THE JOURNAL OF CONCURRENT DISORDERS

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Duo-Ethnographic Kuwentuhan (Storytelling) of Frontline Social Workers on the Exploration of Mental Health Practice in the Filipinx-Canadian Diaspora

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Citation: Segui, J., Tolentino, J. (2026). Duo-Ethnographic Kuwentuhan (Storytelling) of Frontline Social Workers on the Exploration of Mental Health Practice in the Filipinx-Canadian Diaspora. Journal of Concurrent Disorders.

Editor: Fayez Mahamid, Ph.D.

Received: 05/01/2026
Accepted: 07/04/2026
Published: 08/06/2026

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Abstract: In response to the April 26th, 2025, Lapu-Lapu tragedy in Vancouver, local, national, and international communities expressed grief, support, and solidarity following an event that had been intended as a celebration of Filipinx identities, stories, and cultures. This tragedy exposed the enduring structural inequities and underscored the continued inaccessibility and inadequacy of culturally grounded mental health services for Filipinx-Canadians. Guided by decoloniality, this study explores how two Filipinx-Canadian frontline social workers navigate Western mental health systems, identify barriers to care, and examine decolonial and community-led approaches grounded in Filipinx epistemologies. Using a duo-ethnographic methodology and the Indigenous Filipinx research method of *kuwentuhan* (storytelling), the paper discusses three themes: (1) navigating Western mental health systems as Filipinx frontline social workers; (2) the current barriers we experienced as Filipinx-Canadian social workers; and (3) community-led and decolonial approaches in mental health rooted in Filipinx epistemologies. The paper hopes to expand the limited literature on the clinical reflections of frontline social workers in Canadian mental health settings and offer considerations for culturally relevant insights for clinicians working with Filipinx-Canadian diasporic communities.

Keywords: Filipinx-Canadians, Mental Health, Social Work, Decoloniality, Stigma, Duo-ethnography

Introduction

On April 26, 2025, what should have been a joyful celebration of Filipinx presence, memory, and resistance at Vancouver's Lapu-Lapu Day festival was shattered when a vehicle drove into the crowd, killing 11 people and injuring 32 others (Rush & Johnson, 2025). For many Filipinx-Canadians, the tragedy was not only a moment of collective grief, but also a painful unveiling of longstanding structural inequities. It exposed how culturally relevant, accessible, and community-rooted mental health supports remain insufficient for a rapidly growing Filipinx-Canadian diaspora. In the public aftermath, the language of Filipinx "resilience" surfaced quickly. Yet, resilience, while real, can become an inadequate and even burdensome narrative when communities are expected to absorb profound harm without corresponding justice, structural change, and sustained care (Nocos and Batac, 2025).

Mental Health Service Landscape for Filipinx-Canadians

The Filipinx diaspora represents one of the fastest-growing immigrant populations in North America, with Filipinx-Canadians constituting a significant and rapidly expanding community, particularly in urban centres, such as Vancouver (Sanchez & Gaw, 2007). Despite their growing presence, Filipinx-Canadians exhibit low rates of mental health service utilization despite experiencing significant psychological distress (Sangalang, 2022; Tuliao, 2014; Ticar, 2024; Martinez et al., 2020; Hilario et al., 2015; Sato et al., 2022). For instance, a study on immigrant youth in Canada found that youth from the Philippines had a higher volume of patients with first contact for mental health in the emergency department, suggesting that mental health issues may not be addressed until they reach a crisis point requiring emergency care rather than through earlier outpatient interventions (Saunders et al., 2018). The pattern of underutilizing mental health supports indicates significant barriers to accessing outpatient and culturally informed Filipinx mental health services, and highlights the need for early intervention and prevention strategies (Saunders et al., 2018).

Another possible culprit for the underutilization of mental health supports is how Filipinx-Canadians face significant systemic and structural barriers to mental health, such as financial constraints (Peddigrew et al., 2025; Martinez et al., 2020; Torres et al., 2024). For instance, Martinez et al. (2020) report that high costs of services, lack of medical or health insurance, and needing to pay out of pocket are barriers to accessing mental health care among overseas Filipinxs. This was further built on by Peddigrew et al. (2025), who explored clinicians' perceptions of barriers for immigrant, refugee, and diverse populations in Canada, and found that, in addition to costs, long waitlists and the lack of multilingual services were additional structural barriers to accessing mental health care. Conversely, Kirmayer et al. (2007) found that even with universal health insurance, Canadian immigrants are associated with lower rates of mental health service use. Similarly, a U.S.-based study found that even among

participants with access to universal healthcare, employment could act as a barrier to psychological help-seeking, as individuals often prioritized work over attending medical check-ups or consultations (Gong et al., 2003). Therefore, it begs the question of what factors may be contributing to this hesitancy to access mental health care?

Studies have reported that linguistic barriers represent significant obstacles to mental health service access for Filipinx-Canadians (Lin et al., 2020; Peddigrew et al., 2025; Tulai, 2014). Li et al. (2000) found that poor English language ability and a lack of understanding of mainstream culture were major barriers to accessing mental health facilities for Asian Canadians. Tuliao (2014) documented that Filipinx-Canadians were reticent and less likely to express emotions to nurses whom they considered *ibang tao* (outsiders or non-Filipinxs). Interacting with *ibang tao* health professionals, Filipinxs are formal, polite, and cordial and may agree to medical services but may not necessarily comply (Tuano, 2014). However, communications with Filipinx health professionals who are *hindi ibang tao* (one of us) suggest that Filipinx patients are more likely to articulate their emotions and concerns directly and entrust themselves to the care of the health care provider.

Beyond linguistic barriers, studies also point to *hiya* (stigma) as a pervasive barrier for Filipinx-Canadians to formally seek professional psychological help. In particular, Martinez et al.'s (2020) systematic review found that self-stigma and social stigma were prominent barriers to help-seeking among Filipinxs. The authors suggest that self-stigma manifests due to concern for loss of face, sense of shame or embarrassment, self-blame, sense of being a disgrace or being judged negatively, and the notion that mental illness is a sign of personal weakness or failure of character (Whitley & Jarvis, 2025; Vahabi et al., 2017). Further social stigma is evident in their fears of negative perception of the Filipinx community, ruining the family reputation, or fear of social exclusion, discrimination, and disapproval (Martinez et al., 2020). This cultural concept of hiya is further compounded by the concerns about how mental health problems may be viewed as bringing shame to the family or a family's biological disease (Nadal, 2020).

Further, studies note that there are simply not enough culturally informed and Filipinx mental health practitioners. As a result, Filipinx-Canadians were less likely to access mental health services (Lin, 2023). For instance, Torres et al.'s (2024) findings shared that their participant said that while they are going through mental health challenges, it does not mean that the participant is desperate to seek help from a white counsellor. For the participant, having a relationship is more important than getting help from somebody who does not have the capacity to understand the history of her mental health struggle. She believes that a white counselor will only invalidate the real cause of her mental health, which is rooted in intersecting systems of oppression. Torres et al.'s (2024) study is significant as they underscore that to address mental health challenges within the Filipinx community today, the intervention requires a multifaceted approach that

recognizes the impact of colonization, migration, and social and cultural factors.

Colonial Mentality and the Resurgence of Sikolohiyang Pilipinx (Indigenous Filipinx Psychology)

Filipinx mental health in Canada cannot be understood apart from histories of racism, migration, and social and cultural factors (Torres et al., 2024). The Philippines experienced over 300 years of Spanish colonization followed by American colonial rule, creating what scholars described as a "colonial mentality" (Decena, 2014). *Colonial mentality* refers to the internationalization of colonial values and the devaluation of Filipinx culture, language, and identity (Tolentino, 2023), which has been associated with psychological distress and the stigma towards mental health care.

Scholars in the U.S. state that Filipinx-American social workers and mental health professionals play a crucial role in demystifying mental health services within their communities, often educating others about colonial mentality and decolonization (Decena, 2014). These professionals help individuals articulate their experiences and challenges and existing stigmas, fostering a more equitable and culturally grounded understanding of mental health. However, they also navigate challenges, including the taboo nature of mental health discussions, family expectations to keep problems internal, and a lack of accessibility to culturally sensitive services. The concept of colonial mentality has been linked to mental health help-seeking behaviours and treatment credibility among Filipinxs. Research examining relationships between causal beliefs, colonial mentality, treatment credibility, and help-seeking intentions found that cultural beliefs influence perceptions of Western-developed mental health services. This highlights the ongoing impact of colonial legacies on contemporary mental health service utilization.

To address the colonial legacies on the assumptions of the Filipinx community, decolonial approaches rooted in Sikolohiyang Pilipinx offer promising alternatives that honour Filipinx epistemologies while addressing their unique mental health needs (San Juan, 2006; Nadal, 2020). Core concepts such as *kapwa* (shared identity), *loob* (relational will), and *pakikiramdam* (relational attunement) provide culturally grounded frameworks for understanding mental health and well-being within relational rather than individualistic paradigms, and *bayanihan* (communal unity or solidarity) (Desai, 2016; Nadal, 2020). Kapwa, the most fundamental concept, refers to shared identity and interconnectedness, recognizing the self in others (Yacat, 2013). Bernardo et al. (2019) described kapwa as "a 'reciprocal being' between self and other secured only in give-and-take over time," an ancestral principle predating Western contact that emphasizes interconnectedness, shared identity, and spiritual connection to the Earth (p. 85). This concept contrasts with transactional reciprocity, viewing liberation as intertwined, especially with Black and

Indigenous people. Loob represents relational will or inner self, recognizing that Filipinxs consider those who are kapwa as deserving of altruistic will (Billones et al., 2021). Pakikiramdam refers to relational attunement or sensitivity to others' feelings and situations (Cleofas, 2025). Pakikiramdam is crucial for understanding how Filipinxs navigate social relationships and respond to others' needs (Cleofas, 2015). In mental health contexts, pakikiramdam suggests the importance of attuned, relationally sensitive approaches to care. Pakikipagkapwa signifies accepting and treating others as equals, fostering dignity (Desai, 2016). These concepts form the basis for understanding Indigenous Filipinx social relationships and mental health within a relational framework that recenters collective care.

While this body of literature is growing, it remains limited in several important ways. First, there is still a dearth of scholarship on the mental health experiences of Filipinx-Canadians, particularly within Canada, despite the community's size and rapid growth. Second, there remains limited literature that centres on the clinical reflections, lived experience, and practice wisdom of Filipinx-Canadian social workers (Segui, 2026; Sato et al., 2022). This gap matters because dominant Western mental health models often privilege individualism, "professionalism" (i.e., professional distance and sterility), and standardized interventions, which may not fully account for Filipinx ways of knowing, being, relationality, and collective care (Tolentino, 2023). Therefore, this paper aims to examine how two Filipinx-Canadian frontline social workers in mental health navigate Western mental health systems, identify barriers to culturally relevant care for Filipinx-Canadians, and explore decolonial and community-led approaches grounded in Filipinx epistemologies.

Theoretical Framework

Decoloniality is a theoretical, epistemological, and praxis-oriented framework that examines how inequities are produced through colonial histories, Western knowledge systems, and ongoing relations of power (Quijano, 2007; Mignolo & Walsh, 2018; Tuhiwai Smith, 2021). In this study, we use decoloniality to understand the ways in which inadequate Filipinx-Canadian mental health care, hiya, and help-seeking behaviours are, in part, the enduring effects of coloniality within social institutions, professional practice, dominant models of care, and societal and cultural assumptions about mental health. This framework allows us to examine how Western mental health assumptions and models become positioned as universal and authoritative, while other ways of knowing, healing, relating, and understanding distress are marginalized (Quijano, 2007). Decoloniality also informs our methods and analysis. Methodologically, it supports our use of *kuwentuhan* (Indigenous Filipinx storytelling), reflexive journaling, and memory work as relational and culturally grounded ways of generating knowledge that challenge detached or extractive approaches to research (Tuhiwai Smith, 2021). Rather than treating our experiences as merely personal or anecdotal, decoloniality allows us to understand them as

situated forms of knowledge produced through our identities, practice contexts, and relationships to Filipinx-Canadian communities. Analytically, decoloniality guides us to examine our narratives as accounts structured by colonial histories, Western mental health systems, racialization, migration, privatization, and community resistance (Tuhiwai Smith, 2021). In this sense, our analysis attends to how coloniality appears in mental health care while also identifying the relational, community-led, and culturally grounded practices through which Filipinx social workers imagine care (Mignolo & Walsh, 2018).

Methods

Study Design

This study employed a duo-autoethnographic methodology (Sawyer & Write, 2025) through the Indigenous Filipinx storytelling method known as kuwentuhan (Pino, 2023; Guttierez et al., 2023). We decided duo-autoethnography as it allows us to "use self as the site…of [our] inquiry" (Sawyer & Wright, 2025, p. 42). Further, we employ our intersecting positionality and our lived and professional experiences, as Filipinx-Canadian frontline social workers, as a lens for examining broader colonial, cultural, and structural barriers to mental health care. Our study design was also informed by Karalis Noel et al.'s (2023) collective autoethnography framework. However, we adapted it to suit a duo-autoethnographic approach. Specifically, we streamlined and reconfigured their multi-participant process to reflect our two-researcher collaboration, organizing the study into six iterative phases: (1) question development, (2) coordination and scheduling of interviews, (3) interviews and transcription, (4) coding, (5) collaborative discussion and consensus-building on themes (serving as a form of interrater reliability), and (6) manuscript writing. This adaptation allowed us to retain the reflexive and collaborative strengths of the original framework while tailoring it to the scale and relational dynamics of a two-person research team (*see figure 1*).

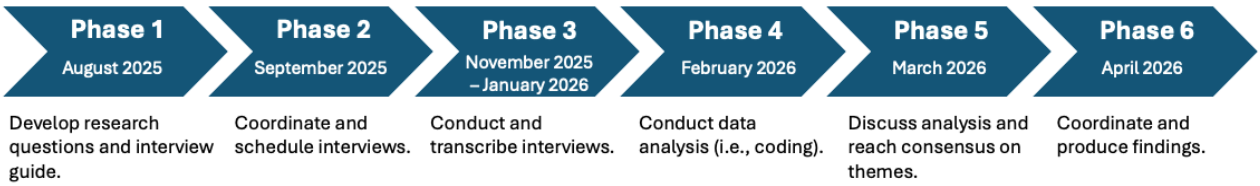

Figure 1: Karalis Noel et al.'s (2023) collective autoethnography framework adapted to a duo-autoethnographic study.

Data Collection

The primary data sources consisted of kuwentuhans, reflexive journaling, and memory work. Drawing from Pino's (2023) conceptualization of kuwentuhan as a method, our *kuwentos* (stories) promote decoloniality by recentring dialogue, shared meaning-making, and the co-construction of knowledge rooted in Filipinx ontologies,

epistemologies, and axiologies (Pino, 2023). Additionally, we chose kuwentuhan as it is methodologically congruent with duo-autoethnography. Further, kuwentuhan allows us to place our stories in dialogue with one another and use what Sawyer and Wright (2025) describe as "storytelling with story-listening" to reflect on how our experiences as Filipinx-Canadian social workers reveal the need for culturally grounded and community-led approaches to care (p. 41). Before the interviews, we coordinated dates for when to meet to conduct the interviews. Then, an interview guide was developed collectively, which consisted of a set of prompts to support open-ended storytelling and critical reflections. The conversations centred on three broad areas: (1) navigating Western mental health systems as Filipinx frontline social workers, (2) experiences with the barriers to mental health care for Filipinx-Canadians, and (3) decolonial and community-led mental health approaches rooted in Filipinx epistemology. We then met over Zoom and engaged in two audio-recorded kuwentuhan sessions, each lasting about 60 to 90 minutes. Each kuwentuhan was facilitated by the first author using the interview guide, while both authors took notes. Then, the interviews were transcribed verbatim for accuracy and coding.

In addition to the kuwentuhans, we engaged in reflexive journaling to document emotional responses, analytic insights, and questions that emerged throughout the study. Memory work also served as a supplementary data source by helping us revisit formative personal and professional experiences related to our clinical practice with the Filipinx-Canadian community (Haug, 1987; Onyx & Small, 2001). Together, the conversational transcripts, reflexive notes, and memory-based reflections formed the analytic materials for the study.

Data Analysis

The data analysis process was iterative and collaborative. We first read the conversational transcripts and reflexive materials closely to familiarize ourselves with the data and note early patterns. We then independently coded the data using the a priori concepts drawn from the aims of the study, including navigating Western mental health systems, barriers to care, and decolonial or and community-led approaches (Karalis Noel et al., 2023). These initial codes provided a shared analytic structure while leaving room for new insights to emerge (Karalis Noel et al., 2023). After independent coding, we met to compare interpretations, discuss overlaps and differences, and refine the coding framework through dialogue (Karalis Noel et al., 2023). We then returned to the data separately to identify emerging themes within and across initial codes, attending to recurring ideas, points of convergence and divergence in our narratives (Karalis Noel et al., 2023). Following this second round of analysis, we met again to discuss the emerging themes, compare our interpretations, and further refine the thematic structure through the same collaborative and dialogic process. Through this process, we grouped related patterns into broader themes, refined overlapping categories, and selected narrative

excerpts to illustrate each theme. Moreover, differences in interpretation were treated as analytically useful, helping us deepen our understanding of how our social locations and practice contexts shaped meaning. Reflexivity remained central throughout, as we continually returned to the data to question our assumptions and consider how our intersecting positionalities shaped or biased our analysis.

Positionality

We write as Filipinx diasporic social workers in private practice in Turtle Island, colonially known as "Canada". Our relationship to this study is personal, professional, and political. Further engagement with Filipinx mental health is shaped by our own experiences of migration, racialization, queerness, kinship, and navigating Western institutions not built with Filipinx communities in mind. This positionality shaped our kuwentuhan, which unfolded through shared cultural references, trust, and mutual recognition, and our analysis as insider practitioners. At the same time, we recognize that proximity can shape what we notice and privilege, so reflexivity remains central in naming our assumptions, emotional responses, and biases throughout the study.

Results

Flattening the Therapeutic Power: Self-Disclosure and Therapy Spaces as Political

Across both of our practices, we described the process of flattening therapeutic power as an intentional shift away from the Western clinician-as-expert model toward a more relational, transparent, and politically conscious practice. Instead of positioning ourselves as neutral professionals, we employ self-disclosure as a theoretically, relationally, and politically informed practice to intentionally and reflexively share, when appropriate and clinically beneficial to the client or the therapeutic alliance, our positionality and praxis within broader systems of oppression (Solomonov & Barber, 2019). For instance, we discussed that in our initial sessions, we create a space to ask whether clients would be open to hearing about our positions as queer and Filipinx social workers and therapists and how our overlapping identities inform the therapeutic modalities we employ and our sociopolitical commitments. Segui (author 1) shares:

> "In my initial sessions, I openly share how I am from the Philippines and moved to Vancouver as a settler and first-generation immigrant. Along the way, I discovered how my queer-Filipinx identity shaped [positively or negatively] my relationship with family and friends, as well as my access to certain institutional spaces, such as education, employment, or healthcare. In hindsight, I recognize that these experiences are part of a broader structural issue involving racism, homophobia, and colonialism within Canadian institutions. As a result, I became a social worker and counsellor for Filipinx and queer communities so that they might find comfort, validation, and representation within an oppressive system. And for some reason,

> clients shared how they appreciated that because they feel not only represented in mental health spaces but also find a therapist they can relate to."

Concurrently, we discussed that practicing self-disclosure requires ongoing reflexivity to determine whether such disclosures are therapeutically useful and responsive to the client's needs (Segui, 2026; Gibson, 2012; Müller, 2019). As Tolentino (author 2) reflected, "Is this self-disclosure for me, or is it for the client?" This underscores that flattening therapeutic power is not synonymous with erasing professional boundaries or engaging in indiscriminate self-disclosure. Instead, the practice calls for an ongoing, complex decision-making process regarding the use of the self, in which disclosure is guided by its potential to support the client and strengthen the therapeutic relationship (Müller, 2019). As Tolentino further explained:

> "It's not about subtracting from the client's lived experience or taking away from what's happening in the therapeutic space but adding other perspectives that may or may not be helpful in their journey."

In this way, self-disclosure emerged not as self-expression for its own sake, but as a deliberate relational practice that remains accountable to the client's context and therapeutic goals (Lichtenstein, 2025). Further, our kuwentuhan highlights how flattening therapeutic power still requires careful discernment so that the social worker's use of self remains in service of care rather than shifting attention away from the client's lived realities.

In addition to self-disclosure, we also framed therapeutic work and therapeutic spaces as political, particularly when mental health struggles are shaped by interpersonal relationships, organizations, public policy, and ideological assumptions embedded in systems of power. For example, Tolentino shared that "the personal is political: we're experiencing oppression not because of individual experiences but because systems shape the policies and rules that guide everyday life." From this perspective, therapy was not limited to intrapsychic coping or symptom management. Instead, we described therapeutic practice as an ongoing recognition of how power and oppression enter the room and shape what clients carry and share with the clinician. For instance, when a Filipinx client presents with anxiety, shame, or self-blame for attending therapy, our role is not to treat these responses as merely maladaptive individual responses. Instead, we work with clients to name these emotions and help them understand how their emotional responses are connected to the broader social phenomena of stigma surrounding mental health within Filipinx cultural contexts, where seeking help may be tied to shame, family dishonour, or expectations of enduring distress privately (Vahabi et al., 2017; Martinez et al., 2020). In doing so, therapy becomes a space for emotional processing and

understanding how deeply personal struggles are produced and sustained through broader cultural and structural relations of power (Wolfe, 2025; Llorens, 2019).

Barriers in Filipinx Mental Health Care

Another central theme that emerged across our kuwentuhan was the set of overlapping barriers shaping Filipinx access to mental health care. These barriers included the limited availability of culturally informed therapy, the privatization of mental health services, and persistent mental health stigma within Filipinx communities.

Lack of Culturally Informed Care and the Privatization of Filipinx Mental Health

A barrier we identified is the limited availability of public and culturally informed mental health services that are attuned to Filipinx epistemologies. We reflected on how many mainstream mental health services continue to be shaped by Western assumptions about the self, healing, and therapeutic process (Chan et al., 2021). Western models often prioritize individualism and standardized clinical interventions (Misra et al., 2025), which may not always resonate with Filipinx ways of relating, communicating, and meaning-making. For instance, Cognitive Behavioural Therapy is often regarded as a gold-standard model because of decades of funding and extensive research supporting its effectiveness (Leichsenring & Steinert, 2017). However, Western models may not always translate well to Filipinx clients whose distress may be understood through family obligation, relationality, spirituality, migration, and broader histories of oppression (Torres et al., 2024).

This absence of culturally informed care was also reflected in our own pathways into social work and mental health practices. For Segui, entering the profession was partly shaped by not seeing Filipinx mental health practitioners while growing up:

> "I think one of the aspects that motivated me to go into social work was that there weren't enough queer and Filipinx counsellors, or social workers, or therapists that I've encountered growing up in Vancouver."

Further in our conversations, we reflected on how the issue was not only that we had rarely encountered Filipinx practitioners, but the frameworks available to us often did not seem to hold the fullness of their experience of distress. For instance, we discussed the nuances of hiya (shame), which we explore further in the following section, and how it shapes Filipinx experiences of mental health. Hiya affects not only help-seeking behaviour but also one's ability to acknowledge, name, and work through difficult emotions. When the culturally specific ways that hiya manifests are not understood, Filipinx clients may find it difficult to feel fully seen, connected, or emotionally safe with a counsellor. Segui further described:

> "I think what felt missing in Western mental health care was the understanding that hiya is not just shame in the individual sense. For many Filipinx clients, it is tied to family, obligation, and the fear of disappointing others. If a counsellor does not understand that, it can be hard to open up because you feel like they are only hearing part of the story."

In contrast, our kuwentuhan emphasized the importance of relationality, shared cultural context, language, humour, and trust. Therapy became more accessible when clients felt recognized not only as service users, but as people whose identities, values, and ways of knowing were understood. Segui described how language itself can carry forms of meaning that cannot be easily translated into English, which can create a sense of familiarity, warmth, and recognition that makes therapy feel less clinical and more culturally grounded.

Segui further reflected how culturally informed therapy can involve bridging Filipinx values of *pamilya* (family) with queer and Western reworkings of kinship, such as chosen family. This approach does not dismiss Filipinx commitments to family; it retains the importance of relational care and interdependence while broadening the possibilities for who can be recognized as family. Therapy became a space where queer Filipinx clients could hold both cultural ties to family and the possibility of reimagining kinship beyond heteronormative or strictly biological forms. Anecdotally, these collective spaces often seemed to resonate more deeply than conventional one-on-one therapy, suggesting that culturally grounded and community-based forms of care may offer important pathways for Filipinx mental health support.

At the same time, the limited availability of culturally informed care cannot be divorced from the broader structure of mental health service delivery. When Filipinx-informed care is not sufficiently available in publicly funded systems, Filipinx clients may be pushed toward privatized services to find therapists who can better understand their cultural, linguistic, and relational realities.

The Privatization of Filipinx Mental Health

We recognize that the limited availability of publicly funded, culturally responsive therapy often leaves many Filipinx people with few options, pushing them toward privatized mental health services to access Filipinx therapists. In other words, the very services that may be more culturally resonant are frequently located outside the public system and therefore available mainly through private practice, insurance, or out-of-pocket payment. As Tolentino recounted:

> "So, moving towards the barriers: there aren't enough culturally sensitive public mental health services. I see many Filipinx clinicians in private practice. And for someone to access private, it has to be through insurance—whether it is through extended health work insurance or have your own

> private health insurance—and a lot of Filipinx communities don't have access to that. So, one of the barriers is the lack of culturally sensitive services for Filipinxs, but also the cost of mental health services in privatized healthcare."

While culturally responsive care may be more available through Filipinx-led or Filipinx-informed private services, such care often remains financially out of reach for many community members. As a result, the lack of publicly funded and culturally informed therapy means that many Filipinxs either do not seek therapy at all or must turn to private Filipinx providers, where care may feel more culturally safe, but cost becomes another barrier (Martinez et al., 2020). In this way, culturally relevant care becomes stratified by income and who possesses insurance coverage or does not.

On the same thread, we also acknowledge our own professional location within this system. As Filipinx frontline social workers in private practice, we recognize that we are not outside the structures of privatized care and are implicated in a broader landscape in which culturally responsive support is often insufficiently available and underfunded in the public system. We reflected on how private practice is not solely the problem in itself, nor are practitioners who offer care within it. Indeed, many Filipinx-Canadian clinicians in private practice are responding to the very gaps left by underfunded public services and are doing meaningful work to provide culturally affirming support to Filipinx communities. However, one possible explanation for the movement toward private practice is that when culturally informed mental health programs and public social services are underfunded, the effects are not only felt by clients, but also by the social workers providing care. For instance, social workers often work within precarious conditions marked by insufficient funding, limited resources, low wages, heavy workloads, and job insecurity (Lai et al., 2024). These conditions may contribute to higher rates of compassion fatigue, burnout, dissatisfaction, and exploitation, despite social workers' commitment to quality care (Baines et al., 2008; Lai et al., 2024). As state funding is withdrawn and economic constraints intensify, the quality and sustainability of public social work services may also be affected (Baines et al., 2008).

Moreover, as we further reflected in our conversation, our own movement into private practice cannot be understood simply as an individual career choice. Instead, it may also be understood as a response to feeling overworked, undercompensated, and devalued within public systems, where private practice can become a means of economic survival and professional sustainability (Benn, 2006; Muzingili, 2023). Our implication in privatized care is expressed through everyday clinical and business decisions, including session fees, insurance billing, caseload size, scheduling, cancellation policies, referral practices, and the availability of reduced-fee spaces. These decisions shape who can enter, remain in, or

return to therapy. Although they are informed by our own financial needs, professional capacity, and desire for sustainability, they also function as forms of gatekeeping. Our positionality as queer and Filipino and social workers, we occupy an ongoing tension, as insider-outsides to a system rooted in oppression of marginalized communities (Segui, 2026). While private practice may support our economic survival within Western capitalist structures, and enable us to offer forms of care that are constrained within public settings, we acknowledge our own complicity within a system in which culturally responsive care remains unevenly distributed. Recognizing our implication in this system therefore requires us to remain continuously accountable, humble, and reflexive about how we exercise our relative power, resist exclusionary practices, and avoid reproducing the very inequities we seek to challenge.

Complicating matters further, we discussed how a shift towards the neoliberalization of healthcare in Canada has increasingly transferred the responsibility for mental health from the state onto individuals, families, and their communities (Brown et al., 2022; Teghtsoonian, 2009). As public investment in social services recedes, access to care becomes more dependent on private insurance, personal finances, and one's ability to navigate fragmented systems (Teghtsoonian, 2009). For instance, before, during, and after the Lapu-Lapu incident, we, the authors, have attempted to make mental health care more accessible where possible through pro-bono work, reduced-fee options, and sliding-scale services. Such efforts reflect our attempts to soften economic exclusions and extend support to Filipinx clients and communities in more materially reachable ways. However, these efforts are not enough, nor should they be the norm, as they function as a harm reduction rather than solutions to the underlying ideologies and prioritization of neoliberalization within mental health care systems. Pro bono and sliding-scale services cannot replace broader structural change and the nation-states' responsibility for creating accessible, publicly funded, and culturally responsive mental health care for Filipinx communities. Moreover, relying on Filipinx and other racialized practitioners to compensate for public-system failures through voluntary labour perpetuates the expectation that underserved communities must care for themselves when the state withdraws. These efforts are therefore insufficient and should not become normalized as substitutes for accessible public services. Conversely, our findings underscore the urgent need for sustained public funding and institutional investment in culturally responsive services and community-based programs that address Filipinx mental health, beyond short-term, crisis-driven, or exclusively privatized models of care (Saunders et al., 2018).

Beyond the neoliberalization of mental health, the lack of culturally informed Filipinx mental health services may be a symptom of broader cultural forces, such as hiya, that continue to shape mental health utilization and help-seeking behaviours within Filipinx communities.

Hiya (Shame) in Mental Health among the Filipinx Community

In our kuwentuhans, mental health stigma also emerged as a powerful internal barrier within Filipinx communities. We reflected on growing up with messages that dismissed mental health struggles, framed them as weakness or a biological disease, or redirected distress toward spirituality without room for professional support. Common phrases we heard from clients' families before accessing mental health are "Why are you going to a mental health expert?" "There's no such thing as mental health," or "Just pray to God." These statements illustrated how shame, blame, and silence can prevent help-seeking before someone reaches a service. In this sense, hiya operated as a cultural and relational force that shaped what kinds of suffering could be named, what forms of help were considered acceptable, and whether distress could be discussed openly. As Tolentino reflected, even when formal barriers such as funding or bureaucracy are addressed, access may remain blocked:

> "Even if the funding, the bureaucracy, and red tape are taken care of, for whatever reason, there's still a blockage for folks being able to access therapy due to fear or shame."

Our reflections suggest that destigmatizing mental health in Filipinx communities requires care and nuance. Further, there is a need to gently question shame-based narratives while still honouring the cultural context in which these beliefs are formed. For example, we have observed that younger generations may be more open to acknowledging their emotions, seeking therapy, and engaging in conversations about them. As Segui shared:

> "In my practice, I work with many first- and second-generation and queer Filipinx young adults, many of whom reached out for counselling until they were in their early twenties. Often, it was only when they left their parents' home that they could begin to reflect on their experiences of rejection for their sexual orientation and say, 'Okay, that was really difficult, and I need to talk to [a counselor] about it.

However, this raises an important question: *how do we bring older generations into these conversations in ways that do not (re)create shame, dismiss, or alienate them?* Bridging this divide may require creative approaches to older Filipinxs with cultural humility and relational care by connecting mental health to concepts they may already value, such as family, *kaibigan* (friendship), *ginhawa* (well-being), care, faith/spirituality, and collective responsibility. In our practice, we discussed that instead of framing older generations as resistant or uninformed, an understanding and curiosity towards their belief around mental health may serve more beneficial. This approach creates space for their stories to be heard and help us clinicians better understand how their assumptions about mental health

is a product of colonial mentality (Decena, 2014). By first understanding where these beliefs come from, we are better positioned to gently disentangle their assumptions and create intergenerational conversations that honour their lived experiences while gently creating space for new understandings of mental health and intergenerational healing.

Re-Imagining Decolonial and Community-Led Approaches to Mental Health Rooted in Filipinx Epistemologies

Decolonial Approach through the Use of Filipinx Language(s) in Therapy

Our findings suggest that one approach to decolonizing mental health care is the intentional use of Filipinx language(s), including Filipinx dialects, in therapy. Filipinx ways of knowing often emerge in therapy through language, such as humour, colloquial terms, everyday speech, and concepts that are not easily captured by Western psychotherapeutic language, as therapeutic tools that create deeper connection and understanding. In our practice, the use of *Taglish* (a combination of Filipinx and English languages), Filipinx euphemisms, or culturally embedded terms helps create rapport, a layer of common understanding, and attunement that exceeds literal translation. Through the use of Taglish or Tagalog in our therapy sessions, the language we use becomes a relational gateway that allows clients to speak from within their own social world without having to translate themselves into Western, English-dominant therapeutic frameworks.

Reclaiming and utilizing Filipinx language(s) in therapy becomes a decolonial practice because it resists the assumption that legitimate mental health knowledge must be expressed through English or Western psychological terminology. The use of Taglish or Tagalog challenges the hierarchy that positions English as the primary language of clinical authority. It also affirms that Filipinx languages, expressions, humour, and ways of speaking are not peripheral to therapy but can be central to healing, meaning-making, and relational connection. At the same time, reclaiming Filipinx epistemologies must not collapse into essentialism. Filipinx culture is not a monolith; it is nuanced, contested, and shaped by generation, class, region, religion, sexuality, migration history, and diasporic location. Reclaiming Filipinx epistemologies therefore means creating therapeutic spaces where multiple Filipinx subjectivities can become intelligible on their own terms. For example, Segui shared:

> “For me, I had one client who said they needed full Filipinx or full Tagalog... by using Taglish, there are certain things English concepts just can't capture. So, 'kilig,' for example—it's a Filipinx term. Or 'charot'—these things are rooted in Filipinx conversations. Oftentimes it's helpful to use this language because there's an unspoken understanding between the client and I."

The use of Taglish and culturally specific terms like *kilig* (the feeling of butterflies or romantic excitement) and *charot* (kidding, a playful remark) allows for emotional and experiential nuances that English cannot convey. This linguistic practice affirms clients' cultural identities and creates a shared symbolic world. Tolentino echoed this practice, connecting it to the social work concept of "use of self":

> "I also speak Taglish with my clients. In social work we talk about the use of self. By talking about our social locations, sometimes there are embedded stories where I know that you know what I'm talking about, and it's such a validating feeling to hold in a session. You understand the struggle, and there's an automatic understanding—not of the specifics, but there's a story there that Filipinx folks are threaded through."

In this sense, language was not merely a communication tool; it was a site of healing, memory, humour, intimacy, and resistance. The use of Taglish, Filipinx expressions, and culturally specific humour disrupted the expectation that legitimate clinical knowledge must be expressed through English or Western psychological terminology. Additionally, our reflections attend to how decolonial practice can involve resisting the pressure to make Filipinx knowledge legible only through Western categories. It also challenges the hierarchy that positions English as the primary language of clinical authority. Instead, Filipinx language and cultural expression become part of the therapeutic process itself. This approach makes space for clients to name distress, joy, relationality, shame, care, and healing through the linguistic and cultural worlds they already inhabit. Reclaiming Filipinx language(s) in therapy, therefore, offers one concrete decolonial pathway for mental health care, as it centres Filipinx ways of knowing and refuses the pressure to make Filipinx experiences legible only through Western clinical categories.

Community-Led Approaches Rooted in Filipinx Epistemologies

Our findings suggest that one-to-one therapy, while valuable, cannot be assumed to be the only or most culturally resonant response. Across our kuwentuhans, we found ourselves returning to a question that felt both clinical and personal: What Filipinx mental health care could become when it is grounded in community, relationality, and Filipinx ways of knowing?

We moved our conversations beyond the organization or clinical spaces where mental health care often formally occurs to communities who have created informal and collective systems of support when formal institutions fail to respond. In this sense, community-led emerged as both a response to the structural neglect and a decolonial practice rooted in kapwa and bayanihan. Particularly, in the aftermath of the tragedy, we discussed how community gatherings, healing circles, group therapy, and Filipinx practitioners mobilized collectively in response to inadequate public support. Segui reflected:

> For me, it is the community piece. When there is no publicly funded system in place to support our community, members of our community come together to fill those gaps. I saw many Filipinx practitioners and allies in the community show up for one another and for our community. So many therapists offered their time, care, and labour to provide pro bono services."

The concept of *bayanihan*, which refers to a Filipinx cultural value representing communal unity and voluntary service to help one's neighbours, was reflected in how Filipinx therapists, community workers, organizers, and cultural organizations stepped in to create support networks in response to the limited capacity of by public systems. Further, this collective response was a counter to the individualism and fee-for-service logic of privatized mental health care that enabled Filipinx-Canadians to access the care that might otherwise have remained unavailable.

As we reflected in the previous section, placing the responsibility on community members and social workers to provide unpaid or underpaid labour is neither equitable nor sustainable. It also perpetuates the expectations that marginalized communities should repair oppressive systems themselves, rather than positioning these problems as collective responsibilities to be addressed at local, provincial, and federal levels. Community-led care must therefore be accompanied by long-term public investments that compensates practitioners, supports culturally relevant services, and consults and transfers meaningful decision-making authority to Filipinx communities.

This need for sustainable public investments was closely connected to desire for services created specifically for Filipinx communities. As one of us reflected:

> "What I really hope is for mental health services that are accessible for the Filipinx community, so they don't have to pay thousands and thousands of dollars out of pocket. Also, finding ways and systems to navigate the mental health care system, because it can go from outreach all the way to inpatient. It's important to have services that are for Filipinxs, by Filipinxs, created by the community."

One such model could involve establishing publicly funded Filipinx community mental health hubs or designated Filipinx practitioners embedded within community centers, public health agencies, or trusted Filipinx community organizations. Building on research emphasizing culturally grounded interventions and community-informed strategies for addressing Filipino mental health disparities (Hall et al., 2016; Javier et al., 2014), these hubs could employ salaried Filipinx therapists, peer-support workers, community navigators, and outreach staff. They could provide free

counselling, group programming, and referrals across the mental health and social service continuum.

Alongside the need for accessible services, we discussed how mental health clinicians are often working in silos, which may have affected not only the support and supervision available for Filipinx clinicians, but also their referral networks. Tolentino acknowledged both the fragmentation and the emerging solidarity within the Filipinx community after the incident. He shared:

> "We often work in silos. I think recently, with the Lapu-Lapu incident, there's been this kind of need and appetite for Filipinx clinicians to work together and collaborate. I've been seeing different groups doing the same work, but in different communities or with different approaches or ways…but ultimately it's working towards the same goal of supporting the mental health of the community."

A second model could therefore be a publicly funded Filipinx mental health collaborative connecting clinicians, community organizations, cultural associations, primary care providers, hospitals, and public mental health services. Collaborative care models integrate professionals through care coordination, systematic referral and follow-up, and consultation across different parts of the health system. A systematic review found that collaborative care showed potential to improve depression outcomes among racialized communities, including people from lower-income backgrounds (Hu et al., 2020). In a Filipinx-specific model, public funding could support a permanent coordinator, a centralized referral and navigation system, regular case consultations, culturally responsive supervision, and shared training. The collaborative could also maintain a roster of practitioners who could be mobilized during community crises while ensuring that their labour via organizing, administrating, coordinating, and facilitating is adequately compensated.

Together, these reflections suggest that community-led Filipinx mental health care is not simply an alternative to formal services, but a necessary expansion of what care can look like when grounded in Filipinx epistemologies. Our kuwentuhans move beyond an individualized treatment model of healing and point toward a collective model of care, where kapwa and bayanihan serve as guiding principles for building accessible, relational, and culturally accountable mental health supports for Filipinx communities. We also acknowledge that the two models proposed here are not the only possible pathways, nor do we seek to universalize or standardize community-led care. Rather, they are offered as possibilities intended to generate further dialogue, experimentation, and collective imagining about how Filipinx mental health care might otherwise be organized and sustained.

Discussion

This study aimed to examine how two Filipinx-Canadian frontline social workers navigate Western mental health systems, identify barriers to culturally relevant care for Filipinx communities, and explore decolonial, community-led approaches grounded in Filipinx epistemologies. The findings suggest that Filipinx mental health care cannot be understood solely through individual help-seeking behaviours, but must also be situated within broader histories and structures of colonialism, racialization, migration, stigma, and privatization, alongside the ongoing need for relational, culturally grounded, and community-accountable forms of care (Decena, 2014; Torres et al., 2024; Ticar & Edwards, 2020).

A central theme in our kuwentuhan is finding the process of flattening therapeutic power within our clinical practice. Across our kuwentuhans, self-disclosure emerged as a deliberate departure from the Western clinician-as-expert model, which often privileges neutrality, distance, and technical authority, and instead invited a more relational, reflexive, and ethically grounded use of self (Ocampo & Pino, 2014; Ticar & Edwards, 2020, Tolentino 2023). Particularly for Filipinxs who inhabit intersecting categories, such as racialized, queer, class, gender, and so on, this approach may foster trust, recognition, and safety by positioning the clinician less as a detached expert and more as a relational witness, collaborator, and co-interpreter of distress. We also want to highlight that self-disclosure is not an argument for boundaryless practice. Instead, the practice can be understood as clinically purposeful only insofar as it benefits the client and strengthens the therapeutic relationship. This finding also extends anti-racist and anti-oppressive understandings of practice by showing that therapy becomes more meaningful when distress is not reduced to an intrapsychic problem, but situated within racism, migration, colonial histories, heteronormativity, family obligation, and shame (Decena, 2014; Nadal, 2020; Torres et al., 2024). For many Filipinx clients, suffering is relational and embodied, often shaped by pressures to endure hardship privately, maintain family harmony, or carry obligations to family and community (Martinez et al., 2020; Tuliao, 2014). In this context, individualized interpretations of anxiety, guilt, or self-blame may miss the broader structural conditions from which such experiences emerge.

Further, our discussion is in line with what scholars have described as the “double burden” experienced by racialized clinicians in predominantly white institutional settings (Sakamoto, 2007; Segui, 2025). Racialized clinicians are simultaneously expected to perform competent professional practice according to Western standards while also managing their own cultural identities, lived experiences of racism, and the emotional labour of serving communities whose needs are structurally underserved (Sakamoto, 2007; Segui, 2026). This “insider-outsider” positionality, such as our professional role in mental health settings while concurrently critiquing the racism in the system we operate within creates a site of tension (Segui, 2026). Our findings revealed that instead of resolving this tension

through assimilation into dominant clinical norms, we emphasize the importance of a continuous reflexive practice with a critical consciousness about the limits of Western frameworks. (Sakamoto, 2007).

Our findings on hiya and mental health stigma are also consistent with existing literature that identifies self-stigma, social stigma, fear of judgment, loss of face, and concerns about family reputation as barriers to Filipinx help-seeking (Martinez et al., 2020; Nadal, 2020; Vahabi & Wong, 2017). In our kuwentuhans, stigma was not simply described as an individual attitude or a lack of education. As we previously discussed, stigma appeared as a relational and cultural force that shaped whether distress could be named, where it could be disclosed, and what forms of care were considered legitimate. This aligns with studies showing that Filipinx communities may avoid formal mental health services because of shame, fear of being judged, and worries that mental illness will reflect badly on the family or community (Martinez et al., 2020; Sato et al., 2022).

At the same time, our reflections complicate any simplistic reading of stigma as a fixed feature of Filipinx culture. We observed that many younger first- and second-generation Filipinx clients, including queer young adults, may be more open to mental health conversations, often using therapy to make sense of family conflict, rejection, migration stress, racism, and intergenerational pain. However, destigmatization cannot focus only on younger generations or position older Filipinxs as merely resistant, uninformed, or backward. Older Filipinx community members have often been shaped by histories of migration, labour, colonization, religion, racism, sacrifice, and survival, where silence and endurance may have functioned as protective strategies (Pino, 2023). Thus, engaging older generations requires an approach grounded in cultural humility rather than correction. Mental health conversations may be more meaningful when connected to values that many older Filipinxs already hold, such as *pamilya* (family), faith or spirituality, *kaibigan* (friendship), *kapwa* (shared humanity), *ginhawa* (well-being), care for children, and collective responsibility. Intergenerational kuwentuhan, family-centred psychoeducation, spititual/church- and community-based conversations, and multilingual mental health literacy initiatives may create less stigmatizing entry points for older adults and families to talk about distress, healing, and support.

Our findings also suggest that community-led approaches rooted in Filipinx epistemologies require us to look beyond the “formal” (Tolentino, 2023), individualized mental health supports as the primary site of healing. While counselling and psychotherapy remain important, our kuwentuhans showed that Filipinx mental health support also emerges through relational, informal, and community-based practices, including community gatherings, healing circles, group-based support, mutual aid, faith-based spaces, cultural organizations, and the collective labour of Filipinx practitioners and community members responding to gaps in public systems.

This raises several important reflective questions for future practice and service provision: *What might decolonial and community-led mental*

health support look like when it is not centred solely on the counsellor's office? Who or what drivers are already supporting the emotional care in Filipinx communities, even if they are not recognized as "mental health professionals"? How might community networks, including parents, siblings, extended family members, elders, faith leaders, peer supports, artists, and community organizers, be involved in the delivery of culturally grounded mental health promotion and care? For example, community-led mental health supports could take the form of intergenerational kuwentuhan circles where older and younger Filipinxs discuss how they identify and navigate stress or mental health stigma prevalent within Filipinx communities. Another example could be peer-supports spaces where queer and trans Filipinx youth can build relationships with older queer and trans individuals to find their chosen family or learn stories about how older generations have navigated or resisted homophobia and transphobia within their families. Moreover, these supports could include Filipinx-language mental health literacy workshops in churches or community centres, as well as community gatherings rooted in religious or spiritual practices, migration, food, storytelling, and cultural connection. In these spaces, trusted elders, cultural workers, faith and spiritual leaders, organizers, and Filipinx practitioners could play important roles in offering relational support and connecting community members to appropriate services.

As Torres et al. (2024) highlight, "addressing mental health challenges in the Filipinx community requires a multifaceted approach that recognizes the historical and cultural context of mental health" (p. 40). Building from this insight, the suggestions offered in our results and discussion may serve as a starting point for broader conversations about context-specific, culturally responsive, community-led approaches to care. More importantly, decolonial and community-led approaches invite us to imagine mental health support otherwise, particularly when public systems fail to adequately respond to Filipinx communities. These approaches remind us that mental health care does not have to be confined to clinical spaces or delivered only through professionalized one-to-one encounters. Healing can also be cultivated through community knowledge, cultural practices, relational networks, and collective spaces grounded in Filipinx ways of knowing, being, and caring.

Limitations

This study makes a significant contribution to the limited literature on the clinical reflections of front-line social workers in Canada's mental health settings. A limitation of our study is that the findings are grounded in the lived experience, clinical reflections, and positionalities of two Filipinx-Canadian social workers from Vancouver, British Columbia, Canada. As such, the insights may not be transferable to all Filipinx-Canadian communities, mental health practitioners, or service users nationally. As Sawyer & Wright (2025) articulate, duo-ethnography is not designed to produce generalizable findings, but to generate "dialogic

inquiry" that illuminates the complexity of lived experiences through the juxtaposition of two perspectives. The value of insider knowledge, the capacity to name, interpret, and theorize experiences that are invisible or illegible within dominant frameworks, is a legitimate and important epistemological contribution, particularly in research contexts where Filipinx Canadian voices have been systematically marginalized (Beltran et al., 2025).

Conclusion

This duo-autoethnographic study contributes to the limited Canadian literature on Filipinx mental health by showing that care cannot be understood only through individual help-seeking or clinical symptomatology. Instead, Filipinx mental health must be situated within broader histories and structures of colonialism, migration, racialization, stigma, and privatization that continue to shape access to care and experiences of distress. By centering the clinical reflections of two Filipinx-Canadian social workers, this paper highlights how flattening therapeutic power, practicing self-disclosure with discernment, and naming distress as political can foster more relational, culturally grounded, and ethically accountable care. The findings also suggest that Filipinx epistemologies, such as kapwa, pakikiramdam, and bayanihan, offer important possibilities for reimagining mental health practice beyond dominant Western models. Ultimately, decolonizing Filipinx mental health care requires more than representation alone; it demands community-led, structurally accountable, and culturally affirming approaches that support dignity, healing, and collective well-being across diverse Filipinx communities.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Author's Contributions

The first author led the conceptualization of the study, data collection, formal analysis, and the writing and editing of the manuscript.

The second author contributed to the development of the study, supported data collection and analysis, assisted in drafting the literature review and results sections, and assisted with manuscript editing.

Ethics Approval

This study did not require institutional ethics approval because it is a duo-ethnography in which the authors analyzed and reflected on their own lived experiences. This study also did not disclose organizations or personal information regarding clients to protect their confidentiality.

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