Experiences of Immigrant Couple and Family Therapists
Clinically Active in the United States:
A Phenomenological Study

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DEDICATIONS

A mi mama, mi hermano, mi cuñada y mi sobrinita por nacer
Ustedes son mi hogar donde quiera que yo vaya.

A mi papá,
El amor por la educación fue lo mejor que me pudiste dejar.

To Salvador Minuchin,
You are our reminder that having a thick foreign accent is not incompatible with excelling as family therapists. I hope you know what you mean to us.
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ABSTRACT

Experiences of Immigrant Couple and Family Therapists Clinically Active in the US: A Phenomenological Study
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Immigration continues to be an important source of demographic growth in the United States (US Census Bureau, 2012). Mental health disciplines in general, and couple and family therapy in particular are paying more attention to immigration as an experience that can profoundly affect the identity and relationships of individuals and families. However, the impact of immigration has been addressed predominantly for immigrant clients. In the extant literature, much less attention has been paid to immigrants as couple and family therapists regarding how their experiences of immigration can affect clinical encounters with clients in the US. In order to fill this gap, this phenomenological dissertation study was designed to examine the clinical experiences of couple and family therapists who were born and raised outside of the US and who are clinically active in this country. Symbolic interactionism (Blumer, 1969; Mead, 1934) and the multicultural perspective as defined by Hardy and Laszloffy (2002) guided the development of this qualitative study which followed the stages and tasks of transcendental phenomenology (Moustakas, 1994). Thirteen immigrant couple and family therapists who were clinically active in the US volunteered for in-depth interviews. Interviews were transcribed verbatim, and the transcriptions were analyzed with the assistance of MaxQDA and using conventional content analysis (Hsieh & Shannon, 2005) to identify frequent and notable themes. The following major themes emerged from the data analysis: (a) the experience of immigration, (b) immigrant therapists and their clients, (c) development as a clinician,
(d) relationships with colleagues and other professionals, and (e) a name for ourselves. The five major themes suggest that the exposure to different cultures during therapeutic encounters in the US and working in the midst of cultural differences affected participants’ clinical work. First, findings supported previous literature that described immigrant therapists as capable of having an outsider perspective, being more aware of their assumptions, being more flexible in their definitions, and experiencing discrimination by clients and other professionals in the US. Second, findings suggest that the therapeutic encounter is a relationship where meanings between therapists and clients are exchanged which facilitates identity transformations, the debunking of stereotypes, and the negotiation of new meanings. Regarding implications, findings from this study suggest that feedback from clients, supervisors, colleagues and faculty members affect the formation of immigrant CFTs’ evolving professional identities. Supervisors and faculty members in training programs should develop a more balanced view of immigrant CFT students and professionals that more closely attends to their needs and nurtures their strengths. CFT training programs and clinical supervisors should teach diversity and multiculturalism in a way that recognizes human diversity without promoting rigid categorization and divisiveness. Future research should pay closer attention to the strategies that immigrant CFTs develop that helps them clinically work in the midst of cultural differences with clients in the US.
CHAPTER ONE: INTRODUCTION

In the field of couple and family therapy (CFT), more scholars and providers have been focusing on diversity and multiculturalism. Some authors are discussing the importance of couple and family therapists being knowledgeable about and sensitive to the diverse racial and ethnic backgrounds of their clients and how this can affect family dynamics and presenting problems in therapy (e.g., McGoldrick, Giordano & Garcia-Preto, 2005; Rastogi & Thomas, 2009; Sue & Sue, 2012). More recently, there has been a focus on couple and family therapists’ backgrounds and how this can affect the therapeutic relationship with clients (e.g., Bula, 2000; Watts-Jones, 2010).

Yet among the variables that remain understudied are couple and family therapists’ places of origin, histories of migration, and whether or not therapists were born and raised in the country where they clinically practice. Regarding the United States (US), extant literature on couple and family therapists who were born and raised in other countries and who are clinically practicing in the US is scarce. This is remarkable considering that many theorists and model developers in CFT have been foreign born therapists, including Salvador Minuchin (Argentina), Cloe Madanes (Argentina), Ivan Boszormenyi-Nagy (Hungary), Paul Watzlawick (Austria), Insoo Berg (Korea), and José Szapocznik (Cuba) among others.

Even more scarce is research designed to examine the clinical activities of foreign born couple and family therapists who are practicing in the US, as available literature and prior studies have primarily focused on other topics such as the training experiences of international students (e.g., Mittal & Wieling, 2006; Ng & Smith, 2009), experiences of international CFT professors in US academia (e.g., Rastogi & Woolford-Hunt, 2005), and
the relationship between supervisors and international supervisees (e.g., Mori, Inman, & Caskie, 2009; Nilsson & Anderson, 2004). Immigration is an experience that can significantly shape the identity and the self of the individual (Akhtar, 1995; Deaux, 2006). For this reason, it is important to better understand how being an immigrant affects international couple and family therapists and their clinical performance in the US.

Prior literature describing the clinical experiences of therapists (either couple and family therapists or clinicians from other disciplines) who were not born and raised in the US but are clinically active in this country has primarily included personal narratives (e.g., Fuertes, Potere & Ramirez, 2002; Mirsalami, 2010; Poulsen, Karuppaswamy, & Natrajan, 2005) or descriptions and conceptualizations of clinical experiences (e.g., Akhtar, 1999, 2006; Akyil, 2011; Cheng & Lo, 1991). The lack of research-based literature designed to examine the clinical experiences of foreign born couple and family therapists who are clinically active in the US is noteworthy. This phenomenological qualitative study was designed to fill this gap in the field of CFT by examining the clinical experiences of couple and family therapists who were born and raised outside of the US and who are currently seeing clients in this country.

In this dissertation study, foreign born couple and family therapists who are clinically active in the US are referred to as “immigrant” couple and family therapists. Some considerations about the selection of this term will be discussed in the following section. Then, a brief summary of the research question, theoretical framework, and methodology is summarized.
Using the Term “Immigrant”

Different terms have been used to refer to mental health professionals who were born and raised outside of the US and who are clinically active in the US (e.g., international, foreign-born, or translocated) (e.g., Chen, 1999; Isaacson, 2001). In this dissertation study, the term “immigrant” will be used. In the context of this qualitative study, the term “immigrant” refers to an individual who was born and socialized in one country and relocated to the US for a period of time long enough to require carrying out everyday life activities (Grinberg & Grinberg, 1984, as cited in Isaacson, 2001). For the purpose of this dissertation, this term refers to first generation immigrants, which is defined by Rambaut (2004) as those individuals who moved from their place of origin to another location at some point during their lifetimes.

According to Rambaut (2004), however, to talk about first generation immigrants is problematic because it groups together individuals who may differ in terms of their acculturation experiences, language acquisition, and family roles because of differences in their ages and developmental stages at the time of the migration. For this reason, the term “immigrant” in this qualitative dissertation refers to one segment of the first generation immigrants: those who arrived in the US during adulthood (operationalized as age 18 or older). This definition includes couple and family therapists who may or may not become US residents or citizens.

Theoretical Frameworks

The main theoretical framework that guided this phenomenological dissertation study was symbolic interactionism (SI) (Blumer, 1969; Mead, 1934). Additionally, the multicultural perspective as defined by Hardy and Laszloffy (2002) complemented this
theoretical framework by adding power as an essential dimension for understanding immigrant couple and family therapists’ experiences in the US. SI (Blumer, 1969; Mead, 1934) is a framework from social psychology that highlights the role of interactions between social actors in the formation of self, society and reality. According to this theory, interactions occur through the continuous exchange of symbols, and the meaning of those symbols is negotiated in the context of social interactions (Charon, 2001). SI also assumes that objects, events and people have distinct meanings for each person, and the person takes into account those meanings to guide his or her actions (LaRossa & Reitzes, 1993). SI promotes a relational view of individuals and of society.

The multicultural perspective (MCP) is a philosophical stance in CFT that suggests that fully understanding an individual requires looking at him or her in the context of his or her relationships, which takes into consideration the multiple axes of power the person is embedded in, such as gender, race, sexual orientation, socioeconomic status, among others (Hardy & Laszloffy, 2002). The main tenets and concepts from these two frameworks and the points of tension and agreement between them will be described in more detail in chapter two.

**Purpose of the Study**

The purpose of this phenomenological dissertation study was to examine the clinical experiences of couple and family therapists who were born and raised in foreign countries and who are now working clinically in the US. The primary aim was to gain a better understanding of the experiences of immigrant couple and family therapists in their clinical roles, taking into consideration both their strengths and challenges. Additionally, this study focused on immigrant couple and family therapists as a distinct clinical
discipline, unlike earlier studies that have grouped together mental health professionals from different fields or that have focused on other populations of clinicians (e.g., counseling students, clinical psychology supervisees).

**Methodology**

The methodology used in this qualitative dissertation study was transcendental phenomenology (Moustakas, 1994). This is a qualitative methodology that aims to understand the meanings and essences (qualities that make something what it is) of the phenomenon being studied by focusing on how this phenomenon is experienced by the individual (Husserl, 1931, as cited in Moustakas, 1994; Husserl, 1913, as cited in Patton, 2002). The four stages of phenomenology as delineated by Moustakas (1994) guided this dissertation study. These four stages are:

- **Epoche**: disciplined effort by the researcher to set aside preconceived ideas, presuppositions, or any commitment to previous knowledge about the phenomenon under study in order to approach it in a way that allows the generation of new knowledge (Husserl, 1931, as cited in Moustakas, 1994). The strategies used to carry out this task were memoing (Daly, 2007) and location of the researcher.

- **Phenomenological reduction**: this stage involves fully describing information about the phenomenon by using an open stance that is reached and maintained through epoche. Conventional content analysis (Hsieh & Shannon, 2005) was used in this stage of the research process.

- **Imaginative variation**: The goal of this stage is to search for the possible meanings of the phenomena by using various frames of reference (Moustakas, 1994). In this study,
the findings were examined through the lens of symbolic interactionism (Blumer, 1969; Mead, 1934) and the multicultural perspective (Hardy & Laszloffy, 2002).

- **Synthesis:** this stage involves the integration of the description of the phenomenon and its interpretation (Moustakas, 1994).

The sample for this phenomenological study included 13 immigrant couple and family therapists who were born in a country other than the US, who immigrated to this country after the age of 18, and who are now clinically active in the US. The strategy to recruit participants was snowball sampling (Newman, 2003; Patton, 2002). The main data collection method was individual in-depth semi-structured interviews (Hesse-Biber & Leavy, 2006). Data was also collected through a self-report demographic survey (see Appendix C). Interviews were audio-recorded, transcribed and then analyzed using conventional content analysis (Hsieh & Shannon, 2005).

Several measures were put in place in order to increase the trustworthiness (Lincoln & Guba, 1985) of this phenomenological study including member checking (presenting the results back to the participants to ensure that their experiences were accurately described), and leaving an audit trail (documenting each step of the research process and leaving those documents open for scrutiny). A detailed description of the methodology and the strategies used to increase trustworthiness is described in the third chapter of this dissertation.

The findings from this study were analyzed by considering how each of the five major themes that emerged (the experience of immigration, immigrant therapists and their clients, development as a clinician, relationships with colleagues and other professionals, and a name for ourselves) could be understood using the two conceptual
frameworks that guided this phenomenological study (SI and MCP). Additionally, results were compared and contrasted with extant literature describing the experiences of immigrant mental health clinicians in the US. The findings of this study are described in the fourth chapter, and analysis of the findings is presented in the fifth and final chapter of this dissertation study. Finally, self of the researcher reflections, limitations, clinical and training implications, and recommendations for future research are described in chapter 5.

**Relevance to Couple and Family Therapy**

The CFT field can benefit from this phenomenological dissertation study because it was designed to examine an important socio-cultural dimension, immigration, which has primarily been addressed with *clients* but has been often overlooked when referring to the *therapist*. As a leading therapy discipline that focuses on contextual and systemic thinking to understand and treat clinical issues, CFT is the best discipline to call attention to immigration as an important social location among practicing couple and family therapists.
CHAPTER TWO: THEORETICAL FRAMEWORKS AND LITERATURE REVIEW

Chapter two describes the two frameworks, symbolic interactionism (Blumer, 1969; Mead, 1934) and the multicultural perspective (Hardy & Laszloffy, 2002), which guided the development of this phenomenological dissertation study. There is also a brief description of immigration and its effects on identity development. Finally, a review of several bodies of literature related to the experiences of immigrant couple and family therapists and other mental health providers in the United States (US) is presented. Below in the introduction to this chapter, estimates for the prevalence of immigrant couple and family therapist currently practicing in the US are described.

Prevalence of Immigrant Couple and Family Therapists Practicing in the US

Estimating the number of foreign born couple and family therapists who are clinically active in the US is difficult given that this type of demographic information is not currently being collected or assessed. For this reason, the percentage of clinically active immigrant couple and family therapists in the US can only be estimated based on other demographic indicators, such as data summarizing employment, education and general immigration trends (Institute of International Education [IIE], 2010, 2012; US Bureau of the Census, 2009, 2012; US Department of Homeland Security, 2012).

Immigration continues to be an important source of demographic growth in the US. In 2010 according to the US Census Bureau (2012), out of the 304,280,000 individuals living in the US, 37,606,000 were foreign born (defined by the US Census Bureau as those who were not US citizens at birth). This represents approximately 12.35% of the total US population. An increasing number of individuals born outside of
the US are relocating to this country. Consequently, the number of foreign born individuals who later decide to become US permanent residents has been steadily increasing since the post-depression years (US Department of Homeland Security, 2012).

The US Census Bureau (2009) has estimated that 14% of civilian workers who are currently employed in the health care and social assistance sectors were born outside of the US. Regarding educational indicators, more than 764,495 students enrolled in US higher education programs during the 2011/2012 academic year were international students, which is 3.6% of the total graduate student population (IIE, 2012). Among them, approximately 60,000 are enrolled in the fields of psychology and the social sciences (IIE, 2010). During the 1999-2000 academic year, approximately 2% percent of graduate students enrolled in marriage and family therapy programs accredited by the Commission of Accreditation for Marriage and Family Therapy Education (COAMFTE) were international students (McDowell, Fang, Gomez Young, Khanna, Sherman & Brownlee, 2003). This percentage has probably increased in the last decade, given that there is a trend towards more international students enrolling in US graduate schools than ever before (IIE, 2012).

These estimates suggest that there are a significant number of internationally born individuals who are currently training in the US to become mental health providers and more specifically couple and family therapists. Although efforts to understand their experiences during the training period have increased (see “Critical Analysis of Substantive Literature” below), there is little information about foreign born therapists’ experiences after their training is completed, and on their experiences as active couple
and family therapists practicing in the US. This is the main gap that this
phenomenological dissertation study was designed to examine.

**Theoretical Frameworks**

The main organizing framework that guided the development of this
phenomenological dissertation study is symbolic interactionism (Blumer, 1969; Mead,
1934). Additionally, the multicultural perspective (Hardy & Laszloffy, 2002) enriches
this theoretical framework by adding power as a necessary dimension for understanding
immigrant therapists’ social interactions, the formation of self and the definition of
reality. Below is a brief description of both SI and MCP, followed by a summary of the
congruencies and tensions between these two organizing frameworks.

**Symbolic Interactionism**

Symbolic interactionism (SI) is a theoretical framework that was developed in
social psychology and highlights the role of interactions between social actors in the
formation of self, society and reality. This theory assumes that interactions occur through
the continuous exchange of symbols, and the meaning of those symbols is negotiated in
the context of interpersonal relationships (Charon, 2001). SI is a theory that privileges a
relational view of individuals and of society.

Charon (2001) described five key characteristics of SI that set this theory apart
from other theoretical frameworks in social psychology. First, it focuses on the
interactions between social actors rather than focusing on individual traits or social
determinism. Second, it views human beings as having an active role in the formation of
their selves and in the negotiation of reality. That is why the term “social actor” is used to
refer to the individual. Third, SI attends to covert processes (e.g., thoughts and
interpretations) as important activities of the social actor in relation to others. Fourth, SI has a fundamental assumption that human beings act according to the definition they give to the situation in which they are embedded. And fifth, SI has a present-oriented perspective that suggests individuals act based on their reality as they define it in the present moment.

Additionally, LaRossa and Reitzes (1993) identified seven basic assumptions of SI that can be organized into three major themes: (a) the importance of meaning, (b) the importance of self, and (c) the understanding of social processes from the points of view of both individual actions and societal constraints. Regarding the importance of meaning, SI assumes that objects, events and people have distinctive meanings for each person, and the person takes into account those meanings to guide his or her actions. Second, SI assumes that these meanings arise and are modified while individuals are interacting with each other. In other words, meaning is not independently given by individuals to external events; it is negotiated during interpersonal interactions, so meaning is intersubjective (Mead, 1934). The third assumption related to the theme of meaning is that the latter is acquired and negotiated in an interpretative process through the use of symbols and language.

Regarding the second theme, the importance of self, SI assumes that individuals develop a sense of self through social interactions and in relation to others. SI additionally assumes that the self provides the individual with a point of reference for action and for conferring meaning to objects and situations. Two assumptions are related to the third theme, which is the view of social processes from the point of view of the mutual influence of interpersonal actions and social structure. SI assumes that
individuals and small communities are influenced by the larger societal context, yet this theory also emphasizes that it is through interactions between individuals that the social structure is negotiated, established and transformed. SI is, therefore, a theory that accounts for both social stability and social change, by taking into account the influence of society on individuals and of individuals on society.

Out of the two main schools of SI that developed during the first half of the 20th century, the Iowa School and the Chicago School (LaRossa & Reitzes, 1993), the latter guided this research study. The Chicago school is based on the ideas developed by George Herbert Mead (1934), as they were later integrated and adapted by his student Herbert Blumer (1969). According to LaRossa and Reitzes (1993), two of the fundamental characteristics of the SI Chicago School are: (a) its focus on the interpretative process during the social negotiation of meaning, which privileges the use of qualitative research methods; and (b) its emphasis on the dynamic and “in the making” nature of the self, society and reality. This phenomenological dissertation study was designed to explore the experiences of immigrant couple and family therapists as interpreted and reported by themselves. By using in-depth interviews as the primary method of qualitative data collection, this study was designed to explore the meanings that immigrant couple and family therapists currently practicing in the US assign to their actions, their selves and their reality as they continue to negotiate and make sense of these meanings during social interactions.

The following section includes a brief summary of the main concepts of SI and how they can be applied to the experiences of immigrant couple and family therapists clinically practicing in the US. The starting point for this conceptual summary is the
individual. The individual is viewed within this theoretical framework as an *actor*, or “a person who acts”. This actor is not assumed to simply react to stimuli present in his/her environment (Mead, 1925). On the contrary, the individual’s actions are directed towards the environment based on the *meaning* that the objects and situations have for that particular individual. Such meaning is negotiated within the context of social interactions. Meaning is, therefore, a social product (Blumer, 1969) and the objects that are given such meanings become *social objects* (Charon, 2001).

*Symbols* are particular kinds of social objects used to represent something else. The social actor continuously uses symbols (e.g., language) for representing and communicating during social interactions (Charon, 2001). From the perspective of SI, immigrant couple and family therapists are social actors who are conferring meaning to social objects that they encounter during their clinical work in the US. These objects are varied, for example, theoretical concepts, clinical interventions, therapeutic models, and caseloads.

In the same way that objects are given meaning, situations also carry meaning for the social actor. The term *definition of the situation* (Thomas & Thomas, 1928, as cited in LaRossa & Reitzes, 1993) refers to the meaning of events for the individual. In order to understand the actions of the individual, it is necessary to take into account how he or she defines the situation in which the actions take place. As social actors, immigrant couple and family therapists define the situations they are involved in (e.g., therapeutic encounters, staff meetings) and they understand their actions and the actions of others (e.g., clients, colleagues, supervisees) from the frame of reference of these definitions. SI also asserts that reality is socially negotiated and defined (Berger & Luckmann, 1966).
Social actors are not seen as reacting to a reality that is “out there”, but acting according to the internal and socially negotiated representation that they have of reality.

The *perspectives* that help individuals explain the definitions of social objects, situations and reality are from the people who are close and meaningful to us, our *significant others* (LaRossa & Reitzes, 1993). As individuals participate in more social interactions, they get less exposed to only one perspective, and more immersed in the shared perspective of the group that they belong to, that is, the perspective of the *generalized other* (Mead, 1925). SI assumes that during the process of symbolic interaction, individuals reach a shared perspective or a working consensus (LaRossa & Reitzes, 1993) which is the basis for the perspective of the generalized other. A social actor in contemporary society belongs to different *reference groups*, each offering a varied perspective that the social actor uses to interpret his or her reality in a given situation and at a given moment (Charon, 2001). According to Shibutani (1955, as cited in Charon, 2001), the perspective of a reference group is the *culture* of that particular group. People who immigrate carry along the perspectives of the reference groups they belonged to from their country of origin. It is from these earlier perspectives that they will initially try to make sense of the different worlds of meaning that they are now encountering in the new country. As immigrants interact with others and enter new reference groups, a complex process of negotiating meaning begins, where immigrants modify and enrich their perspectives.

In addition to acting towards objects in the external environment, human beings also make meaning and act *towards* their own internal processes. As stated by Mead (1925) “pleased palates and irritated or suffering members are *there* in the same sense as
other percepts or objects” (p. 257). The internal experience becomes another object for the actor’s action. This is known in SI as the self. In making the distinction between the self and the actor, Charon (2001) states “it is not the self that acts; it is the actor that acts […] The self is part of the actor’s environment that he or she acts toward” (p. 72). The acts towards the self are multiple, for example, we have emotions towards ourselves, we compromise with ourselves, we judge ourselves, we name ourselves, and we take care of ourselves (Blumer, 1969).

Similar to other social objects, the self emerges during social interactions (Mead, 1934). Other people’s acts (e.g., reactions, language, labels, behaviors) towards that person are the raw material that an individual uses in the development of his or her self. As stated by Mead (1925), “it is just because the individual finds himself taking the attitudes of the others that are involved in his conduct that he becomes an object for himself” (p. 268). Similar to any other social object, the self is redefined during social interactions, and is therefore, constantly evolving (LaRossa & Reitzes, 1993). From this perspective, one can assume that for immigrant couple and family therapists finding themselves immersed in a different culture and a novel world of meaning while interacting with new significant others can deeply transform their selves and their views of reality.

The feedback from significant others is important for the definition of every social object and especially for the definition of the self as a social object (Charon, 2001). The concept of the looking glass self, as coined by Cooley (1902, as cited in LaRossa & Reitzes, 1993) refers to the impression we think others have of us, the judgment we think others make of such impressions, and the feeling that we have about these judgments. In
the specific case of an immigrant couple and family therapist, she might think that a client notices her accent and judges her as less capable of understanding the client’s problems, which can generate feelings of inadequacy. Although social actors form their selves based on the perspectives of others, they do not do this passively or mechanically. The social actor selects, exaggerates, minimizes, and ignores the input of others during the process of developing the self (Charon, 2001).

Because the actor has contact with several reference groups with multiple perspectives, the self of the actor has multiple identities related to the different roles assumed in each particular reference group (Charon, 2001). Roles are shared norms and expectations that are attributed to the occupants of a certain position in a reference group (LaRossa & Reitzes, 1993). Identities are representations that the actor has of him/herself that are related to his/her roles and that have some stability over time (Charon, 2001). Thus, SI views the self as complex and comprised of multiple identities.

These multiple identities that each person has do not all have the same importance for him or her. There is a hierarchy of identities depending on their salience. An identity has salience when it is connected to a role that is important across different situations in which the actor participates (LaRossa & Reitzes, 1993). From this point of view, an identity connected to a vocation could have more salience than perhaps an identity tied to a leisure activity or hobby. For this reason, being a couple and family therapist is likely a salient identity.

These premises and tenets of SI were useful for understanding the experiences of immigrant couple and family therapist who are clinically active in the US. Yet, this theory does not explicitly focus on acknowledging and understanding experiences of
discrimination, prejudice and disempowerment that have been reported in the literature on this topic. Power, as an important dimension of interactions, needed to be included in the conceptual framework of this study. For this reason, the multicultural perspective (Hardy & Laszloffy, 2002) was integrated into this theoretical framework.

**Multicultural Perspective**

The multicultural perspective (MCP) is defined by Hardy and Laszloffy (2002) as a philosophical stance that suggests that fully understanding an individual requires looking at him or her “in relation to other” (p. 569), and involves taking into account the multiple axes of power that each person is embedded in. A framework like MCP responds to what Hardy (1990) calls “the neglect of context” (p. 18) in couple and family therapy. This neglect of context refers to the tendency in CFT to ignore the effect of contextual issues such as race, gender and ethnicity on many domains, for example, family functioning, therapeutic relationships, training programs, and professional organizations.

MCP is an approach that integrates concepts and principles derived directly from clinical practice (Hardy & Laszloffy, 2005) and from clinical models such as intergenerational models (e.g., contextual family therapy and bowenian family therapy), postmodern clinical models (e.g., narrative therapy) and emotionally oriented clinical models (e.g., experiential family therapy and emotionally focused therapy). MCP also developed its conceptual foundations from theories that highlight how issues of social justice shape relationships (e.g., pragmatics on human communication, social constructionism and feminism) (Hardy & Laszloffy, 2002). MCP has been used to understand the effects of contextual variables and power differentials in many clinical
areas, for example, doing family therapy with minority families (Hardy, 1993; 2008; Laszloffy, 2008), adolescent violence (Hardy & Laszloffy, 2005) and the training of couple and family therapists (Hardy & McGoldrick, 2008).

Many MCP tenets and concepts refer to clinical practice (e.g., assumptions about family and couple dysfunction, or descriptions of therapeutic interventions). The following synopsis will only include MCP concepts and assumptions that are applicable to understanding the role of power in relationships, the definition of the self, and the construction of reality which are concepts that directly informed this dissertation study.

MCP assumes that culture is a complex concept comprised of multiple dimensions or contextual variables such as race, gender, religious affiliation, age and sexual orientation among others (Hardy, 2008; Hardy & Laszloffy, 2002). According to MCP, individuals define themselves not only in relation to others, but also in relation to these multiple cultural dimensions, for example everybody has a race, a gender, and a sexual orientation. Each contextual location (e.g., Caucasian, female, bisexual, or middle-class) adds a dimension to the self of a person. For this reason, the self is defined as a “multidimensional phenomenon that emanates from the contexts we are embedded and serves as the basis for the formation of the identity” (K. V. Hardy, personal communication, March 14, 2011).

The location of a person along these many cultural dimensions is not viewed as neutral. On the contrary, MCP suggests that each location is attached to a position of power. One location, for example being heterosexual, can place a person in a position of privilege in relation to another person who occupies a position of subjugation, in this case, a gay person. Given that each person occupies multiple locations along different
cultural dimensions, an individual can simultaneously hold a place of privilege in one dimension and a place of subjugation in another (Hardy and Laszloffy, 2002). Regarding the experiences of immigrant couple and family therapists currently practicing in the US, prior studies and personal narratives (see below) suggest that being an immigrant locates foreign born couple and family therapists in a position of subjugation vis-à-vis individuals who are born in the US. Yet, these same immigrant therapists hold a position of privilege as professionals in relation to their clients. This interplay between positions of privilege and oppression has a central role during therapeutic interactions (Watts-Jones, 2010). Given that the dimensions of the self that tend to be more salient for identity definition are those in which the person holds a position of subjugation (K. V. Hardy, personal communication, October 9, 2009; Killian, 2001) it is possible that being an immigrant is a central factor in the identity definition of immigrant couple and family therapists currently practicing in the US.

Like SI, MCP assumes that an individual cannot be understood in isolation as each person needs to be seen and understood in the context of the many relationships where he or she is embedded (Hardy & Laszloffy, 2002). This context of relationships refers not only to immediate dyadic interactions, but also to the broader cultural and social environment. The context also has a temporal dimension which is both historical and contemporary (Hardy & Laszloffy, 2002). The contemporary context refers to the network of relationships as they are currently affecting the individual. The historical context refers both to the history of the relationship between the actual participants in the event, and to the history of interactions between the groups to which those participants belong. Thus, understanding the relationship between a therapist from Russia and a client
from the US will also involve having a broader understanding of the history of the relationships between their two countries of origin, including the power differentials between them.

Given the contextualized nature of individuals, MCP also assumes that what each person understands as his or her *reality* is also contextualized and, therefore, *relative* (Hardy, 2008). In addition to viewing reality as relative, MCP asserts that reality is socially constructed and is continuously under construction in the context of interpersonal relationships and power dynamics. Because power is a factor that intervenes in the construction of reality, it is assumed that the particular version of reality and discourses held by groups in positions of power are more widely accepted, whereas other discourses are subjugated and, therefore, less validated and known (Hardy & Laszloffy, 2002).

**Congruencies and Tensions between the Conceptual Frameworks**

The two frameworks that guided this qualitative dissertation study, symbolic interactionism (SI) and the multicultural perspective (MCP), were both developed in the US, although at different times. SI, with its assumption that the meaning of self, objects and reality is constantly negotiated during interactions through symbolic exchanges, is a precursor of constructionist ideas and contemporary family therapy models, which were foundations for MCP. Despite these chronological differences, these two perspectives share many assumptions and are complementary frameworks that informed this qualitative dissertation study.

First, these two frameworks have a dynamic, complex and contextualized view of the self, identity, reality and culture. They also share the view of social processes as continuously emerging and developing over time. Although both conceptual frameworks
use the term “self” they seem to be using it with different connotations. SI defines the self as the social object of the actor’s reflexive action. In contrast, MCP does not make a distinction between the self and the individual. Both perspectives, however, share similar views of the phenomenon that is referred to as “self”. First, both perspectives view the self as a complex and ever changing entity that has multiple dimensions. Second, these two frameworks assume that the self is formed in the context of social interactions with others, and is an entity whose formation is contextualized. Third, both theories emphasize the active role of individuals in the definition and redefinition of their selves.

Even though these two frameworks suggest that the multiple parts of the self (“identities” and “dimensions” for SI and MCP respectively) have more or less importance depending on the context of interactions, they explain the organization of the self in different ways. SI suggests that an identity is more salient for an individual when it is related to a role that is important across different situations in which that individual participates (LaRossa & Reitzes, 1993). In contrast, in MCP the dimensions of the self that have a more central place in the definition of the person’s identity are those in which the person holds a position of subjugation and less power (Hardy, 2009; Killian, 2001).

The role that power plays in the definition of self and social dynamics is one of the core differences between SI and MCP. In SI, the role of power is marginal as SI does not explicitly consider whether some perspectives, definitions of the situation or reference groups have more power than others. In contrast, power and power inequality play a central role for understanding relationships from a multicultural perspective. According to MCP, some discourses and definitions are more prominent in our society than others because the groups of reference holding those discourses have more power. In
terms of social locations, being white, male, heterosexual, young, and middle class have been constructed as the normative categories against which other social locations are compared. As a result, all other locations are often viewed as deficient, abnormal or unhealthy (McGoldrick & Hardy, 2008).

The next section of this chapter summarizes the extant literature and research on immigrant therapists including findings from CFT and related clinical fields such as clinical counseling, psychoanalysis and social work. This review identifies the gaps in the literature that this dissertation study was designed to address.

**Critical Analysis of the Substantive Literature**

The following section summarizes findings from several bodies of literature to more fully understand the experiences of immigrant couple and family therapists currently practicing in the US. In this study, the word “immigrant” refers to first generation immigrants, defined as those individuals who were born in a foreign country and who immigrated to a host country at some point in their lifetime (Rumbaut, 2004). Special emphasis was made in the extant literature about individuals who immigrated during adulthood (age 18 and older). First, a brief description of immigration and its effects on the individual is presented. Then, a summary of the extant literature describing experiences of immigrant mental health professionals will follow. Next, a summary of prior research studies that have been conducted on the experiences of immigrant clinicians is presented. This section concludes with a summary of the gaps in the literature that this phenomenological dissertation study was designed to address.
**Immigration and the Immigrant**

*After more than 20 years in the US and in an interracial marriage, my sense of “immigrating” continues.*

Shruti Poulsen – Immigrant family therapist from India.

*Migration* has been defined as the mobility of an individual or group of individuals to a different geographical location for a period of time long enough to require carrying out everyday activities (Grinberg & Grinberg, 1984; as cited in Isaacson, 2001). When this process of migration is approached from the point of view of the place of destination, it is called *immigration*.

Immigration involves experiences of loss, a process of mourning the familiar, and the need to adapt to an often unpredictable and foreign environment, which can cause both anxiety and excitement (Garza-Guerrero, 1974; Mirkin & Kamya, 2008). The profound changes in the external environment are reflected in experiences of discontinuity in the identity of the person. According to Akhtar (1995), the identity restructuring that accompanies the process of immigration offers the newcomer both a threat to the stability of the internal organization and the opportunity for growth. Whether growth or disorganization prevails depends in part on how the immigrant addresses the processes of mourning what is left behind in his or her country of origin in order to create a new sense of familiarity and regularity in the new country (Akhtar, 1995; Garza-Guerrero, 1974).

Garza-Guerrero (1974) used the term *culture shock* to refer to the process individuals go through as a result of prolonged exposure to an unfamiliar environment
and culture. Garza-Guerrero (1974) identified three stages in this process: (a) the initial encounter where the immigrant experiences simultaneously the loss and mourning of the old culture, and the confusion and anxiety while getting to know the culture of the new country; (b) a stage of gradual reorganization of the identity that comes after the initial sense of shock subsides; and (c) the development of a new identity which refers to the continuous and never ending process of re-editing and redefining one’s sense of self.

Migration not only involves a change in the external environment but also a change in the person’s systems of meaning, a phenomenon that Falicov (1998) refers to as uprooting. The uprooting of physical meaning refers to living without the familiarity of the physical environment (e.g., the feel of the neighborhood, weather patterns, and the smells of food). Social uprooting involves the loss of the human network of relationships. Cultural uprooting refers to the separation from established ways of thinking and doing which were infused with meanings in the culture of origin.

In the host country, the immigrant often finds new physical, social and cultural systems of meaning and, therefore, a complex and demanding process of adjustment begins. One of the central tasks that immigrants face, according to Deaux (2006), is to restructure their identity combining elements from their country of origin and from the country where they are now living. The term acculturation has been used to refer to this process. Berry (1997) offers a bidimensional model of acculturation in which two aspects are taken into account: (a) the degree of assimilation to the culture of the country of destination and (b) the degree of retention of the home culture. A person can, for example, embrace the culture of the host country while rejecting the culture of the country of origin, or vice versa. Marin and Gamba (1996) suggest that healthy
acculturation requires balancing and integrating elements of the culture of origin and the culture of destination. This integration of the two cultures also helps to maintain some continuity of the immigrant’s identity in the midst of considerable changes in the environment.

Falicov (2007, 2011) brings attention to the fact that deficit-oriented views of immigration tend to characterize the immigrant’s task of cultural adaptation in terms of either/or choices (i.e., the immigrant will choose one culture over the other) or in terms of mutual elimination (i.e. the immigrant does not fit in either culture anymore). She proposes looking at immigrants as having the capacity to find both/and solutions and living “in two worlds” rather than “between worlds”. According to this author, the experience of immigration is characterized by alternation, hybridization and syncretism. Falicov also affirms that both/and responses show that immigrants “learn to live with the ambiguity of never achieving final closure of the immigration experience” (Falicov, 2011, p. 309).

Sluzki (2008) affirms that the disruption of the social network is one of the most challenging stressors experienced during immigration. He states that a social network is a fundamental part of an individual’s life, and is present in a variety of situations from the most mundane daily activities to the institutionalized celebrations and rites of passage. Attachment losses and difficulty creating support networks in the new country can lead to social isolation, physical health problems, and can even affect the possibilities of survival and adaptation for the immigrant (Sluzki, 2008).

A comprehensive understanding of an individual’s experiences of immigration, however, is not possible without taking into account the social context in which this
process takes place, including the beliefs held in the country of destination about immigrants in general, and about the immigrant’s national group in particular (Deaux, 2006). Some of the contextual factors that can affect the outcome of immigration are whether immigration is temporary or permanent; the degree of choice in leaving one’s country; the possibility of visiting the home country; age at immigration; reasons for leaving one’s country; sentiment with which the host country receives the immigrant; magnitude of cultural differences between host and home country, and the extent to which one’s original role (e.g., vocation) can be resumed in the host country (Akhtar, 1995). Mori and colleagues (2009) stated that the density of the immigrant’s ethnic community in the country of destination and the level of education of the immigrant can be resources for the immigrant, positively affecting the experience of immigration.

Immigrant clinicians’ narratives about their experiences in the US (e.g., Mirsalimi, 2010; Poulsen, Karuppaswamy & Natrajian, 2005; Rivas, Delgado-Romero & Ozambela, 2005) often include a description of contextual factors. These narratives mention, for example, the historical contexts in the country of origin and in the US when the person left, the history of the relations between his/her country of origin and the US, and his/her own developmental stage and age when he/she immigrated to the US.

Immigration and the Immigrant Therapist

Mirkin and Kamya (2008) suggest that immigrant individuals and families usually do not take into account the impact of their pre-migration, migration and post-migration experiences when trying to understand their current issues. Similarly, immigrant therapists might be unaware of the importance of these experiences and how they could be affecting their clinical performance in the US. In a study of immigrant therapists living
in Israel, Basker and Dominguez (1984) found that therapists had a clear awareness of the impact of immigration and cultural differences on their personal lives; however, they did not have this same level of awareness when understanding their professional activities. Yedidia (2005) mentioned the profound identity transformations and emotional conflicts that are often associated with immigrating, and highlighted the importance of immigrant therapists to develop personal awareness of how those transformations and conflicts may affect the clinical services that they provide. Akhtar (1999, 2006) additionally suggested that such levels of professional awareness are necessary not only to prevent immigrant therapist’s issues from interfering with the process of therapy, but also to draw on the richness of their experiences for the benefit of their clients.

Tang and Gardner (1999) asserted that minority therapists have the experience of navigating both their own culture and the majority culture, which increases the possibility of working effectively with minority and majority clients. This assertion can also be applied to immigrant therapists practicing in the US. Cheng and Lo (1991) suggested that immigration provides foreign born therapists with the opportunity to have an outsider’s view of the host culture, making it possible for him or her to approach this new culture with more curiosity and critical awareness. Akhtar (2006) noted that one of the strengths of immigrant therapists is that they are less likely to share cultural blind spots with clients born in the host country. This can make it easier for immigrant therapists to ask questions and offer interpretations that are not restricted by the limits of one culture, but are enriched by at least two cultural perspectives. Additionally, immigrant therapists might have more latitude in assuming a stance of a “curious stranger” and questioning taken-for-granted assumptions when working with clients of different backgrounds (Akhtar,
This attribute is nonetheless a double-edged sword, given that immigrant therapists’ frequent questions for clarification might also interrupt the fluidity of the therapy process (Akhtar, 1999).

For immigrant therapists to be able to use cultural differences between themselves and their clients as therapeutic assets, they have to first acknowledge and accept those differences (Cheng & Lo, 1991). Pressures that immigrant couple and family therapists in particular (Mittal and Wieling, 2006), and minority couple and family therapists in general (Hardy, 1990) feel to minimize differences and assimilate to the dominant US culture can make the process of acknowledgment and acceptance of cultural differences more difficult. As a result, the experiential and conceptual diversity that these therapists can add to the field is often minimized or ignored. Basker and Dominguez (1984) found that immigrant therapists in Israel, for example, highlighted the universality of human problems and equated their own experiences of marginalization with those of their clients as a way to demonstrate that they were qualified to work as therapists in Israel.

When working with individuals who are from the host country, immigrant therapists could face some additional challenges. Cultural differences can generate doubts in clients, who could question the clinician’s capacity to empathize with their reality (Gelso & Mohr, 2002). Furthermore, when immigrant therapists are working within majority cultures whose values are not congruent with their own, tensions and incompatibilities could surface. Cheng and Lo (1991), two Chinese therapists working in Canada, provided an example of this. While the Eastern culture encourages acceptance (defined as knowing and following the natural order and course of the world), in the Western culture acceptance is often negatively perceived as a passive stance of
resignation. In this situation, if acceptance is viewed as a part of the therapy process, this type of cultural incongruity between therapists from Eastern cultures and a Western client could delay the therapeutic process.

Given that both the therapist and client look at each other from perspectives that are influenced by their primary cultures, the possibility for mutual stereotyping does increase (Comas-Diaz & Jacobsen, 1991). According to Comas-Diaz and Jacobsen (1991) people who belong to minority groups, either as clients or as therapists, are easier targets for negative projections. This type of therapeutic impasse could, however, be turned into a strength and a clinical asset. Several authors (Akhtar, 2006; Gelso & Mohr, 2002; Tang & Gardner, 1999) suggested that immigrant and minority therapists offer a fertile ground for the client’s transference material precisely because of the risk of being stereotyped. Gelso and Mohr (2002) introduced the concept of *cultural transference* which refers to culture-related perceptions or behaviors in response to the therapist that are rooted in the clients’ experiences and ideas about members of the therapist’s cultural group. The interpretation of such transference is pivotal for psychoanalytic clinical work to be effective. As an example, Akhtar (1999, 2006) noted that when exploring why a particular client chose him as a therapist, he found that the former had made the decision under the assumption that the education in India (Akhtar’s country of origin) was not rigorous, which would have made Akhtar a less qualified therapist. Ultimately, what this client was unconsciously looking for was the opportunity to avoid directly addressing his internal conflicts.

When working with clients who additionally hold a position of marginalization, including situations where both clients and therapists are immigrants, experiences of
disenfranchisement or exclusion can help immigrant therapists share points of connection and empathy with their minority clients (Tang & Gardner, 1999). This can also be applied to clients who are members of the majority culture and who experience other types of exclusion such as feeling rejected in one’s own family or feeling they do not fit in their own culture (Gelso & Mohr, 2002; Tosone, 2005). One of the risks that immigrant therapists often face under these circumstances is the possible development of a coalition against the mainstream culture (Akhtar, 2006). This coalition, like a relational triangle as seen from a Bowenian perspective (Guerin, Fogarty, Fay & Kautto, 1996), can develop into an avoidance mechanism for diverting anxiety and aggressive emotions for both the therapist and the client. This relational triangle can also lead to an over-identification of the therapist with the client (Yedidia, 2005), in which the former can take a more protective and less challenging role, reducing the possible benefits of therapy.

When immigrant therapists work with clients of similar cultural backgrounds, it is possible for the immigrant therapist to be perceived by the client as an individual who has succeeded in the mainstream culture. This could lead to reactions in the client that range from admiration, to idealization, to envy and a possible sense of betrayal (Comas-Diaz and Jacobsen, 1991). The reaction of the immigrant therapist in these cases can range from survivor’s guilt to emotional distancing and rejection. For example, in describing the experiences of three social workers who immigrated to Israel during their adolescence, Yedidia (2005) found that identity conflicts related to their immigration experiences often affected their therapeutic abilities. One therapist over-identified with her immigrant clients and adopted a protective attitude towards them, while the other two clinicians rejected their clients because their presenting issues reminded them of aspects
of their own identities as immigrants that they did not want to address. In a personal narrative, Luis Antonio Rivas noted that by working with clients that, like him, are immigrants forced him to face his own feelings about being part of a minority group in the US after being part of the majority in his country of origin (Rivas et al., 2005). In a similar way, Mirsalimi (2010), as a member of the privileged class in his country of origin, describes the shock of experiencing prejudice for the first time in his life in the US.

Therapists who had professional identities before immigrating to the host country may find different therapeutic models or theoretical approaches, new regulations and procedures, an unknown terminology, and different health care and social services systems to navigate. In other words, an immigrant therapist may find him/herself in a new professional culture, which can lead to experiences of status dislocation (Basker & Dominguez, 1984) with its associated insecurities regarding their professional identities and clinical skills. As a result, immigrant therapists need to learn how to navigate this new professional environment and integrate their old and new professional cultures to give continuity to their evolving professional identities.

**English as a Second Language and Bilingualism**

Prior research suggests that successful adaptation to a new country requires adequate communication skills in the host language (Winkelman, 1994). This is especially true for couple and family therapists because their professional activities are heavily dependent on verbal abilities. Adequate communication skills not only pertain to the basic use of linguistic structures or fluidity in conversation, but also involve mastery
of the language of the specific therapy discipline (e.g., family therapy or clinical psychology) (Morris & Lee, 2004).

De Zuleta (1990) stated that individuals are viewed less favorably and could feel less confident when speaking in their second language, which for immigrant couple and family therapists can negatively affect their clinical effectiveness. According to Fuertes, Potere and Ramirez (2002), international and regional accents can encourage discrimination because they are an immediate cue to the person’s ethnicity and background, which could elicit in the listeners stereotypes associated with the speaker’s cultural group. Fuertes and colleagues (2002) stated that having an international accent (for example, speaking English with a Japanese accent) can affect clients’ evaluations in areas such as speakers’ competence, level of expertise, status, and similarity with the listener. These authors also noted that being aware and appreciative of cultural differences can counteract the negative effect of accents for the listeners or clients (Fuertes et al., 2002).

Some difficulties can arise when immigrant therapists conduct sessions in a second language. There is a risk for the clinician to miss significant subtleties of what the client is verbalizing. Additionally, the therapist might fail to express his or her ideas in an effective and fluid way (Akhtar, 2006). Misunderstandings and a lack of common ground could also occur at the level of non-verbal communication (Comas-Diaz & Jacobsen, 1991). Akhtar asserts that struggling to express ideas in a second language and wanting to use one’s primary language during therapy sessions might raise issues of loss and mourning for immigrant therapists (Akhtar, 2006).
Bilingualism, however, can offer some advantages for immigrant therapists. According to Cheng and Lo (1991), each language offers its own world of meaning and particular ways of structuring the associations between meanings. By using two languages, bilingual immigrant therapists can access a more complex view of reality (de Zuleta, 1990). Having the possibility of doing therapy in two languages might additionally benefit bilingual clients, given that a wider range of emotions and experiences can be shared. Therapists who speak two or more languages in a country with the level of international immigration that the US has, could additionally counteract the current underutilization of mental health services due to clients’ low levels of English proficiency (Rivas et al., 2005).

The ideas that have been presented about immigrant therapists are based on the personal and clinical experiences of the authors. It is also important for the field of family therapy to contrast these more personal and clinical ideas with empirical findings that examine the experiences of immigrant therapists practicing in the US. As it will become apparent in the next section, this type of research is still scarce.

**Research Findings**

Research studies designed to examine the experiences of therapists in general, and couple and family therapists in particular, who were born and raised outside of the US and who are clinically active in this country are scarce. The few studies that have examined the experiences of immigrant therapists have focused primarily on the training experiences of international therapy and counseling graduate students (Mittal & Wieling, 2006; Ng & Smith, 2009), or the supervisory experiences of international trainees and supervisors (Killian, 2001; Mori, Inman & Caskie, 2009; Nilsson & Anderson, 2004).
Although some of these prior studies addressed the experiences of clinicians in their roles as therapists and during clinical encounters with clients, this has not been the primary aim of the studies. Therefore, this topic has only been indirectly examined. The exception is a study by Isaacson (2001), who examined the effects of evolving cultural identities on the experiences of immigrant therapists. These prior research studies are next summarized.

Training Experiences of International Therapy and Counseling Students

Mittal and Wieling’s (2006) qualitative study examined the training experiences of marriage and family therapy doctoral students. Their purposive sample included 13 current and former international CFT doctoral students, eight females and five males. Participants represented eight different countries, four continents and seven PhD programs in the US. Almost half of the participants spoke English as a second language. Description of the sample in terms of length of time in the US and race was not reported. Participants were qualitatively interviewed and their responses were coded using content analysis.

Mittal and Wieling (2006) reported that foreign born graduate students experienced themselves as outsiders in the US academic environment and struggled with marginalization, racial discrimination, being stereotyped, and feelings of inferiority vis-à-vis their US born counterparts. CFT doctoral students whose primary language was not English experienced anxiety regarding their English proficiency. These doctoral students, especially students of color, reported feeling pressure to assimilate to the dominant US culture and to adopt values such as competitiveness and assertiveness. According to their findings, context played an important role in international doctoral students’ experiences. Thus, when CFT training programs were in geographic areas or universities with high
cultural diversity, or when participants were not the only foreign-born individuals in their programs, they reported having fewer difficulties and finding more institutional support. Despite this finding, international students often reported experiencing a lack of support and validation, and felt that their needs were disregarded in their respective CFT doctoral programs. Participants additionally reported that support and understanding from classmates and faculty members, as well as open communication about diversity, helped them through the process and made them feel like important assets to their doctoral programs. Very little was mentioned by the authors in relation to how immigration affected doctoral students’ clinical activities and performance. Among the few findings that were mentioned in this area were the experiences of covert and overt rejection and racism by their clients, and feeling unprepared to provide therapy to clients in the US.

Ng and Smith (2009) designed a quantitative self-report survey study to compare the training experiences of international counseling trainees (ICT) and domestic counseling trainees (DCT). Fifty-six ICTs (45 females and 11 males) and 82 DCTs (71 females and 11 males) participated in this survey study. ICTs were from 19 different countries in four continents, and were enrolled in counseling programs in 22 states in the US. The average number of years ICTs had been living in the US was 4.24. DCTs represented 16 states in the US. Racial composition of the sample was not reported. Each participant answered a 14-item Likert scale survey and the data was statistically analyzed.

ICTs reported more difficulties compared to DCTs in English proficiency, clinical courses, academic issues, cultural adjustment, and relations with their peers. Regarding their clinical activities, ICTs reported more difficulty adapting to their clinical placements and communicating with their US clients during sessions than DCTs. The
former also reported experiencing more conflicts with Western points of view on mental health. ICTs reported more discrimination by both faculty members and peers than DCTs. Even though ICTs reported experiencing more challenges, there were no significant differences between ICTs and DCTs regarding beliefs about their contributions to their learning environments and the high quality of their clinical performances.

Mittal and Wieling (2006) and Ng and Smith (2009) both suggest that training programs need to become more aware of the particular needs of their international graduate students and should provide them with more support including closer mentoring, emotional support, and assistance in academic areas. They also suggest that programs, faculty members, supervisors and fellow students should pay closer attention to the rich experiences of international graduate students and actively challenge the deficit-centered views about them. Finally, these authors agreed on the importance of creating an academic environment for international trainees to become more comfortable with their cultural differences while in the US. These recommendations are similar to those proposed by Chung (1993) in relation to international counseling psychology students.

The following section summarizes prior research studies on immigrant therapists’ supervisory experiences in the US.

**Supervisory Experiences of International Trainees and Supervisors**

Nilsson and Anderson (2004) surveyed 42 international psychology students about their levels of acculturation, perceived counseling self-efficacy, role ambiguity in supervision (uncertainty in relation to supervisory expectations and evaluation criteria), supervisory working alliance, and discussions of multicultural issues during supervision. Participants came from 20 different countries and five continents. Twenty-six of the
participants were women and sixty percent of the sample had been in the US for 3 to 8 years. Race and other demographics for this sample were not reported.

Researchers reported a positive association between acculturation and the supervisory working alliance. Acculturation (especially acceptance of the US culture) was positively associated with perceived counseling self-efficacy. Perceived prejudice was negatively associated with supervisory working alliance and positively associated with role ambiguity and the discussion of cultural issues in supervision. One of the limitations of this study was that the sample size was small for a survey study, with limited statistical power to detect significant differences. Another limitation of the study was that the measurements for the supervisory working alliance, perceived counseling self-efficacy, and role ambiguity were based on the European-American culture. Based on their survey findings, the authors recommended that supervisors working with international students should assess each student’s level of acculturation, be more specific about supervisory expectations, and develop a stronger supervisory working alliance that facilitates addressing cultural issues in supervision, including experiences of prejudice.

Mori et al. (2009) explored the effects of supervision satisfaction on three different variables: supervisee’s level of acculturation, supervisee’s assessment of the supervisor’s multicultural competence, and discussions about culture in supervision. The 104 participants in this quantitative self-report survey study were international trainees in fields such as counseling, clinical psychology, marriage and family therapy, and social work. Most participants (81%) did not speak English as their first language. Gender, race, country of origin, and length of time in the US were not reported in the description of the sample.
Researchers reported that the level of satisfaction with supervision was significantly associated with the trainee’s level of acculturation and degree of cultural discussion in supervision. They also reported that the association between supervisee’s assessment of supervisor’s multicultural competence and satisfaction with supervision was significantly mediated by how much cultural discussions occurred in supervision. Nilsson and Anderson (2004) and Mori and colleagues (2009) emphasize that it is the supervisor’s responsibility to initiate cultural discussions during clinical supervision, and to also pay closer attention to their supervisees’ levels of acculturation to promote a safer and nurturing supervisory experience.

In a qualitative study conducted by Killian (2001), he explored how differences in supervisors’ and supervisees’ cultures of origin (e.g., coming from different countries of origin and reporting different ethnic backgrounds) in the supervisory experience of CFT supervisors and supervisees. Six supervisors (three from the US and three from other countries) and six international supervisees participated in this qualitative study. The sample was comprised of four males and eight females. The racial background of the participants was varied and included White, Black, Asian, and mixed raced individuals. Eight countries and four continents were represented in the sample. Supervisors and supervisees participated in in-depth interviews that were transcribed and then qualitatively coded using content analysis.

Participants who were not from the US reported that values from their cultures of origin organized the relational dynamics of supervision. For example, in Asian cultures which are characterized by a high regard for respect and hierarchy, supervisors and professors tend to be viewed as authority figures and treated as such. This made the Asian
supervisees less likely to express their needs or to openly disagree with their supervisors. The three supervisors from the US, all of whom were from European descent, had a harder time identifying their own cultural backgrounds and understanding its impact on their supervisory relationships.

Participants reported that coming to the US and experiencing its mainstream culture significantly affected how they viewed themselves. Although the supervisees and international supervisors reported feeling the pressure and the need to “Americanize” or “Westernize” their behaviors, they also reported developing a complex multicultural identity that included elements from the US mainstream culture and their cultures of origin.

Foreign born supervisees and supervisors reported being victims of prejudice, stereotyping and overgeneralization in and out of the clinical training context. This included, for example, being considered representatives or experts of their countries and regions of origin (e.g., a supervisee from Mexico was expected to have expertise about all Hispanic clients). All supervisees reported experiences where they felt they did not fit in their US training programs. Experiences of exclusion and denigration were also reported by international supervisors who felt the need to work harder to prove themselves valuable to their US colleagues. The political context becomes important in the way international supervisors and supervisees are viewed by their US born counterparts and can increase the likelihood of exclusion, stereotyping and discrimination. This is especially important for individuals from countries or regions that are in political conflict with the US (e.g., Middle Eastern countries).
Regarding clinical experiences, supervisees in this study reported that their US clients often questioned their ability to understand their problems and to be therapeutically effective. Additionally, international supervisors questioned the applicability of US-developed intervention models to families that are not the mainstream family in the US.

In her quantitative self-report survey dissertation study, Kissil (2012) examined the associations between foreign born therapists’ reports of counseling self-efficacy and three variables: acculturation, perceived language proficiency and satisfaction with supervision. Her sample included 258 clinicians in different professions (e.g., social workers, counselors, marriage and family therapist, and clinical psychologists). Participants were first generation immigrant therapists from over 60 countries, who were clinically active in the US.

Her findings suggest that therapists’ reports of self-efficacy are not associated with their level of acculturation but instead to how much therapists feel connected to the US, and how much prejudice they experienced in the US. Therapists who felt more connected to the US reported higher levels of clinical self-efficacy, and therapists who perceived more prejudice from the environment reported less clinical self-efficacy. Additionally, Kissil (2012) reported that the supervisor’s multicultural competence was the most significant predictor of clinical self-efficacy, and not the level of acculturation and or therapists’ language proficiency.

The final study that will be described in this review of extant research is Isaacson’s (2001) qualitative research on changes in cultural identity and immigrant therapists’ experiences.
Evolving Cultural Identities and Immigrant Therapists’ Experience

Isaacson’s (2001) qualitative study examined the effects of immigrant therapists’ identity changes regarding their internal experiences and current practice of psychotherapy. The author conducted in-depth interviews with 10 immigrant psychotherapists from different backgrounds (eight females and two males) who had lived in the US for different periods of time (from less than a year to 20 years) to explore if and how the different stages of adjustment to the US culture affected their identity and clinical experiences as foreign born therapists practicing in the US. Eight out of the 10 participants were graduate students. Participants’ race was not reported, and the countries of origin were not disclosed to maintain confidentiality. This study was informed by an intrapsychic and developmental approach which and was guided by a psychodynamic orientation.

Three major themes emerged from this qualitative study. The first theme was evolving cultural identities. Isaacson (2001) reported that there was an evolution of participants’ cultural identities that followed the stages of culture shock as defined by Garza-Guerrero (1974). In Isaacson’s study, therapists who lived in the US for shorter periods of time (less than 1 year) reported more intense feelings of loss and mourning, while therapists and graduate students who reported living in the US for longer periods of time (5 to 10 years) were more open to adopting parts of the US culture into their own identities. Participants who lived in the US the longest (approximately 20 years) described having bi-cultural identities, higher levels of comfort, flexibility, and a fuller integration of their old and new cultures.
The second theme that emerged in Isaacson’s study (2001) was the evolving internal experiences. These internal experiences were categorized in the following three areas: (a) the contrasting values and ideals between the culture of origin and the culture in the US, which participants learned to negotiate over time in the host country; (b) the experience of being different that was present in multiple environments for the participants, which also changed as the therapists reached more hybrid and bicultural identities; and (c) the experience of prejudice from their clients, which generated sadness and anger in the participants who eventually addressed this issue by making a “sincere intent” (p. 68) to learn about the client and to develop an empathic connection.

The third and final theme in this study was the evolution in the practice of psychotherapy. Isaacson (2001) reported that those immigrant therapists and graduate students who immigrated to the U.S. more recently, reported having a more difficult time locating themselves in relation to their clients, especially when the latter were mainstream clients (e.g., White, middle class, US born clients). The longer they reported living in the US, immigrant therapists and graduate students reported finding a more “grounded presence” (p. 58) as clinicians, which allowed some of them to openly acknowledge and embrace the cultural differences between themselves and their US clients and use this difference in a therapeutically effective way.

**Summary of Gaps**

Based on the literature review, there are several gaps in the knowledge about immigrant couple and family therapists who are clinically active in the US which this qualitative phenomenological dissertation study was designed to address. The first gap is the lack of a specific focus on immigrant clinicians who are couple and family therapists.
Some literature and research on immigrant therapists from a variety of clinical fields has been grouped together regardless of the specific clinical discipline (e.g., couple and family therapy, counseling, clinical psychology, social work, and psychoanalysis). This phenomenological research study specifically focused on the experiences of immigrant couple and family therapists.

In the field of mental health in general, and CFT in particular, some attention has been given to multicultural dimensions, including immigration, and how they could affect clinical encounters. Yet, the extant literature on immigration has focused primarily on immigrants as clients. Very little attention has been given to immigrants as therapists. Even the limited literature on immigrant clinicians has focused on other roles, for example, their roles as graduate students (e.g., Mittal & Wieling, 2006; Ng & Smith, 2009), as professors (Rastogi & Woolford-Hunt, 2005), or as supervisors and supervisees (Mori, Inman, & Caskie, 2009; Nilsson & Anderson, 2004). Although this small body of literature includes some helpful suggestions for immigrant therapists in their therapeutic roles, this information is limited. This phenomenological study focused on the experiences of immigrant therapists as currently practicing couple and family therapists and the influence of this salient contextual dimension on their therapeutic encounters with clients in the US.

Ng and Smith (2009) stated that literature on international students (regardless of their major) focused on their needs and difficulties, and only recently some attention has been given to their contributions to the field. Mittal and Wieling (2006) echoed this opinion by suggesting that when the status of being an international therapist in training is more closely considered, it is usually viewed as an obstacle or deficit, and not as a
source of strength or clinical asset. Additionally, Saba, Karrer and Hardy (1990) stated that the field of family therapy needs to move away from a deficit perspective on minorities to an approach that allows us to see the “something else” of individuals who occupy positions of subjugation in the US. This something else refers to the “strengths, legacies, values, history, accomplishments and wisdom” (p. 6) of these individuals, couples, and families. For this reason, the third gap in the extant literature is the scarcity of studies on immigrant couple and family therapists that consider and value the totality of their experiences, including not only their very real needs and struggles but also that something else that has often been overlooked in prior studies. By using a more comprehensive and contextualized approach, this study was innovative because it was designed to examine immigrant CFTs own narratives about their therapeutic work in the US.

It is noteworthy that although Akhtar (2006) and Cheng and Lo (1991) referred to the importance of viewing cultural differences as clinical assets, they did not fully acknowledge that these differences are embedded in a matrix of oppression and subjugation, ignoring the important dimension of power and privilege. Given that experiences of exclusion and oppression have been described in the few studies with international students and immigrant clinicians, it is important to address the experiences of immigrant couple and family therapist working in the US from a perspective that gives a central role to power dynamics for understanding relationships. Using SI and MCP, this qualitative phenomenological dissertation examined how positions of powerfulness or powerlessness affected the selves of immigrant couple and family therapists and how they related to their clients in the US.
CHAPTER THREE: METHOD

In this qualitative study transcendental phenomenology (Moustakas, 1994) was used in to examine the experiences of immigrant couple and family therapists who are clinically active in the US. In the next section, this methodology is referred to as phenomenology. After describing the research question and primary purpose of this study, this chapter presents a brief description of phenomenology and its premises. Next, the methodology and procedures that were used for sampling, data collection, data analysis, and the appropriate criteria to increase trustworthiness are described.

**Main Research Question**

Couple and family therapists who were born and raised in countries other than the US, and who are clinically active in this country have a wide range of experiences that are associated with being immigrant clinicians (e.g., having been international students, being CFT supervisors or supervisees, being in academic settings). This study focused on their experiences in their roles as couple and family therapists currently practicing in the US. For that reason, the main research question that informed the design of this study is: What are the clinical experiences of couple and family therapists who were born and raised in foreign countries and who are now working clinically in the United States? This guiding research question was operationalized by using specific open-ended questions and probes in the interview guide (see Appendix D).

**Primary Aim of the Study**

The primary aim of this phenomenological dissertation study with immigrant couple and family therapists who are currently working clinically in the US was to gain a better understanding of their experiences as therapists, taking into account both their
strengths and struggles. This primary aim was informed by the need to counteract dominant deficit-based perspectives of immigrant couple and family therapists. Additionally, this study was designed to generate new knowledge in an area that has not been the main focus in the extant research with immigrant couple and family therapists: their clinical experiences in the US. Finally, unlike earlier studies that have grouped together mental health professionals from different disciplines, or that have been focused on other populations of clinicians (e.g., counseling students, clinical psychology supervisees), this study focused explicitly on immigrant couple and family therapists as a distinct discipline.

**Methodology**

Phenomenology, a qualitative methodology based on the ideas of Edmund Husserl (1931, as cited in Moustakas, 1994), is used to discover the *meanings* and *essences* of the phenomena of study, which can only be understood by focusing on how these phenomena appear in the individual’s consciousness as an experience (Husserl, 1931, as cited in Moustakas, 1994; Husserl, 1913, as cited in Patton, 2002). Essence is defined by Husserl (1931, as cited in Moustakas, 1994) as “the condition or quality without which a thing would not be what it is” (p.43). According to Moustakas (1994) phenomenology is not focused on explanations or analyses of a particular phenomenon, but on comprehensive descriptions of experiences of these phenomena. Similarly Dahl and Boss (2005) suggest that the primary aim of phenomenology in couple and family therapy research is to understand a phenomenon (in this study, the clinical experiences of couple and family therapists practicing in the US) from the perspective of the social actor.
that has an immediate experience of it (the immigrant couple and family therapists themselves).

Phenomenology is similar in its premises to the two organizing frameworks in this dissertation study, symbolic interactionism (SI) (Blumer, 1969; Mead, 1934) and the multicultural perspective (MCP) (Hardy & Laszloffy, 2002). As stated by LaRossa and Reitzes (1993), the groundbreaking work of the SI developers can be viewed as a precursor to the development of a phenomenological alternative to the more reductionist research approaches in the social sciences. Both SI and MCP view human beings as social actors whose actions are guided by the socially negotiated meanings and definitions that they give to their circumstances. These two conceptual frameworks are congruent with research methodologies like phenomenology, that similarly focus on the perspective of the social actors and how they make sense of themselves and their phenomena. In fact, Mead (1925) stated that studies of social actors and their constructions of meaning should be centered on the perspective of “the environment in relation to the living form, and the experienced world with reference to the experiencing individual” (p. 259).

Finally, according to phenomenology, in order to more fully understand an individual’s experience of a phenomenon it is necessary to study such phenomenon in its natural context (Dahl & Boss, 2005). In other words, phenomenology is a contextualized methodological approach (Dahlberg, 2006) and this characteristic of phenomenology made it especially appropriate for this study because it fits well with the contextualized perspectives of SI and MCP.
Participants and Sampling Method

Sampling strategy.

The final sample of immigrant couple and family therapists included 13 participants. Recruitment of new participants stopped when theoretical saturation was reached. A non-probabilistic sampling strategy was used, combining criterion sampling and snowball sampling (Newman, 2003; Patton, 2002). Regarding criterion sampling, individuals who fit the following inclusion criteria were recruited:

- Being a couple and family therapist. This criterion was fulfilled by:
  - having graduated from an MFT program (masters, postmasters) either in the US or any other country,
  - being currently enrolled in an MFT doctoral program, or
  - holding a state license as a marriage and family therapist.

- Being born and raised in a country different from the United States.

- Having migrated to the United States after the age of 18.

- Being clinically active (e.g., immigrant couple and family therapists have active therapy cases when volunteering for this study).

The exclusion criteria for this phenomenological study were:

- Not working clinically in the US at the time of the study.

- Arriving in the US at an age younger than 18.

- Being in the process of completing the requirements to become a couple and family therapists (e.g., being enrolled in an MFT masters or post-masters program).

Although salient contextual variables such as country of origin, gender, race, current age, and years of clinical experience are all important for understanding the
experiences of immigrant couple and family therapists currently practicing in the US, the position that participants occupied on these variables was not considered a specific inclusion or exclusion criteria, per se. However, in order to identify common patterns and central themes that are shared by a diverse sample of immigrant couple and family therapists, maximum variation on these key demographic variables was pursued. This prevented the final sample from being comprised primarily of participants who were all from the same region in the world, same gender or same race.

Participants were recruited using snowball or network sampling (Newman, 2003; Patton, 2002). This involved asking key informants (e.g., couple and family therapists, CFT professors, CFT program directors) for potential immigrant couple and family therapists and then increasing the sample by inviting current participants to recommend other immigrant couple and family therapists.

**Description of the final sample.**

The demographic profile of the final sample of couple and family therapists who volunteered to participate in this qualitative study is divided into the following three sections: (a) general demographic characteristics, (b) factors related to immigration, and (c) MFT training and clinical work. A full description of the sample is provided to help third parties make an informed assessment about the transferability of findings from this study to other populations and contexts (Lincoln and Guba, 1985). Regarding other strategies used in this study to enhance trustworthiness, see the section below labeled “Trustworthiness”.

The information for this description of the sample was obtained through the “Demographic Survey” (see Appendix C). It is important to point out that this survey was
designed in a way that allowed respondents to report their demographic information using their own words, categories and definitions, rather than make them choose among pre-defined or US-based categories.

**General demographic characteristics.**

The distribution of the sample (in frequency and percentages) for the different demographic characteristics is presented below in Table 3.1. Thirteen participants were interviewed for this study, 10 females and 3 males. Participants’ ages ranged from 31 to 70, with a mean of 45. All participants in this study self-identified as heterosexual, 10 participants were married, two were single and one was divorced.

Regarding race, most participants (six) identified as White or Caucasian. Two participants self-identified as Black, one as Asian, one as Hispanic, one as mixed, and one as White/Semitic. Race was not reported by one participant. In terms of ethnicity, ten participants identified one ethnicity and the remaining three reported more than one ethnic identity. Five participants identified as Hispanic or Latino/a (three and two respectively). Four participants identified their countries of origin as their ethnic backgrounds. Two participants identified as African. Eight other ethnic backgrounds were mentioned, each of them by one participant.

Almost half of the sample (6 participants) reported having no religious affiliation. The remaining seven participants identified as Catholic, Christian, Jewish or Muslim.

With respect to household yearly income, most participants (four) reported earnings between $120,000 and $159,999 per year. The rest of the sample was distributed almost evenly in other income brackets. No participants reported earnings of $200,000 or more.
Table 3.1

*Demographic characteristics of participants*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>76.9</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>40-49</td>
<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>50 or more</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Sexual Orientation</td>
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<tr>
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<tr>
<td>Marital status</td>
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<tr>
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<tr>
<td>Single</td>
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</tr>
<tr>
<td>Divorced</td>
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<td>7.7</td>
</tr>
<tr>
<td>Race</td>
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<td></td>
</tr>
<tr>
<td>White or Caucasian</td>
<td>4</td>
<td>46.1</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Asian</td>
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<td>7.7</td>
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<tr>
<td>Hispanic</td>
<td>1</td>
<td>7.7</td>
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<tr>
<td>Mixed</td>
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<tr>
<td>White/Semitic</td>
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<td>7.7</td>
</tr>
<tr>
<td>Religious affiliation</td>
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<tr>
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<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>Catholic</td>
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<td>15.4</td>
</tr>
<tr>
<td>Christian</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>15.4</td>
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<td>Muslim</td>
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<td>7.7</td>
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<tr>
<td>Annual household income</td>
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<td>$120,000 - $159,999</td>
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<td>30.8</td>
</tr>
<tr>
<td>$160,000 - $199,999</td>
<td>2</td>
<td>15.4</td>
</tr>
</tbody>
</table>
Factors related to immigration.

The distribution of the sample (in frequency and percentages) for the different variables related to immigration is presented below in Table 3.2. The countries of origin for the CFTs who volunteered for this study will not be identified. This information is intentionally being kept confidential to protect the anonymity of participants, because they are part of the same professional community as the readers of this dissertation study. Instead, their regions of origin will be listed below according to the geographical sub-regions defined by the United Nations Statistics Division (see Fig. 3.1).

![World geographical sub-regions](http://unstats.un.org/unsd/methods/m49/m49regin.htm)

Figure 3.1: World geographical sub-regions defined by the United Nations Statistics Division. Retrieved from http://unstats.un.org/unsd/methods/m49/m49regin.htm

Participants represented six regions and eight countries of the world. The region of the world where most of participants came from was South America with a total of six participants. Age of arrival in the U.S. ranged from 20 to 45, with a mean of 28.3 years, however, most participants reported coming to this country in their 20’s for graduate training (10 participants; 76.9% of the sample). Participants reported living in the U.S. from 2 years to 35 years. On average, participants reported spending 16.6 years in the
U.S. English was the primary language among three participants and for most participants in this study, English was a second language. The most frequently mentioned reason for coming to the U.S. was to pursue higher education, which was noted by eight participants. Looking for work and financial stability was the second most common reason for moving to the U.S. Having married a U.S citizen and wanting to live in a different culture were also mentioned as primary reasons for coming to the US.

Table 3.2

*Migration related characteristics of participants*

<table>
<thead>
<tr>
<th>Variable</th>
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<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region of origin</td>
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<td>South America</td>
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<td>46.1</td>
</tr>
<tr>
<td>Northern Europe</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Southern Asia</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Eastern Asia</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Western Africa</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Age at arrival</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>10</td>
<td>76.9</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>40 or more</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Years in the U.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>10-19</td>
<td>3</td>
<td>23.1</td>
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<tr>
<td>20-29</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>30 or more</td>
<td>1</td>
<td>7.7</td>
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<tr>
<td>Reason for moving to the U.S.</td>
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<td>Education</td>
<td>8</td>
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</tr>
<tr>
<td>Work/Financial</td>
<td>3</td>
<td>23.1</td>
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<tr>
<td>Marriage</td>
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<td>7.7</td>
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<td>Travel/New culture</td>
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<td>7.7</td>
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<td>Primary language</td>
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<td>Other than English</td>
<td>10</td>
<td>76.9</td>
</tr>
<tr>
<td>English</td>
<td>3</td>
<td>23.1</td>
</tr>
</tbody>
</table>
**MFT training and clinical work.**

The distribution of the sample (in frequency and percentages) for the different variables related to MFT training and clinical work is presented below in Table 3.3. Participants’ clinical experience ranged from 2 to 35 years, with a mean of 13 years. Some participants reported previous experiences in mental health before moving to the US and/or becoming couple and family therapists. The amount of clinical work that therapists reported doing ranged from 4 to 45 hours per week. Most foreign born couple and family therapists in this sample reported being involved in other professional activities in addition to their current clinical work with clients in the US (e.g., teaching, supervision, research, training, consultation, and management among others).

Most participants (eight) are licensed MFT’s. All participants reported conducting therapy in English. Additionally, eight participants reported also conducting therapy in their native languages. In terms of clinical settings, eight participants reported doing clinical work in their private practices, six in a clinic or agency, and two in a school setting. Three participants reported doing clinical work in more than one setting.

Regarding education, all participants reported getting formally trained as MFT’s in the US, however, some participants reported learning and practicing some marriage and family therapy theories and models in their countries of origin. The formal training as MFT’s was achieved in Master’s programs (six), post-master’s training (three) or Ph.D. programs (three). One participant got trained as an MFT at a time when the profession’s standards for education and accreditation had not yet been defined.
Table 3.3

*Education/Clinical work related characteristics of participants*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of clinical experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>10-19</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>20 or more</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Hours of clinical work per week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>10-19</td>
<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>20-29</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>30 or more</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>MFT licensed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Language(s) used in clinical work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English and mother tongue</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Only English</td>
<td>3</td>
<td>61.5</td>
</tr>
<tr>
<td>Clinical setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private practice</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Agency/Clinic</td>
<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>School</td>
<td>2</td>
<td>15.4</td>
</tr>
</tbody>
</table>

Below is a brief demographic description for each participant (in the order that they were interviewed) and his or her clinical work in the US. In order to maintain participants’ confidentiality, specific demographic information for each foreign born couple and family therapist has been intentionally kept vague and pseudonyms are used.

**Brief description of participants.**

Thirteen participants volunteered for this phenomenological study to describe their experiences as immigrant couple and family therapists who are clinically active in the US.
Yuan is a female therapist in her early forties who was born and raised in Eastern Asia. She racially self-identifies as Asian. In her private practice, Yuan specializes in couple’s therapy. Yuan currently sees primarily middle class and heterosexual White couples, although she reports also working with interracial and same sex couples. She also has previous clinical experience with individuals, couples, and families from different racial and economic backgrounds, and with an array of presenting problems (e.g., parenting issues, conflicts around divorce, loss and grieving, and court mandated cases). In addition to her clinical work, Yuan teaches in a CFT program, and provides supervision in and out of the academic setting. Yuan’s interview was conducted in person at her home.

Daniela is a female therapist from South America who is in her early thirties and racially identifies as Hispanic. Daniela primarily works in two clinical settings, in a school based program and in her private practice. In both clinical settings, she sees clients who have immigrated to the US from Spanish speaking countries. Daniela reported that even though the clients in each of these clinical settings differ regarding their socioeconomic and legal status, their presenting problems and emotional needs that relate to immigration are very similar. Daniela was interviewed in person in her private practice office.

Sandra, a female therapist from Northern Europe, is currently in her early thirties and identifies as Caucasian. She works for two agencies at the moment. One of these agencies specializes in therapeutic work with children and families with histories of trauma, physical or sexual abuse. In the second agency, Sandra works with individual adults, couples and families with a variety of presenting problems such as depression,
anxiety and parenting issues. Sandra reported that her clientele is very diverse regarding race, socio-economic status and immigration status. The interview with Sandra was done in person in the offices at one of the agencies where she current works.

Camila is a female therapist in her early fifties. She racially identifies as White and Semitic. She immigrated to the US from South America. In her private practice, she works with immigrant clients from Spanish speaking countries, and with interracial couples and families. She reported previous clinical experience as a family therapist in community agencies, and as a clinical supervisor for MFT students. Additionally, she is the director of counseling programs at a social service agency. Because this agency serves an area of the country with a large Latino immigrant population, issues related to immigration (e.g., separations and reunification, loss, and cultural and language differences among members of the same family) are an integral part of Camila’s daily work. Her interview was conducted in person at her home.

Tatiana, a female therapist in her late forties, is originally from South America. She self-identifies racially as White. In addition to being a therapist, Tatiana is also the director of an agency that offers clinical services to a diverse immigrant community. Most of her clients are, however, immigrants from Spanish speaking countries. Similar to Camila, Tatiana’s clinical work focuses primarily on immigration and its effects on families living in the US. Tatiana was interviewed in person at her office.

Vera is a female therapist in her late thirties who came to the US from Eastern Europe. Vera racially self-identifies as White. She finished her master’s degree in MFT in the US and after working for a few years, enrolled in a Ph.D. Clinical Psychology program. As part of her academic requirements, Vera is currently seeing clients in three
different clinical settings: (a) an anger management program at a university counseling center, (b) a social services agency specializing in serving youth, and (c) a teen community center. In the first two programs, Vera works primarily with court referred cases. She reported that her clientele is very diverse in terms of race and socioeconomic status. Vera was interviewed in person at an office at the university where she is studying for her Ph.D.

Mario is a male therapist from South America who racially self-identifies as White. Mario is in his early seventies. In his private practice, Mario sees mostly middle and upper class clients who present with issues related to parenting. In addition, Mario works as a family therapy trainer and consultant for agencies that provide foster care, preventive, and home-based services. Mario also supervises couple and family therapists in training. The interview with Mario was carried out in person in a classroom at the university where he current provides supervision. This was the only interview that was conducted in two meetings, with an interval of two weeks between them.

Luisa is a female family therapist in her mid-fifties who is from South America. She describes herself racially as mixed. Luisa has a private practice and, because of its location in the intersection of an affluent and an immigrant community, she sees clients from diverse racial, socioeconomic, and immigrant backgrounds. Luisa works with a wide range of presenting problems, including families who are coping with a chronic illness, immigration related issues, loss and grief, and parenting problems. In addition to her clinical work, she supervises therapists in training and participates in medical family therapy research. Her interview was conducted in person at her office.
Mariam is a female therapist from South Asia. She is in her late forties and racially self-identifies as Caucasian. In her private practice, Mariam primarily sees couples, some of whom are interracial or inter-cultural couples. At her previous jobs, she has worked with blended families, divorced families and families coping with parenting issues. In addition to her private practice, Mariam also works as a faculty member in an MFT program. Mariam was interviewed online via Skype because her geographic location made it difficult to meet in person.

Adeben is a male therapist in his late forties, who originally came from West Africa. He racially self-identifies as Black. Adeben currently works for a social services agency doing in-home therapy with low to middle class families who have a child with a behavioral disorder. Additionally, Adeben works in his private practice with immigrant couples and families who are from Africa, as well as African-American and Caucasian families. Adeben’s interview was conducted in person at his private practice office.

Natalia is a female therapist from South America. Natalia is in her mid-forties and identifies ethnically as Latina but does not self-identify with a particular race. Natalia has worked with immigrant clients, including refugees and victims of torture. She has also worked with interracial and inter-cultural couples and families, and same-sex couples. In addition to her clinical work, Natalia teaches in a CFT program and offers trainings to mental health professionals on topic such as trauma treatment and issues of social justice in CFT. The interview with Natalia was conducted via Skype due to the geographical distance.

Lisha is a female therapist from Northern Europe who is in her late forties and who racially self-identifies as Black. Lisha works at a social services agency that helps
incarcerated individuals and their families navigate the US legal system. She conducts forensic evaluations in preparation for probation hearings, and develops reentry plans for individuals who are going to be released from the prison system. Most of her clients present with issues such as severe mental illness, histories of physical and sexual abuse both as perpetrators and as victims, and anger management problems. Lisha was interviewed in person at her home.

Amir is a doctoral student who originally came from East Asia. He racially self-identifies as White. In his private practice, Amir works primarily with White clients although he also sees families from different racial backgrounds, socioeconomic statuses and countries of origin. The main reasons that families are referred to his private practice are to cope with issues related to divorce, parent and teenager struggles and addiction in the family. Amir was interviewed online because geographical restrictions made the in-person interview not feasible.

Data Collection

Data for this phenomenological study was collected through two main sources: in-depth semi-structured interviews and a self-report demographic survey.

In-depth semi-structured interviews

According to Moustakas (1994) “evidence from phenomenological research is derived from first person reports of life experiences” (p. 84). Therefore, this phenomenological study was based on information collected during 13 in-depth semi-structured interviews with immigrant couple and family therapists who are clinically active in the US. Hesse-Biber & Leavy (2006) stated that the goal of in-depth interviews is to collect rich qualitative data about a specific topic from the points of view of
individuals who have been selected for particular characteristics in relation to that topic. These authors also suggested that in-depth interviews are especially helpful for gaining access to subjugated narratives and subjugated knowledge (Hesse-Biber & Leavy, 2006).

Semi-structured in-depth interviews followed an interview guide (see Appendix D) that had the dual purpose of maintaining consistency by ensuring that all interviews covered the same topics, while allowing participants the freedom to discuss what was important or meaningful to them in relation to the phenomena under study (Hesse-Biber & Leavy, 2006; Patton, 2002). Interviews were conducted between August, 2012 and February, 2013. Most interviews were conducted in person (10 interviews). The location of the interviews (e.g., participant’s home, office) was agreed upon by the researcher and the participant to ensure the confidentiality and safety of both parties.

When geographic distance made face-to-face interviews impossible, online interviews took place (3 interviews). These online interviews were audio-recorded with the assistance of Evaer, a computer software program that records the audio of online communications conducted via Skype. The researcher took notes and wrote memos describing the process both during and after each interview and these notes and memos were analyzed during the data analysis stage. Interviews lasted from one to two and a half hours.

**Demographic survey**

The demographic survey (see Appendix C) is a brief self-report measure that asked about participants’ demographic information such as gender, race, socioeconomic status, country of origin, age at immigration, current age, place of professional training, years of clinical experience, primary language, and languages in which the participant
conducts his or her therapy sessions in the US. This information was used to better understand the context in which the experience of being an immigrant couple and family therapist is embedded. Also, these key demographic variables are, according to the literature review, important for understanding the experiences of immigrant therapists currently practicing in the US.

**Pilot test of interview guide and demographic survey**

During the initial phase of the study, the interview guide and self-report demographic survey were both pilot tested during mock interviews with two immigrant couple and family therapists who fit the inclusion criteria for this study, but who were not part of the recruited sample. The goal of these pilot interviews was to get feedback about the clarity of the questions in the interview guide, to assess the need for additional questions, and to determine whether these two instruments elicited the information that was being researched in this study. The two participants in the pilot interviews reported that the questions were clear and helped them describe their clinical experiences as immigrant couple and family therapists. They also reported that they felt comfortable during the mock interviews.

**Procedure**

After receiving approval from the dissertation committee and the Drexel’s Institutional Review Board, recruitment flyers (see Appendix B) were emailed to key informants. Once an immigrant couple and family therapist contacted the researcher to volunteer for this study, he or she received an information packet about the study. This packet included: (a) the adult consent form (see Appendix A), (b) a brief description of the procedure, and (c) the self-report demographic survey (see Appendix C).
Additionally, participants were informed about compensation they would receive for their participation ($20 Target gift card). For face-to-face interviews, the consent form was signed on the day of the interview and before the actual interview started. If the interview was conducted online, participants were required to first email a scanned version of the signed consent form and the completed demographic survey back to the researcher.

All interviews were audio-taped. The recorded interviews were stored as electronic audio files in a password protected computer that was accessible only to the researcher. An additional copy of the interviews was stored in a password-protected back-up drive. All interviews were transcribed verbatim. Interview transcriptions and notes about the interview process were compiled by the researcher and then qualitatively analyzed. Electronic copies of the transcripts and all written materials were stored in a similar fashion as the audio-taped interviews. All data were qualitatively analyzed following the steps that will be described in the next section.

Research that is based on narrated material runs the inherent risk of generating emotional reactions in participants. In addition to signing the consent form that clearly stated that all participants have the right to withdraw at any time during the study, a practice that was implemented, especially during the in-depth interviews, was the use of processual consent (Piercy & Fontes, 2001). Processual consent requires that the interviewer ask questions or make statements during the interview that explicitly gives participants an opportunity to not answer a specific question, to continue with the interview or to terminate it at any time.
Data Analysis

Moustakas (1994) describes four overlapping and recursive stages in a phenomenological research study: (a) epoche, (b) phenomenological reduction, (c) imaginative variation and (d) synthesis. These four stages guided the development and analysis of the qualitative data from this dissertation study.

Epoche

Husserl (1931, as cited in Moustakas, 1994) uses the term *epoche* to refer to the disciplined effort to set aside preconceived ideas, presuppositions, or any commitment to previous knowledge about the phenomena under study. This disciplined effort is expected to help the researcher access a more original vantage point for experiencing the phenomenon and to facilitate developing new knowledge about it. Although it is presented as a stage, epoche is better understood as a task that has to be continuously exercised throughout the data collection and data analysis phases of the research.

A consistent effort to put aside preconceptions and ideas about immigrant couple and family therapists working clinically in the US was done in the following two ways: (a) ongoing writing of reflexive memos (Daly, 2007) that helped to increase the researcher’s awareness of the theoretical and experiential material that the research process generated for her, and facilitated making distinctions between the researcher’s own experiences and the narrated experiences of the participants; and (b) an acknowledgement and awareness of the location of the researcher (see the last section of this chapter) that described the position the researcher occupied in relation to the topic under study and in relation to other relevant sociocultural dimensions such as race, gender, socio-economic status and sexual orientation.
Epoche was also practiced during the interviews with the 13 participants. The researcher made sure that the interviews reflected the participants’ lived experience as immigrant couple and family therapists, and not her own. As participants shared their experiences, the researcher presented her understanding of their accounts to allow participants to confirm or disconfirm them in the moment.

**Phenomenological reduction**

Epoche allows the researcher to work towards reaching and maintaining a more open and receptive stance in relation to the phenomena that is being studied. *Phenomenological reduction* consists of thoroughly describing the information that is accessed as the result of a more open stance. According to Moustakas (1994) this process requires the following steps: (a) *bracketing* or placing the phenomenon that is the focus of the study into brackets, freeing it of preconceptions; (b) *horizontalizing*, which initially entails treating each piece of information about the phenomenon as having equal value, and then identifying horizons or pieces of information that seem to be more meaningful and essential for the phenomenon; (c) clustering the horizons into themes; and (d) organizing the themes and horizons into a coherent description. This description is the account of the essence of the phenomenon, which is presented in the results section of this phenomenological dissertation study.

A conventional content analysis, as described by Hsieh and Shannon (2005) was used for the process of phenomenological reduction, to identify the horizons and themes. In conventional content analysis, the researcher identifies and extracts categories from the data using inductive category development. The steps during this process were to: (a) read all the data in order to immerse oneself in participants’ narratives and get a sense of
the whole; (b) read each piece of text carefully to identify words or expressions that capture key ideas of the participants; (c) define the initial codes by identifying labels using words or expressions that are reflective of more than one key idea; (d) group codes into categories based on similarities and/or links between them; (e) organize these categories into meaningful clusters until encompassing and meaningful themes emerge; and (f) develop definitions for each theme, category and code. The resulting description of the phenomenon organized into themes and subthemes, and then enriched with quotes from the participants, was used as an outline for reporting the findings (Hsieh and Shannon, 2005; Newman, 2003). The computer software MAXQDA was used in the process of phenomenological reduction.

**Imaginative variation**

The goal of this stage is to search for the possible meanings of the phenomena through the use of various frames of reference (Moustakas, 1994). In order to fulfill the goal of this stage, the suggestion from Larkin, Watts and Clifton (2006) for interpretative phenomenological analysis was followed. According to these authors, after developing a description of the participants' experiences, it is necessary to reach a higher conceptual level by interpreting the findings in relation to their social, cultural and theoretical contexts. With this aim in mind, the findings from this study were examined through the lens of SI (Blumer, 1969; Mead, 1934) and the MCP (Hardy & Laszloffy, 2002).

**Synthesis**

The final step in the phenomenological research process was the integration of the description of the phenomenon and its interpretation. According to Moustakas (1994) this synthesis represents the essences of a phenomenon at a particular place and time, and
from the point of view of the specific researcher. The synthesis is described in the discussion section of this phenomenological dissertation study.

**Trustworthiness**

According to Lincoln and Guba (1985), establishing trustworthiness in qualitative research requires demonstrating to potential audiences of the study that the findings are worth paying attention to, and have been reached through a careful and rigorous process. In order to demonstrate that the findings from this study are trustworthy, they have to meet criteria in four different areas: (a) credibility, (b) transferability, (c) dependability and (d) confirmability.

**Credibility**

Qualitative researchers must take specific measures to increase the probability that the findings from a qualitative research study are believable. The first strategy that was used to strengthen the credibility of this phenomenological study was *member checking* or *member validation*. This procedure involves taking the findings from qualitative study back to the participants for them to evaluate whether or not the descriptions generated by the researcher actually reflect their experiences (Dahl & Boss, 2005; Newman, 2003).

An e-mail was sent to all participants with an attached document that provided a brief description of the major themes and subthemes that emerged from the data analysis. Participants were asked to review the document and to confirm whether they felt that their experiences were captured in this summary of the findings. Six participants replied, five by e-mail and one by telephone. All reported that the description of the findings
reflected their experiences as immigrant couple and family therapists working clinically in the US. A summary of their comments is included at the end of the results section.

Another strategy that was used to strengthen the credibility of this study was prolonged engagement with the participants (Hsieh & Shannon, 2005). This was done by contacting participants at different points during the course of the research process (e.g., interview session, and member checking), and by giving participants the possibility of providing additional comments to the researcher through e-mail. Even though participants were encouraged at the end of their interviews to contact the researcher by e-mail if any new idea about the topics of the interview came to mind, none of them did.

It is important to note that originally, it was proposed to have a follow-up phone call with participants two weeks after the interview to ask for any further reflections on the topics of the interview. Some participants preferred to not be called because of their busy schedules. Others reported by e-mail that they did not have additional comments which made the follow-up telephone call unnecessary. Only one follow-up telephone call was conducted as planned, and the participant did not have anything to add to what was already reported during the interview. After the seventh participant, attempts to have a follow-up phone call were dropped.

A third strategy that was used to increase credibility was triangulation. Lincoln and Guba (1985) suggest that one way to reach triangulation of sources is to have “multiple copies of the same type of source” (p. 305). A sample of 13 immigrant couple and family therapists facilitated theoretical saturation of the data, and increased credibility. Additionally, triangulation of observers in this study involved having the committee chairperson review the study findings. The dissertation chair (Dr. Maureen
Davey) also acted as a reviewer (Lincoln & Guba, 1985), asking questions about the thought processes that led to the themes and horizons during weekly meetings which ensured that the investigator had clarity about this process, and giving the investigator the opportunity to maintain epoche. The researcher also consulted with the methodologist on the dissertation committee (Dr. Kathleen Fisher) during the data analysis phase to verify that the analysis procedures were conducted according to the requirements of phenomenological methodology.

**Transferability**

Transferability refers to the possibility of applying the findings from one study to other groups or individuals. In order to determine whether or not this is possible, it is important to assess for the similarity between the context of the population of this study and that of the group to which the findings are expected to apply. Given that the researcher does not know in advance the characteristics of the contexts where the findings can be transferred to, the task of the researcher is to provide a detailed description of the context of the study and all participants, which can be found in the description of the sample. This detailed description will help third parties interested in transferring the findings to make informed judgments about the similarity of the contexts and the possibility of transferring the findings (Lincoln and Guba, 1985). The information gathered in the self-report demographic survey helped provide a detailed description of the context.

**Dependability**

In qualitative studies it is expected that the actual process of conducting research will affect participants and the phenomenon that is being studied. For this reason,
consistency over time is not expected. In order to promote dependability of the results in this study, the researcher has taken into account and fully described details about the research design and the research process in general which might have led to changes in the participants and the phenomenon that was being studied (Lincoln & Guba, 1985).

**Confirmability**

In this phenomenological study that examined the experiences of immigrant couple and family therapists who are clinically active in the US, the themes and horizons, and the interpretation of findings based on SI and MCP are expected to be consistent with and capture the experiences of the 13 participants. The quality and trustworthiness of findings in qualitative studies is assessed by linking the final product to the initial raw data. In other words, after the process is over, there must way to confirm that the final findings are related to the experiences of the participants. This is called confirmability (Lincoln & Guba, 1985).

In this study, all the steps of the process were documented, generating an audit trail that is open to scrutiny. This includes all the written raw materials, reflective memos, initial coding, and the attempts at categorization of the transcripts and written materials. The ideas and reflections behind the identification of categories and their clustering into higher order themes, the thought process regarding the interpretation of results according to the two theoretical frameworks (SI and MCP), and the rationale behind any adjustment in the study design were included in theoretical and operational memos (Daly, 2007) that are part of the audit trail.
Location of the Researcher

One of the epistemological assumptions of phenomenology is that the researcher is not separate from the phenomena being studied (Dahl & Boss, 2005). This premise is even more meaningful for this dissertation study because the researcher is also an immigrant couple and family therapist clinically active in the US. In this section, I describe my location regarding the topic of this phenomenological study. I will also locate myself in relation to the many contextual factors identified by Akhtar (1999) and Mori and colleagues (2001) as important for understanding the experiences of immigration. Finally, I will describe the location that I hold in many socio-cultural dimensions (e.g., gender, race, socioeconomic status, sexual orientation, level of education) and the position of power or subjugation associated with them, which is an important exercise for couple and family therapists and researchers committed to social justice (Hardy & McGoldrick, 2008).

Location of the Researcher in Relation to this Study

I was born and raised in Colombia and moved to the US in August, 2001. Lack of work opportunities in the mental health field in my country of origin was the primary reason for my migration. When I left Colombia, I was not sure how long I would be gone. It was during my US master’s program in marriage and family therapy (MFT) that I decided to remain in this country. Being bilingual (English-Spanish) became an asset for me as a mental health professional, given the lack of bilingual clinicians available to serve the Spanish-speaking populations in the US.

During the summer of 2005, after living in the US for four years, I had a realization: that I had something in common with other people who, like me, migrated to
the US as adults. At that time, I was renting a room in a 6-bedroom house. One of the other renters was Viola, a school teacher from Burma. A few days after I moved into the house, Viola and I went for a coffee. Our conversation quickly went from a superficial chat to a very profound encounter. We talked about leaving our countries, trying to adapt to a new life in the US, the excitement about our new experiences and the sadness of losing what is familiar. We also talked about the many things that are hard to understand about the “American culture”, which in this context refers to the white, middle class and heterosexist dominant culture in the US. The similarities of our experiences were striking; I felt that her words were also describing my story.

After this conversation with Viola, I had a remarkable feeling: I had been talking for two hours with a person whom I had just met, from a country that is located at the opposite side of the world from my own, and in a language (English) which for both of us is our second language and yet, we deeply connected and understood each other’s life experiences. Then, I realized that this was not the first time I felt this deep connection. I had this same experience of identification and commonality with my colleague from Palestine, my friend from Iran, my client from Nicaragua, and many others who were born and raised in another country and then migrated to the US. Regardless of how different we were, the experience of being immigrants in the US imprinted us with something that we now shared and understood about each other. When I migrated to the US from Colombia in 2001, I became a foreigner here and an occasional visitor there. Finding my place in the world has been a difficult task. After this epiphany, I felt that I had finally found a group that I belonged to: I was an immigrant.
Like the participants in Basker and Dominguez’s (1984) study on immigrant therapists living in Israel, I was keenly aware of how being an immigrant affected my personal life, but not my professional life as a couple and family therapist practicing in the US. It was when I began my doctoral studies at Drexel University and met Karni Kissil, a friend of mine born and raised in Israel, that I started to think more about how this dimension of my self could have a significant impact on my role as a couple and family therapist. During many conversations with Karni, I felt the same experience of commonality I previously had with Viola. In other conversations, however, her experience as an immigrant couple and family therapist working in the US was very different from mine. For example, most of her clients have been US-born couples and families, and she felt her experiences as an immigrant allowed her to have an outsider’s view of her clients’ dynamics and culture, which helped her to more easily question her clients’ culture related assumptions. In contrast, most of my clients were Latino immigrants like me, and my experience as an immigrant allowed me to validate their struggles adapting to the US.

The conversation with Viola opened my eyes to our commonalities and my conversations with Karni highlighted some notable differences. Both of these relationships allowed me to understand that there is a rich experience derived from being an immigrant couple and family therapist in the US that needed to be studied and had not yet been fully recognized.

**Location of the Researcher in Relation to Immigration Contextual Factors**

Here I describe the context in which my immigration occurred and continues to occur according to the contextual factors that Akhtar (1999) and Mori and colleagues
(2001) considered important for understanding the immigrant experience. I came to the US when I was 25 years old with a degree in psychology that allowed me to be seen as a mental health professional in Colombia, but that in the US was not valid as a professional degree. I left Colombia because unemployment rates were very high. My first experience in the US was working in a residential treatment center (RTC) in New York State. Even before moving to the US, I knew that I wanted to become a couple and family therapist. After working in the RTC for 18 months, I applied and got accepted to a COAMFTE accredited MFT program in the US. This allowed me to fulfill one of my professional dreams, which would have not been possible if I had stayed in Colombia because at that time there were no MFT training programs in my country.

In many ways, my history of immigration has been privileged. For example, I can visit Colombia any time. I speak English fairly well, which gives me the linguistic tools and skills to navigate this country. I am single, physically and mentally able and have no dependents, which makes my decisions in the US much easier. I found a Colombian, Latin American and immigrant community in the US to connect to for social support, and was able develop my personal and professional life in the way I planned, including being part of the CFT PhD program at Drexel University. Although both Colombia and the US are often characterized by sexism, as a woman I have felt more respected and found more freedom in the US as compared to my country of origin.

At the same time, I arrived in the US three weeks before the terrorist attacks on September 11, 2001 in New York City, which generated feelings of mistrust towards foreigners, and made my status as an immigrant much more difficult. Additionally, I am part of a minority group that is often discriminated against and stereotyped in the US:
Latinos or Hispanics. The experience of being part of a minority group was especially difficult for me because in my country of origin I was part of the privileged group regarding racial, educational and socioeconomic status.

Even though I was part of the majority in Colombia, from a global perspective Colombians and Latin Americans are in a subjugated and in a less powerful position in relation to the US. First, there is a history of economic, political and military interventions from the US to our countries, which demonstrates that the US is a more powerful country. Also, the “American” way of life has become a standard that many Colombians strive to achieve. The “American” cultural influence is also noteworthy as our movie theaters, TV channels and radio stations are all filled with music, shows and movies from the US. I grew up hearing disparaging comments about Colombians and glorifying descriptions of the US and so I learned to put the US on a pedestal and to accept it as the standard my country had to be compared to. Again, this standard refers to the white, middle class, sexist and heterosexist mainstream US culture. The racial and cultural diversity within the US was unknown to me until I arrived here in 2001.

**Location of the Researcher in Relation to Contextual Dimensions**

I was part of the racially, socioeconomically and educationally privileged class in Colombia. I am a mestiza, a mixed-race woman. My racial composition is the result of centuries of racial mixing that characterize mine and other Latin American countries inhabited by Native Americans, colonized by Spain, and in which the enslavement of Africans was prevalent. In relation to the White standards, I do not hold a position of privilege. However, in relation to Afro-Colombians and Native-Colombians, my mixed
complexion makes me part of the mestizo racial majority that holds privilege and power in Colombia.

As a heterosexual woman I am both privileged and subjugated. Heteronormativity, defined by Schilt and Westbrook (2005) as the group of “cultural, legal, and institutional practices that maintain normative assumptions that there are two and only two genders, that gender reflects biological sex, and that only sexual attraction between these ‘opposite’ genders is natural or acceptable” (p. 441) is prevalent both in Colombia and in the US. Because I belong to one of the two acknowledged genders (female), my gender reflects my biological sex, and I feel predominantly attracted to males, I am “normal” according to the widespread heteronormative standards. Fitting into these standards has saved me from the discrimination that gays, lesbians, transsexuals, intersexuals, and bisexuals face on a daily basis. Having access to discourses that name and aim to deconstruct heteronormativity is one of the privileges that I hold for being in a country in which the discussion about the social construction of reality has matured for decades.

At the same time, being a woman places me in a position of subjugation in relation to men. Acknowledging the oppression that I have endured as a woman because we live in a sexist world is much easier than acknowledging the privileges that I have as a woman because we are in a heterosexist world. There are two reasons for this. First, I learned about heteronormativity very recently. The privileges that I hold vis-à-vis people of the LGBTI community, especially intersexuals, were unknown to me until my last year of coursework in the PhD program. I continue working on raising my awareness in this area. Second, being raised in a traditional household and having a male sibling who is
two years older than I am made evident for me, for as long as I can remember, that there was a world of opportunities that was available to my brother and that was denied to me because of our respective genders.

Because of the hard work of feminists and womanists in the US, who have helped to dismantle sexist practices and discourses, there are privileges that I have in the US as a woman that I did not have in Colombia. For example, my experience with the males that I have met in this country is that they are (even if out of hypocrisy or fear) more respectful of my personal space, less prone to making demeaning comments about women in front of me, and more involved in sharing household tasks. From my point of view, people who fight against gender inequality in Colombia face stronger opposition and more ingrained sexist attitudes.

Although both of my parents came from poor backgrounds, by the time I was born, my father was a successful engineer and I enjoyed the benefits of his economic stability, especially in relation to my access to high quality education. Due to this socioeconomic and educational privilege, I learned English and had access to many personal and professional options, including coming legally and comfortably to the US.

I kept increasing my educational privilege by enrolling at Drexel University’s Couple and Family Therapy Doctoral Program. In the words of Hardy and McGoldrick (2008), I am accumulating “socially reinforced and institutionally buttressed power” (p. 580). Through this dissertation study on the experiences of immigrant couple and family therapists working clinically in the US, I wanted to use that power to bring awareness to an area of subjugation that is vital in my life and around which my identity revolves: being an immigrant. I also wanted to bring a deeper awareness to being an immigrant as a
dimension that has an impact on the clinical activities of couple and family therapists practicing in the US.
CHAPTER FOUR: RESULTS

This chapter describes the main findings of this phenomenological dissertation study. Below I describe the five main themes and subthemes that emerged after conducting the phenomenological reduction (Moustakas, 1994) of the 13 interviews with the sample of immigrant couple and family therapists who are clinically active in the US. The qualitative findings are organized according to the following five major themes that emerged: (a) the experience of immigration, (b) immigrant therapists and their clients, (c) development as a clinician, (d) relationships with colleagues and other professionals, and (e) a name for ourselves.

Quotes from participants are included to illustrate the themes and subthemes, however, pseudonyms are used to protect participants’ confidentiality. Table 4.1 below describes the main themes and subthemes that emerged from the qualitative analysis and the frequency that they were mentioned by the 13 participants.

Note that the order in which the 5 major themes and 23 subthemes are presented in this chapter (listed in table 4.1 below) was determined both by the frequency that they were mentioned by participants and organized in a way that would provide a clearer and cohesive description of participants’ experiences.
Table 4.1

Main themes and subthemes of the study

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Experience of immigration</td>
<td>• Transformative</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>• Challenging</td>
<td>10</td>
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<tr>
<td></td>
<td>• Experiences of discrimination</td>
<td>11</td>
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<tr>
<td></td>
<td>• Views of the US</td>
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<tr>
<td></td>
<td>o Categorization</td>
<td>9</td>
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<td></td>
<td>o Disconnection from the world</td>
<td>9</td>
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<tr>
<td></td>
<td>o Individualism</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>• Home and belonging</td>
<td>11</td>
</tr>
<tr>
<td>Immigrant therapists and</td>
<td>• Exposure</td>
<td>12</td>
</tr>
<tr>
<td>their clients</td>
<td>• Awareness of assumptions</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>• Flexibility</td>
<td>7</td>
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<tr>
<td></td>
<td>• Perspective</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>• Language</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Being questioned or rejected because of accent</td>
<td>10</td>
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<tr>
<td></td>
<td>o Acceptance and use of accents in therapy</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>• Working in the midst of difference</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Establishing a connection</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>o Facing discrimination</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>o Debunk stereotypes / prove themselves</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>o Not being from here becomes secondary</td>
<td>7</td>
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<tr>
<td></td>
<td>• Leveling power</td>
<td>10</td>
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<td></td>
<td>• Being recognized as knowledgeable</td>
<td>9</td>
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<tr>
<td></td>
<td>• Work with immigrant clients</td>
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<tr>
<td></td>
<td>o Understanding the experience of immigration</td>
<td>9</td>
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<tr>
<td></td>
<td>o Being a cultural broker</td>
<td>6</td>
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<tr>
<td>Development as a clinician</td>
<td>• Questioning oneself</td>
<td>9</td>
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<tr>
<td></td>
<td>• Self-confidence and self-definition</td>
<td>6</td>
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<tr>
<td>Relationships with</td>
<td>• Being valued</td>
<td>11</td>
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<tr>
<td>colleagues, supervisors</td>
<td>• Being supported</td>
<td>8</td>
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<tr>
<td></td>
<td>• Being questioned, misunderstood or discriminated</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>• Negative experiences at school</td>
<td>6</td>
</tr>
<tr>
<td>A name for ourselves</td>
<td>• Does it make sense to build a category?</td>
<td>4</td>
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<tr>
<td></td>
<td>• Highlighting strengths</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>• Highlighting immigration experience</td>
<td>8</td>
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The Experience of Immigration

The primary aim of this phenomenological dissertation study was to examine foreign born couple and family therapists’ clinical experiences in the US. Yet, many participants in this study spontaneously described how it has felt and what it has meant for them to live in a country that is different from where they were born and raised. Thus, the first dominant theme and related sub-themes describe participants’ own immigration experiences moving to the US. This major theme and 5 subthemes (transformative, challenging, experiences of discrimination, views of the US, and home and belonging) are first presented below because they describe the experiential and emotional context in which immigrant couple and family therapists currently perform their clinical work in the US.

Immigration as a transformative experience

Immigration was described by more than half of participants (8 out of 13) as an intense transformative experience that led to changes in their identities, personal characteristics and outlooks on life. Participants’ own words and expressions such as “enriching”, “a great experience in terms of growth” and “it opened up other spaces and other possibilities” were used to describe their own life changing experiences immigrating to the US.

According to participants, what made this experience so transformative was the immersion in a different world where behaviors, rules, traditions, landscapes, food, and language were all different from their home countries. For example, the process of learning and growing happens, as Natalia reported, in the “real life immersion and real life relationships” that the person establishes in order to survive, live and thrive. Tatiana
also stated that everyday life becomes a gradual process of integration and accommodation that eventually “transforms who you are”. Similarly, Luisa said “that’s why I think that the experience of immigration is so unique. It’s unique because it includes all aspects of your life.”

This process of transformation, as Mario also mentioned, involves gradually getting “impregnated” and “absorbing” the culture of the host country. But, as Camila said, “it’s not about just taking it all, and leave yours [own culture] on the side, but it’s really integrating both experiences.” According to participants, the main transformative change involves becoming bicultural, or as Natalia described, becoming “very much a hybrid”. This process of integrating what the individual brought from his/her culture of origin and what he/she finds in the new culture was characterized as “demanding”, “complex”, “discontinuous”, and as a process that creates a new identity for the person. Participants additionally acknowledged that both personally and professionally, they would not have been the same person that they are now if they had stayed in their countries of origin.

Additionally, participants reported some specific personal and relational changes that they experienced because of living in a foreign country such as being more mature, tolerant, humble, and understanding. For example Sandra said:

I think I’m a lot more patient; I’m a lot more accepting; I’m a lot more respectful. Yeah, and in lots of ways, I know myself better because I really had to kind of figure out, “well, who am I in all of that?”

Similarly, Natalia reported:
It’s easier for me to let go to things, you know, like attachments, not only material attachments, but also things that have to do with taking things personally, like I’m much more mature in that sense. I feel like I don’t take things so personally, as maybe I would have been had I not had this experience.

Another important transformation mentioned by many participants was changes in their views of human beings. Reflecting on their own experiences immigrating to the US, participants were more attuned to the inner strengths and personal transformations that individuals can tap into while facing the challenging experience of integrating two cultures. In relation to this, Tatiana said, “I have transformed my personality. Don’t tell me that people cannot transform their personalities because they really can.” Sandra also described how her own experiences adapting to a new culture taught her some important lessons about how resilient people can be:

It really has helped me to understand what Carl Rogers was talking about, you know, the inner resources that people have and the resilience that people have, and the drive towards personal growth people have. Now I have a much better appreciation of that, having really had to kind of figure stuff out on my own and rely on myself. And so, I think that has really helped me to kind of believe in the innate capacity of people to cope, even when they’ve got a lot of things going on.

**Immigration as a challenging experience**

The experience of immigrating was described as challenging by most participants (10 out of the 13). As much as it was described as transformative, learning to navigate a different environment and getting acquainted with new surroundings, rules and expectations was also described as an overwhelming and sometimes frustrating
experience. This was especially true for participants for whom English was not their native language, and who were not fluent in English when they arrived in the US. Adapting to the new environment was described by many participants as “being born again”, both exciting and infantilizing. For example, Tatiana described, “I felt very infantile, and I felt extremely incompetent. I felt that I wasn’t able to maintain an adult conversation with my neighbor, that we used hand signals.” Similarly, Vera described her first months living in the US and learning English as a regressive personal experience. She said,

I really felt like small, little kid, like an infant that I was learning all over again from the beginning […] I could not express myself. I could not function on, like, high intellectual level because I couldn’t even really express myself and use the basic words and so on. So I remember that was very frustrating.

The challenges of being an immigrant, especially in the beginning, involved “working extra hard” even to do the simplest everyday tasks such as reading a children’s book or asking for a product in a grocery store. Establishing a social support network and building a sense of normalcy were also described as physically and emotionally draining. For example, Camila said:

There are times when it’s frustrating, and lonely, and stressful when you are figuring out so many parts of your personal and professional life. It can be really exhausting, particularly as you’re trying to develop a support system here as well and develop relationships and all that kind of stuff.

Feeling confused, grieving the loss of what was left behind in their countries of origin, and missing home and what was familiar were also mentioned by most
participants as part of their experiences as immigrants in the US. Participants often described being misunderstood as they struggled to “figure out” how to live in the US. Sandra noted:

If you’ve not had the experience of going and living in another country, then you don’t sometimes know – understand the challenges and the stress and the loneliness that can sometimes come along with that, as well as all the cool things.

The difficulties of understanding and navigating the legal, educational, insurance and mental health systems were frequently mentioned as very challenging tasks that participants had to navigate as immigrants living in the US. Sandra acknowledged that navigating these unfamiliar systems can be an overwhelming task even for individuals who are born in the US. Yet, she stated that this requires even more energy and time when one has not grown up “in some of those systems” and has not gained a “frame of reference” by experience. Understanding these US systems is a particularly important task given that they are part of the context in which couple and family therapists will need to carry out their professional work. In relation to this experience, Daniela said:

When I need to involve other agencies and not knowing how to tap into those resources, not understanding the bureaucracy of Medicaid and social services, and all that, that makes me very nervous just because I don't know about it. And now that I work in a school, it's been taking a lot of time from me to understand the school system.

**Experiences of discrimination**

Part of the challenge of being born and raised in another country and living in the US is the experience of discrimination, which was mentioned by most participants (11
Immigrant therapists described feeling “put aside”, looked at “as if I have two heads”, and seen as “lower” when narrating their experiences as immigrants in this country. Natalia labeled this as “otherization” which she defined as a process of objectification that transforms a person into an “other”. In relation to this, Mariam provided the following description of her experiences being put aside and treated as other because she was an immigrant Muslim woman who wears a veil:

It is exhausting, it is annoying. You want to just one day, just one day a week you want to leave your house and just be. You don’t want to represent something, you don’t want to be different, you don’t want to anything you do be cautious of “I need to walk this way so people won’t be intimidated”

Part of their experiences of being treated as “other” included being mistakenly perceived by people in the US with preconceived assumptions and stereotypes of participants’ countries or regions of origin. Participants also mentioned that countries and regions in the world are not regarded in the same way, which often leads to the differential treatment that immigrants like themselves, receive in the US. For example, Lisha explained that “where your accent is from and the connotations about where your accent is from” have implications for how a person is treated in the US. She said,

If the accent comes from a place where they admire or they look up to or they think is cool, then by association you are cool. If your accent comes from a place where they think that “oh, everybody from there wants to come and live in America because America is the best country in the world and blah, blah, blah”, then they may feel superior to you.
In some cases, these stereotypes are very negative, depending on the history of US relations with that country, or the current climate of international relations. For example, Mariam said, “Just being from [country of origin] is politically incorrect.” Similarly, Amir noted, “A Middle-Eastern man is supposed to be a terrorist, and now he’s here”. He also stated that his presence poses “an almost existential dilemma” to those that are in contact with him because as an educated man who “wears Italian suits with a bowtie”, he defies the prevalent stereotyped profile about adult men from his region of origin.

The current environment of suspicion and rejection in the US since the 9/11/2001 attacks makes the experiences of immigrants living in the US even more difficult. Camila said that the mistrust towards immigrants in the US has increased in comparison to when she started her professional career as a therapist. For example, she said “I don’t think there was an anti-immigrant sentiment or such a strong anti-immigrant sentiment when I first graduated [early 90’s]. And now, it’s horrible.”

Being from a country different from the US was often described as an experience that awakened the curiosity of individuals from the US. This curiosity manifested itself as questions directed towards participants both in formal and more casual conversations. Questions varied from topics such as the person’s history of immigration (e.g., Where are you from? How long have you been in the US? What are you doing here?), the customs and traditions of participants’ countries of origin, and current events in their countries of origin. As described by most participants, these questions made evident for them the assumptions and stereotypes that the individual had about their countries and regions of origin. A noteworthy example of this experience was described by Adeben. He said that
when he introduces himself as a person from his country in West Africa, he is frequently faced with questions such as “Do you have lions walking the streets?”

Participants also described a wide range of personal reactions to these questions. For example, Natalia expressed feeling like “an object of study”. Yuan said that “some of the questions were interesting and some were obnoxious”. Mario experienced this curiosity as inviting and even deferential. Being a reserved person, Lisha said that she had to build up her level of tolerance in order to deal with these often intrusive and disrespectful questions. In contrast, Adeben noted that these questions provided him with an opportunity to connect with others and to clarify any misconceptions about his country in West Africa. In fact, as Yuan stated, these questions are more common when relationships are just starting and people are getting more familiar with each other. With more time together and increased closeness, these types of stereotyped questions became less frequent and the possibility of a more person-to-person relationship emerged, according to many participants.

Instances of discrimination in clinical and educational settings will be further described below.

**Views about the US**

During stories describing their experiences as immigrants in the US, participants mentioned aspects of the US culture that they found salient or meaningful. The most frequently mentioned aspects of the US culture were categorization (9 out of 13), disconnection from the world (9 out of 13), and individualism (6 out of 13). It is important to mention that the comments made about these cultural aspects seem to refer
more to the mainstream White middle class culture in the US, rather than to other minority cultures that are also part of the US.

Americans were described by most participants as disconnected from the realities and events that happen beyond the US border. They were characterized as self-centered and “American focused”. Sandra, for example, noticed few international news outlets in the US, which in her view contrasts with the availability of information about international events in her country of origin. In some cases, participants described people from the US as “clueless” or “ignorant” about the rest of the world. In fact, when Daniela was asked whether the relations between the US and her country of origin might have affected how clients from the US relate to her, she said “I don't think they know where my country even is”. Participants also noted that one of the dangers of this disconnection and lack of international knowledge is that information gaps tend to be filled with stereotypes, misconceptions or generalizations. Tatiana, who lived in colder areas of her country of origin, said that because she speaks Spanish, people from the US tended to assume that she is from the Caribbean, and by extension, she must love the heat.

Putting people in rigid categories was another salient characteristic of the US that was mentioned by many participants. Expressions such as “reducing a person to a checkbox” or “putting everybody in the same bag” were used to describe this practice. According to participants in this study, one of the consequences of categorizing and labeling people is that between group differences are highlighted and within group variability is often overlooked. As Luisa noted, “Latinos, they all put us in one category, and we are so different”.
Participants also described experiencing confusion and frustration when they tried to locate themselves within pre-existing demographic profiles in this country, especially when filling out legal forms. These experiences were more acute when participants had more recently moved to the US. Yet for a few participants, the feelings of discomfort and confusion have remained throughout the years. In relation to this, Daniela said “It has been, I don't know, eight years and I don't know how to answer that box, I really don't know, I cannot categorize myself.” It was not only the act of categorizing or being categorized that caused some uneasiness among participants, but also the attributions and stereotypes that were associated with these US-based racial and ethnic categories. In relation to this, Mariam said,

The boxes that we all put each other into, to very simply put it this way:

“Hispanic people are this way, Black people are this way.” And so, when we have interactions, usually people say, “You’re not like them,” and my comeback is always, “How many like me have you met?” “Well, never.” “Then how do you know I am not like them, because your experience is all based on those boxes and stereotypes.”

Additionally, many participants expressed concern about how this tendency to categorize people affected the education that they received in their clinical training as CFTs. They mentioned, for example, having readings that suggested that all members of a certain ethnic or racial group were or behaved in the same way. For example, Daniela said “you study basically that all Salvadorian families are the same”. This type of rigid categorization and assumption that all people within a racial or ethnic group are the same tends to obscure the uniqueness of families and their stories.
In relation to individualism, participants said that people from the US do not tend to value family and community relations as much as people in their countries of origin do. This is especially true for participants who were, as Amir said, from more “collectivistic societies”. Mario also noted that individualism which tends to characterize the US is also reflected in the type of mental health treatments, psychotherapy models and institutional practices in this country. As a consultant to child welfare programs, he has observed more individualistic ideas reflected in the delivery of foster care services. For example, he said,

That’s one of the aspects of the culture of the foster care, which I call the “parallel tracks treatment plan”. There’s a plan for the child, there’s a plan for the parent, and there’s not a plan for a relationship. That is part of the culture. So, I think that part of the working in foster care is to challenge that subculture which is a subculture this is based on the idea of self-sufficiency and the independence of the individual: the mother can get fixed on her own and take parenting classes—parent training classes that do not include the children.

Home and belonging

Most participants in this study (11 out of 13) shared their feelings about belonging and finding a place that they could call home. According to most participants, immigration is not a discrete event that happens when an individual moves from one country to another. Immigration was described as a never ending process that requires continuous adaptation. In Daniela’s own words “once an immigrant you're always an immigrant”. During this ongoing process of transformation, some participants (5 out of 13) reported that they feel like they belong to their countries of origin and to the US.
They described maintaining their roots and connections to their respective countries of origin while at the same time creating a new network of relationships in the US. Natalia described it as living “with one foot here and one foot there”. Adeben talked about becoming a “link” between the two countries, which allows “crosspollination and collaboration”.

In contrast, some participants (4 out of 13) mentioned losing the experience of belonging altogether, after immigrating to the US which was described as a combination of two feelings: (a) feeling like they do not completely fit in the US because they are foreigners; and (b) experiencing that they do not belong to their countries of origin anymore because of the profound identity changes that they have undergone as immigrants in the US. For example, Yuan said:

I want to be able to find a place that I will feel I belong. And now I don't feel belong, I don't feel I belong here and also I don't feel I belong back home anymore, because I am Americanized.

Similarly, Tatiana said “I would always be an immigrant, even if I go back to live in my country of origin, I will feel an immigrant in my own country”. Another reason that contributed to participants feeling estranged from their countries of origin is that their countries have also changed while they have been living in the US. This made participants feel further disconnected from the countries where they were born and raised. For example Luisa said:

What I left is now transformed into something that is so different that even though I go back and see, there is something that I miss. I don’t know [country of origin]
because it has changed over time like every other country. But this has
transformed the country into something that I cannot even recognize anymore.

In addition to comments about belonging, participants also described what it has
meant for them to feel at home. Participants reported changing the definition of what
feeling at home means. In general, home was not defined as a geographical place, but as
an experience. Lisha, for example described her home as a “secure base” where she can
find balance and comfort, whether it is in her country of origin or in the US. Yuan said
“For me, home is to be with the people I love. Home is not place, home is people.”

They also described having an active role in creating their homes. In other words,
participants talked about building their homes rather than finding their homes.
Participants used expressions such as “my world that I’ve created here”, “a kingdom for
myself”, “the home I created with my husband”, or “I’m building a home here, too” to
refer to their active involvement in building a home for themselves and becoming
grounded and comfortable in the US. Taking an active role in creating their homes
seemed to be essential for many participants so they could establish themselves and
function in this country. Amir, for example, said, “I think anywhere I go I can make it
home for the time period I am there.”

Immigrant therapists and their clients

This second major theme included 9 subthemes related to the direct clinical work
that participants currently do with clients in the US. This involved the relationship that
immigrant couple and family therapists established with their clients, the challenges that
they faced while working clinically in the US, and how the experiences of immigration
became sources of strength for participants’ therapeutic work.
Exposure to different cultures

The most salient sub-theme in relation to US clinical work among immigrant couple and family therapists is the exposure to cultures that are different from their own, which was mentioned by most participants (12 out of 13). For example Dasa, a therapist from Eastern Europe, reported that in the four years that she has been clinically active in the US, she has never seen a client from her country of origin. Evidently, for the immigrant couple and family therapists in this study, the experience of being in contact with cultural differences did not happen exclusively during therapeutic encounters. On the contrary, participants reported that they were frequently in contact with individuals from different cultural backgrounds in other areas of their lives.

Participants reported that in their clinical work, they had the opportunity to meet clients from the US and from other countries. Additionally, participants described gaining clinical experience with clients from various racial, socio-economic, immigrant and religious backgrounds. Thus, therapists reported having to do their clinical work with clients that differed from themselves in terms of one or more salient contextual variables.

Participants described their clinical work with clients from different cultural backgrounds as an enriching learning opportunity. For example, Yuan said, “I had the opportunity to be exposed to different kind of living arrangements, different kind of ways of maintaining relationships.” Similarly, Amir mentioned “I’m learning from clients and families too, because I think they are the best teachers of the culture because they explain everything.” Although this process of constantly learning was sometimes experienced as taxing and overwhelming, it was also viewed as exciting and energizing. As Adeben
expressed, “The beauty in seeing the different cultures as you interact with them is just amazing.”

Even the immigrant Spanish-speaking therapists who are working with immigrant Spanish-speaking clients mentioned meeting clients from different Latin American countries and learning about the economic, political and historic realities of other countries in the continent. In relation to this, Camila, who is a therapist from a South American country, said, “I started hearing about what went on in Central America and what was different in El Salvador from Nicaragua. Each family in their own story helped me understand what was going on in their country.”

It is important to note that during clinical encounters between foreign born therapists and their US clients, exposure was described as a two-way process. In other words, the client is as exposed to the therapist as the therapist is to the client. Thus, both clients and clinicians are engaged in the task of making sense of and establishing a connection with a person who is perceived as different from oneself. These cross-cultural clinical encounters have important implications for the therapeutic relationship and for the course of therapy. These implications will be further described in the remaining sections of the findings.

**Awareness of own assumptions**

More than half of participants (9 out of 13) reported that living in a country different from their own and interacting with people whose traditions, belief systems and behaviors were different from the ones they grew up with, helped them to realize the values and assumptions that they hold about many aspects of family relations and social practices. For example, Sandra, who came from a liberal part of Northern Europe and
moved to a conservative state in the south of the US, very candidly shared “I didn’t realize that in some ways I had a lot of biases of my own, and assumptions about America, about religion, and about culture over here, about so many things.” Participants described becoming more aware of their own assumptions and values which in turn, helped them push the boundaries of what they considered normative, and helped them to consider other possibilities of what families should look like. In relation to this, Yuan said, “you're constantly being challenged with everything. It's like the thing that you are so used to, is not the norm, so you really have to find the way to put your norms and your values aside.”

According to participants, one of the consequences of gaining more awareness about their own assumptions was that during their clinical work they became more “attentive”, “cautious”, and did “not take things for granted”. For this reason, therapists reported getting into the habit of asking more questions and “checking in” with clients to verify that they understood what their clients were expressing, and to also reach a better understanding of their situations. For example, Lisha said,

I do a lot of “This is what I’m hearing”, “This is what I think you’re saying”, or “This just came into my mind, tell me if it’s right.” Then they can say “oh, that is it. That’s what I was trying to say”, or “No, it means this.”

No therapists mentioned being told by their clients that checking in or asking questions was burdensome. In fact, therapists reported that this style of communication seemed to convey to their clients that they are attentive and respectful, and that, as Sandra puts it, “I really understood it from their perspective.” Also, participants reported perceiving that their clients were very patient and understanding with the therapists’
questions because they knew that they were not born and raised in this country. In relation to this, Natalia said,

I’m not from here. So my curiosity is genuine, but also I think people grant me somehow the opportunity to be more curious because I’m not from here. I think that’s really valuable, because it allows me to really piece out things in a lot of detail and it’s not seen as intrusive.

In some cases, the practice of not assuming, checking in, and asking questions became a therapeutic style that participants used with all of their clients. Tatiana, for example, talked about “being naïve” as a clinical approach that she uses to start connecting with her clients. Similarly, Yuan described how she pushes herself to “enter every therapeutic relationship as a new baby […] with fresh eyes”.

**Flexibility**

Flexibility was another salient characteristic of immigrant therapists’ clinical work, which was reported by more than half of the participants (7 out of 13). Participants described having flexible definitions of family structures, expressions of love and affection, parenting practices and expectations, among others. According to many participants, this flexibility was because as immigrant therapists, they have been exposed to different family practices in the US and in their countries of origin.

Flexibility was also evident in the more open parameters of time, space and closeness with clients that participants used to define therapy and the therapeutic bond. This was especially true for participants who were from Latin American countries. For example, Daniela mentioned that her Latina/o clients feel closer to her and are more comfortable in the therapeutic relationship because her “boundaries are more subtle
because of not being from here.” Camila mentioned that after working for many years with Latino families in her community, she has become a part of their lives. So, she occasionally sees clients in public places, who approach her to give her updates about their lives or to share their concerns. Camila said that she takes these chances to have therapeutic moments with her current and former clients, even if it is in the street and not in the privacy of the therapy room. Finally, Luisa said that in her clinical work she has never had weekly or bi-weekly one hour sessions with her clients, because as a Latin American person, she has a more flexible view of time in her therapeutic work. These participants also reported receiving criticism from their US-born colleagues for not upholding the “whatever frame they have about how professionals should be like.”

Participants not only reported feeling constrained by the stricter definitions of therapy in the US, but also noted that excessive rules and regulations, and the more litigious environment in the US are external forces that tended to curtail their creativity, limit their autonomy as therapists, and make them more doubtful about the decisions they make in the therapy room. In relation to this, Sandra said “It seems a lot more regulated here, but it also seems so much more – I don’t know – confined, anxious”.

**Perspective**

According to about half of the participants (6 out of 13), one of the benefits of being an immigrant couple and family therapist is the ability to look at cultures from a critical or outsider’s perspective, or having a “critical cultural eye”. This allowed immigrant therapists to develop critical opinions, to question taken for granted assumptions and to offer their clients a different point of view about their issues. As Lisha said, “Because I’m not from here and I’ve traveled a lot, then I can use that to try
and have a broader perspective or to bring in a different dynamic into the situation”. Luisa also mentioned that during her clinical work, she can offer interventions to her clients that are outside of the US clinical box and that are inspired in the perspective from her country of origin. She said, “I always feel that I can always be crazy, because I’m not from here, so I always say, ‘Look, you can take it or leave it, but I’m thinking as a [demonym\(^1\) from country of origin] person’ and they kind of like it.”

Participants also reported that as individuals who were socialized in a country different from the US, they were able to take a meta-perspective about certain behaviors, relational patterns and practices in the US. Additionally, participants described gaining some perspective in relation to their own cultures of origin after being exposed to different worldviews, practices and life styles in the US. Mario reported that during his US clinical work, he uses the collective perspective from his own culture in order to offer an alternative to the more individualistic self-sufficiency that he tends to see in the US mainstream culture. Yet, when he travels to his country of origin, he “will do exactly the opposite and put a critical eye on that culture from the point of view of this culture.”

Being able to have an outsider’s perspective, which facilitates valuing multiple perspectives in the therapy room, was possible because this is something that immigrant therapists practice in their own lives. In relation to this Natalia said, “I do have the ability to entertain at multiple perspectives and be very flexible about dealing with those multiple perspectives because I have to live like that.”

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\(^1\) *A demonym* or *gentilic*, is a name for a resident of a locality. For example, the demonym for a resident of Mexico is Mexican.
Language and accents

All participants reported using English in their US clinical work. Even Spanish-speaking participants who work primarily with immigrant Latino/a clientele reported speaking primarily English while working with children and adolescents. Additionally, all participants in the sample speak English with a foreign accent. For most, English is their second language (10 participants). For others, English is their first language which they spoke with the accent of their countries of origin (3 participants). Therefore, language and foreign accents became a salient subtheme for participants when they described their clinical experiences in the US. The two main topics mentioned by most participants in relation to language and accents were: (a) being questioned or rejected because of having an accent (10 out of 13), and (b) acceptance and use of accents in therapeutic work (11 out of 13).

Most participants reported that speaking English as a second language and/or with a foreign accent was a source of difficulty with their US clients. One of these difficulties was being questioned by clients about their knowledge, capabilities and expertise. For example, Tatiana said “When you don’t speak the language at the level that other people do, the perception of you is as ignorant. You don’t speak English like they do, therefore you’re an ignorant person.” Similar to Tatiana, Mariam reported that when her White US clients recommend her clinical services, they often preface their recommendations with a warning that she speaks English as a second language which should not dissuade clients from contacting her. In Mariam’s own words: “They will give a referral to another white Caucasian couple and say, ‘Go see her, she’s good. She looks different, she has an accent, but she gets it. So, go see her’.”
Participants reported that speaking English as a second language and having a foreign accent were frequently used by US born clients as the reason they chose to leave therapy or to request a change of therapists. For example, Camila said “after two sessions they called the clinic and asked [name of clinic director] to change therapists because I had an accent and I wouldn’t understand them.” Participants provided three interpretations for using accents as the rationale for stopping therapy or for changing therapists. First, participants acknowledged that the difference in language made mutual understanding more difficult, which led clients to consider changing therapists. Second, it was possible that clients were looking for an excuse to leave therapy and the therapist’s accent seemed like a credible reason or excuse. Vera, for example, said that one of her clients requested a change of therapists and mentioned Vera’s accent as the main reason for this. However, Vera reported that given the client’s mood instability and personality characteristics, it was not unusual for this client to find reasons to quit therapy.

Third, some participants said that assumptions of ignorance or incompetence that are linked to speaking English with a foreign accent also led some clients to reject them as therapists. Participants described developing strategies to deal with these negative assumptions in order to increase their chances of maintaining strong therapeutic bonds with their clients. The most important strategy they described was openly discussing their accents at the beginning of therapy and inviting their US clients to openly talk to them when they did not understand something or when they felt misunderstood. For example, Amir said,

Basically, at the beginning of my session after going through informed consent I discuss about the issues of the language, that “I’m a foreigner. You may have a
difficulty with my accent. You can stop me any moment, I would not be offended, if I said something which wasn’t understandable or sounds ambiguous or vague to you’

Other strategies were also mentioned. Mariam, for example, said that she offers the first session for free to allow clients to first get to know her. Yuan reported that coming to terms with the fact that she has an accent, and doing therapy with the mindset that she has to prove to her clients that she is a competent therapist, have helped her to better engage and to retain her clients in therapy. In her own words:

Everything I have to prove to them. I have to prove to every single client of mine that I have the ability to understand you and to help you. And I think that's something that I learned to be a non-English speaker.

Coping with clients’ negative preconceptions, being rejected, and having to constantly prove themselves were some of the struggles mentioned by participants because English was their second language and/or they had a foreign accent. However, participants also said that with time and practice, having a foreign accent was not an obstacle to establishing a solid therapeutic relationship. In relation to this, Yuan stated that she realized that “I do not need perfect English to be a good therapist.” Similarly, Amir described how his views about accents as a potential problem in the therapeutic work have changed:

I was a little bit concerned about the language component of the therapeutic relationship, but over the time I’ve found language is the least barrier, I do believe, for international therapists because the moment clients and families come to the therapy room and they close the door, they don’t care if you have got an
accent or if they do understand your language. They need somebody who can
listen to them authentically, attentively, and attuned to their emotions and
feelings.

Not only did participants report that with time their accents became less of an
impediment to their clinical work in the US, they also said that speaking English as a
second language and having a foreign accent provided them with additional clinical
benefits. Their accents helped to humanize foreign born therapists to their clients. Yuan
said that having “a shortcoming […] my grammar errors, or my accent” that is so
apparent to her clients makes her less a distant expert, and more “a real person” in their
eyes. Likewise, Sandra mentioned that in her relationships with her clients, having an
accent helps them “to kind of be people with each other”. Tatiana said that as a White
person, sometimes racial/ethnic minority clients have a difficult time connecting with her.
Yet, clients’ perceptions of her immediately change when she started speaking and they
noticed her accent as described by Tatiana below:

When I open my mouth, the perception changes. If I’m in the presence of an
African American, I’m like this white girl. Then I open my mouth and it brings
them closer because hey, I look white, but it doesn't – she doesn't look like one.
So that brings us closer. And if I don’t open my mouth in front of a Latino, there
is a distance. When I speak, then the connection begins.

Other clinical benefits of speaking English as a second language and having an
accent were described by participants. For example, Daniela stated that when she does
therapy in English, she “takes more time to process” her interventions, which helps her to
“slow down the process” and be more careful during her clinical work. Mario said that he
takes advantage of his accent to make challenging statements to his clients and to help bypass their defenses:

I may say something that is very provocative. First reaction of the family is “he could not have said that, I probably misunderstood because of the accent.” And by the time they realize that that’s what I said, it’s too late to react, so that way it is helpful.

Working in the midst of difference

One of the noteworthy characteristics of participants’ clinical work in the US is conducting therapy with clients that differed from them in terms of their cultures of origin. This is true even for South American Spanish-speaking therapists who work primarily with immigrant Spanish-speaking clients in the US, given that clients can come from countries or regions different from the therapists’ (e.g., Central America, the Caribbean). Working with this contextual difference is the challenge that immigrant couple and family therapist constantly face in their therapeutic work with US clients. According to participants, this clinical challenge has different elements such as: (a) establishing a connection, (b) facing discrimination, (c) debunking stereotypes and proving themselves, and (d) realizing that not being from here becomes secondary.

Establishing a connection with clients who are perceived as different or even as having “nothing in common basically in terms of our upbringings” was mentioned by most participants (9 out of 13) as a challenge for their clinical work in the US. For example, Luisa candidly stated that in terms of establishing a therapeutic connection “the biggest challenge was the blond, tall, thin woman” because they are the ones that
“contrast with the way that I look and everybody in my family and everybody who lived with me.”

Connecting in the midst of these differences required participants to “figure out” how to join with their clients and to form strong therapeutic bonds. As Lisha said, “I think maybe being a foreigner, you have to be strong on your joining. If you’re not, then that could be the issue.” Therefore, participants reported working actively on forming “honest, transparent” and “sincere” connections with their clients, and developing the “ability to relate to them [clients] and make them feel validated and understood.”

Participants also reported actively working to establish relationships with their clients that conveyed “passion and interest for their stories”; relationships where clients felt “that you understand them as a person”, and that “this person [the therapist] is quite attuned to us” and where clients could find “a level of comfort” such that they could “trust” that the therapist “can help you.”

An important factor that helped participants better connect to their US clients in the midst of difference was to realize that there is “something that we all share as human” that cuts across nationalities and cultures. Vera, for example, said:

No matter what, no matter where you are coming from, or where – no matter what kinda background we have, there is something that we clearly have in common; that piece of just simply being a human being. It's the humanity. It's a very kinda powerful piece.

In fact, Luisa reported that after working with blond, tall, thin women from the US, she found that “they are as human as everybody else” and that their issues are “the
same things that I see with Latino women.” Also, regarding the commonalities that cut across nationalities and cultures, Mariam reported that:

I have seen the same issues across cultures whether I’m working with white/Caucasian couples or if I’m working with intercultural couples or couples from the same culture, but not from the United States. I see the same dynamics, they use the same language to describe their problems.

Although commonalities among clients and between therapists and clients were acknowledged, differences still played an important role in their therapeutic relationships. As Sandra shared, being from a different country “has been just another step away from people in terms of our life experiences.” Several participants reported that rather than minimizing or hiding the cultural differences that might exist between them and their clients, they developed the habit of locating themselves in terms of their countries of origin and cultural backgrounds. They also reported putting their differences “out there”.

As Camila noted, “I learned to relate to people from other backgrounds and I put my difference right away.” Additionally, many participants said that when they openly discussed their cultural differences and put them “on the table,” they also discussed the possibility that these differences might lead to mutual misunderstandings. Participants also reported encouraging clients to openly express whether they felt misunderstood by the therapist.

Yet, naming the difference was not the only way participants addressed cultural differences with their US clients. Participants also reported engaging in the task of understanding how to “cross bridges”, “cross boundaries” and to get closer to their clients in the midst of these differences. Adeben said that he uses the curiosity that being from
Africa elicits from his clients, especially among children and adolescent clients in the US, as a strategy to get closer to them:

“So do you still have lions in Africa? Do you still have monkeys in trees in Africa?” So then they begin to go into the stereotypes, you know, what they think about Africa. Their interest is peaked just by asking me. And at times I see this as an advantage because then it becomes a story that I can begin to share with them and talk to them about, because if a child or a youth is going to open up to you, you’re going to find connecting points. So, if myself, as an African therapist, can be used at that point in time to open the child up or to open the conversation up for a dialogue and to be able to bring some intervention, so be it. I jump right into it. You know what I’m saying? I take advantage of that.

Mariam shared that her strategy while working with clients from different backgrounds is to “stay with people’s pain.” This not only allows Mariam to establish deeper connections with her clients, but this also allows her clients to get closer to her. Thus, Mariam reported that her clients have said to her “You understand my pain and you can stay with my pain. I don’t care if you have a thick accent, I don’t care how you look.”

Participants reported that the efforts that they make to establish stronger connections with their clients in the US were fruitful. They described many clinical examples when their clients shared that despite the differences, they felt understood. Amir, for example, mentioned that one of his clients said to him, “after seven or eight years I had different therapists. None of them engaged with me as you did”. Similarly Yuan said that “I have clients from all kind of different continents telling me that no one has ever understood them to this level in our first meeting. So that’s something.”
Facing discrimination from their clients was also reported by most participants (9 out of 13) as part of their clinical work in the US. This discrimination came in the form of stereotypes about their countries or regions of origin, or questions about their expertise as clinicians. In addition to the previously mentioned stereotypes related to speaking English as a second language and/or having a foreign accent, participants said that during their US clinical work they experienced people who had preconceived notions about who they were as clinicians based on limited or erroneous information, just as it has happens in other contexts of their lives. The stereotypes that exist outside of the therapy room entered the therapy room and became a part of how therapists were initially regarded by their clients in the US.

Participants described how discrimination happens even before clients meet them. Luisa, for example, said that after successfully working with a White family who was referred to her, the mother in the family revealed that initially she doubted Luisa’s ability to connect with her family: “She told me this, that when she saw my last name she thought, ‘She won’t understand me, she’s from another culture’.” Mariam, a Muslim therapist from South Asia shared a similar story about comments made to her by one of her White clients:

I was working with a couple and after a few sessions the woman said, “When I saw you the first time I was like, ‘Wow, she’s going to help me with my issues in my relationship? She needs to take care of her own issues of equality. Are you kidding me?’ As we continued to work with each other I’m like ‘okay, she’s actually ahead of me when it comes to equality’.”
Clinical encounters like these have made participants believe that US clients might choose not to see them even before they meet them. As Luisa said,

I’m pretty sure that my last name has made people make decisions not to see me, and I’m pretty sure that hearing my accent has made them make the decision not to see me […] they may assume that I don’t know what I’m doing and probably I’m not prepared or professional enough.

Given that therapeutic encounters are a particular type of human interaction characterized by closeness, the therapy room is a context where therapists and clients have an opportunity to see each other more clearly and where mutual stereotypes can get debunked. This was a salient subtheme mentioned by more than half of the participants (8 out of 13). As a therapist committed to issues of social justice, Natalia said that when she is faced with discriminatory comments by her clients, she uses this opportunity to address them. She said, “I stay with it and I ask them what they mean and then I talk about how that’s a prejudice and what it means in terms of a therapeutic relationship.” Tatiana, Amir, Luisa and Mariam, who also reported being committed to issues of social justice, described approaching microaggressions by clients in a similar fashion.

Participants described several examples of stereotypes and misconceptions that they clarified during interactions with their clients. Lisha, a Black therapist from Northern Europe said, “They might say ‘Oh, I’ve never met a Black person from [country of origin]’, and I say ‘well, there are quite a few of us’.” Amir, a therapist from Southern Asia, shared how in his clinical work, clients have taken the initiative to learn about his country of origin:
There were times that my clients asked me where I am from. They went back home and they searched my hometown and find a short, brief story about [country of origin] and came back to session, and we had a conversation about that. They were surprised that [country of origin] has been misrepresented in American mass media; it’s a country with rich culture, and that kind of stuff.

Similarly, Adeben described several misconceptions about his country and continent of origin that he has discussed with his clients, both adults and children:

You have to tell them that Africa is not a country, it is a continent, you know? And that is a big thing for them. So, you are saying that you have one President for Africa, and the one President they know is Nelson Mandela as the President of Africa, but he’s not. He used to be the President of South Africa […] So, I go into more detail and say, “I’m from [country of origin] and [country of origin] has its own President. It’s a country by itself with its own this and that. The system of government is different from what is in Nigeria and what is in Libya.” “Is Libya in Africa?” “Yeah, yeah, yeah. And Egypt”, “Oh is Egypt in Africa? What!” So when you see the expression of shock on their faces, you realize how much they don’t know and yet how much you are able to give them some information. That is a thing of joy to see their face lit up with information.

The stereotypes that participants were debunking in their US clinical work did not refer only to their countries or regions of origin. Participants also reported working hard to prove themselves as qualified clinicians and challenging perceptions of incompetence that clients had about them because they were foreign born. Lisha, for example, said, “I
think you have to really work extra hard because some people will discount you because you’re from another country.” Yuan described:

People judge you by the way you look or people judge you by the way you talk

[…] I had that experience a lot that just because of the way I look people assume that I don't know or I don't understand them. So I have to try harder to prove to them that I can actually do it.

For some participants, dealing with US clients’ misconceptions and stereotypes and having to work harder to be viewed as competent couple and family therapists generated frustration and sometimes anger. Mariam expressed her frustration this way: “I’m tired of explaining myself. I’m tired of trying to impress clients.” However, participants also reported that they understood how larger societal forces are behind these rigid stereotypes and misconceptions that clients might have about them as foreigners. This helped participants to not experience these comments so personally and to continue carrying out their clinical roles as couple and family therapists. Natalia mentioned how she had to “learn to detach myself from the person and see the issue as an issue” and then “address the issue.”

Amir cited news channels and the lack of options for more unprejudiced international news as the main reasons for the negative image that his clients in the US often have about his country of origin. He expressed empathy for his clients’ misperceptions and said that “if I was in their shoes I would have the same perception about my country.” Besides the news channels, Adeben cited “what they are taught in school; maybe because of the media; what they watch on TV; Tarzan and all that kind of stuff” as the ways in which fragmented and inaccurate images of African countries get
perpetuated in the US. He also mentioned being aware that “the issue of racism, and the issue of classism, and the issue of gender” are prevalent in the US. He reported that this awareness helps him to be prepared when encountering these issues in his clinical work. Adeben said “you don’t have to be surprised going into these families and see those things on display.”

The last salient subtheme related to clinically working in the midst of difference was to realize that not being from the US eventually became secondary in their clinical work, which was described by approximately half of the participants (7 out of 13). Similarities in cultural backgrounds between therapists and clients were recognized as one of the factors that can facilitate establishing a stronger therapeutic bond. For example, Camila, a White therapist from South America, mentioned that in relation to African American clients “I think an African American therapist will have a much easier time than me going in” because “she can bring the experience of being African American” whereas Camila would have to “go a step further and do more probing.”

Yet, cultural differences were not viewed by participants as a barrier to effective clinical work in the US, and cultural similarities were not considered a precondition for strong therapeutic connections. Participants reported that based on their clinical experiences in the US, conversations with clients about their accents, countries of origin and cultural differences were more salient and important during the initial joining process, when therapists and clients were unfamiliar to each other. As the therapeutic process develops, other aspects of the relationship became more important like the ability to understand the client and to more deeply connect with their experiences. Sandra for example, mentioned how in her clinical experience, she hears some questions or
comments about her country of origin in the initial sessions. Then, the dynamic changes and “all of a sudden I’m a therapist and they’re a client and they have a problem, and I have a role.”

Participants also said that, when the therapeutic bond is strong, the fact that the therapist is “from a different country doesn’t really matter.” Lisha, for example, described how in her experience cultural or language differences were not as important after all:

We bond because they feel that I know them, I get them. I think if they didn’t feel that, then the fact that I’m a foreigner would be an issue because then they would think I didn’t understand them. But because they feel that I understand them, then it’s not an issue.

Similarly, Camila said:

We [therapist and client] might be the same, from [country or origin] and [religious affiliation], whatever but it might not work out. So, sometimes those kinds of similarities may not be the key ingredient. Am I getting them? Do I understand their problem?

Participants considered that overestimating the importance of cultural differences in the therapeutic relationship can obscure other aspects of the therapist-client system that also need attention. Amir spoke about the tendency of international marriage and family therapist to “culturize therapy”, which according to him, refers to:

Always wearing that lens that “okay, I’m an outsider and I’m different and I have to see them from different perspectives; my clients see me differently.” Yeah, to some degree it exists, but it’s not the whole story.
According to some participants, one of the risks of examining therapeutic relationships between immigrant couple and family therapists and their clients exclusively from the point of view of cultural differences is that it offers “a good excuse” for clinical impasses in the therapy process. Assuming that cultural differences are the only important factor to consider for better understanding interactions between therapists and clients from different countries can obscure an exploration of other important factors that can affect clinical effectiveness. This narrow focus can negatively affect the professional development of foreign born clinicians.

Additionally, both Yuan and Mariam said that differences of country of origin between therapists and US clients are analogous to other differences in social locations and life experience that might encourage clients to question whether therapists can understand and help them. Mariam for example said, “If you’re old, show how you can understand young people. If you’re young, show how you can understand old people.” Similarly, Yuan said, “it's like when you are single, people ask you, ‘are you married? Do you have kids? So how can you help me if you're not married?’ So it is similar to that kind of question.”

Leveling power

One of the benefits of being born and raised outside of the US and working clinically in the US was to level the power differential between themselves and their clients in the US. This subtheme was mentioned by most participants in this study (10 out of 13). Being from a country different from the US can generate curiosity among clients regarding who the therapist is and where he or she comes from. According to most participants, conversations about these topics can facilitate joining and serve as an
“icebreaker”. Sandra, for example, reported that when her clients asked about her country of origin or noticed how she pronounces some words in English, they started feeling closer to her, and she became a real person to them. This, according to Adeben, makes the interactions with clients more fluid and “more informal.”

“Not belonging to the norm”, not having all the answers, being seen as a part of a minority, among others, were mentioned by participants as ways in which not being from the US helped to level the hierarchy between them and their clients. Because of this, clients could see that “you are a person, you are a human being, too.” This seemed to be especially helpful in establishing therapeutic relationships with minority clients. In relation to this, Amir said:

I can see that how African-American and other clients, perhaps those clients from a marginalized population, they connect with me on a different level because perhaps they already have the assumption that “okay, this therapist is one of us and he perhaps gets us.”

Another way that working clinically in the US while being from another country contributes to leveling the hierarchy between therapists and clients was the fact that immigrating was in itself a humbling experience for immigrant couple and family therapists who participated in this study. Daniela said that struggling to understand the educational and legal systems in this country has given her the opportunity of “sharing the experience” of confusion that her immigrant clients go through in the US. Because of these shared experiences, Daniela said that when working clinically with immigrant clients, she is not above them, but on the contrary she is “at their level.” Tatiana
mentioned that her “experience of being misunderstood by society is huge, is challenging, and it makes me feel closer to my clients who have that experience in the courtroom.”

**Being recognized as knowledgeable**

Most participants (9 out of 13) reported that one of the implications of being an immigrant therapist in the US was being viewed as knowledgeable in areas such as immigration, cultural diversity, bilingual therapy, and intercultural relationships. Participants shared that clients would specifically look for their services, and other therapists would refer them clients because of their expertise in these areas. Consequently, being immigrant, bicultural and bilingual, became “assets” for them in their professional work. This is especially true for Spanish speaking therapists.

For example, Camila said that because “I am from another country” she has had an extensive professional experience working clinically with immigrant families. This has created a recursive effect and now she has a reputation as an expert in immigration and family dynamics in the geographical area where she works. Camila also reported that both professionals and potential clients look for her expertise on these topics. Similarly, Natalia said that interracial or intercultural families tend to seek her clinical services because they want “someone who has the ‘cultural knowledge’.” Luisa said,

Sometimes you get those holes that nobody else can fulfill, because you have the bicultural, bilingual thing. People feel that if you go either/or, you’re going to miss because they’re right in the middle; they’re right in the middle. So they need someone who can see both ways, so they look for you.

Yuan also said that couples in which one member is from the US and the other is from another country see her as the most qualified professional who can understand their
relational conflicts. She said, “they feel that I am the best combination because I spent almost 20 years here but I also have 25 years of experience in a different culture.” Yet, Yuan disagrees with this interpretation. She considers that what makes her an ideal professional to work with these and any other couple is not her “cultural background” but her “ability to be real, and to be genuine and empathic with them.”

**Working with immigrant clients**

All but one therapist reported working or having worked with immigrant clients in the US. For Daniela, Camila and Tatiana, immigrant families have been their primary clinical population. In contrast, participants like Adeben, Mariam and Yuan reported occasionally working with immigrant families or with couples in which one or two members were from a country other than the US. Two subthemes related to working with immigrant clients emerged from the data analysis: (a) understanding the experience of immigration, and (b) being a cultural broker.

More than half of the participants (9 out of 13) described using their own experiences of immigration to better understand, empathize and connect with their immigrant clients’ experiences in the US. For example, Vera, a White therapist from East Europe, shared how her experience of being an immigrant in the US helped her to better connect with a Black female client who had recently migrated from Nigeria:

> It’s so hard for her to get used to this new culture. So, she discloses all kind of similar things that I kind of remember that I had a hard time also when I came here adjusting. And that just kind of knowing about it and being very empathic and compassionate about it because I have kind of similar, the same experience from the past is, I think it’s kind of helpful […] So even it’s different country than
I’m coming from, but it’s the same kind of concept immigrating and adjusting to a new culture.

Their own experiences of immigration not only helped them be more empathetic with immigrant clients’ plight; participants also reported that being immigrants informed some of the interventions that they used in their clinical work with immigrant clients. Daniela shared how missing her extended family and the community in her country of origin, and seeing the isolation and lack of social support of many immigrant families she works with, has motivated her to help these families build community resources in the US:

I will always push for extracurricular activities, church involvement, community. Like, one of the things that I've been really pushing and is very valued in my job is coffee in the morning for the [immigrant] mothers, or a knitting club, or a book club, or any club that will get these moms to form a social group because they have to support each other. If they belong to something they're not alone.

Camila shared that knowing and reflecting on her own experience of immigration has helped her better understand the effects of immigration on individuals and families. Using this personal knowledge, she can provide her clients a better frame of reference to understand their current family conflicts in the US. Thus, Camila reported that in her work with an immigrant mother who was able to finally bring her children from their country of origin after nine years of separation, she offered her client a new perspective about the family situation, by attending to their history of immigration:

I maintain the hope for my clients and try to say, “It’s not your fault. It’s not their fault. It’s the fact that they are lost in this country that it made it so difficult for
you to be close to them. When you came, you thought in a year you would be with your children. It took nine years.”

Participants reported that during their clinical work with immigrant clients in the US, especially with illegal immigrants or refugees, they have developed a deeper respect and admiration for their clients’ courage, resourcefulness, drive for survival, and strength to overcome their hardships. Tatiana said that listening to the stories of struggle and survival of her immigrant clients, has helped her learn about their resilience and capacity to take risks. Tatiana said,

I have had an eight-year-old sitting on that chair [client’s chair], spending an hour and a half telling me about his own experience crossing the border, and non-stop, eight-year-old, okay! Over an hour, detail after detail, telling me about the story. Huge admiration, I mean these are people that really have all my admiration.

Participants also shared that by hearing their immigrant clients’ stories of “survival and struggle” they became more aware of their own privileges. To “come in an airplane”, “have my own passport”, “get a visa”, and be in the US out of their own volition and not because of political persecution were some of the privileges that participants became aware of when working with undocumented or refugee immigrant clients.

Another important part of the participants’ clinical work with immigrant clients in the US was becoming cultural brokers. This subtheme was mentioned by almost half of the participants (6 out of 13). They described that being “hybrid”, “bicultural” or “right in the middle” helped them better understand and more deeply connect with both their cultures of origin and the US culture. Participants reported using this in their clinical
work and becoming cultural brokers both with family members and between families and the larger society. For example, participants reported taking the role of cultural and language interpreters between immigrant family members from different generations. Daniela said, “I do a lot of translating a lot of times because English is the strongest language for the kids and parents speak no English at all, so there’s a very interesting dynamic.” Participants also reported becoming translators (literally and figuratively) between members of cross-cultural couples. For example, Tatiana described her job as a translator working with a couple whose members came from two different countries:

I find myself being a translator. I have had couples where they don’t speak one language, so one speaks English and the other one speaks Spanish [...]. They try to use me as an interpreter, as a translator, and they have learned a lot of things from each other during the sessions.

Participants also described being cultural brokers between immigrant clients and the larger US systems and institutions. Mario, for example, described that part of his role as a clinician who works with immigrant clients is to be the person “who explains to people how the things that they used to do at home are not necessarily working here.” Yet, participants reported that being a cultural broker also worked in the other direction, by attending to the voices and the experiences of immigrant families and describing them to others in the mainstream culture. In relation to this, Luisa said “You’re the only one who goes there and comes here, so I think that it is a very privileged position to be able to hear these stories and to bring them to the dominant mainstream.” For example, part of Tatiana’s role as a therapist includes conducting psychological evaluations in cases of
deportation. She assumes this role as her opportunity to show her clients’ side of the story to legal professionals who would not get access to this information otherwise:

It’s almost like you’re the person connecting these two worlds that, especially from the judges in the position of power, they actually don't get to know your client. They don’t get to really know. You have to, in 15 minutes, present that story in a way that really, that they can get it.

**Development as a Clinician**

The third major theme that emerged from the data analysis was the participants’ development as clinicians. During their accounts of their experiences as immigrant couple and family therapists in the US, participants described professional transformations that they have gone through, and the factors that have contributed to their professional development. These transformations are related to becoming more experienced as couple and family therapists and becoming more confident in their clinical skills and abilities. Two subthemes related to their development as clinicians emerged from the data analysis: (a) Questioning oneself, and (b) self-acceptance and self-definition.

**Questioning oneself**

Most participants (9 out of 13) described questioning whether they could be competent clinicians in the US because they were born and raised in other countries. Yuan said that at the beginning of her therapy training, she had a high dropout rate after seeing US clients for one session. This rejection fueled her feelings of self-doubt:

I think that there was a point especially when I don't get that much positive feedback from my client, and then in my everyday life I feel the pressure to prove
myself constantly that I become more discouraged. That was a point that you would wonder "can I ever make it? Can I even do those kinds of clinical work when I don't grow up here?"

Participants also reported that their self-doubts and lack of confidence as clinicians in the US were a combination of personal insecurities, feeling professionally inexperienced, and receiving critical or disapproving feedback from others. They reported that this created self-sustaining feedback loops that reinforced their negative views of themselves as couple and family therapists. Thus, clinicians reported doubting their effectiveness even when nothing in the interaction with their US clients suggested that they were doing a poor job or that their clients were dissatisfied with their clinical services.

Several participants shared that working with “mainstream” White clients, especially if they were middle or upper class, generated the most doubt about their clinical abilities to practice in the US. For example Daniela said “It's like I am not necessarily at their level in a way. So my confidence goes down”. Similarly, Tatiana said “I question myself. If I would be with a family of American mainstream people, I would question if they could feel comfortable being with me, and if they would feel understood being with me.” Camila also said that “with upper-income Anglo professional families I need to look at myself and say ‘Can I do this? Will they take me seriously?’” Adeben mentioned that reaching the point of being clinically effective with Caucasian families was especially meaningful for him because he thought that these families would have the most difficulty accepting him as a professional given his continent of origin and accent.
Luisa reported that for many years she refused to see White US clients because she felt “intimidated” by them and “didn’t feel as prepared, as educated as my white counterparts.” At some point, Luisa felt that she “needed to start seeing White clients” and “cross that boundary” because “if I didn’t cross that boundary, there was something that I wasn’t going to learn.” Working with White clients not only helped her feel more confident about her abilities as a therapist. It also dispelled for her some stereotypes and misconceptions that she had held about White families. In dealing with the challenge of working with White clients, Mariam took a different approach:

I actually made a point not to work with minorities for the first 10 years of my career, because I thought “I’ve got to show the community of Caucasians [clients and colleagues] that it’s about the skills, it’s not about how you look.”

**Self-confidence and self-definition**

In their descriptions of clinical experiences in the US, participants reported that with time and more work experience, they were able to develop their therapeutic skills, build up their self-confidence as couple and family therapists, and define themselves as competent clinicians. This subtheme was mentioned by almost half of the participants (6 out of 13).

Having positive therapeutic processes and US clients sharing that that they experienced them as understanding, empathic and effective clinicians, helped participants gain confidence as couple and family therapists. This positive feedback from clients in the US counteracted negative messages and stereotypes that participants encountered in and out of the therapy room which previously contributed to feeling inadequate as therapists. In addition to their positive clinical experiences in the US, the support of their
mentors and clinical supervisors was also pivotal for their professional development. Camila, for example, reported that her mentor’s support and encouragement taught her “that an accent would not stop you from getting anywhere.” Daniela and Luisa also reported having supervisors who understood their struggles as immigrants but who also encouraged them to value the uniqueness and richness of their experience as immigrant, bilingual and bicultural professionals.

Participants said that during their professional journeys, they discovered their “inner resources”, found their own “voice”, took “the control back”, and did not give “other people the power to determine who you are and what you can do.” In other words, participants reported that rather than allowing others to define who they are, they started to define themselves based on the positive feedback from their clients in the US and the support of their mentors and clinical supervisors in the US. These self-affirming and self-defining experiences also helped participants realize that having an accent or not being from here were not barriers to becoming effective couple and family therapists in the US.

According to many participants, in this process of becoming more confident about themselves and taking a more active role in defining their own identities as therapists, they became less reactive to stereotyped comments from others. Rather than being “very busy hiding”, “firing up” or getting “so angry” about demeaning comments or attitudes from others, participants found themselves becoming more “comfortable with who I am and what I represent.” This helped participants not to “personalize” clients’ comments and at the same time continue debunking stereotypes. Luisa summarized this transformation by saying that when she confronts discriminatory comments or attitudes she does it “not in terms of defending myself but in terms of defining myself”. Natalia
shared that she has learned to “really just be relaxed, take a deep breath and think of how I was going to respond” to micro-aggressions by her clients.

**Relationships with colleagues and other professionals**

The fourth major theme that emerged from the phenomenological reduction was relationships with colleagues and other professionals. This included relationships with supervisors, other clinicians, professors and classmates. Four subthemes are part of this major theme: (a) being valued, (b) being supported, (c) being questioned, misunderstood or discriminated, and (d) negative experiences at school.

**Being valued**

Most participants (11 out of 13) described times when they felt valued and appreciated by their colleagues, supervisors and other professionals at work and in clinical training contexts. Participants said that many of their qualities related to being immigrants were highly regarded by their peers and superiors. Several participants, most notably the Spanish speaking therapists, said that having a “bilingual, bi-cultural background were assets” in their work environments.

Many examples were offered by participants. For example, Amir reported that some of his colleagues have expressed appreciation for the way he conceptualizes clinical cases, which takes into account the theoretical foundation he received in his country of origin. Daniela said that her flexibility and approachability, which she sees as characteristics of her culture of origin, have been well received by her colleagues. Vera and Sandra also mentioned that their opinions and points of view as individuals who have outsider perspectives of the US culture are valued in their US work environments.
Being supported

Feeling supported was reported by most participants (8 out of 13) as an important growth promoting experience with their colleagues and supervisors. Participants said that they counted on the support of their peers and supervisors when they needed assistance with work related issues. Encouragement to overcome the obstacles that they were facing, guidance to navigate the intricate US legal, educational or managed care systems, empathy and validation were some of the ways in which participants received support from other professionals at work or in training contexts. Sandra, for example, said that her coworkers “have been really awesome with that, about kind of giving me examples of paperwork or how to write reports or how the system works.”

Several participants mentioned that working or training in an environment characterized by racial and cultural diversity made them feel more “comfortable”, “connected”, accepted and welcomed. Participants reported instances where minority colleagues or immigrant supervisors better understood their struggles as immigrants and more deeply connected to their experiences of discrimination and exclusion in the US. As Amir mentioned, this support was very important for him “because otherwise you go crazy; you end up in an absolute state of paranoia. You develop self-doubts.” Conversely, when participants mentioned that they were the only international clinician and/or the only person of color in a given context, they described feeling excluded, unsupported and scrutinized.

Being questioned, misunderstood or discriminated

More than half of the participants (7 out of 13) reported that they were questioned about their clinical expertise, misunderstood or discriminated against by other mental
health professionals in the US, who were either at their same level or were their superiors (e.g., supervisors, clinic directors). Mario, for example, said that he has experienced “colleagues maybe questioning my expertise or my credentials.” As participants shared, some of the questioning came from beliefs that because they had not grown up in the US, they were not well prepared to understand the dynamics of families in the US.

Participants reported hearing from US supervisors or colleagues that their accents or international last-names would make clients feel uncomfortable. Even though they did experience these reactions from their clients, what participants like Mariam and Lisha noticed was that these comments were not made with the intention to prepare them for the difficulties that they could face in their US clinical work. On the contrary, these comments were presented with the assumption that “clients won’t be responsive to you, unless you work with your own people from your own group.” This generated doubts among some participants regarding whether they would be effective as clinicians in the US. As Mariam said, hearing these comments affected her sense of confidence which led her to think “Okay, I’m not good.”

Encountering colleagues who assumed “that you were an idiot” because of difficulties speaking English as a second language, or having their previous clinical experience discounted because it was obtained in a country different from the US were other forms of discrimination that participants reported experiencing from US colleagues or supervisors.

In addition to being questioned, participants also reported that colleagues and supervisors did not understand the transformations and challenges inherent to the experience of immigration. This left participants feeling misunderstood and not supported
in their training or work contexts. In the same way that their own experience of immigration was often misunderstood, participants observed that the experience of their immigrant clients was also difficult for other US mental health professionals to consider and validate. In relation to this, Daniela noted “I felt that my clients where being misunderstood and that there was nothing I could do because my supervisor would not understand that.”

Negative experiences at school

Although this was not the main topic of the interview, approximately half of the participants (6 out of 13) spontaneously mentioned experiences of discrimination and exclusion in their US academic or other training settings. Many of the experiences of discrimination that were already described happened with professors, classmates and supervisors during their US training as couple and family therapists. These experiences seemed to be salient for participants because as students or trainees they are/were younger, at the beginning of their careers, had less experience living in the US, and were in positions of less power and more vulnerability. Remarks about negative experiences at couple and family therapy programs were also salient given that in academic or training environments, and in a field that promotes healthy relationships, participants were not expecting “racist remarks” from professors or supervisors. Mariam reframed the discriminatory comments she received from faculty members in her training program this way, “In a way, my professors were very helpful to me because they made me conscious of the fact that people do think this way and you have to stay with their process.”

In addition to the experiences of discrimination, participants also mentioned that training programs sometimes did not understand the particular struggles of immigrant
therapists who are training in the US. Lisha, for example, mentioned that in her program
“I don’t think that there’s enough consideration given to the fact that actually it can be
quite stressful for international students living somewhere and then school and
everything.”

A name for ourselves

The fifth and final major theme emerged from the last question in the interview
guide which was “What name would you give to CFTs that, like you, were born and
raised in another country and are currently practicing in the US?” Three subthemes
emerged: (a) does it make sense to build a category? (b) names highlighting strengths,
and (c) names highlighting the immigrant experience.

When asked for a name for foreign born therapists, a few participants (3 out of
13) questioned the need for finding such a name. They raised concerns about setting
immigrant therapists apart and reifying differences that exist with other therapists who
are from the US. Additionally, they expressed concerns about erasing the diversity that
exists among therapists who come from different regions of the world. Instead of finding
one name, Adeben suggested “to call ourselves therapists from the country that we are
from” because that way “I can be true to my roots and I’m proud of where I come from.”

Yet, most participants, even therapists who initially questioned it, offered some
possible names for themselves. Some participants (5 out of 13) suggested names that
highlighted the strengths that they had or developed as immigrant therapists practicing in
the US, for example, “adventurous”, “pioneers”, “explorers”, “courageous” and “gutsy”.
These names highlight their willingness “to risk living and working in a totally different
environment and find a way to survive” as well as the “perseverance, designation, and
motivation to succeed” that participants saw as characteristics of immigrant therapists. Names like “unique” or “the alternative” highlighted the fact that “we bring something different to the table.”

Other names offered by most participants (8 out of 13) emphasized the experience of immigration. Some names offered by participants were “therapists without frontiers”, “therapists of the diaspora”, “therapists of the borderlands”, “therapists without borders” and “transnational therapists.” These names highlighted their own duality and hybridity, as well as the sense of movement, flexibility and lack of rigid boundaries that is associated with the experience of immigration.

In this chapter I have described the five major themes and 23 subthemes that emerged from the phenomenological reduction (Moustakas, 1994) of the 13 interviews with immigrant couple and family therapists who were born and raised in other countries and are clinically active in the US. The final discussion chapter describes the imaginative variation (Moustakas, 1994) of these findings using the two main frameworks used to develop this phenomenological dissertation study (symbolic interactionism and the multicultural perspective) and an analysis of the findings in the context of the extant literature.

**Member checking comments**

Member checking or member validation (Dahl & Boss, 2005; Newman, 2003) was used in this phenomenological study to increase the credibility of the findings (Lincoln & Guba, 1985). As noted above in the methods chapter, an e-mail was sent to all participants with a summary of the findings, and a request to confirm if the major themes and subthemes that emerged from the data analysis reflected their experiences. Almost
half of the participants (6 out of 13) responded to this electronic request, five via e-mail and one in a telephone conversation. All of them reported that the findings captured their experiences. Below are the comments made by the five participants who responded to me in writing.

- Your conclusions look great to me. I feel 100% reflected!!
- The list and organization of themes is impressive. I think you have covered everything as far as my experience is concerned.
- Your theme analysis look great…it seems like you have captured lots of relevant themes and ideas and my experiences are definitely reflected.
- Perfect! Me encanta. [I love it] I think it covers a variety of experiences that are enriching and empowering! Good job!
- Claro que esta lista refleja mis experiencias [Of course this list reflects my experiences].

The relatively high response rate (46.1% of the sample) and the unanimous positive feedback suggest that the findings of this phenomenological study can be considered a credible description of the participants’ experiences as immigrant couple and family therapists clinically active in the US.
CHAPTER FIVE: DISCUSSION

Introduction

According to Moustakas (1994), the last two stages of phenomenological research are imaginative variation and synthesis. Imaginative variation refers to the search for possible meanings of a phenomenon by using various frames of reference. Synthesis describes the integration of the description of the phenomenon and its interpretation (Moustakas, 1994). In this chapter, the study findings are examined using the two main frameworks that informed this phenomenological dissertation study: Symbolic interactionism ([SI], Blumer, 1969; Mead, 1934) and the multicultural perspective ([MCP], Hardy & Laszloffy, 2002). Additionally, themes that emerged are compared and contrasted to prior literature on immigration and the experiences of immigrant mental health clinicians in the US. Following discussion of the findings, self of researcher reflections, clinical implications, study limitations, recommendations for future research, and final conclusions are presented. Below, I first summarize the gaps in the literature that this phenomenological dissertation study was designed to address.

Gaps in the Literature

The four gaps in the literature that this qualitative phenomenological dissertation study addressed were the lack of: (a) attention to immigrants regarding their roles as therapists versus their roles as clients, students, professors, supervisors or supervisees, (b) specific attention to immigrant couple and family therapists versus immigrant practitioners in other mental health professions, (c) consideration to both immigrant couple and family therapists’ struggles and strengths, and (d) attention to the roles of
power and privilege among currently practicing immigrant couple and family therapists and their experiences with discrimination and oppression in the US.

These four gaps were examined in the following ways. First, this study was designed to explore the clinical experiences of immigrant couple and family therapists who are currently practicing in the US. The questions in the semi-structured interview guide focused on understanding how participants’ experienced their clinical work in the US. Second, the inclusion criteria for the study led to the selection of 13 participants whose main area of clinical training and current practice is couple and family therapy. Third, the use of phenomenology made it possible to develop a more comprehensive description of immigrant couple and family therapists’ clinical experiences using their own words and narratives. These rich descriptions included accounts of their struggles, strategies to overcome them, and areas of growth.

Finally, the inclusion of SI and the MCP as frameworks which were used to interpret study findings provided a more contextualized consideration of the clinical experiences of immigrant couple and family therapists. This more contextualized view facilitated understanding how immigrant therapists participated in the redefinition of their realities and identities during their interactions with other social actors (clients, supervisors, colleagues). Additionally, having a more contextualized perspective also helped me better understand how dynamics of power and privilege affected how these realities and identities were negotiated during social interactions with clients, supervisors, and colleagues.
Imaginative Variation and Synthesis of Main Study Findings

The primary aim of this phenomenological dissertation study was to understand the clinical experiences of immigrant couple and family therapists who were born and raised in another country and who are currently clinically active in the US. The phenomenological reduction of the 13 in-depth semi-structured individual interviews led to five major themes: (a) the experience of immigration, (b) immigrant therapists and their clients, (c) development as a clinician, (d) relationship with colleagues and other professionals, and (e) a name for ourselves. The following sections describe the imaginative variation and synthesis of each of the main themes that emerged in this study. Each section below first includes a brief summary of the major theme followed by considerations of how the theme can be understood using the two conceptual frameworks (SI and MCP), and finally by examining extant literature describing the experiences of immigrant mental health clinicians in the US.

First Theme: The Experience of Immigration

The first theme, the experience of immigration, describes how participants experienced adapting to and living in the US after being born and raised in another country. Participants described experiencing immigration as transformative because it generated changes in their self-perceptions, personal characteristics and perspectives about life. Participants also described their immigration experiences in the US as challenging because of the demanding tasks such as learning to navigate a new system of meanings, rules and expectations, establishing social support networks, and building a sense of normalcy in a new environment and culture in the US.
During their accounts of their immigration journeys, participants also described experiencing discrimination. In their interactions in the US, both inside and outside of the therapy room, participants reported being excluded, treated as less than, and perceived by others using rigid stereotypes that have been developed about their countries or regions of origin. As part of their experiences of immigration, participants also shared their own views about the US. The most salient characteristics of the US culture for most participants in this study were the constant use of rigid categorizations, being disconnected from the rest of the world, and individualism.

**Symbolic Interactionism: Negotiation of meanings and redefinitions.**

From a SI point of view (Charon, 2001; LaRossa & Reitzes, 1993) immigrant couple and family therapists, like other social actors (Charon, 2001), actively participated in the construction of their own identities and realities during interactions with others social actors in the US. After being socialized in one culture and adopting the perspectives of reference groups (Charon, 2001; LaRossa & Reitzes, 1993) in their countries of origin, they faced the challenge of being immersed in and learning how to navigate a new world of meanings, perspectives, social actors and social objects in the US.

Moving from their countries of origin to the US involved a radical change of relational contexts that, as participants described, affected every aspect of their lives. This forced participants to revise and re-construct their definitions of their selves and their perspectives (LaRossa & Reitzes, 1993). Participants became more aware of their own assumptions, and expanded their understandings of reality by taking into consideration new symbols and meanings in the US. It is not surprising that participants described their
experiences of immigration as both profoundly transformative and challenging. Authors such as Garza-Guerrero (1974) and Mirkin and Kamya, (2008) have also reported that the experience of immigration is both a source of anxiety and excitement for most individuals because of the losses, adaptations and opportunities that it entails.

In addition to re-editing and redefining their selves and their perspectives, participants described finding new meanings for situations and for life events because of their immigration experiences. A notable example is how they found new meanings for “home” and new ways to develop a place that they could call home. According to Falicov (1998), immigration involves changes in the external environment and a process that requires uprooting oneself from different systems of meaning. Similarly, Sluzki (2008) suggests that migrating often involves the disruption of social networks, which can be a challenging stressor for immigrants. Even though participants described how hard it was to leave what was familiar in their countries of origin and the confusion they experienced while adapting to the US, they also described searching for ways to build a sense of home in the US. Additionally, participants described actively establishing relationships in the US that gave them a sense of community. While away from what up to that point had been home, participants assumed an active role to find new meanings for “home” that were less restricted by geographical location and instead related to the experience of feeling connected to loved ones and having a secure base. This allowed participants to feel at home, even if they were not living in the country where they had been born and raised.

Likewise, participants described new ways of understanding what it means “to belong”. Similar to what Falicov (2007, 2011) observed during her clinical experiences
with immigrant clients, participants in this study had a remarkable capacity to find
both/and solutions to the challenges of living in one culture after being socialized in
another. Thus, over time some participants reported feeling connected and belonging to
the US and their countries of origin. These both/and solutions were also captured in
participants’ hybrid identities that integrated meanings and perspectives from at least two
cultures and two reference groups.

It is important to note, however, that not all participants reported this inclusive
way of belonging. Some participants reported that their sense of belonging had changed
in a way that they felt they were “neither from here nor there” (the original sentence was
“no soy de aquí ni soy de allá”). Falicov (2007, 2011) suggests that understanding
immigration as “being between two worlds” or “not fitting in either culture” is the result
of a deficit-oriented view of immigration. The findings from this study, however, suggest
that for some participants “feeling in between” or “not belonging” is the most accurate
description of their experience of immigration. Considering this as a deficit-based view
can actually invalidate their experiences and simplify the diversity of responses that
immigrant couple and family therapists have to the challenges of negotiating two
different worlds of meaning.

Identity restructuring.

The emotional aspects of culture shock (Garza-Guerrero, 1974; Winkelman,
1994) were also mentioned by participants in this study and included initially feeling
confused, anxious and overwhelmed. The subsequent dissipation of these emotions, also
mentioned by Garza-Guerrero (1974), eventually led to participants redefining their
identities. Similar to Akhtar’s (1995) description of immigrants in general, participants
shared that they restructured their identities as part of the process of immigration. Although identity restructuring was described by most participants as overwhelming, infantilizing and frustrating, participants also said it was an opportunity for growth. For example, given the challenges that they faced as immigrants in the US, participants developed and/or recognized strengths in themselves that they were not aware of before immigrating to the US. This new awareness was incorporated into their self-definitions. Acknowledging their inner resources also led participants to revise how they defined humanity in general, and encouraged them to be more attuned to the inner resilience and drive towards personal growth that all human beings, especially clients, can develop.

Several authors (e.g., Berry, 1997; Deaux, 2006; Marin & Gamba, 1996) suggest that one of the central tasks of immigrating is to restructure one’s own identity by integrating salient cultural aspects from the country of origin and the country where the person is now living. In fact, Marin and Gamba (1996) suggested that a healthy process of immigration requires balancing elements of the culture of origin and the culture of destination because it helps to maintain continuity in one’s sense of self in the midst of considerable changes in context. Participants in this study also reported that the transformations they experienced and continue to experience have helped them become bilingual, bicultural or hybrid. In other words, because of their exposure to diverse social actors and situations in the US, participants actively incorporated new systems of meaning and perspectives into their identities and worldviews, without denying or erasing what they brought from their countries of origin.
Multicultural Perspective: Privilege and subjugation in the experience of immigration.

According to MCP (Hardy & Laszloffy, 2002), fully understanding an individual requires taking into account the context he or she is embedded in. In order to contextualize the immigration experience, Akhtar (1995) provided a list of factors that can affect the outcome and well-being of individuals who immigrate to a different country. Regarding foreign born couple and family therapists who volunteered for this study, some of those factors made their immigration experience to the US more positive. For example, participants came to the US voluntarily to further develop their careers or to improve their prospects for employment. Although some participants’ countries of origin were facing political unrest, repressive government regimes or economic difficulties when they moved to the US, these were not reported by participants as the main reasons they immigrated to the US.

In contrast to undocumented immigrants who, because of their legal status, are marginalized in the US, participants in this study have integrated themselves in the mainstream work force or in US academia, with the associated power and privileges these statuses confer. The sample of couple and family therapists in this study are also highly educated professionals who earned advanced graduate degrees which qualify them for the professional practice of couple and family therapy in the US. Additionally, given their legal status, participants have the privilege to visit their countries of origin. In fact, many reported regularly doing so in order to maintain their roots and relationships.

Thus, participants in this study have privileges in many domains when compared to other segments of the immigrant population in the US, for example, undocumented
immigrants, refugees, or individuals with lower educational attainments. According to the findings from this study, participants themselves recognized their power and privileges and often used them to empower their immigrant clients or to advocate for them in US institutions.

Conversely, other factors made the experience of immigration difficult for this sample of couple and family therapists. According to Akhtar (1995) and Deaux (2006), it is important to consider the social context in which immigration takes place and the beliefs held in the country of destination about immigrants in general, and about individuals from specific regions or countries. As described by most participants, their processes of immigration included experiences of discrimination, exclusion and being perceived through the stereotypes that have been constructed in the US about their countries or regions of origin.

In the US, immigrant couple and family therapists shared they had to cope with preconceptions and stereotypes that guided the actions of other social actors towards them, both inside and outside of the therapy room. Additionally, events like the terrorist attacks on September 11, 2001 have fueled an anti-immigrant sentiment in the US, which has negatively affected the experiences of the immigrant couple and family therapists in this study. This is especially true for participants from South Asia, given the current international tensions between the US and the Middle East. A notable example of this was shared by Mariam: “I remember when September 11th happened, a client of mine thought that I was part of the plot with Bin Laden and reported me to the FBI.”

Finally, immigrant couple and family therapists encountered US-based racial and ethnic categories that required them to rigidly locate themselves socio-demographically
(e.g., US census forms). These rigid categories were associated with inaccurate or negative attributions and stereotypes. The experiences of discrimination and exclusion might have been more intensely felt by the immigrant couple and family therapists in this study if they were part of the majority population in their country of origin. As Mirsalimi (2010) noted, being part of a privileged class in one’s own country of origin can contribute to feeling shock at experiencing prejudice for the first time in the US.

**Second Theme: Immigrant Therapists and Their Clients**

The second major theme, *immigrant therapists and their clients*, describes experiences related to participants’ direct clinical work in the US. This theme describes being *exposed* to clients who were different from themselves in terms of one or more salient contextual variables (e.g., country of origin, race, or socio-economic status). Experiencing and interacting with people from different cultural backgrounds in and out of the therapy room led participants to reach a higher level of *awareness of their own assumptions* about family relations and social practices, and as a consequence, participants reported becoming more careful about not imposing their own values and assumptions on their US clients. Exposure to culturally diverse client populations in the US also helped participants develop more *flexibility* regarding their definitions of family dynamics, family structure, and normalcy. Participants also reported that having lived in at least two cultures gave them an outsider’s *perspective* which allowed them to offer their clients a different point of view about their issues and relational challenges.

*Language* was another important factor that emerged from the qualitative analysis. Speaking English as a second language and having a foreign accent were reported as sources of rejection and mistrust from US clients and from others who
doubted foreign born CFTs’ ability to effectively work with their clients. Yet participants also described some clinical benefits of having a foreign accent, and at times used it proactively.

Participants faced ongoing clinical challenges and needed to find strategies to clinically work in the midst of difference, because they are working with clients in the US who are different from themselves. Thus, participants described actively working to establish a better connection with their US clients; facing discrimination related to stereotypes made about foreigners and about individuals from their regions and countries of origin; debunking those stereotypes and needing to prove that they are competent clinicians; and coming to the realization that not being from the US and having a foreign accent eventually became less important once a strong connection with their US clients was established.

Participants also noted that being immigrant couple and family therapists and having a foreign accent contributed to leveling the power between themselves as therapists and their clients in the US, so they were not seen as distant experts but as real human beings. Participants also reported being recognized as knowledgeable by clients and other professionals in areas such as immigration, cultural diversity, bilingual therapy, and intercultural relationships.

Working with immigrant clients was another important subtheme described by immigrant couple and family therapists. Most notably, they reported using their own experiences of immigration to better understand their immigrant clients and to offer interventions that better fit their needs. Additionally, participants reported becoming
cultural brokers between members of immigrant families, or between the immigrant families and the larger US society.

**Symbolic Interactionism: Therapeutic encounters as meaning-making interactions.**

From a SI point of view (Charon, 2001; LaRossa & Reitzes, 1993), the therapeutic relationship is a social interaction between social actors with different roles and identities. During this interaction or clinical encounter, the therapist becomes a significant other for the client and vice versa. Therefore, during the therapeutic relationship, like during other social interactions, meanings are exchanged, assumptions are negotiated, identities are transformed and new realities can emerge (Mead, 1934). It is important to note that the social locations of the social actors (therapist and client) affect the dynamics of power during this social interaction (Hardy & Laszloffy, 2002) which in turn affects how the negotiation of meaning unfolds, which will be further discussed below.

During this close and intimate social interaction (the clinical encounter), immigrant couple and family therapists and their clients experience the assumptions they have about each other, which often led to mutual stereotyping (Comas-Diaz and Jacobsen, 1991). Participants in this study reported their US clients often perceiving them with assumptions and stereotypes of immigrants, or of individuals from particular countries or regions of origin. These experiences of being stereotyped were also reported by participants in other studies (e.g., Killian, 2001; Mittal & Wieling, 2006; Ng & Smith, 2009) that were conducted with foreign born mental health professionals (e.g., doctoral CFT trainees, supervisees, and counseling students). Similar to findings in this study,
prior studies reported that immigrant mental health clinicians have experienced covert and/or explicit rejection, questioning, and racism during their therapeutic work in the US. Yet, what seems remarkable is that the therapeutic relationship also provided both clients and foreign born CFTs with opportunities to revise their assumptions and to negotiate new meanings about the other person and with the other person. For example, Sandra became more aware of her assumptions about the US and about religion; Yuan discovered that privacy has different meanings for different people; Adeben’s clients learned that Africa is not a country but a continent; and Mariam’s clients realized that a Muslim woman wearing a veil can also be an advocate for feminist causes. Additionally, participants described how both they and their US clients realized that immigrant couple and family therapists with foreign accents can be clinically effective.

The therapeutic encounter was not only a context for immigrant couple and family therapists to revise their assumptions but also contributed to changes in their identities. Participants reported that during their clinical work (and during other social interactions outside of the therapy room) they were exposed to different worlds of meanings and different perspectives that enriched their points of view. Similar to what Tang and Gardner (1999) reported about minority therapists in general, participants in this study experienced navigating both their own culture and the majority culture. Yet, participants’ reports suggest that beyond entering and leaving two distinct and separate worlds, they actually embarked on the task of transforming their own identities by integrating two frames of reference and thus becoming bicultural.

Akhtar (1999, 2006) suggests that being aware of how their own identity transformation processes affect therapy can give immigrant therapists the ability to
prevent these processes from interfering with therapeutic work in the US. For example, participants in this study became more aware of their own assumptions which in turn, led to a more disciplined effort to not impose their own views on clients. Additionally, participants involved their clients in the negotiation of new meanings by being curious and by regularly “checking in.”

Even though participants reported transforming their identities by integrating two cultures, they also described developing the ability to hold multiple perspectives, and using it in their clinical work. Similar to what Akhtar (2006) and Cheng and Lo (1991) have suggested, participants developed an outsider’s view of cultures in the US and in their countries of origin. Additionally, the study findings support the authors’ assertion that this “critical cultural eye” can help therapists more easily question taken for granted culturally-based assumptions and present clients with different interpretations of their situations and relational issues. Findings from this study also support assertions by Akhtar (2006) and Isaacson (2001) that immigrant clinicians have more latitude to assume the stance of a “curious stranger” or, in Tatiana’s words, a “stance of being naïve” because they are perceived by their clients as having an outsider’s perspective.

Although Akhtar (1999) suggested that one of the risks of this curious stance is that it might interrupt the fluidity of the therapy process, participants in this study said that their curious stance was not perceived by their clients in the US as intrusive, because their clients knew that they were born and raised in a different cultural context. In fact, participants reported that their curiosity conveyed to US clients that they were invested in better understanding their stories. It is important to note that participants did report that some of their US clients dropped out of therapy. It is possible that in some of those cases,
the ongoing questions and curious therapeutic approach might have discouraged these clients from continuing the therapy.

In addition to revising assumptions and restructuring their identities, during therapeutic encounters immigrant therapists also found new ways to understand the cultural differences between themselves and their clients in the US. Initially, the cultural differences felt like an insurmountable obstacle, which led them to doubt their ability to be effective clinicians in the US. Similar to what has been reported by Gelso and Mohr (2002), US clients questioned the participants’ ability to understand their experiences and to help them. With more clinical experience in the US and positive feedback from their clients, cultural differences acquired a new meaning for participants. They were seen as bridges to be crossed to establish a strong therapeutic bond with the clients, rather than obstacles to the therapeutic connection. In the process of redefining and reframing cultural differences, participants also became more aware of the commonalities that we all share as human beings which made it possible for them to establish deeper human connections with their US clients in the midst of cultural differences.

**Multicultural Perspective: Dynamics of power in the therapeutic relationship.**

From a MCP perspective (Hardy & Laszloffy, 2002), immigrant couple and family therapists who participated in this study were in both positions of power and subjugation in relation to their US clients. As immigrants, participants occupied positions of subjugation in relation to clients who were born and raised in the US and were also the subject of stereotypes and discourses about them that prevailed in the dominant US culture. On the other hand, as therapists, participants occupied positions of power vis-à-
vis their US clients because they had the professional and ethical responsibility of providing therapeutic services to clients who met with them in times of need and vulnerability.

Participants reported performing their clinical duties in the midst of difference and sometimes discrimination, which echoes findings reported by Isaacson (2001). In spite of these experiences, they assumed their roles as couple and family therapists, even if they had to work harder to prove to US clients that they were competent CFT providers. Participants were in the position of gaining credibility as professionals in a country that was not their own, and they had to work “extra hard” to prove themselves. These experiences led them to become clinically skilled and to pay more attention to joining, deeply understand their clients’ struggles, and validating and honoring their pain.

According to the MCP, the dimensions of the self in which a person holds positions of subjugation tend to be more salient for that individual (K. V. Hardy, personal communication, October 9, 2009; Killian, 2001). Findings from this study similarly suggest that participants were keenly aware and reported instances of discrimination inside and outside of the therapy room, because this subjugated position of being an immigrant was a salient part of their experiences in the US. Yet, in the therapy room it was their positions of power and privilege in their professional roles that informed their definitions of the clinical encounters with US clients and guided their clinical work.

One of the assumptions of SI is that social actors tend to guide their behaviors according to the definitions that they give to the situations they are in (Charon, 2001). By defining the therapeutic relationship not from their positions of subjugation as immigrants but from their privileged roles as CFT professionals, they approached clinical
encounters differently than other social interactions outside of the therapy room. One example of the effect of defining the therapeutic relationship from their positions of power and privilege as CFT professionals rather than their positions of subjugation as immigrants was how participants contextualized and reframed experiences of discrimination that they experienced from their US clients.

Participants took into consideration the larger context and US society’s dominant discourses and often reframed discrimination experiences in their US clinical work by considering the social forces that were behind clients’ incomplete, inaccurate or even disparaging views about them, their countries and their regions of origin. Taking into consideration systemic dynamics and contextual forces to describe and interpret the interactions between themselves and their clients might be a unique characteristic of immigrant CFTs, as CFT training emphasizes understanding individuals in the context of their relational contexts. Immigrant professionals in other mental health fields such as psychoanalysis or counseling tend to use more individually oriented or intrapsychic frameworks to explain interactions with their clients (see for example, Akhtar, 1999; 2006; Comas Diaz & Jacobsen, 1991; Gelso & Mohr, 2002).

According to postmodern and narrative ideas that have informed MCP (Freedman & Combs, 1996; Gergen, 2009), power is a factor that affects how reality is negotiated during social interactions because certain discourses and definitions held by more privileged groups tend to be more widely disseminated and accepted, whereas other versions of reality often remain subjugated. Findings from this study suggest that the therapeutic encounter became a place where dominant discourses and stereotypes could be deconstructed between immigrant therapists and US clients, and alternative narratives
emerged. An example of this was provided by Amir: “I had a client with family that the grandma of the family told me that ‘we don’t believe whatever they are showing in Fox News. You are the kindest and most engaging therapist that we’ve ever seen.’”

During therapeutic encounters, foreign born CFTs and their clients had the opportunity to expand their definitions of each other. This, in turn, opened up the possibility for new discourses to emerge. From this point of view, the therapeutic encounter became a place where social change, even if on a smaller scale, happened. The therapeutic encounter was, therefore, a context where oppressive discourses were dismantled, and the task of social justice was carried out, thus contributing to heal the world “in fifty-minute intervals” (Hardy, 2001, p. 19). For example, Mariam said that the exposure to difference that occurs during therapeutic encounters is an opportunity for social change: She stated, “it’s good for humanity or all of us to be exposed to each other more, so we see people for who they are instead of what they represent.” Seeing the potential of the therapeutic encounter as a context for social change is also congruent with the SI premise that even though individuals and small communities are influenced by larger society, it is through smaller interpersonal interactions that the social structure can be negotiated, established and transformed (LaRossa & Reitzes, 1993; Mead, 1934).

In their study of immigrant therapists living in Israel, Basker and Dominguez (1984) reported that clinicians were aware of the impact of immigration and cultural differences on their own personal lives. They also reported that regarding their own clinical work, immigrant therapists emphasized their similarities with clients and the universality of human problems in order to establish that they were qualified to work as mental health professionals in Israel. Although initially this can be viewed as a
contradiction or denial of the importance of cultural differences during therapeutic encounters, findings from this study suggest a different interpretation.

It is possible that assuming a position of power and privilege as couple and family therapists helped foreign born CFTs approach their therapeutic relationships in the US differently than other types of relationships outside of the therapy room. In other relationships as immigrants in the US, they did not have the power, privilege and responsibilities that their professional positions afforded them, therefore, cultural differences and the experiences of subjugation were likely more salient in the context of their relationships outside of the therapy room (see more in the discussion of the fourth major theme). In contrast, during clinical encounters with their clients in the US, participants were keenly aware of the responsibilities and duties associated with their positions of power as CFTs. Consequently, paying attention to what “we share as human beings” or taking into account the societal forces and discourses that are behind the perceptions that clients have about them were strategies participants used to remain connected and compassionate towards their US clients in order to fulfill the responsibilities associated with their clinical roles. Findings from this study support the results of Isaacson’s study (2001) who also reported that immigrant mental health professionals experienced prejudice from their clients, which generated feelings of sadness and anger. Yet, similar to my findings, his sample of foreign born clinicians also worked harder to understand their clients’ story in order to remain empathic and effective as clinicians.

A second area to consider is related to leveling the power in the therapeutic relationship. Being in a position of subjugation, not being part of the mainstream US
society and struggling with language (e.g., speaking English as a second language or with a foreign accent) actually helped participants to be regarded more as fellow human beings and less as distant experts by their clients in the US. This was especially true when foreign born CFTs were working with clients who were also in marginalized positions, for example in terms of race or immigration status. The findings from this study support observations by Tang and Gardner (1999) that minority therapists’ own experiences of disenfranchisement or exclusion can help them better connect and empathize with the experiences of clients in similar positions of subjugation.

Akhtar (2006) noted that when immigrant therapists work with other minority clients, there is the risk for developing a coalition against the mainstream culture. This risk was not a salient aspect of the clinical experiences reported by participants in this study. On the contrary, participants reported taking active roles and becoming cultural brokers between their immigrant clients and the mainstream US institutions. In other words, rather than forming a coalition against the mainstream US culture and further alienating their immigrant clients from it, participants reported helping their immigrant clients navigate US institutions. Participants also described using their positions of power as mental health professionals to advocate for their immigrant clients.

Comas-Diaz and Jacobsen (1991) suggest that minority therapists who work with other minority clients can experience survivor’s guilt, or may emotionally distance themselves from their clients to protect themselves from reliving the pain of being marginalized. The findings from this study do not support this observation by Comas-Diaz and Jacobsen (1991). For example, participants working with immigrant clients described being aware of their privileges vis-à-vis their clients, but did not report feeling
guilty or emotionally distant. On the contrary, participants reported feeling admiration for the strength of their immigrant clients. Additionally, participants said they used their own experiences as immigrants to better understand their clients’ experiences of exclusion and disenfranchisement in the US and to inform some of their interventions with immigrant families. According to Aponte and colleagues (Aponte & Kissil, 2012; Aponte et al., 2009), for couple and family therapists to be able to use who they are personally in their clinical practice, they need to be able to access their own vulnerability in the moment with their clients. The fact that the participants in this study reported using their own experiences as immigrants to better empathize and to intervene with their immigrant clients in the US suggests that they were not emotionally distancing themselves from their own experiences.

**Power dynamics and work with immigrant clients.**

The interplay of positions of privilege and subjugation between therapists and clients help us better understand participants’ experiences working with immigrant clients. According to MCP (Hardy & Laszloffy, 2002), it is a prerogative of those in positions of privilege to ignore the realities of those in positions of subjugation. Yet, the opposite does not hold true, as people in positions of subjugation are often keenly aware of the existence, realities and discourses of the dominant groups. Hardy and McGoldrick (2008) stated “the oppressed always know much more about the dominant groups than the dominant groups know about them, as their survival depends on this understanding” (p. 450).

This dynamic is reflected in the interactions between participants and their immigrant clients. Participants who worked primarily with immigrant populations
reported that their clients (and they) were often misunderstood as their experiences were frequently misconstrued by other mental health professionals, especially those from the US. This lack of knowledge became evident for participants during conversations with other clinicians and in reports made by clients that suggested they felt judged, discriminated against or misunderstood by other clinicians. These findings suggests that US-born clinicians, because of the prerogatives associated with their positions of power and privilege, are not as compelled to “cross the bridges” and take the necessary steps to deeply understand and connect with clients in positions of subjugation (in this case, immigrant clients).

Immigrant therapists are in positions of power and of subjugation in relation to their clients in the US. Because of their position of oppression vis-à-vis US born individuals, they felt compelled to understand the perspective of their clients, demonstrate their competence, cross bridges and work extra hard to become clinically effective with their clients in the US. As Hardy and McGoldrick (2008) suggest, their survival as CFTs in this country depended on this approach.

**Use of language in therapeutic interactions.**

Language is a system of symbols used for representing and communicating during social interactions, and has a central role in SI. Language is the main vehicle for negotiating and transforming meanings between social actors (Charon, 2001). Cheng and Lo (1991) and de Zuleta (1990) have suggested that each language offers its own world of meaning and ways of structuring associations between meanings. Because of this, these authors suggest that bilingualism gives therapists the ability to access a more complex view of reality. However, language as a system of meaning was not a salient
theme for participants in this study. On the contrary, the aspects of language relevant for participants were the practical and relational implications, both positive and negative, of having a foreign accent and speaking English as a second language with their US clients.

According to participants, having a foreign accent often had negative meanings for their US clients. For example, participants said that their clients sometimes doubted their competence as CFTs which in turn, organized clients’ approach to them during sessions. Thus, some clients used the fact that their therapists spoke English as a second language and/or had foreign accents as an explanation for why they left therapy or requested a change of therapists. Participants who experienced these types of interactions with their US clients integrated these experiences into their own self-definitions which led to feelings of inadequacy and self-doubt. Findings from this study support assertions by de Zuleta (1990) who suggested that individuals who have foreign accents are often viewed less favorably by others. Additionally, similar to findings from Fuertes and colleagues (2002), foreign born CFTs in this study reported that having foreign accents affected their US clients’ assessments of their competence, expertise, and ability to connect and understand them.

Although having a foreign accent and the negative connotations associated with it adversely affected CFTs’ self-definations, the meaning of having a foreign accent was later renegotiated during interactions with clients. With more time and experience practicing in the US, participants said that having a foreign accent was no longer an impediment to their clinical effectiveness. In fact, participants realized that making grammatical mistakes or having difficulty pronouncing some words in English made them appear more human to their clients, which allowed the latter to feel closer to them.
as CFTs. Developing new meanings for their foreign accents also enabled them to modify their self-definitions, which in turn, helped them feel more confident about their therapeutic effectiveness in the US. This process of transformation from self-doubt to self-confidence will be further discussed in the section below that describes participants’ development as clinicians.

In addition to finding new meanings for having an international accent, participants also reported that being proficient in more than one language became a clinical asset. This was especially true for Spanish speaking therapists who could serve a large segment of the US population for whom Spanish is their primary language. As Rivas and colleagues (2005) have noted, bilingual therapists are an important resource for clients with lower levels of English proficiency who otherwise would not have access to mental health services.

Akhtar (2006) also suggested that conducting sessions in a second language could raise issues of loss and mourning in clinicians. Even though participants reported feeling frustrated, confused or infantilized in their use of English as a second language in their daily lives, they did not specifically report any issues of loss and mourning using English during clinical encounters with clients in the US.

**Third Theme: Development as a Clinician**

The third main theme that emerged in this study describes participants’ development as clinicians. Participants reported that during their professional journeys, they initially questioned themselves, their expertise and whether they could be clinically effective in the US. With more time and clinical experience practicing in the US, they developed their therapeutic skills, gained self-confidence and began to see themselves as
competent CFTs despite the stereotypes and discriminatory comments made about them both inside and outside of the therapy room.

**Symbolic Interactionism: Interactional contributions to clinician’s development.**

According to SI (Blumer, 1969; LaRossa & Reitzes, 1993) how a person defines himself or herself is the point of reference for this individual’s actions and for conferring meaning to objects, significant others, situations and relationships. So, how immigrant CFTs view themselves will help us better understand their clinical experiences in the US. Participants in this study reported a change in how they viewed themselves which went from self-doubt to self-confidence and self-affirmation.

The feedback from significant others, primarily clients and supervisors, was pivotal for the changes that participants made in their self-definitions. Thus, discouraging comments from supervisors or rejection from US clients reinforced feelings of incompetence, which contributed to participants’ negative self-images. Similarly, support and encouragement from clinical supervisors and positive comments from US clients were important for participants to become more confident in their therapeutic abilities.

Finding new meanings for key factors such as having a foreign accent (e.g., it is not an impediment for my clinical effectiveness in the US) or having a different cultural background than their clients in the US (e.g., cultural differences are not obstacles, but bridges that need to be crossed) also contributed to changes in how participants viewed themselves and eventually became more confident as CFTs. The changes in participants’ self-definitions are examples of how the self continues to evolve and to reach new meanings during social interactions with significant others (Blumer, 1969; Charon, 2001).
Therapists’ self-competence and acculturation.

Isaacson (2001) reported similar changes among foreign born clinicians who participated in his qualitative study that examined immigrant therapists’ identity changes. When comparing participants who had lived in the US longer and who had more clinical experience in the US to participants who had immigrated more recently and who were less clinically experienced, Isaacson (2001) reported that the later reported more difficulties defining and adopting their roles as therapists in the US. In contrast, the former reported feeling more grounded in their roles as mental health professionals in the US. More experienced clinicians in Isaacson’s study also reported acknowledging and embracing cultural differences between themselves and their US clients and using these differences to their advantage during clinical encounters.

Yet, one of the main differences between Isaacson’s findings and the results of this study is that the former suggests that the changes in self-concept reported by study participants were because of a combination of acculturation to the US and increased clinical experience and time living in the US. In contrast, participants in this study primarily attributed these changes to becoming more experienced as CFTs practicing in the US and to the positive feedback from significant others (e.g., clinical supervisors and clients). Acculturation was not mentioned by participants in this study as an important factor contributing to the development of more positive definitions of themselves as competent CFTs.

The present study both supports and contradicts findings from other studies that have examined the role of acculturation in mental health professionals’ perceptions of clinical self-efficacy. For example, in their quantitative survey study that examined
factors affecting the supervisory experience of international psychology students, Nilsson and Anderson (2004) reported a positive association between acculturation (especially acceptance of the US culture) and perceived counseling self-efficacy. In contrast, findings from Kissil’s (2012) quantitative survey dissertation study suggest that therapists’ reports of clinical self-efficacy are not related to their level of acculturation to the US. Kissil’s (2012) findings suggest that other variables such as how connected the therapist feels in the US and the levels of perceived prejudice from the environment are more important than acculturation in predicting participants’ perceptions of clinical self-efficacy. More research is needed to better understand the factors (including acculturation) that contribute to immigrant CFTs perceptions of clinical self-efficacy in the US.

**Self-doubt and race from a Multicultural Perspective.**

One of the factors that was mentioned by participants as contributing to self-doubt and feelings of incompetence as clinicians was working with “mainstream” middle or upper class White clients. Participants reported feeling like they were not at their clients’ level, wondering if these particular US clients would take them seriously, and worrying about whether they would consider them competent CFTs. These results support Isaacson’s (2001) findings that immigrant therapists who had immigrated to the US more recently and who were less experienced as clinicians had a more difficult time with their roles as therapists especially when working with mainstream clients.

According to MCP (Hardy & Laszloffy, 2002) “ethnic differences in general and racial differences in particular have unique potency and volatility in our society” (p. 572). This statement is supported by the findings of this study. Foreign born CFTs in this study
reported experiencing more insecurities and self-doubts in relation to being “less than” Caucasian clients. It appears that participants viewed White, US-born middle and upper class clients as occupying positions of power and privilege, and regarded their opinions and judgments as more important. It is noteworthy that among the participants who expressed self-doubt while working with White US-born clients were also clinicians who self-identified as White or Caucasian. Perhaps participants perceived themselves in a position of subjugation in relation to these clients not only in terms of origin (being immigrant vs. US born) but also in terms of race and social class.

**Fourth Major Theme: Relationship with Colleagues and Supervisors**

The fourth theme in this phenomenological study was *the relationship with colleagues and other professionals*. Participants’ experiences in these relationships ranged from being valued and supported by peers and superiors, to being questioned, discriminated against or misunderstood. In addition, participants described experiences of discrimination and exclusion in academic or other formative settings.

According to SI, social actors construct and revise their identities and their sense of self in relationships with significant others. (Charon, 2001; LaRossa & Reitzes, 1993). In addition to clients, other salient significant others for the immigrant CFTs in this study were their supervisors, professors, classmates and colleagues. Interactions with these significant others deeply affected the identities and clinical experiences of participants in the US. Discouraging and derogatory feedback was noted as contributing to participants’ self-doubts. Similarly, reassuring and supportive feedback was regarded as pivotal for participants to develop more self-confidence as CFTs practicing in the US. Encouraging feedback was especially important for participants to counteract the effects of dominant
discourses that put their clinical competence and expertise into question because they are foreign born.

According to qualitative studies conducted on the experiences of international CFT doctoral students, supervisors and supervisees (Killian, 2001; Mittal & Wieling, 2006), participants reported pressure to “Americanize” and adopt values of the dominant US culture. Participants in this study did not specifically describe experiencing these pressures. They did, however, share examples of criticisms they received from US-born colleagues and supervisors because they did not conform to certain parameters of what therapy or the therapeutic relationship should look like in the US. These parameters referred to timing (e.g., how long and how often the sessions should be), place (e.g., whether you can have therapeutic moments with your clients outside of the therapy room), and closeness in the therapeutic bond.

The contexts in which these collegial or supervisory relationships took place also shaped the quality of these interactions. For example, participants reported that in environments where they were not the only minorities or the only international clinicians, they felt more understood, accepted and connected. The opposite occurred in less diverse work or learning environments. Similarly, Mittal and Wieling’s (2006) stated that participants in their study reported having fewer difficulties and feeling more supported when their CFT doctoral programs were located in universities or geographic areas characterized by high cultural diversity.

**Educational experiences in the US from a Multicultural Perspective.**

Although participants’ educational experiences were not the main topic of this dissertation study, several participants spontaneously shared their experiences in their
respective CFT training programs in the US. The most salient aspects mentioned by some participants about their training were feeling discriminated, excluded, misunderstood and unsupported. Results from this study support findings by others (Killian, 2001; Mittal & Wieling, 2006; Ng & Smith, 2009) who reported that international students in CFT and counseling programs in the US experience racial discrimination, exclusion and marginalization both by faculty members and their peers. Findings from this study are similar to the Mittal and Wieling (2006) study that international trainees feel that their particular circumstances are often misunderstood or disregarded in their respective CFT training programs.

Two factors might have contributed to the salience of these experiences of subjugation for some participants in this study. First, as students and as immigrants, participants are/were in a disempowered position in relation to US-born peers and professors. This might have made participants in their role as students/trainees especially vulnerable to experiences of oppression. Second, it is possible that during their CFT training participants are/were going through the initial phase of culture shock (Garza-Guerrero, 1974; Winkelman, 1994) which is characterized by mourning, confusion and anxiety. The rigors of CFT training combined with the challenges of adapting to a new culture might have made this period in participants’ lives particularly difficult and thus, sadly memorable.

Fifth Major Theme: A Name for Ourselves

The fifth and final major theme emerged from the last question in the interview guide and was finding a name for ourselves. Although a few participants questioned the need and utility of finding a name for immigrant CFTs as a group, many offered some
suggestions. Some of the names highlighted the strengths that immigrant CFTs develop because of their own immigration experiences in the US. Other names focused on the experiences of immigration and the sense of movement, integration and the lack of rigid boundaries that is often associated with immigrating.

Both SI and MCP recognize the power of language in the construction of realities. By naming something, we are recognizing its existence as separate from other social objects in the environment (Berger & Luckmann, 1966). Finding a name for immigrant CFTs as a group can have the effect of acknowledging our presence among other CFTs while highlighting the experience of immigration as an important factor that needs to be taken into consideration. In their responses to previous interview questions, participants mentioned the danger of emphasizing intergroup differences and negating intragroup variability when creating names or categories. A few participants mentioned that these risks could also apply to finding a name for immigrant CFTs as a group.

Despite this caveat, participants were excited and creative when offering suggestions for a name. The names and the explanations provided for them were self-affirming, highlighting their strengths (e.g., “adventurous”, “courageous”), uniqueness (e.g., “the alternative”), flexibility, and the capacity of integrating two cultures (e.g., “therapists without borders” and “transnational therapists”). This suggests that despite the hardships of immigration and the experiences of discrimination, what is most salient for participants about themselves and their clinical experiences in the US are the positive aspects. Several authors (McGoldrick & Hardy, 2008; Saba, Karrer and Hardy, 1990) have stated that the narratives about minority groups in the field of couple and family therapy tend to be based on a deficit perspective that portrays minorities as deficient,
vulnerable or unhealthy. These findings suggest that by allowing a subjugated group to
tell the story of their own experiences, a more comprehensive picture can emerge,
describing both the struggles and the triumphs.

**Self of Researcher: My Personal Reflections and Transformations**

When I started working on the dissertation proposal, I had the conviction that
there was something that we immigrant couple and family therapists in the US shared in
common, even though there were many differences among us in relation to country of
origin, language, gender, race, age, etc. My primary goal was to find and highlight those
commonalities that I saw as unique and special about the experience of being an
immigrant couple and family therapist in the US. I also wanted to give us, immigrant
CFTs, more visibility as a group and to add “country or origin” or “immigrant status” to
the existing salient contextual variables that need to be taken into consideration for
understanding the experiences of CFTs.

I continue to believe in these goals; however, after completing this dissertation
study, I am not seeing them the same way as when I stated this process. These changes in
my own perspective emerged after listening to the experiences of the 13 participants in
this study. In the following paragraphs I explain these personal transformations that have
resulted from conducting this phenomenological dissertation study.

**The Importance of Exposure**

This phenomenological study required that I closely listen to and try to understand
the experiences of fellow immigrant CFTs from different parts of the world. In order to
conduct the phenomenological individual interviews, I had to put my own beliefs, values
and experiences as an immigrant CFT in brackets in order to better understand this
phenomenon from the participants’ perspectives. The experience of “getting” their point of view taught me about the transformative power of being exposed to how others make sense of their own reality. After this process, I came to understand exposure as an act of being in the presence of, getting to know, and allowing yourself to be affected by another person with his/her own experiences and perspectives. I learned and reflected on the importance of exposure not only because this was one of the salient themes reported by participants, but also because I was experiencing the transformative effect of exposure as a result of the interviews. In other words, I learned about exposure both on the levels of content and of process.

The interview process itself can be viewed as an encounter between two social actors in which I was exposed to how participants made sense of their own experiences of being couple and family therapists in a country where they were not born and raised. I gained access to new meanings and interpretations of this phenomenon, which in turn, enriched my own perspective as an immigrant CFT. This was especially true when the interviewees’ experiences and meaning-making processes were very different from mine.

The rules of the phenomenological interview required that I understand the experience of the interviewee but not the other way around. So, this encounter was at the same time more demanding and less risky for me than other social interactions where the exposure is mutual. It was also more demanding because the work of getting the other person’s perspective required me to continuously exercise epoche (Moustakas, 1994). Getting the point of view of my interviewee also required attention, open-mindedness and allowing myself to entertain and to embrace different points of view. At the same time,
the interviews were less risky for me personally, because this was a one-way exercise. In other words, I did not have to expose myself to the other person.

After co-teaching the Person of the Therapist Training (POTT) class with Dr. Harry Aponte for three years, I have become more familiar with my own signature themes. Signature themes are defined by Aponte (Aponte & Kissil, 2012; Aponte et al, 2009) as the lifelong, ongoing issues in our own personal journeys and the hurts, disappointments, and losses that lie at the core of them. My signature themes (e.g., feeling that I am defective and somehow wrong, and as a consequence assuming that others’ opinions, needs and points of view are more valid than mine) tend to fill me with feelings of shame and fear, which can lead me to doubt myself, to hide, to disconnect, and in some extreme instances even to deny my own experiences when I am in relationships. Because of this, I tend to experience being exposed to others in relationships as a very risky act.

Yet, by conducting this dissertation study, I have learned both logically and experientially that exposure is essential to really seeing and being seen during our interactions and close relationships. My new understanding of the importance of exposure has made me realize that my own fears and doubts can rob me of possibilities for growth and enrichment, as well as possibilities of fully participating in the transformation of my own identity and the construction of reality with other social actors.

Additionally, I have also realized that exposure is a way to further the agenda of social justice in CFT. It is through our very presence and our engagement in therapeutic encounters with others that we can begin to dismantle the negative dominant narratives that exist about us. Exposure is risky for me, and yet, there is an even bigger risk in not
allowing myself to be truly seen. Although at some level I knew this before conducting the study, the process of interviewing the 13 participants made me more keenly aware of what I will lose by hiding and not being vulnerable with others.

**Realizing my own Assumptions**

By being exposed to how participants made sense of their own experiences as immigrant CFTs in the US, I realized some of my own assumptions. One of the main assumptions that I realized and revised after conducting this study was my belief that having an outsider’s cultural perspective was a prerogative of immigrant therapists. Although participants reported that being socialized in one country and moving to the US gave them an outsider’s perspective regarding both their own culture of origin and the US culture, what I realized after conducting the interviews is that having an outsider’s perspective does not depend on immigration but on assuming the tasks of: (a) looking at the dominant culture from a critical perspective and (b) crossing cultural bridges. Living in a country that is not where an individual was born and raised puts him/her in a situation where he or she is more compelled to doing these two tasks in order to adapt and to survive. Yet, it is not necessary to leave one’s own country to do this; what is necessary it to be willing to be critical and open.

Another personal assumption that became clearer to me was that there are degrees of “migration”, and that all of them require certain levels of adaptation, exposure, challenges and transformations. Moving from one neighborhood to another, changing careers, going from elementary to middle school, moving to another city or another region in one’s own country, all require us to change from one group of reference to another and from one culture to another. All of these changes involve challenges and
transformations. Moving from one country or one continent to another is among the most radical changes of context that a person can experience, and the associated cultural shock can be intense, as was reported by most participants. At the same time, as human beings, we change contexts, culture, groups of reference and roles constantly throughout our lives. Change and adaptation is a human experience that at some level we can all relate to.

I think that the main overarching assumption that I realized and started to question was that, as immigrant CFTs, we have experiences that are absolutely unique and special. While conducting this study I started to realize that the experience of immigration shared characteristics with other experiences of change and adaptation, and that what I thought was exclusive of the immigrant experience, was not necessarily so. Therefore, my goal of finding and highlighting what makes us, immigrant CFTs, unique and special changed. My goal ceased to be only to highlight what is unique about the experience of immigration which set us apart. In the same way that the CFTs I interviewed worked on finding what is common about us as human beings, I also started to see what is shared between us as immigrant CFTs and other CFTs.

**Walking the Line between Diversity and Common Humanity**

One of the initial goals of this study was to help immigrant CFTs become more visible, by giving us a name (this goal inspired the last question in the interview guide), and to highlight “country or origin” or “immigrant status” as an often overlooked contextual variable to take into consideration when describing CFTs’ social locations. During my own CFT training I learned that naming, recognizing and embracing my own social location was an important part of recognizing and honoring my own identity. I
learned that who I am and how I am seen by others is strongly related to my own social locations as a woman, mixed-raced, middle-class, heterosexual and from Colombia, among others.

Doing this dissertation gave me the opportunity to bring the voices of 13 immigrant therapists to the forefront and to honor and validate the stories that they shared with me. The paradox is that the stories they told me were about connecting across differences and finding ways to cross the boundaries that divide us. Their personal stories warned about the divisive and stereotyping potential of categories and labels.

This paradox brought me to one of the most important lessons that I learned by doing this dissertation study. The task of honoring diversity and pursuing social justice requires balancing acknowledging and validating what makes us unique and at the same time recognizing what we share in common as human beings. If the task of affirming ourselves and our value is not balanced by also recognizing and valuing the experiences of others, we run the risk of creating oppressive and divisive narratives of others in order to validate ourselves. On the other hand, only paying attention to the commonalities not only put us at risk of denying an important part of our experiences and identities, but also make us vulnerable to supporting ideas of equality that are not neutral but based on what is considered to be the norm (e.g., White, male, middle class, heterosexual). The task of pursuing social justice requires honoring what makes us unique and at the same time valuing the other person’s humanity and dignity without having to deny our own.

**Relational and Professional Ethics**

The last valuable lesson that I learned from my participants was about relational and professional ethics. While listening to how my interviewees coped with instances of
discrimination during their clinical work in the US, I found myself admiring their integrity and strength. It was commendable that they continued to perform their therapeutic tasks and maintained a caring and compassionate attitude towards their US clients by taking into consideration the societal forces that explained their clients’ discrimination towards them. What I found most remarkable was that this was not an act of submission, but actually an act of self-affirmation in their roles as CFTs. By working harder to understand their clients, they were able to become self-efficacious, asserting themselves as capable CFTs, and delegitimizing discourses that questioned their competence as CFTs. Kiselica (2012, as cited in Sue & Sue, 2012) said that confronting sources of oppression, especially when they are subtle, involves “the tricky challenge of balancing discomforting confrontation with empathic understanding” (p.14). Several participants in this study performed this balancing act in their clinical work.

Hearing the stories of immigrant CFTs who have worked hard to validate themselves, and who have empathy for their own experiences of self-doubt and subjugation helped me recognize how much I have been hiding and how much I need to validate my own experiences. I became aware of how often I have refrained myself from asking for help because I did not want to look inexperienced or ignorant as a foreign born CFT. Now, I can say that I did not know because I was not supposed to know, and I am giving myself permission to ask the questions that I did not allow myself to ask before because being vulnerable and asking questions is a competent approach to CFT.

**Study Limitations**

When considering the transferability of findings (Lincoln & Guba, 1985) to other populations, it is important to compare the characteristics of the sample and the
characteristics of the populations to which findings are expected to apply, and assess the degree of similarity between them. For that reason, a thorough description of the study participants was provided (see “Participants and sampling method”). Readers are advised to consider these characteristics when making decisions about the scope of applicability of these findings.

It is important, for example, to keep in mind that this sample includes highly educated (Master level or above) professionals who voluntarily and legally arrived in the US, and who chose CFT as their field of clinical specialization. Additionally, the findings of this research might only be transferrable to one segment of the immigrant CFT population: first generation immigrants who came to the US after the age of 18. Important differences in terms of socialization, identity formation, acculturation, language acquisition and family roles between those who immigrated as adults and those who came during their earlier formative years could prevent the findings from this phenomenological study to be transferable to other first generation immigrants and to the descendants of first generation immigrants.

Maximum variation (Newman, 2003) along different contextual dimensions (e.g., country and continent of origin, race, sex, and age among others) was desirable for the selection of the sample of this phenomenological dissertation study. Yet, strategies to ensure maximum variation could not be explicitly used because they would violate IRB regulations regarding equitable selection process (e.g., all participants who meet the inclusion criteria and are willing to participate can volunteer for this study). For that reason, one of the limitations of the study is the homogeneity of the sample in relation to contextual variables such as sexual orientation (all participants self-identified as
heterosexual), marital status (three quarters of the sample are married), age at arrival (three fourths of the participants arrived at the US in their 20’s), race (almost half of the sample self-identified as White or Caucasian) and region of origin (almost half of the participants came from South America). Participants, however, had a high degree of variability in terms of age, length of time in the US, years of clinical experience and type of clinical setting.

A limitation related to the description of the sample and the presentation of findings is that the participants’ countries of origin were not identified in order to maintain their confidentiality. More richness in the description of the results and the meaning of the findings would have been possible by revealing this information, but the confidentiality of the participants would have been compromised.

Another limitation of this study is the scarce attention to the intersectionality between immigration as a variable and other salient contextual variables such as gender, sexual orientation or religion. Even though the interview guide included questions to address intersectionality (see Appendix D), these questions were presented to the participants at the end of the interview. It is possible that participants at this point had some level of fatigue from the interview process, which prevented them from more deeply reflecting on these questions. Other questions such as “How often do you find yourself thinking about or discussing the topics that we addressed here today?” were easier for them to answer at that point in the interview. Although some participants did describe rich experiences that highlighted the connection between immigration and other contextual variables, no salient themes emerged from the analysis of these data.
Clinical implications

Some of the clinical implications of this study are related to immigrant CFTs while others can be extended to CFTs in general. One of the clinical implications of this study that is applicable to CFTs regardless of country of origin is to reconsider how our imperfections and vulnerabilities can actually make us more human in the eyes of our clients, which in turn allows for a more genuine presence and a stronger therapeutic bond. For this reason, it is important for CFTs to work not only on accepting that we are not perfect, but also work on realizing that, as Yuan said, we do not have to be perfect to be good therapists. Additionally, acknowledging and embracing our shortcomings could help us to better connect and understand the struggles of our clients (Aponte et al., 2009).

There is an English proverb that states that “necessity is the mother of invention.” From that point of view, it is possible to suggest that the struggles that we have had in our own personal and professional lives can be the source of skills, coping strategies and wisdom about human relationships. As participants reported during the interviews, immigration was a challenging experience, but also a continuous source of transformation and growth. It is important for immigrant CFTs to take a closer look at our own journeys and see how the challenges of living in a country that is not where we were born and raised have led us to develop certain abilities that can be used to enhance our therapeutic effectiveness. The findings of this study also invite us to have a more comprehensive view of ourselves as foreign born CFTs, taking into account the particular needs and struggles that we might have as active clinicians in the US, and the resourcefulness, capacity for adaptation and therapeutic abilities that are also part of our clinical work. In
sum, this study is an invitation to look at us not only for what we need but also for what we can contribute as clinicians.

Findings of this study suggest that immigrant CFTs made an effort to connect with US clients from the majority culture, however, immigrant clients shared with participants their experiences of being misunderstood by majority therapists. As Hardy and McGoldrick (2008) stated, it is easier for us to ignore others’ experiences of oppression when we are in positions of power in relation to them. It is important, then, for all CFTs to make our best effort to connect across differences, whether our clients are in a position of privilege or subjugation in relation to us.

**Implications for training programs**

The findings of this study suggest that the confluence of several factors (being in a position of subjugation as students and immigrants, going through the initial phase of culture shock, and the demands of intensive training programs) make CFT training an especially challenging and vulnerable time for individuals who are born and raised in other countries and who are receiving their clinical education in the US. For that reason, there are important considerations that need to be taken into account in training programs to help immigrant CFTs succeed in the US.

**Help Immigrant Therapist See and Use their Own Resources**

Immigrant therapy trainees in the US have particular needs and face unique challenges (Chung, 1993; Mittal & Wieling, 2006; Ng & Smith, 2009). This study echoes the training recommendations by Mittal and Wieling (2006) and Ng and Smith (2009) who have suggested that therapy training programs need to become more aware of the specific needs of their international trainees. Among their recommendations are to offer
international trainees mentoring, emotional support, and assistance with academic assignments.

Yet, using a deficit-based framework to understand the learning experiences of immigrant CFTs obscures the fact that there are specific strengths and resources immigrant therapy trainees have and can use during their clinical work in the US. It is important for faculty members, advisors and supervisors in training programs to help immigrant CFT students clearly identify their strengths. It is important, for example, to point out to immigrant CFTs in training that exposure to cultural differences, a central characteristic of immigration, can lead to the development of specific skills (e.g., flexibility or the capacity to have an outsider cultural perspective). The goal of presenting this information to immigrant trainees is for them to become more aware of these potential gains and to more intentionally work on the development of these skills and strengths.

Additionally, professors and supervisors can help foreign born CFT trainees proactively use their unique strengths and skills during clinical encounters with clients in the US. For instance, rather than forcing international CFT trainees to abandon their own points of view and look at families from the perspective of the mainstream culture of the US, supervisors and mentors can encourage immigrant CFT trainees to share their perspectives about family relations in the US from the point of view of their own cultures of origin. This will not only validate the knowledge and experience of immigrant CFTs but can also open the dialogue in the classroom to discuss the relativity of cultural norms, values and practices. This type of discussion can also benefit trainees who are born and
raised in the US and who can be exposed to the experiences of families in other countries by listening to the experiences of their immigrant counterparts.

Training programs can also help immigrant CFT students reframe their “limitations” (such as speaking English as a second language or with an accent) as issues that do not have to negatively affect the possibility of becoming clinically competent in the US. It is important for faculty members, advisors and supervisors to convey to immigrant CFT trainees the message that it is possible for them to become effective clinicians in the US. Training programs can also assist immigrant CFT students in reframing their “flaws” as factors that are potentially beneficial for their clinical work. For example, trainers can help immigrant CFT students notice that having a foreign accent can have the positive effect of leveling the power imbalance between therapists and clients, which in turn contributes to establishing strong therapeutic connections with clients, both US-born and immigrant.

Of course, for supervisors and faculty members to be able to deliver encouraging messages to their immigrant CFT students, they need to believe in their students’ potential and possibility to be clinically effective in the US. Yet, as the findings of this study suggest, this is not always the case. Therefore, it is important for faculty members, supervisors and advisors to become more aware of their own assumptions about the abilities and limitations of immigrant CFT students, and to challenge their beliefs with actual evidence of clinical experiences of immigrant CFTs such as the ones described in this phenomenological dissertation study.

Findings from this study also highlight the important role that feedback from authority figures in training settings, especially supervisors, has for CFT students’ sense
of clinical self-efficacy. This feedback can contribute to either self-doubt or self-affirmation depending on whether it is supportive or discouraging. It is important for supervisors, faculty members, advisors and mentors to understand the power that their feedback has, given that immigrant CFT students use it in their constructions and re-definitions of their sense of selves as professionals.

Professors, supervisors and advisors not only have an important role in providing nurturing feedback to immigrant CFT trainees. They also need to prepare immigrant CFTs for the difficulties that they may encounter as clinicians in the US. First, immigrant CFTs need to be aware of the discrimination and rejection that they may face in their clinical work. That way, immigrant CFTs will not be caught off guard when they encounter stereotypes and microaggressions in their work with clients in the US. Preparing for the possibility of discrimination can also help immigrant CFTs take a more proactive stance and, as Adeben suggested, see the therapeutic encounter as an opportunity to clarify misconceptions and generate new meanings in interactions with their clients.

Second, immigrant CFTs also need to be aware of the fact that connecting with clients who are different from themselves across several contextual variables would require from them some specific tasks. These tasks include locating themselves (Watts-Jones, 2010), putting cultural differences on the table, agreeing with clients on strategies to prevent mutual misunderstandings, continuously checking in to not impose their own assumptions and values on their clients, and working hard to prove their competence and counteract negative stereotypes about their clinical capacities.

Third, because most participants in this study reported that working with middle or upper class White families in the US generated more feelings of self-doubt and
insecurity about their clinical abilities, supervisors and trainers should proactively ask immigrant CFTs in training about their current clinical experiences with these types of families in the US. Supervisors should also help immigrant therapists discern whether these feelings of insecurity are related to the social dynamics of power and privilege that locate White US middle or upper class families in positions of privilege in relation to other populations in the US, or if these feelings of self-doubt are related to their lack of clinical experience in the US. It is important to not assume that all impasses between immigrant therapists and their White middle or upper class clients are due to differences in cultural backgrounds. There might be clinical skills that immigrant CFTs in training need to develop in order to better serve these types of families.

Supervisors can use self-report assessments with foreign born CFTs such as the International Student Supervision Scale (ISSS) which was developed by Nilsson and Dodds (2006). This self-report measure can be completed by immigrant CFTs to report whether or not factors such as the impact of cultural differences in clinical relationships or English proficiency are being fully addressed in clinical supervision. This self-report tool was designed to help international students report how open their supervisors are regarding addressing their unique training needs as foreign-born mental health providers. The feedback that can be obtained through this tool can be used by supervisors and other professionals involved in the training of immigrant CFTs to modify their teaching or supervisory style to better meet the needs of international CFTs.

**Teaching Diversity in CFT Programs**

As Hardy and Laszloffy (2002) stated, all therapy is cross-cultural. For this reason, to one degree or another, all CFTs have to learn to connect with our clients in the
midst of difference. In our CFT training programs (especially in classes about diversity and multiculturalism) we learn about the characteristics, traditions and interactional patterns of families from specific cultural backgrounds. By receiving this information, we learn that not all families are the same, and that social, historical, and cultural factors shape how families organize themselves, make sense of their realities, define their identities, and cope with life challenges. This information can help us understand how and why the experiences of Latino families might differ, for example, from those of White families, African American families or biracial families. This information also give us a contextual framework to better understand, for example, the particular challenges that families headed by same-sex couples face in the US.

As participants in this study reported, however, one of the consequences of this type of training is that it can encourage rigid categorizations and even stereotyping. Training can inadvertently promote the idea that all the members of a group share the same characteristics, which obscures intragroup variability. It is important for CFT as a field to find ways to recognize human diversity without promoting rigid categorization that can lead to divisiveness. This divisiveness is manifested in phenomena such as the “Oppression Olympics”. This term was coined by Elizabeth Martinez (1993; as cited in Dhamoon, 2010) to describe the tendency of members of different oppressed groups to defend the distinctiveness and importance of their unique positions of subjugation, and compete rather than cooperate with other marginalized groups for attention and access to limited resources and opportunities.

One of the main contributions of this study is that it highlights the transformative and teaching power of exposure to differences. Therefore, it is important for training
programs to encourage trainees to be exposed to and to closely work with families from different cultural backgrounds in the US. Class exercises, clinical placements, and community engagement can help to connect CFT students with a wide range of families from diverse cultural backgrounds. This way, learning about diversity will not be limited to reading books and journal articles, but can come alive experientially during interactions with those who are different from us.

For example, immigrant and US-born CFT can interview each other about their views about family, their experiences of discrimination or subjugation in the US society, and any fears or insecurities about their clinical work. Given that the ratio of students in a class might not allow for all US-born CFT students to each find an immigrant counterpart, this exercise should be expanded by asking students to interview a classmate who differs from themselves in at least two major contextual variables (e.g., race, gender, class, sexual orientation, age, religious background). These interviews might lead to facilitate exposure and help immigrant and US-born CFT students to get more familiar with their cultural differences and their commonalities as human beings.

Similarly, both US-born and immigrant students can describe to classmates the meaning and importance of a particular family tradition, custom or practice that is characteristic of their cultures of origin. This type of exercise can make both immigrant and US-born students more familiar with the different practices that exist in families. Additionally, this knowledge can augment and complement assigned class readings about diverse families, or help students develop critical opinions about diversity literature in the field of CFT.
In order to help US-born students become more familiar with the experiences of immigration, in relation to their immigrant classmates and their immigrant clients, an exercise that could also be helpful is to find out the requirements and costs of obtaining a visa to the US, as well as the scope of the visa (e.g., what the visa allows the foreigner to do in the US and the limitations that it imposes). The student could reflect on how his or her life would be different if he or she was not in the US as a citizen but as a foreigner with a visa.

**Recommendations for Future Research**

The intersectionality between immigration and other salient contextual variables needs to be addressed in future studies by examining the clinical experiences of immigrant CFTs in the US. Future studies should examine how the clinical experiences of immigrant CFTs vary according to their social location in contextual variables such as race, gender, sexual orientation, religious affiliation and others. Given that different locations in these contextual variables are associated with varying positions of power and subjugation, it is important to examine intersectionality using a theoretical framework that takes into account the role of power in relationships.

Future studies using the following three research designs are recommended in order to more closely examine intersectionality in future research about the clinical experiences of immigrant CFTs in the US: (a) recruit a more diverse sample (e.g., more racially and socioeconomically diverse) by using sampling strategies different from snowball sampling, for example quota or stratified sampling (Patton, 2002), (b) recruit a sample large enough to allow comparisons among subgroups of immigrant CFTs, and (c)
introduce the topic of intersectionality to participants earlier in the data collection process.

Another salient variable that can affect the clinical experiences of immigrant CFTs in the US is whether or not they received their formal clinical training and/or acquired clinical experience before immigrating to the US. Comparing immigrant CFTs who trained in the US with those who were trained in other countries could provide a better understanding of the unique training needs of immigrant CFTs who trained in the US compared to those who trained in other countries.

Working in the midst of difference was one of the salient subthemes that emerged in this study. Participants reported that in order to clinically work with clients who were different from themselves along many contextual variables (most notably, country of origin), they worked hard to establish a strong therapeutic connection, dealt with discrimination and rejection, realized their own assumptions, debunked stereotypes held by clients in the US, and realized that once a strong therapeutic bond was established not being from the US and/or having a foreign accent eventually became secondary. Each of these tasks needs a closer look in order to more clearly understand how immigrant CFTs accomplish them.

Yet, identifying and understanding the strategies that CFTs use to clinically work with clients who are different from themselves does not pertain to just immigrant CFTs. If we consider that all therapeutic encounters, in one way or another, are cross-cultural encounters, then understanding how CFTs in general work in the midst of difference becomes an important research area for the development of the CFT field. It is important to identify and understand strategies used by other CFTs who work across difference
along other salient contextual variables such as race, sexual orientation, religion, social class among others.

This study focused on the clinical experiences of immigrant CFTs. Nonetheless, participants mentioned their experiences in CFT training programs. The findings of this study suggest that immigrant CFTs in their roles as students or trainees felt less empowered compared to their role as clinicians. It is important to design future studies to examine whether immigrant CFTs indeed feel more empowered in their clinical roles, and if so, identify the key factors that contribute to the changes from feeling less to more empowered. This line of research can be extended to other minority therapists in order to identify factors that can contribute to their clinical self-efficacy as CFTs.

The role of acculturation in immigrant CFTs’ perceptions of clinical self-efficacy remains unclear in the extant literature. Future research is also needed to better understand how acculturation as well as other factors can help or hinder perceptions of clinical self-efficacy for foreign born CFTs.

**Final Considerations**

The 13 immigrant couple and family therapists who participated in this phenomenological study came from 4 continents and 8 countries, spoke different first languages, and arrived in the US at varying times. Yet, when interviewed, they told stories that had remarkable similarities. This highlights the fact that there is something particular in the experience of being clinically active as a CFT in a country where one has not been born and raised. Furthermore, this suggests that there are commonalities in the experience of conducting therapy as an immigrant couple and family therapist in the US.
Immigration, the therapeutic encounter and phenomenological research are all experiences where the encounter of social actors with different characteristics and social roles take place. Because of this, in these three types of experiences there is the potential for rich exchanges of meanings and for redefinitions of identities and realities. This became evident in the process of conducting this dissertation study. First, participants described the transformative power of immigration. Second, the findings suggest that the therapeutic encounter was a place where identities, meanings and assumptions were revised and redefined. Finally, hearing the stories of the 13 immigrant CFTs was enlightening for me as a phenomenological CFT researcher. This helped me realize that opening up our minds and expanding our definitions about others and about the world is facilitated by participating in social interactions where we get exposed to the realities and world views of others, and where we allow ourselves to be seen, heard, and known. It is my intention to tap into this power of exposure in my own professional and personal life as I make the next professional transition in the field of CFT.

An important contribution of this study to the understanding of the clinical experiences of immigrant CFTs in the US was to examine this phenomenon keeping in mind the dynamics of power that characterize the relationships that immigrant CFTs establish with other social actors such as clients, colleagues, supervisors, and trainers.
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APPENDIXES
Appendix A: Consent Form

DREXEL UNIVERSITY
CONSENT TO TAKE PART IN A RESEARCH STUDY

1. SUBJECT NAME: _________________________________________

2. TITLE OF RESEARCH: Experiences of Immigrant Couple and Family Therapists Clinically Active in the US: A Phenomenological Study

3. INVESTIGATOR’S NAME: Maureen Davey, Ph.D., LMFT
   CO-INVESTIGATOR: Alba Nino, MS, LCMFT

4. RESEARCH ENTITY: Drexel University

5. CONSENTING FOR THE RESEARCH STUDY: This is an important document. If you sign it, you will be authorizing Drexel University and its researchers to perform research studies on you. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with a family member, attorney or anyone else you would like before you sign it. Do not sign it unless you are comfortable participating in this study.

6. PURPOSE OF RESEARCH: You are being asked to participate in one face-to-face interview and a follow-up telephone call as part of this research study. The aim of this study is to gain a better understanding of the clinical experiences of couple and family therapists (CFTs) who were born and raised in another country and who are now working clinically in the US, taking into account both their strengths and struggles.

   This study is being conducted as a partial fulfillment to obtain a degree in Couple and Family Therapy.

   We are planning to include approximately 20 CFTs in this study, who were born and raised in another country, migrated to the United States after the age of 18, and are clinically active in the present. We are not including CFTs who were born in the US, who came to the US prior to age 18, or who are currently in training to become therapists.

   Your participation in this study is voluntary. You can withdraw your consent and discontinue participation in the study at any time.

   Your participation in this study may be ended by the principal investigator if she feels it is in your best interest.

7. PROCEDURES AND DURATION: You understand that the following things will be done as part of this research study.
• The procedure involves one face-to-face or telephone interview and a follow-up telephone call. The face-to-face interview will take place in a location and a time that you and the researchers will agree on and the duration will be approximately 2 hours.

• In the case of telephone interviews, the time will be agreed upon by the researchers and you. The topics to be addressed in the interview are attached to this document.

• Two weeks after this, a follow-up telephone call will be made to ask you for any comments that you would like to add to the content you have already provided.

• In addition, you will be given an e-mail address to which you can write additional comments for as long as the data collection period lasts. You will also be asked to complete a form to gather demographic information about you.

Only after you have signed this consent form will the completed demographic form be collected and the face-to-face interview conducted. If the interview is being conducted over the telephone, the interview will not take place until the signed consent form is faxed or mailed to the researchers.

Both, the face-to-face and the telephone interviews will be electronically recorded. The content of these recordings will be transcribed verbatim. All the identifiers that are mentioned in the interviews that could affect your confidentiality or the privacy of third parties will be removed and will not be recorded in the transcriptions.

Any information collected about you will be held confidential unless otherwise required by law. The recorded interviews will be stored as electronic files in a password protected computer that is accessible only to the researchers. Interview transcriptions, transcriptions of follow-up telephone calls, notes about the interview process, and any e-mail communications will be stored in a similar fashion.

8. **RISKS AND DISCOMFORTS/CONSTRAINTS:** The research is not expected to cause any harm or discomfort. While it is very unlikely, you may experience some discomfort discussing your thoughts during the interviews. In the event this occurs, you can stop the interview.

You can also refuse to address a specific topic or answer a specific question. You will also be provided with a list of names and telephone numbers to use in case of emergency. Additionally, you can withdraw from this study at any time.

9. **UNFORESEEN RISKS:** Participation in the study may involve unforeseen risks. If unforeseen risks occur, they will be reported to the Office of Regulatory Research Compliance.

10. **BENEFITS:** There may be no direct benefits to you from participating in this study. However, benefits that may occur from the interview and study are said to
include learning new things about yourself that may also be helpful to others, and having your story being heard and validated.

11. **ALTERNATIVE PROCEDURES**: The alternative is *not* to participate in this study.

12. **REASONS FOR REMOVAL FROM STUDY**: You may be required to stop the study before the end for any of the following reasons:
   
   a. If all or part of the study is discontinued for any reasons by the university authorities or government agencies.
   
   b. If you fail to adhere to requirements for participation established by the researcher.
   
   c. If the principal investigator feels it is in your best interest to end your participation in the study.

13. **VOLUNTARY PARTICIPATION**: Participation in this study is completely voluntary, and you can refuse to be in the study or stop at any time without the loss of care benefits to which you are entitled if you should suffer an injury. There will be no negative consequences if you decide not to participate or to stop.

14. **STIPEND/REIMBURSEMENT**: You will receive a $20.00 Target gift card at the end of the interview.

15. **RESPONSIBILITY OF COST**: There is no cost to you for participation in this study. All costs related to the study will be the responsibility of the researchers.

16. **IN CASE OF INJURY**: If you have any questions or believe you have been injured in any way by being in this research study, you should contact Dr. Maureen Davey at 215-762-1708. However, neither the investigators nor Drexel University will make payment for injury, illness, or other loss resulting from your being in this research project. If you are injured by this research activity, medical care including hospitalization is available, but may result in costs to you or your insurance company because the University does not agree to pay for such costs. If you are injured or have an adverse reaction, you should also contact the Office of Regulatory Research Compliance at 215-255-7857.

17. **CONFIDENTIALITY AND PRIVACY**: In any publication or presentation of research results, your identity will be kept confidential, but there is a possibility that records which identify you may be inspected by authorized individuals such as, the institutional review boards (IRBs), or employees conducting peer review activities. You consent to such inspections and to the copying of excerpts of your records, if required by any of these representatives.

18. **OTHER CONSIDERATIONS**: If you wish further information regarding your rights as a research subject or if you have problems with a research-related injury, for medical problems please contact the Institution’s Office of Research Compliance by telephoning 215-255-7857.
19. **CONSENT:**

- I have been informed of the reasons for this study.
- I have had the study explained to me.
- I have had all of my questions answered.
- I have carefully read this consent form, have initialed each page, and have received a signed copy.
- I give consent voluntarily

_____________________________
Subject or Legally Authorized Representative       Date

_____________________________
Investigator or Individual Obtaining this Consent       Date

List of Individuals Authorized to Obtain Consent

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<th>24 Hr Phone #</th>
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<tr>
<td>Maureen Davey</td>
<td>Assistant Professor</td>
<td>215-762-1708</td>
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<tr>
<td>Alba Nino</td>
<td>Doctoral Candidate</td>
<td>215-762-1708</td>
<td>301-219-2921</td>
</tr>
<tr>
<td>Karni Kissil</td>
<td>Doctoral Candidate</td>
<td>215-762-1708</td>
<td>215-762-1708</td>
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Appendix B: Recruitment Flier

If you were born and raised outside of the US and are now practicing as a couple and family therapist, then we would like to hear from you!

We are conducting a research study to develop a better understanding of what it has been like for you to clinically practice in the US

Couple and family therapists who moved to the US after the age of 18 and who are now clinically active are eligible to volunteer for this study.

Participation in this study involves one in-depth interview and a follow-up telephone call. You will also have the opportunity to describe your experiences throughout the study via e-mail. All information that you share will be kept confidential. You will receive a $20 Target gift card upon completing this study.

For more information please contact Alba Niño at (301) 219-2921 or aln38@drexel.edu or Dr. Maureen Davey at (215) 762-1708 Couple and Family Therapy Department - Drexel University

This research is being conducted by a researcher who is a faculty member at Drexel University and her doctoral student. This study is being conducted for a doctoral dissertation.
Appendix C: Demographic Survey

DEMOGRAPHIC SURVEY

General information

1. Age ________________________________
2. Gender ________________________________
3. Sexual orientation ________________________________
4. Race ________________________________
5. Ethnicity ________________________________
6. Marital status ________________________________
7. Religious affiliation ________________________________
8. Yearly household income (please circle a response)
   a. Less than $40,000
   b. $40,000 - $79,999
   c. $80,000 - $119,999
   d. $120,000 - $159,999
   e. $160,000 - $199,999
   f. $200,000 or more

Information about immigration

9. In what country were you born? ________________________________
10. How old were you when you moved to the United States? _____________________
11. How long have you lived in the United States? ________________________________
12. What was your main reason for moving to the US? ________________________________

________________________________________
Information about clinical work

13. What type of training did you receive to become a couple and family therapist (CFT)?
   In what country did you receive this training?
   
a. Undergraduate degree__________________ Country__________________

   b. Graduate degree____________________ Country__________________

   c. Other _____________________________ Country__________________

   d. Other _____________________________ Country__________________

14. How many years of experience do you have as a CFT?
   ________________________________

15. How many hours of clinical work do you do each week?
   ________________________________

16. In what language(s) do you currently conduct your clinical work? ________________
    ________________________________
    ________________________________

17. What is your current place of employment? ________________________________

18. Are you licensed as a CFT? If so, in what State? ________________________________
Appendix D: Interview Guide

INTERVIEW GUIDE

Introduction

I am going to ask you a series of open-ended questions about your clinical experiences as a therapist who was born and raised in another country and who is currently seeing clients in the US. By clinical experiences, I refer to the work that you do with your clients, including your relationship with your clients, the models that you use, the ways you conceptualize and intervene in your cases, the languages that you use in therapy, and the context of your therapeutic work.

If during the interview there is any question that you do not want to answer, please let me know, and you are free to not answer the question. You can also stop the interview at any point if you do not wish to continue.

For confidentiality purposes, you have the option to pick a pseudonym for me to use throughout this interview. If you decide not to use a pseudonym, I will not refer to you by name during our talk and later will remove your name from all the transcriptions and other documents.

Do you have any questions for me before we start?

Information about clinical practice

1. Describe for me the type of clinical work that you currently do in the US

The following prompts might be used if the interviewee does not address these topics in his/her answer:

a. What types of clinical issues do you typically address?
b. What types of clients do you usually see?
c. What therapeutic models do you usually use?
d. In what types of settings do you currently practice?
e. How diverse (culturally/racially/age groups) is the setting where you work?
f. What types of therapeutic modalities do you currently practice (group therapy, family therapy, in-home therapy, etc)?
General experience

2. When thinking about your clinical experience as a CFT who was born and raised in another country and who is now working clinically in the US, what would you say are the most important aspects of that experience?

3. Tell me about a memorable clinical experience that you had as foreign born and raised person who is now working as a CFT in the US.

4. Do you feel that being born and raised in a country different from the US influences your practice and approach to clients? If so, how?

Relationship with clients

5. Now let’s talk about the therapeutic relationship. How does being born and raised in a foreign country affect that in your opinion?

If during the discussion, the following issues are not addressed, these prompts will be used:

a. Are there any aspects of being born and raised in a country different from the US that help in connecting with your clients?
b. Are there any aspects of being born and raised in a country different from the US that hinder your connection with your clients?
c. Do you notice any difference in relation to working with different types of clients (especially in terms of country of origin and nationality)? If so, what differences do you notice?

Language

6. What language(s) do you use at work? Do you do therapy in a language different from your mother tongue? How is it for you to do therapy in those languages?

Context of therapeutic work

7. Now, let’s talk about your work environment including colleagues and supporting staff, do you feel that being from another country affects your relationships at work? How?
8. In your opinion, does the relation between the US and your country or region of origin have any effect on your clinical experiences?

9. In your experience, how have your characteristics affected your clinical work as a therapist coming from another country?

If during the discussion, the following issues are not addressed, these prompts will be used:

   a. What about your gender?
   b. What about your race and ethnicity?
   c. What about your socio-economic status?
   d. What about your age?
   e. What about your religion?
   f. What about your sexual orientation?
   g. What about your marital status?

**Interview closing**

10. Was there anything that you wanted to mention about your experience and that I did not ask?

11. How often do you find yourself thinking about or discussing the topics that we addressed here today?

12. What name would you give to CFTs that, like you, were born and raised in another country and are currently practicing in the US?