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The Experiences of Recently Graduated  
Marriage and Family Therapists Working with  
Immigrants and Refugees

by  
Cristina Plaza Ruiz

A dissertation submitted to the faculty of Bethel University  
in partial fulfillment of the requirements for the degree of  
Doctor of Education.

St. Paul, MN  
2019

Approved by:

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## Abstract

The purpose of this phenomenological study was to explore the experiences of recently graduated mental health professionals from Marriage and Family Therapy (MFT) programs in the United States who work with immigrant and refugee populations. The study intended to examine the experience of Marriage and Family Therapists (MFTs) working with immigrants and refugees to gain a deeper understanding of the therapists' experience of working with these clients and their perceptions of their training. The body of literature on diversity training for mental health providers reveals a gap in the peer-reviewed literature regarding the understanding of how MFTs perceive their graduate school education prepared them to effectively work with immigrant and refugee populations (Adams, 2010; Shannon, Vinson, Cook, & Lennon, 2016; Villalba, 2009), and to improve cultural awareness in mental health professionals (American Psychological Association, 2008; Dadras & Danesphour, 2018; DuPree, Bhakta, Patel, & DuPree, 2013; Nixon et al., 2010; Seponski, Bermudez, & Lewis, 2013). The results of this study demonstrated that a need remains to reexamine current practices in the field of MFT to train future MFTs to work with diverse populations. This study underscores the idea that to work across cultures, and with immigrants and refugees, MFTs must be trained in settings that foster deep, difficult conversations about culture and inequalities in therapy with well-trained professors. This study highlights serving the mental health needs of refugees and immigrants is best supported by a family systems lens, and requires specific training, as well as a posture of flexibility, curiosity, self-awareness, humility, and adaptability to work with a population that is not a monolithic group but a vibrant, diverse, and complex group with needs and strengths that go beyond immigration trauma.

*Key terms: Marriage and family therapists, training, immigrants, refugees, phenomenology*

## Dedication

This dissertation is dedicated to the millions of immigrants and refugees all over the world who seek refuge in new and unfamiliar settings while holding on to memories of their homes left behind. May you be welcomed with open hearts and minds, and find sanctuary and rest in your journeys.

I also dedicate this work to marriage and family therapists working with immigrants and refugees who wholeheartedly pour their lives into the intimate and transformative practice of psychotherapy. May you keep alive your calling and mission, may your connections be meaningful, and may your work bring healing and justice.

“for such a time as this.” (Esther 4:14)

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Second, I would like to thank my parents, who taught my sister and I to love the world without ever traveling much, but by showing radical hospitality at our dinner table where there was always room for others, no matter what part of the world they came from. They taught me to love and enjoy simple meals seasoned with intense conversations that were the beginning of my love for learning.

I would like to recognize my friends, colleagues, and extended family that have supported me during this long and enduring process.

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## List of Abbreviations

AAMFT	American Association of Marriage and Family Therapy
APA	American Psychological Association
COAMFTE	Commission on Accreditation of Marriage and Family Therapy Education
ESCSR	Eco-Systemic Critical Self-Reflection
IOM	International Office for Migration
IPA	Interpretive Phenomenological Analysis
LAMFT	Licensed Associate Marriage and Family Therapist
LICSW	Licensed Independent Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LP	Licensed Psychologist
LPCC	Licensed Professional Clinical Counselor
MFT	Marriage and Family Therapy
MFTs	Marriage and Family Therapists
POT	Person of the Therapist
UNHCR	The United Nations High Commission for Refugees

## **Chapter 1: Introduction**

### **Introduction to the Problem**

In the field of Marriage and Family Therapy (MFT) there exists an interest in studying how to improve the education of future Marriage and Family Therapists (MFTs) to better serve the needs of diverse populations (McGoldrick, Giordano, & Garcia-Preto, 2005; Dadras & Daneshpour, 2018, Papadopoulos, 2001, 2018; Seponski, Bermudez, & Lewis, 2013). This interest has been coupled with an increase in the number of studies to understand the experience of MFTs who serve diverse populations (Elias-Juarez & Knudson-Martin, 2017; Seedall, Holtrop, & Parra-Cardona, 2014). However, among the issues that remained understudied are the experiences of MFTs who work with immigrants and refugees.

The body of literature on diversity training for mental health providers reveals a gap in peer-reviewed literature regarding how MFTs perceive their graduate school education prepared them to effectively work with immigrant and refugee populations (Adams, 2010; Seedall et al., 2014). Literature demonstrates a need to improve cultural awareness in mental health professional preparation due to population diversification demands (American Psychological Association, 2008; DuPree, Bhakta, Patel & DuPree, 2013; McDowell, Fang, Gomez Young, Khanna, Sherman, & Brownlee (2003); Seponski, Bermudez & Lewis, 2013). Today's higher education institutions have a responsibility to clients of their future graduates and to respond to the needs of our globalized societies by producing research and training professionals who are well equipped to face those needs (Christensen & Eyring, 2011).

This study explored the apparent gap in the understanding of the perception that recently graduated MFTs, who work with immigrants and refugees in the United States, have in their experience of preparation during graduate school. The American Association for Marriage and

Family Therapy (AAMFT, 2004) has mandated that therapists learn how to “deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client)” (p. 4). Nonetheless, little attention has been given to explore how general diversity training supports the work of MFTs who work with immigrants and refugees.

### **Background of the Study**

Serving the needs of diverse populations, through best practices, has been an area of interest in the field of all mental health professional training programs for a long time (Patterson, Edwards, & Vakili, 2017). The field of MFT, as a part of the broader mental health provider community, has made advances in the application of cultural sensitivity training to prepare therapists to work with diverse populations (Seponski et al., 2013). Despite this intentionality and progress with culturally responsive training overall, exploring how training accurately prepares MFTs to serve the mental health needs of immigrants and refugees remains mostly underdeveloped and only marginally addressed in mental health professions (Akyil, 2011; Patterson et al., 2017).

Data from 2015 states that there are 244 million migrants in the world (Schachner, Juang, Moffitt, & van de Vijver, 2018) and that the United States is ranked in second place as a country of reception of immigrants and refugees (Marks, McKenna, & Garcia Coll, 2018). The population of the U.S. is amid a historic shift regarding the racial and ethnic background of residents; by 2060, minorities are expected to become most of the resident population at 50.4% (Annapolis Coalition, 2007). This population shift is due to the number of children born in the



U.S., as well as a higher number of immigrants and refugees whose migration leads them to the U.S.

The current global refugee crisis is the largest since the Second World War, 65 million people have been forced to leave their countries of origin, this number includes 21.3 million refugees who have settled in different parts of the world (Gangamma & Shipman, 2018; UNHCR, 2015). The U.S. accepted 66,500 refugee applications in 2015 (UNHCR, 2015). Refugee resettlement programs have been scaled back at an unprecedented rate due to changes in federal policies in 2016 (Utržan & Northwood, 2017). However, given the large number of immigrants and refugees already resettled in the U.S., an increased likelihood exists that mental health professionals will encounter immigrant and refugee clients who present to therapy with trauma related to displacement and effects of a hostile socio-political climate in their host and home countries (Utržan & Northwood, 2017).

The American Psychological Association (APA) (2008) highlighted the small number of racial and ethnic minority mental/behavioral health professionals who are qualified to treat the needs of immigrants and refugees. The U.S. Census Bureau (2009) estimated that 14% of civilian workers, who are employed in the health care, were born outside of the U.S. Of that group, Latinos, for example, comprise only 5.0% of psychologists and only 8.38% of students in MFT programs (American Association for Marriage and Family Therapy, 2015). Furthermore, the demographics of providers and clients reveal disproportionate ratios in the ethnic backgrounds of these two populations. According to the Annapolis Coalition report (2007), about 90% of mental and behavioral health professionals are non-Hispanic white, yet they serve a population of more than 30% ethnic minorities.

Language and ethnic discrepancy between provider and patient has been documented to pose a barrier to access to mental health care and to predict worse outcomes for patients; however, language and race congruency between provider and patient alone does not guarantee better outcomes either if the provider is not culturally sensitive (Edwards, 2015; Franks, 2007; George, 2015; Gramaglia, 2016; Pham, 2011; Sargent, 2009; Verissimo & Grella, 2017; Villalba, 2009; Wood, 2012).

These demographic changes highlight the need to increase attention to mental health care that is culturally sensitive for diverse immigrant and refugee groups and to the training received by the mental health providers who serve them (Chaze, Thomson, George & Guruge, 2015). Two studies (Chan, Yeh, & Krumboltz, 2015; Owen et al., 2016) included hypotheses that a lack of sufficient cultural appropriate training for therapists in graduate school may affect the delivery of mental health services to immigrants and refugees. Considering the changing population needs, all mental health providers must be trained to provide culturally responsive mental health care to their patients (Gantt & Adams, 2010).

### **Statement of the Problem**

The problem addressed by this study is multi-faceted, yet related in its disparate parts. A review of the literature revealed the need to increase attention to culturally sensitive training for mental health practitioners (Aponte & Méndez, 2014; Arredondo & Rosen, 2007; Falicov, 1995; Gantt & Adams, 2010; Gutierrez & Natrajan-Tyagi, 2018; Inman, Meza, Brown & Hargrove, 2004; Kuo & Arcuri, 2014), address barriers to access mental health care services by immigrants and refugee populations (APA, 2008; Saraceno et al., 2007; Shannon, Wieling, Simmelink-McCleary, & Becher, 2015), and stop ineffective approaches in therapy settings (James & MacKinnon, 2012; Koch, 2014; Saraceno et al., 2007; Seponski, Bermudez & Lewis, 2013).

The healthcare disparities between persons of color and White individuals have been well documented (CDC, 2005, as cited in Tucker, Daly, & Herman, 2010; Cook et al., 2018; Good, James, Good, & Becker, 2005; U.S. DHHS, 2001; Verissimo & Grella, 2017). These problems may be compounded by additional struggles for immigrants and refugees (Anagnostopoulos, Triantafyllou, Xylouris, Bakatsellos, & Giannakopoulos, 2016; Ballard, Wieling, & Solheim, 2016; Chen, 2015; Chi-Yung, Bemak, Ortiz, & Sandoval-Perez, 2008; Edward & Hines-Martin, 2015; George et al., 2015; Ponce, Hays, & Cunningham, 2006; Short et al., 2010). The rapidly burgeoning immigrant and refugee population (American Community Survey Reports, 2010) may encounter inferior treatment in mental health settings due to language barriers, limited understanding of culturally bound symptoms (Nicolas et al., 2007), or a general lack of cultural understanding (Betancourt, 2003).

Additional barriers to access mental health care emerge as immigrants and refugees navigate unfamiliar systems and institutions (Codrington, Iqbal & Segal, 2011). Written and verbal communication is often hindered by language differences, safe and reliable transportation can be challenging to find, and unfamiliar therapy approaches and interventions may create confusion. These are examples of circumstances that can make pursuing mental health care an overwhelming prospect for immigrants and refugees (Saraceno et al., 2007).

Researchers have demonstrated that immigrants and refugees who access mental health care enter a therapeutic relationship with providers who receive minimal training to meet the specific needs of these populations (Augsberger, Yeung, Dougher, & Hahm, 2015; Chen, 2015; Edward & Hines-Martin, 2015). While health care professionals are trained to identify and address trauma in clients, there are issues specifically related to the trauma of immigrants and refugees that are not included in the generalized training. Some of the models of treatment used

today come from work with populations not exposed to the stressors related to displacement, and little is known regarding the adequacy to capture the full range of contextual factors impacting their lives (Gangamma & Shipman, 2018).

Although it is impossible to train mental health providers to anticipate all mental health needs, it is also important to recognize that the interconnectedness of the world today makes it imperative that all mental health providers increase their awareness and understanding of migration causes and patterns and become aware of unfamiliar cultures so they can effectively address the mental health needs of a wider range of patients (Chan, Yeh & Krumboltz, 2015). Ensuring benefits to the health and stability of immigrants and refugees result when therapists can address the trauma of migration and the impacts of dislocation (Derr, 2015). This more substantial impact supports the need to prioritize the training of future therapists to work with immigrant and refugee populations (Edward & Hines-Martin, 2015; Derr, 2015).

Higher education is in a position of mediation that can affect how knowledge is shared and accessed (Christensen & Eyring, 2011). The inequalities that exist in the mental health world can be more effectively addressed by strengthening specific programs within higher education. Graduate programs have a fiduciary responsibility to utilize their strengths and apply the best methods in the education of therapists (Ross et al., 2012). Exploring what is useful and what is not in the preparation of future mental health providers will not only serve students and clients but will also add credibility to educational institutions and contribute to the body of research supporting best practices for training qualified professionals to serve immigrants and refugees.

Current research on training MFTs does not include data related to the lived experiences of recently graduated MFTs who work with these populations, reflecting the gap in the clinical supervision research described by Kith (2015). Instead, researchers consistently review

immigrant and refugee trauma symptoms and use of mental health treatment (Björn, Gustafsson, Sydsjö, & Berterö, 2013; Clarke & Borders, 2014; Papadopoulos, 2001). Supplementing the research into the therapeutic experiences of immigrants and refugees with research into the experiences of individuals providing the therapy will potentially enhance the understating of the experiences of MFTs who work with said populations.

### **Purpose of the Study**

The purpose of this study was to explore the experiences of recently graduated mental health professionals from MFT programs in the U.S. who work with diverse immigrant and refugee populations. The intent of the study was to examine the experience of MFTs working with immigrants and refugees to gain a deeper understanding of the MFTs' experience and their perceptions of their training.

### **Rationale**

As the population of the U.S. diversifies and the mental health needs of immigrants and refugees increase, so does the need to improve training for MTFs who work with immigrants and refugees (Zong, Batalova, & Hallock, 2018). This study focused on understanding MFTs' experiences and perceived preparedness to work with immigrants and refugees. The results of this study revealed the strengths and weaknesses in current approaches to training and could potentially aid in the identification of best practices for training future MFTs in higher education institutions.

Migration can be an extremely stressful experience that can include separation from family and friends, economic hardships, learning a new language and different cultural systems (Bogart, 2013; Chen, 2015; George et al., 2015). Researchers in mental health studies revealed the reality of distress among migrant populations (Anagnostopoulos et al., 2015; Bhugra &

Becker, 2005; Cavazos-Rehg, Zayas, & Spitznagel, 2007; Hebebrand et al., 2016; Pumariega, Rothe, & Pumariega, 2005). Immigrants and refugees experience “uprooting” or “cultural mourning” through the migration process, which contributes to a higher prevalence of mental health problems among immigrants and refugees than their native counterparts (Ainslie, 2001; Hebebrand et al., 2016; Kartal & Kiropoulos, 2016; Ríos, 2008)

Immigrants and refugees experience documented disparities in the delivery of mental health services (George et al., 2015). Mental health professionals often do not adequately address the unique mental health needs of immigrants and refugees due to the shortage of trained providers and other barriers mentioned earlier (Augsberger, Yeung, Dougher, & Hahm, 2015; Robiner, 2006; Shannon, Vinson, Cook, & Lemon, 2016; Villalba, 2009).

The historical trend in migration across borders, oceans, and continents presents an opportunity for mental health professionals to embrace adaptation and innovation of established practices to make them more suitable for meeting the needs of today’s population. In the U.S., immigration continues to be a significant source of population growth. Despite the recent decrease in refugees allowed to settle in the U.S. under the President Trump administration (U.S. Department of State, 2018), refugee populations have also contributed to population growth for decades. In 2010, according to the U.S. Census Bureau (2012), out of the 304,280,000 individuals living in the U.S., 37,606,000 were foreign-born (defined by the U.S. Census Bureau as those who were not U.S. citizens at birth). This number represents approximately 12.35% of the total U.S. population.

### **Research Question**

This phenomenological study investigated the following research question: What is the experience of recently graduated MFTs who work with immigrants and refugees?

Several derivative sub questions explored include:

- What is the recent graduate's experience as a recently graduated MFT who works with immigrants and refugees?
- What is the recent graduate's perception of their MFT graduate education (academic course work, practicum placement, and experience) in preparing them to work with immigrant and refugee populations?
- What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees?
- What role does the therapist's own self-awareness and commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?

### **Significance of the Study**

The needs of immigrants and refugees as they settle in their receiving country are numerous and varied. The mental health profession, of which MFT is a part, has developed many initiatives to stay up to date with the changes and demands of a shifting population. Obtaining the perspective of recently graduated MFTs on this topic may add insight into effective training models for future therapists who aspire to offer efficacious mental health treatment to immigrant and refugee families.

Patterson, Edwards, and Vakili (2017) estimated that by the year 2025, there would be shortages of psychiatrists, clinical counselors, school psychologists, mental health and substance abuse counselors, social workers, school counselors, and MFTs in the United States. A shortage of mental health providers is a domestic and global issue (Saxena, Sharan, Garrido & Saraceno, 2006). Nearly half of the world's population lives in a country where less than one psychiatrist is

available per 100,000 people, and in low resource countries, this is only one mental health worker for 100,000 people, whereas one per 2,000 exists in high-income countries (World Health Organization, 2014). A report by the World Health Organization (2014) stated that, in low- and lower-middle-income countries, less than one in four individuals can access mental health professionals.

In the U.S., existing data indicates current and projected shortages of mental health professionals across the nation—although the exact shortage is difficult to determine due to a dearth of research on the topic (Nayar et al., 2017). Regional variations illustrate how people in different states experience access; the upper Midwest and Northeast regions of the U.S. have the highest percentage of mental health professionals per capita while the South and Mid-Atlantic regions have the lowest percentage of mental health providers per capita (Mental Health America, 2018). Higher education institutions are not training enough mental health providers to respond to the changing and diversifying demographics of the U.S. (APA, 2008).

Training provided by higher education institutions is essential to effective cross-cultural therapy. Some of this training needs to address the development of cultural awareness among therapists, considering most mental health providers are of a different cultural, linguistic, and ethnic background than the clients they serve (Aponte et al., 2009; Tervalon & Murray-Garcia, 1998). The work of cultural awareness is part of the ongoing inner development of therapists and is an essential aspect of training and supervisory feedback (Dadras & Daneshpour, 2018).

Despite the challenges in offering effective training, institutions of higher education are charged with delivering culturally responsive, concurrent mental health training in dignified settings to best prepare mental health professionals who will work with immigrants and refugees



(Akyil, 2011; Patterson et al., 2017). An important aspect of this training will be to increase the cultural awareness of all mental and behavioral health professionals (APA, 2008).

The solution to this scarcity and disparity in the mental health field lies in human resources, trained professionals specifically (Robiner, 2006). A report by the World Health Organization in Mental Health (2017) stated that human resources are essential as no equipment can replace person-to-person mental health treatment and the power of human connection. Nayar et al. (2017) suggested that the delivery of mental health care will only be as good as the providers who staff it, which is why training and educating a mental health workforce that is ethnically, culturally, and linguistically responsive is essential.

The universities that train future therapists have a responsibility to utilize their strengths to respond to these specific areas of attention. Data collected and analyzed through this qualitative study highlighted strengths and revealed some areas of improvement for graduate programs that train mental health professionals, specifically MFTs, leading to opportunities for program enhancement and eventual positive impact on clients.

### **Definition of Terms**

In this section, the traditional definitions of the terms refugee and migrants will be presented as well as a rationale for using the term “immigrant/refugee” from this point onwards in this study. Also, a definition of marriage and family therapists and its use in this dissertation will be offered as well as a brief exploration of the terms “client” versus “patient,” in mental health care. Additionally, clarification of terminology regarding culture is briefly explained.

**Immigrants.** “Immigrant” is the term used to describe an individual who moves to another country for settlement (International Organization for Migration, 2018). 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 U.S., staying long enough to carry out everyday life activities (Grinberg & Grinberg, 1984, as cited in Isaacson, 2001).

Immigrants move for a variety of reasons, representing myriad push and pull factors (Abbott, 2016; Anagnostopoulos et al., 2016; Anthias, 2012; Fortuna, & Pérez, 2005). While some immigrants resettle for aspirational reasons, such as educational or economic opportunities, this study focused on immigrants who leave their countries of origin because of extreme hardship, or involuntarily.

The legal status of one's immigration is a significant factor in shaping the experience of immigrants in the country in which they settle (Porche, 2014). According to the United Nations Educational, Scientific, and Cultural Organization (United Nations, 2012), an undocumented immigrant is an individual who enters a country without the necessary documents that legally allows them to stay. While this study will include documented and undocumented immigrants, it is necessary to note the increased stress faced by immigrants without legal status. Undocumented immigrants do not have open and transparent access to the social infrastructure available to immigrants with legal status, creating or exacerbating problems and stresses to daily life (Arbona et al., 2010; Gasson, 2018; Pérez & Fortuna, 2005; Porche, 2014).

Mental health challenges faced by immigrants often relate to the impact of their uprooting experience and the cultural mourning that occurs throughout the settlement process. In this way, there are similarities between immigrants and the mental health needs of refugees.

**Refugees.** The United Nations High Commission for Refugees (UNHCR, 2015) has offered the following definition:

A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for

reasons of race, religion, nationality, political opinion, or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War, and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries (para. 1).

The UNHCR's definition of the word "refugee" states that similarly to immigrants, refugees experience migration, yet their movement across borders is for different reasons that are internationally recognized as particularly distressing (International Organization for Migration, 2018). Refugees flee their countries of origin because of war, genocide, feared persecution, natural disasters, or pervasive lack of access to basic needs like food and water (International Organization for Migration, 2018).

Refugee status is granted by the receiving country, and, in the U.S., refugees must complete a comprehensive application process before access is granted (U.S. Citizenship and Immigration Services, 2014). Once approved and admitted, refugees have legal status and, therefore, transparent access to the social infrastructure that exists to assist with employment, housing, education, and medical care (U.S. Citizenship and Immigration Services, 2014).

**Immigrant/refugee.** Researchers have made a clear distinction between forced and voluntary migratory movements. This distinction has given form to refugee, migrant, and asylum definitions, among others, which in turn have shaped laws as well as affected the usage of these terms in research (Lorenzen, 2017). However, a growing body of literature includes the proposal that the distinction between the terms "immigrant" and "refugee" and those of forced or voluntary migration is not as clear as it may appear at first glance, and that the motives for migration are indeed mixed (Lorenzen, 2017; Van Hear, Brubaker, & Bessa, 2009).

The definitions and distinctions between terms “immigrant” and “refugee” are set by governing bodies that regulate and support the work in this field, and it is beyond the scope of this dissertation to argue about such terms. However, the usage of the terms immigrant and refugee necessitates emphasizing that increased attention is given to the gray areas in the realities of those who are forced to migrate in contrast with those who do not have a given “refugee status” (Nallu, 2016). This attention in the current literature emphasizes the common experiences of immigrants and refugees while, at the same time, noting the differences. Long (2013) stated that, often, refugee advocates insisted that “refugee” and “migrant” were separate categories even though evidence stemming from field-work showed that these labels were blurred in practice.

A process of displacement describes both immigrants and refugees, along with asylum seekers and migrants of all forms. Displaced persons from all categories have overlapping symptoms and interventions related to their mental health. Mental health providers who work with displaced persons and families do not differentiate when treating these populations since the common experience of leaving their place of origin due to extenuating circumstances provides a strong-shared experience from which to draw from in a therapeutic setting. The research focus of this study is on MFTs who work with immigrants and refugees, with and without legal documentation. Unless a distinction is warranted, for the remainder of this dissertation, the term “immigrant/refugee” will be used to describe the population at the center of this research.

**Marriage and family therapists (MFTs).** Another term that warrants an early clarification is that of MFTs: “Marriage and Family Therapists (MFTs) are mental health professionals trained in psychotherapy and family systems, and licensed to diagnose and treat

mental and emotional disorders within the context of marriage, couples, and family systems” (AAMFT, 2018, para. 5).

Different states use different terms to refer to MFTs and their level of licensure. The laws for licensure or certification for MFTs offer a way for the public to be able to identify qualified practitioners of marriage and family therapy. MFTs who have obtained an MFT license or certificate have met high educational and clinical experience criteria. All states require a master's or doctoral degree and supervised clinical experience. The terms used to refer to MFTs, regardless of their licensure status, are "Marriage and Family Therapist" or "Marital and Family Therapist" (MFT Licensing Boards, 2018). For the purposes of this research, the term MFT was used to refer to all MFTs that meet the inclusion criteria for the study, regardless of licensure status.

The American Association of Marriage and Family Therapy (AAMFT) states: “Marriage and family therapy is a distinct professional discipline with graduate and postgraduate programs. Three options are available for those interested in becoming MFTs: master's degree (2-3 years), doctoral program (3-5 years), or postgraduate clinical training programs (3-4 years)” (AAMFT, 2018, para. 15). After graduation of an MFT program, there is further need for training, 3-4 years, but it can be longer depending on the state and personal circumstances. Based on the estimation of this timeframe of subsequent postgraduation training, for the purpose of this study, nine years since graduation is the years used to determine the term “recently graduated MFT.” Hence, for this study, recently graduated MFTs are persons who completed their MFT degree since 2010.

The rationale behind this more expansive timeframe was a desire to explore the experiences of the MFTs’ work without too much influence of the normative feelings of

inadequacy experienced by many novice therapists early on and up to five years after graduation (Frediani & Rober, 2016). By opening the window since graduation beyond five years, I intended to explore the MFTs' experience considering the MFT's graduation but free from exclusively considering the initial feelings of inadequacy normal to many novice therapists, but not excluding those either (Frediani & Rober, 2016).

**Patient/client.** As Joseph (2013) opined, in psychotherapy, there is a preference for the use of the word client over the term patient, perhaps, he states, "some of it stemming from Carl Rogers' influential book, *Client-Centered Therapy* (1951)" (para 3). For this study, the words patient and client will be used interchangeably to refer to immigrant/refugee persons who seek out psychotherapy treatment or any other individuals or families seeking mental health treatment. In Chapter 4, the word used by the participants will not be changed—whether client or patient.

In this dissertation, I proposed the use of the term "cultural humility" over "cultural competence" in chapter three (Tervalon & Murray-Garcia, 1998). The literature on the topic of mental health needs of immigrants/refugees used a variety of terms when referring to working across cultures or the training of clinicians in general and MFTs specifically. Some authors utilized the term "cultural competence," others "cultural responsiveness," others "cultural awareness," or "intercultural responsiveness," among others. In this dissertation, when making a reference to a specific source, the term utilized by the authors was not changed.

### **Organization of the Remainder of the Study**

Chapter 2 of this study provides a review of the literature concerning the following areas: mental health needs of immigrants/refugees, the current approach of mental health professionals as a whole and MFTs, and the specific training provided to MFTs to serve the needs of immigrants/refugees. Chapter 3 provides the methodology and theoretical framework that guided

this study, including a thorough discussion of the research design and data analysis along with an outline of the research instruments that were used throughout the interview process. This chapter also identifies the selected sample, setting, and limitations associated with this study. An examination of the data analysis results is presented in Chapter 4. Chapter 4 includes a discussion of the sample as well as a narrative analysis and images representing the qualitative data. Lastly, Chapter 5 focuses on the general conclusions and implications of the study as well as recommendations for future research.

## Chapter 2: Review of Literature

### Introduction

More research is needed regarding the most pressing issues clinicians encounter when serving immigrants/refugees (Seedall et al., 2014). Although the MFT field's attention to multicultural issues is laudable (Falicov, 1995; Gantt & Adams, 2010; Inman, Meza, Brown, & Hargrove, 2004), there appears to be little research about the experiences of recently graduated MFTs who work with immigrants/refugees. Literature reveals a gap remains between MFT training programs and the demands of an increasingly diverse client base (Aponte et al., 2009; Aponte & Méndez, 2014; Artavia-Turckel, 2017; Chenail, 2009; Gutierrez & Natrajan-Tyagi, 2018).

The American Association of MFT has included an emphasis on recognizing “contextual and systemic dynamics” (AAMFT, 2004, para 1.2) and ensuring that future therapists are trained to be able to provide care that accounts for the needs of clients. This approach is a necessary response to the increase of immigration in the world and the United States (United Nations High Commissioner for Refugees, 2015).

Among the most significant challenges in the world today, are massive human migration and the needs of immigrants/refugees (Anagnostopoulos et al., 2016; IOM, 2016; Kartal & Kiropoulos, 2016; Nosè et al., 2017). Research in mental health literature reveals the reality of distress among immigrant/refugee populations and suggests that immigrants/refugees have more serious mental health problems than their native counterparts, possibly due to the uprooting process (Bhurgra & Becker, 2005; Cavazos-Rehg et al., 2007; Kartal & Kiropoulos, 2016; Pumariega et al., 2005).



MFTs have an opportunity to join the efforts of other professions working to solve the global refugee crisis by helping families heal from the effects of displacement trauma (Patterson, Abu-Hassan, Vakili, & King, 2018). With the increased exposure and opportunity for serving displaced persons, training programs must prepare future MFTs to appropriately serve the mental health needs of this and other diverse populations (Kohrt, Marienfeld, Panter-Brick, Tsai, & Wainberg, 2016; Regas et al., 2017).

In multiple studies, mental health providers have self-reported that they are lacking the necessary tools and training to effectively work with immigrant/refugee populations (Shannon et al., 2016; Singer & Tummala-Narra, 2013; Villalba, 2009). To be able to address these challenges mentioned above, more data needs to be collected about how MFTs feel their graduate school training has prepared them to work with immigrant/refugee populations. This phenomenological study examined the lived experiences of recent graduates of MFT programs in the United States. MFTs were the target population for this research even though they were not the only mental health professionals providing these specialized services.

### **Mental Health Needs of Immigrants/Refugees**

To understand the experiences of recently graduated MFTs who work with immigrants/refugees, it is essential first to identify the mental health needs of immigrants/refugees (which is the focus of this section). Literature includes the idea that pre-migration, in-journey, and post-migration trauma and stressors put immigrants/refugees at risk for depression, anxiety, and post-traumatic stress disorders as well as other mental illnesses (Franco, 2018). This section begins with a summary of migration-related trauma and then focuses on additional stressors common to the resettlement process.

**Migration journey.** Immigrants/refugees face countless challenges that begin in their countries of origin, continue throughout the migration journey, and follow them into the process of resettlement in the receiving country (Patterson, Edwards, & Vakili, 2017; Pérez & Fortuna, 2005; Ríos, 2008). Overcoming physical and psychosocial trauma and loss, navigating disruptive transitions and further losses during migration, and acclimating to a new culture are among the most universal stressors to migrants regardless of their reason for leaving or their legal status (Collins & Saxena, 2016; Connor & Krogstad, 2016; Mock, 1998 as cited in Walsh, 2007).

Challenges emerge depending on the specific context of the migration; persecution forces many individuals and families to leave in search of asylum while others are displaced by war or environmental disasters (Derr, 2015; Nosè et al., 2017; Patterson et al., 2017; Ríos, 2008; Shannon et al., 2015). Hunger, abuse, incarceration, and barbaric treatment are common experiences for immigrants/refugees—adding to the witness of atrocities and multiple traumatic losses of loved ones, homes, and communities (Papadopoulos, 2001, 2018; Mollica et al., 2004; Walsh, 2007).

The refugee crisis that affected the world in 2018 has been extensively discussed in the news. Twenty-one million (among the 65 million people who were forced out of their homes in 2015) were refugees from the Middle East, Africa, and Asia—representing one of every 100 people in our worldwide population (Patterson et al., 2018). In Europe, the largest movement of people since the Second World War is being experienced right now; in 2017 alone, more than 1.2 million people requested asylum in a European country (Jefee-Bahloul, Bajbouj, Alabdullah, Hassan, & Barkil-Oteo, 2016). In contrast to the demographics of previous world refugee crises, the United Nations High Commissioner on Refugees estimated that over half of the current

refugee population is comprised of children and adolescents, some of whom are unaccompanied by adults (Patterson et al., 2018).

Refugees may experience a variety of mental health symptoms that stem from different situations, some being the result of not being able to safely remain in their country and having to escape war (United Nations High Commissioner for Refugees, 2015; Patterson et al., 2018). While enduring conflict in their country, immigrants/refugees can be exposed to war, poverty, traumatic loss, food scarcity, and housing insecurity, leading to long periods of struggles and family separation (Anagnostopoulos et al., 2016; Codrington, Iqbal, & Segal, 2011; Hebebrand et al., 2016; Patterson et al., 2018). Many immigrants/refugees face insurmountable challenges in their pursuit of safety (Hebebrand et al., 2016; Patterson et al., 2018).

The stress resulting from migration can add on to the existing mental health symptoms created by the traumas that an immigrant/refugee experiences prior to fleeing his or her home country (Patterson et al., 2018; Shannon et al., 2015; Slobodin & de Jong, 2015). Addictions and relational violence can also emerge because of the stress brought about by migration (Franco, 2018; Patterson et al., 2018; Walsh, 2007; Wieling, 2018). These issues can exacerbate preexisting conditions and create a compounding set of mental health issues for an individual and family (Walsh, 2007). Most of the adverse mental health consequences immigrants/refugees experience are because of extreme stress endured by people who perhaps have no prior history of mental health disorders. Refugees can acquire serious illnesses that create dysfunction in families such as posttraumatic stress disorder (PTSD), major depression, prolonged grief, and psychotic disorders (Slobodin & de Jong, 2015; World Health Organization, 2015).

**Resettlement.** In this subsection, resettlement challenges and its effects on immigrant/refugee individuals and families, including the ambiguity of losses because of

migration, will be explored. Understanding resettlement stressors is not complete without looking at the stigma immigrants/refugees may experience when seeking mental health services. Spirituality will also be analyzed as a source of strength immigrants/refugees may utilize in their resettlement process.

***Resettlement stressors.*** Upon arrival in the receiving country, immigrants/refugees, away from the hardships or imminent dangers of their home countries, face new challenges (Ballard, Wieling, & Solheim, 2016). Immigrants/refugees often face inadequate infrastructure, complex legal procedures, difficulties adjusting to the new culture, as well as challenging family dynamics (Anagnostopoulos et al., 2015; Hebebrand et al., 2016; Kartal & Kiropoulos, 2016; Patterson et al., 2018). The ongoing work of adapting to new circumstances in living quarters, employment, education, social spaces, legal processes, and communication patterns builds over time and can create significant emotional and psychological stress (George et al., 2015; Kartal & Kiropoulos, 2016; Porche, 2014). The loss of their social network and cultural roots may create in many immigrants/refugees a feeling of lack of belonging (Falicov, 2003). Addressing acculturative stress is a foundational step for equipping all mental health therapists to develop culturally appropriate interventions for immigrants/refugees (Kartal & Kiropoulos, 2016; Ainslie, 2001; Arbona et al., 2010; Rios, 2008). This acculturative stress often develops because of discrimination against immigrants/refugees, ongoing challenges to their adjustment in the receiving country, and cultural mourning (Ainslie, 2001; Arbona et al., 2010; Rios, 2008).

Significant and compounding stressors are often experienced as immigrants/refugees are separated from family and friends, encounter economic hardship, possibly learn a new language, and attempt to navigate a different cultural system (Anagnostopoulos et al., 2016). Immigrants/refugees also often experience discrimination and complications with legal status

(Bryant-Davis & Ocampo, 2005; Cavazos-Rehg et al., 2007). People who experience discrimination and prejudice regularly can suffer from a form of posttraumatic stress disorder, whether the exposure is direct or vicarious in nature (Bryant-Davis & Ocampo, 2005).

Many immigrants/refugees come from cultures that have a collectivist view of the world in contrast with the majority culture in the U.S. that is individualist (Codrington, Iqbal, & Segal, 2011). Family connections can have a protective effect on the disruption of one's cultural system, while separation from family can exacerbate symptoms (Falicov, 2007). This makes family mental health and functioning particularly important when there has been loss and exposure to traumatic stress (Nixon et al., 2010). In communities with immigrant/refugee populations, individuals are typically viewed in the context of their families, and the displacement experience often strengthens the interdependence of family members even if they are not physically together (Codrington, Iqbal, & Segal, 2011).

*Uprooting impacts on individuals and the family.* Falicov (1995) noted that migration affects the immigrants/refugees' abilities to develop new attachments while at the same time acknowledged that in the resettlement process, there exist opportunities for growth. Many studies on the mental health of immigrants/refugees focus on posttraumatic effects of migration such as nightmares and panic attacks, while others focus on grief and the disorienting anxieties experienced when faced with the shock of new surroundings (George et al., 2015; Gramaglia et al., 2016; Porche, 2014). However, the disruptions in the new environment may affect immigrant/refugee families and have treatment implications for the therapist, assessment, and effective therapeutic approaches (Falicov, 1988). Resettlement stressors also impact the family stability, and the execution of traditional roles may have to be negotiated for the family to

function, including many parents becoming dependent on their children who become accustomed to the new culture faster (Falicov, 1988; Patterson et al., 2018).

*Ambiguous loss.* When considering the mental health needs of immigrants/refugees, the concept of ambiguous loss is helpful (Boss, 1991, 1999). Boss (1991, 1999) described situations in which loss is unclear, incomplete, or partial. Boss (1991, 1999) identified two types of ambiguous loss. The first type is when people are physically absent but psychologically present (the family with a soldier missing in action, the noncustodial parent in divorce, or the migrating relative) and the second is when family members are physically present but psychologically absent (the family living with a person with dementia or the parent or spouse who is emotionally unavailable due to stress or depression).

Falicov (2002) applied the concept of ambiguous loss to losses experienced by immigrants. The tension that originates from the psychological presence and physical absence that immigration cause is not a definite loss, rather ambiguous, but it may affect the relationship dynamics causing another layer of stress and have an impact on the mental health of immigrant/refugee patients (Falicov, 2002). For example, some immigrants/refugees may struggle with the lack of clarity stemming from the physical absence of family members who might have stayed behind in the country of origin but who nonetheless are psychologically present through the use of technology and may be involved in the decision-making process of the family's life.

Unlike the finality of death, after migration it is always possible to fantasize the eventual return or a forthcoming reunion. Furthermore, immigrants seldom migrate towards a social vacuum. A relative, friend or acquaintance usually waits on the other side to help with work, housing, and guidelines for the new life. A social community and ethnic

neighborhood reproduce in pockets of remembrance, the sights, sounds, smells, and tastes of one's country. All these elements create a mix of emotions: sadness and elation, losses and restitution, absence and presence that make grieving incomplete, postponed, ambiguous. (Falicov, 2002, para 3)

Boss (1999) names this process a "crossover," containing partially both types of ambiguous loss: loved ones are left behind, but they remain present in the imaginations and emotions of immigrants/refugees and family members, or even friends may be physically present in the country of resettlement may not be psychologically present due to the stressors associated with life in a new country.

Immigrants/refugees experience cultural uprooting often due to the loss of familiar surroundings exacerbated by resettlement stressors while adjusting to new places (Abbot, 2016; Bhugra & Becker, 2005). Solheim, Zaid, and Ballard (2016) described the effect of unclear losses in immigrant families for whom: "Families in which one or more of their family members leave to work in another country may experience the type of loss that Boss described. Typically, families of migrant workers believe the immigrant's physical absence will be temporary, yet often the absence lasts for years or even decade" (p. 340). Solheim et al. (2016) argued that the ambiguity or uncertainty of the separation implied a loss that increased the stress of migration and resettlement, impacting family roles and functions. Knowing how to strengthen families in the therapeutic encounter was highlighted by Solheim et al. (2016) to help transnational immigrant families make sense of the losses, compounded by other resettlement stressors, through empowering them and connecting them to practical resources.

***Stigma.*** Stigma about mental health illness, while not unique to displaced persons, prohibits some immigrants/refugees from seeking care and has been discussed at length in the

literature (Schreiber, Stern, & Wilson, 1998). Several additional fears and subsequent behaviors may be addressed through education about mental health systems of care in the United States. These behaviors include fears and worries that no effective treatments exist; fears are rooted perhaps in the notion that hospitalization may lead to losing a job or not knowing how to access care. Mental health providers may engage immigrant/refugee survivors in treatment more successfully by informing them of what treatments are effective and fostering a collaborative relationship that maximizes survivors' autonomy and choice in the treatment process (Shannon et al., 2015).

***Spirituality.*** A literature review revealed that religion and spirituality had been found to be important for many immigrants/refugees in making meaning of life, accepting and managing challenges in life (Arora & Bava, 2018; Blanch, 2007; Schreiber et al., 1998), and coping with them (O'Mahony, Donnelly, Bouchal, & Este, 2013; Walsh, 2004).

Spirituality is connected intrinsically to the lives of many immigrants/refugees and should be considered in their treatment (Chaze, Thomson, George, & Guruge, 2015). Hodge (2019) recommended assessing spirituality to identify strengths, immigrants/refugees' worldview, and to adapt and adjust treatment interventions to fit the patients' culture and belief system. Countries in East and Southeast Asia have long recognized the relationship between spirituality and health (Blanch, 2007), in contrast to Western systems and approaches that have traditionally minimized the importance of spirituality to mental health.

Griffith and Griffith (2003) highlighted the importance of including patients' spirituality in the practice of psychotherapy, also stating its importance in the work with immigrants/refugees. Griffith and Griffith (2003) postulated that it was important to hold a stance of curiosity and respect toward patients' belief system and spiritual experience to explore



how spirituality and religious practices were affecting their lives, either benefiting or harming them.

Spirituality is not always connected to collective religious practice or ritual, so mental health providers need to develop a keen sensitivity to cues that indicate the significance of these realities for each client. Koenig (2010) underscored the role of religious beliefs in providing a sense of meaning and purpose in times of difficulty, providing an optimistic worldview and positive role models for processing suffering, illness, loss, and cultural upheaval.

Many health practitioners, of different backgrounds, can be reluctant to incorporate spirituality into their practice because of the historical belief that religion and spirituality are antithetical to science (Chaze et al., 2015; Koenig, 2010). Other reasons could be the ambiguity in their understandings of spirituality and lack of training in integrating spirituality into patient/client care (Chaze et al., 2015; Koenig, 2010). Evidence that health practitioners' own religious beliefs could impact the provision of services also exists (Curlin, Nwodin, Vance, Chin, & Lantos, 2008). Although not specifically focused on spirituality in immigrants/refugees, Hauge, Paine, Ruffing, and Sandage (2019) investigated spirituality concerning the intercultural development of individuals and found that spirituality played an important role in providing internal resources and affected regulation skills that were employed by individuals engaged in intercultural exchanges. Similarly, Rupert, Moon, and Sandage (2019) found that the inclusion of spirituality in clinical training added an important area of growth for future mental health providers by helping future clinicians gain the capacity to hold different cultural points of view, and afforded them the capacity to be aware of the impact of systems in their patients (Rupert et al., 2019).

The need for effective mental health care for immigrant/refugee populations has been demonstrated. The provision of therapy to individuals who must leave their home countries under traumatic, stressful, and painful circumstances is often exacerbated by the unique issues associated with displacement and relocation. Difficulties include accessing services, limited availability of qualified mental health professionals, lack of adequate funding, and cultural impediments to care (Patterson et al., 2017; Saraceno et al., 2007; Shannon et al., 2016). Immigrants/refugees are arriving in the United States with layers of trauma and stress-related to their migration journeys.

All mental health providers must be aware that immigrants/refugees bring unique needs that reflect their life experiences before, during, and after the migration journey. Immigrants/refugees experience documented disparities in the delivery of mental health services (George et al., 2015). The degree to which mental health professionals are aware of and trained in global issues, such as wars, genocides, natural disasters, or political/religious persecution, will impact their understanding of cultural contexts for immigrant/refugee patients; this will affect the capacity of mental health providers to be able to meet the unique needs of immigrants/refugees (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008; Kakuma et al., 2011; Kuo & Arcuri, 2014; Saraceno et al., 2007).

### **Training Future Mental Health Providers to Respond to Immigrant/Refugee Mental Health Needs**

Exploring the mental health needs of immigrants/refugees and their interactions with therapists is important. Exploring what is being done in the academic institutions that train mental health providers to prepare them to serve these populations is also important.

There are several professional categories qualified to treat and diagnose the mental health needs of individuals: psychologists, counselors, therapists, clinical social workers, psychiatrists, psychiatric or mental health nurse practitioners, MFTs, primary care physicians, and family nurse practitioners (NAMI, 2019). Mental health professionals of different backgrounds (as mentioned previously) serve increasing numbers of immigrant/refugee clients as the global population shifts due to migration factors outlined in previous sections. Provided here is an example from the field of counseling psychology that demonstrates effective practices to train counselors to serve immigrants/refugees.

**Counseling psychology practice.** Recent research by Schweitzer, van Wyk, and Murray (2015) suggested four major themes directly related to counseling psychology practice with immigrants/refugees, regardless of specific training: (1) principles informing therapeutic practice, (2) therapy as a relational experience, (3) the role of context in informing therapeutic work with refugee clients, (4) the impact of the work on the therapist. Implemented together, these themes can greatly enhance the effectiveness of the therapist's approach to immigrants/refugees.

***Principles informing therapeutic practice.*** Schweitzer et al. (2015) proposed that the principles informing therapeutic practice revolve around the ability of the therapist to help immigrant/refugee clients make sense of their traumatic experiences, which allows them to have a sense of continuity in their experience of themselves. These authors designated curiosity as a key quality of the therapist because it allows for continual reinforcing of a learning posture toward a situation and cultural background that is unfamiliar (Schweitzer et al., 2015). According to Schweitzer et al., (2015), experienced therapists have a keenly developed ability to tolerate strong feelings and demands associated with the role of being a therapist while maintaining a

strong sense of self. Many therapists believed that a single therapeutic paradigm was insufficient to account for experiences of immigrant/refugee clients, leading to the integration of multiple perspectives and therapeutic paradigms to address client needs.

***Therapy as a relational experience.*** Schweitzer et al. (2015) also highlighted the ability to consider the relational experience of therapy as foundational to delivering successful mental health care to refugees. Therapists identified the therapeutic relationship as essential in the treatment of immigrant/refugee mental health needs because it provided clients who had experienced trauma a sense of safety in the therapist-patient interactions (Schweitzer et al., 2015). In this way, therapists valued the therapeutic relationship over technique, evidenced by a more natural, fluid, and flexible approach that was less tied to formal methods and established boundaries (Schweitzer et al., 2015).

***The role of context.*** Therapists work with people from refugee backgrounds often in the context of resettlement (Schweitzer et al., 2015). Thus, the practical needs of resettlement were prioritized as an essential first step in the client's ability to regulate themselves and have a sense of well-being, thereby increasing their readiness to address pre-migration trauma (Schweitzer et al., 2015). Empowered therapists grow in confidence and competence by acknowledging the complexities of the client's presentation and the need to adjust therapeutic interventions accordingly (Schweitzer et al., 2015).

***Impact of work on the therapist.*** The final theme for therapists to consider when working with refugees is the impact of therapeutic work on themselves. Therapists reported feeling emotionally overwhelmed by the difficult experiences of their clients and often had difficulty managing their intense emotions connected to feelings of inadequacy as a professional, which was also highlighted as important by other authors in similar research (Reupert, 2008).

Those therapists who were able to develop the capacity to stay engaged with clients, credited disciplines of self-care as primary to their sense of balance. Therapists reported exercise, meditation, and managing personal schedules as examples of helpful self-care practices. Access to quality supervision increases the capacity of therapists to engage with clients while also continuing to learn and develop new skills. Most helpful were supervisors who could help therapists tolerate uncertainty, manage difficult emotions, cope with the impact of work through guidance and normalizing, and increase therapeutic skills (Schweitzer et al., 2015).

Other researchers, such as Toporek, Gerstein, Fouad, and Israel (2006), highlighted several factors that graduate programs, specifically counseling psychology, should include to introduce structural changes to training future mental health professionals. These included strong efforts to: (1) actively commit to diversity, and state this goal explicitly; (2) recruit a diverse student body; (3) seek out and maintain a diverse faculty core; (4) ensure that the process of selecting students is equitable; (5) promote students' self-knowledge, and awareness about their background and culture, and the necessary tools to serve a diverse population; (6) critically explore the content of all courses to make sure that they shape cultural competence; and (7) regularly assess students' cultural competence.

Arredondo and Rosen (2007) explored training programs for mental health providers and examined the degree to which training programs foster cultural competence. The researchers focused on the environment in which clinicians' professional identities developed and the strong connection between faculty, supervisors, and clinicians-in-training. An underlying premise of their research was that multicultural skills could be taught and improved upon over time if they are guided by strategies that infuse cultural competence into programs that train mental health providers (Arredondo & Rosen, 2007).

*Summary of mental health providers' training to serve immigrant/refugee mental health needs.* Immigrants/refugees' resettlement is affected by stressors stemming from difficulties in the migration journey as well as post-migration poor living conditions that affect the capacity to adapt to the new environments (Murray, Davidson, & Schweitzer, 2010). Training provided to a wide variety of mental health providers did not prepare them for the myriad challenges of working with refugees; specifically, they lacked training in cross-cultural relationships, professional development in this area, and adequate supervision (Eleftheriadou, 1999; Koch, 2014; Villalba, 2009).

The literature review regarding different professional mental health providers who work with immigrants/refugees pointed to the fact that any mental health provider who wants to help immigrants/refugees recover from traumatic experiences could enhance their effectiveness by developing a global perspective, addressing the spiritual and religious facets of immigrant/refugee identity, understanding unique trauma related to the immigrant/refugee experience, recognizing the reality of stigma and fear in many immigrants/refugees as they consider seeking care, and intentionally developing skills to work well with interpreters on behalf of their client (Ríos, 2008). Higher education institutions can introduce or improve training in these areas, along with teaching therapists, of different fields, to apply mental health interventions from treatment models that have empirical support, such as cognitive-behavioral therapy and narrative exposure therapy (Kuo & Arcuri, 2014; Nosè et al., 2017; Slobodin & de Jong, 2015).

A gap exists in the literature regarding the specific experience of MFTs working with immigrants/refugees. For that reason, it is important to explore the current literature regarding

the field of MFT's theoretical foundation offers to respond to the needs of immigrants/refugees as well as the training practices.

### **Field of Marriage and Family Therapy and Immigrant/Refugee Mental Health Needs**

MFTs' ability to meet the needs of immigrants/refugees depends in part on the training and supervision received in higher education institutions that prepare them (Akyol, 2011; Apolinar, Claudio, & Watson, 2018). As mentioned previously, there are several professional categories qualified to treat and diagnose the mental health needs of individuals (NAMI, 2019)—of which MFTs are one. Marriage and Family Therapists are mental health professionals who have been trained in family systems to offer diagnosis and treatment for mental disorders in the context of relational systems. The field of MFT broadens the traditional emphasis on the individual to attend to the nature and role of individuals in relational networks. MFTs are trained to take a holistic perspective on health care; they are concerned with the overall, long-term well-being of individuals and their family systems (AAMFT, 2004). Among the professions that provide mental health care/services, the field of MFT is ideally situated to serve the needs of immigrant/refugee families; its systemic orientation and culturally collectivistic worldviews translate to a special readiness and fecundity for effective delivery of services (Ballard et al., 2016; James & MacKinnon, 2012).

**Field of MFT and family systems approach.** The field of MFT is well positioned conceptually to train future therapists to attend to the needs of immigrants/refugees because it holds a systemic perspective that emphasizes the importance of relationships and family connections as well as taking into account the multiple systems that people are embedded in, including communities and cultural groups, and can serve immigrants/refugees while holding to

this systemic awareness of needs (Ballard et al., 2016; Dadras & Daneshpour, 2018; Flood, 2010; Gantt & Adams, 2010; James & MacKinnon, 2012; Titelman, 2014).

MFT is a mental health profession focused on families and family dynamics as a therapeutic approach (Pinsof & Wynne, 1995). The field of MFT incorporates the entire family system, while many mental health professionals, including counselors, clinical psychologists, and social workers, primarily focus on the individual in therapy (Bowen, 1978; Pinsof & Wynne, 1995). MFTs are trained in systems theory, which suggests that it is the interactions of individuals within the family system that helps or hinders recovery (Bowen, 1978; Phillips, 1981; Pinsof & Wynne, 1995). This systemic focus allows MFTs an opportunity to incorporate issues related to social support and family dynamics in therapy (Gantt & Adams, 2010).

Watzlawick, Bavelas, and Jackson (2011) highlighted that the field of MFT's emphasis on viewing individuals in terms of relationships, and as part of larger systems, is a unique quality that can be brought to therapeutic interventions. The field of MFT views human interactions as parts of systems in which changes that occur in one part of the system will cause changes in all other parts as well as in the total system (Watzlawick et al., 2011). This system is composed of the people within the system and the relationships among them that are best understood as an ongoing, circular process of influence (Watzlawick et al., 2011).

Theoretically, an immigrant/refugee patient will benefit from this systemic approach because the migration experience often occurs in familial or community groups, creating a network from which to draw support for the recovery process (Patterson et al., 2018). Family therapy principles and practices may hold deep resonance with the needs of immigrant/refugee communities. It is common for immigrants/refugees to see themselves in the family context (Björn et al., 2013; Patterson et al., 2018). Family therapy principles can lend themselves to offer



interventions to address the mental health needs of immigrant/refugee families, but specific, effective approaches are only recently being developed and documented (Patterson et al., 2018).

***Field of MFT and resiliency.*** A multi-systemic, resilience-oriented approach contextualizes the distress, addresses the family impact, and strengthens interpersonal and institutional capital (Walsh, 2007). By adjusting the values and systemic orientation of the profession, family therapists can better respond and offer adequate mental health treatment immigrants/refugees (Wieling, 2018). The systemic and relational focus of family therapy that includes concepts such as family hierarchy, boundaries, strengths, adaptability, cohesion, and expressed emotion could help therapists conceptualize and plan interventions that meet the pressing needs of immigrant/refugee families (Patterson et al., 2018).

***Field of MFT and culture.*** One important aspect of a global perspective is to understand the psychological aspects of migration and how to engage clients in a migration narrative (Falicov, 1995). Imperative to this approach is a therapist's robust, sophisticated understanding of culture. Falicov (1995) viewed culture as existing in multiple contexts that created common "cultural borderlands" such as adversity, unpredictability, and possibility, as well as regularity and constraint. A link exists between therapists' personal growth and a multidimensional, comparative training framework designed to integrate culture with all aspects of family therapy (Falicov, 1995). Models of training mental health providers typically reflect Western values and norms and are not adequate or appropriate for use with immigrants/refugees representing non-Western cultures (Dadras & Daneshpour, 2018; Seponski et al., 2013). Worldwide, therapists are examining ways of using therapeutic models in a culturally sensitive manner, especially when working with clients who are perceived to have minority status or as "other" by the dominant

group. This “other” status is compounded for immigrants/refugees because of the multiple layers of stress and trauma rooted in their migratory journey.

MFTs who can effectively integrate a nuanced understanding of culture into aspects of therapy will be better positioned to treat the increasing number of immigrant/refugee clients needing mental health services. Understanding one’s own culture and that of those in their community is part of developing a global perspective (Aponte et al., 2009).

Falicov’s (2002) research on behaviors of immigrants/refugees demonstrated the ambiguous conflictual nature of migration losses. Immigrants/refugees may be able to develop responses or “solutions” to resettlement stressors, indicating that it is possible to function with the ambiguity of not having closure after loss. Furthermore, Suárez-Orozco, Suárez-Orozco, and Qin-Hilliard (2005) stated that successful adaptation hinged on the level of contextual stress immigrants faced. Family systems concepts utilized in the exploration of acculturation stressors illuminate a possible way in which the ambiguity of the losses may be integrated in a manner that immigrant families are strengthened and become more resilient, allowing those strengths to raise their voices against issues of social discrimination and injustice (Suárez-Orozco et al., 2005).

***Field of MFT and collectivist worldview.*** The field of MFT supports an understanding of individuals within the context of their family and other significant relational networks (Bowen, 1978; Pinsof & Wynne, 1995). Individuals also exist within the worldviews they are socialized to adopt; these worldviews vary across cultures and influence belief systems, organizational patterns, and communications processes (Maxie, Arnold, & Stephenson, 2006). Attending to these patterns and processes in immigrant/refugee families can increase the chances of healing and recovery (Walsh, 2007).

Belief systems are rooted in cultural and spiritual traditions, which influence each family/community member's perceptions and coping responses to traumatic experiences (McGoldrick & Hardy, 2008; Papadopolous, 2018). Clinicians who employ these concepts can help to contextualize distress as understandable and common among those who have experienced similar tragedies, allowing for resilience to develop as families gain a sense of coherence and find their traumatic experience more comprehensible, meaningful, and manageable (Walsh, 2007).

***Field of MFT and identity.*** Exploring how the field of MFT approaches the complex intersection of different aspects of the therapists' identities and the people they serve is another significant area of this research. Religious beliefs, political views, ethnic and national background, and circumstances of migration have increasingly become points of contention in North America, making it necessary to explore how therapists navigate these complex realities. The interconnectedness of identity-making and context is a dynamic relational process that involves the therapist and the individuals or families being served (Arora & Bava, 2018). The field of MFT recognizes and amplifies points of connection between individual clients and their families, communities (Arora & Bava, 2018), and belief systems held by all (Akyil, 2011; Aponte & Carlsen, 2009; Regas et al., 2017).

***Field of MFT and work with interpreters.*** Understanding the complex dynamics of working with immigrant/refugee patients in a therapy setting is made more difficult by cultural and language differences that are experienced as barriers to effective communication. Like many of the professions working across cultures and facing language barriers, MFTs must work alongside professional interpreters. The interactions between therapist, interpreter, and client influence the therapeutic process, as described in the field of psychology by Ríos (2008).

Robertson (2014) asserted that working with an interpreter is a skill that should be required for all therapists, yet minimal, if any, training exists. MFTs may feel confused about the roles of all parties involved and can become especially disorientated as they utilize interpreters for a specific function instead of as whole persons, countering their systems training and practice (Robertson, 2014).

The utilization of interpreters can mitigate this difficulty if mental health providers of all different fields are trained to partner with interpreters. Interpreters are an important link in the communication between clients and providers who do not share the same language (Robertson, 2014). In such cases, the emotional and linguistic skills of the interpreters are acting as a filter for the experience of the client, adding layers of complexity to the therapeutic interaction (Akinsulure-Smith & O'Hara, 2012). The triadic relationship between the provider, interpreter, and client is viewed as the whole system (Robertson, 2014). Each dyadic relationship of therapist-client, interpreter-therapist, and interpreter-client influences the other relationships in that the therapist-interpreter relationship will affect the interpreter-client relationship, which will affect the therapist-client relationship, and so on.

These relationships will continue to evolve and influence one another throughout the therapy process. The dyadic relationships, then, cannot be viewed as independent units, affecting only one person in the system. Research has traditionally focused on the effect of the interpreter on the therapist-client relationship, ignoring the triadic system and the mutual influences of each relationship (Robertson, 2014). Several documented interventions help create a foundation for effective working relationships between therapists and interpreters. Akinsulure-Smith and O'Hara (2012) suggested that mental health providers who work with migrants must be willing to engage with the complexities associated with interpreters.

Having explored the conceptual suitability of family systems theory to working with immigrants/refugees, the next section explores current training standards and practices aimed to prepare MFTs to treat a diverse set of clients. This will serve as a platform to examine specific approaches to training MFTs to work with immigrants/refugees, a diverse patient population (Ballard et al., 2016).

### **Current Approaches to Cultural Training in the Field of MFT**

The MFT profession is broadening its focus to better train graduates acknowledging “contextual and systemic dynamics” (AAMFT, 2004, para 1.2.1) as well as delivering “interventions in a way that is sensitive to special needs of clients” (AAMFT, 2004, para 4.3.2). Along with systems theory, MFTs who graduate from regionally accredited programs are required to take a wide range of courses, including diversity issues, theoretical knowledge of family therapy and empirical foundations, family therapy models, psychopharmacology from a systemic perspective, sex therapy, violence, addictions, and abuse, development across the lifespan, ethics, and research methods and statistics (AAMFT, 2015). While some individuals who work in this area will solicit additional training, the accreditation requirements for MFTs do not require any specific training on working with immigrant/refugee populations specifically.

The field of MFT has governing entities that provide structure to the scope and sequence of training programs. While minimum standards for graduation in professional programs are determined by these entities, institutions of higher education can adopt additional areas of focus that reflect the institutions’ mission, vision, and values. Within the last few decades, several scholars noted the need for MFT programs to more proactively integrate multicultural issues into their training modules (Falicov, 1995; McDowell et al., 2003; McGoldrick, Giordano, & Pearce, 1996). MFT programs, whether accredited by COAMFTE or another accreditation body, must be

housed in accredited institutions. Accreditation, whether national or regional, guides course content and sets guidelines related to issues of diversity and inclusion. The Commission on Accreditation of MFT Education (2014), for example, demonstrates concern for the provision of equitable care for minorities by offering coursework in cultural diversity. This governing body has stipulated that:

MFT training programs must strive for diversity and inclusion. Programs strive for a diverse faculty and student body in terms of race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious and spiritual practices, nation of origin or other relevant social categories, immigration, and/or language, with a regard for the rights of religiously affiliated institutions. Not only does this prepare MFT professionals for today's diverse, ever changing globally connected society, but also it creates a stimulating, creative, and synergistic learning context. The standards focus on creating an inclusive teaching/learning environment that incorporates educational practices reflective of a broad spectrum of students.

(COAMFTE, 2014, p. 3)

However, the existence of standards does not always translate into effective training for students in MFT programs (Inman et al., 2004).

MFT programs, institutions, and professional organizations struggle to incorporate systemic changes that reflect increased commitment to diversity issues despite a consensus among proponents of enhanced multicultural aptitude. Already in 2004, Inman et al. investigated how the integration of multicultural issues in MFT training programs translated to students' sense of multicultural competence and concluded that, although several strengths were identified within the accredited programs, participants noted several weaknesses, as well. Specifically, the

researchers found significant deficits in the following categories: minority representation, research considerations, student-faculty competency evaluations, and physical environment (Inman et al., 2004). Along the same lines as the research by Inman et al. (2004), Nixon et al. (2010) highlighted the importance of bolstering the incorporation of multicultural considerations into MFT training programs, proving a need still existed in 2010. Nixon et al. (2010) identified that being intentional in creating safe places for professors and MFT students to have difficult conversations surrounding issues of diversity, would ultimately result in moving students (and trainers) to a more proficient level of therapeutic engagement that would result in better help for clients from diverse backgrounds.

Standards are helpful to provide abstract guidelines, but higher education institutions and training programs need to translate those standards into practice. As mentioned previously, it is impossible to train all MFTs to anticipate every mental health need, but it is imperative to acknowledge the interconnectedness of the world today that places all mental health providers in a position to require an increase in their awareness and understanding of migration causes and patterns in order to effectively address the mental health needs of a wider range of patients. Recently, Dadras and Daneshpour (2018) studied family therapy's approach to cultural training and stated that MFT as a field has to move away from "the colonial attitude of multiculturalism and emancipate himself/herself from the obsession of knowing the Other and rather focus on empowering the oppressed Other" (p. 8). Dadras and Daneshpour's (2018) research brought attention to the need for MFT as a field to move from only discussing issues of diversity to action, advocacy and justice, and the need to improve intercultural training in MFT education as an ongoing concern.

The inequalities that exist in the mental health world can be more effectively addressed by strengthening certain programs within higher education. MFT graduate programs, as higher education institutions, have a fiduciary responsibility to utilize their strengths and apply best methods in education of therapists (Ross et al., 2012).

Exploring what is effective and what is not in the preparation of future MFTs will serve students and clients well and add to the credibility of the educational institutions and contribute to the body of research supporting best practices for training qualified professionals to serve immigrants/refugees. Although the focus of this dissertation was not the exploration of specific MFT graduate school curriculums, understanding what is being done in the academic institutions to train MFTs provided context to the exploration of MFTs' experiences in their work with immigrants/refugees.

The next section outlines specific recent attempts among researchers to develop mental health interventions to work with immigrant/refugee clients. In this section, a specific attempt by the field of MFT will be presented as it demonstrates incipient signs that the field of MFT is beginning to address the unique challenges of delivering care to immigrants/refugees. Innovative approaches that account for migration-related trauma are being explored and will be addressed in the following section.

#### **Innovative approaches in the field of MFT to work with immigrant/refugee clients.**

Interest in multicultural education in MFT training programs has existed for several decades (Akyil, 2011; D'Aniello, 2016; Falicov, 1988, 1995; Isaacson, 2001; Patterson et al., 2018). Early focus of this exploration centered around the therapist; the priority was to gauge the degree of consciousness of his or her culture, the level of awareness and understanding the therapist had of different cultures, and the therapist's effectiveness in applying culturally appropriate skills to



treating clients of different backgrounds (Adams, 2010; Akyil, 2011; D'Aniello, 2016; Patterson et al., 2018).

***Improvements to training structure.*** Gutierrez and Natrajan-Tyagi (2018), Patterson et al. (2018), and Wieling (2018) recommended structural changes in training programs as a concrete way to increase intercultural skill and readiness to work with immigrant/refugee populations. These changes might include a more intentional selection of practicum sites that serve immigrants/refugees, guest speakers or supervisors with experience working with immigrants/refugees, or faculty training to learn treatments for immigrant/refugee trauma (Patterson et al., 2018). Since these considerations and action steps are still in the developmental phase, scant research exists to demonstrate what is most effective in training future therapists who operate with a family systems lens as they work with immigrants/refugees, even though innovative approaches are beginning to emerge (Gutierrez and Natrajan-Tyagi, 2018; Wieling, 2018).

Efforts to make classroom teaching of multiculturalism more integrated into a student's life are also a priority for MFT training programs (Gutierrez & Natrajan-Tyagi, 2018; Maxie et al., 2006; Wieling, 2018). Models of training rooted in systems theory and classroom-life integration better prepare students for working with diverse populations and can include opportunities for trainees to provide direct psychotherapy to community-referred, culturally, and linguistically diverse refugee clients under culturally-grounded supervision (Wieling, 2018).

***Culturally responsive family interventions.*** Dadras and Daneshpour (2018), Jordan and Seponski (2018), Patterson et al. (2018), Seponski et al. (2013), and Wieling (2018) pointed to the importance of creating and evaluating culturally responsive therapies by examining client/therapist context, culture, power, needs, and beliefs. Family therapy models that line up

with the needs of immigrant/refugee families include those that support and enhance natural connections and structures within migrant communities and those that are preventative by design (Patterson et al., 2018). Shifting away from crisis management toward strength-based, present-focused, and solution-oriented interventions will empower clients to understand how to address ongoing mental health needs by building on the resiliency of their community relationships and assets (Björn et al., 2013; Patterson et al., 2018). This approach can have a ripple effect on refugee communities as those who have developed skills to enhance their mental health can organically, relationally, pass their insight on to other immigrants/ refugees, many of whom will never see a professional therapist (Tol et al., 2014).

## **Conclusion**

Current MFT training standards and practices are increasingly reflecting a commitment to multiculturalism and diverse needs of clients, yet the literature review highlights the need to explore further the experiences of recently graduated MFTs who work with immigrants/refugees. MFTs, along with other mental health professionals, as noted earlier, are concerned with their ability to meet the needs of immigrants/refugees effectively. A gap remains in the understanding of MFTs who work with immigrants/refugees and exploration of how the MFTs perceive their training prepared them to work with these specific populations (Akyil, 2011; Aponte & Carlsen, 2009; Inman et al., 2004; Regas et al., 2017).

The focus of this qualitative research study was to examine the lived experiences of MFTs who work with immigrants/refugees considering their graduate training. The unique issues immigrants/refugees face related to their migration, the demanding work of therapists to become more culturally responsive, and standards that may not keep pace with current trends in

populations seeking mental health care are ongoing challenges for MFTs who treat immigrants/refugees.

This chapter included an analysis of current and potential trends in training future MFTs to be sufficiently equipped for working with immigrants/refugees, highlighted the importance of culture in the field of MFT (Akyil, 2011; Apolinar, Claudio, & Watson, 2018; Falicov, 1995), and noted the centrality of honing a collectivist worldview (Maxie et al., 2006; McGoldrick & Hardy, 2008; Papadopolous, 2018). It also examined the interest in the field of MFT of the exploration of identity and POT (Akyil, 2011; Aponte & Carlsen, 2009; Arora & Bava, 2018; Regas et al., 2017), current trends in the training of MFTs (Patterson et al., 2018), as well as the impact of the use of interpreters in the work of MFTs.

The field of MFT is well positioned conceptually to train future therapists to attend to the needs of immigrants/refugees, given its systemic perspective that emphasizes the importance of relationships and family connections (Ballard et al., 2016; James & MacKinnon, 2012). However, a lack of knowledge on how that translates into the practice of providing mental health care for immigrant/refugee populations still exists, specifically on what is the lived experience of MFTs working with immigrants/refugees. The next chapter builds upon the material presented thus far by detailing the methodological approach that was used to guide this qualitative research study.

## **Chapter 3: Methodology**

### **Introduction**

The purpose of the study was to explore the experiences of recently graduated MFTs working with immigrants/refugees. As the literature review highlighted, the research on the lived experiences of recently graduated MFTs working with immigrants/refugees is in its infancy. I selected a phenomenological approach because of my interest in capturing the lived experiences of a group of persons concerning how they interpreted the phenomenon they experienced. These sections offer descriptions of the methodological procedures in this study.

Firstly, I submit a rationale for the qualitative research inquiry. The following section explains in-detail the frameworks that informed this research study. The third subsection focuses on the phenomenological approach that was utilized in the study. The fourth subsection describes the research question, followed by a description of the instrument used, and the sample. The next subsection outlines data collection, storage, and analysis. To conclude, two subsections capture ethical considerations and a bias statement.

### **Rationale for the Qualitative Research Inquiry**

Qualitative research is defined as “not a type of research, but the label for an entire knowledge-producing paradigm” (Tesch, 1990, p. 67). Patton (1990) emphasized, “methodological appropriateness as the primary criterion for judging methodological quality” (p. 39). Phenomenological research, a subset of qualitative research, could be understood as an approach that highlights the importance of the shared meanings and experiences of participants (Creswell, 2007; Flood, 2010; Giorgi, 2009; Merriam, 1998, 2002). Creswell (2007) stated that a phenomenological study “describes the meaning for several individuals of their lived experiences of a concept or a phenomenon” (p. 57). Hence, describing a phenomenon is declaring a lived

experience as a common occurrence for individuals who are part of a specific group. This statement does not overlook the fact that each person comes from a unique background and has a particular view of the phenomenon in question.

Phenomenological research was most appropriate for this study because the goal was to capture the lived experiences of people in their expression (van Manen, 1990). The way that people locate themselves in the world and how they describe what this means for them is considered the force that supports phenomenology (van Manen, 1990). This approach appeared to be the most appropriate, as the problem entails having to “to understand several individuals’ common or shared experiences of the phenomenon” (Creswell, 2007, p. 60). This research was concerned with seeking meaning and arriving at essences through intuition and reflection of conscious acts of experience, leading to ideas, concepts, judgments, and understandings (Moustakas, 1994).

The goal of this qualitative phenomenological research was to describe a "lived experience" of recently graduated MFTs working with immigrants/refugees; the focus was to identify commonalities among the reported experiences. Since the focus on phenomenological research was to seek aspects of the participants’ experience (Wertz, 2005), this research focused on the details of the person’s lived experience and not on their abstract views or interpretations of that experience. A naturalistic inquiry that permits a holistic examination of the phenomenon was most appropriate since the focus of this study was investigating the lived experiences of recently graduated MFTs.

### **Theoretical Frameworks**

Theoretical frameworks are traditionally developed before data collection in quantitative designs (Merriam, 1998). Qualitative research necessitates the acknowledgment that the

theoretical framework in which a study is grounded informs the researcher's assumptions about the study. However, in qualitative research designs, it is desirable to begin with a less structured and more open theoretical framework to prevent the researcher from imposing preconceived ideas of the findings (Creswell, 2007).

Boss, Doherty, La Rossa, Schumm, and Steinmetz (1993) adopted an inclusive definition of theory in social sciences based on Turner's (1986, as cited in Boss et al., 1993) and Alexander's (1987, as cited in Boss et al., 1993) definitions. Boss et al. (1993) focused on the process of developing ideas rather than having a sole emphasis on outcome. Boss et al. (1993) adhered to a broad understanding of theory that supports the concept that: "most family research studies are involved in theory in some way. To do otherwise would be to impose an evaluative hierarchy of theoretical quality on scholars who have different goals for theory and different methods of examining its validity" (p. 20). Multiple frameworks were used in this dissertation to support the research without the imposition of a rigid evaluative hierarchy (Boss et al., 1993). The theory is formed by multiple selected frameworks that support the researcher's thinking as well as the concepts and definitions that are relevant to the review of the literature (Grant & Osanloo, 2014).

Above all, these frameworks offered a foundational view of "self" (therapist and client) that incorporates identity, culture, and systems. Therapists who understand their lenses and biases and know how to navigate their social location in therapy relationships humbly are assets to the therapeutic experience for the client. Aponte and Carlsen (2009) emphasized the need for therapists to develop skills to use their biography and their experiences while differentiating themselves from patients. Commitments to personal and professional development reflect the core tenets of the ecological model and cultural humility.

The following section represents a pivot in the focus of this chapter; the remaining sections focus on the particularities of the research design and processes for data collection and analysis. Figure 1 links the different frameworks illuminating this research project into one, which informs the researcher's stance on this study.

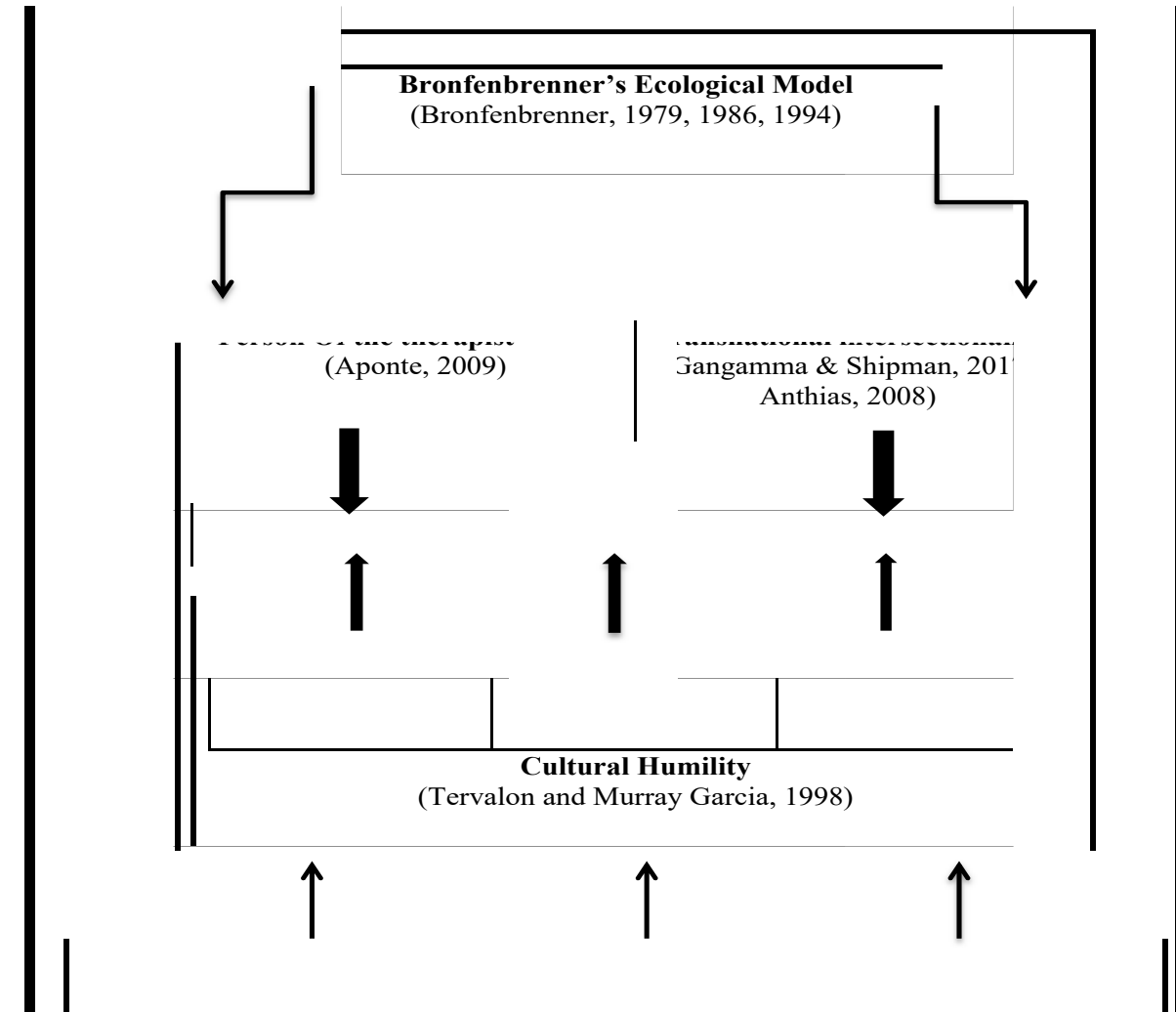


Figure 1. Frameworks informing research project.

Phenomenology as a philosophical framework is complementary to the theories that guided this research and underscored the need to address the complexities of identity, culture,

and interpersonal dynamics when preparing for and practicing mental health care: cultural humility and family systems theory. Additional models will be introduced to create a comprehensive analysis that includes several layers of interaction; these are ecological model, transnational intersectionality, and Person of the Therapist (POT).

**Phenomenology.** First, phenomenology as a framework will be explored, and phenomenology as a method will be expanded in the research design section.

*Phenomenology for family therapy research as a framework: The search for meaning.* Phenomenology functions as an interpretive inquiry and emphasizes the cultural and political contexts that influence the interpretation of meanings, holding significance when examining marriage, family, and close relationships of everyday life (Dahl & Boss, 2005). Phenomenology, as a philosophy, emphasizes language, symbols, and icons of lived experience (van Manen, 1990). While there are many versions of what one would consider to be phenomenology, this study is based on Dahl and Boss' (2005) phenomenological framework that has three philosophical assumptions that informed this research project. These three assumptions relate to (1) how we know, (2) what we need to know, and (3) where we locate ourselves in the research process (Dahl & Boss, 2005).

- How we know: Knowledge is socially constructed and, therefore, inherently tentative, and incomplete; therefore, meanings vary for individuals. Phenomenology emphasizes the importance of approaching the lived experiences of recently graduated MFTs with an open stance through different ways of knowing “We can know through both art and science” (Dahl & Boss, 2005, p. 66),



- What we need to know: Common, everyday knowledge is epistemologically important, and “language and meaning of everyday life are significant” (Dahl & Boss, 2005, p. 67).
- Where we locate ourselves in the research process: As researchers, we are not separate from the phenomena we study, “because of the desire for understanding this range of experiences, the phenomenological approach also assumes that everyday knowledge is shared and held by researchers and participants alike. Regardless of method, bias is inherent in all research and is not necessarily negative but needs to be acknowledged as an influence in researchers and therapists” (Dahl & Boss, 2005, p. 67).

The researcher in a phenomenological study serves as an instrument that brings flexibility, insight, and an ability to build on tacit knowledge. These qualities outweigh any liabilities of the researcher in terms of fatigue, stress, confusion, or bias (Boss & Dahl, 2005). Phenomenological researchers are able to derive clear understandings of research subjects, “including increased sensitivity to the experiences of others, corrections and amplifications of empirically derived knowledge, and improved responsiveness of public policy to the realities described by participants” (Polkinghorne, 1989, as cited in Boss & Dahl, 2005, p. 80).

**Cultural humility.** In recent decades, MFT training programs have increasingly recognized the importance of preparing practitioners to become “multiculturally competent” (Falicov, 1995; McGoldrick et al., 1996). The field has focused on counselors’ attitudes, beliefs, knowledge, and skills in working with clients from diverse cultural (racial, ethnic, gender, social class, and sexual orientation) groups (Sue, Arredondo, & McDavis, 1992). The Commission on Accreditation for MFT Education’s (COAMFTE, 2014) standards for MFT programs include

attention to issues of race, ethnicity, and gender as they relate to MFTs. For this research, it is important to differentiate “cultural competence” from “cultural humility” to highlight the centrality of cultural humility as a theoretical framework that heavily informs this dissertation.

***Cultural competence.*** Cultural competence is emphasized in professional mandates and national policy guidelines and is intricately used in the current discourse in the social sciences. Despite the prevalence of this approach to understanding intercultural connection, there exists efforts to counter the assumptions in cultural competence (Tervalon & Murray-Garcia 1998).

Even though there is a degree of attention given to self-awareness in cultural competency models (Fisher-Borne, Cain, & Martin, 2015), the various models tend to emphasize creating an environment where practitioners are more “comfortable” with others or exposure to different (i.e., nondominant) cultural groups. This kind of self-awareness does not account for power differentials (between health care provider and client) or what bias and assumptions therapists may bring to the provider-client relationship when working with clients from different backgrounds and/or identities.

A cultural competence framework fails “to explore ways in which cultural values and structural forces shape not only client experiences and opportunities but also providers’ approaches and capacity for care” (Fisher-Borne et al., 2015, p. 5). For example, Owen et al. (2016) reported that clients who rated their therapist as being more culturally humble also reported better therapy outcomes. Conversely, clients who perceived that their therapist missed cultural opportunities and were less culturally humble reported poorer therapy outcomes.

Cultural competence as a framework for mental health care is insufficient for equipping therapists to work effectively with immigrants/refugees. The language of “competence” frames human connection as an outcome rather than an ongoing dynamic that has complex and changing

realities influenced by each person in the relationship. A framework more suitable for equipping MFTs to treat immigrants/refugees is that of cultural humility, which is addressed in the following section.

***Cultural humility.*** Cultural humility is a framework that stands in contrast to cultural competence. Cultural humility emphasizes ongoing processes of learning about another's cultural context along with a steadfast commitment to not place one's own culture in a superior position over and against the patient (APA, 2013). The cultural humility framework is instructive to this study's exploration of therapists' posture towards clients.

While cultural competence is associated with "arriving" at understanding minority groups, cultural humility is associated with a more long-term journey of cultural growth (Tervalon & Murray-Garcia, 1998). Cultural humility acknowledges power differentials between provider and client and challenges institutional-level barriers. Arao and Clemens (2013) deconstructed the idea of "safe places" and proposed using language of bravery to discuss what is required when therapists and clients openly and honestly address power imbalances and social injustice.

MFTs that learn how to weave self-reflection, honesty, intentionality, and courage into their cultural humility framework will have a higher likelihood of creating a truly safe environment for clients. This proficiency begins in the classroom and supervisory experiences during training when professors and students alike feel safe talking about issues related to power imbalance, culture, and injustice. Students are then prepared for personal and professional transformation that ultimately benefits clients as well as themselves (Nixon et al., 2010).

Cultural humility is a posture and collection of skills that can be taught and experienced in the context of training interactions of future therapists, building on training strategies already

in place. The idea of cultural humility parallels principles informing therapeutic practice, has a foundation on a therapist' healthy curiosity, and necessitates the ability of the therapist to help clients make meaning of their traumatic experiences—which allows them to have a sense of continuity in their experience of themselves (Hockett, Samek, & Headley, 2014; Schweitzer et al., 2015). Hence, curiosity appears to be a quality of culturally humble therapists (stemming from a learning posture toward a situation and cultural background that is unfamiliar).

Tervalon and Murray-Garcia (1998) advocated a framework that requires accountability in challenging barriers that impact marginalized communities rather than an emphasis on mastery of facts about a person. Cultural humility is a preferred framework since it better reflects the mindset that is needed for mental health professionals who want to treat diverse groups of immigrants/refugees effectively. This framework coheres with family systems theory, which is outlined in the following section.

**Family systems theory.** Another critical framework that illuminates this research is family systems theory (Bowen, 1978). This theory emphasizes the familial system in which an individual is a part, as well as the larger systems in which the family system is located, recognizing the interrelatedness and interconnectedness of traumatic experiences such as migration (Bowen, 1978). Stresses related to the migration experience can cause ripple effects in family members because routines and systems of communication and mutual care are disrupted (Falicov, 2003; Walsh, 2003). Family members do not act or function independently of one another, but rather interdependently, with single events or individuals having impact and influence on other events and individuals (Bateson, 1972). Therapists who operate with a family systems theory framework have a better understanding of how traumatic events affect individuals

differently and can affect family dynamics for an extended period after the traumatic event occurred (Phillips, 1981).

Systems theory, in general, suggests that wholeness, or the whole being, is greater than the sum of its parts (Bowen, 1978). In family systems theory this means that individuals in the family come together to create a bigger and greater whole as a family system than when evaluated or considered in isolation as individuals (Phillips, 1981). This holistic approach is an important concept when working with individuals after disasters because of the strong empirical evidence demonstrating that supportive family and social networks serve as protective factors to negative psychological distress (Patterson, 2002; Walsh, 1998, 2002, & 2003).

In the field of MFT, two systemic researchers offered an approach that fits entirely within the family systems framework—although it is not explicitly targeted exclusively to work with refugees and immigrants but with all marginalized and minorities. Dadras and Daneshpour (2018) offered a “paradigm shift in thinking about the inclusion of diversity and social justice in practice to help clinicians understand multicultural clients’ dilemmas and challenges” (p. 1). Dadras and Daneshpour (2018) presented this approach as a way to bridge the apparent vacuum and insufficiency of current methods to educate MFTs in cultural responsiveness while considering systemic societal injustices in a way that honors the needs of the patients being served by acknowledging that the systemic societal forces that affect their health.

Dadras and Daneshpour (2018) valued the field of MFT’s effort to work on future therapists’ own differentiation of self while in graduate schools and encouraging MFT to embrace this to be part of clinicians’ commitment for life. However, these authors considered these efforts limited as they often do not critically address therapists’ own social, racial, class, gender, and position in the context of the larger systemic influences: “Lack of a broad

implication of a sociopolitical lens toward an understanding of human behavior is inherently against the core assumptions of systemic epistemology that argues human experiences are influenced by the large context of a given society” (p. 12).

Immigrants/refugees seeking mental health care bring a perspective shaped by the ecology of their relational networks and the functionality of their family systems, along with experience of events that are often traumatic or painful. Nevertheless, another layer of immigrant/refugee experience exists sociopolitical movements, global events, and economic factors that transcend national boundaries. This layer of influence is an example of a system that impacts the lives of individuals and families who may have little to no opportunity to effect change at this level. These points of interconnectedness will be explored through a different yet complementary lens in the following section.

**Ecological model.** This research study was concerned with systemic factors that influence the lived experience of MFTs working with immigrants/refugees. Systemic theories posit that each person functions within a complex web of interactions, groups, and systems; each of these layers of relationships and connections shapes a person’s identity and social location, a reality not unlike ecology in the natural world.

An ecological understanding of human relationships allows for serious consideration of how race, gender, physical ability, religion, income class, and sexuality factor into identity (Walker, 2002 in Comstock et al., 2008). Bronfenbrenner’s (1979, 1986, 1994) ecological model provided a particularly salient lens for analysis in this research study. This model addressed development and functioning as nested systems that each relate to and are encompassed by the previous layer. The ecological model explores various facets of an individual’s identity, including (1) microsystems, or the immediate interactions, (2) mesosystems, the interaction

between these microsystems, (3) exosystems, indirect systems, and (4) macrosystems, contextual factors. Macrosystems, particularly, represent aspects of culture that serve as deep undercurrents to one's own internalized principles.

***Microsystems.*** According to Bronfenbrenner (1979, 1986, 1994), microsystem represents one's immediate environment or the face-to-face interactions that occur directly with other people. These interactions may include relationships with family members, co-workers, classmates, among other relationships.

***Mesosystems.*** Mesosystems are created by connections made between and among microsystems (Bronfenbrenner, 1979, 1986, 1994). When particular people within the microsystem interact with each other, Bronfenbrenner (1979, 1986, 1994) suggested that on a mesosystemic level, potential changes, linkages, or transformative processes may result.

***Exosystems.*** Mesosystems provide a relational foundation for exosystems, the next layer of the ecological model. Bronfenbrenner (1979, 1986, 1994) stated that these systems exist in arenas outside of or beyond those directly connected to the individual yet have an influence on the person's immediate environment.

***Macrosystems.*** The final level of the ecological model is the macrosystem; this level defines the broader societal context that shapes an individual. Macrosystems may include aspects of culture, deeply ingrained systems of belief, social functioning patterns, and various opportunities or barriers. This latter category is highly relevant when exploring the experience of mental health providers offering cross-cultural care, as such, how macrosystems impact their training, clinical services, and community functioning. Exploring these areas provides additional insight for mental health clinicians, particularly when trying to understand or explain barriers to mental health (Arredondo & Rosen, 2007).

***The chronosystem.*** The transitions, personal, and socio-historical events that happen in a person's life make up the chronosystem (Bronfenbrenner, 1979, 1986, 1994)

***Therapists in the ecological model.*** Therapists who embrace an ecological framework understand their role in the relationship and purposefully work within the points of interconnection without supporting power imbalances. Proficient integration of an ecological model in therapeutic settings will mitigate clients' impulse to withdraw or censor their contributions; they will feel more secure in their participation when their culture, racial identity, and relational networks are acknowledged and validated (Lau & Ng, 2014; Weintraub, 2008).

Understanding societal and systemic influences and how they infiltrate human relationships, including those of both the therapist and client, will further increase cultural humility and sensitivity in cross-cultural interventions. The complex issues facing immigrants/refugees require therapists who are well-trained to identify and understand these complexities so they can effectively address them in therapeutic interventions. The ecological framework could provide MFTs with a paradigm that allows for consideration of sociopolitical realities, multiple levels of concern in the client, and awareness of their location in the dyadic relationship (Robbins, Mayorga, & Szapocznik, 2003 as cited in Falicov, 2007).

**Transnational intersectionality.** Transnational intersectionality is a complementary lens through which to view the treatment of immigrants/refugees. The field of Family Therapy has advocated for the utilization of frameworks that include culture, race, gender, sexuality, and socio-economic status, etc. (Anthias, 2008, 2012; Falicov, 1995; Hernandez-Wolfe, Acevedo, Victoria, & Volkmann, 2015; McGoldrick & Hardy, 2008). A therapeutic approach that considers transnational intersectionality attempts to address ambiguous terminology, overlapping and evolving sociopolitical realities, and nuances that often arise as MFTs provide mental health



care to immigrants/refugees (Anthias, 2008, 2012; Gangamma & Shipman, 2018; Seedall et al., 2014).

Intersectionality was utilized initially to help explore how different identities such as race and gender interacted in the lives of African-American women while not overlooking the power of inequalities and privilege and how those affect a person's relational system (Anthias, 2012; Gangamma & Shipman, 2018; Hernandez-Wolfe et al., 2015; Hernandez & McDowell, 2010).

The term "transnationalism" may be used to explain the experiences of migrant families who are while trying to sustain relational systems across nations while wrestling with the tension of having competing identities depending on their location (Anthias, 2012; Gangamma & Shipman, 2018; Stone, Gomez, Hotzoglou, & Lipnitsky, 2005). These "transnational identities" may differ depending on the stage of migration and may experience different degrees of marginalization (Gangamma & Shipman, 2018). Exploration into transnational intersectionality within the immigrant/refugee experience often reveals injustice at a macro or societal level.

***Social justice in the transnational intersectionality model.*** Diversity and social justice are ideas that have appeared in MFT literature for decades, yet they lack standard definitions (Seedall et al., 2014). Social justice/injustice is understood to highlight how both existing structures and new policies offer privileges to certain groups by overlooking the needs of others (McIntosh, 1998 as cited in Seedall et al., 2014). MFTs can address the realities of social justice issues by going beyond an analysis of each social inequality in isolation and instead accounting for the complex dynamics embedded within a broad social context (Leslie, 1995, as cited in Seedall et al., 2014). Due to the increased number of immigrants/refugees who have transnational identities and intersecting contexts and influences, the transnational

intersectionality framework provides therapists with a way to integrate sociopolitical and cultural approaches with foundational aspects of family therapy (Falicov, 2007).

***Power imbalances in the transnational intersectionality model.*** Transnational intersectionality also emphasizes paying attention to how power and marginalization affect the lives of immigrants/refugees. Awareness of these realities can be incorporated into the family systems approach utilized by MFTs, adding rich and nuanced meta-framework supporting treatment strategies. MFTs have applied the intersectionality framework to nonrefugee populations to help center examination of systemic issues of power and oppression related to family relationships (Falicov, 2007), thus creating a starting point for applying intersectionality to transnational situations. Gangamma and Shipman (2018) suggested that this framework more comprehensively addresses the unique intersections of identities and marginalization experiences of refugees.

Adopting the transnational intersectionality lens enhances the ability for therapists to intentionally examine differences in experiences of refugees relative to their social identities and acknowledge experiences of injustice during resettlement. This framework also prompts ongoing critical reflection upon multiple intersecting identities in the therapist-client relationship. This reflection can lead to concrete actions that translate theory into practice. Specific actions of the transnational intersectionality model may be applied to the therapy relationship by intentionally examining multiple identities of the therapist and patients, being open to discussing cultural similarities and differences, having a posture of curiosity by asking questions about patients' cultural identities (Addison & Coolhart, 2015; Gangamma & Shipman, 2018).

In addition, Stone et al. (2005) provided possible questions for exploring transnational family stories with immigrants/refugees—which may guide therapeutic conversations with

refugees. Such conversations with families could help therapists understand the interpersonal and intergenerational nature of transnationalism (Falicov, 2007).

Therapists play an integral role in the therapy relationship and the ultimate success of therapeutic interventions. The following section addresses some of the most salient considerations for therapists who are dedicated to personal development and professional growth in their work with immigrants/refugees.

**Person of the therapist (POT).** The therapist is not a neutral party in the therapy relationship but rather holds significant influence over the success of interventions and the client's perception of emotional safety (Aponte et al., 2009). Aponte & Wampold (2001, as cited in Regas et al., 2017) stated that effective therapists have stronger interpersonal skills, such as verbal articulacy, warmth, acceptance, and empathy, as well as a greater ability to be genuinely engaged with and spontaneously responsive to their clients. Therapists who attend to self-reflection and have a commitment to personal development around issues related to their therapeutic role in intercultural settings will be more effective than those who do not make these same commitments (Kissil & Niño, 2018; Regas et al., 2017; Watson, 2018).

Apolinar, Claudio, and Watson (2018) raised the need for therapists to develop a unique ability to use their biography and their subjective emotional experiences in favor of identifying themselves and, at the same time, differentiating themselves from their patients. Then, each therapeutic experience becomes unique and unrepeatably—which does not mean that the therapist faces this impromptu or lacks relevant techniques and knowledge. Therapists must be able to withdraw from the consulting system to look at the representation that emerges from the patients while also being sufficiently involved to be empathetic (Apolinar, Claudio, & Watson, 2018; Aponte & Carlsen, 2009).

Aponte (1991) and Aponte and Méndez (2014) stated that therapists who work with disadvantaged families must be willing to face personal challenges to connect and intervene with their clients while being fully aware of the differences between them and their clients' life experiences. Therapists must be willing to face their biases that blind or prevent them from connecting to the humanity of their clients; they may find themselves wrestling with deeply held beliefs and feelings about their emotional vulnerabilities that may be brought to the surface by the nature of therapeutic content and interactions (Aponte & Méndez, 2014). Aponte's (2014) POT model is very applicable to the dynamics encountered serving immigrants/refugees and offers a proven lens to examine the experiences of MFTs who work with immigrants/refugees (Aponte & Carlsen, 2009; Aponte & Méndez, 2014).

### **Frameworks in Collaboration**

The theoretical frameworks outlined in the previous section have several shared tenets that allow them to function complementarily and with many overlapping points. The shared ideas and values shaping these approaches help to provide a coherent meta-framework that values and prioritizes curiosity, humility, self-awareness, interconnectedness, and transnational intersectionality.

Understanding the myriad of effects that a migratory experience has on individuals, families, and communities requires integrative discernment of multiple approaches and theories. MFTs and clients (immigrants/refugees) are embedded in an ecosystem (Bronfenbrenner, 1979, 1986, & 1994) that affects all and sheds light on how broader societal dynamics play out within the context of individual relationships. In this integrative approach, phenomenology as a theoretical framework (Dahl & Boss, 2005) offers the first platform on which all the other frameworks rest and connect.

Cultural humility (Tervalon & Murray-Garcia, 1998) is directly supported by phenomenology (Dahl & Boss, 2005). The three tenets of cultural humility (commitment to self-exploration, challenge, or power imbalances, and keeping institutions accountable) connect with certain aspects of Dahl and Boss' (2005) phenomenology as well as the other frameworks. For example, a long-life commitment to self-exploration as described by Tervalon and Murray-Garcia (1998) parallels Aponte's (2014) POT's approach (2009), Bowen Family Systems Theory's concept of differentiation of self (Bowen, 1978), and phenomenology's foundational concept of the person of the researcher as an instrument (Dahl & Boss, 2005).

Falicov's (2002) attempt to integrate concepts from family systems theory (ambiguous loss, boundary ambiguity, and relational resilience) with concepts from studies on migration, race, and ethnicity (familism, biculturalism, and double consciousness) deepens the understanding of risks and resilience accompanying migration loss. This both/and approach reflects the intersections of many experiences and external forces that shape a migration experience and the emotional processing of that experience during the resettlement process. Recognizing the effect of migration experiences and societal influences in immigrant/refugee clients as well as their multiple identities is a framework for cultural humility (Anthias, 2008; Gangamma & Shipman, 2017; Tervalon & Murray-Garcia, 1998). The emphasis in transnational intersectionality fits perfectly as a framework with the idea of cultural humility due to challenging power imbalances and aligning with phenomenology as a theoretical framework.

Cultural humility's third tenet of keeping institutions accountable connects directly with phenomenological researchers' efforts to maximize the effectiveness of research by including implications for practitioners and policymakers as phenomenology functions as interpretive inquiry and emphasizes the cultural and political contexts that influence the interpretation of

meanings (Polkinghorne, 1989 as cited in Dahl & Boss, 2005). This concept is parallel to that of Aponte et al. (2009) and the idea of intentionally facing deeply held beliefs, thoughts, and assumptions to prepare and “train” to engage in therapeutic interactions.

Differentiation is closely linked with the commitments of therapists to address their psychological health and psychosocial awareness, present both in POT (Aponte, 1991) and cultural humility (Tervalon & Murray-Garcia, 1998). The concept of differentiation suggests that relationships with self and others are a lifelong process of negotiating independence and interdependence (Bowen, 1978). Differentiation allows one to relate to the emotional system while maintaining a solid sense of self (Titelman, 2014); it is the ability to have mature connections while also being autonomous.

The ability to differentiate in relationships leads to lower chronic anxiety and increased psychological adjustment (Jankowski & Sandage, 2011, as cited in Regas et al., 2017). Because differentiation and emotional maturity appear to have obvious benefits for personal functioning, it follows that differentiated therapists—no matter what therapeutic model they use—may be more effective than those who are not. The cultural humility framework is especially helpful in this regard, as is the ecological model, transnational intersectionality framework, and phenomenological approach. These frameworks guided this qualitative dissertation study by sharing many complementary assumptions.

## **Research Design**

**Phenomenological research approach.** Phenomenological methods are qualitative in nature. A qualitative research method allows researchers the opportunity to consider values, external structures, cultural beliefs, and socially constructed realities (Fossey, Harvey, McDermott, & Davidson, 2002). This approach results in a deeper understanding of the essence

of the phenomenon. Phenomenology's primary concern is the study of experience from the perspective of those participants; hence, phenomenology does not utilize a hypothesis.

Understanding a phenomenon through the awareness as it was received from the person living the experience is a central tenet of phenomenology (Giorgi, 2009).

Creswell (2007) stated that phenomenological studies are distinct because they include a search for meaning that a group of persons have of their lived experiences of a concept or common phenomenon producing a single essence that is composed of their distinctly different experiences within a common occurrence.

Phenomenology uses a methodology different from most research methodologies since its goal is to describe a lived experience, not to quantify or explain it (Giorgi, 2009). The methodology in phenomenology is open-ended and encourages participants to freely share details of their experience using well-designed questions, conversations, participant observations, focus meetings or diaries, and personal texts (among other methods). In general, less structured interviews are most effective (Moustakas, 1994). Phenomenology emphasizes subjectivity using different methods with the goal of maximizing the depth of the information gathered (Giorgi, 2009).

Phenomenology is an approach that has roots in the fields of anthropology and sociology, both of which align with the MFT paradigm and have similar systemic therapy roots (Ponterotto, 2005). Phenomenology, as systems theory, emphasizes social context, complexity, and circular causality, leading the researchers to bracket their own findings. Phenomenology provided a structure that allowed both myself and the participants to approach concrete questions that have experiential underpinnings in a conversational style. The goal was to explore participants'

experiences of growth and development in their graduate program, specifically as it pertains to the needs of immigrant/refugee populations.

**Research question.** This phenomenology study investigated the following research question: What is the experience of recently graduated MFTs who work with immigrants and refugees? In addition, the following sub questions were explored:

- What is the recent graduate's experience as a recent graduated MFT who works with immigrants and refugees?
- What is the recent graduate's perception of their MFT graduate education (academic course work, practicum placement, and experience) in preparing them to work with immigrant and refugee populations?
- What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees?
- What role does the therapist's own self-awareness and commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?

**Instrumentation.** Qualitative research methods view the researcher as the primary instrument for acquiring and analyzing data, hence influencing the study (Patton, 2002). The central method of data collection was in-depth interviews of participants audio-taped for subsequent transcription and analysis.

The interview questions were developed using a body of existing research related to therapists who work with immigrants/refugees, as well as other literature that illuminates this segment of therapy work. Semi-structured interviews, which included four questions with several prompts (Appendix C), were utilized to collect data. In a semi-structured interview, the



researcher is responsible for including a mix of more- and less-structured interview questions (Merriam, 2002). Semi-structured questions allow the researcher to inquire about insights outside the scope of predetermined questions (Patten, 2014). This flexible approach allowed me the freedom to adjust the questions based on responses or actions of the participants. Table 1 links the research question and the sub questions to the current literature themes.

To maximize the breadth of the geographical location of prospective participants, and since I had no funding to perform in-person interviews, I intentionally chose to conduct only phone interviews, which took up to 90 minutes and were recorded via a digital recording device. The decision to limit the research to only interviews was purposeful to highlight the interactive interview method, magnifying the power of the interview, participant voices, and their own descriptions of their experiences in the interpersonal context of the interview (Dahl & Boss, 2005). Demographic questions were asked, but I chose not to administer any written or electronic survey to maintain the essence of a qualitative phenomenological study. Hence, the data collected for this dissertation research came exclusively from study participant interviews.

Table 1

Research Questions Informed by Literature

Sub questions derived from main RQ	Literature Themes/Framework
What is the recent graduate's experience as a recent graduated MFT who works with immigrants and refugees?	Phenomenology in family systems (Dahl & Boss, 2005)
What is the recent graduate's perception of their MFT graduate education (academic course work, practicum placement, and experience) in preparing them to work with immigrant and refugee populations?	Diversity education (Gangamma & Shipman, 2017; Anthias, 2008) Brave spaces (Arao & Clemens, 2013) Safe spaces, (Nixon et al., 2010) Societal influences-ecological models (Bronfenbrenner, 1979, 1986, 1994)
What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees?	Person of the therapist (Aponte, 1991) Differentiation of self (Bowen, 1978) Transnational intersectionality (Gangamma & Shipman, 2017; Anthias, 2008) Spirituality (Walsh, 2004)
What role does the therapist's own self-awareness and commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?	Cultural humility (Tervalon & Murray-Garcia, 1998) Meaning making (Schweitzer et al., 2015)

**Bracketing.** Qualitative research's validity and reliability greatly depend upon the researcher's ability; therefore, the researcher needs to maintain a high level of self-awareness about personal experiences that may cloud the data collection and data analysis process (Flood, 2010). According to Patton (2002), "the credibility of qualitative methods hinges to a great extent on the skills, competence, and rigor of the person doing the fieldwork" (p. 14). The researcher plays an integral role in this method of qualitative approach, a role requiring nuanced and careful consideration of the impact of personal assumptions and biases. Even though total objectivity is impossible and not necessarily desirable in qualitative research, it is encouraged for

researchers to lay aside assumptions for the authentic experiences of participants to be echoed in the analysis and in the reporting of research (Ahern, 1999).

Van Manen (1990) conceptualized phenomenology as “a project of sober reflection on the lived experience of human existence” (p. 12), being free from researchers’ assumptions. A researcher, in the phenomenological tradition, withholds judgments about the phenomena even if they strongly believe in it (Husserl, 1962). Phenomenological researchers acknowledge biases that present themselves throughout the research process and are mindful of minimizing the expert stance because participants are the experts in their own lives (Dahl & Boss, 2005; Giorgi, 2009). The phenomenological approach demands the researcher’s awareness of the phenomenon in question, while at the same time, the researcher will bracket himself or herself from the data collected (Creswell, 2007).

This section underscores these considerations and the attempt to mitigate personal biases in this research process using bracketing (Giorgi, 2009). To ensure the validity and reliability of the researcher in this study, reflexivity through bracketing was employed during the data collection and analysis processes—as described by Patton (2002)—as a way of recognizing the centrality of self-awareness, self-analysis, and being aware of one’s perspective. According to Chan et al. (2013), using a journal can allow the researcher to document automatic thoughts and reactions throughout the research process—which potentially increases mindfulness about personal assumptions related to the research topic.

Throughout the interview process, I “bracketed out” personal assumptions, in an attempt to approach the study of the phenomenon from an unbiased perspective, by keeping a journal, in order to minimize biases by increasing my awareness of my personal interpretation of the

participants' experiences (Chan et al., 2013; Glesne, 2006). Bracketing was very important to be able to isolate the phenomenon and separate the knowledge already gained.

**Sample.** The invitation to participate in this study appealed to those MFTs providing psychotherapy to immigrants/refugees and who graduated from MFT programs. Qualified participants needed to have graduated since 2010. This delimitation allowed for focused attention on current trends in immigration/refugee settlement and timely reporting of graduate school effectiveness. Hence, the population sample for this study was MFTs, who have graduated from MFT training programs in the United States since 2010 and who work with immigrants/refugees. Participants represented a variety of clinical contexts, including hospitals, clinics, school settings, and nonprofit organizations that directly address the mental health needs of immigrants/refugees.

The target interview population was 10 participants. For phenomenological studies, Creswell (1998) recommended 5-25 participants, and Morse (1994) suggested at least six. These recommendations helped estimate how many participants were needed, but, ultimately, the required number of participants depended on when saturation was reached.

Purposeful sampling was used to select recently graduated MFTs (Patton, 2002). According to Patton (2002), "random probability samples cannot accomplish what in-depth, purposeful samples accomplish" (p. 245). Patton (2002) also highlighted the need to be aware that "there are no rules for sample size in qualitative inquiry" (p. 244), but rather the sample depends on the purpose of the study, the goal of the researcher, and the availability of time and resources (Patton, 2002). Participants were self-selected or sought after by contacting MFT professional organizations, organizations that serve immigrants/refugees, or participants directly, based on preselected criteria.

After the invitation was disseminated, 14 MFTs responded with interest in being interviewed. Out of the 14, all of them met the inclusion criteria of the study; 13 interviews were conducted. One of the interested recently graduated MFTs was unable to find a time to do the interview; after a few attempts to find a suitable time, the person did not respond.

The demographic profile of the final sample of recently graduated MFTs working with refugees and immigrants who responded to the invitation to participate in this research study is represented in Table 2 compiled with the information participants themselves filled out in the demographic survey form (Appendix D).

Table 2

## Demographic Characteristics of Participants

Variable	N	%
Gender		
Female	11	84.6
Male	2	15.4
Age		
23-39	8	61.5
40-55	5	38.5
Years in practice		
1-3	5	38.5
4-6	5	38.5
7-9	3	23.0
Race		
American Indian/European	1	7.7
White	4	30.75
Hispanic	4	30.75
African American	1	7.7
White/Jewish	1	7.7
African (foreign born)	1	7.7
White/Vietnamese	1	7.7
Language		
Bilingual	10	76.9
Spanish/English	9	90
Igbo/English	1	10
French/English	1	
Monolingual	3	23.1
Native Language		
Spanish	2	15.4
Igbo	1	7.7
English	10	76.9

**Data Collection, Storage, and Analysis**

This qualitative research study process followed standards set by the Institutional Review Board and best practices for phenomenological research. This section provides a detailed

description of the data collection (including invitation process and confidentiality), storage, and analysis processes.

**Data collection.** In-depth interviews were used as instruments to collect data from the lived experiences of research participants (Chenail, St. George, Wulff, Duffy, & Charles, 2008). Upon approval from the Institutional Review Board, I approached organizations through a process described in the section below titled “invitation process” to extend the invitation to participants who met the inclusion criteria. The inclusion criteria for this dissertation study were to be a recently graduated MFT (since 2010) from an MFT graduate school training program and having worked at some point since 2010 and/or currently working with immigrants/refugees. Those who met the inclusion criteria were identified and invited to participate in this phenomenological study.

This phenomenological study was based on the information gathered during 13 in-depth semi-structured interviews with recently graduated MFTs who work with refugees and immigrants. Participants were asked to participate in interviews and were told that interviews might take up to 90 minutes. Interviews were conducted with a semi-structured approach reflecting on the framework presented previously. Interview times and dates were determined through online communication to accommodate the participants’ availability and convenience.

Every interview was conducted by telephone, took up to 90 minutes, and was recorded via a digital recording device. The direct, interactive interview method allowed participants to describe their experiences in an interpersonal context (Dahl & Boss, 2005). During the interviews, participants responded to open-ended questions related to their experiences as MFTs working with immigrants/refugees.

The interview method allowed me an opportunity to ask for clarifying descriptions of their experiences as MFTs working with immigrants/refugees (Wimpenny & Gass, 2000). In addition, the interview method allowed a deeper understanding of the research topic because it provided participants the opportunity to share their experiences without being limited to answering “yes” or “no” to questions (Merriam, 2002). Follow-up questions and prompts were used based on the responses of the participants, the interview protocol, and the objectives of the research study. As a result, the interview was a collaborative interaction between myself and the participants—requiring me to bracket personal assumptions and existing ideas about the phenomenon under study (Chan, Fung, & Chien, 2013).

*Invitation process.* I made initial contact via email to organizations (nonprofit organizations, clinics, community clinics, listservs, etc.) that provide mental health care services to immigrants/refugees and/or that employ MFTs, as well as agencies that work with immigrants/refugees (Appendix A). The email included a description of the study and reassurance that the study would be completely confidential. The email also explained that interview recordings would be transcribed by a professional transcriptionist under strict confidentiality. Recipients of this correspondence were invited and encouraged to disseminate the invitation to potential participants connected to the institution who would then be instructed to contact me directly if they were interested. Other means of seeking prospective participants included advertising in regional MFT newsletters and social media platforms by MFTs.

The following institutions and organizations are the organizations were contacted:

- The Minnesota Association for Marriage and Family Therapy (MAMFT),
- Spanish Consortium of Mental Health Providers,
- The North American Society of Refugee Health Providers (NASRHP),



- and The American Association for Marriage and Family Therapy (AAMFT).

These organizations were contacted to distribute the study invitation, as they also distributed the invitation to their contacts such as nonprofits and community clinics that provide mental health care to immigrants/refugees and might employ MFTs throughout the United States.

Social media recruitment was also used following precedents set in other peer-reviewed research projects (Forgasz, Tan, Leder, & McLeod, 2018; McRobert, Hill, Smale, Hay, & van der Windt, 2018) and The Harvard Program in Refugee Trauma Alumni Facebook Page was used to disseminate the invitation to participate in the study. Snowball sampling was also used as potential participants may offer me contact information for other MFTs who may potentially contribute to or participate in the study. This method helped me find and recruit participants that may have otherwise been hard to reach.

Once the prospective participants expressed interest in the study, they received a consent form (Appendix B) and demographic form (Appendix D) for their review and signature. This form had interview audio-recorded consent. Care was also taken to ensure that participants met all inclusion criteria (Creswell, 2009). The final step was to arrange a date and time for the interview, provide instructions, and clarify any aspects of the process that were unclear.

After the interviews, a brief message of gratitude was sent to all participants. Per the pre-interview agreement made between myself and the participants (Appendix A), gift cards were given within two weeks of the interview date as tokens of appreciation.

***Confidentiality.*** Participation in this study was voluntary, and identifying information of participants was removed after their responses had been reviewed. All information collected throughout this study was archived until I presented the findings, then all confidential information was deleted. I left the participant's code key on the collected documents until the

review of participants' transcripts was completed. No one was identified in written reports or publications.

To ensure confidentiality, study participants were identified by code names. A further measure of confidentiality was taken as interviews were transcribed in private settings, all electronic devices were secured, transcriptions were secured with password protection, and none of the written notes or transcriptions had the written names of the participants.

**Storage.** Data from the interviews were stored securely on an external hard-drive and personal computer in the privacy of my office and was analyzed by myself, an external transcriber, the inter-coders, and members of the dissertation committee. Data included handwritten notes I took during interviews, email correspondence with research participants, notes made during analysis, signed consent forms, and my personal journal for bracketing.

**Data analysis.** Interviews were audio-recorded for subsequent transcription and analysis. Transcribed interviews were reviewed several times before submitting transcripts to the participants for their review and verification. To ensure accuracy, participants were provided with an electronic copy of their transcribed interview and invited to verify correctness, and make any remarks or clarify any discrepancies. Participants could make desired corrections or clarifications prior to the analysis of the data. Two participants replied with minor changes due to typos in the transcription process. Although I did not seek the input of the participants after analysis began, each participant was entitled to withdraw from the study at any time, a right that was made clear throughout the informed consent process.

***Interpretative phenomenological analysis model.*** Data analysis followed models considered appropriate to this qualitative study, notably Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). IPA ensured that the data analysis moved from

what is unique in each participant to commonalities among the participants; themes were identified and prioritized over specific details of an interview. The experiences relayed by study participants were explored in a manner that points to interpretation more than relying on facts.

The IPA approach enhances commitment to understanding the participant's point of view by concentrating on the individual's process of making meaning of lived experiences. This research study used IPA because of its emphasis on the participants' personal perceptions of the experience rather than an objective view of it (Smith & Osborn, 2003). I focused on recently graduated MFTs' perceptions of their experiences working with refugees and immigrants. IPA makes room for both the participants' and the researcher's voice in the study, acknowledging that it is not possible for the researcher to attain a completely neutral stance. It is also crucial for the researcher's voice not to overshadow the voices of the participants. IPA acknowledges that themes are influenced by both the participant's and the researcher's perceptions of experience.

A detailed explanation of the analysis is presented below; IPA's steps of analysis were utilized in the data analysis phase as described by Pietkiewicz and Smith (2014).

*Step 1: Multiple readings and taking notes.* During this first step, that according to Smith and Pietkiewicz (2014) requires the ability to be able to immerse oneself in the data, I saturated myself in the interviews by listening to each recording twice and reading and rereading written transcripts in order to enter the experience of the participants while being actively engaged with the data. This process helped me integrate the different parts of the experiences shared by the participants into a cohesive narrative. As I was listening to the audio, this served as a means to verify the accuracy of the transcript, and corrections were made as needed. As I was listening to the voices of the participants, it helped to "bring alive" the participants' words that later

facilitated the analysis process. As I was doing this, I was journaling in a separate notebook, written by hand, regarding my observations, ideas, and assumptions as a means of “bracketing.”

During this phase of the analysis, the objective was to develop a solid group of notes and comments on the data collected. I paid attention to and explored each participant’s language and content while keeping an open stance. I used the left margin of the document to annotate reactions to participant responses during the initial readings of interview transcripts. The notes and comments on the left side of the transcript afforded me increased familiarity with the transcripts and the ways in which each participant spoke about and reflected on the topics explored (Pietkiewicz & Smith, 2014).

*Step 2: Transforming notes into emergent themes.* According to Pietkiewicz and Smith (2014), this step requires an analytical move to working with the notes rather than working with the transcript directly. During this phase, I concentrated on the initial notes with the intention of identifying the connections and patterns recorded in the notes to identify emergent themes. Margins along the right side were used to write emergent themes connecting data that identified commonalities among all participants. This notation process provided a foundation for deeper analysis and ordering of themes. These comments in all their descriptiveness became the focus as they related to the way the participants made meaning of their experiences. The participants were describing stories, places, people, and values that were important to them, which allowed me to comprehend better each participants’ experience.

At this point, themes began to emerge as some key phrases were repeated similarly in many of the transcripts. These themes were a representation of my interpretation of the participants’ reflections on their lived experiences. Clustering and reducing data to small but

significant themes would ideally accurately reflect the lived experiences of participants as they pertain to the researched phenomenon.

*Step 3: Seeking relationships and clustering themes.* During this phase, I was able to distinguish themes, and I was able to examine how these themes connected to each other. When the themes were carrying a similar sentiment, they were placed in the same category. Page numbers and transcript numbers were assigned to themes and subthemes to facilitate ready access to the original transcript to find exact quotations. Care was taken to ensure that emergent themes were recorded in the voice and perspective of the participants and that their interpretations remained central to any analysis.

*Step 4: Writing a narrative account of the study.* The detailed analysis, as described above, is a process that led me to take the identified themes and place them in a table (Table 3) as well as to write about them one-by-one with extracts from the interviews followed by analytical comments. IPA was a very demanding process that necessitated systematic and rigorous analysis, combined with “patience and openness to see the world through someone else’s eyes and the ability to control a temptation to a priori impose conceptual categories” (Pietkiewicz & Smith, 2014, p. 9).

### **Trustworthiness**

In this study, I adhered to the recommendations and understanding of reliability and validity offered by Golafshani (2003) as stated: “Reliability and validity are conceptualized as trustworthiness, rigor, and quality in qualitative paradigm” (p. 604). Golafshani (2003), when describing qualitative research, explained that qualitative studies do not use instruments with specific metrics about validity and reliability. Instead, Golafshani spoke of trustworthiness, making it necessary then to explore how qualitative researchers establish that the research

study's findings are credible, transferable, confirmable, and dependable. Golafshani (2003) asserted that when those elements are in place, then it can be said that trustworthiness is established.

**Credibility.** To enhance the analysis of the data generated by the in-depth interviews, triangulation is a common step taken by qualitative researchers that brings in other peer researchers' interpretation of the data at different times or locations (Golafshani, 2003). To add an additional layer of trustworthiness, two other coders, both MFTs, came into the process during this analysis phase to aid in the analysis of the transcripts by independently coding themes and comparing these themes with the principal investigator's identified themes. By offering two independent appraisers, the standard of trustworthiness in cataloging the themes was increased (Eatough & Smith, 2008).

As the researcher, credibility is about my level of confidence in the truth of the research study's findings (Patton, 2002). To increase the credibility of this study's findings, triangulation was used through the inclusion of two other coders, both MFTs, who assisted in the analysis of the transcripts by independently coding themes and comparing these themes with my identified themes (Eatough & Smith, 2008). Both independent coders responded with themes like those I identified in my IPA analysis of the results. Both independent coders highlighted the theme that pointed toward the apparent inadequacies in most of the participants' MFT programs, specifically addressing not only how to sufficiently prepare future MFTs to serve the needs of immigrants/refugees but the lack of preparation for therapy work across cultures that takes into consideration issues of equity and marginalization.

Both independent coders also identified a theme surrounding the experiences of minority MFT students and painful episodes in MFT programs. Independent coders also saw the richness

of the life experiences of the MFTs who chose to work with immigrants/refugees; their experiences afforded them exposure to differences not because of privilege but because they were reflective and made sense of their own lives, which in turn prepared them to serve the needs of immigrant/refugee populations better. Both coders highlighted the concern over those MFT students who were not inclined to go out of their comfort zones and explore other ways of being in the world; the coders identified this as a potential danger for programs that do not intentionally address this need for all students.

**Transferability.** The question of how transferable these findings are to other contexts (i.e., similar situations, populations, or phenomena) depends heavily on how descriptive the study is about the participants and the participants' description of their lived experiences (Korstjens & Moser, 2018). To respond to this concern of transferability, I presented detailed descriptions of participants' testimonies throughout Chapter 4 using the participants' chosen words. I hoped to achieve a more vibrant and personal understating of their lived experiences without mediating it with my own language and narrative. To accomplish this, I did not edit the participants' testimonies unnecessarily and offered their testimonies in their own words. I intended to offer an in-depth and detailed description of their lives as part of the segment that was used while at the same time honoring the commitment to confidentiality (Korstjens & Moser, 2018).

Transferability was improved by describing the behavior and experiences of the participants as well as their context as they shared it in the interviews, making their testimonies more meaningful to readers. Future readers of this dissertation study will have to decide if the results of this study are transferable to their own specific contexts and settings based on the full descriptions of the data.

**Confirmability.** The degree of neutrality in the research findings is called confirmability (Golafshani, 2003). Since complete objectivity is not possible, and neither is it desirable, as a phenomenological researcher, I was intentional in acknowledging my biases throughout the research process, honoring the fact that participants were the experts in their own lives (Dahl & Boss, 2005; Giorgi, 2009). In my journal, I was able to reflect on my own thoughts as a recently graduated MFT working with immigrants/refugees; and, in the discussion of the findings, I presented my own responses to the results—making clear what was my lived experience as a researcher and what were the voices of the participants (Chan, Chien, & Fung, 2013). To ensure confirmability, I provided a detailed description of the data analysis to establish that the study’s findings depicted the participants’ responses.

**Dependability.** Lastly, the stability of research findings over time is its dependability, which was strengthened by the trail I left. Chapter 3 explained every step of the research process to provide transparency from the start of a research study to the report on its findings.

### **Assumptions and Limitations**

The assumptions are those elements that, even being outside of the researcher’s control, are nonetheless accepted as true, or possible, by researchers (Creswell, 2007). The limitations of a study are potential weaknesses and influences that the study will have that are not within the scope of influence or the control of the researcher. Limitations are constraints that are largely beyond your control but could affect the study outcome (Creswell, 2007).

**Assumptions.** I hold the assumptions that the 13 participants who agreed to participate in this study (a) were expressing their own thoughts and feelings, (b) provided personal descriptions of their own experiences as recently graduated MFTs who work with immigrants/refugees, (c) and felt no coercion to participate in the interviews. Although research participants graduated



from MFT programs in the U.S., their experiences were individual and highly contextualized. It was beyond the scope of this study to account for factors that affected the experiences of recently graduated MFTs beyond what is addressed through the research questions and data collection process. Factors were generally acknowledged but not analyzed for relevance to the research.

**Limitations.** This study was limited by the fact the data collected was confined to 13 self-selected recently graduated MFTs who worked with refugees and immigrants in the U.S. The selection bias, that may be a weakness in many statistical analyses, may be perceived as a strength in qualitative research according to Patton (2002) because it is seeking participants who are providing “information-rich cases” (p. 230) for in-depth study. Nonetheless, it is essential to highlight the possible limitation this selection bias poses as participants may be offering “extreme” cases or “testimonies that are unusual” (Patton 2002, p. 231). The criteria for population selection for this study included a few characteristics to be met. Participants needed to have graduated since 2010 from an MFT graduate program and to have worked with immigrants/refugees. Accounting for other categories of classification of the participants, such as specifics of their MFT programs, whether face-to-face or online or whether regionally or nationally accredited, did not occur. A limitation of the sample is the necessary omission of specific identifiable characteristics embedded in participants’ comments to protect their identities. A broader description of the participants might have been achieved if I had included more details about their lives, but confidentiality would have been compromised.

Another limitation of this study is that MFT academic programs were not reviewed to research specific MFT curriculum or academic plans; neither did this study include interviews with MFT program directors. Thus, knowledge is limited to the participants’ testimonies shared in the interviews.

The setting where the interviews occurred could be a limitation as the researcher had no control over what location each participant chose to engage in for the interview. Participants may have had different levels of comfort and privacy in their chosen location that was out of the control of the researcher. Moreover, it could be that other factors outside of the researcher's reach could have influenced the participants being interviewed and could have affected participants' moods or elevated their anxiety—influencing their disposition to answer and engage with the interviewer.

### **Ethical Considerations**

Ethical considerations are crucial to the safety of all subjects as well as to those conducting research. This section highlights the ethical principles outlined by the Belmont Report (1979) and then addresses the process of securing informed consent.

**The Belmont Report.** Respect for persons, beneficence, and justice are the three ethical considerations outlined by the Belmont Report (1979). Respect for persons is one of the most important ethical principles for this qualitative study. I ensured that every participant understood that they could remove themselves from the study at any time. The second principle, beneficence, ensures that individuals/participants are treated ethically, respecting their decisions, and protecting them while also attempting to secure their well-being (Belmont Report, 1979). Beneficence may require the researcher to stop the research if participants are being exposed to significant risk(s).

The final principle discussed in the Belmont Report is justice related to participants involved in the study. An example of a consideration of justice would be how research participants are identified and invited to participate in the study; if participants from a socio-

economic background were prioritized or excluded or if a specific organization, or agency, was given preference in the research analysis, injustice would exist.

**Informed consent.** Another decisive ethical aspect that must be considered prior to beginning the study is understanding informed consent. Informed consent is the process that ensures participants have a full understanding of what the research is and their role in it (Hicks, 2014). Informed consent involves thorough written descriptions of the study that participants sign, indicating comprehension and agreement to the stated terms (Patten, 2014).

To protect all individuals from ethical malpractice, the researcher and researcher's dissertation advisor's contact information was included in the consent form. This information was provided so that participants could contact the researcher at any time with questions or concerns related to the study.

Participants were allowed adequate time to process information the researcher provided during the informed consent process to avoid impulsive decisions (Hicks, 2014). Upon agreement to the terms of the study, and after any concerns were addressed, a signed voluntary agreement was obtained, and the study began.

### **Self of the Researcher**

As mentioned in earlier sections of this paper, a phenomenological study involves the researcher to a significant degree. Therefore, serious consideration must be taken when considering researcher bias as a potential undermining factor to the study's integrity. One way to address this risk is through the formation of a bias statement.

A bias statement acknowledges that the researcher's background influences the perception and identification of meanings, and making those perceptions transparent is essential. Creswell (2007) stated that it was imperative for the researcher to discuss and be open about

personal views and knowledge about the research topic with the intention to clarify personal and professional information that may impact the research process, including data collection and analysis. The writing process increases the ability of the researcher to bracket or set aside bias while conducting the phenomenological inquiry. Prior to this study, a bias statement was written to bracket my biases and to highlight the voices of the participants involved. A detailed description of this bias can be found in Appendix F. According to Moustakas (1994), researchers should write about their own perception with the research to make transparent the context that may influence their analysis.

My initial interest in researching this topic was birthed out of my work as a recently graduated MFT working with refugees and immigrants. I am also a foreign-born therapist working with foreign language interpreters and immigrant/refugee clients, and an adjunct assistant professor in an MFT training program. I was born in Spain and moved to the United States at 24-years-old. My biography is different from the immigrant/refugees' journeys as I encountered considerable privilege in my resettlement process. Nonetheless, the process of feeling like an outsider is a commonality between immigrants/refugees and one that influenced my interest in this subject, which may have allowed the recent MFT graduates to participate in the interviews in a manner different than if I had been born in the United States.

My education in an MFT program has some similarities and some differences with the participants' experiences. I completed my MFT graduate education at Bethel Seminary, where I felt that the integration of faith helped me in my interactions across difference as it moved me toward differentiation. In my MFT program, faith integration was a central tenet and value of the program, embedded in the academic curriculum, classroom discussions, personal reflections, and readings. Through wrestling with issues of spirituality and faith, I grew as a person and as a

therapist in differentiation of self. I chose to do my practicum in a clinic serving refugees and immigrants and participated in co-therapy for nine months. The education gained by being mentored by an expert in the field of refugee mental health complemented and potentiated my personal and professional growth. These two salient occurrences impacted my impressions of my training in a positive light. However, my MFT education also included some areas of weakness. I felt I was not exposed to issues of social justice and advocacy in many MFT classroom discussions and missed diverse voices in the faculty.

Working with immigrant/refugee clients as a therapist also influenced my own lens. As a therapist, I have come across mostly positive working relationships, but I am very aware of difficulties in serving this population. My process of learning and adjusting to serving the needs of immigrants/refugees as an MFT has not been void of challenges, and I have had to adjust my personal style to the demands of serving this population.

My work in MFT education brings me tremendous joy. As an adjunct assistant professor in an MFT program that integrates faith and spirituality, I see the benefit of wrestling with issues from a theological lens, always exploring my own assumptions and opening classroom conversations to hard topics with my students. I witness the importance of intentionally incorporating in the classroom issues of justice, race, language, ethnicity, immigration and displacement, and other systemic inequalities that affect the therapeutic encounter. I realize that I cannot lead my students to places I am not willing to go myself and that my responsibility as a therapist and MFT educator is to do my part in my commitment to critical self-reflection.

## **Conclusion**

An increasing demand for a response to the adequate graduate school preparation and training of mental health providers, specifically MFTs who work with immigrants/refugees,

necessitates a better understanding of the lived experiences of recently graduated MFTs who work with immigrants/refugees. The purpose of this phenomenological study was to understand the perception of recently graduated MFTs who work in the United States with immigrants/refugees. I hoped to gain a deeper understanding of recently graduated MFTs' experiences that may help facilitate a more informed conversation regarding the training of future MFTs.

A literature review on mental health needs of immigrants/refugees, responses to that need in the mental health field in general and in the field of MFT, and the current state of training of mental health providers in general and MFTs, in particular, demonstrated a gap in the body of research—specifically as it pertains to MFTs who work with immigrant/refugee populations. The research in this area is sparse at this time; further research would add to the current body of literature and would, in turn, benefit the profession of MFT.

Researching MFTs who work with immigrants/refugees surfaced as an appropriate response given the scarcity of research coupled with the demographic increase in the immigrant/refugee population, as well as the demonstrated higher and more complex mental health needs of said population.

Semi-structured, in-depth, qualitative research methodology appeared to lend itself to the research questions I developed. The methodological approaches, considerations, and processes outlined in this chapter guided this phenomenological research study. The methodology outlined in this chapter was built on the rationale and significance of this study described in previous chapters.

Careful consideration was made to ensure enough protections and accountability for every stage of the research process. Participants were recruited and selected for participation in

this study based on their training as MFTs and their work with immigrant/refugee populations. The semi-structured in-depth interviews were audio-recorded and confidentially transcribed. I used IPA methodology to analyze the data. The themes that emerged from the data were included in Chapter 4, along with participants' narrative descriptions of their experiences. Chapter 4 also includes the results of the study, including a detailed analysis of the process and data.

## Chapter 4: Results

This chapter describes the primary findings of this phenomenological dissertation study. The following are the four main themes and 16 subthemes that emerged after conducting the Interpretative Phenomenological Analysis (IPA) (Pietkiewicz & Smith, 2014) of 13 participant interviews with recently graduated MFTs working with immigrants/refugees. The qualitative research findings are organized in accord with the themes that emerged: (a) working with immigrants/refugees, (b) the reason for this work, (c) making sense of my own complex story, and (d) my experience in graduate school.

The purpose of this study was to explore the experiences of recently graduated mental health professionals from MFT programs in the U.S. who work with diverse immigrant/refugee populations. A disparity in the healthcare of minority groups, particularly immigrants and refugee populations exists (Cook et al., 2018; Verissimo & Grella, 2017), perhaps due to language barriers and lack of cultural knowledge of healthcare professionals (Betancourt, 2003). Earlier literature identified the need to address the barriers, increase culturally sensitive training for mental health professionals (APA, 2008), and increase appropriate therapy approaches received by immigrants and refugee populations (Saraceno et al., 2007). Immigrants/refugees may receive mental health care from providers with minimal training to meet the specific needs of these populations (Augsberger, et al., 2015; Chen, 2015; Edward & Hines-Martin, 2015). Within the field of MFT there is an interest in studying how to improve the education of future MFTs to better serve the needs of diverse populations, however the experiences of MFTs who work with immigrants/refugees remains understudied (Elias-Juarez & Knudson-Martin, 2017; McGoldrick, Giordano, & Garcia-Preto, 2005; Seedall, Holtrop, & Parra-Cardona, 2014). The fact that experiences of MFTs who work with immigrants/refugees remains under researched led



to the development of the following research question that guided this study: What is the experience of recently graduated MFTs who work with immigrants and refugees?

The following sub questions also guided the study:

- What is the recent graduate's experience as a recently graduated MFT who works with immigrants and refugees?
- What is the recent graduate's perception of their MFT graduate education (academic course work, practicum placement, and experience) in preparing them to work with immigrant and refugee populations?
- What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees?
- What role does the therapist's own self-awareness and commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?

Addressing the research questions involved collecting interview data from 13 MFTs who have graduated from MFT training programs in the United States since 2010 and who work with immigrants/refugees. The participants were purposefully selected from a variety of clinical contexts, including hospitals, clinics, school settings, and nonprofit organizations that directly address the mental health needs of immigrants/refugees. All 13 participants' names were omitted, and pseudonyms were used to maintain confidentiality. Interview data was audio-recorded and transcribed for the purposes of analysis. The analysis of the data was guided by IPA (Smith, Flowers & Larkin, 2009) in which patterns in the data were interpreted. The themes and subthemes that emerged from the data are depicted in Table 3.

Table 3

*Main Themes and Subthemes of the Study*

<b>Theme</b>	<b>Subtheme</b>
Working with Immigrants/Refugees	Immigrants/refugees' lives in context Immigrants/refugees' strengths Interpreters Power imbalances Curiosity, flexibility, and self-awareness
The Reason for This Work	
Making Sense of My Own Complex Story	My life is a bridge Language, travel, and exposure
My Experience in Graduate School	Strengths of my MFT program I chose this program because of the cultural lens Basics of MFT Systems lens is far superior Weaknesses of my MFT program "Cut Freud-add more difficult conversations" "There was one multicultural course/there was one professor." "I taught myself" "MFT is taught by white people for white people."

**Theme One: Working with Immigrants/Refugees**

Participants in this study revealed that working with immigrants/refugees presented specific challenges. According to participants, identifying and addressing these difficulties in their jobs as MFTs required cultural sensitivity and heightened awareness to reduce bias. These challenges also resulted in a separate set of dilemmas while working with immigrants/refugees that they had not anticipated. The first primary theme that emerged in the analysis included five subthemes related to everyday work with immigrants/refugees. These subthemes included:

- the importance of considering the contextual variables that affect the lives of immigrants/refugee patients,

- the salient role that strengths play in understanding how to work with immigrants/refugees,
- the relevance of the work with interpreters,
- the personal work of challenging power imbalances that MFTs engage in as they relate to their immigrant/refugee patients, and
- the central role of curiosity, flexibility, and self-awareness.

These five subthemes illustrate, in the voices of participants, some of the common challenges they face in their work.

**Immigrants'/refugees' lives in context.** The first subtheme that emerged was the participants' realization of the centrality of contextual variables in the lives of the patients they serve. All 13 participants, when describing their work, mentioned the influence of their patients' current context on their patients' lives and the subsequent effect on their mental health.

According to participants, the effects of contextual variables in the lives of immigrants/refugees manifested in different ways. A paramount effect of such contextual variables that participants frequently observed and counseled was the fear and worry expressed by their patients about how their needs would be met. Another variable frequently mentioned by patients and observed by therapists, was how the patients were victims of discrimination. According to the study, participants stated that these contextual challenges experienced by immigrant/refugee patients often translated into mistrust of the system.

Ten out of 13 participants shared the need to increase their awareness of the context in which the patients lived. Jacob shared an instance from which a visualization exercise with a client helped him realize that not all clients experience the same privileges as he did, such as taking vacations. Jacob narrated:

[...] active, constant, steadfast commitment to be hyper-aware of the biases and how things are for me. Because I remember, I think it was one time I was doing a visualization exercise with this client, and I realized, I caught myself, but I was almost going to have the client picture vacation spots. And this [immigrant] client was very, pretty poor, and she had three kids, and she was [a] single mother. So, I mean the last thing on her mind, and even possible for her, is vacation. So, [...] that wouldn't be a good visualization tool for certain clients. And then sometimes a good number of my clients, probably five, 10%, don't have cars. I can't talk about having a car like it's normal because that's a privilege that I have.

Jacob's experience reflected the possibility that his clients may be struggling with a lack of resources. Enjoying privileges such as taking vacations or owning a car could be easily overlooked as a mundane occurrence.

Several participants mentioned their surprise as they gradually realized how a lack of resources, stemming from material needs not being met, permeated therapeutic interactions, and affected individuals and families. These adjustment stressors resulted, for example, from immigrants/refugees being worried that their aid would be cut after three months in the country.

Veronica, a Latina therapist, working with immigrants/refugees in a large county clinic, identified the many contextual layers that add to the complexity of the mental health of immigrants/refugees to which other providers are often oblivious and miss, regardless of how many years they have been in the field:

So right off the bat that was missed. All those layers like this family doesn't have documentation. That means that they cannot be driving. They do not know the language, so even if they have money or things that they can take to the second-hand store [they

cannot take them]. Other needs more imminent. Kiddo was in the hospital, so she was going to be discharged and who's going to take care of the baby. Who's going to drive them.

Unlike most clients, some immigrants/refugees may not have proper documentation to be in the country, which may impair them from obtaining insurance needed to access mental health care, in addition to other adjustment struggles such as language barriers. Linea illustrated the idea of immigrants/refugees experiencing challenges that affect their access to mental health care, such as not having documents to live in the country, that impact how they interact with health care system- she stated, "Especially when a lot of the parents feel disenfranchised for one reason or another. [...] when they don't have documentation or they describe feeling, you know, like they live in the shadows here." As evidenced by the quotes above, study participants provided examples of the importance of awareness of the direct impact of barriers and contextual forces on the lives of their patients and in the clinical settings.

Additionally, eight out of 13 participants reported how the political climate impacted their patients and the work they did as MFTs. Cathy, a White U.S.-born therapist who identifies as "latinga" (Latina-gringa), referenced the challenges she faced when serving immigrant/refugee patients with migration trauma: "Working with minority immigrant populations is another layer of complexity. [...] You know, be that due to war or be it due to intra-family violence. To the migration journey. To how they are received and treated here in the U.S." According to Cathy, the effects of the context on the lives of her patients are sometimes also discrimination and xenophobia. Benjamin explicitly stated, "like the current political atmosphere in the news and these things that are outside [of] our control really affected their day

to day living.” Further, Jacob shared a story of one of his patients that illustrated the direct impact politics has on the mental health of his patients:

Then, because San Diego is so close to the border, there are [about] 40,000 [Deferred Action for Childhood Arrivals] DACA recipients in San Diego, so I’ve gotten a few of those. [...] I’m working with this 13-year old boy who about a year ago, he watched his dad get detained all a sudden by [Immigrations and Customs Enforcement] ICE. This was like 4:00 p.m. in the afternoon after he picked him up from school.

In general, the participants shared that the experiences of immigrants/refugees differed from the experiences of non-immigrant/refugee patients; therefore, their struggles required a different approach in therapy. Experiences related to fleeing war, adjustment stressors, documentation, discrimination, and detention were among the struggles generally not needed to be addressed when dealing other patients but needed to be addressed by the MFTs when dealing with immigrant/refugee patients.

The participants’ words are illustrative of how contextual variables are numerous and varied in nature; they range from lack of resources and poverty to the impact of an increase in discrimination because of political changes and perceptions of immigrants/refugees in society. Participants described their perception that the political climate affects the mental health of their patients and that these contextual variables are impacting the lives of the patients they served to a degree they had not been prepared for while in graduate school. Participants shared how issues of poverty, discrimination, and lack of access to resources impacted their clients and forced them to adjust their therapeutic interventions to account for these challenges and deficits.

Many participants recounted their uncertainties about the way they were supposed to respond to the effect of injustices in the lives of their patients, wondering what type of answer or

work is appropriate. Lora May perceived that the work of MFTs might require activism to be able to provide for the needs of immigrants/refugees. Lora May stated:

In the political changes that there are, and stopping people that come for refuge and fire them, and there's a lack of awareness of how important it is and how the refugee program and the asylum program, how it changes people's lives and it saves people's lives. How can you not be an activist?

Jacob also highlighted the importance of MFTs being aware of how the political climate impacts patients and questioned what response is required of MFTs working with these populations:

Yeah, it's just we must be involved politically somehow, and MFT has been notoriously the worst as just compared to psychologists and social workers, and clinical counselors.

It's more important now than ever based on all the injustice that our clients face.

Participants wrestled not only with the impact of political stressors in the lives of their patients but also with how to best address and respond to these factors in the clinical setting and as professionals, whether through activism or advocacy.

According to participants, the current historical moment requires MFTs to be consciously aware of the impact political climate has on the lives of immigrants/refugees and in the clinical setting. Jacob elaborated further:

The political and the private clinical, those two realms, you can't really separate them.

They just have major overlaps, and it's like if you really care enough about this population and the work that you do, you just must be involved somehow politically.

There's no way to avoid it. [...] And the marginalization that I think that we face as therapists, sometimes we're just not taken seriously by insurance companies, etc. So now this is, with this Government, and all this injustice that we're seeing? Like this is the call

to action, and people in privilege need to ... we need to be exercising our privilege muscles to help.

These testimonies and stories manifest participants' descriptions of how the political climate not only influenced immigrant/refugee patients' lives but necessitated a response from MFTs working in this field.

According to participants, this contextual layer that stems from large societal and political movements is not happening in a vacuum and is not an abstraction; it permeates the perceptions immigrant/refugee patients have about providers. Naya, an immigrant MFT working with refugees, shared this insight she had gained in her work: "most Somali refugees come with some conceived notion about healthcare in America [...] that drugs were used for medical experiments during a time and that it has continued. I don't know how that information permeated into the Somali community." Naya revealed that immigrants/refugees might have some skepticism about the healthcare system. These beliefs may hinder providing proper healthcare and, thus, needed to be considered as a contextual variable when dealing with immigrants/refugees. Lora May also described how, in her own experience, it was important to explore how mistrust and xenophobia affected mental health as well as to pay attention to "equitable access to mental health services."

For most participants (eight out of 13), one reason awareness of contextual variables was so significant, particularly in their initial work with immigrants/refugees, was the fact that in their MFT graduate school, general mental health needs were a significant component of the training. However, the therapeutic response of MFTs to the contextual impact of external situational variables in the health of patients, in general, received little emphasis, and even less so in the lives of immigrant/refugee populations. Participants described detailed stories about the



hardships faced by immigrants/refugees as they settled in the U.S. Contexts such as pre-migration trauma and adjusting to living in the U.S. needed to be taken into consideration when addressing the mental health and well-being needs of immigrants/refugees.

**Immigrants'/refugees' strengths.** Ten of the 13 participants depicted the immigration story as full of challenges and difficulties, but several participants (eight out of 13) indicated that what is often forgotten is the resilience and strength of immigrant/refugee patients. Benjamin described the reliance on family, memories, spirituality, and traditions as strong sources of support for many immigrant/refugee patients “That’s the memories and the familiarity that immigrants bring with them. It’s kind of their anchor to their immigration experience.”

Katherine works in a medical clinic; she mentioned her amazement at the resilience shown by some of the families she works with and how gradually they learn how to maneuver in this new culture. Sometimes the unsurmountable challenges immigrants/refugees face blind therapists from seeing the strengths in their patients’ lives. Jacob emphasized that what for some might appear pathological, for immigrant/refugee patients is a strength; he highlighted the importance to stay cognizant of different cultural variables:

Countries (of origin) tend to be more collectivist, and I think that if the therapist isn’t aware, they may accidentally kind of pathologize these very close-knit, seemingly enmeshed families when really, the enmeshment, or whatever you want to call it, can be a sign of strength.

Similarly, Carole stated that in her practice she has learned the importance of focusing on resilience and immigrant/refugee strengths, not just pathology, Carole, like many participants, also believed in spirituality as a significant source of strength. Similarly, Hawa commented on

spirituality as a strength, as well to include immigrant/refugee patients' spiritual and cultural background:

I think it's very important. [...] I mean, I've done work with families, for example, I have this mother and she saw this book I had on my shelf, which was "The Past Lives of Children," and she said, "Oh my God, I didn't think I could talk about that here." And that was her belief that her child had this trauma and it was related to a past life, and we could actually talk about that.

Francine also discussed how it was important for her to be aware of focusing on strengths and community resilience "and looking at the communities that they are serving now but looking in positive light as well."

The areas of strength can be harnessed in therapy when they become meaningful, as Benjamin highlighted in this comment: "Also, finding meaning from the client about if immigration or being in a different country affects them and if why." Participants also wished that the immigrant/refugee population were regarded more positively (not just disparities but strengths and culture). They expressed a desire for the utilization of a more inclusive lens when looking/working with other cultures—an understanding that patients have different cultures that offer strengths, and this should be taken into account when working with immigrants/refugees.

**Interpreters.** Most of the participants, 10 out of 13, mentioned interpreters or working with interpreters regularly in their work with immigrants/refugees. For example, Katherine commented that "often times they will require an in-person interpreter, so we'll do an hour [...]. We don't have interpreters on-site, but we work with a couple companies and [...] [they] help us schedule in-person interpreters." When MFTs do not have the language ability to offer services

in the language of the immigrant/refugee patients, interpreters appeared to be central but underestimated personnel in the service of mental health needs for immigrants/refugees.

This subtheme had three marked areas, as explained by participants. The first area is that working with interpreters requires adaptations on the part of MFTs to navigate the clinical interaction successfully. Second, many clinics or organizations that hire MFTs are not aware of the regulations surrounding the provision of services of patients who speak languages other than English. Third, none of the MFTs in this study received any education on how to work with interpreters in the MFT program.

*Adaptations on the part of MFTs.* The detailed description of MFTs' work cannot be completed without acknowledgment of the centrality of interpreters who are an integral part of therapeutic work with immigrants/refugees. Participant interviews indicate that learning how to navigate a clinical encounter with interpreters necessitates attention, as it can affect positively or negatively the therapeutic outcome. According to participants, working with interpreters results in added complexities and challenges to the therapeutic interaction. Participants referenced challenges related to the difficulty of juggling schedules, complexity of interactions within the therapeutic session, and the confusion over the role of each of the professionals. A story provided by Naya highlighted the impact that interpreters can have in the clinical encounter, as some messages may not be as easily relayed by the patients to the MFTs:

So, when I came in with this Somali interpreter, my client went blind on one eye and started shaking and was just exhibiting some very serious reactions to the presence of this guy, a mental health behavior. She wouldn't say why and so I asked the new guy to leave us for a moment. So, the new guy left. I did tell him to go downstairs, so we were left with that woman. And then, all of a sudden, she started seeing again, and the whole

reaction stopped. So, I asked what's going on. So, she told my interpreter to tell me that that guy, that guy's father ... I'm not sure it's exactly the father, but just from the tribe. But that guy's father, that this guy is from a tribe that killed her daughter, and then they wounded her on one eye. So, [this reaction happens whenever] [...] she experiences anybody from that tribe.

This unique story illustrates the impact the presence of an interpreter can have in the clinical encounter, not only the presence of a third person in the room, but also because of what that third person can represent culturally, and psychologically, for that patient. According to the participants, the added complexities in those situations can be very difficult for therapists to learn and navigate.

***Organizations that hire MFTs are not aware of the regulations.*** An additional challenge related to working with interpreters occurs when clinics may not be aware of the rules and regulations required when serving patients who have limited English proficiency, such as the fact that some clinics may use family members as interpreters. For example, in her interview, Carole challenged the practice of using children as interpreters. Another example of not following guidelines is not using an interpreter, despite the need because the MFT has limited language ability in the patients' language hence putting the MFT and that patient in a precarious situation. Hawa, a therapist who had expressed some knowledge of Spanish, stated she felt pushed to do therapy in her second language, although she did not feel sufficiently fluent, because her agency did not want to hire interpreters. In her interview, she emphasized the importance of working with interpreters and wished she had the opportunity to offer high-quality services to patients by using professionally trained language interpreters. According to Hawa, agencies often do not prioritize hiring interpreters and, although positions for bilingual providers were being

advertised, they hired MFTs who were not proficient enough in the second language to be able to provide care. Hawa stated, “I thought, this doesn’t make sense. You’re not really putting the effort to get qualified interpreters.” Similarly, Francine commented on how some agencies did not hire interpreters and instead would take advantage of her Spanish skills even when she felt uncertain:

Even though I am somewhat fluent in this, I don’t feel fluent sometimes, and so especially when in therapy trying to understand things and stuff like that. And so, I think for me it was a good learning experience just to become a more qualified therapist and a better Spanish speaker and working with these families.

These participant testimonies illuminate the experiences of some MFTs in clinics or organizations that exhibit a lack of understanding of the rules and regulations that surround the proper use of interpreters in the practice of MFT.

***None of the MFTs received any education in the MFT program to work with interpreters.*** Finally, related to work with interpreters, none of the participants had received any instruction on how to work with interpreters as MFTs. In her interview, Angela, alongside the other nine participants who mentioned this topic, commented on the important and central role that interpreters serve in clinical settings and yet no specific education on working with interpreters in her MFT training was provided:

How I work with interpreters. It was all about how to position yourself in the room, and the role of the interpreter and your role as a therapist and how you’re going to work well with your interpreter. And I think these are things that if you’ve never done it before, it’s crucial. But if you’re not even speaking your own language and you’re relying on an

interpreter, how to take advantage of that as the amazing resource that it is. But also make sure that you're maintaining control of the session.

Participants indicated they would have preferred instruction in their MFT programs related to professionally integrating interpreters into their MFT practice, due to the commonality of the occurrence.

In summary, several participants described the experience of a learning curve to adapt to working with interpreters. The participants generally learned of the many implications that come with doing MFT with interpreters at the therapeutic level as well as the administrative level. Working with interpreters also emphasized the need for awareness of regulations and availability. The theme of working with interpreters was salient, as participants described their daily work with immigrant/refugee patients, a skill in which they seemed to wish they had received more training during graduate school, given the frequent interactions with interpreters.

**Power imbalances.** According to the participants, managing the power dynamics in any therapeutic relationship is challenging. The importance of being aware of power imbalances and the need to adjust the traditional Western collaborative role of mental health providers emerged as two subthemes in half of the interviews. What transpired from the participants' responses regarding this theme is twofold, first, the awareness by participants to accommodate the expectation patients had of them to be more directive and enter the position of "expert." Second, the need to challenge the societal power imbalances that permeated into the therapy room also remained.

Firstly, nine out of 13 participants commented that many of their immigrant/refugee patients expected a more direct and hierarchical approach from their providers as experts and not a collaborative style. In her interview, Lora May described how she had to learn how to

challenge power imbalances while maintaining the posture of being the expert as the therapist. She offered an example of working with Hmong men to whom she would show respect by sitting on the floor during in-home therapy visits. She explained the clinical situations in this manner:

They would be sitting on the couch and I would deliberately put myself in a lower position because I'm coming in, and I already know that they're looking to me to be the expert and that's when they're going to respect me as the expert but also I pay attention to the social dynamics of putting myself into a lower place because I'm in their home.

And, they also ... I reinforce that they know themselves more than I know them. And so, I need to be able to ask the questions, and they need to be able to tell me them.

This example provided by Lora May illustrates how participants gradually became aware of the power they had as therapists and how they utilized this clinical authority in different cultural settings.

Veronica mentioned her realization that therapists held a lot of power and that power needed to be harnessed carefully, "that is something I think it needs to happen more because we have a lot of power as a mental health professional when we give a diagnosis. That label can do a lot of harm." Likewise, Carole stated, "I mean, I think for me what's right, there is balance of power, right? Or the interactions of power." Amanda also described this insight as she began to realize how her patients viewed her role; she stated, "people call me doctor all the time, and that's just kind of OK to recognize I'm not a doctor. But just realizing that that's the authority that it has." Furthermore, Angela, an MFT working in a federally qualified clinic mentioned that she had to change her traditional "style" learned in graduate school for an approach that challenges power while reinforcing her position of authority:

Let's see ... So, I think maybe this is my personal style of doing therapy... Or maybe it's just there's this challenge of how do I manage my position of authority as a therapist and kind of defer to different people's needs and to kind of make sure that I'm kind of following their senses and not necessarily applying my own. But I think I've always tended to be a little bit more passive in some of my cases in the past. And working here and talking with my supervisor, there's been a lot more of a shift of like things will be really simple, and you're going to be really direct, probably more direct than I would be maybe... I know I'm more direct than I am with a client than the private practice that I work in. I work in a private practice in the evening. Very wealthy area. People are coming in with different resources.

The quotes above all clarify interview responses that reveal how several participants had to learn, in their work as MFTs, how to wrestle with these power imbalances related to the perceived power and style their position as therapists has in relation to their patients.

Secondly, as participants were describing this issue of power imbalances, some posited a need to make the power imbalance in the therapeutic interaction explicit. Lora May described it well when she asked, "I mean I think for me what's right there is balance of power, right? Or the interactions of power. And they are different, right?" Linea also referenced how it was important to be aware and make explicit the power inherent in being a white therapist when she stated, "Especially being, I think, white in this country it's really important for the work this field because you can do a lot of damage. It's a position of power." Similarly, Lora May elaborated on the idea that being a white therapist has an impact in the work with diverse populations, "[immigrants/refugees] [they]'re entering into a white dominant society." Some of the power imbalances described by participants referred to the position of authority inherent in being a



therapist; other power imbalances stemmed from the perceived power in differences in language, culture, ethnicity, and social status.

In summary, participant stories created an understanding of a need for balance when working with immigrants/refugees. MFTs were considered experts in their field, but they also appeared to have a lot to learn from their patients. The participants shared some of the elements needed to achieve that balance in practice, which led to the next theme: curiosity, flexibility, and self-awareness (humility).

**Curiosity, flexibility, and self-awareness.** According to participants, one of the realizations of working with immigrant/refugee patients was that, to be effective, the therapist must exercise great flexibility, curiosity, and self-awareness. Eleven out of 13 participants explicitly mentioned curiosity, flexibility, or self-awareness as essential skills to work with this specific population. In her interview, Katherine gave a simple example of being flexible and adaptable when she spoke about how she had to learn to use a different language style to achieve a balanced work with immigrant/refugee populations. She stated:

We talk a lot about stress rather than some of the concepts like depression and anxiety, which sometimes don't translate as well, as everyone knows what stress is. So, I think changing my language a little bit has been really helpful.

Angela had an illustrative story of flexibility, grounded in her curiosity and desire to understand the experience of the patient; this flexibility was exercised in the therapeutic encounter:

I was working on a case for a woman... We were both speaking French as a second language. She'd been in a refugee camp, just so much trauma, and ended up here as a minor. We were talking, and I specifically asked her how she was feeling, and her answer didn't seem to make sense to my question. I wasn't sure if she understood what I was

saying. It wasn't until I started saying, "What's happening in your heart? What does your heart feel like right now?" Then it made sense.

Veronica, in her interview, also reflected on the importance of remaining curious and flexible at a deeper level as well: "we need to check our own biases, and we need to when we see a client, we need to have a little bit of curiosity to look into what is the cultural background." Angela raised a similar concept when she stated:

That if we can't be curious, to keep perpetually learning, then we're not gonna be effective tools. And I think that it looks differently ... What am I trying to say? I think that in many different ways. So, one, just even being aware politically and news-based. I have people come in and will mention, "Oh, this thing is happening in Ethiopia," and I honestly don't know what's happening in Ethiopia. And so, she'll tell me stories and show me these terrible pictures that I wasn't aware of. There's no way to keep up with everything, but I think to the best of one's ability to have a general sense of what is gonna be helpful, right. I think the next is just being aware of what I mentioned earlier, how much we don't know, and to have that respectful curiosity of letting the person explain their particular terms of world view or their particular experience of something in their own words without assuming.

The preceding quotes describe the creativity exercised by some participants to effectively work with immigrant/refugee patients; these examples emphasized the centrality of curiosity, flexibility, or self-awareness.

Amanda commented on the value she places on having curiosity about larger historical issues as well as curiosity about the specific situation of her patients, she stated, "curiosity to

learn about a global sense of where a person comes from. And then curiosity to learn about that particular person.”

In the context of increased diversity and increased awareness of not knowing what to do or what to say in therapeutic interactions, Naya found that the antidote to fear and to being overwhelmed is the skill of staying curious and willing to be flexible. She stated:

The only thing is to pay attention and then be curious. Don't presume to know anything. Actually, believe that you know nothing and then be open to learn from the people. Learn the values, learn what is important to them. And then the worst mistakes the system makes, not just mental health workers, but also people like case managers, people like health workers. One of the worst mistakes they make is to think that they know what is good for an immigrant.

The importance of remaining curious and open is linked by six out of 11 participants to the idea that there is a vast diversity within the immigrant/refugee population, and not all immigrants/refugees are the same. Katherine stated how learning from, and with, her patients had been enriching “Yeah, all over the place and it's been ... and obviously a lot of our Central American countries as well. We get a lot of people from El Salvador. It's been a huge learning experience for me.” These participants highlighted this point because they had shared anecdotes in which they had to remain curious about groups of immigrants they felt they already knew very well.

In the interviews, participants shared how they constantly had to remind themselves to remain curious about the immigrants/refugees' backgrounds and their lives. Naya, an MFT who is an immigrant herself, stated, “simply not the same, all Africans, East Africans, West Africans

have different ethnicity, different traits, different culture. The only thing that puts them together is that we are blacks and we are from Africa.”

Alongside the huge diversity among immigrants/refugees, five out of 13 participants included other nontraditional immigrant/refugee categories in their work with patients, i.e. Puerto Ricans who are U.S. citizens but whose experience is often one of displacement and marginalization. For example, Francine stated “Puerto Rico is considered a U.S. territory; well I would consider it immigrant.” Francine continued:

I think being able to understand how much diversity there is within these two populations as well. In the U.S. these populations are growing, the U.S. is becoming more and more kind of like a melting pot. Every single day no matter what’s going on politically it’s still becoming more and more diverse. [...] okay ‘Latino’ but there is so much diversity, and with all the diversity there comes like so many different types of mental health concerns. And if we come from a global health perspective these people are all across the board. So just being flexible, but also just being educated on the extent of diversity and not kind of getting scared of it, but just embracing.

Participants expressed that understanding the diversity within the immigrant/refugee population was important and to remain curious about the immigrant/refugee population would be helpful as it is a very diverse group. Many felt training should include knowledge of where immigrants/refugees were from, what their government was like, and what stresses they experienced, allowing clinicians to learn more about their future patients’ backgrounds.

In their interviews, several participants mentioned the importance of not making assumptions and asking authentic questions, even if the therapists felt they already understood a specific belief and what it represented for an immigrant/refugee patient. Several participants used

expressions such as “be able to question and to stay humble” or “exercising humility.” Jacob very specifically raised the importance of holding a humble stance regarding culture, stating “moving from the old term ‘cultural competence’ to the new term ‘cultural humility.’”

Furthermore, Angela suggested maintaining a constant stance of curiosity, commenting “a lot of clients who came from Mexico. But Mexico is a big place, even though Spanish is spoken, so are hundreds of more dialects among the indigenous population.”

In his interview, Benjamin combined the many sentiments shared by other participants in a very clear and explicit manner when he stated: “When I think about the sessions that I have or have had with these clients and the, what’s the word. It’s just maintaining a curiosity about their lives.” Francine also eloquently summarized the centrality of this theme for all participants:

The flexibility would be helpful in understanding that just because you think one way doesn’t mean that everybody is connected in a thinking from that same orientation because I think in working with people that come different cultural backgrounds, it’s almost like you have to be really flexible and understand that if ... Me as a clinician if I’m not exercising that flexibility that means my client might have to be a little bit more flexible.

Like Benjamin, all the participants who mentioned curiosity as a central element of their work with immigrants/refugees also held flexibility and humility simultaneously with the notion that they had to learn by “trial and error.”

According to the participants, closely related to the importance of remaining curious and being flexible was the idea of being self-aware about their own personal experiences and emotions, and checking personal biases as Naya stated when she referred to the importance of checking “underlying assumptions” held by therapists. Jason emphasized the importance of

being “hyper-aware of the biases and how things are for me.” Benjamin also commented on how important it is for this kind of work to increase awareness, “helping emerging therapists become more aware of their biases.” Veronica eloquently offered a position that summarized curiosity, flexibility, and self-awareness:

This is one example and to talk about my own biases which is at the root of I think everything, even when you're not dealing with someone from another country. I think everyone has their own culture in their home, so when talking and working with someone and treating someone else, checking our biases.

This quote by Veronica parallels other participants’ sentiments that bring forth the centrality of engaging in honest self-examination of personal biases to work effectively with this population.

In summary, the theme, the work with immigrants/refugees, highlights the day-to-day work of recently graduated MFTs who serve the needs of this population, which unearthed the pressures that contextual forces have on the lives of immigrants/refugees and therefore places MFTs in a position to adjust their roles beyond what they had been instructed in graduate school in order to meet their patients’ needs. This dynamic means moving into roles of advocacy and reassessing the impact of social and political variables in the lives of their patients. This shift contrasted with the big emphasis they thought their past trauma and other pathologies explored in MFT training would have on the lives of their patients.

But the work of recently graduated MFTs serving the needs of immigrants/refugees is not complete without the consideration of the strength of the immigrant/refugee patients. Recently graduated MFTs express admiration to the fortitude of their patients, hinting at the reality that knowing how to assess for strengths and how to help patients and families harness those would make their day to day work more effective. The work with interpreters was mentioned by most

participants as central in the work with refugees and immigrants. An added layer of complexity is the patients' expectation regarding the role of "providers" as doctors and experts, above the hierarchy of power.

In their interviews, participants described situations in which they had to face the power dynamic challenges with grace, having no prior inclination of how to overcome the challenges inherent in working across cultures and with marginalized populations. How participants navigated this challenge, and many others, is described in the concluding sub-section of the first theme, which gives rise to the importance of having a curious, flexible, and self-aware stance. Participants named these characteristics as valuable in managing the daily challenges of working with displaced patients who are deeply pressed by harsh circumstances.

### **Theme Two: The Reason for This Work**

The second primary theme that emerged from the interviews was related to what led participants to do the work they do. This theme mainly resulted from the question, "What is your experience as a recent graduated marriage and family therapist who works with immigrants/refugees?" The participants reported personal stories and experiences that led them to their current jobs. For many participants, seeking a position as MFTs for immigrants/refugees was intentional, while for two of the 13 participants working in the position was incidental. Most of the participants sought work as MFTs due to various reasons, including fulfilling their calling or purpose, taking advantage of their bilingual skills, or having the desire to make a difference. The reasons for working as MFTs for immigrants/refugees are further described in this section.

Out of the 13 participants, 11 sought work with this population, and only two, Benjamin and Katherine, ended up working with this population because they happened to be in a setting that was very diverse. Benjamin practices in a very diverse area of the U.S. "I mean, Texas, it's

on the border with Mexico and I know a lot of immigrants come through Mexico to come to the United States.” Katherine described how she ended up working in a clinic that was very diverse:

Yeah, it did just happen. It sort of fell into my lap based on, again, I think this area is a landing point for a lot of refugees, and so our population is with them and since we serve the general population it was bound to happen, I think. I never really set out to do that, it wasn’t actually an area that I was aware that needed the intense amount of care that they do. Again, it’s been this peeling back the layers of, ‘Oh, my goodness, A) there’s so many people who are coming to this country for asylum or refugee status. And B) all the things that they have endured and just how many services that they really need’. So, it’s been just a total learning experience for me.

Benjamin and Katherine described finding themselves working with immigrants/refugees due to the location of their respective clinics, which is representative of the increase in diversity in the demographic composition of the U.S. Almost all participants seemed to indicate that with the increasingly diverse population in the U.S., more connection with others who come from different backgrounds happens organically. Some suggested that nowadays it is inevitable to know someone who is an immigrant/refugee, whether neighbor, doctor, school teacher, grocery storekeeper, etc.

The other 11 MFTs who for a variety of different reasons intentionally sought to work with immigrant/refugees described their current work using language such as:

- “my heart really likes this population,”
- “I’m called to,”
- “the population grew on me,”
- “what is not to love,”



- “I was meant to do this work,” etc.

This language reflects and speaks of a deep sense of calling, purpose, and vocation; participants attributed this deep meaning as particularly instrumental in helping them face the complexities and challenges as MFTs. Angela shared how she can trace back finding her calling to work with immigrants/refugees to her experiences prior to starting graduate school education. Through her travels and exposure to diverse populations, she saw a very clear need and felt a sense that that was her “life’s work.” She stated, “It was kind of at that point when I decided I wanted to work with that population.”

Some participants started working with immigrants/refugees to respond to a need for which they were qualified through different means. For example, Cathy offered:

I knew I wanted to keep serving and I did another year of service in Chicago with a Spanish speaking community and that’s when I noticed and it was brought to my attention the gap in mental health services for Spanish speaking. Specifically, in Chicago, there were just ... there was a therapist there at our workplace and she was booked for months, because of the lack of affordable, accessible care. [...] I’d always felt the call to serve others and the capacity or the direction of that service was, of course, it developed over time.

Like Cathy, other participants described how they ended up working with immigrants/refugees using language descriptive of calling, vocation, and service. In her interview, Angela described a desire to use her history of working with refugees as a volunteer to make a difference in the world “So I don’t honestly know why. It just felt really important to me, that I needed to help people that wouldn’t have access otherwise.” Similarly, Lora May also shared how starting to work with immigrants/refugees initiated a sense of vocation and a call to respond to a need:

I saw a unique need, especially around the help that they were getting and it just not being useful. I like being useful and I like being efficient. [...] And, it's one of those things that I used to always say, like I would leave my clients' houses and I would feel amazing, like I was, this is the work I'm supposed to do. This is awesome.

The participants' past experiences working with immigrants/refugees in other capacities, outside of mental health, made them feel the need to continue working with this population as MFTs.

Within this theme of reason for this work, most participants mentioned the significant need for mental health services for immigrants/refugees. Participant responses not only pointed to the needs of this population, but also to the recognition of the part that MFTs play in attending to these needs and how a sense of calling is often an inseparable part of the equation. In her interview, Veronica stated:

I had the privilege to have an awareness and see that, again, my reality was different from their reality and that's why I say that I didn't decide it, I think it just needed to happen. I said that once that you know, you know and you cannot not know.

Veronica described how her newfound knowledge of the needs of immigrants/refugees led her to be engaged in finding a solution to the needs of this population, which appeared to initiate a sense of calling.

While discussing becoming aware of the need to provide culturally appropriate mental health care for immigrants/refugees, participants also reflected on how they realized they could participate in the fulfillment of that need because of their own set of expertise. Participants described expertise such as speaking another language for example, as skill that would be very valuable for serving diverse immigrant/refugee populations. In her interview, Carole shared this illustrative story:

I sought after it definitely. [...] I am a resource, right? It would be a shame if somebody could speak Spanish and know the things that I do that I would be on the sidelines. [...] People needed help now, and that's why I was very interested in that work. And it was very clear for me, no, this is a terrific population to work. It plays to all of my strengths. And it gives me an opportunity to provide. It was one of those things where it was a good match. I felt fulfilled in that sense.

Comparably to Carole, Francine began working with immigrant refugees when she identified a need and found herself able to offer something to partially meet this need:

I think it was a little bit of both, I saw that there was a need and of course that I spoke Spanish it was kind of like easier for me. So, I think it was a little bit of both, there was a need and I could still enjoy the work, I understood it, and it came easy to me.

Generally, the participants felt a sense of calling towards the immigrant/refugee population initially due to their enthusiasm and genuine interest in this population. Later, the participants' commitment to serving this population was fueled by many factors such as finding out that they had resources they could utilize in working with this population like bilingualism.

The theme of calling is not exclusively connected to speaking another language, nor is the main element identified. Rather, the inner movement in the lives of the participants was feeling challenged to look within themselves to see how they could be part of the solution to a need, sometimes using bilingualism, but others much deeper than that to a sense of vocation. As many were pondering the challenges inherent to working with this population, vocation and calling was at the initial impetus to work with this population but also a source of strength throughout. Vocation appeared to be a significant fountain of encouragement in the midst of needing their work buttressed by a deeper than skills type of sustenance. Participants identified

this sense of calling as a beginning of a journey, but also a source of motivation when the work got hard. Cathy stated:

[...] is that sense of purpose. That ... that believing that what I do serves a higher good. And that, you know, that ability to, you know, trust in a higher power—You know, when there are days, multiple days, multiple hours where I have no idea where to go with this client—Or, no clue if anything is improving. You know, those moments of uncertainty. It allows me to have a place to trust. And you know they tell, of course they use the word, *trust the process*. Well, that's all well and good, right? But that's easier said than done, right? And having faith just helps me to kind of center myself and say, you know, I have to ... I have to trust that if I'm listening and I'm present and I'm, you know, I also believe in spiritual guidance—And intuition. If I'm allowing myself to be led and that that something beneficial will come.

It appears that for some participants, like for Cathy, working with immigrants/refugees was not without challenges; however, considering the work as a calling and a sense of vocation, most of the participants were able to overcome the challenges. For some participants, the feeling of fulfilling their calling or vocation served as their drive to continue doing well in their jobs.

For many of the participants, the work with immigrants/refugees appeared to be more than just a “job.” In the interviews, the word “job” was rarely used, rather, the default terminology was “service.” Lora May described above how this sense of calling both brought her to this work and how calling kept her in a job that was more than a job, but rather a vocation:

But it also comes down to like, is it just a job for people? I think for some people it's just a job whereas for me it's like, it's a calling. I like it. I'm good at it. I'm going to do something that I'm good at and enjoy. If I'm going to spend 1/3 of my life or eight hours

a day doing something, I'm going to enjoy it. It shouldn't be work, like there's going to be hard days, yeah, but that's also just part of the journey, it's exciting.

For some participants, being an MFT was not just an obligation. Participants such as Lora May shared that they felt good doing their jobs.

In her interview Veronica described how she started working with immigrants/refugees and why she continues, explaining, like many others, how a calling is also a sense of sustenance amid the challenges and stressors of a difficult but rewarding job:

That is just the greatest thing. Even if there is not an ah-ha moment, even if there is no breakthrough or changes, just the fact that you can meet with another human and you can be there in their pain and hold that space, that loving sacred space for me is so special.

The participants' stories in their own language offer a strong, thick, deep description that underscores what motivated many of them to work with the immigrant/refugee population, seeing a very clear need and seeing their part in fulfilling the need.

Participants illustrate how, for many of them, this work with immigrants/refugees is more than a job, and the fact that it is more than a job sustains them and supports the many challenges they face in the daily work of serving the mental health needs of this population. Several participants felt a calling to work with immigrants/refugees, in part stemming from that exposure and life experience.

### **Theme Three: Making Sense of My Own Complex Story**

The third primary theme that emerged from the participant interviews was making sense of their own stories. This theme emerged as participants were wrestling with the idea of how awareness of their own life experience (ethnic background, immigration journey, skills, travel, language, exposure, etc.) impacted their sense of preparedness to work with

immigrants/refugees. This theme includes the following two sub-themes: my life is a bridge, and language, travel, and exposure. These two subthemes are similar but have distinct characteristics that grouped them in separate subcategories. “My life as a bridge” subtheme describes the reflections of participants regarding how gaining awareness of their own family of origin story, identity and culture afforded them a sense of connection to their patients. On the other hand, “language, travel, and exposure” as a subtheme, contains reflections of participants about travel, learning another language, or being exposed to different cultures, and how those positioned them in a way that facilitated connection to their immigrant/refugee patients. The participants generally experienced a connection to different cultures either by ancestry, marriage, or friendship or through their own experiences of being an immigrant. Having learned a second language, traveled overseas, or exposed to diverse situations also appeared to have contributed to the participants’ narratives. These sub-themes are further described below.

Ten of the 13 participants had a connection to a person from another ethnicity or language either through marriage, work, travel, or their own family of origin. As participants were sharing their experiences of working with immigrant/refugees, sub-themes founded in their personal life stories were easily identifiable, such as:

- how they made sense of their own life story to bridge their experience to their immigrant/refugee patients,
- how language learning was a path to connecting with this population helpful skill and the practical and simple step of being exposed to cross-cultural differences to grow and prepare to serve the mental health needs of immigrants/refugees.

**My life is a bridge.** Ten of the 13 participants described how becoming aware of their own life stories of immigration or exploring their families of origin’s history, or having

relationships with others who are different from themselves in language, ethnicity, or socioeconomic background, afforded them a sense of connection to their patients.

The participants shared what it felt like to have to learn new skills as an adult, to adapt, to be the “other,” or to be looked down upon based on their own backgrounds. Prior to or during the interview, this realization surfaced, and it helped them realize how having an awareness of their own life story played a part in how they made sense of their current work with immigrants/refugees. For example, in her interview, Hawa, who identifies as part American Indian, described how her own ethnic background, language skills, and being married to a man from another country impacted an important part in her work and gave her a sense of connection. Jacob, who described himself as Jewish-American, explicated how having grown up with a speech impediment instilled in him sensitivity toward others. Also, he described how speaking another language and being in a cross-national marriage afforded him a sense of preparedness to serve immigrants/refugees:

It's hard to isolate where I learned it. [...] It's the Mexico City training, it's being married to a Mexican woman who was raised in Mexico and had only been living in the US for a year and a half. It's working with a lot of these families and client's kind of being open to them, teaching me how things are, and me tailoring my theories and my clinical judgment to match their cultural needs.

In a like manner, Jacob made sense of his own identity, family of origin story, and difficulties in his background to create a bridge which he crosses in his work with immigrants/refugees. Other participants discussed stories and events in their lives that allowed them to create “bridges” of connection to others, who, for different reasons, live at the margins of society.

In her interview, Veronica harmonized her own journey, perhaps not considered a “true immigration experience,” in a way that contextualizes her time living in Europe and having to learn another language, as well as brings her closer to her patients. She also shared how becoming aware of her own story did not happen in a moment but rather was a process that took time:

It took me a couple of years to understand that I'm not fully part of that category of being a[n] immigrant because I'm from Puerto Rico and Puerto Rico is a colony or U.S. territory. But because of the same issue we do share some of those, we have those commonalities of the language and the barriers and our traditions and whatnot.

Making sense of their own stories and their journeys, participants found points of connection with their patients. For some, the points of connection were not direct and required a nuanced interpretation of their lives. For others, the similarities in their backgrounds were so strong that it gave them a granular view of what their immigrant/refugee patients go through upon arrival to the U.S. In her interview, Naya, a participant who is herself an immigrant from Africa, described her own experiences with the hardships of moving to a new country and the initial struggles to adapt to a system that she perceived as very rigid:

First of all, I myself I'm a recent immigrant [...] Even though I came in as a Ph.D. student who had already done all her studies in English, I still found out that America has its own nuances, some method of speaking English that is not just what I'm used to having been brought up in British English colony or former colony. So, I learned that even if people were speaking English from when they come in as immigrants, it's still difficult with language. It's still difficult even with the environment. There are many things that are so confusing about American culture. No matter how much you read about it or watch it in



movies, when you start living it, it's a lot difficult, very difficult. And then navigating the social system. America loves paperwork.

Naya shared this story as she was reflecting on the complexities of her life journey and how those paralleled some of her patients.

Many participants reflected about their own experiences when they felt different, or were a minority themselves, even if for a short period of time. For participants who did not view themselves as having an “immigration story,” a story that was not mainstream afforded them, or pushed them, to have to reflect early on about their identity, which became useful in their interactions with immigrant/refugee patients. For example, Lora May commented:

I think it might be different, and maybe this is because I don't view myself as an immigrant story, because there's that identity of yes, this is part of me, that my biological father was a refugee, which is not part of my story because of my upbringing. So, I think it might be different for somebody else in my cohort that maybe had a really different story or if they came to America or growing up in the United States. [...] I think it's incredibly relevant because I catch myself doing it, I used to, and I would be like, "Stop it, Lora May! You're making an assumption, and you know what an assumption does."

As participants delved into their own stories, they found ways to connect them to areas in which a commonality existed with the experiences of their patients.

The idea of bridge and connection to others, was summarized by Veronica:

Yes, because again, talking about so you go to school and they teach you the theories and they teach you the models and they teach you how to do a treatment plan. How to take notes. But then how to see yourself and how you see the others through yourself.

Overall, the participants emphasized being able to relate to their immigrant/refugee patients when their own stories of being different helped them understand how individual humans have different stories of their own.

Another example of MFTs experiencing bridging and connection to their immigrant/refugee patients originates from how they experienced many of the same microaggressions and discrimination faced by immigrant/refugee patients. For example, Veronica, who identifies as Latina and speaks English with an accent, commented on how she was a victim of discrimination by peers in the mental health field. She shared how her own life experience can help her connect and understand when her patients had experienced discrimination because of their language ability or accent. Another participant, Naya, shared how she felt discriminated against in her own MFT program, as an immigrant and student of color.

In her interview, Lora May shared that she did not embrace her own ethnic identity until adulthood, due to being the daughter of a biracial relationship, raised by a white mother although her biological father was from a southeast Asian country. Lora May shared how her external appearance and physical features did not match her life experience, but making sense of it was an epiphanic moment or process that offered her a sense of proximity and closeness to the immigrant/refugee population:

So, my social experience was being the poor white person. Growing up in a really strict evangelical family. [...] I wouldn't say that my biological father's background in any way influenced me, because I don't know him. I don't have a relationship with that at all. What I do have a relationship with is the people that I met, the people growing up on the east side and growing up poor [...] Because poverty recognizes poverty. [...] And then, there's also the part of those working with refugees and immigrants is, I'm not part of the

culture, but I don't look like the dominant culture. So that's one of the things that I've always said is really nice about being an outsider.

Lora May illustrated how she made sense of her own identity straddling two worlds and, in doing so, it created a bridge to connect with the experiences of refugees with whom she was working.

This theme intersects with the idea of participants seeing their identity as containing a multiplicity of identities, and holding loosely the idea of rigid identity. Ten of the 13 participants indicated they were able to be an element of connection especially because their sense of identity was fluid. Lora May commented on this specific issue, stating:

And I think that there has to be, like for me, just with my background had finally gotten after years of struggling with it, of being able to own my background and be able to say to clients that it doesn't make sense to them at all to say my biological father is Vietnamese. And technically I'm half Vietnamese, but I identify as white. Because I grew up with two white parents. I grew up in a Norwegian and Italian household.

Carole also mentioned how becoming aware and embracing her sense of her own ethnic identity was a catalytic event and process that helps her work with immigrants/refugees:

[...] in 1994, when I was applying for a federal government job, I was afraid to mark Hispanic, right? But now, no way. I am totally Hispanic. I totally own that I am Hispanic. That is how I identify because I am. I happen to have an American father, but I am also Hispanic. I own that now. But I also feel that I can hold both sides. It gives me a container. Because I also know the prejudices, and I know what people say and what their expectations are. The word I always use is integration. All of it has been meant for me. I just saw such a clear path for integration.

Similarly, Francine shared that making sense of her own life story, ethnic background, and her immigration journey influenced her sense of being prepared to work with immigrant/refugee populations:

[...] my father, he immigrated from West Africa, and then my mom is Southern, she's from Florida. I kind of grew up, when I was growing up most of my family was my dad's side of the family so it was mostly West African family, they're my only family. And so, I grew up sort of in an immigrant setting, I was an immigrant there.

The interviews demonstrated how participants' making sense of their own complex stories allowed them to connect with their patients' complex stories. Further, that participants were able to see their own identities as fluid seemed to allow them to see their patients as real people beyond just being "refugees" or "immigrants."

**Language, travel, and exposure.** Ten out of 13 participants described their journey to work with immigrants/refugees with different degrees of fluency. Out of the ten that are bilingual, eight learned a second language as adults. The two participants who grew up bilingual are as adults, multilingual. For those participants, their language skills led them to work with this population and influenced their staying at the job. For the participants who learned another language as adults, for example, in college, the theme that emerged was that through language acquisition, they learned about a different world that led them to travel or to specific jobs, which then exposed them to other lifestyles, which resulted in openness. Jacob recounted his story of how language learning placed him on a path of international travel, which allowed him to explore the world and be exposed to a variety of people. In addition, Amanda shared how her undergraduate degree in Spanish facilitated opportunities to work with diverse populations. Similarly, Cathy stated:

So, it started ... well it started with an interest first in the language. And that was in college and then it wasn't until I went to Mexico and did some mission work for a couple of weeks that I just felt called to serve the community. That was the Spanish speaking community. And I had ... no idea what that meant. Or what that was going to look like. I just felt very connected to the culture. Very connected to the values, the people, the warmth.

Many participants connected this idea of exposure to other subthemes that emerged at other times in the interviews. For example, participants talked about exposure in balance with interest in languages.

In her interview, Hawa shared how her own interest in languages and cultures led her not only to work with refugees and immigrants but provided a sense of ability to do so:

I just have always been attracted to a variety of cultures and just wanting to expand my awareness, so several years ago I did that ESL volunteer work. It's just very fulfilling to work with people and to provide that service that is very highly needed. Then while I was in graduate school, I worked at a social services agency, well I volunteered there.

Francine, who shared her own immigrant story, also named exposure to diversity as a key element in desiring to work with immigrants/refugees, but also giving her a sense of readiness to do so. Amanda explained how her travels and language learning had provided her with a sense of familiarity with her patients, which is helpful in working with immigrants/refugees:

I've been exposed to a lot of different cultures for a while, whether it's through travel or friends I've grown up with or family [...] [that] has enabled me to connect with people. So, whether it's just food or someone mentions the capital of their country, to be familiar with it. Or having sat down with Ethiopians that I know what she's referring to ... Not at

all perfectly... [...] but I think it's helped me to have some level of connection with most of the clients that I've worked with.

This example demonstrates how many participants viewed their own experiences in cross-cultural situations, through travel or language learning, as avenues for connection to their patients.

Almost all participants (11 out of 13) explained how having experiences of immersion in other cultures, not as a majority but as part of a diverse group of individuals, allowed them to learn and be able to do therapy across different backgrounds and cultures. The words that participants used to describe these encounters were: “able to relate,” “listen to people’s stories,” “learning from different cultures,” “living in Guatemala with a family,” etc. Similarly, Linea stated:

I also lived in a few different Latin American countries. [...] And then in college and after college I lived abroad in different places. I did live in a refugee settlement in Ghana with Liberian refugees after the conflict and I saw the extent of the need ... just to, like, give me the experience and the importance of addressing mental health issues.

Like Linea, in her interview, Katherine described an experience illustrative of how being exposed to different cultures through travel allowed her to become accustomed to being uncomfortable by intentionally embracing positions in which she was not the majority:

I think it just sort of removed the shock factor of it. I can only assume that if I was raised in a town where everyone looked like me and talked like me, and that sort of thing, that coming into this profession and being confronted with people who were very different, it probably would have been then sort of like, lack of understanding or maybe even nervousness in that sense.

Participants described in detail how they felt their own lives made sense in the context of their work, as they had experienced what it was like to be in a position of minority and what it was like to be “the other.” This theme emphasized the connection of participants’ lives to their work through a process of self-reflection and making sense of their own life stories. Participants were able to reflect on experiences in which they were outsiders, recipients of other people's hospitality and kindness. For example, Linea shared, “so many times I relied on the kindness of strangers.”

In their interviews, participants also identified how self-awareness or commitment to personal self-reflection impacted their sense of being an MFT working with immigrants/refugees. Several participants had experience and exposure to diversity in their personal lives, and some participants drew on their own immigration story, cross-cultural experiences, or relationships with others from other ethnic and language backgrounds. Also, stories of living with a diverse minority population, and exposure to diversity often fueled a sense of proximity to immigrant/refugee populations.

#### **Theme Four: My Experience in Graduate School**

All 13 participants described their experiences in their MFT program as it related to their current work, in response to the interview question: “What is your perception of your marriage and family therapist graduate education (academic course work, practicum placement, and experience) in preparing you to work with immigrant/refugee populations?” As an outcome of this question, two broad subthemes surfaced as participants shared insights and reflections regarding their perceptions of their graduate school preparation. The sub-themes were: strengths of my MFT program and weaknesses of my MFT program. Experiences from graduate school

appeared to help participants identify and implement proper approaches to therapy and areas of therapy that they could further improve.

**Strengths of my MFT program.** This subtheme is also subdivided in three more specific subthemes. The first subtheme within Strengths of my MFT program, is related to participants who intentionally chose MFT programs that had a reputation for attending to issues of equity and cross-cultural therapy; the second subtheme highlights the fact that participants identified being taught the basics of family therapy very well; and the third subtheme refers to the foundational benefits gained by using a systems lens.

*I chose this program because of the cultural lens.* Three of the 13 participants stated that they were well equipped to effectively serve the needs of immigrants/refugees. Important to highlight is that members of this “outlier” subgroup had intentionally selected programs that had a clear emphasis on culture and equity. These three participants referenced satisfactory preparation not only to work with immigrants/refugees but also to work across different racial, socioeconomic, and minority statuses. These three participants used words such as “very humanistic,” “honored people for their culture,” and “exposed to diverse professors and clients” to describe their MFT programs.

These three participants elaborated on their positive experience of MFT graduate education, reporting that this experience was outstanding because of the integration of cultural awareness in all aspects of their education. In her interview, Carole reflected on how fortunate she felt to be trained in an MFT program that had such a specific cross-cultural emphasis:

I researched and went to a program that was [...] very humanistic, very transpersonal, very much like ‘honor people for their culture.’ ‘Look for the positives not the deficits.’ ‘Educate yourself first.’ ‘Read your history.’ [...] And then we had professors who would



always give us some background about their clients, whether it was in child therapy or in our, I remember in our systems course, and then would talk about the differences. [...] It really was woven in very well there, in my opinion.

In like manner, Jacob related how he felt privileged to find out that the program in which he was interested aligned with his combined desire to use his language skills and enroll in an MFT U.S. program that also had a campus in Mexico:

And then I found out [MFT program] has a campus in Mexico. So, I actually did my Master's degree in MFT at the Mexico campus. I lived there for two and a half years. I think I was at a big advantage to work with these clients based on where I did my master's degree. That was a good career choice.

These participants elaborated on the rich education they received because of the specific focus of their MFT programs, which exposed them to complex cases and stories, and diverse faculty, as well as diverse practicum settings. They highlighted their MFT education, academic coursework, practicum placements, and experience as a solid foundation in preparing them to work with the immigrant/refugee population with which they now work.

The three participants expressed that their graduate programs exposed them to real experiences, in-person and academically, affording them a new perspective useful in working with refugees and immigrants. In her interview, Carole stated, “nothing beats going into neighborhoods [...] you have to eat the culture, drink the culture, know the identity, the family structure, the role of boys, the role of girls, the different ages and stages that they come into the country.” Jacob also referenced the intentionality in his program to require readings from a diverse selection of authors from different backgrounds and different languages:

We read a lot of him [Paulo Freire] and it was like in retrospect, it was really dense and kind of hard to read for me. And that's also because it was translated text from Portuguese, but it was good to be exposed to literature and psychological human paradigms that originate from Latin America because so much of the Western Imperialism is in our psychology Western theories often don't fit so well and ignore important cultural factors.

Katherine, who also had a very positive experience in her MFT program, although not as intentional in seeking it out as the other two participants, commented on this specific theme by highlighting the benefits of combining a solid MFT foundation with cultural awareness, difficult conversations, and supervision and exposure to a diverse set of cases.

Participants described their programs as offering a complex and nuanced understanding of the lives of their “future” patients, offering case studies that resembled the growing diversity in today’s U.S. population and the world, while teaching about what it was like to work with individuals and families.

**“Basics” of MFT.** For the ten other MFTs who did not identify their programs as having strengths in cross-cultural awareness, areas of strength were still identified. The area of strength that appeared to be most common was how their MFT programs provided a solid necessary foundation that prepared them very well as professionals and therefore offered a solid base for their clinical work. Interview reflections demonstrated that participants considered the basics of *MFT* to include:

- foundational knowledge of MFT theories,
- along with a good foundation on ethics,
- the importance of reflection on family of origin,

- and meeting great supervisors.

Participants described being well instructed in the history and theories of MFT, among other areas of strength in their MFT programs. Several participants expressed appreciation about the emphasis on its theoretical foundation as preparation for further examinations post-graduation. Several participants described receiving a strong ethical foundation and clear teaching of the ethics of MFTs, applicable to many patient and clinical situations. In her interview, Naya commented, “on the side of being an ethical therapist, that's where my MFT education prepared me very well.”

Lora May described how she felt that her program offered some opportunities for those who engaged and accepted the invitation to reflect on their family of origin and identity. Also, Cathy shared how it was her MFT program in which she began to start reflecting on her own assumptions and ways of seeing the world. Cathy described a seemingly common sentiment among the participants, regarding how they learned to do deep personal reflection in their programs:

[...] one of the most important, I would say reflection, maybe that I received in graduate school was to never ... never think that you know. Not necessarily of yourself, but of your knowledge. Because it's impossible to know someone else's experience. Never be so sure of yourself, no matter how many books you read about whatever you're studying. So, just the idea of always remaining curious. Is the best way to describe it. Always remaining curious about someone else's experience.

It is apparent participants were very proud and thankful for a solid education in their MFT programs that included emphasis on growing in curiosity, and an ability to remain open was a salient theme as participants remembered their graduate MFT education.

Some participants (four out of 13) discussed practicum supervisors as a decisive element in their MFT program. However, they also shared the tension between the lack of exposure to diversity and cultural issues in their course work and good supervisors who were willing to engage in conversations about race, equity, discrimination, and/or other difficult topics. One such example was provided by Benjamin, “the supervisor helped me think about the context of the individual. Like the similarities from Latin American culture to maybe Texas culture [...] Like, remembering there's more to the story than just being an immigrant.”

In her interview, Angela, who trained at a campus with a clinic, stated that although the actual MFT program was not focused on issues of culture, the exposure to diverse patients in her practicum partially made up for the deficit:

So, I think in the practicum setting, because we were on a university campus and it was well established, and they had people coming in and out, I feel like it did prepare us simply because we had a really wide stance of people that we were serving. And the way the department was set up was such that we were a lot of times in group supervision, either behind a one-way mirror or watching videotape recordings...

These statements are descriptive of the positive aspects that participants were able to identify in their graduate MFT education that offered them solid foundational knowledge and praxis to work as marriage and family therapists, and that included a much appreciated and praised self-reflection.

*Systems lens is far superior.* Most participants (10 out of 13) described that one of the aspects they most valued about their MFT education was the emphasis on systems work. They used language like “I value looking at the entire family,” “understanding the generations and the family,” “when I do a genogram, that really helps,” and “when I go through their history,”—all

of these comments indicate the participant's perceived centrality in offering a paradigm that potentially could set MFTs apart to work with immigrants/refugees. In her interview, Linea shared her perspective on the importance of having a systems lens when working with immigrant/refugee populations. She described how having been trained to use a family systems lens made her very comfortable "with family work. [...] And, honestly, just building relationships."

Cathy, for example, reported that although no specific training regarding working with immigrants/refugees occurred within her MFT education, simply using an MFT lens is unique in terms of providing a way to conceptualize cases and that a systems lens aligns with many of the cultural backgrounds of her immigrant/refugee patients. She explained:

I don't think that I could do this work with refugees and immigrants without having a systems perspective. At all. And I think that partly is due to the fact that the culture, as I experienced it and so, I ... I don't see any other way to approach an individual, who sees themselves as part of a system, how else to treat them other than as part of that system.

So, yeah. That's pretty much it. Yeah. I don't think there's any other way to do the work.

Cathy's example is not an isolated sentiment. Participants who identified being trained during their MFT program to work with a systems lens described this training as very helpful and conducive to "creating trust and comfort," as Linea stated.

Ten participants indicated that a systems lens differentiated MFTs from other mental health professionals because of the conceptualization of pathology and emphasis on the relational and social contexts of immigrant/refugee patients. MFTs are trained in a systems lens to understand systemic relationships, which were identified by some participants as helping them be more prepared to work across cultures. Although 10 of 13 participants distinctively mentioned

an MFT lens as far superior to other mental health approaches, participants also expressed tension with the fact that a family system lens alone is insufficient professional preparation for MFTs to work with immigrants/refugees. In his interview, Benjamin illustrated this idea by stating that the MFT systems lens is valuable and helpful in working with immigrant/refugee populations, but only once the MFTs understand how contextual factors affect the families with whom they work. He stated: “only after the therapist has been educated about the different systems in place. And really understanding the context of the immigrant,” are they able to help and support them.

Similarly, Hawa indicated a strong sentiment of pride in her education in general terms with a great attention to systems thinking, but no emphasis on specific immigrant/refugee populations. Francine also expressed this idea when she shared about how systems thinking occasionally included the exploration of cultural issues. Many of the interviews highlighted the value participants placed on being able to practice mental health from a system perceptive and the degree to which it is central to their work with refugees/immigrants. Many participants discussed multi-generational parenting in some of the countries of origin of the immigrants/refugees and pointed toward the need to break out of the Western idea of family and look collectively at what is the family system within their patients’ lives, such as their faith communities, extended family, healers, or other roles that are important.

**Weaknesses of my MFT program.** Ten out of 13 participants discussed in detail the areas in which their MFT programs did not prepare them well, not only to work with immigrants/refugees but also with other cultures. Participants in this category clearly and firmly described receiving minimal training to work with immigrants/refugees, which to them did not appear to be surprising; however, participants seemed very surprised to receive minimal and

mediocre education regarding issues of diversity, equity, racism, and cross-cultural therapy. The four themes that emanated from this finding were as follows:

- participants believed that the increased diversity in the world should have been taught instead of other outdated theories, “Cut Freud - add more difficult conversations,”
- even though cross-cultural emphasis in the program was minimal, participants often referenced a professor whose passion impacted them, “there was one professor” or “there was one multicultural course,”
- the shortcomings from their programs were compensated by some participants teaching themselves “I taught myself,” and
- the lack of diversity both in the faculty and student body “MFT is taught by white people for white people.”

***“Cut Freud-add more difficult conversations.”*** This subtheme is a combined verbatim expression from Linea and Veronica, who shared that their educational experience lacked relevant material that all future MFTs should know for serving immigrants/refugees in today’s diverse society. This same subtheme intersects with the idea referred to by others (8 out of 10 in this group) who would have preferred more difficult conversations about issues of serving, not only immigrants/refugees, but diverse populations in general. In her interview, Cathy indicated that personal reflection was a practice she resonated with during her journey in her MFT program because of her predispositions, however in contrast, some of her fellow classmates’ attitude was to “slide through the program without any real awareness of their bias.” Similarly, Linea stated:

I mean, do we need so much Freud emphasis? [...] But I do find that cutting Freud and focusing on what other people are going through. Most of the classes we weren't

challenged. Basically, there just wasn't a lot of conversation or, like, what are people going through today as far as immigration or refugee issues. [...] there should have been something built into every class, because none of my clients, really, are white. I have one white client right now, and they're transgender. And there just wasn't a lot of support or discussion about what's outside the norm. What's going on today, and especially with MFT's, [...] what's going on in society.

Linea's words parallel other participants' sentiments. Participants repeatedly described a desire to engage in relevant current issues that would better prepare them to navigate today's society as therapists, particularly in a diverse and globalized society.

In contrast to the dissatisfaction described by most participants regarding desiring harder conversations, Katherine (one of the three participants satisfied with the level of cultural engagement in their program) described how important it was for her to have been trained in a way that made her comfortable to be able to have difficult conversations in the therapy room such as be able to say "Hey, we're not the same. We don't look the same, how is that impacting your ability to relate to me as your therapist?"

Participants described a desire not only for more relevant lectures and books but also harder discussions, engaging in difficult conversations about relevant topics of where therapy meets the world. Veronica stated:

Absolutely. Not enough, there were some difficult conversations. [...] there are not enough conversations about what difficulties the immigrants and the refugees are experiencing. So, it's having conversations about that. It's not only knowing that they're differences. [...] it's about being uncomfortable. And this profession is about being uncomfortable a lot of times, even with people from our same background. Because



experiences are different for everyone, so it's just acknowledging that we're going to have differences and again, checking our biases.

Veronica, as well as several other participants, identified her desire to have had discussions about interactions in their daily therapeutic practice with immigrants/refugees that highlight the different backgrounds of therapists and patients, and that can affect the clinical outcome that could have been explored in their MFT training.

In her interview, Cathy expressed regret, wishing that, through dialogue and difficult conversations in her MFT program, she would have been taught “the depth of suffering.” Benjamin would have preferred more exposure to various case studies, perhaps by the inclusion of case examples that represented individuals from many different backgrounds, which might have opened conversations surrounding cross-cultural therapy. He stated, “here's an individual of, I don't know, an African background. How would you work with them other than calling attention to the fact that they're different from you? You're black; I'm white.”

Linea stated that she found it disconcerting, in a diverse society like the U.S. and in an increasingly diverse world, the limited focus on serving displaced populations. She described a common sentiment among participants about their desire to work with immigrant/refugee populations: “I was the only person who ever said immigration issues. And even teachers would be like, ‘Oh. Wow. I never heard of that.’”

Benjamin reflected upon his sense of getting mixed messages about faculty’s openness to having difficult conversations, while simultaneously experiencing a sense of being judged by professors when he approached them and authentically shared difficulties surrounding working cross-culturally. He named this prerogative a “double bind”:

I think graduate programs could do or focus on building an environment that's safe. So that graduate students can feel comfortable and becoming vulnerable to say, 'I really do have an issue with x-population' but with some of the faculty it's like, come to me for help, but also pushing you away with their language of like, 'what's wrong with you? Why can't you figure this out on your own?' [...] definitely a double bind. Kind of like what Bateson said in the schizophrenia experiments.

The interviews underscored a dominant theme of participants desiring a deep wrestling with current issues in society and how those issues affect therapeutic interactions. Participants repeatedly described a desire to have conversations led by professors who were not afraid to address hard-to-discuss topics that had deep relevance to the lives of their students and future patients.

*“There was one multicultural course/there was one professor.”* In interviews, participants were asked how their graduate school education prepared them to work with immigrants/refugees, and the answers were overlapped for the 10 participants who had not intentionally sought out programs that emphasized cultural issues. In general, the answers included comments such as “not enough,” “very general,” “yeah, we had the ‘cultures class,’” and “it was a chapter in that culture book.” In her interview, Veronica found fault with the narrow approach used in MFT programs of having “one course” or “one book” that often reinforce stereotypes, describe cultural patterns and customs, and gastronomical preferences and religious beliefs in general groups and subgroups of the world’s population such as the Latino culture, or Somali, Muslim, or Jews. She stated:

[...] they tell you about their background and you can assume that okay, so I know the[y are] Muslim, they do Ramadan, so they don't eat during the day and they do prayers

every so often during the day and that's what they do and how that can maybe impact their lives or have an impact when they encounter situations where they have someone that do[es]n't understand why they're doing what they're doing.[...]

She continued describing how this limited approach that results from textbooks that look at different ethnic groups in a superficial manner only leads to stereotypical stances and that books, even good books, have to be supplemented by experience: “the differences and how we can all work with immigrants/refugees, it cannot be only from textbooks.” Similarly, Naya highlighted the importance of going out into the community and relying less on books:

[...] actually, go into that community to have an experience. Let anybody studying MFT or any mental health field [...] be able to at least have one client during internship if possible or just go to the community and relate with them as human beings and see what you can learn.

In addition, Cathy reflected on the education she received in her MFT program:

the closest thing that kind of shot in the direction of preparing me was the work done around cross-cultural [...] therapy, maybe a chapter in a book and a fifteen-minute conversation of a generalization of what, you know, Latino culture is about. And learned more during my practicum. But I would say it came definitely more from my lived experiences.

Comparably, Linea observed, “there wasn't a focus on it at all. We had, you know, the multicultural class which, I think, you know ... the professor was great and I think the professor did the best she could.”

These comments by participants illustrate a larger problem beyond MFT programs not teaching about how to serve the needs of immigrants/refugees, suggesting that MFT programs

are only discussing issues of inequities in care and disparities due to the background of patients superficially. Lora May shared an illustrative story:

The thing is, with the whole, like, diversity thing, I have my own issues with that, because, number one, it's not enough. And number two, in the McGoldrick and Hardy book, done only with the research that they have, any yeah, it can be multicultural or something like that, but it's not any new information. It's stereotypical information that you just kind of ... there's always the caveat, this may not apply. Right?

Angela, like many others, communicated receiving minimal exposure on immigrant/refugee mental health and a very brief class on multicultural issues, “When it comes to specifically working with refugees and immigrants, I felt very under-prepared and I guess still do, with just the amount of trauma that we would be dealing with.” As participants described minimal or nonexistent instruction on how to work therapeutically with immigrants/refugees, they were highlighting the larger issue of feeling underprepared to work across cultures partly due to minimal attention as evidenced by reading one chapter in a book, or one very general course, that in their experience accentuated and reinforced stereotypes.

Much like the idea of the “one course that was not enough,” the idea that the MFT program did not have faculty who were trained to provide enough exposure to cultural awareness was present in participant interviews. Such an experience was identified by Veronica, who highlighted the fact that only one professor emphasized cross-cultural work:

I've been very lucky. I have to say that I took classes with the person that was the head of the department, Dr. (named deleted). [...] Dr. (name deleted) is from (place of origin deleted), and she is a great advocate about cultural awareness and sensitivity. So, her view it was with a cultural lens. I think she, how to say, I'm looking for words here. She

shared her experience and challenged us to look at clients as a whole, so taking into account the cultural background. So, I have to say that... she's the one that pops up in my head as the one who talked about culture and talk[ed] about immigration and refugees.

This subtheme surfaced in comments that mention the presence of one professor among an entire faculty body as the only one who had an interest in cross-cultural therapy.

Most participants, seven out of 10, adverted the presence of one single professor for whom issues of diversity was of value or priority and “shouldered” the burden not being carried by the entire faculty. Many referenced that the faculty were not focused on initiating issues of cross-cultural therapy, let alone working with immigrant/refugee populations; however, one professor stood out as someone who had a passion for working across cultures. Linea, for example, exemplified this by sharing her admiration for the one professor who prominently approached issues of therapy across cultures. Similarly, Angela highlighted a specific professor who was the exemplar, among a faculty who did not address cross-cultural issues. However, even with the dedication of that one professor, Angela highlighted:

we only had one specific class on cultural competency in marriage and family therapy, but the professor that we had was really outstanding. It was a personal value of hers that we apply that lens to all of our cases. So, as we were working with clients, before and after we had taken this class, there was just this sense of we always need to [be] mindful of privilege, and we need to be mindful of trauma. Anyway, so she crammed as much of that into one of these semester-long classes.

In this section, the interview participant voices clearly described the value they found in the presence of isolated efforts by a lone professor to surface issues of cross-cultural therapy, inequalities in mental health care, or working with marginalized populations. Participants

described with appreciation the efforts of these isolated faculty, while also acknowledging their desire to have had a more comprehensive effort by their MFT programs in matters of cultural preparation.

*“I taught myself.”* Because many participants stated that they did not receive enough instruction regarding issues of diversity and working across cultures, participants (6 out of 10) described teaching themselves through books but even more so experientially within this broader topic and very specifically in regards to working with immigrants/refugees. In her interview, Veronica mentioned how much was missed in her MFT education regarding the challenges of treating immigrant/refugee patients and how many therapists are not aware of the extra layer of need of this population. She stated, “if they miss it that means that the traditional system is failing to prepare them enough not to miss those opportunities.”

Lora May described in detail how she felt underprepared to serve diverse populations and even more so immigrants/refugees, due to the lack of academic preparation within her MFT graduate education. She indicated that the information was not only limited but also inaccurate and stereotypical. She recommended using texts originating within the culture that would expose students to full descriptions that honor the cultures and are not overly simplistic to prepare future MFTs to work in a pluralistic society. She noted:

I think it's the job of our institutions to address it and to make sure that we understand the world that we're walking into and to support us in learning how to be advocates and activists and prepare ourselves to know that, "Yeah, we're doing therapy, and we're doing theory, but it's grounded in these principles, and if we don't live by the principles that we're so called teaching our clients, then we really don't stand for anything.

Like Lora May, many participants described their MFT programs as lacking attention to issues of diversity and equity in therapy not only because of limited content and material but also because students were not offered enough opportunities to engage in experiences across cultures; hence, the participants who had a desire or inkling initiated the experiences themselves. According to Veronica, “it’s about the experience.” Similarly, Hawa described how she increased her own education by reading books that provided full, deep, non-stereotypical descriptions but felt nothing would substitute being exposed to a different perspective in real life:

I increased my education about working with different populations through reading some other books that had just basic issues that come up for different cultural groups. There wasn't really a practical experience in that. [...] Again, I think it just comes down to awareness and even, I mean just being introduced to a different perspective ... I think that's the minimum that people need to be able to relate to others is hearing personal experiences rather than statements about groups, but have personal connection. [...] increasing that experiential part of really getting out there and meeting people as a part of the graduate program I think that would be very helpful. Other than just reading ... and in general that could go with any population. Meeting people face to face is going to give a broader perspective than just reading about it.

Furthermore, Francine had mentioned that aspects of her program were positive, however in the arena of cultural awareness, and in preparing MFTs to work across cultures, big deficits had to be filled by the students themselves.

In her interview, Lora May stated, “It would have saved me a lot of money, all the amount of money that I've spent learning it myself.” Amanda expressed, “my professors didn't have that knowledge. I brought in stuff that I had learned.” Francine pointed out how she was

one of three students in her entire program with interest in working with minorities (not just immigrants/refugees) and had to teach herself, her professors, and her peers and went on to offer this insight:

we had to teach ourselves [...] also adapting and change things and what we would get from supervision and translate that into something that would work for us and our families. And not even just translate that in terms of language but just in terms of culture because it just didn't seem like there was that awareness or that help.

Participants were describing extra work they had to do on their own to be able to adapt the content they were learning in their MFT program to the populations they had an interest in.

In their interviews, other participants expressed similar accounts, feeling as though they were the only students in a cohort in which no one, including professors, considered the needs of immigrant/refugee as MFTs. Benjamin made a comment regarding this idea that, in his experience, professors did not connect the material taught in class to the realities of our current changing world: “There's definitely this idea of this, we'll teach you what you need to learn in the room. We'll teach you what you need to know academically. Then it's your job to integrate it into the therapy room.”

This subtheme demonstrates how student participants compensated for the educational deficit of material and content not received in their MFT graduate program by educating themselves through workshops, reading books, and making connections to other therapists who worked in similar fields. However, a shared sentiment amongst many of the participants was the belief that their MFT programs should have been fulfilling this void.

In summary, many participants felt a need to learn more about their patient's needs, while approaching immigrants/refugees with a positive lens, valuing their cultural experience, allowing



for different definitions of family, and assessing diversity within a diverse group of immigrants/refugees.

*“MFT is taught by White people for White people.”* Closely connected to the theme that students interested in reaching out to immigrants/refugees, and to other minority groups, had to teach themselves is the topic of minority/students of color and lack of diversity in the faculty. Participants described that MFT classes generally lacked minority students, and lacked racial diversity in the faculty as well. As such, some participants reported how they had to do a lot of the work to make-up for the program deficit in attention diversity and how having faculty of color would have brought a broader perspective about minority populations that included strengths and resilience.

This subtopic was important because the participants that had personal experiences with being foreign-born, being an immigrant, having a strong accent, and being identified with a minority status expressed occurrences of discrimination towards them in their MFT programs. For example, Veronica, also as a Latina participant, described experiences of being discriminated by a supervisor assuming things about her background.

Similarly, Francine, an African American participant, noted, “I’m African American, [...] even though there are a lot of mental and health disparities, amongst African American, you have all of this kind of momentum in the communities through civil rights movements.” She believed her MFT program did not place enough emphasis on the strengths and contributions of communities of color. In a similar response, Naya explained, “Our MFT program [...] is technically prepared for White people, for White population. That’s the basic fact we all know. So, even [the] efforts that some students made to expand [the program] were not even received

gracefully.” As one of the few minority students in an MFT program, Francine shared the struggles she experienced:

I'm the one who had to be flexible to adapt to *the other* understanding of my White classmates, but they didn't really understand the concept of flexibility and having to be flexible and adapt with the situation because they never had to be, or they wouldn't describe being, ever being in that situation.

Francine continued sharing a difficult experience throughout her MFT program as a minority student taught by mainly White professors:

I know that all of our faculty, they were White faculty, American Mid-Western. [...] And also trying to help the faculty understand where we were at and what we needed, and then also being there for a lot of other students. [...] And so having to kind of help educate them, some of them they never had to sit in a room with a minority for, until that time they had to sit with us in supervision, and here we have to juggle their needs, and so trying to be sensitive their process, while being sensitive to my process, while being sensitive to my professor's process, I think with all of that it, it really was a different kind of education. I kind of had to learn myself and how to fit into the space. Instead of having my professors teach me.

Participants who identified as minorities themselves commented on how being one of the few minorities was a difficult experience, exacerbated by the lack of faculty of color, which then contributed to feelings of isolation and having to educate and teach their professors as the student MFTs were perceived as experts or representative of minority groups.

Several participants talked about how, in MFT programs, most students were White and had never experienced situations like those of their immigrant/refugee patients. In her interview,

Allison also suggested that the field is primarily White females and questioned how to prepare ourselves to work with diverse populations. These comments point to a disparity in professors' representation of the current demographics of the U.S.; moreover, according to the interview participants, this lack of minority representation among faculty impacted the education of MFT students in two ways. First, minority students felt isolated and had to educate their professors, as stated by Francine. But second, future MFTs are also impacted as the range of experience brought into the classrooms was narrower, limited by the demographic representation in faculty.

Several participants, not only minority participants, indicated that MFT as a field was perceived as a discipline that served White people. Participants discussed that they felt this actuality was in contrast with expressed intentions by MFT programs to recruit immigrant/refugee prospective students. Naya, when referring to the increase in the recruitment of future MFTs who are immigrant/refugee themselves, commented:

Is it possible for MFT to recruit interested [immigrant/refugee] people [...] They fear those programs like MFT. When I talk to them, they say 'it's White people's program.' They're getting into social work now. There are many Somalians who are becoming licensed as social workers, but not MFT. They see MFT as an elite program for the Whites.

According to the participants, the lack of diversity in faculty, alongside the lack of diversity in the MFT student body, impacted the field, both in the education current students are receiving and the perception of MFT as a White field amongst minority patients as well as prospective students.

To conclude, the fourth theme, my experience in graduate school, summarized the belief of many participants that their MFT programs were generally strong, but the academic

curriculum or faculty interactions did not present how to work with immigrant/refugee families specifically, or diverse populations in general. Some participants felt that they had one good class on cultural responsiveness, and several spoke with gratitude toward the experiences learned in their practicums. Participants identified needs to learn about their patients' lives without cementing stereotypes or shutting down their curiosity. Many participants highlighted that learning about diversity helped decrease fear in working across cultures. Some participants resented having to educate their professors and fellow students on diversity and work with different populations. Some participants felt that MFT students were predominantly white, as were the professors, and a lot for remained for them to learn. These participants felt that the MFT programs needed to do a better job educating students on working with diverse populations, wrestling with topics of diversity through difficult conversations, and not avoiding contextual topics that affect the lives of many of their future patients.

### **Summary**

Chapter 4 included the description of the major themes and subthemes that emerged from the interpretative phenomenological analysis of 13 interviews with recently graduated MFTs working with immigrants/refugees. The four primary themes were: working with immigrants/refugees, the reason for this work, making sense of my own complex story, and experience in graduate school. Recent graduates of the MFT program perceived that working with immigrants/refugees required a distinct set of training and experience. Immigrants/refugees tend to have experiences not typically encountered by majority clients and therapists; thus, conventional approaches to therapy may not always be the most appropriate. Participants recommended being more mindful of the experiences of immigrants/refugees, as therapeutic activities practiced and tested as effective for White clients may not only be unhelpful toward

immigrants/refugees but may also trigger negative thoughts and feelings. In the experience of the participants, immigrants/refugees generally faced challenges in understanding the language, financial hardships, and discrimination—which may add to the stress of such patients.

Experiences prior to graduate school contributed to the participants' reasons for intentionally or incidentally holding a position as MFTs working with immigrants/refugees. For two of the participants, their area of duty happened to have a diverse population of immigrants/refugees; however, for many of the participants, their desire to fulfill their calling or purpose or desire to make a difference pushed them to their current career paths. Furthermore, their own complex stories involving ethnic backgrounds and connections through language, travel, and exposure were also considered as part of their experiences as MFTs. Lastly, the participants' experiences in graduate school helped them prepare for their work as MFTs through identifying the strengths and areas of improvement of the MFT program. The final discussion chapter describes the interpretation of these findings using the frameworks utilized to develop this phenomenological dissertation study and includes analysis of the findings in the context of the literature review.

## **Chapter 5: Discussion, Recommendations, and Conclusion**

### **Introduction**

This chapter discusses and elaborates on the research study findings and conclusions based on the results presented in Chapter 4. The findings are considered using the multiple frameworks described in Chapter 3. The four emerging themes are compared to the literature review on immigrant/refugee mental health, as well as to the response of the field of MFT in assessing these needs to prepare future MFTs to work with immigrants/refugees. In addition to a discussion of the findings in the context of the literature review and frameworks, this chapter will describe the limitations and recommendations and final conclusions. An interpretative phenomenological analysis was used for the study of the findings, and, thus, my reflections were intercalated in the examination of the findings within the frameworks and literature review by writing in the first person.

### **Discussion of Findings**

In this study, I examined the research question: What is the experience of recently graduated MFTs who work with immigrants and refugees? The current study also used these sub-questions to guide the in-depth interviews with 13 recently graduated MFTs who work with immigrants and refugees: (a) What is the recent graduate's experience as a recent graduated MFT who works with immigrants and refugees? (b) What is the recent graduate's perception of their MFT graduate education (academic course work, practicum placement, and experience) in preparing them to work with immigrant and refugee populations? (c) What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees? (d) What role does the therapist's own self-

awareness and commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?

Chapter 4 summarized my findings and highlighted the four main themes emerging from the interpretative phenomenological analysis; this summary facilitated an understanding of the main research question that guided this study. The emerging themes included the following: (a) working with immigrants and refugees, (b) the reason for this work, (c) making sense of my personal story, and (d) my experiences in graduate school. The next section considers each of the four themes in further detail, explicating the meanings that arose from the interviews in connection to the relevant literature as they relate to the lived experiences of recently graduated MFTs working with immigrants/refugees.

### **Theme One: Working with Immigrants/Refugees**

According to the findings, working as MFTs with refugee/immigrant populations poses many challenges. When participants were asked about their experience as recently graduated MFTs who work with immigrants/refugees, they described in detail their experience working with these populations considering their graduate school preparation. The participant responses clearly demonstrated that recently graduated MFTs faced difficulties in serving the mental health needs of immigrants/refugees that extend beyond offering the right diagnosis or treatment; the struggles were directly connected to and impacted by the forces of contextual variables of inequality and disadvantage that impact the lives of immigrants/refugees. Participants reported how this awareness was surprising because of the minimal instruction during their MFT education and training regarding this issue. As a result, recently graduated MFTs had to adapt their work to honor the contextual needs of their patients, in areas such as lack of resources, material possessions, or access to services as well as discrimination and xenophobia. A common

experience among the participants was that they had to increase their contextual awareness of their patients' needs. Without having heightened awareness for the contextual variables experienced by the clients, some therapeutic techniques used by participants, such as visualization exercises, could potentially trigger negative thoughts and feelings rather than help patients' mental health and well-being. This adaptation of the MFT's clinical work to respond to these expressed needs included reshaping the role of MFTs to include advocacy and activism.

Alongside an awareness of the relevance of considering the contextual factors affecting immigrant/refugee mental health is the notable role of strengths. Participants highlighted the relevance of using patient resilience as part of their therapeutic work, emphasizing patient strengths. Participants described how, as they worked with and treated immigrants/refugees, they were impressed with their patients' fortitude and will to adapt to a new and unfamiliar environment. Some participants identified spirituality and family as examples of such strengths; the MFTs learned to utilize these strengths therapeutically in their work with immigrants/refugees.

Inherent to any therapeutic encounter is the power imbalance due to professional positions and requirements of the job. An awareness of these imbalances emerged as a subtheme in the testimonies of participants regarding the work with immigrants and refugees; they realized the imbalances added another layer to their already complex work. The participants noted their perception that some immigrant/refugee clients bestowed upon them a higher status, which meant a higher level of trust and respect based on their perceived position of authority. Participants discussed the necessary adjustments they needed to make in these situations, contrary to the more collaborative and less hierarchical therapeutic approaches learned in graduate school. On the other side of this power dynamic, participants found that while they held



a more directive therapeutic role than taught in graduate school, they also had to be learners—students of their patients—culturally, historically, as migrants, and in regard to the political aspects of their lives; each of these areas impacted clinical situations.

According to participants, interpreters were often utilized when a language barrier existed between provider and patient in therapeutic encounters. However, though the language differences were a common occurrence in practice, the use of interpreters received limited attention in their MFT training programs. Participants shared the challenges of working with interpreters, including scheduling, seating arrangements, session pacing, and the need to simplify language. Cultural and societal dynamics between patients and interpreters also occurred since the MFTs often knew the interpreters outside of the clinical situation. Participants described the importance of learning how to approach these complex situations.

As participants worked with immigrants/refugees, they recognized the need to be flexible, curious, and adaptable. As they developed these traits, participants discovered an increased understanding of how the immigrant/refugee population was not a monolithic entity but rather a diverse and complex group of individuals and families for whom displacement may not have been the most pressing issue. Participants' personal growth was implied as they shared the essential elements of working with immigrants/refugees: developing humility, self-awareness, and flexibility. In work that is often accompanied by feeling overwhelmed and lost in a literal foreign world, participants learned that MFTs must check their assumptions at the door.

**Connection to literature review.** In accordance with the literature review, the participants of this study shared testimonies that corroborated the power of contextual resettlement stressors over immigrants/refugees as they established their lives in a new country (Anagnostopoulos et al., 2015; Hebebrand et al., 2016; Schweitzer et al., 2015). The results

highlighting the centrality of contextual factors align with the research by Patterson et al., (2018) proposed utilizing the World Health Organization Inter-Agency Standing Committee Intervention Pyramid of care that starts “with contextual needs as the vehicle through which other services, including mental health care, are delivered” (p. 199). This approach suggested by Walsh (2007) emphasized the application of a strength-based, solution-focused approach to family therapy with immigrants/refugees. Through their own experiences as MFTs working with immigrants/refugees, participants in the study witnessed how, their patients, even after moving away from the original pre-migration stressors now residing in the United States, were not free of hardships as new challenges arose (Cabazos-Rehg et al., 2007; Collins & Saxena, 2016; Connor & Krogstad, 2016; Dadras & Daneshpour, 2018; Patterson et al., 2018; Schweitzer et al., 2015) and these hardships “caused by sociopolitical factors such as perceived racism, neighborhood poverty, family stress, acculturative stress” (Dadras & Daneshpour, 2018, p. 2) as well as discrimination against immigrants/refugees (Ainslie, 2001; Arbona et al., 2010; Bryant-Davis & Ocampo, 2005; Rios, 2008) affected the clinical interactions in unexpected ways.

Participant responses relating to the complexity of the legal system and how it affected the lives of their patients paralleled extensive research that pointed to the damaging effect of resettlement stressors in the lives of immigrants/refugees, as well as systemic issues in society such as poverty and discrimination (Anagnostopoulos et al., 2015; Bryant-Davis & Ocampo, 2005; Falicov, 2007; George et al., 2015; Hebebrand et al., 2016; Porche, 2014). Stigma of mental health affecting immigrants/refugees was not a salient theme in the participant responses and was only mentioned briefly by one participant in connection to fear of the health care system even though it was highlighted in the literature review (Schreiber, Stern, & Wilson, 1998).

Stigma of mental health affecting immigrants/refugees was not a salient theme in the participant responses and was only mentioned briefly by one participant in connection to fear of the health care system even though it was highlighted in the literature review (Schreiber, Stern, & Wilson, 1998).

The testimonies of the 13 participants regarding how treating mental health problems among immigrants/refugees was affected by their context went beyond the lack of material resources and financial stressors and included patient experiences of discrimination and xenophobia. These findings were consistent with what Dadras and Daneshpour (2018), as well as Wieling (2018), acknowledged regarding the negative effects of the United States' sociopolitical climate and its impact on the lives of immigrants/refugees at the time of this research.

Researchers have stressed the importance of including the impact of acculturative stress as foundational in the training of mental health therapists to advance culturally appropriate interventions for immigrants/refugees (Ainslie, 2001; Arbona, et al., 2010; Jordan & Seponski, 2018; Kartal & Kiropoulos, 2016; Rios, 2008). The sentiments of participants regarding their observations about the need for MFTs to move toward advocacy and social justice were not abundant in the literature but were not ignored entirely as highlighted by Jordan and Seponski (2018), as well as Dadras and Daneshpour (2018) highlighted the urgency to prepare future MFTs to consider “social justice and advocacy work, so they become more conscious of their sociopolitical positions inside the power structures” (p. 15).

In-depth interviews of the participants revealed not only the effects of discrimination against immigrants/refugees, but the perceived lack of preparation they received to deal with these resettlement and societal issues; dealing with these issues was time-consuming in therapy. Quite notably, resettlement stressors seem to be the most pressing need therapists navigate in

their day-to-day work with immigrant/refugee patients. The stories shared by the 13 participants in this study echoed the results of research in the field of counseling psychology. Schweitzer et al. (2015) declared the importance of prioritizing the practical needs of resettlement as a therapeutic first approach to help patients grow in their ability to achieve well-being and consequently better address pre-migration trauma. The results of this dissertation study in the field of MFT were like those of Schweitzer et al. (2015) in counseling psychology, which stressed the importance of training future mental health providers to recognize the complexities of patient presentation and the necessity to adjust therapeutic interventions accordingly.

Alongside the contextual stressors were recognized strengths that cannot be ignored for their therapeutic value. Interview participants described their amazement at witnessing the strength and resiliency in many immigrant/refugee individuals and families. Some participants described how their patients' sense of connection to family, culture, and spirituality were perceived as sources of strength; learning how to harness and maximize those traits while attending to mental health needs was found to be critical. These comments parallel findings that demonstrated that religion and spirituality were central strengths for many immigrants/refugees helping them making meaning of life and offering sources of strengths in the face of challenges (Arora & Bava, 2018; Blanch, 2007; O'Mahony et al., 2013; Schreiber et al., 1998; Walsh, 2004). Falicov (1998, 2002, 2007) and Walsh (2006) stressed the importance of attending to strengths, family, as a resilience factor and even suggested including the utilization of ambiguous loss concepts (Boss, 1991, 1999) to catalyze it into strengths to empower patients.

Acculturative stress has been identified in the literature as an important aspect in immigrant/refugee populations that greatly impacts mental health and hence making it necessary for clinicians in training to learn how to identify it and treat it (Kartal & Kiropoulos, 2016;

Ainslie, 2001; Arbona et al., 2010; Rios, 2008). Furthermore, understanding the effects of acculturative stress has been identified in the literature as an important step for equipping all mental health therapists to develop culturally appropriate interventions for immigrants/refugees (Ainslie, 2001; Arbona et al., 2010; Rios, 2008; Kartal & Kiropoulos, 2016). Acculturative stress symptomatology often develops because of discrimination against immigrants/refugees, ongoing challenges to their adjustment in the receiving country, and cultural mourning (Ainslie, 2001; Arbona et al., 2010; Rios, 2008). Participant responses described acculturative stressors but had received insufficient training to treat its symptoms and its effects on families and individuals.

The results of the interviews aligned with the findings of other researchers in acknowledging spirituality as an important resiliency factor for many immigrants/refugees; their spirituality often aided them in the adjustment process (Bouchal, et al., 2013; Griffith & Griffith, 2003; Hodge, 2019; Schreiber et al., 1998; Walsh, 2007). Hodge et al. (2019) found that therapists who utilized these concepts may have been better positioned to help their patients make meaning of their pain and, as a result, patients may be able to tap into their strengths to heal. Participants again reported that, for the most part, spirituality was not addressed in their graduate school preparation, which is similar to the findings of existing research (Chaze et al., 2015). Graduate training has traditionally minimized the importance of spirituality as it relates to mental health, and that deficit can create challenges for the therapy relationship and impair adequate treatment (Collins & Guruge, 2008; as cited in Chaze et al., 2015; Walsh, 2004).

Some participants in this study shared their desire to incorporate spirituality into their practices but had received minimal training in how to do so or how it fit into the western model of mental health. These results were consistent with the existing literature that suggested that health providers may have been reticent to incorporate spirituality into their practice for many

reasons, including lack of training as well as considering it less scientific (Chaze et al., 2015; Koenig, 2010). Similarly, Blanch (2007) found therapists were willing to incorporate spirituality into their practices because it was a value to them, but not because they obtained thorough training in how to do it. The participants in this study commented on how the importance of their own belief systems and spirituality made them more open to their clients. Similarly, Walsh (2007) found that therapists who utilized these concepts may have been better positioned to help their patients make meaning of their pain and, as a result, patients may be able to tap into their strengths to heal.

Robertson's (2014) research with interpreters in mental health found that often, MFTs felt unprepared to manage the complexities of working with interpreters. The current study's participants lived experiences working with interpreters, in the context of family therapy with immigrants/refugees, confirmed Robertson's (2014) findings about how disconcerting it can be to manage the many variables of working with interpreters; the contextual influences affect all three parties involved: the therapist, the patient, and the interpreter. The research findings supported Robertson's (2014) claim that more training and research is needed in this area to fill the significant gap in knowledge.

The inherent power imbalances in therapeutic relationships posed a challenge for participants as they navigated cultural norms that affected how they interacted with their immigrant/refugee patients. Participants explained how they had to exercise personal skills of curiosity, flexibility, and self-awareness, and awareness of biases, as identified by Tervalon and Murray Garcia (1998). Self-reflection is highly regarded in the field of MFT as a key ingredient in personal growth as part of the POT framework to work with disadvantaged families but not yet applied to work with immigrants/refugees (Aponte & Méndez, 2014; Watson, 2018). Dadras

and Daneshpour (2018) stated that a deeper process of critical personal reflection in MFT education may facilitate the challenging of the power of systemic imbalances in the therapeutic interactions. Research in the field of counseling by Schweitzer et al. (2015) singled out curiosity as a central skill for therapists to use to help refugee clients make meaning of their traumatic experiences.

### **Theme Two: The Reason for This Work**

The second emerging theme necessitates its own short section as it appears to be a new theme not previously discovered, based on the review of the literature; thus, the theme warrants being explored in its uniqueness. The responses that contributed to the central body of this theme arose out of the following question: “What is your experience as a recently graduated MFT who works with immigrants/refugees?” As participants pondered this question, they reflected on how they resolved to work with this population. Of the 13 participants, 11 specifically sought to work with this population, and two settled working with this population because they found themselves in a diverse setting. The participants who worked with immigrants/refugees because of their own life experiences used terms such as “vocation” and “calling” in regard to their work with immigrants/refugees; they expressed how making sense of their life and past helped them understand the work they do, and also sustained them in moments of difficulty associated with the stressors of the job. Two participants in the study worked with immigrants/refugees because they happened to be living in very diverse areas of the United States that received large influxes of immigrants/refugees. Making sense of their own stories also provided these therapists with a sense of purpose for the work they do.

As participants described their lived experience working with immigrants/refugees—answering the question of why they chose this work—they shared how witnessing a need in the

mental health field and seeing how their own unique stories, faith, and beliefs, and/or abilities positioned them to meet this need. Several participants explained how they felt a sense of calling, which brought them to work with this population, a calling in cases related to spirituality, that keeps them in those settings despite the lack of preparation and the ongoing difficulties and challenges. As participants shared their experiences, a sense of vocation, calling, and awareness of the need seemed to undergird their reasons for doing this work.

**Connection to literature review.** Although my review of the literature prior to this study did not yield research findings related to vocation and calling for those working with this specific population, the unexpected results clearly indicated it to be a central factor. Of the 13 participants, 11 shared how a sense of vocation and calling significantly influenced their decisions to work with immigrants/refugees, making sense of their own life experiences led them to serve as MFTs with this population.

Vocation and calling, and participants' own spirituality were sources of sustenance when the work was hard and motivated MFTs to persist in the difficult job of serving immigrants/refugees. Although my review of the literature prior to this study did not yield research findings related to vocation and calling for those working with this specific population, the unexpected results clearly indicated it to be a central factor. This theme had some points of intersection with research into how people make sense of their own stories and identities, and how that may affect their preparedness for work in cross-cultural therapy, as indicated by Aponte and Carlsen (2009) in their work on the development of therapists.

Interestingly, even though the literature review did not reveal a substantive examination of MFTs' own faith and spirituality as it relates to vocation for the population at the center of this research, it did reveal a connection to a sense of "resourcefulness" for clinicians. For example,



these findings intersect with the literature and the research by Hauge et al. (2019), who stated that spirituality in relation to the intercultural development of individuals positively impacted a person's intercultural exchanges. Participant statements regarding spirituality and vocation serving a source of sustenance and support parallel Rupert, et al.'s (2019) research that revealed that the inclusion of spirituality in clinical training helped clinicians gain the capacity to relate to people of different faiths, languages, and cultural backgrounds, and afforded them awareness of the impact of systems in their patients.

This theme had some points of intersection with research into how people make sense of their own stories and identities, and how that may affect their preparedness for work in cross-cultural therapy, as indicated by Aponte and Carlsen (2009) in their work on the development of therapists. However, the literature review did not reveal a substantive examination of MFTs' own faith and spirituality in their own professional identity and influence in their work.

From the perspective of counseling psychology, Regas et al. (2017) researched therapists' belief systems and training and highlighted the importance of paying attention to the actual persons doing therapy, not just observing how the therapy was conducted. However, no reference was made to issues of calling, vocation, or a sense of purpose in their therapeutic interventions. Calling and vocation were explored by Arora and Bava (2018) in their research with MFTs from marginalized faiths, in the United States. According to Arora and Bava, MFTs made sense of their own faiths while responding to self, their patients, and their communities.

Participants described self-reflection as an important way to remain aware of the challenges and serve this population well, which in turn, supported their sense of calling and vocation. This connected directly with Reupert's (2008) work related to the well-being and self-care of MFTs. Reupert (2008) stated that therapists reported feeling emotionally overwhelmed

by the difficult experiences of their immigrant/refugee patients; they described their struggles with regulating their own emotions and feeling unprepared. Similarly, participants in this research described how “trusting a higher power” allowed them to manage the difficulties inherent to working with immigrants/refugees. These results echoed Rupert, et al.’s (2019) findings regarding spirituality as a catalyst to differentiation of self, which in turn helped in intercultural settings by diminishing clinicians’ anxiety.

Reupert’s (2008) results paralleled comments by participants about being surprised by the depth of suffering and being “perpetually overwhelmed.” Participants in this research study mentioned vocation, sense of purpose, and calling to stay engaged, in contrast to Reupert’s research (2008), in which participants credited self-care and supervision as their reasons to persist in the work.

Two participants stated they chose to work with immigrants/refugees because they resided in an area with much diversity. Data (United States Department of State, 2018) showed that the U.S. population is changing and, consequently, most MFTs will eventually end up working with a diverse population. This parallels the well-documented evidence, such as that presented by Anagnostopoulos et al. (2016), which described global migration as one of the biggest challenges in the world today. MFTs will continue to work in a globalized society, and to prepare future mental health providers to respond to the specific needs of immigrants/refugees is among the many challenges of the profession. Hence, whether the participants in this study indicated an intentional choice to work in diverse areas or they inadvertently found themselves living and working in a diverse area, they have become aware of the challenges of the diverse culture. Anagnostopoulos et al. (2016), among others such as Kohrt, Marienfeld, Panter-Brick, Tsai, and Wainberg (2016), emphasized the need to prepare all future MFTs to work with

immigrants/refugees because ongoing demographic changes suggest they will most likely serve patients who are immigrants/refugees.

### **Theme Three: Making Sense of My Own Complex Story**

Participants expressed a wide variety of responses to the question: “What role does the therapist’s own commitment to a long-life journey of self-reflection play in the experience of preparedness to work with immigrants/refugees?” Answers to this question paralleled answers to the question of why therapists chose their work, which prompted the distinct thematic responses described in the prior section.

Participants described how they became aware of the opportunities to have experiences in which they were in relationships with others different from themselves, either through travel, language learning, service, and volunteer work, family relationships, neighborhood experiences, and so on. Participants identified making sense of their own life stories to connect or bridge their own experiences to that of their patients. Eleven of the 13 participants were able to describe situations, stories, moments, and periods in their lives when they were immersed in other cultures, which provided learning opportunities for bridge-building. Doing therapy across cultures gave them a sense of being able to relate to their patients better and provide space for patients to share their own stories. Participants described and pondered how making sense of their own unique life experiences served to help them feel more prepared to address the mental health needs of immigrants/refugees. Participants described how being in the minority in their lived experiences, living in cross-cultural settings, and being exposed to differences diminished “the shock factor” when it came time to conduct therapy across cultures.

Most participants credited learning how to do self-reflection to develop their own sense of self as an important aspect of their graduate school training. Several participants mentioned

that they had to write a paper about their own cultural background and cultural identity. They shared how they appreciated this difficult assignment because they were already personally inclined to self-reflection. However, they described how many of their peers managed to go through the graduate program without doing the hard work of self-reflection; they simply slid by.

**Connection to literature review.** Participants in this research study shared how they became increasingly aware of their life experiences and how their own identities afforded them a window into their patients' lives by virtue of creating bridges as well as facilitating the relational experience of therapy. These experiences influenced how participants perceived their preparedness for working with immigrants/refugees. This theme connected with the literature in the field of MFT that discusses the complexities inherent to different aspects of identity, both in therapists and their patients (Aponte & Carlsen, 2009). Participants alluded to how their own lives stories afforded them a sense of connection to their patients as a bridge, which related to MFT research relating to the interconnectedness of how MFTs make sense of their identities. The relational process is dynamic and involves the therapist and the individuals or families being served (Arora & Bava, 2018). However, Dadras and Daneshpour (2018) proposed that self-reflection, related to class and socioeconomic status, is insufficient if it does not include a critical analysis of the societal system in which both therapist and patient are immersed, as well as a deep reflection on the therapists' own position in it, with the intention to challenge: "visible or invisible loyalty of the psychotherapist toward the maintenance of a classist structure" (p. 4).

Schweitzer et al.'s (2015) research on the therapeutic relational experience in counseling psychology also paralleled the results from this study and highlighted an ability to consider the relational experience of therapy as foundational to delivering successful mental health care to immigrants/refugees. Therapists identified the therapeutic relationship because an authentic,

mutual relationship afforded traumatized clients the opportunity to experience a sense of safety within the relational dyad (Schweitzer et al., 2015). In this way, therapists valued the therapeutic relationship over technique, evidenced by a more natural, fluid, and flexible approach that was less tied to formal methods and established boundaries (Schweitzer et al., 2015).

Participants who knew a second language or who were exposed to other cultures through travel also described a more nuanced understandings of culture and how the migration experience of their patients and their own life journeys affected their current work. In a similar way, Falicov (1995) also stated how doing therapy with different cultures required the therapist to have a nuanced and sophisticated understanding of culture. Falicov (1995) also identified a clear link between the therapists' personal growth and a multidimensional framework that fostered the integration of culture with all aspects of family therapy. However, researchers demonstrated that a complex understanding of culture is even more involved when working with immigrant/refugee clients (Seponski et al., 2013). The participants described how making sense of their own lives helped them better connect with their immigrant/refugee patients, a perspective that aligns with the research by Aponte et al. (2009).

In researching MFTs in training, Aponte et al. (2009) discovered how future therapists made sense of their own life stories and the lives of those in the communities they served. No evidence existed in the literature however, aligning with the claim by several participants that learning to speak a second or third language provided a sense of connection in their work with immigrants/refugees. The literature also did not demonstrate how travel and personal exposure to varying cultures may serve as ways to create bridges to the immigrant/refugee population.

Participants seemed to value the ability to engage in deep personal self-reflection, and as research by Nixon et al. (2010) demonstrated, MFTs who learned how to weave self-reflection

into their therapy work likely created a safer environment for clients. As participants described their training experiences, it became clear that they desired an even deeper connection to professors to sharpen their abilities to self-reflect in the context of their classroom and supervisory experiences. Dadras and Daneshpour (2018) favored self-reflection that included the understanding of MFTs' own location in society and their advantageous position and did not "only explore clients' marginalized experiences" (p. 15).

Participant descriptions of their experiences in graduate school revealed a desire to engage with professors on issues related to power imbalances, culture, and injustice in ways similar to those described by Nixon et al. (2010), who found that students who experienced these interactions were better prepared because they had experienced personal and professional transformation that ultimately would benefit their patients.

#### **Theme Four: My Experiences in Graduate School**

In addition to their experiences with immigrants/refugees, the participants' graduate school experiences provided a large amount of material and description in the interviews. As memories of graduate school were fresh in the minds of these 13 participants, they vividly described their current work with immigrant/refugee patients felt considering the preparation they received in graduate school. Participants were asked this question: "What is your perception of your MFT graduate education (academic course work, practicum placement, and experience) in preparing you to work with immigrant/refugee populations?" Their responses were insightful.

Three of the 13 participants had significantly different experiences and perceptions of their MFT programs. The most significant difference, as identified by this small outlier subgroup, was the reason for choosing their specific MFT program: they knew it had a reputation for preparing future MFTs to work cross-culturally. These three participants described a

satisfaction with the level of instruction, practicum placement and discussion, choice of readings, and the professors' diversity. They did not explicitly state that the program had an emphasis on working with immigrants/refugees, but rather that it had a lens of social justice, critical thinking, and cross-cultural work that afforded them a solid foundation and ultimately better positioned them compared to the other participants.

Among all participants—those who intentionally chose programs that empathized cross-cultural work and those who did not—participants described several aspects as very helpful in their MFT programs, including solid MFT teaching of basic skills and concepts as well as a solid understanding of ethics and theoretical foundations. Most participants described the MFT systems lens as suitable for work with immigrants/refugees because this viewpoint promoted an understanding of persons in a systemic context and upheld the value of family work. Many reported they could not imagine working as mental health providers with immigrants and refugees from anything other than a family systems perspective.

The 10 participants who did not intentionally select their MFT programs based on cultural diversity shared detailed reflections and stories that depicted how their MFT education did not prepare them to work cross-culturally nor with immigrants/refugees. Several participants said they believed their MFT programs spent too much instructional time on topics that were not relevant to current population trends and expressed a desire that more attention had been given to the needs pertinent to the changing demographics in the USA as well as global migration trends. Many participants described fleeting moments of helpful, hard conversations on the issues that affect many immigrant/refugee patients in the therapeutic encounter, such as issues of discrimination and contextual challenges; however, these participants explained they would have appreciated more challenging face-to-face discussions with professors on topics relating to

xenophobia, racism, discrimination, and similar issues. Participants often mentioned single books or classes that discussed issues of cross-cultural dynamics, but in their perspectives, these books and discussions tended to reinforce stereotypes, and no follow-up through personal student-faculty interactions occurred.

Several participants expressed a desire for more professors of color, more diverse voices in the faculty, and a more diverse student body. Some described the MFT programs as preparing white professionals to treat the needs of a predominantly white population. These participants brought personal interest, experience, and awareness to their education and work. In this section of responses, participants who identified as students of color described painful experiences of being discriminated against while others explained how they had to educate their professors and fill information gaps regarding the immigrant/refugee population, issues of equity, and about minorities in general. The participants described a divide between their own understanding of the needs of the immigrant/refugee population and that of the outdated and/or stereotypical instruction they received.

**Connection to literature review.** It is notable that only three of 13 participants could describe in-depth training during their MFT program to prepare them to work with diverse populations. However, many participants described a satisfactory and solid MFT education as it related to excellent knowledge of theories, ethics, and basics of MFT. Most participants described feeling well prepared in general because the systems lens afforded them a perspective that included the family but also reported that they did not receive solid training to work with the diversity represented in the US population. Ten participants described minimal content regarding diversity, equity, and cross-cultural therapy. Considering the review of the literature with MFTs and other mental health professions, providers who want to serve the mental health needs of



immigrants/refugees need to develop a global perspective for addressing contextual needs while understanding the trauma related to the immigrant/refugee experience. The testimonies of most participants in this study reiterate and extend the existing body of literature that demonstrated the need for higher education institutions to advance training in these areas (Adams, 2010; Kuo & Arcuri, 2014; Slobodin & de Jong, 2015; Nosè et al., 2017).

Although awareness of the need to educate MFTs for work with diverse populations is increasing, the participants in this study indicated a vacuum remains in bridging the gap between recognizing the need to increase training and offering adequate training to prepare MFTs to serve the changing population. As a researcher, I was surprised that the participants' experiences pointed to a broader need—having hoped they had received a solid foundation for working with a diverse population and only needing specialized training for immigrant/refugee populations. The results indicate a need to train future MFTs for work with immigrant/refugee populations; it also revealed the more significant problem of a foundational vacuum relating to diversity and equity training for future MFTs. As Apolinar, Claudio, and Watson (2018) described in their research, mental health providers' ability to serve the needs of immigrants and refugee populations is, in part, hinging on the training and supervision that graduate programs offer to their students.

The review of the literature clearly demonstrated that the field of MFT is conceptually well-positioned to train future therapists to serve the needs of immigrants/refugees because it holds the centrality of relationships and family connections (Ballard et al., 2016; James & MacKinnon, 2012), which in theory would benefit the work with immigrant/refugee clients since immigration experiences often occur in familial or community groups (Patterson et al., 2018). Some participants believed the systems lens to be far superior in treating the needs of

immigrant/refugee populations because the systemic orientation is suitable in culturally collectivistic worldviews. Ballard et al. (2016) and James and MacKinnon (2012) found that specific preparation was needed for working across cultures and treating diverse populations, including immigrants/refugees. According to Gutierrez and Natrajan-Tyagi (2018), MFT students need to explore how to use the systems lens to serve specific immigrant/refugee populations using diverse case studies and exposure to diverse practicum sites.

Many participants favored the systemic lens and appreciated being able to work with immigrant/refugee families within the strong family systems perspective used in their training, as described by Patterson et al. (2018) who found that family therapy principles may offer a better lens to undertake the delivery of care for the mental health needs of immigrant/refugee families. However, several participants critiqued their MFT programs. I initially thought the critiques related to serving the needs of immigrants/refugees, but the stories and experiences shared by participants pointed to a larger problem. Participants explained how their MFT programs generally lacked attention to larger issues of therapy across cultures, to diversity in general, and to stereotypical and antiquated descriptions of cultural groups. This finding contrasts with the review of literature that highlighted increased attention to these issues in MFT training (AAMFT, 2004).

The participants' stories regarding minimal integration of diversity issues in their MFT programs align with research by Inman et al. (2004), who described clear gaps between integration and translation of multicultural issues in MFT to offer students a sense of readiness. Like the results in the current study, Iman et al. (2004) found important shortfalls in minority representation, research considerations, student-faculty competency evaluations, and the physical environment as they related to multicultural considerations in MFT training programs. According

to Brown et al. (2016), the training was inadequate for MFTs to serve the needs of an increasingly diverse population, including immigrants/refugees.

Responses by participants of this study likewise illustrated the fact that the presence of standards did not always translate to effective training for students in MFT programs (Iman et al., 2004). Dadras and Daneshpour (2018) specifically mentioned that an increase of multicultural education in MFT programs did not translate to a reduction in discrimination towards patients in the clinical practice of MFTs, possibly because the theoretical foundation for many of the psychotherapeutic techniques taught in MFT programs came out of the “white-hegemony doctrine” (p. 10). Dadras and Daneshpour (2018) further posited that what is needed is to include “more critical frameworks such as critical race theory and feminism in order to counterbalance the inherent bias of the MFT trainings and interventions which are significantly shaped by patriarchy, racism, classism, and heterosexism” (p. 10).

As stated by participants in this dissertation research study, MFT programs have found it difficult to integrate systemic changes that manifest their written commitment to matters of diversity even though an accord among professional organizations to do so exists (Inman et al., 2004). Inman et al. (2004) and the participants of this study shared similar sentiments that highlighted how MFT programs are improving the integration of issues of diversity, but many weaknesses remain. Although the objective of this dissertation was not the exploration of specific MFT graduate school curriculums, participants shared discontent over the lack of academic attention to these particular issues and the apparent lack of knowledge or desire among professors to deeply engage in conversations that would foster growth in these areas which points to the need to train MFT professors. This sentiment was supported by several participants

who expressed an explicit desire to have had opportunities to wrestle with issues of inequality in the delivery of mental health care to all marginalized populations and to immigrants/refugees.

The participants' responses echoed research by Dadras and Daneshpour (2018), who recommended big changes in MFT training programs to improve intercultural skills and readiness to work with immigrant/refugee populations. Some of the recommendations by Kohrt et al. (2016), McDowell et al. (2003) and Maxie et al. (2006) were voiced by participants in this dissertation—who received their training between 2010 and 2019—corroborating a sentiment among MFTs to initiate changes in order to effectively serve the needs of today's diverse patients. Gutierrez and Natrajan-Tyagi (2018), Koch (2014), Kuo et al. (2014) and the participants of this study indicated the need to include more diverse practicum sites, have more supervisors with experience working with immigrants/refugees, and increased diversity among faculty, both in their ethnicity as well as in their experiences, to better address how to treat immigrants/refugees.

Similarly, participants expressed a desire for exposure to integration of classroom instruction on multiculturalism—as highlighted by Wieling (2018), who proposed models of training with a foundation of systems theory but potentiated by classroom-life integration in order to more effectively prepare students for working with culturally and linguistically diverse refugee and immigrant populations under culturally-grounded supervision. Artavia-Turckel's (2017) research aligned with the responses of some participants who identified as minorities and raised issues of discrimination in their MFT programs because of their ethnic background, color, or language abilities. These findings were also supported by Cort (2016).

These participants also described a lack of diversity among the faculty and practicum sites. These interview comments were particularly troubling for minority MFTs as their identities

as professionals were being developed in their interactions with faculty. In the field of counseling psychology, Arredondo and Rosen (2007) found that the environment in which clinicians' professional identities developed correlated with the strong connection between faculty, supervisors, and clinicians-in-training. Hence the importance for graduate programs to seriously commit to recruiting a diverse student body, commit to hiring and training diverse faculty, as well as working on students' self-awareness about their own background and culture was emphasized (Toporek, Gerstein, Fouad, & Israel, 2006).

Regarding participants' perceptions that MFT is taught by white teachers for white populations, Dadras and Daneshpour (2018) found that the AAMFT had a very small number of members who were part of minority groups in comparison to the majority population. The experiences of participants of color in this study echoed Dadras and Daneshpour's (2018) writings, as they suggested that very little attention is given to social justice in the MFT field to prepare future MFTs to become "socially conscious clinicians" (p. 10), as it appears that many MFT programs favor "Eurocentric paradigm and in favor of a white-hegemony doctrine" (p. 10). Further, Dadras and Daneshpour's (2018) findings overlapped with some participant results: "the majority of mental health professionals are white and there is a sociohistorical mistrust within African-American communities to seek such professional support from white psychotherapists" (p. 6). The finding that some participants perceived MFT to be taught by white teachers for white populations, and that even minority prospective students choose social work over MFT because it feels more relevant to serve the contextual needs of patients, paralleled Robiner (2006), Shannon et al. (2016), and Villalba's (2009) research around the urgent need to increase the number of well-prepared mental health professionals who enter the workforce well-trained to deal with the needs of immigrants/refugees. These populations exhibit specific needs that require

specific training, as demonstrated by a shortage of trained providers (Robiner 2006; Shannon et al., 2016; Villalba, 2009).

Comments by the participants regarding the lack of diversity among the MFT faculty were closely linked to the issue of providing appropriately culturally responsive mental health care to immigrant/refugee populations. The results of this research paralleled those of Inman et al. (2004), who found deficits in minority representation. The role of higher education institutions in meeting the needs of diverse populations lies in how future MFTs are trained and how well they are prepared to work and be effective in cross-cultural therapy (Adams, 2010; Aponte et al., 2009; Tervalon & Murray-Garcia, 1998). These findings suggest a larger need regarding how the current faculty in MFT programs are prepared and equipped to educate future MFTs and develop the necessary depth of cultural awareness (Akyil, 2011; Cort, 2016; Dadras & Daneshpour, 2018; Patterson et al., 2017; Seponski et al., 2013).

Participant responses corroborated the need to augment the cultural awareness of all mental and behavioral health professionals, and MFTs, in particular (APA, 2008). The World Health Organization's report on Mental Health (2017) stated that human resources are central in the delivery of equitable and professional mental health services to all, no other equipment may substitute person-to-person mental health treatment and the power of human connection. This finding is true both for the delivery of mental health services as well as the delivery of training for future mental health providers. The participants' responses must be calibrated against existing research declaring the responsibility that higher education institutions have in effectively preparing future professionals to deliver mental health care, which highlights that this delivery will only be as good as the therapists who provide it (Nayar et al., 2017). These findings confirmed the urgent need to train a mental health workforce that is ethnically, culturally, and

linguistically responsive. The universities that train future therapists have a responsibility to utilize their strengths to respond to these specific areas of attention (Nayar et al., 2017).

### **Connection to Theoretical Frameworks**

In this section, the results of this dissertation are interpreted within the theoretical frameworks used to support the research. The research frameworks were selected because they presented a central view of self (for both the therapist and the client), integrating identity, culture, and systems. These frameworks were chosen because of their assumption that therapists add strength to clinical interactions when they can make sense of their personal biases and maneuver their social location in therapy relationships. Being able to more deeply comprehend the multitude of effects that the experience of migration has on individuals, families, and communities necessitates an integration of multiple approaches to working with immigrants/refugees.

The theoretical frameworks will be used to offer another layer to interpret findings and provide a more contextualized consideration of the experiences of recently graduated MFTs working with immigrants/refugees. This process will enhance the understanding of participant experiences considering a coherent meta-framework that values and prioritizes curiosity, humility, self-awareness, interconnectedness, and transnational intersectionality. The frameworks chosen for this study included: phenomenology, cultural humility, family systems theory, an ecological model, transnational intersectionality, and the POT, all of which highlighted the need to consider complexities of identity, culture, and interpersonal dynamics when preparing for and practicing mental health care as well as the elegant nuances these frameworks offered for understanding the person in context. The frameworks will be addressed

considering participant responses following the flow of the interviews (not the order in which they were presented in Chapter 3).

**Ecological framework.** Bronfenbrenner's ecological framework (1979, 1986, & 1994) offered a solid lens to understand not only the effect of migration on individuals and families but also to improve understanding of the therapists working with this population and the interactions between them and their patients. The ecological model (Bronfenbrenner, 1979, 1986, & 1994) considered a person in context, holding the immediate interactions in the microsystems, followed by the interactions between these microsystems in the mesosystem. This model also considered exosystems, which are systems that indirectly affect a person, as well as the larger societal contextual factors or macrosystems (Bronfenbrenner, 1979, 1986, & 1994).

The results of this study underscored the reality that both MFTs and their patients (immigrants/refugees) are embedded in an ecosystem that influences the clinical dynamics between them while illuminating the way in which societal dynamics affect individual relationships. In this sense, the participants in the study clearly demonstrated their concern over how current macrosystemic influences are affecting their patients' lives and mental health. Equally important would be to explore the macrosystemic effects on the therapists' lives and how those affect the clinical interactions as both MFT and patients are embedded in the same macrosystem; however, the two groups are affected differently because of varying protective factors.

The placement of both the patient and the therapist in this ecological model is important (as well as the professors and interpreters, but the focus for this section will remain on therapists and patients), as they all experience the forces of the systems at different levels. In the microsystem, the therapists and patients were affected directly by those closest to them. Patients



were affected by their family, religious groups, and connections in their immediate networks, peers, or work, all of which played an influential role, either as sources of strength or stress. For example, participants described in-detail microsystemic influences over the immigrants/refugees relating to the effect of lack of financial resources, good housing, and so on, but also those influences were evident in the experiences of recently graduated MFTs in their stories they described.

The next level up was the exosystem, which included the individual's external environmental influences. For example, the ways in which future therapists were trained or not trained to work with issues related to immigration indirectly affected their patients because the therapists were, for better or worse, trained to serve patient needs; the patients themselves had no direct influence on the graduate schools. The mesosystem refers to the bidirectional influence the different system levels have on one another, and the interactions between the levels (Bronfenbrenner, 1994). Participants in the study mentioned how being able to visualize both the patient and the therapist in the web of systems helped clarify the contextual forces influencing the mental health of immigrants/refugees.

As important as it is to understand the impact of the ecology on the patient, it is also vital to investigate how the ecological influences affect the therapists and the interactions between them and their patients. MFTs that were able to hold an ecological framework were better positioned to comprehend their role in the patient-therapist relationship and to find areas of connection as well as challenge the imbalances of power that might negatively affect patient outcomes (Weintraub, 2008).

In view of participant responses to the interview questions, this framework illuminated the understanding of how context impacts those who are disadvantaged because of societal and

cultural forces; it also revealed how therapists are part of the ecological system that affects the clinical encounter. Lau and Ng (2014) noted that inclusion of the ecological framework in therapeutic settings would diminish client fears or reticence to participate in therapy because the clients' culture, racial identity, and relational networks are validated. Exploring this ecological framework in the context of MFT training will benefit the relationships in the classroom and undoubtedly inform future therapist-patient interactions. Equally important is for MFT faculty to acknowledge their place in the ecological framework and to understand how the macrosystemic influences impact the interactions with students in their MFT programs.

Societal and systemic forces affect human relationships between both the therapist and client as well as between faculty and students. How therapists wrestle with these forces will depend on the posture they adopt. Being aware of the complexity of variables that affect immigrants/refugees is not sufficient; therapists need to be well equipped and able to identify and understand the complexities so they can better address them in therapeutic interventions. The ecological framework is complemented by family systems theory (Bowen, 1978), as it sees the person always in the context of the familial system.

**Family systems lens.** All participants expressed high esteem for family systems theory and their belief that family systems theory was superior and better suited than other theories in their work with immigrants/refugees. It is helpful to look at this study's results through the lens of family systems theory (Bowen, 1978) because of its emphasis on the familial system and its attention to the interconnectedness of a migration. Understanding the effects of family interactions and learned patterns in the process of migration can aid therapy not as an added consideration but as a central element in the treatment of individuals and families who are immigrants/refugees (Walsh, 2003). Participants expressed a strong commitment to their systems

training even as they reported struggles applying and integrating it with the work of families and individuals affected by migration. The reality of the day-to-day struggles of therapists working with immigrants/refugees can be efficiently explored using systems theory, as the family systems theory framework offers a solid understanding of the ways in which past trauma affects family dynamics (Bateson, 1972; Phillips, 1981).

Exploring the lived experiences of MFTs who serve the needs of immigrants/refugees highlighted the complexity of the immigration experience that includes both strength and resilience as well as the inevitable effects of loss. The integration of family systems theory as it relates to ambiguous loss, boundary ambiguity, relational resilience, and related research on how the migration process affects an individual's and family's sense of self (Falicov, 2002) provides a helpful lens to view these findings and further understand the risks and resilience accompanying migration loss. While building on Falicov's (2002) exploration of the concept of ambiguous loss to immigration (Boss, 1991, 1999), a careful exploration of the patient's perception of the losses associated with migration is required in order not to impose the provider's own interpretation of said losses.

Integrating family systems thinking alongside the ecological framework benefits the immigrants/refugees seeking mental health services as they gain an ecological perspective of their own relational networks. Participant responses expanded the understanding of the systemic influences of the political and social stressors on their patients, and they stressed the importance of addressing the issue in MFT training. Participants hinted at being confused as to their roles when faced with issues of discrimination, xenophobia, and racism in the lives of their patients (and themselves, as many of them were minorities). Hence, participants highlighted the need to

explore what a family systems response looks like for the inclusion of societal dynamics in family therapy.

Differentiation, a term coined by Bowen (1978), is part of the family system but is also closely linked to a person's commitments to work and self-awareness, which is also a central idea in both the POT framework by Aponte (1991) and cultural humility (Tervalon & Murray-Garcia, 1998). In the context of systems thinking, Bowen (1978) described differentiation as the idea that relationships are a lifetime process that continuously negotiate independence and interdependence. In the context of the work with immigrants/refugees and the consequent challenges that accompany this work, differentiated therapists can relate to the emotional system while maintaining a solid sense of self (Titelman, 2014), which, according to Jankowski and Sandage (as cited in Regas et al., 2017), can lead to lower anxiety and increased psychological adjustment. Increasing differentiation will help future MFTs work more effectively cross-culturally because, no matter what therapeutic model therapists use, differentiated therapists will be more effective than those who are not (Titelman, 2014). This concept of differentiation of self is closely related to the first tenet of cultural humility, as it focuses on the understanding that personal growth is a life-long effort. As Dadras and Daneshpour (2018) posited, it is not possible to adequately prepare future MFTs to work cross-culturally while ignoring "how systemic coercion and subjugation of clients impacts their everyday experiences, how they engage in the therapeutic process, and how they understand their own lived experiences" (p. 15).

**Cultural humility.** The points of interconnectedness mentioned in the family systems framework cannot be explained solely through the family systems lens; cultural humility must also be explored. Participants who were recently graduated MFTs described the need to consider sociopolitical realities that directly impacted their patients and the awareness of their location in

the dyadic relationship (Tervalon & Murray-Garcia, 1998). The three tenets of cultural humility—which are (a) commitment to self-exploration, (b) challenge or power imbalances, and (c) keeping institutions accountable (Tervalon & Murray-Garcia, 1998)—offered a solid framework against which to contrast the responses participants shared when describing their day-to-day work with immigrants/refugees.

Participants commented on how they felt their graduate school training prepared them to work with this population; most felt underprepared to navigate issues related to displacement. Of greater seriousness was their expressed lack of foundational preparation to work across cultures and through situations of discrimination, inequity, and power imbalances in the therapeutic interactions. One participant mentioned cultural humility specifically, and others referenced it conceptually, although not naming it as a framework. Most participants spoke of the need to move from cultural competence (i.e., basically understanding how minority groups live in a predominately white society) to cultural humility as a way of living and to interact across cultures (Tervalon & Murray-Garcia, 1998). While referencing the need to be continually aware of differences, participants mentioned the need to maintain a posture of curiosity, flexibility, and self-awareness—all of which are components of cultural humility. Participants perceived curiosity as a quality an effective therapist should possess, one that is birthed from a learning posture toward a situation and cultural background that is unfamiliar; this observation directly corresponded to the idea of cultural humility (Headley, Hockett, & Samek, 2014; Schweitzer et al., 2015).

Several participants mentioned finding themselves in situations in which they felt their role as therapists required them to advocate for their patients because of the need for interpreters, or through political activism, or assisting patients in finding organizations to help with resource

allocation. These atypical roles of therapists fall under the third tenet of cultural humility (Tervalon & Garcia-Murray, 1998), which is keeping intuitions accountable. Cultural humility is a helpful lens for defining this central role of MFT regarding the provision of mental health services for immigrants/refugees.

Participants mentioned their on-the-job learning related to their position of authority and the position of their patients in regards to social inequalities. Patients and therapists both experience situations with challenging and oppressive power imbalances, but these situations require the therapists to affirm professional power dynamics. Arao and Clemens (2013) referred to this delicate balance when they described cultural humility as recognizing power differentials between therapists and patients and the hard task of fighting against institutional-level barriers. Arao and Clemens (2013) described bringing this injustice to the clinical situation explicitly not as safe places but as brave spaces, referring to the space created when therapists and clients openly and honestly address power imbalances and social injustices. Arao and Clemens' (2013) concept of safe spaces to discuss difficult social issues that impact immigrants/refugees, echoes participants' expressed desire to engage in difficult conversations during MFT training.

According to participants, a strong desire exists to have more of these brave conversations during MFT training. Nixon et al. (2010) clearly explicated that MFTs who learn how to integrate self-reflection, honesty, intentionality, and courage into their cultural humility framework will be better prepared to create a safe environment for patients. A strong parallel exists between the participants' desire for more training in these areas and the proposal by Nixon et al. (2010) that prioritized classroom and supervisory interactions as a means of producing hard conversations that require brave interactions but ultimately benefit patients. The results of the study and the review of the literature point to the need to train MFT professors and MFT

supervisors for them to gain the necessary skills to have these conversations with MFT students. This type of conversation is not safe by virtue of avoiding difficult topics, but rather, it is safe because professors and students feel invited to wrestle with topics of power imbalances, culture, and injustice. In this context, future MFT students are prepared for personal and professional transformation that ultimately benefits clients as well as themselves.

**Transnational intersectionality.** Following the framework of cultural humility, transnational intersectionality (Anthias, 2008) appeared to be a suitable lens to understand the experiences of recently graduated MFTs working with immigrants/refugees. Many of the responses from participants regarding their work with immigrants/refugees had to do with making sense of their own identity, which created bridges of connection with their patients who came from many different backgrounds, countries, socioeconomic statuses, and who had many immigration stories. Anthias (2008) and Gangamma and Shipman (2017) acknowledged the impact of migration experiences and societal influences in immigrant/refugee patients as part of a complex web of identities. Transnational intersectionality (Anthias, 2012), which highlighted complexities of identity, is a suitable lens for looking at the reality of patients who are immigrants/refugees, offering a way for MFTs to add cultural approaches with foundational aspects of family therapy (Falicov, 2007).

Several participants shared that working with immigrants/refugees demanded action beyond the clinical encounters and into the area of social justice. The participants disclosed sentiments of confusion of inadequacy, not knowing how to respond to the contextual needs of their patients who required more than mental health solutions when the macrosystemic impact of social injustices was taken into consideration. In light of participant responses regarding the current increase in mental health needs due to the impact of xenophobia and discrimination, it is

important to consider recently graduated MFTs' views of the impact of social justice issues as going beyond looking at inequalities as isolated events and seeing them as part of the complex dynamics that are part of the social context (Leslie, 1995, as cited in Seedall et al., 2014).

Social justice is central to the transnational intersectionality model (Seedall et al., 2014). Aligned with the participant responses, this framework allows for the realities of social justice to be addressed by taking into consideration the dynamics within the broad social context (Leslie, 1995, as cited in Seedall et al., 2014). This approach is useful for the work with immigrants/refugees as it holds their transnational identities and intersecting contexts and influences, which may allow MFTs to integrate sociopolitical and cultural approaches in the therapeutic interaction (Falicov, 2007). But social justice has traditionally been neglected in the field of MFT (Dadras & Daneshpour, 2018). Dadras and Daneshpour (2018) pointed to research that compels the field to investigate social justice issues and take part in critical conversations MFT programs about xenophobia, racism, and discrimination.

Power imbalances were mentioned by several participants as affecting their work with immigrants/refugees and can be viewed from the cultural humility lens as well as from the transnational intersectionality framework. Transnational intersectionality attends to the ways in which power and marginalization affect the lives of immigrants/refugees and examines the intersections of identities and marginalization experiences of this population, as observed by the participants of this study (Gangamma & Shipman, 2017). As suggested by Falicov (2007), the incorporation of social realities in the practice of therapy may support the treatment strategies of the clinician and may facilitate the examination of the experiences of immigrants/refugees as they relate to their social identities while acknowledging experiences of injustice during resettlement.



Addison and Coolhart (2015) offered a practical application of the transnational intersectionality framework for a different population; Stone et al. (2005) added to this framework the importance of exploring transnational family stories with immigrants/refugees, which may guide therapeutic conversations with refugees with relevant clinical application as also noted by Falicov (2007). The above-mentioned authors suggested starting by intentionally examining multiple identities of both therapist and clients, then looking for opportunities for conversations about cultural similarities and differences, followed by asking open-ended questions about cultural identities and, finally, doing this with a stance of curiosity (Addison & Coolhart, 2015).

Based on participant responses and struggles with the complexities of serving the needs of immigrants/refugees, the use of a transnational intersectionality framework, in addition to the other frameworks, appeared to offer valuable insights in supporting a meta-framework that allows for the complexities but does not narrow the work into boxes or stereotypes. This framework is appropriate in light of the responses from the 13 interviewees, as it aligned with participants' desire to understand their patients' lives in all of their complexity, strengths as well as challenges, while holding their own lives under the lens of self-reflection—all of which may develop into concrete actions that translate theory into practice. Addison and Coolhart (2015) described practical application of transnational intersectionality that can be transferred to working with immigrants/refugees and may offer solid and identifiable actionable steps for the therapeutic encounter, including (a) intentionally examining multiple identities of therapist and patients, (b) increasing the awareness of incorporating conversations about cultural similarities and differences, (c) asking open-ended questions about cultural identities, and (d) adopting a stance of curiosity. Within the context of translational intersectionality and Addison and

Coolhart's (2015) suggestions, participant experiences were validated and empowered as they pointed to an existing reality that requires attention in the field of MFT.

**Person of the therapist (POT).** Participants in the study shared detailed aspects of how they ended up working with immigrants/refugees. Several participants described how they realized that their identity was not neutral in the clinical encounter, making it essential that they make sense of their power and impact in the relationship. Many responses pointed to the benefits received during training in learning to incorporate self-reflection into their work as therapists. Within the context of the POT framework by Aponte and Carlsen (2009), the participant responses reiterated that this is an important topic that is often overlooked after graduation by many therapists. However, as Aponte and Carlsen (2009) suggested, for mental health professionals to do their job effectively, they need to be trained in environments that support and model the inner development of therapists—in a way that leads to a high degree of self-understanding. That some participants hinted that self-reflection, as needed as it is, was avoided by some of their peers was interesting; according to participants, apparently, only those inclined to do so by their own experiences engaged seriously in self-reflection and personal growth work.

Aponte and Carlsen (2009) highlighted the importance of therapists knowing how to make use of their personal biography and life experiences while at the same time, being able to differentiate from patients. This skill is even more important when working with disadvantaged families because the therapist must face their own challenges and biases that might obstruct true connection with their patients (Aponte, 1991; Aponte & Méndez, 2014). This framework supported the expressed needs of participants desiring to engage in difficult conversations regarding how social injustices affect the lives of their patients. The participants in the study expressed a serious commitment to working with their own biases but questioned to what degree

their professors had been willing to do likewise. However, even though attention in MFT programs was devoted to “Self-of-the-Therapist” or POT, with the intention to help new therapists deal with the emotions that come up as they interact with patients, there has not been a lot of emphasis on “critical self-examination of therapists’ positionality [...] on how the larger social system (economic, political, ideological) plays a role in the mental health of individuals and families,” which in itself represents a vacuum of social awareness in the attempt to understand patients’ lives that are intrinsically embedded in societal layers, a systemic “core assumption [...] that argues human experiences are influenced by the large context of a given society” (Dadras & Daneshpour, 2018, p. 12).

**Phenomenology.** Lastly, it is important to look at the results of this study through the lens of phenomenology as a framework (Dahl & Boss, 2005), which serves as a foundation supporting principles of cultural humility, ecological framework, family systems, POT, and transnational intersectionality.

Uruguayan writer Eduardo Galeano described his writing method as “having an eye in the microscope and the other in the telescope . . . from the small things, look at the large mysteries of life, so that this world may be the house of many, not the house of a few and the hell of many” (as cited in Sánchez, 2015, para. 4). Galeano’s approach to writing, bringing the small and big things to attention to create change, parallels phenomenology’s intentions.

Phenomenology offers a framework to consider both the person in context while holding the large and small view of interactions, some cultural and political, as well as personal (Dahl & Boss, 2005). This ability to hold the small details of a person’s story (whether therapists or their patients), as well as the large societal truths and injustices can only be accomplished through a moment-by-moment examination of the human experience.

The participants of this study openly described their commitment to self-exploration, examining the intrinsic challenges of their clinical interactions while holding larger professional and power dynamics inherent to the work with immigrants/refugees. They also described the personal impact of similar challenges within the institutions where they worked and studied. They were sharing experiencing struggles with the big and small things of life in the microcosm of the clinical encounter.

Dahl and Boss (2005) detailed the assumptions of the phenomenological framework and how they related to the socially constructed nature of knowledge, which renders it tentative and incomplete. Since knowledge is constructed (Dahl & Boss, 2005), the meaning varies, which emphasized the importance of approaching the lived experiences of recently graduated MFTs with an open mind. Another assertion by Dahl and Boss (2005) was that everyday knowledge is epistemologically important and shared and held by researchers and participants alike. In phenomenology, the researcher brings flexibility, insight, and an ability to build on implicit knowledge to the study (Dahl & Boss, 2005).

### **Summary of Results Within the Context of Theoretical Frameworks**

As stated in Chapter 3, I adhered to the idea that phenomenological qualitative study does not necessarily need to begin with a theory or conceptual framework but that the framework will evolve and develop as the results of the study are interpreted (Boss et al., 1993; Creswell, 2007; Grant & Osanloo, 2014). Creswell (2007) stated that qualitative research designs allowed beginning research with a less structured and more open theoretical framework to allow the researcher not to impose preconceived notions of the findings. This dissertation study utilized multiple frameworks to give shape to the research without the imposition of a rigid evaluative hierarchy (Boss et al., 1993). Following Grant and Osanloo's (2014) recommendations, multiple

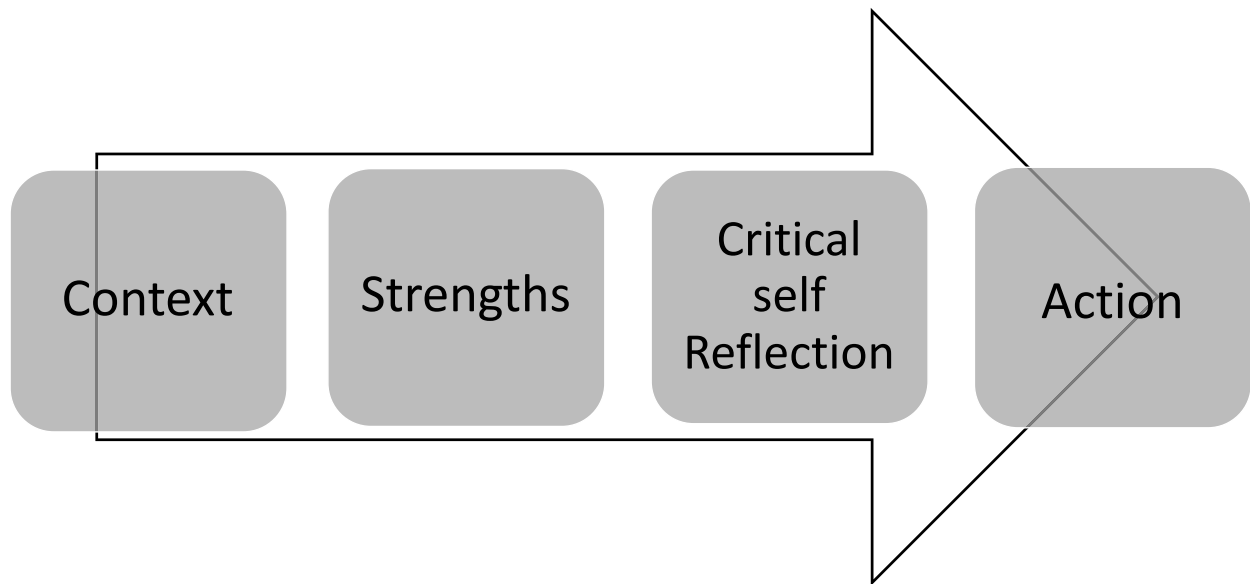
selected frameworks were chosen with the intention to support the researcher's thinking as well as the concepts and definitions that were relevant to the review of the literature; choosing only one theoretical framework for the entire study may not have suitably described the experiences of participants when data was collected.

However, the frameworks utilized were essential and provided a guide to frame the study. As a result, this study was guided by six helpful frameworks, each of which sustained the research questions and against which the results were contrasted. The frameworks offered complementary concepts to define the study. The result was a meta-framework that valued and prioritized curiosity, humility, self-awareness, interconnectedness, and transnational intersectionality, all of which allowed me to understand better the experiences of recently graduated MFTs serving the needs of immigrants/refugees.

Following interpretative phenomenology analysis (Smith, Flowers, & Larkin, 2009), I reflected on how each of the frameworks affected the results of the study. Comparing the findings to the frameworks that guided the study was very helpful, particularly at the discussion stage; after the analysis of findings, these frameworks helped make meaning of the data. The following findings that emerged after contrasting them with the six frameworks:

- **Context.** Considering the contextual forces that impact the mental health of immigrant/refugee patients, the question of how prepared MFTs feel to respond to those needs in the clinical context highlighted the role of social justice and advocacy. Several frameworks aided in conceptualizing this salient theme: ecological framework, phenomenology, cultural humility, and transnational intersectionality. These frameworks elevated the importance of challenging institutional and systemic injustices and explored how they affected the lives of patients.

- **Strengths.** The focus should be shifted from trauma-focused clinical interventions only to strengths-based therapy to be able to address both the pre-migration trauma and attend to the current adjustment stressors, all the while focusing on the strength of the patients. This strength-based approach can be supported by POT, ecological framework, and transnational intersectionality, all those frameworks illuminated the importance of considering the person's identity as fluid, multilayered, and interacting with the many spheres and strata of society as the person is embedded in a web of systems.
- **Critical Self Reflection.** Just as the contextual forces affected the lives of patients, they also affected the lives of therapists. The POT framework, as it pertains to personal reflection about the lives of therapists, was very useful, along with the idea of differentiation and cultural humility and a commitment to a life of self-exploration. However, these exercises in self-reflection cannot be done without considering that both patients and therapists were immersed in the same macrosystem but affected differently by their forces. Hence, critical self-reflection was, by nature done within the ecological framework.
- **Action.** Power imbalances remain present in clinical settings, and it is imperative to consider them and learn how to challenge them appropriately, both in clinical and higher education settings. Cultural humility, transnational intersectionality, as well as phenomenology, present clear lenses for these findings. As Dahl and Boss (2005) mentioned, the location of the researcher is important. Although the therapists in the study were not researchers, they were in a way exploring the lives of their patients; thus, their location was important.



*Figure 2.* Summary of results in light of frameworks.

The frameworks utilized in the exploration of results necessitated integration into a model that may describe the elements that impact the work of MFTs with immigrants/refugees as part of a larger complex issue of serving the needs of minorities and marginalized populations. Although all the frameworks clarified the various elements that impacted serving immigrants/refugees, they were not enough on their own to fully encompass the essence of the work of recently graduated MFTs with immigrants/refugees. Therapists who receive training and ongoing support in the areas outlined in this section will be better equipped for working with immigrants/refugees and be better equipped for making a long-lasting impact on the health of immigrant/refugee communities. For MFTs to effectively do their clinical work in a diverse and globalized society with inequalities and injustices, they need to be trained in environments that support and model inner development of therapists, leading to maturity and a high degree of self-understanding (Aponte & Méndez, 2014; Dadras & Daneshpour, 2018).

**A proposed framework.** With the intention to summarize the participant responses considering the review of the literature and the chosen frameworks, in this section, I will explore

a way to conceptualize the results. Many of the participants shared that they felt that they had not only not received adequate training to serve immigrant/refugee patients (for whom contextual stressors were very challenging), but that the general cultural training they had received was, for the most part, ineffective. Gathering participant sentiments regarding their cultural training and utilizing central tenets of the frameworks utilized for this study, I will offer a tentative framework that could serve as a platform to take a step back and explore how to offer a foundation in cultural responsiveness in MFT training while maintaining the centrality of the population the MFTs in this study serve: immigrant/refugees. The chosen frameworks for this study offered the ideal base upon which to do this as they allowed to hold a prominent view of self (for the therapist and the patient, as well as professors and interpreters), integrating identity, culture, contextual variables, and systemic thinking.

As described by many participants, the current training methods to prepare MFTs to work with immigrants/refugees specifically were almost nonexistent, and to work with minorities or marginalized clients in general still appear to be insufficient in spite of an increase in attention in the field of MFT (Akyil, 2011; D'Aniello, 2016; Nixon et al., 2010; Patterson et al., 2018). Cultural competence models start their approaches trying to understand and learn about the target population to be served as a focus of learning (Fisher-Borne et al., 2015; Tervalon & Murray-Garcia, 1998), and, although this is indeed important, exploring MFTs' own biases and life journey seems to be a more solid way to start given the field of MFT's emphasis on self of the therapists and differentiation of self (Aponte et al., 2009; Bowen, 1978); hence not starting with other but with *self*. Also, as Dadras and Daneshpour (2018) proposed, the self of the therapist's work is incomplete if it does not include social, political, racial, and economic self-reflection in the context of the ecosystem.



Based on the review of the literature, the chosen frameworks, and the participants' testimonies that mentioned their desire to engage in deeper and harder difficult conversations (Nixon et al., 2010) about culture, equity, and inequalities in therapy with their professors during training, a need seems to exist to shift the starting point in cultural responsiveness training of future MFTs. Of equal relevance is shifting the focus on the environment in which MFT students are being trained and their connections to professors and academic experience, which I will call "relational academics." As demonstrated earlier, the training offered by graduate institutions is essential to provide effective cross-cultural therapy.

Addressing the development of cultural awareness among therapists, given that a large majority of mental health providers are of a different cultural, linguistic, and ethnic background than the clients they serve, is of high importance (Akyil, 2011; APA, 2008; Aponte et al., 2009; Patterson et al., 2017; Tervalon & Murray-Garcia, 1998). The answer to this discrepancy in the mental health field is in human resources, trained professionals, as there is no equipment that can successfully substitute person-to-person mental health treatment and the power of human connection (World Health Organization in Mental Health, 2017).

Nayar et al. (2017) reminded us that the delivery of mental health care would only be as good as the providers who offer it, elevating the importance of the training of mental health providers who are culturally responsive. Therefore, it is important to ensure that MFT professors are well equipped to prepare the next generation of therapists.

***Eco-systemic critical self-reflection (ESCSR).*** As I continue to explore what this framework could look like in the training of MFTs, I will use the term eco-systemic critical self-reflection (ESCSR) because it includes components of all the frameworks used for this study while placing in a prominent place the much needed critical self-of-the-therapist reflection

(Dadras & Deneshpour, 2018) by explicitly understanding that said reflection does not happen in a vacuum but in the eco-system in which individuals are embedded—which by definition includes culture as well as all other sociohistorical forces present in all the layers of the ecosystem (Bronfenbrenner, 1994). I will briefly analyze each of the words chosen to make sense of the framework.

- *Eco-systemic*: Eco-systemic refers to the idea that all individuals are born into an ecology with several layers impacting the individual and family systems across their life span (Bronfenbrenner, 1979, 1986, & 1994; Bowen, 1974). This word is chosen intentionally to include ecological influences as understood by Bronfenbrenner (1979, 1986, & 1994) as well as systemic influences of family and society as understood by family systems theory (Bowen, 1978).

According to this model, the different environments in which people participate directly and indirectly influence their lives and their cognitive, moral, cultural, and relational development as they operate and relate in the microsystem, mesosystem, exosystem, macrosystem, and finally the chronosystem that refers to the moment of life in which persons are in relation to the situations they are living (Bronfenbrenner, 1979, 1986, 1994). The emphasis in considering the different layers of environments explains the reasoning for not explicitly including the word “cultural” in the name of this tentative framework. When the ecological framework is utilized, culture by definition is embedded in the understanding of the ecological location of the person, which includes, culture, ethnicity, language, migration, historical oppression, historical moment, life transitions, sociopolitical influences, inequalities, poverty, mental health, economic factors, strengths and resilience,

spirituality, community support, and interpersonal resources. According to the ecological model, culture is to be paid attention to outside of moments of stress also while allowing space for culture to make sense of a person's position in the world (Stormshak & Dishion, 2002).

Participants lauded family systems lens as superior in understanding their patients' lives. Systems lens offers the opportunity to view individuals in terms of relationships and as part of larger systems: family and society (Watzlawick, Bavelas, & Jackson, 2011). MFTs who learn to effectively integrate the ecological and systems model in their own critical self-reflection will be better equipped to work with inequalities and challenging clinical situations, as culture, racial identity, and family and social-relational networks are acknowledged and validated (Weintraub, 2008).

- *Critical*: Dadras and Daneshpour's (2018) critique of traditional multicultural models of training in MFT programs was, in part, the lack of critical reflection. Dadras and Daneshpour (2018) proposed an increase in the attention given to "critical discourses within MFT programs" (p. 10). The word "critical" is intentionally chosen to address the vacuum highlighted by Dadras and Daneshpour (2018) while also validating (a) the call of cultural humility to challenge power imbalances, which includes advocacy-based principles in cultural humility by keeping institutions accountable (Tervalon & Murray-Garcia, 1998) and (b) transnational intersectionality's inclusion of advocacy and social justice in praxis and critical consideration of intersection of identities by not stereotyping individuals with a narrow view of identities (Seedall et al., 2014). Phenomenology also adds an element of critical reflection as it emphasizes cultural and political contexts that influence the

interpretation of meanings in relationships that exist in everyday life (Dahl & Boss, 2005).

- *Self-reflection*: MFTs are not neutral as they engage in clinical settings, having influence over therapeutic interventions (Aponte et al., 2009). Learning how to use self-reflection and their own life experiences to differentiate themselves from their patients is essential for MFTs (Apolinar, Claudio, & Watson, 2018; Aponte & Carlsen, 2009; Bowen, 1974). MFTs have traditionally emphasized self-of-the-therapist work to aid new therapists in growing as individuals and professionals (Aponte & Carlsen, 2009; Bowen, 1974).

However, this self-reflection must be inseparable of the critical component of this framework which includes examination of the location therapists in the ecosystems in which they are embedded: “in relation to race, class, gender, sexual orientation” (Dadras & Daneshpour, 2018, p. 12).

This self-reflection also draws from Tervalon and Murray Garcia’s (1998) cultural humility, as it includes self-reflection as a commitment to a long-life journey of self-exploration, knowing that it is not finished when MFTs graduate from their programs but rather it becomes an integral part of the day-to-day work. This self-reflection is not an individualistic introspection; rather, as Dahl and Boss (2005) propose, it is a way to consider cultural, political as well as personal interactions, large and small, across different layers of the ecosystem in which individuals are embedded.

Based on the results of this research, the ESCSR framework is a possible approach to the training of MFTs. This proposed framework emphasizes the ecology of human interactions

within the many layers of society. The concept of *The Edge Effect* from field of permaculture (Praetorius, 2006), although it has its limitations within agriculture and biology, may offer a helpful analogy to visualize the importance of using an eco-systemic lens for self-reflection: “In ecology, the ‘edge effect’ is the tendency for boundary areas where two ecosystems come together to have a greater diversity of plants and animals than either of the adjacent ecosystems. Making use of the edge effect in designing natural areas promotes the biodiversity that is necessary for a self-sustaining system” (Praetorius, 2006, p. 8).

*The Edge Effect* refers to the fact that an “edge” is the meeting point between two ecosystems, such as the edge of the forest, the shore of a river, or a lake. Those environments characterized by the meeting of two ecosystems appear to be more synergistic by supporting life from both sides of the edges, making it a highly productive area because the resources of both systems can be used. If this analogy is transported to the training of MFTs in graduate programs, conceptualizing reflection with professors in a way that allows for the meeting of two ecosystems, the *edge effect* may render personal fruit and professional growth. Hence viewing interactions, whether between professors, supervisors, MFT students, patients, or interpreters, as eco-systems meeting, where *the edges* meet, in ESCSR, can illustrate the importance of critical self-reflection as personal and social ecosystems meet, whether in graduate school or clinical settings.

The ESCSR framework could be conceived as having two stages that set into motion a process that will continue with a commitment to a long-life of critical self-reflection beyond graduation from an MFT program. The first phase of the ESCSR framework prioritizes relational interactions between professors and students in training in MFT programs, not to the detriment of curriculum or content but to enhance it (see Figure 2). MFT programs have a responsibility to

train proficient therapists who can work with an increasingly diverse population in the U.S., and that includes immigrants/refugees—though not exclusively.

Per participant responses, learning how to be in relationship with those who are different, whether in the clinical, professional, or personal context, cannot be learned only from a book, or a chapter in book, but must come from experiences within personal, clinical and academic settings that offer a diversity of relational experiences. The ecological framework (Bronfenbrenner, 1979, 1986, & 1994) has been used to research the training of counseling professionals by Lau and Ng (2014) to explore how future mental health professionals could utilize: “the ecological theory [as] a viable and comprehensive model for researchers and trainers to conceptualize the training environment of counselor preparation programs, because the theory’s multisystemic framework seems well-suited for the integration of the various counselor training domains into a larger comprehensive training environment” (para. 6). Building on the work of Lau and Ng (2014) and focusing specifically on training in cultural responsiveness in the field of MFT, it appears that Bronfenbrenner (1979, 1986, & 1994) presented a helpful platform for the inclusion of the other frameworks utilized in this dissertation.

The macrosystemic components of an MFT program are understood as the “consistency observed within a given culture or subculture in the form and content of its constituent microsystem, mesosystem, and exosystems, as well as any belief systems or ideology underlying such consistencies” (Bronfenbrenner, 1979, p. 258). The macrosystem includes beliefs and culture and subcultures of the MFT program and the MFT profession, the government policies that affect the delivery of MFT graduate education, etc. (Bronfenbrenner, 1994; Weintraub, 2008).

Equally important is for MFT programs to explore the exosystem, defined as “one or more settings that do not involve the developing person as an active participant but in which events occur that affect, or are affected by what happens in that setting” (Bronfenbrenner, 1979, p. 237). An example of exosystem would be an MFT student who has a Deferred Action for Childhood Arrivals (DACA) status, and his/her migratory status puts in jeopardy their ability to remain in the program, which affects the relationship with peers and professors.

The mesosystem refers to a: “set of interrelations between two or more settings in which the developing person becomes an active participant” (Bronfenbrenner, 1979, p. 237). For example, if the MFT student is interested in pursuing an internship in a site with immigrants/refugees, but the MFT program does not have connections with sites that serve marginalized populations or minorities, the MFT student will be affected. Finally, the microsystem refers to: “pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics” (Bronfenbrenner, 1979, p. 22). At this level, Bronfenbrenner (1979) emphasized the lived experience of the person (phenomenological dimension)—highlighting that an environment that allows for meaning-making is a powerful one. Here is where the critical self-reflection of the whole ecology of systems is prominent, as the perception of the environment is as relevant as the environment itself (Bronfenbrenner, 1979; Lau & Ng, 2014).

The chronosystem is very important as it refers to the: “changes in patterns of environmental events and sociohistorical conditions (e.g., transitions over the life course of the individual). The chronosystem further exemplifies Bronfenbrenner’s belief that individuals’ learning and their environments change through time as they further develop” (Lau and Ng, 2014, para. 17).

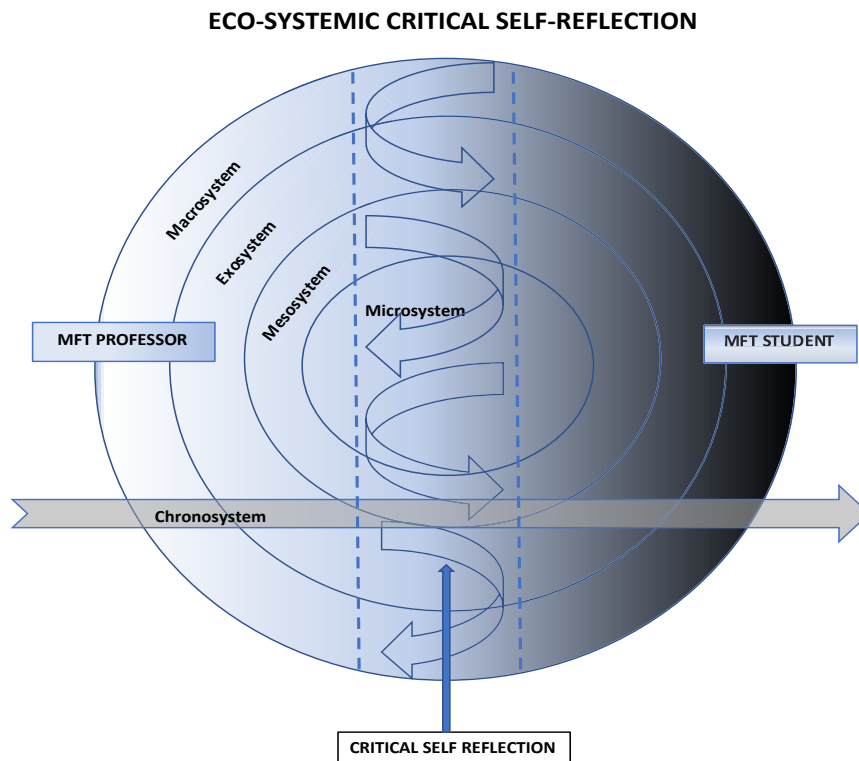


Figure 3. Eco-systemic critical self-reflection (ESCSR) in marriage and family therapy (MFT) training.

The eco-systemic lens opens a way to explore professor-student interactions as the meeting of two ecosystems that metaphorically create an *edge effect* through what can be called relational academics (depicted in Figure 2, as the vertical discontinuous lines, where the several circular layers of the ecosystem meet). This interaction allows for hands-on education that, with the guidance of well-trained mature professors who can withstand the tension of difficult conversations (Nixon et al., 2010), may guide students to engage in critical self-reflection.

Critical self-reflection occurs in the place where the professors' ecosystems and students' ecosystems meet in dialogue and critical self-reflection (relational academics), creating *the edge effect* that may produce growth. The act of critical self-reflection takes place not only in dialogues about self and context but also in discussing academic readings that offer full



descriptions of the diverse population of the United States without stereotyping; the readings should include case studies that represent the true distribution of the U.S. population.

Professors who are well trained to lead these conversations can offer a rich platform for critical self-reflection. In this context, personal reflection provides room to explore future MFTs' lives in context and helps them understand and make meaning of their social and historical contexts through relational academics. In this eco-system, professors, and students wrestle with therapeutic information as part of a macrosystem they share, not evading it, making sense of what therapy is like in today's world with today's challenges.

The second phase occurs when MFTs are immersed in clinical interactions with immigrants/refugees or any other population that offers opportunities to relate across differences (see Figure 3). Having been trained in programs that understand the person in context, themselves first, understanding the immigrant/refugee patient in context will be familiar, although not necessarily void of challenging aspects. When MFTs wrestle with difficult conversations and make sense of their own stories during academic training through critical self-reflection, they will better be able to have such difficult conversations with their patients in therapeutic interactions as a commitment to a long-life journey of self-exploration (Tervalon & Garcia-Murray, 1998). The MFT in the therapeutic interaction understands and is willing to explore the eco-systemic influences in the patient's lives (contextual challenges and strengths, historical influences, etc.) because they have explored theirs.

MFTs understand the clinical interaction as not occurring in a vacuum but rather in an ecosystem starting from the microsystem, including individual characteristics, family, and peer relationships, as well as exploring how the family, peers, school, clinic, and workplace interact (mesosystem). As MFTs increase their awareness of the relationships between the systems or

exosystemic influences in which their patients are immersed, they will be able to pay attention to the macrosystemic influences that affect the life of immigrant/refugee patients at the level of values, policies, etc., that affect the lives of their patients. The chronosystemic includes the call to understand that life transitions in immigrant/refugee lives as well as how the historical moment influences patients, which at the time of writing this dissertation were significant with an increase in their vilification and limitation of access to services by restrictive policies (Grodin, Crosby, & Annas, 2019; United States Department of State, 2018).

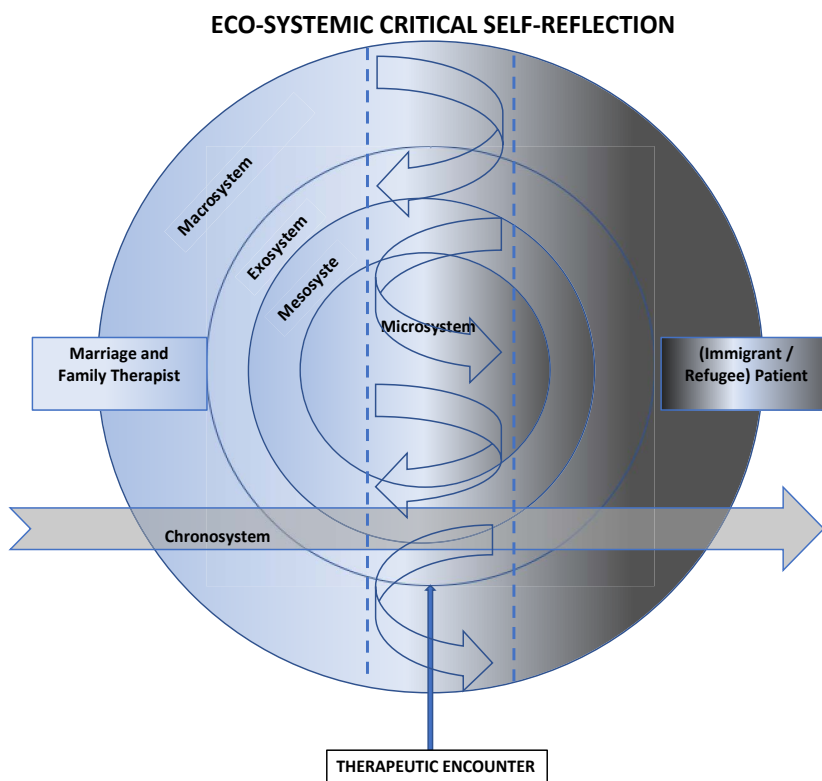


Figure 4. Eco-systemic critical self-reflection (ESCSR) in the therapeutic interaction.

Figure 4 depicts how the used frameworks in collaboration form the ESCSR and how it may serve as a path that can offer a suitable lens to explore the training of MFTs to work with immigrants/refugees. It further could be utilized for other cross-cultural therapeutic interactions in which the contextual eco-systemic forces are strong and negatively impact the mental health

of patients. This model does not begin with the patients' characteristics, as many of the cultural competency models do, although it does not minimize the challenges and peculiarities or overlooks the inherent challenges in doing cross-cultural therapy in the context of inequities.

This proposed model starts with MFT professors and programs that are training future therapists, acknowledging that, in order to work therapeutically with significant differences between therapist and patient, exacerbated by contextual variables such as immigration, displacement, discrimination, xenophobia, etc., the stance of the therapist is central to creating a space that is free of discrimination, patronization, and stereotyping. This is a framework that aims at gaining ability to look the small and the big things simultaneously in the lives of therapists themselves, professors, and later patients alike, considering both the person in context while holding a large and small view of issues at hand (Galeano, as cited in Sánchez, 2015; Dahl & Boss, 2005).

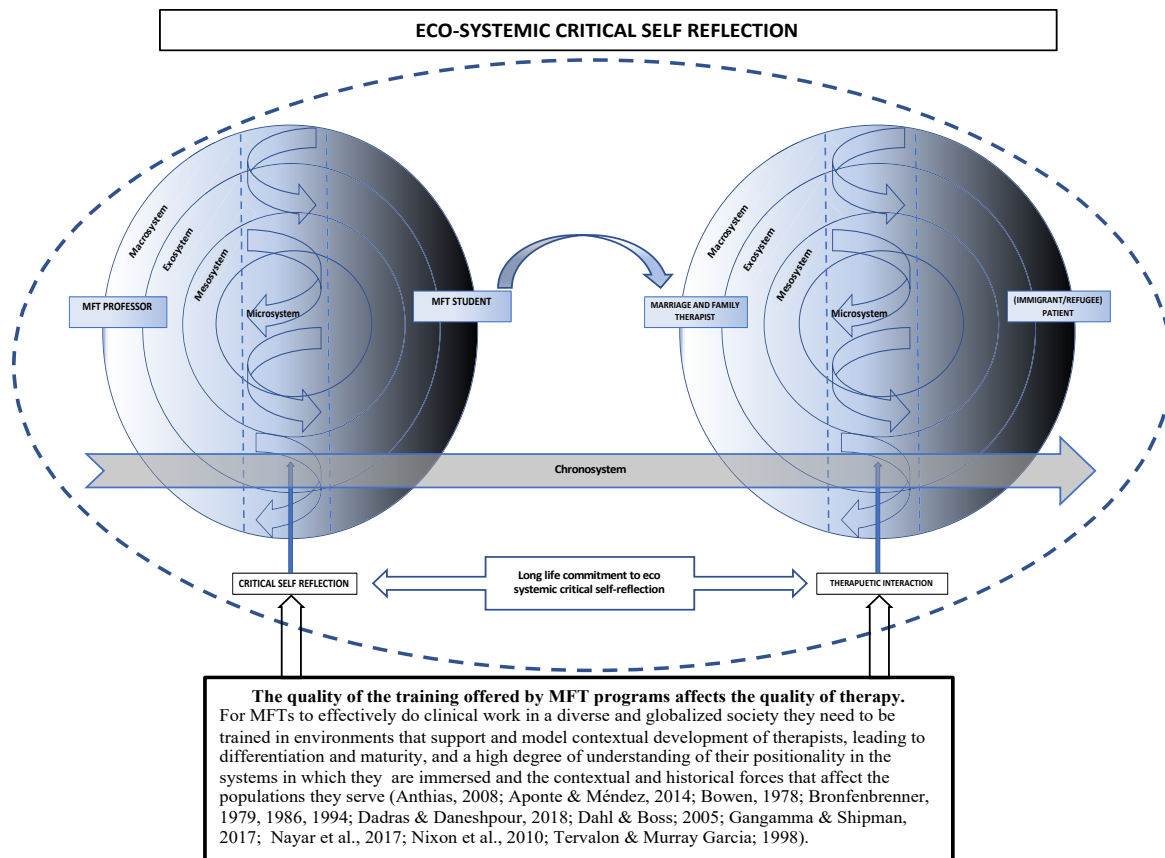


Figure 5. Eco-systemic critical self-reflection (ESCSR).

ESCSR begins with the MFT programs and professors increasing their capabilities to foster and curate difficult conversations as described by the participants of this study. This model rests on the need to increase MFT programs and professors' potential to lead their MFT students into difficult conversations, to challenge and critically explore their own biases, personal history, and views of self and others during training, with a commitment to critical self-reflection through curiosity, flexibility, and humility, utilizing the personal history as a tool of connection.

### Recommendations

The results of this study offered a picture of the lived experiences of the participants who work with immigrant/refugee patients considering their MFT education. The stories of the participants formed a body of knowledge that, when contrasted against the review of the

literature and the study frameworks, serves as a platform to offer these recommendations. The essence of the participants' voices informs this section in which I will explore possible implications for clinicians as well as recommendations for academics. Some of the recommendations of this study relate to MFTs who work with immigrant/refugee populations as well as other minorities and marginalized populations. Other recommendations relate to MFT professors and program leaders who train these therapists. Lastly, possible directions for future research are suggested.

**Recommendations for clinicians.** Participants reported that working with refugees/immigrants was both very rewarding and very challenging; particularly, participants described the importance to consider patients' strengths as well as the contextual challenges and social disadvantages of their patients, these results are informing the first of the recommendations for clinicians.

*Consider the centrality of contextual challenges.* MFTs who are working with immigrants/refugees, as well as other marginalized populations and minorities, need to maintain a critical and reflective posture in their clinical work that allows them to see their patients with an open fluid lens, being able to see beyond their migratory status' identity or disadvantage, but that allows for the exploration of the intersection of identities highlighting strengths and community resilience. Being able to hold contextual challenges, pre-migration trauma, and strengths simultaneously, from a lens of growth and not victimization, is very important to serve this population. Awareness of contextual variables in therapy could help MFTs provide more appropriate approaches to therapy by being intentional in including therapeutic applications of ambiguous loss, ecological frameworks, and transnational intersectionality.

*Incorporate the concepts of ambiguous loss into therapeutic practice.* Ambiguous loss (Boss, 1991,1999) as a conceptual framework has been applied to family therapy and issues of migration and to help to understand better how migration affects life cycle transitions such as separations and reunions among all the generations and subsystems of immigrant families (Falicov, 2002). As stated by the study participants integrating the reality of the loss inherent in migration with the concept of family strengths may foster the utilization of family relational dynamics that might aid individuals and families overcome and be more functional in the face of the contextual stressors they encounter (Falicov, 2002). MFTs must consider ambiguous loss as a foundational concept in helping immigrant/refugee families manage family dynamics affected by displacement, as family members might be in distant geographical locations. This recommendation requires intentionality about including Boss' (1991) concept of "boundary ambiguity" as a helpful concept in family therapy used to pay attention to the impact of the loss of active family membership due to migration as proposed by Solheim et al. (2016).

*Incorporate clinical interventions of the application of the ecological model to the work with immigrants/refugees.* Stormshak and Dishion (2002) applied Bronfenbrenner's (1979, 1986, 1994) Ecological Framework to work with children and families in clinical and counseling psychology, developing specific mental health interventions. Stormshak and Dishion (2002) developed a service delivery framework that integrates assessment, intervention, and motivation at all phases while considering the centrality of contextual variables. Stormshak and Dishion (2002) explored ways in which the application of the ecological model can be helpful in clinical settings in the field of counseling psychology, furthering its application to the field of MFT will offer MFTs working with immigrants/refugees a solid foundation for their work. The utilization of the ecological framework to the therapeutic work with immigrants/refugees holding a family

systems lens will offer clinicians a broader platform that includes the different social systems the patient is embedded in, and not only their individual symptomatology to implement specific interventions at different levels.

*Incorporate transnational intersectionality to work with immigrants/refugees.* Addison and Coolhart's (2015) transnational intersectionality appears to be suitable for the work with immigrants/refugees as well as with the work of MFT professors with their students. Since the interventions utilized by therapists and their stance in therapy is central to the therapy relationship, and, ultimately, its success, it is necessary to look at transnational intersectionality exploring their own multiple identities in training. Since the field of MFT has already used this lens in its work with nonimmigrant/refugee populations the application of this framework to the clinical work with displaced populations will broaden the understanding of intersection of identities and positively impact immigrant/refugee patients who may feel constricted by the label given to them based on their history of displacement (Gangamma & Shipman, 2017).

*Integrate advocacy in MFT.* MFTs need to explore how to integrate advocacy and activism while delivering mental health services to immigrants/refugees as well as other populations that, due to contextual variables, are more vulnerable to discrimination (Dadras & Daneshpour, 2018). It seems to be helpful for MFTs working with refugees and immigrants to look at each clinical encounter and determine for each circumstance what advocacy or social justice interventions might look like from a family systems perspective (Jordan & Seponski, 2018).

Many MFTs serve immigrants/refugees in clinics or community settings such as health centers, primary health clinics, schools, etc. In the context of these health agencies, immigrant/refugee patients are not exempt from discrimination or biases; it is important for

MFTs to assess the needs of patients taking into consideration the ecosystems that affect them—one of which is the clinic or health agency or school where the therapeutic interaction takes place (Dadras & Daneshpour, 2018; Jordan & Seponski, 2018). Thus, heeding Tervalon and Murray-Garcia's (1998) call to keep institutions accountable and to explore critically the clinical encounters challenging power imbalances is important.

***Develop the necessary skills to work with interpreters.*** Participants described working with interpreters as a surprising element they had not thought of during graduate training that, however, occupied a large part of their clinical interactions. MFTs that are currently in practice need to seek out further training to learn how to work with interpreters and learn to integrate them in the therapy setting in a way that increases the effectiveness of the therapeutic interaction. Also necessary is to see interpreters as an asset to the clinical encounter and not a hindrance. Learning how to work professionally with interpreters is essential to the successful delivery of appropriate and contextually sensitive mental health services.

***Commit to critical self-reflection.*** A central element of MFT training is the development of the self of the therapist. A recommendation offered here is to explore how that self of the therapist work continues as a commitment to a long-life journey of self-reflection in a way that is critical and that includes eco-systemic forces that affect the practice of MFT. A commitment to critical self-reflection can be enhanced by participating in consultation groups, collaborating with other colleagues, and being intentional to continue to be educated on issues of equity and social justice from a system lens—which will ultimately benefit patients (Dadras & Daneshpour, 2018). Also, participants responses elevate the role of curiosity, flexibility, and humility in their work as MFTs—all virtues central to the systemic thinking and POT approach (Aponte et al., 2009)—and follow the commitment to a life of self-exploration, being learners of ourselves first and also of



our patients and their complex lives (which go beyond the 50-minute therapy hour and have a rich history and contextual factors that MFTs may be unaware of if we do not exercise curiosity beyond diagnosis and pathology).

***Evaluate and adapt the clinicians' own therapeutic style.*** MFTs working with immigrants/refugees and many other minorities and/or marginalized populations face the challenge of adapting and adjusting their own therapeutic style to fit the cultural needs of diverse patients. Participant responses illustrated how they had to adapt in these situations and develop new styles of interacting with patients different than the collaborative and less hierarchical therapeutic approaches learned in graduate school. Findings of this study revealed the importance for MFTs who work in these settings to be flexible and explore power dynamics in the clinical setting while at the same time being willing to take more directive therapeutic styles than the traditional western style of theory learned in graduate school (Dadras & Daneshpour, 2018).

**Recommendations for academics.** The recommendations for academics' section is subdivided into recommendations for MFT program leaders and professors and recommendations for future research.

***Recommendations for leaders in the field of MFT.*** In the field of MFT, the quality of training given to MFT students to effectively engage in cross-cultural therapy has a direct impact on the quality of clinical services provided. In other words, the degree of MFTs' preparation to work with issues of injustice and contextual forces, as well as trauma, influences patients' outcomes, as it is partially dependent on how MFT programs prioritize efforts to fulfill this need. As stated earlier, the increase in attention given to issues of diversity is still insufficient or inadequate (per participant responses). This research highlighted the fact that participants felt

that there was still a foundational need to strengthen education in MFT programs to work in cross-cultural settings, and with disadvantaged and marginalized populations, beyond the work of the specific population of immigrants/refugees.

*Train future MFTs on how to work with systemic inequalities.* In light of participant responses regarding their day-to-day struggles responding to their patients' needs, wrestling with their patients' lack of resources, and wondering how to respond therapeutically to these disadvantages, it would be helpful to train future MFTs utilizing a lens that broadens the problem from specific migration trauma, as well as lack of needs and resources, to understanding large societal forces that place these patients at a disadvantage (Jordan & Seponski, 2018). MFTs who have wrestled with issues of inequality in graduate school will feel better equipped but, as Dadras and Daneshpour (2018) stated, the field of MFT: "has not incorporated the impact of classicism and poverty into academic training, supervision, and research, it further enables the structural injustice and normalizes the internalized oppression of the clients and families who are dealing with poverty" (pp. 4-5). MFTs continue to be underequipped not only to serve refugees and immigrants but to deal with many issues of systemic inequalities, hence supporting the need to increase attention to systemic inequalities in the training of future MFTs.

Higher education institutions are responsible for preparing MFTs to serve all patients, not just those who belong to the mainstream culture. Despite the challenges in the provision of effective training, institutions of higher education are charged with delivering culturally responsive, concurrent mental health training in dignified settings to best prepare mental health professionals who will work with immigrants/refugees as well as other marginalized populations (Dadras & Daneshpuor, 2018; Jordan & Seponski, 2018). The results of this research indicate a lack of preparation in the part of MFT faculty to engage in the necessary dialogue to prepare

future MFTs to wrestle with issues of inequalities and marginalization and to serve the mental health needs of an increasingly diverse society in the U.S. Intentionally exploring specific methodology and models to train MFT faculty to effectively integrate critical cultural reflection and exploration of topics of inequality in their MFT programs is a necessary next step.

*Train future MFTs to engage in critical self-reflection.* This research findings stress the importance for MFT programs to examine how they are integrating cultural responsiveness and how this integration is impacting students' learning and growth. Similarly, it is necessary also to explore how all MFT students are engaging in critical self-reflection and not only to those who have a personal inclination towards cultural awareness due to their own background. This recommendation is made based on experiences shared by participants regarding how many MFTs made sense of their own diverse experiences thanks to their own desire to be in contact with others who are different than them. These findings made room for the question regarding how students who may not be so inclined to process their own experiences manage to work cross-culturally and how to raise their consciousnesses and improve their interpersonal skills despite a lack of awareness on their part. Exploring how to integrate critical systemic self-reflection as a foundational skill for all future MFTs in the MFT programs will strengthen the preparation of future MFTs to work with marginalized populations.

*Regularly revise and update MFT cross-cultural curriculums.* A surprising finding, along with the lack of training to work with immigrants/refugees, was the more foundational lack of solid training to work across all cultures and, with marginalized and minority populations, in general. Questions arose regarding the ability of current faculty to engage in the difficult conversations and discuss inequalities, racism, xenophobia, and the many other factors that negatively affect the lives of those served by the MFTs interviewed, as well as the millions of

Americans who are part of a diverse society. An important aspect of training will be to increase the cultural awareness of all mental and behavioral health professionals (APA, 2008).

Even though attention has been given to cultural issues in the field of MFT for decades, as Dadras and Daneshpour (2018) suggested, revisions to include broader voices and issues of advocacy and social justice to match the needs of today's society are necessary. It appears essential then for MFT program leaders to revise their curriculums with a lens that explores how the existing curriculum supports the goal of training future MFTs to serve marginalized populations and the current U.S. demographic trends and needs. Regularly revising and updating the textbooks used, including non-western voices, as well as extending and diversifying the list of the practicum sites to include organizations that serve minorities and marginalized populations, is a necessary forward step towards supporting a robust, culturally responsive MFT curriculum.

*Hire diverse MFT faculty.* Several participants mentioned that, in their experience, MFT as a field was viewed as being for white populations and that MFT programs appeared more attractive to white students. Participants also referenced their experience of their MFT programs as lacking diverse faculty as well as not recruiting many diverse students. An increase in attention is given to these issues in the MFT literature with more research devoted to studying the diversity of MFT faculty, and MFT student body demographic composition. More research has also been devoted to studying MFT programs' efforts to hire more diverse faculty, and exploring existing efforts to recruit and retain diverse students and faculty in MFT programs (Artavia-Turckel, 2017; Brown, McHatton, & Scott, 2016; Chen, Austin, & Hughes, 2018; Chen, Austin, Hughes, & May, 2019; Harris-McKoy, Gutierrez, Strachan & Winley, 2017). Given this wealth of recent research, it is key for leaders of MFT programs to become proficient in this

research and engage in conversations regarding the results of these studies and their recommendations to inform the direction of these programs in order for MFT programs to reflect the demographics of the populations MFTs serve in their faculty and putting into action this research in their specific programs.

*Train future MFTs in graduate school to work with interpreters.* Given the linguistic diversity of the populations MFTs serve in the U.S. (Akinsulure-Smith & O'Hara, 2012; Akyil, 2011; Nicolas et al., 2007; Patterson et al., 2017; Robertson, 2014; Saraceno, et al., 2007), investing time and efforts in MFT programs to train MFT students to work with interpreters is a central task that is recommended to be added to the MFT curriculum. As MFTs are more exposed to working with linguistically diverse individuals and families in the therapeutic interaction, teaching future MFTs how to work with interpreters as a specific therapeutic skill seems foundational knowledge that all MFTs should have.

*Prioritize and update ways to explicitly apply system lens to the training of MFTs to work with immigrants/refugees.* Most participants appreciated the centrality of family systems theory in their work with immigrants/refugees. Research supports the conceptual suitability of marriage and family therapy (MFT) as a field to train future therapists to serve the needs of immigrants/refugees as it positions relationships and family connections at the center (Ballard et al., 2016; James & MacKinnon, 2012; Patterson, 2002; Walsh, 1998, 2002, 2003). The inclusion of the concept of acculturative stress as foundational in the training of MFTs, in order to support culturally appropriate interventions, is necessary for the preparation of MFTs capable of working with the challenges experienced by immigrants/refugees (Ainslie, 2001; Arbona, et al., 2010; Kartal & Kiropoulos, 2016; Rios, 2008).

Still, since specific training is needed for working across cultures and treating diverse populations, including immigrants/refugees (Ballard et al., 2016; James & MacKinnon, 2012) it will be important to examine how to explicitly integrate system lens to the education of future MFTs through the use of case studies, or exploration of how a systems lens can assist patients whose backgrounds are not part of the majority culture. Family systems concepts may potentiate findings already existing in immigration research; hence the integration of these two fields may be helpful in the development of training for MFTs working with refugee/immigrant populations (Falicov, 2002). I recommend that MFT leaders prioritize the application of the specific recommendations of Gutierrez and Natrajan-Tyagi's research (2018) to the training of MFT students. This application will necessitate a detailed study on how to use the systems lens to serve specific immigrant/refugee populations using diverse case studies and exposure to diverse practicum sites. Participants in this study identified family as a source of strength for many immigrants/refugees, but knowing how to harness the inherent power of family, when families might be separated by thousands of miles for many years, has to be included in the training of therapists working with immigrant/refugee families as Solheim, Zaid, and Ballard's (2016) research with Mexican immigrants uncovered, particularly applying the concept of ambiguous loss during training (Boss, 1991).

***Recommendations for future research.*** This study found several factors that point to how recent graduates of MFT programs wrestle on a day-to-day basis in their work with refugees and immigrants. Some of these factors have already been researched in the existing literature. However, some other themes were not elaborated on in the literature. General recommendations for future research may start by looking into areas which this study did not include. Hence, a need exists to research specific academic programs to explore course content taught in MFT

training as it relates to finding out how effective said academic content appears to be in preparing future MFTs to work with immigrants /refugees. Equally important will be to interview program directors to gain their perspective and understating on how to prepare MFTs in graduate school who work with immigrant/refugees. Other specific research recommendations are as follows.

*Research the role of vocation and spirituality for MFTs working with immigrants/refugees.* A vacuum appears to exist in the literature in the exploration of the role of vocation and calling of MFTs who work with immigrants/refugees. This vacuum opens the door to explore the role of vocation and calling and to examine if it is a protective factor against MFTs' burnout. Equally important would be to examine to what degree the apparent lack of preparation during graduate school to work with immigrant/refugee population is being compensated by the MFTs' own sense of calling and perhaps acts as a protective factor to early burnout. Building on research by Hauge, et al. (2019) and Rupert, et al.'s (2019), exploring the integration of spirituality in MFT training to work with immigrants/refugees might render interesting results to offer to the field of intercultural responsiveness working with displaced populations. It also warrants studying the lives of those who are veterans in the field of refugee and immigrant mental health and explore what sustains them, exploring the roles of faith, consciousness, altruism, and personal commitment to a larger cause. Several questions arose from the participants' responses as it relates to issues of vocation and calling: (a) Is vocation an insurance against burnout? (b) How is vocation nurtured and maintained? (c) How do we care for MFTs who work in stressful environments with immigrants/refugees as well as those who work across cultures and in very diverse environments? (d) What are the sources of joy?

*Research MFT programs with emphasis on social justice.* Based on participant responses regarding a felt need to move into positions of advocacy and social justice as MFTs, and

following Dadras and Daneshpour's (2018) recommendations to include "more critical frameworks such as critical race theory and feminism in order to counterbalance the inherent bias of the MFT trainings and interventions which are significantly shaped by patriarchy, racism, classism, and heterosexism" (p. 10), it is crucial to research MFT programs in the U.S. that are known to have an emphasis on social justice, critical theory, and advocacy, and explore specifically how MFT professors in said programs integrate these concepts in their curriculum and engage in conversations with students. Equally beneficial will be to interview students from these programs to learn how graduates from these programs apply these frameworks to the practice of MFT.

*Research MFT faculty training.* Coupling the research of how future MFTs engage in critical self-reflection during training with exploring how current MFT faculty are being trained to engage in difficult conversations regarding inequalities, marginalized populations, and cultural issues will offer a foundation to close the gap for MFT faculty to be equipped to adequately train future MFTs to work with marginalized populations. The faculty in MFT programs must be trained to teach about issues of cross-cultural therapy and work toward cultural awareness; this must be part of the ongoing development of MFT faculty and an important aspect of training and supervisory feedback that necessitates further research. Recommendations of this study include the need to investigate current efforts to train existing MFT faculty in cultural responsiveness with a systemic social justice lens and how to equip current MFT faculty to be able to curate and hold difficult conversations in the classroom.

*Research efforts to diversify MFT faculty and student body.* Significant emphasis was given by several participants and corroborated by literature to warrant a recommendation to further investigate the apparent lack of minority faculty and minority students going into the field



of MFT (Artavia-Turckel, 2017; Brown, McHatton, & Scott, 2016; Chen, Austin, & Hughes, 2018; Chen, Austin, Hughes, & May, 2019; Harris-McKoy, Gutierrez, Strachan, & Winley, 20170). The robust body of research in this area offers a stable platform in which to continue studying how to strengthen existing efforts to diversify and retain MFT faculty and student body, with specific emphasis on retention of minority faculty and students. Diversification of MFT faculty and student body is critical, considering that most mental health providers are of a different cultural, linguistic, and ethnic background than the clients they serve.

*Research the role of learning another language.* Several participants described a life journey that led them to learn another language other than their birth language and described how that opened doors to work in the field of immigrant/refugee mental health. The researcher recommends to explore the role of language learning and speaking a second language in offering a sense of preparedness to work with immigrants/refugees. Particularly interesting is that many participants described how learning another language broadened their view of the world. In the words of Flora Lewis, “Learning another language is not only learning different words for the same things, but learning another way to think about things” (Mittal & Rathore, 2015, p. 63). It warrants studying how speaking a second language is related to the sense of preparedness of MFTs working with refugees and immigrants and with other minority and/or marginalized groups as well. The objective of this dissertation research was to explore the lived experiences of recently graduated MFTs working with refugees/immigrants. Some of the results have highlighted the perception among participants, not only of the lack of preparation to work with immigrant/refugee populations, but the existence of an underlying need to learn how to work with diverse populations effectively. This research may shed light on how learning a language may broaden a persons’ sense of the world, offering more flexibility and curiosity.

*Research effective methods to train MFTs to work with interpreters.* Exploring how the work with interpreters affects the clinical work of MFTs with immigrants/refugees has not been given enough attention in the field of MFT. It is important to examine further how, and if, current MFT students are being trained in how to work clinically with interpreters and explore the triadic system formed by patient-interpreter-therapist, as Roberson (2014) described. Researching effective methods to train MFTs to work with interpreters is essential as well as developing collaboration with certified university level interpreter training programs to explore interdisciplinary collaboration into how to best train MFTs to work with interpreters taking into consideration family and systemic dynamics.

Isomorphism is a concept that can be helpful in guiding the exploration of establishing norms for successful marriage and family therapist-interpreter relationships (Liddle & Saba, 1983). Within isomorphic dynamics, patterns emerge across various systems, creating a systemic counterpart to parallel processing in individual psychotherapy. Isomorphic dynamics involve identifying similar patterns that emerge from various systems; this understanding of relational dynamics can be applied to the therapist-interpreter-client triad.

Isomorphism has historically been used as a framework for understanding how the therapist-supervisor relationship impacts the therapist-client relationship (White & Russell, 1997). To create trust and safety between the therapist and client, trust and safety need to be developed between the supervisor and therapist. Researching the application of the concept of isomorphism to the use of foreign language interpreters in therapy, with immigrant/refugee clients, one can hypothesize that a trusting and collaborative relationship between the therapists and interpreter will enhance the potential for a safe and collaborative relationship among all members of the therapeutic system (Gangamma & Shipman, 2018).

*Research the work of experienced MFTs working with immigrants/refugees.* Researching the lived experiences of veteran MFTs who, having worked with immigrants/refugees from family systems perspective for decades, may share their expertise, along with specific strategies, and foundational conceptual approaches to work with this population may provide insight into how to fill the void in MFT education to work with immigrants/refugees.

## **Conclusions**

The purpose of this study was to explore the experiences of recently graduated MFTs working with refugees/immigrants. After an extensive review of the literature on diversity training for mental health providers, a gap was identified in peer-reviewed literature regarding how MFTs perceive their graduate school education prepared them to work with immigrant/refugee populations (Adams, 2010; Seedall et al., 2014). I explored the gap in the literature through studying the perceptions that recently graduated MFTs, who work with immigrants/refugees in the U.S., have about their experience of preparation during graduate school. In spite of the increase in attention on diversity training and cultural education in MFT programs, little research has been done to explore how general diversity training supports the work of MFTs who work with immigrants/refugees.

I began this dissertation, having hoped that participants had already been given foundational knowledge and practice to work with diverse populations and then only being necessary to explore what kind of specialized training for immigrant/refugee populations was needed. The results of the interviews in this study demonstrated that a need remains to improve methods to train future MFTs to work with the growing diverse population of the U.S.

The results unveiled the apparent fact that a need exists to reexamine current practices in the field of MFT to train future MFTs with diverse populations. The results of this study also

demonstrate that there is small evidence of how general training in cultural diversity supports training to work with immigrants/refugees. However, the results of this research have revealed a more foundational need to revise how the cultural awareness education to MFTs is being implemented and delivered.

This study underscores the idea that to work across cultures and with immigrants/refugees a family systems lens is very suitable. The results of this research study support the fact that MFTs must be trained in settings that foster deep, difficult conversations about culture, equity, and inequalities in therapy with well-trained professors. This study highlights the reality that working with refugees and immigrants requires a degree of commitment and specific training as well as a posture of flexibility, curiosity, self-awareness, humility, and adaptability to work with a population that is not a monolithic group but a rich, diverse, and complex group with needs and strengths that go beyond immigration trauma (although it includes that as well).

My hope is that the results of this study will serve as an impetus for MFT program leaders and professors to improve the training of MFTs to serve the needs of the increasingly diverse population in the U.S. in general and improve the preparation of MFT students to serve the needs of immigrants/refugees in particular. I hope that there is an increase in the desire to revitalize the efforts and methods of training in cultural effectiveness that already exist in MFT programs to reflect in practicality what already has been so well described by the recent research in the field of MFT.

But more importantly for me is that this study will serve to increase the interest in research about how to effectively train MFTs to serve the needs of immigrants/refugees, which is the population that would hopefully benefit ultimately from the results of this study. For this

reason, I conclude heightening the importance of training MFTs to serve vulnerable populations as “[t]he greatest tool the therapist can use is the self” (Minuchin, Reiter, & Borda, 2013, p. 9).

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## **Appendix A: Invitation to Nominate/Participate in the Interview**

### **Introduction letter to leaders of professional organizations:**

Dear Colleague,

My name is Cristina Plaza Ruiz and I am a student in the Doctorate in Leadership in Higher Education Program at Bethel University. I would like to ask your cooperation disseminating the invitation letter included below. I would like to invite Marriage and Family Therapy (MFT) graduates to participate in a research study conducted at Bethel University for my dissertation research. The study aims to explore the experiences of recently graduated Marriage and Family Therapists working with immigrants and refugees. No license pre-requisite is needed to participate in the study; prospective participants may have completed their masters in Marriage and Family Therapy, be LAMFTs, or LMFTs and have graduated after 2010. My intent is to utilize the findings of this study to improve the training of future therapists who work with immigrant and refugee populations.

Your cooperation in this research study will be greatly valued, please share the email bellow with all those that you consider will be interested in participating and have them contact me as indicated in the email. Ethical approval for this research was obtained from the Ethics Committee at Bethel University.

Sincerely,

Cristina Plaza Ruiz, MAEd., LMFT  
Graduate Student  
Doctorate in Leadership in Higher Education  
Bethel University  
[cplazaru@bethel.edu](mailto:cplazaru@bethel.edu)  
651-233-7936

## Invitation letter to prospective participants:

Dear Colleague,

My name is Cristina Plaza Ruiz and I am a student in the Doctorate in Leadership in Higher Education Program at Bethel University. I am also adjunct assistant professor in the Marriage and Family Therapy at Bethel Seminary. I would like to invite you to participate in a research study conducted at Bethel University for my dissertation research. The study aims to explore the experiences of recently graduated Marriage and Family Therapists working with immigrants and refugees. No license pre-requisite is needed to participate in the study; prospective participants may have completed their masters in Marriage and Family Therapy, be LAMFTs, or LMFTs and have graduated after 2010. Your participation in this research study will be greatly valued. Ethical approval for this research was obtained from the Ethics Committee at Bethel University. I will conduct the interviews in person at a location convenient for you, over the phone, or via a web-based communication vehicle of your choice; interviews could take up to 90 minutes and the audio will be recorded. To maintain confidentiality and anonymity, a pseudonym replacing your name will be used in the research. Also, all audio recordings used will be transcribed verbatim by a professional transcriptionist under strict confidentiality, stored in a safe location, and later destroyed. Only the researcher will have access to the audio recordings and transcripts. Participation in this study is entirely voluntary. If you would like to be a part of this research study, please reply to this email at your earliest convenience so we can schedule the interview. Your participation and input are extremely valuable, as you will be contributing to the improvement of training professionals in the field of Marriage and Family Therapy.

Please indicate whether you are interested in participating in this research by contacting me by email or phone at the contact information listed below. I look forward to hearing from you and to the opportunity to learning from you. As a token of my appreciation for your time you will receive a \$40 gift card to Amazon/Target.

Sincerely,

Cristina Plaza Ruiz, MAEd., LMFT  
Graduate Student  
Doctorate in Leadership in Higher Education  
Bethel University  
[cplazaru@bethel.edu](mailto:cplazaru@bethel.edu)  
651-233-7936

APPROVED IRB  
Jan. 25, 2019

## **Appendix B: Consent Form to Participate in the Interview Process**

### **Bethel University**

#### **Background Information**

You are invited to participate in a research study part of dissertation process being conducted by a student at Bethel University Doctorate in Leadership in Higher Education. The purpose of this study is to better understand the experiences of recently graduated marriage and family therapists who work with immigrant and refugee populations in light of their graduate training. I hope that you will consider taking part in this work. My intent is to utilize the findings of this study to improve the training of future therapists who work with immigrant and refugee populations.

#### **Protocol**

Cristina Plaza Ruiz is the researcher who will conduct the interviews; her contact information can be found below. If you decide to participate, you will be scheduled to meet with the researcher. During that session, the researcher will review the purpose of the research with you, will solicit your consent to complete a brief survey and an interview, answer any questions you may have regarding the research, and will ask for your signature on this consent form. You will then be asked to complete a brief survey that will be used to categorize participants demographically and to engage in an interview with the investigator. You can expect the total process to take up to 90 minutes. At the conclusion of your scheduled appointment, you will receive a \$40 gift card as a token of appreciation for the time and energy required by your participation.

#### **Risks and Benefits of Being in the Study**

Care will be taken to protect your privacy during the interview. The interview will be conducted in such a way that you will have full control over the nature of what you choose to disclose. Some of the interview questions may generate discomfort and you are free to skip any question that are deemed uncomfortable.

#### **Confidentiality**

Any information obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. In any written reports or publications, no one will be identified and only aggregate data will be presented. No third parties will be informed of anyone's participation in the study. Audio recordings will be stored on a password protected cloud-base storage system and printed copies of transcriptions will be kept in a locked file cabinet in the researcher's office. Electronic copies of the transcriptions will be saved in a private server folder on a password-protected Bethel University computer. Participant identities will be protected by use of a code known only to the interviewer. A singular copy of personal identification key to the codes, the demographic surveys, and the signed informed consent forms will be stored in a separate locked filing cabinet in the researcher's office. Audio recordings, personal identification key, and demographic surveys will be destroyed following completion and presentation of the final report. The expected date of destruction by deletion or shredding is no later than December 31, 2020. Electronic versions of summary demographic data and interview transcripts will be kept on a password protected cloud-based storage server for no more than 3 years. The expected date of deletion is not later than December 31, 2020. A

professional transcriptionist who is not an employee of Bethel University will transcribe interviews verbatim. The transcriptionist will sign a statement of confidentiality regarding the content of the audiotapes. The transcriptionist will have access to the personal identification key.

**Voluntary Nature of the Study**

Your decision whether or not to participate will not affect your future relationship with Bethel University or the referring institution in any way. If you decide to participate, you are free to discontinue participation at any time without affecting such relationships. If you decide to participate, you are free to withdraw at any time up to and until the final report has been submitted to this dissertation’s research committee. Should you decide to withdraw prior to that date, data collected about you will be withdrawn and excluded from the study. You may decline to respond to any demographic survey question or to any interview question or probe.

**Contacts and Questions**

Cristina Plaza Ruiz  
Doctoral Candidate  
Bethel University  
651-2337936  
[cplazaru@bethel.edu](mailto:cplazaru@bethel.edu)

**You will be offered a copy of this form to keep.**

**Statement of Consent**

I understand that I am making a decision whether or not to participate. My signature indicates that I have read the information provided above, that my questions have been answered to my satisfaction, and that I have decided to participate. I am at least 18 years of age. I give permission for the researcher to audio record this interview. I understand that I may withdraw at any time after signing this form without prejudice should I choose to discontinue participation in this study.

\_\_\_\_\_  
Signature of Study Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Study Participant

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

Personal Identification Code: \_\_\_\_\_

**Appendix C: Interview Questions for Participants**  
THE EXPERIENCES OF RECENTLY GRADUATED  
MARRIAGE AND FAMILY THERAPISTS WORKING WITH  
IMMIGRANTS AND REFUGEES

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**Purpose of this research study:** The purpose of this study is to explore the lived experiences of recently graduated mental health professionals (five years since graduation) from Marriage and Family Therapy (MFT) programs in the United States who work in clinical therapeutic settings with diverse immigrant/refugee populations in light of their graduate school preparation.

This qualitative study will investigate the following research question:

- RQ: What is the experience of recently graduated marriage and family therapists who work with immigrants and refugees?

Thank you for your consideration to meet with me. If you choose to participate in this interview, please sign and return the consent form. You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigator or Bethel University. Your decision will not result in any loss of benefits to which you are otherwise entitled.

**(Turn on audio recorder)**

**Interview #...**

Thank you for agreeing to be interviewed for this research project. I am hopeful that the information you and the other participants share will provide insight into the experiences of recently graduated MFTs who work with immigrant/refugee populations.

In order to understand how well your graduate school training prepared you to work with immigrant/refugee populations; I need to know about your time at the training institution. I want

to understand your experiences, feelings, and thoughts about your current work and the preparation you received from your graduate school training. I have a set of questions to guide our conversation. I will give you an opportunity to share additional thoughts or questions at the end, but please feel free to broaden the conversation throughout the entire interview if a question seems limiting.

Do you have any questions about what I've said or about the purpose of the interview?

**Interview questions:**

- What is your experience as a recent graduated marriage and family therapist who works with immigrants and refugees?
- What is your perception of your marriage and family therapist graduate education (academic course work, practicum placement, and experience) in preparing you to work with immigrant/refugee populations?
- What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees?
- What role does the therapist's own commitment to self-awareness and a commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?

This interview will focus on your experiences as a marriage and family therapist working with immigrant/refugee populations in light of your graduate school preparation. Let's start:

1. What is your experience as a recent graduated marriage and family therapist who works with immigrants and refugees?
  - Prompt: Briefly describe how you began working in your current work. How long



have you been in this position? What is your exact title currently?

- Prompt: Why did you decide to work with this specific population?
- Prompt: Did you start directly after graduate school?
- Prompt: Could you describe what you do?
- Prompt: Can you give me an example of a typical day at work?

2. What is your perception of your MFT graduate education (academic course work, practicum placement, and experience) in preparing you to work with immigrant/refugee populations?

- Prompt: How do you feel about the graduate education you received in order to work with the populations in your caseload?
- Prompt: What knowledge, skills, and attitudes did you perceive as essential during your time in graduate school?
- Prompt: Of all the knowledge, skills, and attitudes that you perceived as essential during your time in graduate school, what are most relevant to your work now?
- Prompt: Are knowledge, skills, attitudes as valuable now as you perceived them to be during training? Yes/no? Why yes/why not? Please explain.
- Prompt: What do you perceive are the essential knowledge, skills, and attitudes an MFT needs possess to work with immigrant/refugee populations? Please describe.
- Prompt: Did you take any specific course(s) during your time in graduate school in working with immigrant/refugee populations?
- Prompt: Did you read any required books specifically targeting therapy with immigrant/refugee populations?

- Prompt: What information do you wish you had known about working with this population that you were not aware of during graduate school?
  - Prompt: What, if any, content knowledge that you learned about another minority group easily transferred to your work with immigrants and refugees?
3. What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in preparedness to work with immigrants and refugees?
- Prompt: Are there any experiences that especially stand out?
  - Prompt: Describe what elements of your own life give you a sense of being prepared to work with immigrant/refugee populations.
  - Prompt: How does your own sense of cultural identity play in your sense of preparedness?
  - Prompt: Describe what elements from your own personal life and life experience motivate you to continue as a therapist who works with immigrant/refugee populations.
4. What role does the therapist's own commitment to self-awareness and a commitment to personal growth play in the experience of preparedness to work with immigrants and refugees?
- Prompt: How important is your own commitment to self-reflection and personal sense of vocation to the experience of preparedness to work with this population?
  - Prompt: How does your own sense of cultural humility (cultural competence/cultural responsiveness) play in your sense of preparedness?

- Prompt: How does your own learning (seminars, reading, friendships with diverse individuals, travel, etc.) outside of what was required in graduate school contribute to a sense of preparedness?

Is there anything I have not asked you that you would like to share?

**Close:** Thank you for taking time to talk with me today. Your information shared today is confidential and will be used only to inform this study. This interview will be transcribed by a professional transcriptionist working under strict confidentiality. Do you have any questions?

Thank you again for talking with me. End of interview. (**Turn off audio recorder**)

## Appendix D: Demographic Form

Please complete the following form. The answers will contribute to the descriptive aspect of this study and will assist the researcher in understanding responses to the interview questions. This form will be kept confidential and will be assigned a code number for referral. Thank you for your participation.

### Demographic Survey

**Code:** \_\_\_\_\_

**Instructions:** Please respond as instructed to each of the demographic categories below. If there are categories to which you choose not to respond, please leave them blank. **DO NOT** write your name on this form.

1. Gender \_\_\_\_\_

2. Age category (please select one)

\_\_\_\_\_ 18-22 years

\_\_\_\_\_ 23-39 years

\_\_\_\_\_ 40-55 years

\_\_\_\_\_ 56 and over

3. Education \_\_\_\_\_

4. Race/Ethnicity \_\_\_\_\_

Is there another category that best describes you? \_\_\_\_\_

5. What is your primary language? \_\_\_\_\_

6. How many years have you worked as a Marriage and Family Therapist? \_\_\_\_\_

## **Appendix E: Bias Statement**

My interest in the subject matter stems from my experience as a student in a Marriage and Family Therapy (MFT) Program in the United States and now my work as a therapist who works with immigrants and refugees. I was born in Spain and moved to the U.S. at age 24. This experience was different from the many immigrant/refugees' experiences, as I have experienced considerable privilege in my resettlement. Nonetheless, the process of feeling like an outsider is a shared experience between immigrants and refugees and one that certainly may influence my interest in this subject. As a foreign born MFT, and in my current clinical work, I have the opportunity to work with foreign language interpreters and immigrant/refugee clients. Moreover, working as an adjunct faculty in an MFT training program, and being a recently graduated MFT, I share similar experiences to the prospective interview subjects. This may allow the recently graduated MFT participants to say things they may not have said to a researcher born in the U.S. My own experience working with immigrant/refugee clients as a therapist influences my lens as well. As a therapist, I have experienced mostly positive working relationships although I am aware of the challenging issues in serving this population. My work with immigrant/refugee patients in a primary health clinic, my experience as a recently graduated MFT, together with working as adjunct faculty teaching in an MFT program has influenced my desire to pursue this research topic. I began to think about this idea early in my graduate school experience and noticed only sporadic intentional teaching about working with diverse immigrant/refugee populations. Later my review of the literature confirmed a need to further research this topic.

## **Appendix F: Researcher's Consent Process Script**

Thank you for agreeing to be interviewed for this research project. I am hopeful that the information you, and the other participants, share will help provide information that gives insight into the lived experiences of recently graduated Marriage and Family Therapists (MFTs) working with immigrants and refugees in the United States. The intent of this research project is to utilize the findings of this study to improve the education of future MFTs who work with immigrant/refugee populations. Data will be collected via one-on-one interviews. The interviews will be transcribed by professional transcriptionists, working under strict confidentiality.

### **1) Review purpose of the study**

The purpose of this study is to explore the lived experiences of recently graduated MFTs working with immigrants and refugees in the United States. This phenomenology study will investigate the following research questions:

RQ: What is the experience of recently graduated marriage and family therapists who work with immigrants and refugees?

These dimensions of experience will also be explored:

- What is the recent graduates' perception of their graduate education (academic course work, practicum placement, and experience) in the MFT program to prepare them to work with immigrant/refugee populations?
- What role does the therapist's own life experience (ethnic background, own immigration journey, etc.) play in the experience of preparedness to work with this population?
- What role does the therapist's own self-awareness and commitment to of self-reflection play in the experience of preparedness to work with this population

In order to understand your experience as a recently graduated MFT working with immigrants and refugees, I need to know about your experience. I have a set of questions to guide our conversation. I want to understand your experiences, feelings, and thoughts about your time working with immigrant/refugee populations as a MFT.

Do you have any questions about what I have said or about the purpose of the interview?

**2) Assessment of participant's understanding of his/her participation in this study:**

- How did you find out about this opportunity?
- What is your name (confirm participant identity) and what is your current work place?
- Did you receive an electronic copy of the consent form prior to this interview? Have you read the form? (If not, allow time for review).
- What do you understand to be the purpose of this interview and how long to you expect it to last?
- What concerns, if any, do you have regarding your participation in this interview?
- Having read the consent form, do you have any questions regarding how your identity will be protected in this process?

**3) Secure signature on consent form.**

**4) Assign code to consent form.**

**5) Offer a copy to participant.**

**6) Remind participant of their right to terminate participation at any time without penalty.**

**7) Distribute gift card/send via mail.**

**8) Assign same code to demographic survey.**

- 9) **Provide demographic survey and ask participant to complete as much of the form as they are willing.**
- 10) **Turn on audio recording equipment.**
- 11) **Identify participant by code on audio recording.**
- 12) **Begin interview protocol.**