big reflections, I have had is that in fulfilling the strict American Psychological Association (APA) structure to academic

writing it is, in many ways, pulling me from my authentic approach to work, academia, and life. A large component that comes from the disparities experienced by BIPOC folks is the systemic barriers that exist in every facet of our lives that are brought on by colonial structures. Being a non-practicing nurse and university student, I have come to appreciate and have a desire to find evidence-based materials to strengthen my practice. I use evidence-based materials in all areas of my life from school to work to parenting, but over the years I have come to know that evidence-based materials can carry bias, and there are often gaps in research for folks outside of the White and European-centric groupings. I have come to learn that research can carry and perpetuate harm for BIPOC folks. I explore this in depth throughout various components of chapter two, but it is important to express for my Self-Positioning Statement because though I value and still look to this Western way of knowing and being, I also strive to look to Indigenous ways of knowing and being throughout this work and other areas of my life. This approach is the concept of Two-Eyed seeing, which Mi'kmaw Elders Albert and Murdena Marshall first brought to light as "learning to see from one eye with the strengths of Indigenous ways of knowing and from the other eye with the strengths of Western ways of knowing and to use both of these eyes together" (Koscielniak et al., 2024, p. 4). I believe that there are strengths and weaknesses from both eyes, and my hope is that I will honour my authentic self throughout this some-what restrictive process. I try to do this in some noticeable ways such as identifying locations as 'known colonially as' because it is part of my decolonizing approach to my work. I anticipate that I will also incorporate unconscious forms of decolonizing and Western work, which could possibly display as bias.

Pirayesh (2019) describes how they had the scientific method taught to them since Elementary school, this resonated with me as someone who has always enjoyed and thrived in

educational settings. I was a proud science kid throughout high school and this is one of the many reasons I pursued healthcare, but this structure stripped away many of the traditions of my ancestors which are traditions that I continue to relearn and reclaim. When I wrote this Self-Positioning Statement, I felt I must name that I struggled with the need to find peer-reviewed sources to name and justify these lived experiences I have had. It is a true testament to how the scientific method lives inside of me as an academic, as a person. In a conscious effort to name that my experiences are valid and true I have refrained from inserting some sources in this Self-Positioning Statement section. These things are shared amongst other Indigenous people who pursue Western academia, I know they are because I have had verbal conversations and read similar things about this very topic. In consciously choosing to refrain from inserting a source here, as I honour my Indigenous traditions of oral history. I honour my Indigenous peers and loved ones to not be a resource to be extracted. Though I cannot fully remove these etched memories and views, I aim to approach this paper with as little bias as I can possibly present but acknowledge that bias exists.

Definition of Terms

BIPOC

Black, Indigenous, People of Colour is particularly used to indicate that though there are similar inequities, oppression, and systemic racialization for all people of colour, it acknowledges the shared historic and present experiences of violent and deadly oppression that Black and Indigenous peoples experience (Wong & Jackson, 2023).

Countertransference

Gait and Hazelwood (2022) describe countertransference as the therapist's emotional response to the client and what they are sharing. These responses can be resolved or unresolved.

They also indicate that it is important for therapists to reflect on their countertransferences because a failure to do so can be harmful for the client. Especially if the therapist allows these to be acted out for the benefit of the counsellor.

Decolonization

The process and mindset of decentering colonial views and criticizing structures that enforce one way of knowing and being onto all peoples. Decolonization is a process that redefines the relationship between existing colonial power structures and Indigenous perspectives. … [It] can be seen as an active 'disruption' and critiquing of the dominant colonial knowledge" (Pirayesh, 2019, p. 89).

Health Disparity

A health disparity is "viewed as a chain of events signified by a difference in: (1) environment, (2) access to, utilization of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny" (Carter-Pokras & Baquet, 2002, p. 427)

Social Determinants of Health

Our lifestyle choices are not the primary factors shaping our overall health and wellbeing, instead it is our living environment (Astle et al., 2024). Astle et al. indicate that the main social determinants of health in Canda are identified as income and social status, education, unemployment and job security, employment and working conditions, unemployment and job security, food security, housing, early childhood development, social exclusion, social safety net, Aboriginal status, gender, race, and disability.

Therapeutic Alliance/Relationship

"[T]he collaboration and strength of the bond between the therapist and client, [which] is a crucial factor influencing treatment outcomes for various therapeutic interventions and

psychological complaints" (Baylar & Yurtsever, 2025, p. 688). Therapeutic alliance will be used interchangeably with therapeutic relationship as they carry the same context for this capstone.

Two-Eyed Seeing

Two-Eyed Seeing is a concept and practice introduced by Mi'kmaq Elder Albert Marshall integrating the strengths of both Indigenous and Western ways of knowing and viewing things from both perspectives simultaneously (Cirkony et al., 2023).

Outline of Capstone Project Chapters

Chapter Two Outline

Chapter two of this capstone project will encompass a literature review of existing information surrounding disparities experienced by BIPOC folks within health-care related settings. The specific disparities explored include racism, 'othering' and microaggressions as well as how these impact BIPOC folks' overall wellbeing. Additionally, it explores mental health bias carried by some healthcare providers and how that can impact people living with a mental health condition. Furthermore, chapter two discusses some of the challenges that BIPOC individuals experience when trying to access mental health services.

Additionally, chapter two explores the role that research and education institutions have in perpetuating disparities throughout the healthcare field. Specifically exploring the role of the American Psychological Association (APA) has and had in elevating what dominant research and approaches to mental health treatment plans were and are. Discussing how the APA heavily influences treatment, research, and views surrounding mental health. Additionally delving into other limitations in mental health research. Furthermore, it will take an in-depth look at cognitive behavioural therapy and whether it has a part to play in furthering disparities experienced by BIPOC folks when accessing mental health services.

Finally, chapter two will discuss the current state of cultural awareness training in colonial Canadian university psychology programs and external continuing education. Also exploring the how equitable or inequitable it is for BIPOC populations in accessing psychology and healthcare related higher education in prevalent colonial Canadian universities. Culminating into an exploration of the San'yas Anti-Racism Indigenous Cultural Safety Training Program (San'yas). Discussing the basic premise of San'yas and which organizations utilize the training program.

Chapter Three Outline

Chapter three of this capstone will discuss the limitations of this research project. The limitations discussed are gaps in research surrounding disparities experienced by BIPOC populations when accessing healthcare services. Much of these research gaps originate with the stigma surrounding BIPOC folks and the additional stigma surrounding mental health. Furthermore, there is the hefty financial investment that is required for Western academic research. Finally, discussing the limitations that the APA has imposed on psychology through systemic perpetuation of Eurocentric ideologies.

The third chapter also has a discussion section about the literature review and how the content revealed perpetuating factors of disparities BIPOC populations experience when accessing health services.. Also, discussing how the psychotherapeutic modality, CBT, can perpetuate harm for BIPOC folks when accessing mental health services. Lastly, reviewing the San'yas cultural sensitivity training program and my reflections and critiques of the current state of cultural sensitivity training available in colonial Canada.

Chapter three will culminate into an application section where I apply information gathered throughout the literature review and discussion sections on how I believe some

disparities may be reduced for BIPOC populations when accessing healthcare services. A large component of this application comes from increasing BIPOC representation in health-related fields and those respective education fields. In addition, by making it more equitable for BIPOC students to access colonial Canadian university programs in the respective health education programs. Additionally, exploring some suggested systemic mental health changes including using culturally adapted CBT and the importance of the therapeutic alliance. A crucial element of the therapeutic alliance comes from self-reflection and building empathy for clients/patients. Effective self-reflection is another important component of effective cultural sensitivity training, which is the final application piece that I recommend from the information collected for this capstone.

Chapter Two: Literature Review

This literature review examines inequities faced by Black, Indigenous, and People of Colour (BIPOC) in mental health care through three key areas. First, it explores disparities in healthcare-related services, where BIPOC communities experience interpersonal racism (othering, microaggressions), systemic structures and mental health bias, and poorer health outcomes compared to white counterparts. Second, it considers barriers to mental health services, as BIPOC individuals face financial, cultural, and systemic inequities, compounded by White-centric approaches like CBT, limited BIPOC representation, and underfunded inclusive research. Finally, it reviews existing tools, training, and educational practices aimed at reducing these disparities, focusing on approaches that promote cultural responsiveness and equity in mental health service delivery.

Disparities Experienced by Black, Indigenous, People of Colour in Healthcare-Related Services

There are several factors that contribute to disparities experienced by BIPOC folks when they access health services. A large contributing factor towards these disparities originates with the healthcare workers, some of whom have underlying or overt racism, practice ‘othering’, commit microaggressions or carry various biases. Furthermore, there are systemic issues that exist within the very structure of the healthcare system, which some individuals perpetuate.

Racism and ‘Othering’

Many of disparities in healthcare for BIPOC populations originate with the healthcare workers themselves. Some of these disparities come from a concept of ‘othering’ which Johnson et al. (2004) described as “a process that identifies those that are thought to be different from oneself or the mainstream, and it can reinforce and reproduce positions of domination and

subordination" (2004, p. 253). The act of 'othering' creates a distinct barrier between oneself, and another based on their identities, it is similar to an 'us vs. them' mentality. Rix et al. (2013) describe an encounter with an Aboriginal Elder in colonial Australia, who described feeling 'othered' when encountering health professionals, which caused a noticeable difference in care observed by the Aboriginal Elder. Unfortunately, these are not isolated occurrences and can cause long-term harm for BIPOC individuals.

Wong and Jackson (2023) describe a process similar to 'othering' as a microaggression. A microaggression described as being a "brief, commonplace, often unintentional yet harmful communication against Black and Indigenous people of color that demean, stereotype, or discriminate against them" (Wong & Jackson, 2023, p. 209). Furthermore, Rogers (2022) describes microaggressions in a feminist context as healthcare providers exerting their power over their patients. We can see these forms of 'othering' or microaggressions when healthcare workers allow their pre-existing biases to come observably forward during their interactions with any patient or client, particularly marginalized populations. In the Rix article mentioned previously we saw a testament to how these microaggressions cause harm to patients in a plethora of ways that will be explored later in the impacts section of this chapter.

Mental Health Bias

Some studies have shown that clinicians providing mental health supports will 'other' people based on their mental illness which can negatively impact the quality of care they provide and further increase the disparities experienced by BIPOC populations. For example, Jacob et al. (2021) describe a common occurrence within Canadian emergency departments where patients with mental illness often experience "controlling and even abusive interventions" (p. 286). These interventions include the usage of physical and chemical restraints even when people are not

demonstrating dangerous or harmful behaviors (Jacob et al., 2021). This inequity is further increased when someone has a mental illness, and a concurrent substance use disorder (SUD). For instance, in an American study it was found that medical residents were less likely to provide empathetic and personalized care for people with mental illness and a SUD when compared to patients without a mental illness (Avery et al., 2019). Furthermore, Avery et al. (2019) indicate that in over 55% of emergency department visits it was found that no treatment was provided for people with a mental illness and a concurrent SUD. Patten et al. (2016) reinforce these findings by describing Canadian folks with mental illness that have expressed feeling disregarded and disrespected by emergency department staff and even their primary practitioners.

Stigmatization and the 'othering' of people with mental illness is not limited to healthcare settings, folks often feel these inequities throughout all areas of their lives. Patten et al. (2016) indicate that people with a mental illness are impacted in the "areas of work/school and family and romantic relationships" (p. 483). This is further supported by Dobson and Stuart (2024) who indicate that those Canadians surveyed with a mental illness and/or SUD suffered from interpersonal strain and withdrawal from relationships. This is also perpetuated in larger social settings where Grey (2016) describes a concept of 'benevolent othering' through colonial Australian advertising campaigns. Grey (2016) describes 'benevolent othering' of people with mental health conditions as being othered with the intent of implying that they can still be the same as everyone else. This is not limited to their advertising campaigns, as it is perpetuated through training practices and personal behaviours where people speak of those with mental health conditions positively but fail to recognize that they are still separating or 'othering' them and perpetuating subservience (Grey, 2016). When we add in this intersectionality of mental illness, we continue to see a compounded strain and further disparity for BIPOC populations.

A significant component of why disparities in healthcare exist for BIPOC Canadians come from systemic structures that perpetuate harm and exclusion for non-White populations. Systemic structures exist throughout individual healthcare locations like private practices/hospitals, health authorities, education institutions, and throughout all levels of government (Denaro et al., 2022; Sheppard, 2010). For example, at the individual location level Rix et al. (2013) describe how healthcare workers perpetuate their "own feelings of superiority and whiteness" when working with Aboriginal patients in a healthcare setting (p. 6). In addition, Rogers (2022) describes how microaggressions perpetuate systems of power and either misdiagnose, mistreat, or completely neglect the individual in need. Furthermore, Razack et al. (2024) describe how Canadian medical schools elevate and dictate what an 'expert' is, even when the 'expert' incorrectly describes Indigenous practices through pan-indigeneity and bias. Mickleborough and Martimianakis (2021) describe how Canadian government systems create unnecessary barriers for internationally educated healthcare workers from being able to work in the jobs they are trained for because the structure wants to maintain power in 'Whiteness'. These are just a few examples of systemic issues that perpetuate disparities for BIPOC folks, next I will navigate how these disparities impact some BIPOC folks.

Impacts of disparities on Black, Indigenous, People of Colour

The impacts of disparities experienced by BIPOC folks within the healthcare system show a pattern of perpetuated harm both physically and mentally, which can even affect one's sense of self-worth.

Disparities experienced by BIPOC populations when accessing healthcare impact their overall health and often lead to people avoiding seeking help when necessary. Johnson et al. (2004) recount instances where BIPOC folks would not go in for medical treatment when they

had an infection. These documented avoidances were a result of mistreatment experienced by these individuals during prior maternity care. There are high risks for not treating an infection such as loss of function, sepsis, and even death (Lewis et al., 2019). Though their recounts are linked to prior maternity care, we can see avoidance occur throughout other treatment settings. Silverman and Teachman (2022) describe BIPOC folks avoiding seeking mental healthcare because of previous experiences of racism and mistreatment in healthcare settings. Furthermore, to harken back to the report done by Turpel-Lafond (2020), we can see that well over 70% of colonial Canadian Indigenous people have felt unsafe while accessing BC healthcare systems, and many of those reported also avoiding future healthcare services.

There are discrepancies in how medications are prescribed to BIPOC folks when compared to their White counterparts. For example, Flores et al. (2024) describe how practitioners are less likely to diagnose a pain disorder and prescribe pain management medications to "racial/ethnic minorities" (p. 720). A lack of pain management can have detrimental effects to one's overall physical and mental function as it triggers a stress response and effects the whole body's function (Lewis et al., 2019). Additionally, Kassam et al. (2024) outline how medication providers are more likely to believe that the BIPOC population is less likely to have medication compliance, which often leads them to prescribe long-acting antipsychotics and increase the usage of as needed/pro re nata (PRN) psychotropic medications. PRN usage of psychotropic medications in healthcare settings is high and is often used as a "coercive practice" with psychiatric patients because of the healthcare staffs' views of 'othering' (Jacob et al., 2021, p. 287). The usage of PRN medications takes away the autonomy of the patient and can cause or trigger trauma responses for the individual.

When we add in additional intersectionalities, such as being a woman, we see further increased healthcare related disparities and barriers for BIPOC folks. Johnson et al. (2004) describe the added disparity that BIPOC women experience in healthcare access by describing the lack of female representation in healthcare professionals. This underrepresentation can prevent some women of colour from accessing healthcare services all together. Having limited access to women of colour in healthcare related fields increases feelings of a lack of safety and security. Furthermore, Rogers (2022) describes how some healthcare providers can, and have, committed microaggressions towards women by telling them that they are "overreacting when they cry" during health-related assessments and treatments (p. 357). By perpetuating a systemic belief that women are highly emotional we can see increased disparities by providing further barriers in accessing health services. Overall, a lack of trust and fear in the medical system for BIPOC women can cause long-term health consequences.

The disparities experienced by BIPOC individuals can even begin to affect their view of themselves. Rogers (2022) describes patterns of microaggression in healthcare settings as causing marginalized folks being "denied the full status of knower, which is central to human dignity and value" (p. 356). When folks are being discredited for their own knowledge of themselves, they are discouraged from accessing healthcare services in the future. In addition, it can lead to self-doubt and for some, internalized stigma. Internalized stigma is when someone begins to adopt external negative views about oneself based on their intersectionalities (Laquidara et al., 2025). Willis et al. (2021) describes that internalized stigma about one's race increases psychological distress and mental disorder diagnosis. Additionally, Capar and Kavak (2019) describe that internalized stigma can negatively affect people with schizophrenia from accessing treatment, following treatment recommendations, and affects coping strategies.

There are vast implications for the disparities experienced by BIPOC people when they access healthcare services. From being 'othered' to experiencing microaggressions, BIPOC folks are treated differently than their White counterparts. This difference in treatment can impact their quality of care and future desires to seek help. Many of these problems occur in many different settings and with many different people. Additionally, these disparities can cause people to view themselves in negative ways. Those that have the privilege to access psychotherapy services, for navigating injury and trauma they may have experienced both inside and outside the healthcare system, face similar disparities.

Challenges Accessing Mental Health Services

Accessing psychotherapy services is a challenge for many. Some of those challenges exist due to a lack of funds and/or support. Aside from systemic barriers, there are also barriers within the field of psychology where many therapeutic approaches are geared towards the White population. Since there are several psychotherapy modalities to choose from, for this paper I will focus on cognitive behaviour therapy (CBT), how it was designed in a White-centric lens, and it can potentially cause harm to BIPOC clients. I chose CBT because it is widely considered to be the 'gold standard of psychotherapy' (Clark & Holttum, 2022; David et al., 2018; Leichsenring et al., 2018).

Black, Indigenous, People of Colour's Difficulties Accessing Mental Health Services

The act of accessing mental health services proves to be a disparity for many and can be an increased challenge for many BIPOC individuals. In colonial British Columbia (BC), Canada, accessing psychotherapy services is not covered through publicly funded health coverage, the Medical Services Plan (MSP). Though MSP does not cover individual counselling services, they do cover things like doctors' appointments, hospital stays, and some prescription medication that

are in relation to mental health (Government of British Columbia, 2025). Similarly in colonial Ontario, Canada, their publicly funded health coverage, Ontario Health Insurance Plan (OHIP), covers these same services (Government of Ontario, 2025). However, OHIP and MSP do have some social services in place to aid with mental health support (Fraser Health, 2025; Ontario Health, 2025). In 2023, the average 50-minute individual counselling session cost a BC resident approximately $125, with similar costs in Ontario (Cressman et al., 2023). The BIPOC population are often disproportionately in the lower socio-economic class, which makes the cost of psychotherapy unattainable for many (Statistics Canada, 2023).

On top of an increased financial barrier, many BIPOC folks struggle in finding the right psychotherapist and finding time is a challenge for many. Earlier I mentioned that many BIPOC clients want to seek a psychotherapist who comes from a similar background. Chang and Yoon (2011) describe this preference as clients having a perception that the therapist has the skills to understand the multidimensional complexities that exist within certain intersectionalities. This is a preference for some and not all BIPOC folks, but does prove to be a disparity as there is underrepresentation of BIPOC therapists throughout Canada. Additionally, finding time to access therapeutic support services is limited for many BIPOC individuals, with many belonging to lower socio-economic classes, many are often burdened with more than one job. Furthermore, when someone has children, this lack of time and support becomes even harder (Hopson et al., 2025). With underrepresentation and a lack of time, accessibility to counselling services can be limited for BIPOC populations. For those that can access psychotherapy services and either cannot find or do not want a therapist from a similar background, they do face an unexpected barrier of which modalities the therapist uses.

The Role of the American Psychological Association in Disparities Experienced by BIPOC Populations in Mental Health Fields

Many psychology perspectives and modalities were developed with White and Western, Educated, Industrialized, Rich, and Democratic (WEIRD) populations in mind. Much of the research and development in the psychology field focuses on White and WEIRD groupings, which means that it excludes much of the BIPOC population and often lacks cultural sensitivity. In 2021, the American Psychological Association (APA) made a public apology for their involvement in "promoting, perpetuating, and failing to challenge racism, racial discrimination, and human hierarchy" (American Psychological Association, 2021, para. 1). The APA's apology included their involvement in supporting research that "centered" and "advanced the careers of White researchers who became 'experts' with respect to the ethnically diverse studied groups" (APA, 2021, para. 20). The APA's apology is vast and acknowledges how they perpetuated harm for people of colour. Though the APA is based in the United States (U. S.), it is widely used as a standard of practice throughout Canada as well. For example, this capstone follows the APA guidelines to Western academic writing (City University in Canada, 2024). Furthermore, the APA's Diagnostic and Statistical Manual of Mental Health 5th edition (DSM-5) is used to diagnose mental illness in Canada (Government of British Columbia, 2021).

The DSM itself can be problematic for BIPOC populations. For decades there was a lack of cultural awareness in the DSM, and consequently throughout the mental health field. For example, the DSM only introduced cultural considerations in 1994 with their 4th edition, with the cultural considerations being flawed and minimal at the time (Mezzich et al., 1999). In 2013, the APA further expanded their cultural awareness throughout the DSM 5th edition by implementing a cultural formulation interview, which the APA describes as being a useful tool to better

understand patients' perspectives on mental health with cultural context in a "standardized approach" (Lewis-Fernández et al., 2016, p. xxvii). However, the 5th edition still perpetuates disparities by creating "ethnic dividing line(s) between those seen culturally as 'other' and those who are not" (Bredström, 2019, p. 348). Cultural exploration and understanding are not something that can effectively be standardized and it fails to incorporate the uniting of people in a space by preserving the 'othering' mentality.

CBT and its Role in BIPOC Disparities in Mental Health Services

Since there are so many therapeutic modalities being utilized, I chose to focus on how CBT can perpetuate harm for BIPOC folks. I chose CBT specifically because it is one of the most widely researched and used modalities (David et al., 2018; Gaudiano, 2008). CBT was developed in the 60's by Dr. Aaron Beck with the core belief that people can "recognize and change negative patterns of thinking and behavior in order to better cope with challenging situations and improve overall quality of life" (Beck Institute, 2025). The fundamental components of CBT include the cognitive model of schemas, dysfunctional assumptions and negative automatic thoughts which are changed using different tools to shift maladaptive cognitive behavioural patterns (Fenn & Byrne, 2013). The Beck Institute describes CBT as being a useful modality to treat things from post-traumatic stress disorder to obesity and even improves schizophrenia symptoms (Beck Institute, 2025). Despite, the wide range of functions and the thorough research for CBT, it still causes harm to specific populations.

Since CBT's main focus is changing internal schemas and negative thoughts, it focuses on how the individual can solve a problem and can miss the mark on how many external factors are not changeable for BIPOC individuals and other marginalized communities. Many of those external factors I discussed earlier such as microaggressions, othering, and additional systemic

oppressions. Ahuvia and Schleider (2023) describe these types of difficulties as structural and are not within the client's control. By overlooking these external structural factors, a clinician may cause harm (Ahuvia & Schleider, 2023). In doing so, we risk ignoring the systemic structures that have oppressed BIPOC folks. Furthermore, it can also perpetuate harm for BIPOC clients because some of their traumas or struggles come from external factors in relation to their identities, which is something that is not inherently wrong, nor can be changed. Another limiting cultural factor within CBT is that it has a heavy WERID influence.

CBT research and development was primarily done with a White and WEIRD influence (Hays, 2006). With the limited populations included in the development it is not surprising that there are gaps for BIPOC populations. For example, much of CBT's framework comes from an individualistic perspective that neglects the importance of collectivist structures for many cultures. For example, Naeem et al. (2023) discuss how CBT needs to be culturally adapted for South Asian Canadian populations because of the importance of collectivism in South Asian cultures. Hays and Iwamasa (2006) indicates that along with collectivistic limitations there are also linguistic limitations for some populations as the language used throughout CBT work, such as the term schema.

Furthermore, the therapists use of language can perpetuate and validate harm done by other people (Samuel & Simonds, 2025). In addition, for colonial North American Indigenous peoples CBT without cultural considerations "reinforce[s] and perpetuate[s] the historical assimilation practices [that] Indigenous peoples have experienced" throughout historical policies and practices (Kowatch et al., 2019). Furthermore, Rathod et al. (2019) indicates that the majority of CBT research is done in high- and middle-income countries, which means little has been done to better understand the impacts of CBT for lower-income countries. With the lack of

research on lower-income countries there is limited knowledge on how CBT may impact those who may immigrate to colonial Canada.

According to Rathod et al. (2019), meaningful cultural adaptations of CBT involve the incorporation of several different elements. The main elements of meaningful culturally adapted CBT entail; ensuring that the psychotherapist has an awareness of the cultural issues experienced by the client, ensuring that there is engagement, as well as adjusting and doing assessments throughout the process (Rathod et al., 2019). What Rathod et al. (2019) describe as an effective culturally adapted version of CBT is quite reminiscent of general cultural sensitivity, which is an important aspect of any therapeutic modality and approach to health-related services. Additionally, though CBT has some restrictive elements for BIPOC populations, it would be unethical to assume that it doesn't have elements that could be beneficial for specific individuals.

Though there are some peer reviewed studies that show effectiveness for culturally adapted CBT, there are still additional considerations to be made. Culturally adapted CBT has been shown to be effective with certain BIPOC populations in peer reviewed sources such as Chinese gamblers and Latino caregivers experiencing caregiver burnout (Gonyea et al., 2016; Wong et al., 2015). These are just a few studies listed that have shown effective treatment for non-White, non-European participants. However, it is important to note that these two specific studies have yet to be replicated, which serves as a good reminder that what may work for a section of a certain population, may not work for all folks from the same population. In addition, there is the consideration that perhaps the dominant literature surrounding culturally adapted CBT were ones with selective reporting bias. Selective reporting bias occurs when only research with desired outcomes or viewed as successful may have been published (Ioannidis et al., 2014).

Reviewing meta-analysis repots on culturally adapted CBT, it seems apparent that published reports often carry positive results but have distinguishable limitations. Silveus et al. (2023) conducted a meta-analysis of culturally adapted CBT studies for anxiety and depression and found that studies that were done outside of the US were less likely to have statistically significant improvements as a result of culturally adapted CBT. Another meta-analysis done by Kowatch et al. (2019) surrounding culturally adapted CBT for colonial North American Indigenous children and youth with varying mental health conditions. Their analysis indicates though culturally adapted CBT can be effective with this population, many of the studies with statistically favorable results had small sample sizes and there were "limits [of] generalizability of the adaptations outside of the communities" (Kowatch et al., 2019, p. 12).

Mental Health Research

CBT research is not the only area that has limitations for BIPOC populations. Psychology research often favors WEIRD and White populations, which can prevent the wide recognition of newer, more culturally sensitive modalities. Furthermore, mental illness is highly stigmatized, and less money is "dedicated to research about it than for other illnesses and less money is allocated to adequate care and management (Jacob, 2021, p. 284). If mental illness in general has less dedicated researched, then it is not surprising that BIPOC populations are not a focal point for the mental health research that is being done. For example, in the APA's 2021 apology they indicate that the field of psychology "often continues to publish research that conforms to White racial hierarchy" (APA, 2021, para. 9). Furthermore, in relation to CBT research for BIPOC populations, Huey et al. (2023) indicates that "more rigorous testing … [and] further research is needed" to better understand which CBT methods are beneficial for different cultural backgrounds (p. 66). If research for BIPOC populations is scarce for one of the most studied

psychotherapies, CBT, then it seems unlikely that there is adequate research throughout the rest of psychotherapies. The Government of Canada (2025) also address that "systemic barriers within academic and the research ecosystem are well documented in Canada" further demonstrating the disparities evident in our research-based society (para. 12). Since there is limited research, it seems apparent that disparities BIPOC folks continues to be prevalent and are perpetuated. So, if there are disparities, what is currently being done to bridge those gaps?

Existing Tools, Training, and Education Practices for Reducing BIPOC Disparities in the Mental Health Field

As I explored earlier, there is recognition that there are disparities experienced by BIPOC individuals when accessing health related services. In addition, as I discussed earlier, it is widely acknowledged that there are gaps in psychology research for these populations. In this next section, I will explore how some colonial Canadian universities are working to reduce inequities for BIPOC folks by improving the admissions process to health-related programs, exploring cultural awareness practices embedded within these programs, and what forms of continuing education cultural sensitivity training programs may be available.

Cultural Inclusivity for Admissions in Colonial Canadian Universities for Health Professionals

Starting from before practitioners are even out of the gate, I will discuss how some universities are implementing cultural awareness and practices in their core education practices for people in health-related fields. Firstly, some health-related programs have designated spots saved for Indigenous students. For example, the University of British Columbia's (UBC) medical school program has designated admissions pathways for Indigenous and Black students (UBC, n.d.). Similarly, the University of Saskatchewan (USask) has a pathway for Black students and

an Indigenous admissions circle, where they state that there are “twenty seats designated to the IAC [Indigenous Admissions Circle]” (USask, 2025, p. 6). Both UBC and USask indicate that these specialized pathways are to increase equitability and inclusiveness for these underrepresented populations in the healthcare field. A similar program exists for the University of Toronto’s nursing program where they indicate that applicants will be reviewed and “considered [based] on their qualifications, rather than in relation to other applicants” (University of Toronto, n.d.). Similarly, UBC’s nursing school has special considerations for Indigenous applicants by allowing them to be considered permitting they achieve the minimum general admissions GPA requirement for UBC as opposed to the higher GPA requirement for the nursing program. The University of the Fraser Valley’s (UFV) nursing school offer “up to 10% of program seats may be allocated to Aboriginal students on a competitive basis”, but they do not clearly describe how this is done (UFV, 2024, para. 49). Both UBC and UFV’s nursing school admissions programs lack any equitable pathway for Black students. By increasing representation in these schools of education it appears more hopeful that there will be diverse representation and ideally, increased safe spaces for BIPOC communities in healthcare.

Regarding psychology-related programs, I did not find any clear information identifying designated seats reserved or specialized pathways for students in the BIPOC populations. I searched large and widely known colonial Canadian universities for psychology programs in relation to designated spots for BIPOC students or specialized pathways and it appears that those searched did not have any increased accessibility. For example, Simon Fraser University (SFU) has no information designated for BIPOC students on their Master of Arts/Education in Counselling Psychology information page (SFU, n.d.). The University of Calgary, Dalhousie University, City University in Canada (CityU), and Yorkville University all offer some form of

master's degree in psychotherapy, but all of them do not clearly indicate a pathway for equitable access for underserved BIPOC populations. However, SFU has some Indigenous Initiatives in place as part of their academic integrity. In addition, CityU (2025) has information about Indigenous Engagement and a link to an Indigenous Student Page, which at the time of writing this, was a broken link. I acknowledge that this particular search did not cover all colonial Canadian universities, but since these are some of the largest and/or most popular psychology master's programs in colonial Canadian educational institutions, I do believe that it does still demonstrate that the field of psychotherapy has an under representation of BIPOC folks. This underrepresentation further demonstrates that access is inequitable and adds to potential disparities.

Cultural Awareness in Colonial Canadian University Education for Psychology Students

Moving from admissions to the state of cultural awareness education in Colonial Canadian psychology student programs. Colonial Canadian university programs utilize evidence-based material for their education syllabi. Evidence-based material is important; it helps prevent harm, elevates practices, and increases effectiveness of treatments (Melchert et al., 2025). However, as discussed earlier, it is apparent that evidence-based research carries bias towards BIPOC populations and can perpetuate systemic harm. Furthermore, with a lack of adequate BIPOC or other minority representation the research contains gaps. The existence and prevalence of these gaps are both addressed by the APA (2021) and the Government of Canada (2025). Since there are gaps in the research and the evidence-based materials that are used to educate the newest psychotherapists and other health-related professionals, then the question of how students are learning about the needs of these underserved populations comes into play.

Peer reviewed sources about the structure, state, and effectiveness of cultural awareness and inclusivity education in colonial Canadian psychotherapy education, is limited. This appears to be a reflection on the state of available research funding and interest to serve these populations. For instance, in their limitations section, Williams et al. (2025) describe the importance for "future scholarship" and "robust attention" to the areas addressing the needs of "underrepresented groups in professional psychology training programs" (p. 13). This is not limited to psychology programs but also colonial Canadian nursing and medical programs. Onabadejo (2020) describes that Canadian nursing programs have good intentions to incorporate cultural awareness practices but still fall a bit short with the implementation. Colonial Canadian health-related education programs indicate that cultural awareness, inclusivity, and safety are important and strive to incorporate these teachings but are falling short on meaningful implementation.

Some difficulties that come from meaningful implementation of cultural awareness come from an underrepresentation of BIPOC psychotherapists in the field already, amongst other barriers. For instance, Ansloos et al. (2019) describe there only being "12 Indigenous peoples practicing and/or teaching psychologists throughout Canada", as per the Canadian Psychological Association in 2018 (p. 266). Though this information is from 7 years ago, the shift to present day likely is not a drastic one. There are unique perspectives that can only come from Indigenous peoples surrounding their cultural traditions, beliefs, and disparities. This is not limited to Indigenous peoples either, Black people and other people of colour are the best people to be presenting their peoples struggles, needs, and perspectives. Having adequate representation does not just provide perspective, but it also facilitates a safer learning environment for BIPOC

students. Williams et al. (2025) holds education institutions accountable for a lack of representation and emphasizes their role in perpetuating these systemic gaps.

An underrepresentation of faculty diversity is not the only challenge faced by these educational institutions. Many of the White staff that have been in the field long enough to teach have done enough training or developed enough of an understanding to meaningfully educate their students from an appropriately culturally competent way. France et al. (2021) describe the importance of a life-long commitment by psychotherapists to appropriately develop their necessary cultural competencies. Furthermore, much of the education received by both the teachers and the current students is rooted in Eurocentric views, which further perpetuates the disparities experienced by BIPOC populations (France et al., 2021). An additional concern is that if education institutions do not properly uphold standards for their instructors, instructors with harmful views can pass them along to their students. When bias goes unaddressed it can "[interfere] with teaching about racial disparities, Indigenous issues, and non-White ethnic and cultural perspectives" (Williams et al., 2025 p. 2). Turpel-Lafond and Johnson (2021) further describe this occurring for Indigenous healthcare students and workers indicating that they "face racism and discrimination in their work and study environments" (p. 8). Since there are cultural awareness gaps in the present education of psychotherapists, it is reasonable to believe that there were also gaps in past education structures. A way to help improve cultural safety support for BIPOC populations for already practicing healthcare related professionals is through continuing education and training.

San'yas Training

A prevalent continuing education cultural awareness program utilized throughout colonial British Columbia is the San'yas Anti-Racism Indigenous Cultural Safety Training

Program (San'yas). Since its origins in BC, San'yas has now spread to offer cultural safety training for Manitoba, Ontario and nationally. San'yas is an "Indigenous-led and developed initiative of PHSA [Public Health Services Authority] Indigenous Health. San'yas means 'way of knowing' in Kwak'wala language of Kwakwaka'wakw Peoples" (San'yas, 2025, para. 1). It was designed to address a cultural competency gap for BC healthcare providers by providing the research and "lived experiences of Indigenous people" necessary for the changes that are "essential for decolonizing and uprooting anti-Indigenous racism" (San'yas, 2025, para. 3). Browne et al. (2021) describe the San'yas training as being "rooted in critical anti-racist pedagogy, transformative learning theory, and evidence-based strategies" to increase cultural awareness for participants and to "support broader organizational and systemic change" (p. 2).

Many of BC's health authorities require San'yas cultural safety training (San'yas, 2025). For example, the BC PHSA (2025) describes the availability of the San'yas training and indicates that the aim of the course is to help health authority employees increase their Indigenous people's knowledge base and build skills and self-awareness surrounding one's biases and culturally safe care. Many BC health authorities offer this course as a free resource for their healthcare employees (Fraser Health, 2025; Island Health, 2025). It is also a requirement by the First Nations Health Authority (FNHA) to be added to their mental health providers list. Those on the FNHA mental health providers list offer 22 hours of psychotherapy services, with the potential of an extension, at no-cost for status holding Indigenous peoples, but the providers still receive compensation from FNHA (FNHA, 2024). This FNHA service helps bridge a disparity gap for colonial Canadian Indigenous peoples. The San'yas training provides a valuable tool for healthcare providers to ensure systemic inequities and disparities are reduced, and hopefully one day they disappear.

The reception and adequacy of San'yas training appears to be varied and under researched. A simple search of the term San'yas on EBSCO and Google Scholar yielded one result, which was the same source available on both platforms. In addition, San'yas is discussed the BC Addressing Racism Review data report, In Plain Sight. Within the In Plain Sight data report, it describes various San'yas thematic analyses, which describes an "overwhelmingly positive" response to the training program that allowed users to learn from others and self-reflect on past experiences (Government of British Columbia, 2020, p. 79). Browne et al. (2021) describe similar observations about the San'yas training program. However, Browne et al. (2021) stress that San'yas training alone cannot bring forth the change necessary to reduce these disparities, but rather "full-scale policy and organizational transformations" (p. 15). Though San'yas is a valuable tool for helping reduce disparities for Indigenous peoples in healthcare settings, it does encourage people to reflect on the way they interact with difference people in general. Thus, showing an introduction to overall cultural awareness, sensitivity, safety and inclusion. A similar program for Black or other people of colour could not be located in a Canadian context.

Chapter Three: Discussion and Applied Practice

The literature review supported that Black, Indigenous, People of Colour experience several disparities when accessing healthcare related services in colonial Canada. The colonial Canadian and British Columbian healthcare system contains many systemic barriers for BIPOC folks when accessing these health-related services. Furthermore, there are a dipropionate number of inequities for BIPOC individuals when accessing health-related services that affect them in numerous ways.

Chapter three will explore these summaries and contain the following additional reviews. The literature review consisted of some limitations, mostly deriving from the current state of research and what is deemed and distributed as relevant research. Next, I move into the discussion of my findings throughout the literature review. Finally, I explore potential application measures to hopefully decrease disparities experienced by BIPOC folks as they access health related services.

Limitations

The limitations from the literature review within this capstone include the limited available literature on the topic of disparities experienced by BIPOC folks within healthcare related fields. Though there were supportive peer-reviewed articles expressing racism, ‘othering’, and microaggressions; there are still gaps and more research is necessary to better understand the exclusionary nature of our existing colonial Canadian healthcare system for BIPOC individuals. Only in further extensive research will there truly be a clear picture of the current state of the colonial Canadian healthcare system and the disparities experienced by BIPOC folks while utilizing these systems. Additionally, exploring each uniquely diverse population is necessary.

This is a limitation for this capstone, as the disparities experienced by BIPOC folks may be further broken down into each population to give a more focused picture of what each grouping of people may experience. Though there are many shared experiences within the broader BIPOC category, further research is necessary to truly understand what each population experiences when accessing health related services. In-depth research for each marginalized population within the BIPOC grouping will better allow systemic changes to better serve not just BIPOC populations, but additional marginalized groupings.

There is also the consideration of bias that exists towards BIPOC folks and people with a mental health condition, which can impact whether research is done involving these populations. As was explored in chapters one and two many people carry bias towards BIPOC populations and/or towards people living with a mental health condition. This can make these populations less desirable for research studies which would cause underreporting. Jacob et al. (2021) argues that severe mental illness, like schizophrenia, is so highly stigmatized that "less funding is dedicated to research about it than for other illnesses and less money is allocated to adequate care and management" (p. 284). Since research requires a heavy investment of time and money this poses an additional barrier for research that is geared towards exploring disparities experienced by BIPOC populations in healthcare related fields. There is an even greater barrier exploring the mental health of BIPOC populations due to the high stigma and bias that surrounds these intersectionalities.

The heavy financial investment that is often required for research causes many researchers to compete for funding. Research funding allocation often favours those with previous experience with successfully published peer-reviewed papers, the number of citations from previously published works, large research groups, and those belonging to a "tightly knit

research community" (Ebadi & Schiffauerova, 2015, p. 15). This is just a snapshot into the complex nature of research funding allocation and is a contributing factor to the gaps in research surrounding the disparities experienced by BIPOC folks when accessing healthcare related services.

Another large component of the gaps in mental health-related research for BIPOC populations and a part of the limitations for this capstone stems from the American Psychological Association (APA). As was reviewed in chapter two surrounding the APA's 2021 apology there were several factors that they held themselves publicly accountable for as to how they built and perpetuated systemic harm towards these marginalized populations. In their apology and in relation to research the APA specifically names that psychology "often continues to publish research that conforms with White racial hierarchy" and uses "Eurocentric research standards" (APA, 2021, para. 9; APA, 2021, para. 19). Furthermore, naming that "psychology has minimized and marginalized psychologists from communities of color and their contributions to the field", which are large contributing factors as to why there are gaps in the research for BIPOC communities (APA, 2021, para. 17).

The other areas of research in other healthcare services do not appear to be much further ahead than what the APA has named for the field of psychology. The research gaps are similar to the ones mentioned in the previous paragraph, but the Government of Canada has named some of these inequalities and outlined how they strive to address these social determinants of health and health inequalities. The Government of Canada (2024) state that there are inequalities for "Indigenous Peoples, Black Canadians, [and] immigrants" and that there needs to be a "strengthening [of] the evidence base to inform decision-making" (para. 11). There is available research for disparities experienced by BIPOC populations when accessing colonial Canadian

healthcare services, but more in-depth research remains necessary. This research will remain necessary until there is an equitable healthcare system where BIPOC individuals feel safe entering a healthcare setting and feeling confident that there has been enough systemic change that they are being treating fairly and adequately.

The larger overview of systemic structures that play a crucial role in disparities experienced by BIPOC folks when accessing healthcare related services was not entirely explored in this capstone. This is because it is a vast area of research that cannot be explored in depth for this particular capstone. Furthermore, there is the continued limiting factor of available research that thoroughly examines systemic structures from facility to health authority and from each level of government. It warrants additional research and continued examination until the colonial structure has been morphed into an inclusive and equitable one. Additionally, a more thorough investigation of colonial Canadian universities who offer medical school, nursing school, and master's and doctorate level psychology degrees to determine the number that offer equitable access for their programs is warranted.

Discussion

The literature review explored and reinforced the knowledge that BIPOC populations experience a disproportionate number of disparities when accessing healthcare-related services. Disparities impact these populations in several physical and mental ways. Regarding mental health supports, CBT can be a contributing factor to these disparities. An additional perpetuating factor are the inequities that exist for BIPOC individuals wanting to access colonial Canadian health related education programs. Finally, discussing the current state of cultural sensitivity training and the S<u>a</u>n'yas program.

Discussion: Disparities Experienced by Black, Indigenous, People of Colour in Healthcare-Related Services

Through the literature review of chapter two, it is evident that there are a disproportionate number of disparities experienced by BIPOC individuals when accessing colonial Canadian healthcare systems. A large component of these disparities comes from the healthcare providers who carry bias and are exclusionary based on someone's background. This is prevalent with those who are racist and 'other' BIPOC clients and patients. These acts of 'othering' maintain an 'us vs them' mentality and lack a cohesive sense of community. Clint Curle who wrote for the Canadian Museum of Human Rights (2020) describes the process of 'othering' as one that can "set the stage for discrimination or persecution by reducing empathy and preventing genuine dialogue" (para. 10). Curle's description encapsulates a lot of what the chapter two literature review discusses. This is because much of the disparities caused by practitioners because of 'othering', as well as systemic inequities, is a lack of empathy for another human. A lack of perspective that this person may experience difficulties and that oneself could be a reason for those difficulties. An increase in empathy could be a step towards a reduction in some disparities experienced by BIPOC folks when accessing health related services. Perhaps this could be achieved through effective cultural sensitivity training and reflection, which will be explored later in this chapter.

The implications for disparities experienced by BIPOC individuals when accessing health related services in colonial Canada is vast. These disparities can affect a person in all areas of their health. The length of these consequences varies. For some, it is linked to short-term discomfort. For others it can culminate into avoidance of care all together as was

explored by Johnson et al (2004), Silverman and Teachman (2022), and the in-depth report by Turpel-Lafond (2021). Furthermore, it expands into difficulties for BIPOC folks accessing mental health supports to navigate these disparities and other impacts of racism, microaggression, and 'othering'. With limited publicly funded mental health services, the high cost for private psychotherapy, and additional impacts of intersectionalities, it is quite evident that access to effective mental health services is inequitable for many BIPOC folks. This is further stressed by the prevalence of outdated and prominent psychotherapies, ones that lack the perspective necessary for a culturally sound approach to psychotherapy, like CBT can be.

Discussion: CBT Overview and Relation to Disparities for BIPOC Individuals When Accessing Mental Health Services

Through the literature review it is apparent that CBT is a contributing factor for disparities experienced by BIPOC folks when accessing mental health care services. CBT is so prevalent throughout mental health communities, the label of it being the 'gold standard of psychotherapy' is a prominent one (Clark & Holttum, 2022; David et al., 2018; Leichsenring et al., 2018). Having such a prestigious title would cause many to want to access this therapeutic modality. Furthermore, it may cause practitioners to gravitate towards the modality, and without critical thinking, could utilize it and potentially perpetuate harm with certain demographics. Furthermore, since healthcare providers and psychotherapists maintain a power imbalance in the client-clinician relationship, a clinician may use a modality like CBT and the client may not have the courage to express their discomfort with the approach. This could be because the clinician is viewed as the 'knower' or the 'expert' and even if a BIPOC individual is already distrusting of a healthcare provider they may believe this CBT approach is the best thing for them. This power imbalance can negatively impact the client by increasing "feelings of powerlessness" and

increasing “feelings of decisional incapacity in patients, further hindering their participation” (Mertens et al., 2025, p. 8). In addition, the client may proceed with the CBT modality despite potential harm or ineffectiveness.

CBT is prevalent throughout publicly funded healthcare services in colonial BC. For example, during a brief exploration of available mental health positions that are designated for registered clinical counsellors and registered social workers listed as a skill and ability on several job postings was “comprehensive applied knowledge of counselling techniques including Cognitive Behavioural Therapy (CBT) and other psychotherapeutic techniques” (Fraser Health, 2025, para. 24). Though other psychotherapeutic techniques are listed under the skills section of these job postings, there is still clear gravitation towards people who utilize and are knowledgeable in CBT approaches.

CBT is listed as the primary psychotherapy for those within the Fraser Health Psychosis Treatment Optimization Program where people are referred when their “medication is not working well to treat their psychotic illness” (Fraser Health, 2025, para. 2). Within the Fraser Health Psychosis Treatment Optimization Program, it is listed that those referred to the program will participate in “15-20 weekly sessions with a trained CBT therapist” to explore and treat their hallucinations and delusional thoughts (Fraser Health, 2025, para. 8). Furthermore, Island Health specifically lists CBT as the psychotherapeutic modality used to assist people with anxiety disorders in their counselling, treatment & recovery section of their webpage (Island Health, 2025). This is indicative that those who are able to access publicly funded mental health supports in the Fraser Health Authority and Island Health area are likely to encounter CBT. Notably, Vancouver Coastal Health and Interior Health, the remaining health authorities in colonial BC, did not explicitly state a CBT approach on their publicly accessible websites or job postings

(Island Health, 2025; Vancouver Coastal, 2025). Transparency in publicly and privately funded mental health programs is an important aspect for those who want, and have the ability, to investigate what services are available.

Discussion: Current State of Colonial Canadian University Programs for Healthcare-Related Education

The exploration of the current state of some colonial Canadian university admissions access for BIPOC students in health-related education programs shows progress in medical school and nursing programs, but master's level psychology degree programs are falling behind. The University of British Columbia (UBC) and the University of Saskatchewan (USask) medical schools outwardly have a strong avenue for amplifying access for Black and Indigenous students. Similarly, the University of Toronto and the University of the Fraser valley have an increased equitable access for Indigenous applicants to their nursing programs. It is unknown how well these programs are designed for retention and the success of these students. The explored colonial Canadian universities that offered a master's level psychology programs demonstrate lacking any form of equitable access for BIPOC students. This sheds a light as to why there could be such an underrepresentation of BIPOC psychotherapists in colonial Canada, and likely other parts of the world.

Discussion: Cultural Awareness and San'yas Training

San'yas cultural sensitivity training outwardly seems meaningfully well prepared to reduce the disparities experienced by Indigenous peoples in colonial Canada. However, it appears to be the only prevalent cultural awareness or sensitivity training that is widely utilized throughout the colonial BC health sector. Outwardly it appears to be meaningfully developed and widely utilized. Without access to the training materials, I cannot adequately describe the

process. However, I have taken San'yas training in the past, as I mentioned in my introduction, and for those that were willing to participate, I recall it having thought provoking material. This is supported through Browne et al.'s (2021) research where they describe the program as causing participants to not only increase their knowledge and skills surrounding cultural safety with Indigenous peoples but also provides them with an "increased ability to identify strategies to integrate their new understanding into their actions and work functions" (p. 14). There is room for improvement and since it is designed to be a one-time access workshop, it could continue to be expanded to further the necessary cultural sensitivity work. San'yas is not the only solution to increasing cultural awareness for health professionals and for decreasing healthcare related disparities for Indigenous populations, but it appears to be a good starting point that needs further adaptation for other BIPOC populations.

Application

Since there are a disproportionate number of disparities experienced by BIPOC populations when accessing health related services in colonial Canada, in this next section I will explore potential ways to decrease these disparities and hopefully improve BIPOC populations overall holistic health. One keyway that the literature review has revealed is by increasing BIPOC representation throughout health-related fields. Doing so requires systemic changes at the university level by adjusting admissions and retention approaches to more equitably fit BIPOC students. Additionally, evaluating and altering psychotherapy approaches as per the needs of individual clients is an important step towards decreasing disparities for BIPOC populations. Furthermore, by making additional systemic changes throughout existing health fields by implementing and requiring cultural safety programs like San'yas.

Increasing Black, Indigenous, People of Colour within Health-Related Fields

Increasing BIPOC representation throughout all areas of healthcare is a crucial step towards reducing disparities. Having an increased number of BIPOC health and mental health providers increases overall cultural safety within these environments. This increase in cultural safety is because BIPOC individuals can more easily pick up on safety cues by other members within these populations (Cipollina & Sanchez, 2023). Having representation does not excuse clinicians from diverse backgrounds from having to put in the work to also become culturally competent individuals, they must still put forth the effort to be culturally competent and foster safe environments for BIPOC populations and the general public alike. Furthermore, Cooper Brathwaite et al. (2023) indicate that representation needs to occur within all-levels of government to help improve existing oppressive legislation. Part of increasing representation also aides in shifting Eurocentric systems of mental healthcare towards diverse and more inclusive systems (Faber et al., 2023).

Equitability for Health-Related Colonial Canadian University Programs

Equitable access for admissions applications is an important step towards appropriate BIPOC representation throughout health-related fields. Since BIPOC populations have a higher chance of having a lower socio-economic status they not only are more likely to have poorer health outcomes, but this also limits access to post-secondary education (Canadian Federation of Medical Students, 2010; Canadian Poverty Institute, n.d.; National Collaborating Centre for Indigenous Health, 2020). In regard to medical school admissions, the Canadian Federation of Medical Students (2010) argue that those from less affluent backgrounds are less likely to pursue medical education as opposed to higher income students. They have increased barriers for application fees, tuition costs, and potential relocation costs. Furthermore, they are less likely to consider a career in medicine because they are less likely to have “access to role models in

medicine, and [have] a more accurate perception of a medical career" (Canadian Federation of Medical Students, 2010, p. 3). These points about barriers to cost and a likely lack of role models in medicine are reminiscent throughout other areas of healthcare like nursing and psychotherapy positions. With a lack of diverse BIPOC representation in the fields also comes a lack of role models for younger BIPOC individuals to aspire to be.

Encouraging BIPOC admissions and decreasing barriers to access healthcare related field post-secondary programs is an important step to increasing BIPOC representation throughout various healthcare related fields. This can be done in a plethora of ways including, offering additional scholarships for BIPOC student applicants. Scholarships are not only a financial benefit they are also linked to increased "academic success, motivation, satisfaction, retention, and engagement" (Ahmed et al., 2022, p. 234). The possibility of having access to reduced or fully covered tuition may increase admissions applications and therefore admissions of BIPOC students. An additional barrier that could be removed by colonial Canadian institutions is removing or reducing the application fee for underrepresented students. Additional measures such as early retention and inspiration to pursue higher education is also important for BIPOC students in grade school. Though there is room for improvement to increase equitable access for BIPOC applicants for colonial Canadian universities that offer medical and nursing programs; there is tremendous improvements that need to be done for master's level psychology programs.

Through the literature review it was quite apparent that the evaluated colonial Canadian universities lack sufficient equitable access for BIPOC students aspiring to apply to their master's level psychology programs. By providing available scholarships, bursaries, or grants for BIPOC students these universities are increasing equitable access for these students. Notably, City University in Canada (2025) does offer an Indigenous Students Tuition Reduction Grant

that reduces Indigenous students' tuition by 25% and has a specific needs-based scholarship and investing in Indigenous scholars' scholarship. However, it is unclear whether the scholarships have been awarded as the recipients are not listed publicly. There is no specific financial aid awards designated for Black students or other people of colour at City University of Canada. From my research there was no specific reduction grant for any BIPOC population at The University of Calgary, Dalhousie University, Yorkville University, or Simon Fraser University on their publicly accessible websites. However, there could be scholarships or grants available on their intranet or in specific locations that I could not locate.

In terms of increasing admissions, these institutions could benefit by looking towards their medical school counterparts at the University of British Columbia (UBC) and the University of Saskatchewan (USask). UBC and USask medical programs already have a foundation that, if functioning as advertised, is on track to improve Indigenous and Black representation in the field of medicine. By incorporating aspects like reserved seats or specific panels with adequate representation the path to a master's degree in a psychology field may feel more attainable for some prospective BIPOC applicants. Additionally, altering how these students are examined academically could be beneficial to increase admissions for BIPOC students in not just master's level psychology programs, but medical schools, nursing schools, and schools designated for various other health professions.

Education is dominated by colonial perspectives and is systemically geared toward amplifying Eurocentric ways. Smith et al. (2019) argue that "academia is often considered a pillar of colonialism in monopolizing the production of knowledge" (p. 103). BIPOC populations have historically been unable to determine what is considered to be important knowledges and teachings. Colonial Canadian residential schools and other colonial structures stripped away

Indigenous ways of knowing and being, which continues to be seen as lesser in academia. Bonikowska et al. (2024) indicate that Black students and other students of colour are less likely to succeed in colonial Canadian school systems. Traditional ways of knowing and being are not viewed as adequate in colonial academia. In addition to the lack of honouring these diverse populations in their traditional ways of knowledge, they are also not set up for success in colonial Canadian education settings. Many of these education disparities arise from their intersectionalities and challenges in other aspects of their lives like low socio-economic status, lack of role models in various professional fields and their overall health. We have managed to circle back to the importance of reducing disparities experienced by BIPOC individuals not just in education or healthcare, but their overall life. A key element to aiding in reducing disparities is by improving and supporting the mental health needs of BIPOC individuals.

Application: Suggested Mental Health Systemic Changes

Systemically, government agencies could invest in stronger, more diverse mental health supports. According to the Mental Health Commission of Canada (2012) in a study done in 2011 mental illness had an "economic cost to Canada [of] at least $50 billion per year" (para. 3). This was a study done nearly fourteen years ago; an updated study does not seem to be available surrounding the estimated collective costs of mental illness in colonial Canada. Some of those costs are preventable with appropriate access to publicly funded, diverse and culturally safe mental health services. One of the key gaps in the existing system is the lack of diverse and culturally safe mental health services. There does appear to be a limited number of publicly funded services in colonial BC, with some explored in colonial Ontario earlier in chapter two, but many of those services are designated as being CBT orientated.

CBT and BIPOC Populations

With CBT being outwardly prevalent and the focal point of psychotherapy in two colonial BC health authorities, it seems apparent that additional work needs to be done to enhance awareness surrounding mental health supports throughout healthcare fields and government structures. Though CBT can be quite restrictive and can perpetuate disparities in mental health services for some BIPOC folks, there does appear to be a conscious effort to incorporate culturally adapted versions to better serve these populations. Since many health authorities and likely other institutions are gravitating towards the 'gold standard' that is CBT, it is important for psychotherapists to approach it from a culturally adapted CBT standpoint. Furthermore, it is important that psychotherapists in a position where they are required to use CBT in some variation to advocate for their clients throughout the therapeutic process. Additionally, knowing that each person is unique and carries various elements that make them similar and different to others from similar backgrounds is one of the most crucial elements for an effective and ethically sound psychotherapist. Which means that despite CBT historically perpetuating harm for some BIPOC individuals, it could still be the right fit for certain people. It is important to consistently evaluate what is working and what is not for a client.

CBT Therapeutic Fit and CBT Therapeutic Alliance.

When working with a BIPOC client, CBT psychotherapists need to evaluate whether CBT, either culturally adapted or traditional, is the most appropriate modality for a client. Huey et al. (2023) mention that psychotherapists should be cognizant of provider bias where they utilize their preferred modalities, like CBT, to treat a client without the consideration that another modality may be more beneficial for them. Failure to recognize this is considered unethical, and typically the best practice is for the psychotherapist to adapt their primary approach or consider referring the client out (Haworth & Gallagher, 2015). Not every psychotherapist and modality fit

everyone, whether they are BIPOC or not. This is why it is important for psychotherapists to evaluate fit with clients throughout the process, doing so also enhances the therapeutic alliance.

Kowatch et al. (2019) describe that a strong therapeutic alliance is an important factor in predicting successful outcomes in culturally adapted CBT approaches. Furthermore, Naeem (2019) argues that a strong therapeutic alliance helps increase engagement and improve outcomes for culturally adapted CBT participants. Bose et al. (2025) examine the relationship between the therapeutic alliance and positive symptom outcomes for youth using traditional CBT practices. Their research indicated that a strong therapeutic alliance actually demonstrated a poorer outcome in the surveyed youth's anxiety symptoms. Bose et al. (2025) believes this to be the case because the "providers who perceived a strong initial alliance with youths might have shied away from challenging youths with intense exposures, out of fear of rupturing the alliance" (p. 573). It appears that there is quite the contrast from these culturally adapted and traditional CBT articles regarding outcomes. It is worrisome that the article by Bose et al. (2025), which was published the same year as the writing of this capstone, carries a narrative that contradicts the recommendations of culturally adapted CBT reviews.

The Importance of Therapeutic Alliance

It is not only important for CBT therapists to examine their therapeutic alliance and fit for a client, but also for all psychotherapists to evaluate these components throughout the therapeutic process. Determining efficacy, safety, and fit occurs within well-established therapeutic alliances. Horvath et al. (2011) argues that having an effective therapeutic alliance "results in a secure holding relationship within which the work of the therapy can begin", it also is a crucial component in the client being willing and able to invest in the therapeutic process (p. 10). It is through the therapeutic alliance that a psychotherapist should be able to evaluate their fit for a

client and refer a client out when the therapeutic fit either is not established or is no longer present. Building, maintaining, and evaluating the therapeutic alliance and relationship is a crucial step to providing the best care possible to all clients.

The therapeutic alliance is not only important for psychotherapists, but it is also crucial in other health-related fields. Jagosh et al. (2011) describe how a strong doctor-patient relationship is a central component for successful clinical outcomes. For nurses, Camedda et al. (2023) indicate that the nurse-patient relationship provided patients with "a feeling of being understood, [gave] them the strength to fight the disease, restor[ed] hope" and increased their understanding of their disease process (p. 991). A strong therapeutic alliance is also beneficial for physiotherapists, occupational therapists and dieticians; who are other commonly accessed allied health professionals (Haynes et al., 2022; Robertson & Davies, 2024; Smith et al., 2023). Increasing the therapeutic alliance helps each of these professions in understanding their clients/patients and aides in reducing disparities for not just BIPOC populations, but each person they work with.

Building the Therapeutic Alliance

There are various ways to build and strengthen a therapeutic alliance. Some of these components come from working on general communication skills and authenticity. Additional ways come from self-reflection to review their own approaches, bias, and impact on BIPOC populations. Finally, working on cultural sensitivity training can further deepen a clinician's relationship and treatment of clients/patients.

Building and fostering a strong therapeutic alliance originates from the general communication skills of the clinician. Smith et al. (2023) describe how simply approaching a client in a friendly, flexible, and caring manner can set the foundation for a strong therapeutic

relationship. Furthermore, authenticity, consistency, and genuineness are crucial components as it allows the patient to build trust and come to know what to expect with the clinician (Jagosh et al., 2011; Muran & Barber, 2011). Furthermore, addressing and managing power differentials is beneficial for strengthening the therapeutic relationship (Muran & Barber, 2011; Smith et al., 2023). Additionally, by approaching situations in a "non-judgemental observation of the ongoing stream of internal and external stimuli" they further foster a strong therapeutic alliance (Smith et al., 2023, p. 1442). In doing so, clinicians are more capable of building empathy and viewing the client/patient as a person and not their disease or a biased perception (El et al., 2024; Muran & Barber, 2011; Robertson & Davies, 2024; Smith et al., 2023). By increasing empathy there is ideally a decrease in 'othering' and disparities experienced by BIPOC populations.

Self-Reflection and Building Empathy in the Therapeutic Alliance

Self-reflection is a critical component in building and maintaining empathy in the therapeutic alliance. By self-reflecting people are encouraged to review how their actions and thoughts may have or could have had an impact on another person. According to Vass and Adams (2021) an effective self-reflection process can decrease racism, and by extension disparities for BIPOC folks. In this process participants look into their own culture and explore how these components influence how they interact with their patients and how the healthcare system might treat them verses someone from a different cultural background (Vass & Adams, 2021). This is also a large component of cultural sensitivity training. Self-reflection can occur in a variety of ways via journalling, answering specific prompts, and in some cases sharing these thoughts and experiences in a discussion group setting (Rix et al., 2014; Vass & Adams, 2021). Through the reflection process it is common for focal points of racism, privilege, and White privilege to be explored (Hadley et al., 2022; Rix et al., 2014; Vass & Roberts, 2021). Self-

reflection is a life-long commitment, much like how most healthcare careers involve life-long learning. The hope is that people practicing self-reflecting will better understand how they fit into society and how their actions impact others.

Application: Cultural Sensitivity Training

An effective, but not the only solution, to aiding in increasing self-reflexivity, educating, and reducing disparities for BIPOC populations is through appropriate cultural sensitivity training. The core reasons why exploring culture is so important for health professionals is because culture is deeply complex and can shape our views around health and wellbeing. Our culture also influences who we view as healers, who we go to for support in the healing process, and can precipitate or aid in dealing with illness (Bhugra, 2006). Furthermore, in the self-reflection of one's own culture, they are able to view their role in either reducing or perpetuating disparities for BIPOC and other marginalized populations.

Ideally, cultural sensitivity training should occur within health-related education programs. Gregus et al. (2020) indicate that when clinicians are effectively taught appropriate cultural sensitivity training, their patients had increased positive outcomes. They go on to criticize the current state of many clinical psychology doctoral programs indicating that many are not effectively teaching these important competencies (Gregus et al., 2020). Some of these problems stem from the lack of BIPOC representation amongst the education staff, which could be increased. Additionally, Razack et al. (2024) describe an appalling experience of an Indigenous medical student at a colonial Canadian medial school where the instructor candidly joked about an allele being present on Indigenous peoples' genes originated all the way "back when they lived in teepees and hunted buffalo" (p. 115). Razack et al. (2024) continue to describe how this experience impacted the only Indigenous medical student in the class and how

they observed their peers hanging onto every word of the ‘expert’ instructor. It is important to hold this university, and all universities, accountable for the staff they hire to train the next generation of health professionals. Additionally, it is important for the university institutions to support their BIPOC students when they present any possible perpetuation of disparities for BIPOC populations observed to be occurring by instructors and university staff. It is important for all university educating staff to practice their own cultural sensitivity training, this could be assisted with programs like San’yas.

San’yas is a good starting point for colonial Canadian health-related fields. It would be incredible if there was a Black specific training similar to San’yas and continuing on to other specific people of colour groupings. As was mentioned in the definitions section, I utilize the term BIPOC throughout this capstone because it acknowledges that all BIPOC folks experience inequities, but Black and Indigenous peoples have shared historic and present experiences of violent and deadly oppression (Wong & Jackson, 2023). This is why I suggest starting off with encouraging and expanding San’yas training to increase awareness for Indigenous peoples living in colonial Canada and then adding in training focused on cultural training focused on Black peoples. Further expanding training for other specific groupings. Acknowledging that training for each people of colour population may not be entirely attainable but developing these types of focused training programs for populations with higher densities in specific areas. Furthermore, encouraging the self-reflection process should lead to an increase in self-accountability.

Application: Exploring Cultural Views on Mental Health

Throughout the psychotherapy and the cultural sensitivity process it is important to explore how the individual views mental health and illness. Their views on mental health and illness should shift the approach to psychotherapy and it deepens the psychotherapist’s

understanding of the client. For example, when we examine the views of some people with Hispanic heritage in relation to mental health and schizophrenia, it is often that they carry a heavy stigma around the topic and will often avoid discussing the topic all together (Gearing et al., 2023). Whereas in Japanese culture, though mental health problems are also highly stigmatized, they view symptoms of schizophrenia as potentially being explained away as the person being in a meditative state (Withers, 2023). These are just two examples of how some cultures view mental health and one specific mental health condition, schizophrenia. Though these are descriptions from peer-reviewed sources surrounding Hispanic and Japanese views on mental health and schizophrenia, it is still important for the psychotherapist to work to understand the individual's views on such topics as they can vary. Failure to do so can demonstrate a lack of cultural awareness and perpetuate harm by the psychotherapist.

Application: Systemic Change

As one navigates the self-reflection process, it is hopeful that people will eventually begin to reflect on systemic reflexivity. Rix et al. (2014) describe 'system' reflexivity as "reflexivity [that] scrutinises and reflects on institutional policy and practice" that inherently increases disparities for BIPOC populations. This means evaluating and holding larger institutions accountable for their role in perpetuating inequities for marginalized populations. Vass and Rogers (2021) describe the importance of self-reflecting not just for practicing healthcare professionals, but also for those that are educating these groupings, as well as the institutions themselves. Through appropriate self-reflection it is possible for clinicians to not only view their interactions with BIPOC populations and their clients/patients, but also how to strive to create a more equitable society. Hadley et al. (2022) call these types of process out for potentially being performative, which is why it seems important to include some kind of measure

where institutions commit to education and enforce repercussions for those that are identified as causing disparities.

Additionally, it is important to acknowledge the systemic issues perpetuated by organizations like the APA and push for change. The APA acknowledged several things that they were responsible for in perpetuating harm towards marginalized populations. Including how "psychological tests and instruments … contribut[es] to the overdiagnosis, misdiagnosis and lack of culturally appropriate diagnostic criteria to characterize the lived experience and mental health concerns of people of color" (APA, 2021, para. 23). There are also the various components of the Truth and Reconciliation commission reports that name how the colonial Canadian government has perpetuated harm for Indigenous peoples in a variety of ways. The naming of these systemic inequities is long overdue and is only a minor step in the right direction to achieve equitable research and access to health services for BIPOC populations.

Final Thoughts and Reflection

It is apparent that BIPOC populations experience many disparities when accessing health-related services in colonial Canada. Many of these disparities can be reduced at the clinician level through adequate cultural sensitivity training and constant self-reflection. However, the biggest changes come from systemic changes with accountability and resources coming from the institutional level. With these systemic changes we should find better ways for held accountability for educators within health-related university programs and clinicians out working who may perpetuate these problems. Furthermore, an increase in empathy and reinforcing the human connection will immensely help with the reduction of these disparities. The time for reconnection, once again, largely comes from the systems at play, by providing adequate clinician to client ratios in large healthcare settings and by increasing funding for

adequate mental health supports. It is a long and necessary journey to reduce disparities for BIPOC populations accessing health-related services in colonial Canada both at the systemic level and individual levels.

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