Anti-oppression psychotherapy: An emancipatory integration of intersectionality into psychotherapy

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Introduction

The therapeutic alliance between psychotherapist and client has been demonstrated to be a key element for psychotherapy effectiveness (Wampold, 2015). The alliance, however, exists within transnational, socio-historical contexts determined by social and structural relations. For this reason, there have been multiple calls for a change in the predominant Eurocentric, colonial, and androcentric paradigms in counselling and psychotherapy (e.g., Boonzaier & Van Niekerk, 2019; Cole, 2010; Duran & Duran, 1995; Fanon, 1967). The required change involves a shift towards frameworks that take into consideration power dynamics based on dimensions such as race, socioeconomic status, gender, Indigeneity, age, and sexual orientation, among others, moving beyond “one size fits all” approaches (Timothy, 2012; Norcross & Wampold, 2018). From a health promotion perspective, it involves a comprehensive integration of a perspective that addresses the social determinants of health (Johnson & Sampson, 2019; Paradies, et al., 2015). The field of social work, influenced by the civil rights movements of the 1960s, expressed concern in relation to racism in the 1970s, which in the 1990s expanded into understandings of the role of multiple oppressions, leading to the emergence of anti-oppressive practice (Laird, 2008). For over 15 years, social work scholars and practitioners (e.g., Baines, 2011; Bishop, 2002; Carniol, 2010; Dominelli, 2002; Fook, 2002) have continued to advance anti-oppression praxis, more recently formulating micro level interventions (Curry-Stevens, 2016).

Within the field of counselling, psychotherapy, and psychology, the call for a practical and epistemological evolution has resulted in the emergence of approaches that attempt to address issues such as gender/sexism, as in the case of feminist psychotherapy (Brown, 2018), and issues related to other individual and community differences through what has been called “multicultural counselling” (Palmer, 2002). The predominant feminist approach, however, has been critiqued due to its white, heterosexist, Eurocentric tendency to address unidimensional variables (such as gender) as absolute discrete aspects explained at the individual level without addressing their interconnection to other variables within sociohistorical and transnational contexts (Green, 2005). A similar critique has been articulated in relation to approaches by prominent scholars in the fields of “cultural competence” that look at cultures through perspectives that replicate the

colonial gaze over the “other,” often manifesting in books that resemble an “essentialising tour” that present specific populations as if they were monolithically homogeneous across time and space (Gorski & Goodman, 2015). Several authors within academic and grey literature have elaborated on anti-oppressive practice in counselling and psychotherapy (e.g., Brown, 2019; Moodley, 2006); however, there remains the challenge to integrate a perspective that addresses the power dynamics embedded in this phenomenon, which has resulted in reiterated calls to decolonise multicultural counselling (Goodman & Gorski, 2015). Intersectionality (Combahee River Collective, 1978; Crenshaw, 1991; Hill Collins, 2015; Timothy, 2019) has been examined as a useful construct to capture the complexities derived from individual and collective multiple social positionalities due to systemic power imbalances in psychotherapy (Cole, 2009; Green, 2005; Grzanka, 2020).

In this article we provide a glimpse into our model, *anti-oppression psychotherapy* (AOP), which originated from our work within Black, Indigenous, transnational, anti-colonial, feminist paradigms. Significant components of the model emerged from the doctoral work of Roberta Timothy (2007), as well as from our over 25 years of experience providing counselling and psychotherapy, as well as clinical supervision (15 years). Our model is informed by our personal and professional experiences as women of African and Indigenous descent, with transnational and transgenerational connections directly related to multiple oppressions and resistance.

We grew up in different countries—Canada and El Salvador respectively—and were heavily influenced by our social locations as a Black woman (Roberta), and a woman of Indigenous and African descent (Mercedes). Roberta grew up actively involved since the age of seven in the feminist movement, anti-apartheid movement, pan-African movements (her mom was an activist and feminist counsellor). Mercedes grew up in El Salvador during the years of war, was involved in the feminist movement in her country, and obtained her undergraduate degree from the Central American University Jose Simeon Cañas in the Department of Psychology Chaired by Ignacio Martin Baró, who was brutally assassinated by army units due to his promotion of human rights, peace, and the *psychology of liberation*. We both met in Toronto, Canada, practicing as psychotherapists and counsellors while pursuing graduate degrees. It was based on our passion for social justice and equity, grounded in the understandings from African/Black/Indigenous knowledges that we articulated the AOP model in response to the limitations in approaches and models that do not integrate adequately an intersectional perspective. We have trained and presented the AOP model in national and international conferences since 2005, including the American Psychological Association Convention (Timothy & Umana, 2015), and the Canadian Psychological Association Convention (Timothy & Umana, 2011). A more specific formulation on its applicability as trauma informed praxis has also been published by the Centre for Addictions and Mental Health (Timothy, 2012). We are currently working on a book publication that will discuss the model in more detail.

Anti-Oppression Psychotherapy

Anti-oppression psychotherapy is a therapeutic approach that counsellors, psychotherapists, and other clinical practitioners can use with clients of all social locations to support an empowerment-centred change process needed to deal with the effects of oppression, trauma, and intersectional violence in clients' lives. AOP incorporates both anti-oppression theories and practices, and psychotherapy to understand and work with individuals and/or groups under internal and external distress due to the lived experiences of oppression, trauma, and intersectional violence. By examining the impact and experiences of intersectional violence based on therapists' and clients' social locations, identities, and lived experiences, within transnational and trans-generational contexts, AOP can provide a catalyst for change in the lives of clients, therapists, and their communities. The actualisation of resiliency and resistance for clients and therapists through an integrated psychological change process is critical to AOP.

Central to AOP practice is the notion of *social location*. Specifically, this term refers to how individuals and groups are placed differently within systems of power and dominance based on categories such as race, Indigeneity, gender/gender identity, sexual orientation, (dis)abilities, socioeconomic status, age, as well as spirituality/religious affiliations (Hill Collins, 2015). From an intersectional perspective, social locations are intrinsically related to the systems of power and dominance that give meaning to them (e.g., racism, anti-Indigeneity, colonialism, sexism, misogyny, homophobia, heterosexism, transphobia, ableism, and classism) (Timothy, 2019).

The Evolving Socio-Historical and Transnational Contexts from which Anti-Oppression Psychotherapy Emerges

There is much evidence demonstrating that experiencing racism, classism, homophobia/heterosexism, ableism, ageism, social exclusion/violence due to spirituality/religion, and/or other forms of oppression, has detrimental impacts on the mental health of individuals, collectives, and communities (e.g., Hatzenbuehler, Phelan, & Link, 2013; Lewis, Cogburn, & Williams, 2015; Livingston & Boyd, 2010; Pachankis, Hatzenbuehler, & Starks, 2014; Pascoe, & Smart Richman, 2009;; Williams & Mohammed, 2009). AOP views the socio-historical and transnational contexts of therapist and client as always present in their interactions. Hence, forming a strong therapeutic alliance requires therapists' active awareness, understanding, and accountability regarding their own historical and contemporary positionalities and subsequent ideologies and practices in relation to interlocking systems of dominance and oppression. These ideologies and practices are key as they constitute systemic vehicles to perpetuate exclusion and violence of large segments of the population based on categorisations that render some as oppressed and excluded, while giving others *unearned privilege*. Here the notion of "unearned" is significant as it illustrates that based on systems of power and dominance, some individuals who fit the social construction of whiteness do not have to demonstrate merit in order to be assumed to be "competent," "trustworthy," and "good citizens," while others are deemed "suspect," "criminally inclined," and "untrustworthy," as exemplified by global practices of racial profiling in relation to

people of African ancestry who fall within the social phenotypical construction of “Black”. We contend that these parameters of social and political exclusion are always present in the therapy room in implicit and explicit ways.

Some of the fundamental sociohistorical contexts influencing the therapeutic alliance involve ideologies and practices related to colonialism, white supremacy, anti-Black racism, anti-Indigeneity, sexism, misogyny, homophobia, heterosexism, transphobia, ageism, classism, ableism, and discrimination/violence based on spirituality/religious affiliation. A task in AOP involves active tracing and de-constructing of the ways in which these systems of dominance and oppression are reproduced in the therapeutic interactions, for example in intake/assessments and the moment-to-moment interactions between client and psychotherapist.

Anti-oppression psychotherapy contends that the “here and now” simultaneously coexists with a “there and then” across generations and beyond nation-state borders. Hence, African Enslavement, genocide of Indigenous communities, police brutality, multiple holocausts, Jim Crow laws and apartheid systems, head tax and immigration laws, abuse of children and women, homophobia, transphobia, eugenics, ableism, hate crimes, violence based on spirituality/religious affiliation, and other injustices, locally and transnationally, are not the past, but rather a continuation of struggles and violence. The above-mentioned historical struggles intertwine with the present, rendering the concept of the “here and now,” so often spoken about and revered in psychology, void of the “before, during and since,” which is often needed to explain the totality of clients’, therapists’, and communities’ experiences .

For example, utilising the focus on “here and now” from Yalom’s group psychotherapy model (Yalom & Leszcz, 2005) in processing of emotional distress in relation to experiences of sexual harassment in the lives of women of Indigenous and African ancestry risks silencing and retraumatisation. We contend that these experiences cannot be fully understood and therapeutically processed adequately without dimensioning the complexities derived from the colonial historical and contemporary use of “controlling images” (Hill-Collins, 2000) and without acknowledging the particular social location and experiences of the therapist in relation to this history.

Anti-oppression psychotherapy arises as an accountable response in a world where oppression is rampant and frequently accepted and practiced as a normative right to protect certain individuals and collective human rights while excluding others, as evidenced, for example, by the global silence of the horror in Rwanda and Congo, versus the outcry and immediate action in Eastern European countries during ethnic cleansing dilemmas. AOP exist in a world where “man and woman” still represents a white universal gender. It exists where sexual orientation and gender rights are debated in “civilised” United States courts, versus racialised media portrayals of far-away places where LGBTIQ peoples are “savagely” murdered, without exploring the notions of identity branded by historical connections to colonised religious indoctrinations or ignoring the widespread violence of hetero-normative practices globally. AOP exists in a world where disability means inability (Harpur, 2019), where privilege is “okay” if stated nicely (Gerster

& Bowden, 2020), and where new immigrants and refugees are second-class citizens (Bhuyan, 2014) and Indigenous peoples “classless” and “landless” (Peters & Christensen, 2016).

Anti-oppression psychotherapy was developed after many years of reading, writing, analysing, and developing practices in and outside of the psychotherapeutic field. Unlike many psychotherapeutic models, anti-oppression in AOP is not an “add on” at the end of a text. AOP can be used to support other psychotherapy disciplines in understanding and working through difference or it can be used on its own. Difference is not associated to a category of “otherness” to be only explored by like-minded people but rather a reality of the different locations of client, therapist, and community, based on dynamic factors of identity that include race, gender, sexual orientation, age, disability, class, immigration status, spirituality/religions, and Indigeneity, among others.

Working Definitions

The following are key definitions in AOP:

- *Oppressions*: Ideologies and practices sanctioned by state and cultural institutions and individuals in positions of hegemony (power) that create marginalisation and subjugation of certain groups of people based on violence: racism (e.g., anti-Black racism), classism, sexism, homophobia and heterosexism, ableism, ageism, colonialism, cultural imperialism, oppression based on spirituality/religion, anti-Semitism, Islamophobia, and anti-Indigeneity.
- *Intersectional violence*: The interconnectedness of experiences of violence due to oppressions (e.g., racism, heterosexism, ableism, ageism, classism, sexism, and colonialism). In addition, interconnected oppressions and systems of interlocking dominance are interchangeably used to mean intersectional violence.
- *Factors of identity/intersectional factors*: These are factors such as race, class, gender, sexual orientation, age, (dis)ability, Indigeneity, immigration status, language, and education attainment, that interconnect with each other to form social locations.
- *Transnational and trans-generational contexts*: These terms are used throughout this article to indicate global, local, contemporary, and historical connections in psychotherapy that impact therapists and clients’ locations, experiences of intersectional violence, and therapeutic processes.
- *Trans-generational trauma* (TT): Any form of mental, physical, social, financial, or spiritual distress and dis-empowerment experienced consciously or unconsciously by current generations of peoples (survivors) on an individual, collective, and/or community basis. This distress is directly related to, or caused by, experiences of historical and contemporary violence (traumas) such as African enslavement/slavery, genocides, holocausts, colonialism, etc., inflicted on numerous generations of peoples that drastically altered their cultures, familial practice, economies, knowledge institutions, land acquisitions and resources, health access, outcomes and treatment, language acculturation and governance (including self-determination), and autonomy processes.

- *Resistance education*: The methodology employed in AOP. It is used for research and praxis, inside and outside of academia, to create critical methods and practices that support both broad revolutionary social change and, in particular, resistance against intersectional oppressions.

Anti-Oppression Psychotherapy Principles

In this section, we briefly outline the eight fundamental principles of AOP (Timothy & Umana, 2009).

1. Committing to Addressing Intersectional Violence and Oppressions in the Therapeutic Process.

Anti-Oppression Psychotherapy is dedicated to addressing intersectional violence and oppression in the therapeutic process. Examining and building clients' and therapists' anti-oppression competencies is critical to the approach. This is done by acknowledging and respecting different worldviews and knowledges, as well as learning new ones, as an essential part of establishing and maintaining the therapeutic alliance between client and therapist. Clients' experiences of having intersectional violence validated in therapy result in stronger therapeutic relationships, as this facilitates increased trust, communication, and knowledge about client's lived experiences. Psychoeducation on oppression and anti-oppression praxis is necessary.

2. Understanding That Systemic Oppression and Practices of Exclusion Contribute to Trauma and Violence of the Body, Mind, and Spirit

Anti-oppression psychotherapy acknowledges that systemic oppression and practices of exclusion by intersectional violence and oppression are traumatic. Hence, experiences of oppression determine mental health. Understanding the impact on mental health of continuous insidious trauma on the lives of clients, therapists, and communities, based on interlocking systems of dominance and exclusion, and due to differently located identities, is critical to working from an AOP approach. Addressing systemic oppression and practices of exclusion in therapeutic practice is significant**.**

3. Examining and Determining Clients' and Therapists' Identities

Acknowledging and exploring clients' and therapists' identities is central to AOP as this allows for processing of individual and collective daily experiences of insidious trauma from systems of power and practices of exclusion. Additionally, this provides avenues to prevent intersectional violence-related re-traumatisation in the therapeutic interactions, and promote resiliency, resistance, and meaningful change.

The *identity trichotomy* (Timothy, 2007) is our construct which represents three aspects that must be addressed when working within AOP. The identity trichotomy is the constant struggle, internally and externally, with fixed, intersected, and collective identities.

The first tenet of the trichotomy is called *fixed notions of identity* and is represented by a world enclosed in a box. It indicates the process whereby identities are prescribed by others, usually in the form of essentialised, discriminatory, prejudiced, and violent notions and practices sanctioned by systems of oppression and practices of exclusion. These fixed identities, created in mainstream (colonial based) societies and institutions , constitute notions of otherness, incivility, and worthlessness. Therapists' and clients' fixed notions of identity need to be addressed in and outside of therapy for a strong therapeutic alliance and change to happen. The intersecting box, comprising rigid notions of client and therapist identities, is a mosaic of specific colonial, white supremacist, racist, anti-Black racist, anti-Indigenous, sexist, misogynist, homophobic, classist, ageist, ableist, Islamophobic, and anti-Semitic (and anti-other spiritualities/religious practices) constructs that exist independent of clients' and therapists' wills. These constructs vary according to history, geography, and the social locations of therapist and clients.

The second tenet is comprised of *different notions of intersecting identities*. AOP requires therapist and clients to openly examine their intersecting identities to explore their different or similar social locations and experiences. This constitutes a powerful component that enables clients and therapist to reveal, process, and create their own notions of their intersecting identities, an exercise needed to understand their lived experiences. Exploring intersecting identities fosters more robust therapeutic alliances through the creation of self and collective representations that are no longer based on fixed or prescribed notions; this exercise constitutes a liberatory process from the box (tenet 1).

The third tenet is called *therapeutic alliances, negotiation of understandings, using identities for change***.** Tenets 1 and 2 result in a process where client and therapist forge a more robust therapeutic alliance, where understandings about and beyond intersectional violence are safely negotiated with fluidity. This process of negotiating intersecting identities and rejecting fixed notions of identity allows for the emergence of notions related to identities as fluid and constantly changing, therefore facilitating new coping strategies, including strategies for resisting intersectional violence through connection and creation of community.

We argue that therapists' skill (or lack of) in sorting through the identity trichotomy in their work with their clients constitutes a powerful determinant of the therapeutic alliance, and of therapeutic outcomes. Simply, if therapists are not aware of, or are unwilling to dismantle, their own fixed notions of intersecting identities, and if they lack the skills to facilitate their clients' processing of the impact of intersectional violence in their psychotherapeutic concerns and lived experiences, the risk for re-traumatisation is high, no matter how well meaning and trained the psychotherapist may feel or be.

4. Understanding Dissociation and Re-Traumatisation in the Therapeutic Process

Anti-oppression psychotherapy acknowledges that the stressful and potentially traumatic experiences due to daily intersectional violence sanctioned by systems of oppression and practices of exclusion can lead to fragmentation, memory loss, isolation, and other

symptoms associated with dissociation in clients, therapists, and communities. Therapists are responsible for addressing dissociation, and preventing and/or dealing with re-traumatisation in the therapeutic process. Dissociation of traumatic events due to experiences of intersectional violence must be processed with clients in the therapeutic process. Therapists need to be able to assess and explain dissociation in relation to intersectional violence.

This is a sharp contrast with the prevalent “out of sight, out of mind” approach often found in mainstream psychotherapeutic relationships due to therapists’ inability to understand, or their devaluation of, clients’ experiences of intersectional violence. Sue (2015a) illustrates this by describing the dynamics in racial dialogues between white people and people of colour (2015b), where what he calls “white talk” legitimises the perspectives of the majority and purport them as the natural order, in opposition to counternarratives that constitute hidden perspectives that challenge the racial realities of white people. The out of sight out of mind approach inhibits client and therapists from forming meaningful, authentic therapeutic alliances. Addressing therapists’ and clients’ dissociation, however different, is critical to supporting clients to engage in conversations about material that often feels painful, chronic, and immutable. Therapists need to understand the multiple intersecting locations of their clients to understand systemic re-traumatisation.

The *healing matrix* illustrates the extreme difficulty of the healing process when intersectional violence is uncontrollable and reoccurring daily in clients’ lives. Prevailing systemic conditions create ongoing experiences of oppression that can re-traumatise clients at any moment during the therapeutic process. The AOP therapist must support clients to process their experiences of intersectional violence, to lessen dissociative, or fight/flight reactions. More importantly, though, therapists need to assist clients to correlate and understand how their dissociation functions during repeated experiences of violence to assist in the development of coping skills. For example, consider a Black client dealing with depression, who was doing well, and arrives to the next session traumatised after being followed and harassed by security in a local drug store right before session. The connection between her depression and experience of racial profiling needs to be addressed in session, for which the therapist’s validation and witnessing of her experience of intersectional violence is vital.

Moving from chaos to cooperation and communication is a process that enables the client to process their dissociative responses by examining and communicating about different and complex intersectional identities and experiences that have resulted from prolonged exposure to intersectional violence, stress, and trauma. Cooperation and communication as an approach should not try to force or rush to dismantling or disconnecting the dissociative responses or “integrate” these elements of intersectional identities and experiences, as dissociation is already interrelated. The impact of dissociation due to intersectional violence is in a place of disorder (chaos) which happens in “out of sight, out of mind” reactions and in the difficulties to fully grasp the unpredictable re-traumatisation and dissociation that occurs as a result from the healing matrix. Hence, seeking to immediately eliminate dissociation would not be effective in dealing with the daily

experiences of intersectional violence, as dissociation can become a positive coping strategy if used through processes of internal and external cooperation and communication. Cooperation is an internal process that looks at clients' dissociated experiences and intersectional identities as enabling self to be able to survive, thrive, resist, and be protected in a hostile external environment. Processing and communication of clients' experiences of intersectional violent events, their dissociated responses, and their intersectional identities allows for a strong association with the segregated places of personal/collective experience, which in turn allows for a cohesive internal (personal) and external alliance (with therapist and community) that facilitates clients' own empowerment, protection, nurturance, and even growth, knowingly utilising dissociation when needed.

Therapists must also engage in their own therapeutic and supervisory processes to help them to connect with the internal and external parts of dissociation, and to move from chaos into a relationship of cooperation and communication within themselves to gain an awareness of their own re-traumatisation due to their own experiences of intersectional violence. This is critical as in AOP we acknowledge that therapists also hold subject positions within systems of power and dominance that may at times render them also negatively impacted by intersectional violence due to being oppressed, or with feelings of guilt, shame, and avoidance due to having a subject position similar to those who perpetrate and benefit from intersectional violence. In relation to race, racism, and white fragility, Brinkman and Donohue (2020) state, "it is paramount that white clinicians develop insight into how [they] reinforce white supremacy, behave in racist ways, as well as being open to feedback about [their] own racism without deflecting, responding defensively, or shutting down". We argue that therapists' personal work is necessary in relation to their social location based on to other interlocking systems of dominance and oppression (i.e., colonialism, sexism, etc.).

5. Locating Clients' and Therapists' Frameworks Historically and Geographically (Locally and Transnationally) Based on Intersectional Factors

Fostering authentic therapeutic alliances requires understanding the connection of client's distress in transnational and trans-generational contexts. Locating clients and therapists' frameworks historically and geographically (locally and transnationally) based on factors of identity and intersectional violence allows client and therapist to be engaged in grounded, thorough processes that include historical and contemporary factors**.** Questioning the "here and now" and bringing in the "before, during, and since" creates holistic understandings of clients' past and present while supporting a more viable future. AOP requires that clients share freely their experiences connected to local and transnational contexts, allowing a broader life history to be shared. This inquiry into the multiplicity and power dynamics behind the "here and now" challenges the often local-centric view that to be in the present is to be healthy and that time and space in history is unchanging. AOP examines whose "here and now" is represented and whose is not, and what exists in the "here and now" for clients and what is left out.

Psychotherapists must also locate their own frameworks historically and geographically, including that of their psychotherapeutic approach of choice as it will help in deconstructing embedded biases that may hinder the therapeutic alliance and re-traumatise clients.

6. Engaging in Emancipatory, Empowerment-Centred Change Process with Client and Therapist

Anti-oppression psychotherapy facilitates emancipatory, empowerment-centred therapeutic change processes. Learning how to facilitate empowerment processes with clients who are daily experiencing intersectional violence and trauma is essential. It is also vital that therapists learn to work with clients who are empowered in certain areas of their lives. Change and therapeutic alliance requires deconstructing and challenging of internal and external views and practices of oppression in relationships. Therapists and clients must work on an ongoing basis to dismantle oppressive ways of thinking and acting in and outside of therapy. Without engaging in deconstructing processes, emancipatory and empowerment centred praxis cannot fully evolve. This process is usually difficult and painful, as both client and therapist may believe that they are impartial to being oppressive or not in need of emancipatory change. Often therapists' and clients' "I have arrived, hence I know this already"-scenario is challenged through this learning process, as AOP considers that *un*learning of oppressive notions and learning new emancipatory skills and tools to deal with intersectional violence is a life-long journey that requires constant feedback. Therapists need to first explore and deconstruct their oppressive notions with peers, groups, and clinical supervisors knowledgeable in AOP before doing so with clients.

7. Practising Accountability and Responsibility

Client and therapist in AOP are accountable and take responsibility regarding implications of their intersection social locations. Therapists need to reflect on how they participate in the perpetuation of systemic oppressive violence. In AOP therapists engage in personal work to deconstruct notions of oppression. The process of *resistance education* (Timothy, 2007) seeks accountability from individuals that is not always offered from societal systems of oppression. Practices of inclusion by therapists offset the practices of exclusion outside of therapy. Hence, ongoing self and peer/group dialogue and supervision is necessary to be fully engaged in the self, collective, and community commitment needed to successfully engage in an AOP. Therapists addressing accountability and responsibility in local and transnational contexts allows client to re-examine their experiences and coping skills, often addressing the missing links that are needed to explain the reoccurring and systemic practices of intersectional violence in client's lives. Clients also look at their accountability and responsibility in the therapeutic process, their lives, and communities, to engage in healthy coping and thriving mechanisms and to dismantle inequitable practices, internally and externally. Moreover, the use of language, actions, and experiences are reviewed daily to identify accountability and responsibility of client and therapist in the therapeutic process.

Therapists knowledge, skill base, and continuous education is another dimension of accountability. Therapists need to continuously work on enhancing their knowledge and skills in relation to how intersecting systems of dominance and exclusion evolve in their local and transnational contexts, and how they may manifest and influence their therapeutic work.

8. Re-defining Resistance and Resiliency

Learning and teaching resiliency and resistance is crucial in AOP. Resistance is the struggle to survive, exist, and eradicate ideologies and practices of colonialism, racism, classism, sexism, and all other forms of intersectional violence in the lives of clients, therapists, and communities. Resistance is not in opposition to the therapy process but rather constitutes the manifestation of critical coping strategies in everyday life.

Another dimension of this principle involves the notion that the therapeutic process takes place beyond the therapist-facilitated session as clients actualise change daily through processes of resistance and resiliency. Therapists hence must support clients by utilising resiliency-centred tools to actualise change in clients' lives and/or communities, one of which is the evaluation of clients' learned resistance tools, strategies, and resources.

Anti-oppression psychotherapy facilitates a process of deconstructing, using intersected and fluid identities for change, practicing resiliency, and finally, identifying and strengthening resistance strategies to all forms of intersectional violence.

Resistance is not looked as "overcoming" but rather as non-linear processes and resources valuable for dealing with the unpredictable nature of daily experiences of stressful and traumatic intersectional violent experiences. It provides clients with tools to support and reduce stress while enabling them through strong identity associations and resilient actions to cope and live in a climate that is violent. Resistance allows hope and opportunities to avoid internalisation of violence and oppression by allowing reframing through empowerment.

Conclusion

This article has outlined our model of anti-oppression psychotherapy (AOP), which integrates anti-colonial and intersectional perspectives. Anti-oppression psychotherapy provides an understanding of the therapeutic alliance that moves beyond the "one size fits all" approach of most mainstream psychotherapy models by acknowledging that therapeutic alliances always exist within transnational, socio-historical contexts determined by social and structural relations. Decolonising counselling and psychotherapy is critical, especially in the current global context of COVID-19, where anti-Black racism, anti-Indigenous racism, and intersectional violence is rampant. Uprisings against systemic oppressions, including white supremacy, is a matter of life and death. It is our responsibility as counsellors and psychotherapists to take a stance: to think, act, and practice anti-oppression.

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