RACIAL MINORITY IMMIGRANT THERAPISTS' PERSPECTIVES WORKING WITH RACIAL MINORITY IMMIGRANT CLIENTS: CHALLENGES, OPPORTUNITIES, AND RELATIONAL EXPERIENCES

by

Jennifer Jinjoo Oh

A dissertation submitted to the faculty of Radford University in partial fulfillment of the requirements for the degree of Doctor of Psychology in the Department of Psychology

June 2022

Cohn, Tracy Digitally signed by Cohn, Tracy Date: 2022.06.07 08:33:33 -04'00'

Tracy J. Cohn, Ph.D. Date
Dissertation Chair

Pei-Chun Tsai Digitally signed by Pei-Chun Tsai Date: 2022.06.08 23:52:51 -04'00'

Pei-Chun Tsai, Ph.D. Date
Committee Member

Sarah Hastings 6/6/2022

Sarah Hastings, Ph.D. Date
Committee Member

ABSTRACT

While disparities in mental health access, utilization, and treatment outcomes continue to persist for racial and ethnic minority (REM) immigrant individuals, delivering culturally competent care continues to be a challenge for therapists as it is unclear how therapists practice theory-driven concepts of multicultural counseling competence (MCC). Historically and presently, MCC research has focused predominantly on White therapists and constructs related to gender and race, and inquiries related to the construct of immigration have mostly focused on the immigrant client. Despite the imperative for therapists' self-awareness of all sociocultural identity factors that impact their social locations and relationships with clients, the experiences of REM therapists who identify as immigrants has been largely ignored. This qualitative study seeks to add to existing literature by exploring the perceptions of currently practicing REM immigrant psychologists in their work with REM immigrant clients.

Keywords: racial and ethnic minority immigrant, multicultural counseling competence, relational-cultural theory, therapeutic relationship, ecological, xenophobia

Jennifer Jinjoo Oh, MSW, M.A.
Department of Psychology, 2022
Radford University

DEDICATION

This work is dedicated to my family and especially to my mother, Shin Hye Sook, whose loving care, warmth, and remarkable compassion is rivaled by her ingenuity, creativity, and resourcefulness. I am forever encouraged.

ACKNOWLEDGEMENTS

Thank you to all of the participants who shared so generously for this study. Thank you for desiring to inform, enlighten, and teach. Your words reverberate ongoing.

I'm also grateful to my team, my coding partner Hadley Brochu, and my debrief partner, Amanda Pentiah. As colleagues and supports, your commitment and sacrifices helped me move onward and forward. Thank you.

Lastly, thank you to my committee members, Drs. Tracy Cohn, Sarah Hastings, and Pei-Chun Tsai, for your encouragement, feedback, and support. I am especially grateful to you, Dr. Cohn, my advisor and Chair, for your vote of confidence, your time, and your discerning guidance.

TABLE OF CONTENTS

CHAPTER ONE

STUDY OVERVIEW

Over the course of four decades, research, training, and practice of psychology in the United States have focused on the importance of psychologists to provide services that are culturally sensitive and meet the distinct needs of racial and ethnic minority (REM) individuals. At present, multicultural counseling competence (MCC) is considered a foundational skill that is codified in both the American Psychological Association's (APA) *Standards of Accreditation for Health Service Psychology* (APA, Commission on Accreditation, 2018) as well as the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017a). Additionally, varying theories and related constructs of MCC have been proposed (e.g., M. Chao et al., 2011; Fowers & Davidov, 2006; Owen et al., 2011b; Pitner & Sakamoto, 2005; Ponterotto, 2010; Sue et al., 1982; Vera & Speight, 2003) while aspirational guidelines on how psychologists should implement and practice MCC have been issued throughout the years (e.g., APA, 2003, 2017b; Arredondo et al., 1996; Hays, 2016; Sue et al., 1992).

Despite such developments, standards, principles, and recommendations, translating theory into culturally-competent practice continues to be an evolving challenge for psychologists (Rogers & O'Bryon, 2014; Tummala-Narra et al., 2012), with little known about therapists' actual behaviors as they relate to MCC practice (Mollen & Ridley, 2021). Additionally, the extent to which clinicians' own definitions and beliefs about MCC impact their cross-cultural counseling behavior is relatively obscure and deserves attention. For example, Sehgal et al. (2011) found significant discordance between what psychologists believe they *should* do and what they *would* do, according to multiculturally competent practice. Indeed, research shows that REM clients compared to non-REM clients are more likely to lack access to culturally competent

providers (Alegría et al., 2008, R. C.-Y. Chung et al., 2008) and are less likely to be referred for counseling by providers (Blanco et al., 2007). While REM individuals are far less likely to utilize mental health services compared to non-REM individuals (Stockdale et al., 2008), when they do utilize services, they continue to experience higher drop-out rates (Owen et al., 2012) and disparities in mental health treatment outcomes (Maura & Weisman de Mamani, 2017), disparities for which *therapists* have been found to be one of the primary sources (Drinane et al., 2016; Hayes et al., 2015, 2016; Imel et al., 2011; Larrison et al., 2011; Owen et al., 2012).

Even though MCC research in psychology continues to build upon its substantial theoretical base with ongoing empirical investigations that aim to explore therapists' traits, skills, and processes that account for cross cultural sensitivity and effectiveness, studies have historically been conducted using predominantly or exclusively White trainees or therapists (e.g., Constantine, 2002b, 2007; Dickson et al., 2010; Gelso & Mohr, 2001; Utsey et al., 2005; Vinson & Neimeyer, 2003), and this trend continues presently (e.g., Atkins et al., 2017; Castillo et al., 2007; D. F. Chang & Berk, 2009; R. C.-L. Chao et al., 2017; Day-Vines et al., 2018; Hayes et al., 2015; King & Borders, 2019; Wilcox et al., 2020). As such, even less is known about the experiences and perceptions of non-White therapists as it pertains to their cross-cultural work. Additionally, while much of the literature regarding MCC and therapy has focused on race and gender, very little consideration has been given to therapists who are immigrants and how this salient identity factor of "being not from here" impacts the therapeutic relationship (Kissil et al., 2013b) when working with REM clients. Accordingly, the present study aimed to explore the experience of REM immigrant (first- and later-generation immigrant) therapists with regard to the relational opportunities and challenges they experience in the therapy room when working with REM immigrant clients.

Review of the Literature

Both theoretical and empirical literature regarding the experiences of REM immigrant individuals demonstrate the heterogeneity among and within such groups on account of the interaction of individual-level (e.g., age at immigration, reasons for immigrating) and macro-level (e.g., experiences of discrimination, racism, and xenophobia) factors (APA, 2012). Two theories offer a framework for understanding the contextualize the relational experience between the REM immigrant therapist and the REM immigrant client: relational cultural theory (RCT; Miller, 1976) and the ecological model of multicultural counseling psychology processes (EMMCPP; Neville and Mobley, 2001)).

Relational Cultural Theory (RCT)

RCT is an inclusive model that places human relationships as central to psychological and emotional maturity (Jordan, 1999). RCT theorists posit that as humans, we both grow *through* and *toward* relationships rather than separation from them (Comstock et al., 2008). RCT views interconnectedness as central to human desire such that increased relational competence is the primary goal of development. Individual racial, cultural, and social identities are viewed as being inextricably linked to this process, and navigating increasingly complex and diverse relationships is one of the core tenets of RCT (Comstock et al., 2008).

RCT is contextual in nature and rests on the assumption that oppression, humiliation, marginalization, and other "relational violations" perpetuate human pain, trauma, and suffering (Comstock et al., 2008). These social injustices, which are systemic and institutionalized, are enacted in the context of interpersonal relationships with a resulting "severance of human bonds" that can be restored only with new, healing bonds (Birrell & Freyd, 2006; Comstock et al., 2008). RCT posits that mutuality is central to relationships. Mutual empathy and investment in

the well-being of the other is key to fostering growth during the movement of the relationship, which is marked by periods of connection and inevitable disconnection. Miller (1976) posited that connection is characterized by mutual zest, agency, and greater sense of worth that prompts an individual to want to connect even more with others. Disconnection, which can be the consequences of large societal injustices (e.g., cultural oppression), as well as interpersonal dynamics (e.g., power differentials) can engender feelings of disempowerment, shame, unworthiness, and self-blame (Miller & Stiver, 1997). While acting on opportunities to repair disconnections can yield more authentic and stronger relationships, repeated and persistent disconnections can lead to a sense of "condemned isolation" or feelings of an impossibility for future belonging or connection (Miller & Stiver, 1997).

Those for whom disconnections are most painful are individuals who are more vulnerable in the relationship—such as clients in a therapy relationship—or for those who are from marginalized and devalued cultural groups (Comstock et al., 2006). RCT relational concepts such as empathy and authenticity render the framework particularly fitting to use as a lens to explore REM immigrant therapists' experiences of cultural connections and disconnections with their REM immigrant clients, perhaps because of or in spite of their differences. Whether and how REM immigrant therapists perceive relational movement, or lack thereof, as a result of their own clinical decisions and behaviors can illuminate contextual, nuanced understandings of therapists' way of being in cross cultural dyads.

The Ecological Model of Multicultural Counseling Psychology Processes (EMMCPP)

Neville and Mobley (2001) put forward the EMMCPP, a revised version of Bronfenbrenner's ecological model, which frames human interactions as influencing—and influenced by—five interrelated, nested systems: (a) individual and their characteristics, such as

genetic make-up, ethnicity, age; (b) microsystem, or immediate interpersonal interactions in a given environment; (c) mesosystem, or interactions between two microsystems; (d) exosystem, or the interactive influence of two subsystems; (e) macrosystem, or the overarching societal values and norms that define social roles and expressions of identity (1979). The EMMCPP expands the macrosystem as encompassing not just values, but also social structures of race, class, gender, and sexual orientation that are stratified in a hierarchical social system. For the purposes of this study, I will present the historical racialization of REM immigrant groups and the resulting impact of stratification on relationships among and within the U.S. REM immigrant population.

Immigration and the REM Immigrant

Migration and the post-migration adaptation process have been documented as posing unique barriers and challenges that are sometimes exacerbated by "culture shock" (Ticho, 1971). Acculturation, or the ways in which immigrant individuals experience and manage difficulties in their attempts to adapt to new cultural contexts (Berry, 1997), looks different for each immigrant. Experiences of discrimination are the most powerful predictor for poor adaptation (Sam & Berry, 2010) and increased psychological stress (Jasinskaja-Lahiti et al., 2006; Missinne & Bracke, 2012; Schmitt et al., 2014). Such challenges can be precipitating factors for mental illness for immigrants, including severe mental illness (Bhugra & Gupta, 2011; Cantor-Graae & Selten, 2005). Indeed, an overview of the research demonstrates that immigrants who are non-White are also at increased risk of developing mental illness and suicidal ideation (Forte et al., 2018). Further immigration-related marginalization, such as documentation status, can lead to additional unique mental health burdens, including chronic fear and uncertainty (Garcini et al., 2016).

REM immigrant individuals are less likely to utilize mental health services (Derr, 2015) due to language barriers, high cost of services, and lack of health insurance (Bridges et al., 2012). Although immigration status (i.e., foreign-born versus U.S.-born) was not specified, a review of epidemiological studies that included adult Latino refugee populations (Cabassa et al., 2006) demonstrated a similar significant trend in underutilization. Additionally, an aggregate study of multiple large-scale studies—one of which included interview translations for respondents in Spanish, Mandarin, Cantonese, Tagalog, and Vietnamese (Alegría et al., 2008)—showed that compared to non-REM clients, REM clients were far less likely to receive any mental health treatment for depression and were more likely to receive inadequate care, including experiences of mistreatment from providers. For REM immigrants who are not proficient in the English language, communicating with a therapist can be a barrier to service, especially when considering that only 10.8% of U.S. health service psychologists are able to provide services in a language other than English (APA, 2016). Albeit there are very few studies regarding the impact of the use of language interpreters in therapy, what inquiries have been conducted have shown its potential to negatively impact assessment and diagnosis (Price & Cuellar, 1981) as well as the therapeutic relationship (Tribe & Tunariu, 2009), while a more recent study demonstrated no significant impacts on the therapeutic alliance (Villalobos et al., 2015). Moreover, REM clients may manifest symptoms of culture-bound syndromes, which therapists could misinterpret or misdiagnose if they do not properly attend to cultural variants of psychological functioning (Sue & Sue, 2016).

REM immigrant therapists—by virtue of their identity factors—may have personal experience with the some of the aforementioned mental health challenges, while it is also possible that REM immigrant therapists have not had dealings with any of these challenges.

REM immigrant therapists' perspectives of their awareness and understanding of REM immigrant clients' presenting distress may inform the role they step into. Understanding the impact of therapists' perspectives in these particular relationships is imperative for building a more inclusive and accurate picture of how therapists experience the cross-cultural therapeutic dyad.

Immigration and the REM Therapist

Few factors have been explored on the subject of therapists who are immigrants, including from renowned psychoanalysts who immigrated during the Second World War (Akhtar, 2006). Given that therapists are called to continually build self-awareness as cultural beings that impact the intersubjective, therapeutic space (Ainslie et al., 2013), Kissil and authors (2013b) pointed out that such self-awareness should necessarily include the distinct experience of being "not from here," which, according to the authors, is a unique domain of a therapist's identity that cannot be wholly accounted for by proxy factors, including race, ethnicity, or experiences of being minoritized. This contextual consideration may be one that immigrant therapists themselves are not wholly cognizant of as it regards the impact on the therapeutic relationship (Kissil et al., 2013b).

In their presidential address titled "Immigrant Counseling Psychologists," Y. B. Chung presented informally gathered narratives of 10 first-generation immigrant counseling psychologists, among which included the perspective that their own immigration experiences facilitated an understanding of their immigrant clients (Y. B. Chung, 2013). The understanding that emanates from this shared status has been reiterated by others (Kissil et al., 2013b) who conceptualize the experience of "otherness" as a conduit for immigrant therapists to have more empathic understanding for their clients who have also been marginalized. These same othering

experiences, however, may impact immigrant therapists and their work with immigrant clients in myriad other ways. Two separate quantitative studies that investigated the clinical experiences of immigrant therapists revealed that those who perceived discrimination and prejudice in their larger environment perceived themselves as having weaker clinical skills in relation to their counterparts (Kissil et al., 2013a; Kissil et al., 2015).

Other researchers have added theoretical postulates regarding what it means to be an immigrant therapist. For example, in addition to noting the possibility that immigrant therapists have "intuitive empathy" when working with immigrant clients, Akhtar (2006) warned that for those immigrant therapists who may not have fully examined their experiences of immigration-related loss, therapists may enter into "nostalgic collusion," or overidentification with the experiences of their clients. The possibility of overidentification and a resulting "shared fortress" between therapist and client is echoed by Comas-Díaz and Jacobsen (1991) in their description of the various types of "ethnocultural countertransference" experiences REM immigrant therapists may encounter. Finally, in their presentation of case studies from their own clinical practice, Tummala-Narra (2020)—a first-generation, REM immigrant therapist—contended that personal experiences of xenophobia and racism are "key aspects of clients' and therapists' identity and relational life" such that REM immigrant therapists should necessarily reexamine the complex layers of their lived experiences, including "unresolved personal conflicts with sociopolitical conditions, accompanying feelings of guilt, shame, envy, rage, and fear, histories of sociocultural trauma, internalized stereotypes and prejudice, and more broadly, public discourse on issues of race and immigration, and how these various layers manifest in clinical process" (p. 51).

While development of self-awareness has been examined through the lens of White clinicians (e.g., Atkins et al., 2017), the extent and ways in which REM immigrant therapists engage in such examinations of self and how they perceive these processes to impact the therapeutic relationship in their experiences with REM immigrant clients is unclear and warrants attention.

MCC in Psychology Training, Practice, and Research

MCC research started and has generally presumed that non-White therapists are more culturally competent by virtue of their identities as minorities (Dickson et al., 2010; Vinson & Neimeyer, 2003). Important inquiries regarding MCC and relational processes—such as developing self-awareness of privilege (Akins et al., 2017; R. C.-L. Chao et al., 2017) and broaching the topic of race and racism with clients (King & Borders, 2019)—have been conducted with exclusively White trainees and clinicians, while others have also utilized predominantly White clinicians as their subjects (Castillo et al., 2007; D. F. Chang & Berk, 2009; Constantine, 2002b, 2007; Day-Vines et al., 2018; Gelso & Mohr, 2001; Utsey et al., 2005; Wilcox et al., 2020). Furthermore, research indicates that differences in treatment outcomes for REM individuals are not a function of *therapists'* racial identity; that is, differences are not *between* REM and White therapists, but rather *within* (Drinane et al., 2016; Hayes et al., 2015, 2016; Imel et al., 2011; Larrison et al., 2011; Owen et al., 2012, 2017). Unmasking therapist-level factors that lend themselves to these differences necessarily involves investigating the perspectives of not just White therapists, but especially those therapists for whom traditional MCC scholarship and resources have not been tailored or written. Adding the voices of REM immigrant therapists who work with REM immigrant clients can render a more nuanced and inclusive foundation for this emerging domain of inquiry.

Purpose of the Present Study

This study aimed to add to the emerging scholarship that seeks to understand therapists' cross-cultural relational experiences by exploring the perceptions of REM immigrant therapists in their work with REM immigrant clients. Cultural-relational theory of human development and the ecological model of multicultural counseling psychology processes (EMMCPP) were used as conceptual frames that emphasize the fundamental impact of systemic issues of race, power, and oppression on identities and relationships. A constructivist paradigm was employed using qualitative, grounded theory (GT) design in order to widen the scope and depth of the present inquiry (Charmaz, 2018). The goal of the constructivist approach is to understand the "lived experiences" of those who live it (Starks & Brown Trinidad, 2007). It contrasts sharply from the postpositivist paradigm, which rests on the view that there is one true, objective reality that is knowable through explanation, prediction, and control of phenomena (Ponterotto, 2005).

Method

Research Paradigm

GT is rooted in the concept of symbolic interactionism, which theorizes that social processes are the avenue through which meaning is created (Kendall, 1999). It is posited that individuals construct their realities in interpersonal interactions where shared symbols (e.g., words) are used to communicate meaning (Fassinger, 2005). The goal for grounded theorists is to examine and produce an explanatory theory of social processes that is "grounded" in the data that is collected from participants' lived experiences in a particular social context (Fassinger, 2005). The current study emphasizes the centrality of the historical, political, and social context and considers multiple dimensions of this context (i.e., individual, interpersonal, systems-level)

as essential factors to understanding the ways in which REM immigrant therapists experience their relationships with REM immigrant clients.

Participants

Twelve REM immigrant psychologists who were licensed and providing direct clinical care in the United States completed the interview for this study. Participants' ages ranged from 31 to 45, and the mean age of participants was 36.5. Six participants identified as male (50%), while six participants identified as female (50%). Eight participants (67%) identified their race as Asian, two participants (17%) identified as South Asian, one participant (8%) identified as Asian American, and one participant (8%) identified as Asian and LatinX. With regard to participants' ethnic identities, three participants (25%) identified as Chinese, two (17%) participants identified as Chinese American, one participant (8%) identified as Southeast Asian, one participant (8%) identified as Southern Chinese American, one participant (8%) identified as Chinese/Pakistani, one (8%) participant identified as Filipino, one (8%) participant identified as Korean American, and one (8%) participant identified as Latina. Years lived in the United States ranged from 9.5 to 30. Age of immigration ranged from 4.5 to 22 years old, while seven participants (58%) identified as first-generation immigrant, two participants (17%) identified as 1.5 generation immigrant, one participant (8%) identified as an "Expat," and one participant (8%) did not use any terms to identify their immigration status. All participants received their psychology graduate training in the United States. Five participants (42%) received training from a Ph.D. Counseling Psychology program, three participants (25%) received training from Ph.D. Clinical Psychology program, two participants (17%) received training from a Pys.D. Clinical Psychology program, and one participant (8%) received training from a Pys.D. Counseling Psychology program. See Table 1 for additional demographic data of the participants.

Table 1

Demographic Characteristics of Participants

Demographic Characteristics	n (%)
Age	31 – 45
Gender Identity	
Female	6 (50%)
Male	6 (50%)
Racial Identity	
Asian	8 (67%)
South Asian	2 (17%)
Asian American	1 (8%)
Asian and LatinX	1 (8%)
Ethnic Identity	
Chinese	3 (25%)
Chinese American	2 (17%)
Southeast Asian	1 (8%)
Southern Chinese American	1 (8%)
Chinese/Pakistani	1 (8%)
Filipino	1 (8%)
Korean American	1 (8%)
Latina	1 (8%)
Years Lived in the U.S.	9.5 – 30
Age of Immigration	4.5 – 22
Immigrant Status	
First-generation	7 (58%)
1.5-generation	2 (17%)
Expat	1 (8%)
No terms used	1 (8%)
Type of Psychology Graduate Training	
Ph.D. Counseling Psychology	5 (42%)
Ph.D. Clinical Psychology	3 (25%)
Psy.D. Clinical Psychology	2 (17%)
Psy.D. Counseling Psychology	1 (8%)
Languages Used in Psychotherapy	
English	7 (58%)
English, Spanish	1 (8%)
English, Urdu	1 (8%)
English, Mandarin	1 (8%)
English, Cantonese, Mandarin	1 (8%)
Current Clinical Setting of Practice	
Private Practice	4 (33%)
Group Private Practice	2 (17%)
Medical Hospital	2 (17%)

Community Mental Health	1 (8%)
College Counseling Center	1 (8%)
Region of Practice	
Urban	8 (67%)
Urban/Suburban	2 (17%)
Suburban	1 (8%)
Rural	1 (8%)

Note. $N = 12$

Procedures

Prior to commencing with interviews, a pilot interview was conducted with one participant, after which questions on the semistructured interview guide were altered for clarity. A mixed approach of chain and network sampling was utilized to identify interested participants. All non-White, racial, and ethnic minority individuals were considered, while those who self-identified as immigrants (i.e., first-, second-, and third-generation immigrants) were included to account for phenomena that is unique to REM immigrant individuals. That is, REM individuals, regardless of origin of birth or length of stay in the United States, are perceived to be foreigners and the degree to which one perceives themselves as an immigrant may be influenced by interactions shaped by these perceptions, including the therapy space. I initiated the process by first asking faculty members of the Radford Counseling Psychology Department, as well as clinicians from the local university counseling center, for suggestions in recruiting currently practicing psychologists who fit the initial sampling criteria and may have an interest in taking part in the study. Additionally, recruitment flyers were distributed via listservs of professional psychological associations. Approval for research for human participants was obtained from the Institutional Review Board of the affiliated university prior to initiating interviews.

Interviews were conducted over the course of approximately 13 months in the participant's chosen format of audio-only or video and ranged from 50 to 90 minutes in length ($M = 77$). Preliminary information regarding participant's demographic information as well as

immigration history and clinical experience was gathered via a uniform demographic form. Additionally, a copy of the semistructured interview guide was sent to each participant prior to the interview to provide for opportunity for participants to review the questions in advance. With the prior expressed and documented consent of each participant, interviews were recorded using the data recording software, Otter.ai. In order to preserve confidentiality, participants were asked to choose a pseudonym to be used for direct quotations. Before commencing in the data coding process, all identifying information of participants was excised from the data. Additionally, a copy of the cleaned transcript was sent to each participant in order to ensure accuracy and to invite participants to add, modify, or delete data for the purpose of preserving their and their clients' confidentiality.

Positionality and Bracketing Biases

The role of the researcher as the primary instrument for data collection necessitates that they should acknowledge, describe, and "bracket" their personal biases, values, and assumptions at the outset (Creswell, 2009; Ponterotto, 2005). I am a first-generation, REM immigrant woman. I was also responsible for recruiting, selecting, and conducting all interviews. The questions that are at the heart of this inquiry transpired from my relational experiences in the therapy room as a doctoral counseling psychology practicum student at a university college counseling center. My first REM client was a first-generation immigrant student who also had Deferred Action for Childhood Arrivals (DACA) status. For me, the relationship started even before our initial in-person encounter when, upon reading his intake information, I started the mental process of identifying ways to connect and potential difficulties I might experience. During the course of my experience with this client—and other REM students thereafter—I was confronted with myriad challenges and successes that impacted the relationships I had with my clients that made

me wonder about the ways in which other therapists who are racial and ethnic minority immigrants were navigating these challenges.

Data Analysis

All interviews were closely examined times and transcribed for accuracy before commencing the coding process. The coding team consisted of a coding partner and a debriefer. Both team members identified as White, female, counseling psychology graduate students who have, and continue to work with, clients who identify as REM immigrant individuals. To optimally prepare for the coding process using the grounded theory approach, I prepared a guideline that was shared with my team members and also engaged in a norming process with the first three pages of the transcribed interview. This norming process entailed a brief study of GT rationale and coding methods, initial engagement with the transcribed interview as independent coders, after which the team met to discuss how and why initial interpretations diverged, as well as strategies and rationale for keeping codes succinct and active. During this meeting and meetings thereafter, I engaged in reflective dialogue with my team members regarding my role, my identity factors, and the possible power dynamics that might interfere with an objective and systematic process of analysis. After individually coding the entire interview of the first transcript, we had extensive meetings to examine and engage in dialogue line by line, code by code, while keeping detailed process notes until we reached complete consensus. To ensure fidelity and accuracy of the coding process, the finished codes of the first transcript were also reviewed by the chair of my dissertation committee. In the process of individually coding the first three transcripts, I met weekly with my coding partner to engage in ongoing reflexive discussions to clarify conceptual depth and verify emerging categories, all towards the end of improving the coding analysis.

In accordance with the GT (Charmaz, 2014) inductive method of data analysis, a constant, recursive method of comparing, categorizing, and contrasting ensued towards the goal of creating successively abstract categories. Specifically, data was compared (a) from different individuals; (b) from individuals to their own data at distinct and separate points in their own narratives; and (c) from conceptual categories to other categories (Fassinger, 2005). As the "bones" of analysis in grounded theory, coding is the process of defining what the data is about with names, giving particular focus to actions and processes. Given the focus of the present research topic, accurate intensity of how participants feel, think, behave, and experience their interactions was preserved and examined closely for what was stated and unstated. Memo-writing after interviews and initial re-reading of transcripts functioned as a critical element to my reflexive interaction with my thoughts, ponderings, and ideas. Three levels of coding—initial, axial, and selective—were undertaken in both a phasic and recursive manner, as opposed to a strict sequential format, in following with the constant comparison method (Fassinger, 2005). At the initial level of coding, each transcribed interview was examined from units of meaning as they arose from my interactive analysis of them. I looked for sensitizing concepts, or points in the data that indicate "action, meaning, process, agency, situation, identity, and self" (Charmaz, 2014, p. 117), and whenever possible, utilized gerunds to help give meaning to implicit and latent concepts. At the axial level of coding, properties and dimensions of categories were identified so as to ascertain relationships among categories (Strauss & Corbin, 1998). At this level of coding, categories were compared and links between categories were developed by utilizing Strauss and Corbin's (1998) organizing scheme to think about the conditions under which interactions or processes take place; actions and interactions, or the participants' responses to problems and events; and consequences or outcomes of the interactions. The final level of

coding entailed a selective coding process in which central categories were selected to integrate all other categories into an assembled, explanatory whole (Fassinger, 2005).

Memo-Writing and Reflexivity

Reflexivity, or engaging in self-examination of the researcher's own ideas and judgments (Davies & Dodd, 2002), is a core feature of GT research. In order to document and monitor the ways in which researchers engage with and analyze the data, GT researchers stress the importance of interacting with one's thoughts and ideas as they occur early and often by way of writing informal, spontaneous memos (Charmaz, 2014). To this end, I engaged with an interactive journal to track methodological dilemmas, decisions, and rationale for making these decisions. Additionally, I engaged in memo-writing during and after data collection, as well as through each level of the coding process in order to make explicit reasons and rationale for making comparisons and connections between data, between data and categories, and between categories and categories.

Findings

The collective, coded narratives yielded an analytic framework comprised of 13 initial categories and sic axial categories across four selective categories (Table 2). The following analysis is organized as a function of the four selective categories: 1) Person of the REM Immigrant Clinician, 2) Experiences of the Relationship, 3) Navigating Barriers, Negotiating Tensions, and 4) Reflection as Catalyst; Catalyst for Reflection. Descriptions of the axial categories are arranged in subsections.

Table 2

Selective, Axial, and Initial Categories

Selective	Axial	Initial

I. Person of the REM Immigrant Clinician	A. Before and Beyond the Room: REM Immigrant Identity as Backdrop	1. To be a REM Immigrant in the U.S. 2. Positive Views of Self in Relation to Work
II. Experiences of the Relationship	B. "In Our Own Living Room": Experiences of Connections	3. "More Than What's Visible": Feeling, Sensing, Perceiving Connections 4. What is Enabled: Knowledge, Skills, and Strengths as REM Immigrant Individuals 5. "Two Well-Practiced Individuals": Broaching and Disclosure
	C. Attending to Intersections of Identities and Experiences	6. Guarding Against Assumptions 7. Power in Role, Privilege in Identities
	D. Relational Challenges and Ruptures	8. Difficult Emotional and Psychological Reactions
III. Navigating Barriers, Negotiating Tensions	E. "Contextually Driven" Clients and Clinicians	9. Clients, Cultural Tension, Conceptualization and Clinician's Role as Intertwined 10. Where Barriers are Embedded in Systems and Institutions 11. Ongoing Navigation: Helpful Sources and Resources
IV. Reflection as Catalyst; Catalyst for Reflection	F. Ongoing Reflection	12. Past, *In Vivo*, and Future Reflexivity to do "Good Work" 13. Views of the Researcher and Research in Relation to Self

Person of the REM Immigrant Clinician (Selective)

All participants in this study invoked aspects of self, vis-à-vis their immigration story and acculturative experiences—both positive and negative, as well as awareness of self in the eyes of others, mainly their REM immigrant clients. This category emerged as particularly important as

it illuminates the ways in which participants experience connections and empathy with their REM immigrant clients, as well as the ways in which participants feel knowledgeable or skillful to utilize strategies in the therapy room, as well as the ways in which participants view themselves in relation to their work in the larger macro context.

Before and Beyond the Room (Axial)

Before REM immigrant psychologists step into the therapy room with their REM immigrant clients, REM immigrant identities and experiences serve as "backdrop." REM immigrant psychologists invoked experiences and illustrations of navigating identity development, acculturation, and xenophobia and discrimination as immigrant individuals in the United States, as well as the formative impact of these experiences. Such impact included decisions to pursue professional psychology as a career, the general stance that their REM immigrant identity is always "operating in the background," and being able to see reflections of themselves in their REM immigrant clients. One participant noted, "I see myself in them. So, it's, like I'm helping an earlier version of me" (TM, 421). The invocation of earlier versions or past experiences included intimate acculturation experiences. One participant spoke of their fear of "developing an accent," such that they stopped speaking the language of their country of origin at a young age, as well as their perception in the eyes of others as a perpetual "visitor" (Esmy, 8). The notion of being perceived as a "perpetual foreigner" (Michelle) was echoed in various ways by participants, who noted that they had to learn to "read the room" (Heather)—a strategy that they now view as a nuanced skill for therapy—as well as "walking in the skin of otherness" (Vanessa) or their "sense of otherness" as a linchpin of their sense of self that is "never going away" (Charlie).

Like Vanessa, the awareness of self in the eyes of others—that of what is visually and audibly perceived by others—was invoked in various ways regarding their cognizance of "how they look," how they talk or do not talk with "an accent" or, for one participant, the fact that they do not wear a "hijab" (Yasmin). This aspect of awareness—at times noted as the reasons for which their REM immigrant clients "seek them out" specifically—was especially influential for how they viewed race and culture as always "salient" in the therapy room.

Beyond the therapy room, REM immigrant clinicians articulated overwhelmingly positive views of their work, themselves, and their REM immigrant clients, at times alluding to the depth of personal value and regard by the use of the word "love," invoked by five participants. REM immigrant clinicians also articulated a sense of return and gain by way of feeling "blessed" and that the work is "exciting," "fulfilling," and "rewarding," (TM, 187), especially in the context of experiencing congruence between purpose and practice, as in, "this is the population that I really wanted to work with, serving my people. So, it's wonderful that I'm able to do exactly what I planned to do, that I worked so hard for" (TM, 484). Simultaneous with positive views, REM immigrant clinicians also voiced their appreciation of the "multifaceted," "nuanced," "complicated," and "complex" nature of their work. Nuances and challenges were cited as having been a "very positive experience" in recognizing "what I don't know" (Stephen, 305), a "humbling" experience to be reminded of "the amount of things that I need to keep knowing and understanding" (Jack, 119), and "a good reminder" for the "work I need to do to stay up to date in terms of the literature, techniques and resources" (Yasmin, 71).

Experiences of the Relationship (Selective)

The relational experience for REM immigrant psychologists was described in various ways that they felt and sensed connections with their REM immigrant clients. While describing

their sense of connection, REM immigrant participants also identified strengths, skills, and what is enabled in the therapy room by virtue of the identities and experiences of the dyad. Similarities in identity markers impacted REM immigrant clinicians' attention to intersections of identity and experiences, particularly as they relate to their and their clients' assumptions and aspects of power and privilege in the therapy room. When relational challenges and ruptures occurred, REM immigrant psychologists experienced varying degrees of difficult emotional and psychological experiences.

"In Our Own Living Room": Experiences of Connections (Axial)

All participants spoke at length about how they felt, sensed, perceived, and experienced themselves in connection with their REM immigrant clients with regard to both broad generality as well as specific moments. Participants described feeling "instantly closer" (Michelle, 7; Leslie, 58), experiencing "immediate connections" (Michelle, 34), or perceiving "instant credibility" (Jack, 6). One participant described the connection as one that is "bidirectional" and felt mutually that they cherish and value highly:

> I love being able to instantaneously have that point of connection with my clients, in the sense of, despite all the other demographic characteristics that might be different between us, we can have the shared experience from the get-go. ... We can kind of agree that that experience in many ways shapes us, sometimes even outside of our own awareness. (Michelle, 7)

REM immigrant clinicians at times expressed the challenge of describing the felt sense of connection. Michelle described the relational experience as encompassing an "intuitive component" (Michelle, 61), at times connected to—among other things—the shared understanding of "implicit" messages and meanings of phrases and words, while also adding, "I

can't quite explain it and can't quite put my finger on it, which is what I think your study's about." (Michelle, 45). Similarly, Esmy described a "touch moment" that is accompanied by "when the rapport is there on the immigrant level, there is always that kind of like, you know, ET-phone-home kind of moment [laughs], where you touch something" (45).

The connections were also felt by way of what is enabled in the therapy room. Both universal and specific experiences of being a REM immigrant individual rendered specific elements of "understanding," "knowing," "having," "recognizing," "anticipating," and being able to "use," "contribute," and "include" that REM immigrant clinicians describe as being consequential for how they experience themselves, their clients, and ultimately, what is "enabled" in the relationship, including further credibility, rapport, and trust building. For example, for Jack, giving knowledge regarding mental illness and behavioral implications for a young Asian family was also supplemented by their nuanced ability to observe the family's "high context" communication style:

> Asian cultures in general, you just don't rely on what they say because Asian families definitely—their communication style is very high context. You don't just listen to what they say, but what they do and how they say it. And so, if you're not really careful in being observant of that, you might miss something. And I'm sure I have missed certain things. I think with this family, I had a pretty good working relationship and I think I'm fortunate enough to be Asian and to be immigrant that I was able to use that to maintain my credibility with this family but think that that can be a challenge with non-ethnic minority therapists or psychologists. (31)

Communicating specific emotional challenges by way of being able to "recognize," "name," and "reflect" were described by two participants, who also described the process as

occurring simultaneously with deepening of empathy for their clients. For REM immigrant psychologists, emotional recognition transcended the need to identify with a specific parallel experience and may, rather, be contingent on a lived emotional understanding of the overarching themes of the immigrant experience or, as one participant labeled it, an understanding of the "common constellation" of the "emotional impact that those experiences have on the individual" (Michelle, 49).

To further elucidate this point, Michelle and several other participants described specific moments of experiencing mutual access to a "common language" that enables the clinician to understand and use "shorthand," "mnemonics," and "heuristics" without having to "explain and give a dissertation":

> A statement like "mama issues, I'm having mama issues" encapsulates so much from an immigrant's perspective. There are moments like that where just simple phrases become a lot more available for examination because those kinds of things really start to speak to a lot more layers underneath them (Michelle, 41).

What this participant insinuates is that what is positively enabled by the clinician is a function of what is known, understood, and shared together, between the REM immigrant clinician *and* REM immigrant client, a sentiment echoed by another participant who noted mutual access to the same "shorthands" regarding temporary visa labels and feeling that "it's so awesome to not have to explain it; they can just say the acronym, and I'm like, Oh yea, that's the one where you have to apply for that" (Stephen, 269).

For all REM immigrant participants, self-disclosure was both a function and product of the connection that was experienced in the room. Additionally, self-disclosure was intricately connected with the topic of broaching discussions regarding race, identity, culture, and context,

and the similarities and differences between. Three participants (Heather, Leslie, Michelle) explicitly described themselves as using more self-disclosure when working with their REM immigrant clients. Heather, an East Asian-identifying clinician, described themselves as being "more cautious" about using self-disclosure when working with their non-East Asian clients, while Leslie described themselves as being "more comfortable" (Leslie, 100) with disclosing their felt emotional experience as well as information about their own immigration challenges when specifically with clients they know are experiencing similar challenges. Related to the notion of interpersonal safety, two participants (Heather, Yasmin) described self-disclosure as frequently initiated by their REM immigrant clients who, in most cases, specifically sought out the clinician by virtue of their REM immigrant identity factors such that discussions regarding race, ethnicity, and culture are present at the "outset" (Yasmin, 307) such that the clinician's identity is the "first things that the client will typically talk about":

> They want to know what my background is. If they have an immigrant identity, they want to know a little bit more about where I'm from, how long I've had been here what other countries do I have experiences living in. So that's just standard like, 'Hi, how are you,' conversations for me. (Yasmin, 241).

While explicitly stated as more enabled by some participants, the clinical judgment to self-disclose or to broach topics of identity differences or similarities was described also by others—including those same participants cited above—as an ongoing "mental process" (Leslie, 97) and one that is a "dance" that accompanies a question of, "do I share with the patient, or do I not with the patient?" (Leslie, 109), which sometimes involves "self-monitoring" and self "query" in the form of, "is this self-disclosure for the client or is it for me?" (Yasmin, 243). A similar initial tension was described by another participant, whose decision to explicitly disclose to especially

their Asian immigrant clients, "I'm proud of you, I think you're great. I'm proud of the work that you've done" was in conflict with their supervisor's stance that clinicians should say only "proud for you":

> I remember that moment saying that I don't know if I agree with that. I think that there are times especially when I'm working with my Asian clients that I feel like it's okay to say I'm proud of you because we see ourselves as part of a whole. The best way of understanding our individual selves comes from how we relate to other people. And that may not be damaging, to have an experience of the people around me are proud of me (Esmy, 124)

The above quote indicates that for this REM immigrant clinician, the nuanced understanding of their Asian clients' Confucian values renders the clinician to permit themselves—against prevailing institutional values—to "give" access to a positive emotional experience that may not be accessible to their clients for themselves. In turn, self-disclosure of the clinician's felt emotional also renders a "giving" back from their REM immigrant clients in the form of gratitude.

Attending to Intersections of Identities and Experiences (Axial)

For REM immigrant clinicians who work with REM immigrant clients, the awareness of the "ever-present" (Yasmin, 328) potential "hazards of being too similar" (Michelle, 143), that while "differences might make it [therapy relationship] difficult … very close similarities can make it difficult as well" (Stephen, 167) such that REM clinicians need to engage in a "constant work of checking in" (Michelle, 143), was voiced by almost all participants in varying ways. One participant acknowledged their "constant struggle" of "countertransferences" and imposition of their own values that may occur (Heather, 7), while another participant voiced the many

occurrences of realizing, "my gosh, me too. I've had that experience too" that demands a "constant staying on top of it" (Yasmin, 321). Yet another participant commented, "I find it's really important for me to not make assumptions, even more than usual," while adding that it is also "the hardest challenge for me as a therapist" (Vanessa, 15). Several participants voiced the importance of "assuming I don't know everything from the start" (Jack, 35), described also as a "humble" stance of "I still don't know. Just wait for this person to tell me their story; I still don't know" (Vanessa, 15). Another participant voiced themselves as requiring "a great deal of humility" to be "okay with not getting it the first time" (Michelle, 57).

The attention to intracontinental and interracial variability served especially important for REM immigrant participants, including regional and religious variability when a REM immigrant client identifies themselves as Filipino (Vanessa), or the attention to intracontinental sociopolitical divides when a client identifies themselves as Indian (Yasmin). The reason, as one participant described it, is due to the "historical and cultural divides" that may ultimately compromise a sense of perceived "safety" (Esmy, 323) for the client. Indeed, one participant described it as "more hurtful" for them as clinicians to harbor assumptions about "what you think they might understand or identify with" such that the need to "center" was noted in the context of their appreciation of the intracultural variability that exists within:

> So even though I look Chinese and that's, you know, that's unavoidable, I think even within Chinese there are so many nuances. There's Malaysian Chinese, there's China, there's Taiwan, there's Hong Kong, and there's crazy stuff that's happening now with Hong Kong and China. And I was born in Hong Kong right, and my parents migrated to Singapore. And do I know fully the historical sort of context and trauma of all that? My parents certainly don't talk about it. (Stephen, 166)

Along the notion of creating safety, REM immigrant clinicians viewed power differentials as "always existing" and "always salient" in the room by virtue of their role as the clinician as well as their setting (e.g., medical setting). Participants identified certain strategies they utilize to attend to the power differential, including recognizing and voicing agency for the REM immigrant client to follow through with advice, acknowledging REM immigrant client's decision to place trust in the clinician in the room, and expressing gratitude.

Where power differentials are perceived, not all participants felt the need to act to modify or rebalance the dynamic. For one REM immigrant participant, power was perceived—particularly from their first-generation REM immigration clients—as an "automatic labeling of authority figure, and I'm going to listen to this person. They're going to tell me what to do" such that the clinician avoids making "a great attempt to rebalance the power differential in therapy":

> And I do that because I do believe that some of these parents prefer it the way it is. They enjoy that they're seeking an expert … they're seeking a doctor to tell them what to do and they're able to sort of defer their concerns and considerations to me. There's a level of safety that they think that they experience. So, depending on their resistance, I don't try to reinforce this idea that we're on equal playing field. (Raymond, 177)

Where power dynamics appear to elicit a reaction from their REM immigrant clients, participants also described various engagement strategies. One participant described sensing "hesitation" at times that seemed to communicate "fear of upsetting or offending me" so that "I have said whatever you have to say it's not about me, the space is about you" (Yasmin, 318). Another participant engaged in more "regular check-ins" with their REM immigrant clients and readily answered their clients' personal questions who, at times, would vocalize, "I feel like it isa one-way thing, and it feels very uncomfortable for me. So, I want to be able to know what you're

doing, I want to know you as a person" (Heather, 40). This same participant engaged in giving "verbal permission" for REM-I clients to disagree with them: "I'm not always right so you need to let me know and inviting [them] to take that power, share that power with me" (Heather, 227).

Relational Challenges and Ruptures (Axial)

What many described as the point of connection and joy—the moments of "getting it" without saying much—was cited by one REM immigrant participant as potentially triggering feelings of being "trapped" and feeling at times "invisible" when the clinician remains silent about what the client may wrongly assume that the clinician understands by using phrases like "Well, you know what I mean, or, I think you know how it is" or paraphrasing in Mandarin, a language that the clinician did not fully understand: "And I remember my concern at the time was, the more I wait, then the more she'll realize maybe I just wasn't on the ball the whole time" (Stephen, 175). This participant described the way in which they were able to finally broach the subject with the client and reach clarity and understanding.

Two REM immigrant clinicians described varying degrees of "frustration" regarding what may have been a miscommunication regarding what the client perceived as the clinician's role. One participant recounted the experience of feeling "frustration and sadness" after being "fired" by their client, who was undocumented, had a disability, and also had four young children. Yasmin described as ongoing the "challenge" of REM immigrant parents of young clients frequently expecting and desiring that the clinician will "side with them" and their view, when conflicts arise between them and their children, such as when the parents perceive that the "misbehavior" of their teenaged children is due to their being too "American":

> This is what American teenagers do—and that's code for White teenagers, White Americans do … and this is what our kid is learning. So can you please just tell our kid,

> ABC and D, and we'll be through with this, because there really is nothing wrong. And, and for me the challenge has then been to say, I respect you. I understand what you're saying. I cannot tell your child this because it's not true. And I really need you to understand how this works. So, there's been a few yelling matches there. (Yasmin, 227)

For another REM immigrant participant, the emotional experience and source of rupture was not readily made apparent for themselves until they engaged in reflection after the rupture and therapeutic relationship had ended such that repair was not possible. This participant described remembering having "a lot of unconscious and conscious feelings about" the client's identity factors and their own, including "socioeconomic status, client's generational status, client's kind of level of acculturation or slash assimilation almost, and the differences in our ethnic identities" such that the clinician identified something that was "embedded or ingrained within me somewhere that I couldn't even access it until later that I really had to do a whole sit down reflection for like a week":

> This is such a vague way that I'm explaining this, but all of those intersections of identities … really triggered me to not have interest in the client, or I couldn't really connect with the client's pain point. Because I was thinking, you're privileged in all of these different areas. And, yes, we have shared experiences or identity as a woman of color, but I'm not even sure she identifies as a woman of color … so I had a lot of resentment towards that because of all these privileged identities that client holds that I don't identify with or feel really resentful towards. So then that kind of ultimately led into like, I'm not really interested in you, like, why do I have to offer my service to someone who … is privileged? (Heather, 119)

This clinician touches on a topic seldom addressed, that of clinicians perceiving less power and privilege in the room *in relation to* the client by virtue of their social locations.

Navigating Barriers, Negotiating Tensions (Selective)

The third category captures REM immigrant participants' views of their and their clients' navigation of intercultural and intergenerational tension as they intersect with systemic and institutional challenges and barriers. REM immigrant participants also identified resources and sources that they viewed as helpful for their ongoing navigation and work.

"Contextually Driven" Clients and Clinicians (Axial)

REM immigrant clinicians recognized that their REM immigrant clients' distress was intertwined with culture and or "navigating" (Michelle, Leslie, Jack, Yasmin) elements of cultural tension or conflict within their families, regardless of whether their clients explicitly voiced it as such. One participant described their "first inclination" to be an assessment of the "mismatch" between clients' upbringing in their country of origin, and that of the United States, irrespective of the referral reason such that the clinician asks, "How is this [problem] dealt with back at home?" (Raymond, 48, 54). Another clinician described their young adult REM immigrant clients' reasons for coming to therapy as "contextually driven" by transitions to new stages of life (e.g., finding romantic interests, finding job prospects) such that the intergenerational and intercultural tensions experienced by their clients was described as "significant" to their conceptualization that with clinician's "probing" for factors related to initial symptoms of "presenting depression and anxiety" demonstrated an emerging, "surfacing" process of "more evident roots" tied to "family stressors as well as issues related to enculturation as well as acculturation" (Michelle, 20). This same participant highlighted one client example that demonstrated their "struggle between expectations set by their family of origin, and what

they are expecting of themselves and for themselves in a romantic partnership, and what it means to really fall for someone that your parents perhaps wouldn't have selected for you" (Michelle, 34):

> With this client in particular, the mom was more averse to the idea of her daughter dating without having the partner declaring his intentions, in the sense of having a plan to eventually marry her daughter. And so, there was tension about you know whether or not a daughter can be free to just explore her relationship further without having to commit to marriage … whether or not dating is something that will have a negative connotation with the daughter, and social connotation in the sense of, is she giving up her sense of pride or civility or whatever it is by just engaging in premarital sexual relations? (Michelle, 36)

For REM immigrant clinicians who work with families, the tension played out *in vivo* between REM immigrant parents and their children. One participant described broadly the children of immigrant parents who have anxiety and depression as having the added difficulty of being "trapped in two worlds" (Jack) while the parents may perceive their children and their proclivities as being "too American" (Michelle, Yasmin), a tension that is also intertwined with religious identity development for the children, adding yet another layer of religious tension (Yasmin, 289).

REM immigrant participants who conceptualized their clients' presenting concerns as navigating intercultural and intergenerational tensions bracketed their own intimate knowledge, appreciation, and understanding of living through the experiences of both the younger and older generations, which informed their roles as one who is a "cultural broker" (Michelle, Yasmin), "arbiter," and "cultural concierge" (Michelle), or one who is a "collaborator" and "mediator," as well as an "observer" who is also almost like a "surgeon, trying to piece together this complex

system without having to create additional ruptures so that I can put them together as a functioning family system" (Jack, 145). The idea of "forming a bridge" and "pulling" together members of a family to avoid further ruptures (Yasmin, 294), while invoked by family clinicians, was also invoked by another participant who works with REM immigrant individuals, who also described themselves as having moments of "riding two worlds" when engaging with clients who may not be as aware of how cultural influences impact their way of life, as exemplified by an illustration of a client who had suffered a "terribly traumatic" death of her mother, who was "carrying around all this anxiety because people in the family just don't do feelings" (Vanessa, 38).

Where REM immigrant clients need instruction and guidance for knowledge gaps, several participants spoke as being most helpful the role of "teacher," "educator," or "advisor." Still others, by virtue of the nature of their role and medical setting, voiced their general perception of themselves as an "educator and advocate" (Leslie, 322), an "educator, because I tell them about different things, different resources. I teach them about their health … I see myself primarily as a teacher and then also as a helper connecting them to whatever they need that's in my reach" (TM, 417), which was also echoed by Charlie who voiced their role as "inherently multifaceted," including a "healthcare coach, medical educator … oftentimes, I'm a social worker" (239). Still, another participant described their general role when working with REM immigrant families to be different than when working with others, such that they perceive themselves to be "less of a psychologist" and more of "a teacher or an advisor … I feel like I come with more roles, maybe as a social worker or maybe as a close friend of the family. A child's teacher" (Raymond, 226).

REM immigrant participants described to varying degrees the way in which they "appreciate" and view as "valid" their REM immigrant clients' systemic barriers as they intersect with each other and with their cultures such that they add "layers" (Leslie, 136) to their clients' distress and treatment in the following ways: racism and discrimination (Stephen, Leslie, Esmy, Heather, Vanessa, Michelle), low socioeconomic status (TM, Leslie, Charlie, Yasmin, Jack), lack of documentation status or limitations on visa status (Stephen, TM, Leslie, Charlie), high cost of insurance and/or lack of providers who take insurance (Yasmin, Stephen, Michelle, Jack, Vanessa), lack of access to decent jobs (Jack), the persistence of the stigma of mental health (Yasmin, Michelle, Heather, Charlie, Jack, Vanessa), and lack of REM psychologists and other mental health providers (Michelle, Charlie, Leslie, TM, Yasmin, Leslie, Vanessa). Several participants also discussed barriers and shortcomings of psychological training and institutions. In this regard, clinicians discussed how they and their clients experienced these barriers and, for some, how they impact their role in the macro context.

Among the perceived obstacles, this participant seems to allude to the stigma of mental health that persists for REM immigrant communities and informs a "reluctance of certain racial or ethnic immigrant families to seek help" (Jack, 108), a stigma that informs a client's "cautiousness" and "testing the waters" (Heather, 30), as well as "hesitation" and sense of, "I'm not sure if I actually want to do this but I'm going to give it a try" (Michelle, 85), and, for one participant, leaves them feeling "most impressed with their openness to seeking help" (Yasmin, 194).

Concurrently, many of these same participants noted their acute awareness of "being the only" or "being one of a very few" REM providers (Charlie, Stephen, Leslie, Yasmin, Vanessa) or Muslim providers (Yasmin) in their setting, community, region, or city, with varying

consequences. One East Asian participant noted, "I haven't been able to find a therapist that is East Asian either, right?" (Stephen, 290).

Insofar as it impacts REM immigrant clients' treatment, some REM immigrant clinicians voiced ways in which the system of psychotherapy (e.g., therapeutic frame) or the institutions of training—including literature, supervisors, and "what we're told" to do and not do—serve as barriers to treatment, directly contradicts or challenges their own experiences, or ways in which they fail to address what they perceive are important elements in providing treatment to their REM immigrant clients. For example, one participant voiced their perception that "colonized concepts of traditional old school therapy" that include abstaining from certain emotional disclosures as well as assumptions that all clients are aware of the parameters of the traditional "therapeutic frame"—that is, that all clients "understand confidentiality, they understand what a 50-minute session looks like, they understand this process of, what the hell are we doing here? (Esmy, 132)—serve as barriers for REM immigrant clients to not only seek therapy, but to adhere to medication referrals, to build rapport, and to sustain treatment. Yet another participant described recognizing their perceived "internal pressure" to use "evidence-based approaches" as proscribed by their "training in counseling" against the grain, experience, and intuition that "it's more helpful if I can just be in this moment, hear the patient and see what's going on" (Leslie, 128).

Several participants voiced their perceptions of institutions of training. One participant voiced their perception that the "multicultural piece" of psychological training was a "short form for, how do you work with a Black client? And how do you work with Asian client? But I think even within that ethnicity, there's so much more nuance that doesn't get talked about" (Stephen, 288). Similarly, another participant described feeling as if psychological training did not prepare

them for their perceived role with working with REM immigrant clients as the "classes on cultural understanding and cultural identities of families" were "prescribed and superficial, like, these types of parents are more family-oriented or these families are more authoritarian in their family dynamics … and not a lot of ... dialogue, in terms of ... discussing why you would approach this way" (Raymond, 238).

What parts of training or institutions lacked, all REM immigrant participants voiced aspects as helpful, or "seeking out" other sources and resources that were "helpful" to "grow" and to be "encouraged." Training supervisors were perceived to have been helpful for four participants, two of whom described themselves as intentionally "seeking out" REM supervisors (Vanessa, Heather). Vanessa described seeking out and being trained by a "wonderful clinical psychologist of color" whose style of "transparency" was congruent with theirs (Vanessa, 166). Relatedly, Heather voiced that they "sought out" East Asian supervisors who were helpful in the ways in the "parallel" ways that many clients voiced as helpful—that is, "I don't have to worry, like are you going to understand? Or do I have to explain every detail in order to make you understand? … with my East Asian supervisors, I've never had to do that and that has been a very liberating experience" (Heather, 262). As well, another REM immigrant clinician described their "grateful" experience of feeling as if their REM supervisor and bilingual supervisor not only rendered intimate understanding and resources but helped them to recognize areas of discomfort and "recognize the power dynamics in relationships" with "candid" and "upfront" conversations, such that they felt that they modeled what it looked like to "comfortably" broach difficult topics with their clients (Leslie, 228). Contrastingly, one participant described the ways in which their White supervisor "was very, very affirming" and who "was intentionally touching on and soothing of, and taking care of" aspects of their racial and ethnic immigrant identity

factors such that it was a "shock": "That was incredible for me, and I did not expect to get it from my White, older generation, Southern supervisor. So, it was a shock, but a most wonderful shock" (Esmy, 35).

Reflection as Catalyst; Catalyst for Reflection (Selective)

REM immigrant clinicians expressed the pivotal role of reflection and reflexivity in their work with their REM immigrant clients, including *in vivo* reflections of tensions and insights, as well as explicit acknowledgement of the interview, the researcher, and the research in providing yet another space to engage in reflection.

Ongoing Reflection (Axial)

Almost all participants acknowledged to some varying degrees the importance of engaging in self-reflection to do "good work" with their REM immigrant clients, that despite, for example, "having a keen sense of who you are, I think there's always different layers and textures that still need to be considered" (Michelle, 152). Relatedly, two participants noted their work with their REM immigrant clients as the broad impetus to engage in self-reflection (Heather, Yasmin), including for one participant constant reminders to be "aware" of their blind spots:

> Knowing that I have all these prejudicial thoughts how my background kind of affords me different privileges and power, those are also helpful in kind of like, okay I need to be aware of this, and I need to be aware so that I don't harm people. (Heather, 327)

Still, another participant described their ongoing process of "sitting" with their own experiences of "race, immigration, class language," intersects with the experiences of their clients as most helpful (Stephen, 282).

Two REM immigrant participants explicitly described their experiences of having engaged in reflection after difficult experiences, which the clinicians described as leading to challenging reflections about themselves as well as what they would do differently if given the opportunity to work with their clients again (Leslie). One participant voiced that engaging in reflexivity after-the-fact gave rise to the realization that they should have voiced their difficulty connecting with the client "much earlier" than they did, but also expressed difficulty while they "tried to understand" the client, the presenting concern, and themselves. Relatedly, three participants experienced *in vivo* tensions and realizations during the course of reflecting during the interview, such as curiosity of their own decision to withhold self-disclosure of their own identities and privileges while working with clients (Leslie). Another participant voiced that they realized that they had "denied" either "articulating or acknowledging the felt sense of pressure that I have towards the work of destigmatizing mental health and the use of psychotherapy in our Asian American community … I just didn't know the emotional toll that that sometimes has on me" (Michelle, 160).

Several participants voiced how they felt and responded internally when they first encountered the initial recruitment flyer, which included a note on their motivation to participate in the research itself. Said one participant:

> I am so excited that I was able to even contribute a tiny piece. When I saw this come across my desk, I thought, oh my god, this means, this was my thought Jenn, and I said it to my wife … oh my god there's enough of us now that someone's doing a study! And by "enough of us now," I meant enough of clinical psychology PhDs who come from different ethnic groups who maybe even have an immigration situation. Like, what? (Vanessa, 182)

Discussion

The grounded theory of REM immigrant psychologists' experiences indicates that relational experiences, including opportunities, challenges, and how REM immigrant clinicians view their roles in their work, are varied and richly influenced by a multitude of internal and external factors rooted in prior experiences and future wishes and desires in the context of extant barriers and challenges. At the time of interview, participants demonstrated ongoing navigation and reflection regarding the potential dynamism for both healing and harm owing to their appreciation for the complexities in each of themselves, their clients, and the macrosystemic environment under which all relationships are encapsulated. REM immigrant psychologists invoked and referred to their own immigration and acculturation experiences as reference points for that which informs their sense of deep understanding and empathy for their REM immigrant clients as individuals and families embedded with histories and futures embedded in a larger context of narratives and systems. Participants' intimate knowledge of creating a new life in a new land that is constantly "operating in the background" was also a source for how therapists experience themselves as knowledgeable, or skillful to use certain strategies to build trust, rapport, and continued connection in the therapy room. Just as perceptible was the appreciation of challenges clinicians experience especially when attempting to safeguard against their and their clients' assumptions about shared understandings and experiences that could potentially bias and undermine the clinical work. REM immigrant clinicians reported a constant curiosity about what it means for a client's values, worldview, and beliefs when they identify as a certain racial minority individual or to identify as their home country as one outside of the United States—even when clients' and clinicians' stated identities were similar—which demonstrated nuanced understandings of intraracial, intraethnic, and intracultural variability that exists across

and within all individuals. REM immigrant clinicians' understandings were at times amplified by their identification with experiences of navigating struggles and obstacles at times distinct in nature and scope depending on factors, such as age and developmental period of immigration. Such experiences were seen as formative and invaluable parts of self as REM immigrant therapists first for how they perceive themselves as individuals and as psychologists in the United States and their role and purpose both in and outside of the therapy room.

Strengths and Limitations of the Current Study

The aim of this study was not to arrive at a generalizable theory but, rather, to illustrate rich experiences of a therapeutic dyad that is rarely mentioned in the multicultural counseling literature, a reality that undermines the fact that people from all racial and ethnic groups are "subject to the socialization of prejudiced and biased attitudes" (Dickson et al., 2010, p. 249). In fact, in a recent review of the counseling psychology literature spanning almost two decades, Hawkins and colleagues (2022) found that topics that are critical to the work of counseling psychology and counseling professionals, including therapy process and outcomes, techniques and therapy models, and supervision, training, and education, were much more understudied in REM-focused articles, compared with non-REM focused articles. As they regard REM immigrant psychologists, the current study illuminated aspects of therapy processes that prior literature have identified as understudied, such as managing therapists' emotional reactions due to countertransference when working with REM clients (Comas-Díaz & Jacobsen, 1991; Gelso & Mohr, 2001), addressing cultural misunderstandings, impasses, or other ruptures in the therapeutic relationship (Gaztambide, 2012), effectively broaching the topic of race and racism with REM clients (Day-Vines et al., 2018; King & Borders, 2019), or therapists' use of self-disclosure (Solomonov & Barber, 2018) with varying degrees; however, these results cannot yet

be generalized. Several limitations of the current study should be addressed in future research. While grounded theory allowed for the depiction and appreciation of thick descriptions to arise, the therapist's account of the relationship between and within a dyad is not a complete substitute for what might be illuminated by accounting for the clients' experiences, as well as the therapist's. Therefore, a limitation of this study is the unidirectional perspective of only the clinicians' perspectives on a relational experience. Secondly, while the aim of the study was to gather the perspectives of psychologists who identify as racial and ethnic minority immigrant psychologists, broadly, the racial identity of participants was overwhelmingly Asian-identifying such that it can hardly be said that the results can be generalized to be true of all psychologists who identify as such, given the multitude of racial and ethnic minority individuals and backgrounds of REM immigrant individuals in the United States. Additionally, given the dearth of REM immigrant psychologists in the United States and given some of the participants' own explicit proclamation of enthusiasm and excitement, it is possible that the perspectives of the participants are biased with regard to their sense of passion and positive experiences as they describe their work with REM immigrant participants.

Implications for Practice and Training

Mollen and Ridley (2021) argued that while multicultural counseling competence has been elevated to a prominent status in professional psychology, lack of clarity and confusion around the construct still persists such that now there exists an "impasse" that is exacerbated by leaving unanswered inquiries echoed by graduate student trainees that span the following:

> After amassing all this multicultural information in our courses, I still am uncertain in how to proceed in my counseling with culturally diverse clients. I learned about the values, attitudes, and beliefs of various cultural and racial groups, but when I counsel a

> client from one of those groups, I still feel stuck. There must be more to multicultural counseling than what I learned in class. (p. 497)

The findings in the current study offer implications for trainees and practitioners who work with REM immigrant clients who may have similar inquiries and whose identities as REM immigrant individuals may yield nuanced reflections. For example, sharing racial and ethnic markers of identity may indicate a greater need to safeguard against not only therapists' assumptions, but also the REM client's assumptions such that self-disclosure is not only warranted, but also may be imperative in order to clarify expectations and goals for therapy. When REM immigrant trainees and practitioners feel stuck with their REM clients, a part of the therapeutic essence of what it means to provide a connective, healing space may be for the clinician to utilize aspects of identifying and resonating with the struggles and hardships to not only offer empathy, but to tolerate and accept the difficult feeling of being "stuck with them," as one participant pointed out (e.g., Leslie). On the latter reflection, REM immigrant psychologists seem to voice that indeed, there is much more to multicultural counseling than what is taught in an academic setting, which has some implications for clinical training. First, educators and supervisors should first recognize, be sensitive to, and familiarize themselves with the nuanced aspects of intracultural, intraracial, and intraethnic variability across all groups. Such awareness and acknowledgement may be consequential for curriculum design and the choosing of literature and texts from which educators fundamentally iterate and influence how trainees, including REM immigrant trainees, view as valid or invalid their own tensions and perceptions that arise in the therapy dyad as well as skills, knowledge, or even roles they feel pulled to utilize but may question the viability or legitimacy of their perceptions. In other words, as iterated by Mollen and Ridley (2021), rather than assume that general training materials and scholarship is an adequate representation of

People of Color, training programs, supervisors, and other leadership should seek out resources and research that are specific to REM immigrant individuals and populations.

Conclusion

REM immigrant psychologists who work with REM immigrant clients experience relational opportunities and successes that are at times profound for themselves and their clients. By virtue of their own REM backgrounds and intersectional identities, REM immigrant psychologists also contend with a complex array of cultural and systemic dynamics—some of which they are aware of, and some of which are outside of their purview until a catalyst for reflection occurs. In revisiting Mollen and Ridley's (2021) last point of lingering reflections, REM immigrant psychologists seem to indicate that there is more to multicultural counseling than what *can be* taught in the classroom. Akin to the way in which there is no substitution for the first-hand experience of relocating, acculturating, and cultivating a new life to appreciate aspects of what it means to be an immigrant individual in the United States, there is no substitution for the first-hand gains of knowledge, experience, and nuanced awareness therapists gain with each new relational success and challenge that is experienced in the therapy room. More critical than content, what participants in this study seem to emphasize and what may be consequential for training programs is the rigorous and recursive act of self-inquiry and reflexivity that requires intentionality and, at times, tolerance and acceptance of challenging emotions and tensions that, when harnessed, may have a profound impact on future practice.

References

Ainslie, R. C., Tummala-Narra, P., Harlem, A., Barbanel, L., & Ruth, R. (2013). Contemporary psychoanalytic views on the experience of immigration. *Psychoanalytic Psychology, 30*(4), 663–679. https://doi.org/10.1037/a0034588

Akhtar, S. (2006). Technical challenges faced by the immigrant psychoanalyst. *The Psychoanalytic Quarterly, 75*(1), 21–43. https://doi.org/10.1002/j.2167-4086.2006.tb00031.x

Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C-N., Takeuchi, D., Jackson, J., & Meng, X.-L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*(11), 1264–1272. https://doi.org/10.1176/ps.2008.59.11.1264

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377–402. https://doi.org/10.1037/0003-066X.58.5.377

American Psychological Association. (2016). *2015 survey of psychology health service providers* [Report]. https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf

American Psychological Association. (2017a). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code

American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality, 2017*. https://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association, APA Task Force on Race and Ethnicity Guidelines in Psychology. (2019). *Race and ethnicity guidelines in psychology: Promoting responsiveness and equity*. https://www.apa.org/about/policy/guidelines-race-ethnicity.pdf

American Psychological Association, Commission on Accreditation. (2018). *Standards of accreditation for health service psychology and accreditation operating procedures*. https://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

Arredondo, P., Toporek, R., Brown, S. P., Sanchez, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling & Development, 24*(1), 42–78. https://doi.org/10.1002/j.2161-1912.1996.tb00288.x

Arredondo, P., Tovar-Blank, Z. G., & Parham, T. A. (2008). Challenges and promises of becoming a culturally competent counselor in a sociopolitical era of change and empowerment. *Journal of Counseling & Development, 86*(3), 261–268. https://doi.org/10.1002/j.1556-6678.2008.tb00508.x

Atkins, S. L., Fitzpatrick, M. R., Poolokasingham, G., Lebeau, M., & Spanierman, L. B. (2017). Make it personal: A qualitative investigation of White counselors' multicultural awareness development. *The Counseling Psychologist, 45*(5), 669–696. https://doi.org/10.1177/0011000017719458

Bashi, V., & McDaniel, A. (1997). A theory of immigration and racial stratification. *Journal of Black Studies, 27*(5), 668–682. https://doi.org/10.1177/002193479702700505

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*(1), 5–34. https://doi.org/10.1111/j.1464-0597.1997.tb01087

Bhugra, D., & Gupta, S. (2011). *Migration and mental health*. Cambridge University Press.

Birrell, P. J., & Freyd, J. J. (2006). Betrayal trauma: Relational models of harm and healing. *Journal of Psychological Trauma, 5*(1), 49–63.

Blanco, C., Patel, C. S., Liu, L., Jiang, H., Lewis-Fernández, R., Schmidt, A. B., Liebowitz, M. R., & Olfson, M. (2007). National trends in ethnic disparities in mental health care. *Medical Care, 45*(11), 1012–1019.

Bridges, A. J., Andrews, A. R., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-Southern United States. *Journal of Transcultural Nursing, 23*(4), 359–368. https://doi.org/10.1177/1043659612451259

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health, 33*(3), 316–330.

Cantor-Graae, E., & Selten, J.-P. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry: Official Journal of the American Psychiatric Association, 162*(1), 12–24. https://doi.org/10.1176/appi.ajp.162.1.12

Carter, R. T. (2007). Racism and psychological and emotional injury. *Counseling Psychologist, 35*(1), 13–105.

Castillo, L. G., Brossart, D. F., Reyes, C. J., Conoley, C. W., & Phoummarath, M. J. (2007). The influence of multicultural training on perceived multicultural counseling competencies and implicit racial prejudice. *Journal of Multicultural Counseling & Development, 35*(4), 243–254. https://doi.org/10.1002/j.2161-1912.2007.tb00064.x

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*(4), 521–536. https://doi.org/10.1037/a0016905

Chao, M. M., Okazaki, S., & Hong, Y. (2011). The quest for multicultural competence: Challenges and lessons learned from clinical and organizational research. *Social & Personality Psychology Compass, 5*(5), 263–274.

Chao, R. C.-L., Paiko, L., Zhang, Y. S. D., & Zhao, C. (2017). Service-learning: A training method to enhance multicultural competence toward international students. *Scholarship of Teaching and Learning in Psychology, 3*(1), 28–42. https://doi.org/10.1037/stl0000078

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage.

Charmaz, K., Thornberg, R., & Keane, E. (2018). Evolving grounded theory and social justice inquiry. In N. K. Denzin & Y. S. Lincoln. (Eds.), *The Sage handbook of qualitative research* (5th ed., pp. 576–599). Sage.

Chung, Y. B. (2013). Presidential address: Immigrant counseling psychologists. *The Counseling Psychologist, 41*(1), 152–169.

Chung, R. C.-Y., Bemak, F., Ortiz, D. P., & Sandoval-Perez, P. A. (2008). Promoting the mental health of immigrants: A multicultural/social justice perspective. *Journal of Counseling & Development, 86*(3), 310–317. https://doi.org/10.1002/j.1556-6678.2008.tb00514.x

Clauss-Ehlers, C. S., Chiriboga, D. A., Hunter, S. J., Roysircar, G., & Tummala-Narra, P. (2019). APA multicultural guidelines executive summary: Ecological approach to context, identity, and intersectionality. *American Psychologist, 74*(2), 232–244. https://doi.org/10.1037/amp0000382

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*(3), 392–402. https://doi.org/10.1037/h0079267

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G., II. (2008). Relational-cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development, 86*(3), 279–287. https://doi.org/10.1002/j.1556-6678.2008.tb00510.x

Constantine, M. G. (2002b). Racism attitudes, White racial identity attitudes, and multicultural counseling competence in school counselor trainees. *Counselor Education & Supervision, 41*(3), 162–174. https://doi.org/10.1002/j.1556-6978.2002.tb01281.x

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16. https://doi.org/10.1037/0022-0167.54.1.1

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12*(2), 279–289. https://doi.org/10.1177/104973230201200211

Day-Vines, N. L., Booker Ammah, B., Steen, S., & Arnold, K. M. (2018). Getting comfortable with discomfort: Preparing counselor trainees to broach racial, ethnic, and cultural factors with clients during counseling. *International Journal for the Advancement of Counselling, 40*(2), 89–104.

Derr, A. S. (2015). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services, 67*(3), 265–274. https://doi.org/10.1176/appi.ps.201500004

Dickson, G. L., Argus-Calvo, B., & Tafoya, N. G. (2010). Multicultural counselor training experiences: Training effects and perceptions of training among a sample of predominately Hispanic students. *Counselor Education & Supervision, 49*(4), 247–265. https://doi.org/10.1002/j.1556-6978.2010.tb00101.x

Drinane, J. M., Owen, J., Adelson, J. L., & Rodolfa, E. (2016). Multicultural competencies: What are we measuring? *Psychotherapy Research, 26*(3), 342–351. https://doi.org/10.1080/10503307.2014.983581

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156–166.

Forte, A., Trobia, F., Gualtieri, F., Lamis, D. A., Cardamone, G., Giallonardo, V., Fiorillo, A., Girardi, P., & Pompili, M. (2018). Suicide risk among immigrants and ethnic minorities: A literature overview. *International Journal of Environmental Research and Public Health, 15*(7), 1438. https://doi.org/10.3390/ijerph15071438

Fowers, B. J., & Davidov, B. J. (2006). The virtue of multiculturalism: Personal transformation, character, and openness to the other. *American Psychologist, 61*(6), 581–594. https://doi.org/10.1037/0003-066X.61.6.581

Garcini, L. M., Murray, K. E., Zhou, A., Klonoff, E. A., Myers, M. G., & Elder, J. P. (2016). Mental health of undocumented immigrant adults in the United States: A systematic review of methodology and findings. *Journal of Immigrant & Refugee Studies, 14*(1), 1–25. https://doi.org/10.1080/15562948.2014.998849

Garcini, L. M., Galvan, T., Peña, J. M., Klonoff, E. A., Parra-Medina, D., Ziauddin, K., & Fagundes, C. P. (2019). "A high price paid": Migration-related loss and distress among

undocumented Mexican immigrants. *Journal of Latinx Psychology, 7*(3), 245–255. https://doi.org/10.1037/lat0000127

Garza-Guerrero, A. C. (1974). Culture shock: Its mourning and the vicissitudes of identity. *Journal of the American Psychoanalytic Association, 22*(2), 408–429.

Gelso, C. J., & Mohr, J. J. (2001). The working alliance and the transference/countertransference relationship: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists. *Applied and Preventive Psychology, 10*(1), 51–68. https://doi.org/10.1016/S0962-1849(05)80032-0

Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., Burke, C., Kershner-Rice, K., & Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research & Practice, 37*(1), 66–74. https://doi.org/10.1037/0735-7028.37.1.66

Hawkins, J. M., Bean, R. A., Smith, T. B., & Sandberg, J. G. (2022). Representation of race and ethnicity in counseling and counseling psychology journals. *The Counseling Psychologist, 50*(1), 123–144. https://doi.org/10.1177/00110000211041766

Hayes, J. A., Owen, J., & Bieschke, K. J. (2015). Therapist differences in symptom change with racial/ethnic minority clients. *Psychotherapy, 52*(3), 308–314. https://doi.org/10.1037/a0037957

Hays, P. A. (2016). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (3rd ed.). American Psychological Association.

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study

of cultural competence. *Journal of Counseling Psychology, 58*(3), 290–298. https://doi.org/10.1037/a0023284

Jasinskaja-Lahti, I., Liebkind, K., & Perhoniemi, R. (2006). Perceived discrimination and well-being: A victim study of different immigrant groups. *Journal of Community & Applied Social Psychology, 16*(4), 267–284. https://doi.org/10.1002/casp.865

Jones, C. T., & Welfare, L. E. (2017). Broaching behaviors of licensed professional counselors: A qualitative inquiry. *Journal of Addictions & Offender Counseling, 38*(1), 48–64. https://doi.org/10.1002/jaoc.12028

Jordan, J. V. (1999). *Toward connection and competence* (Work in Progress No. 83). Stone Center Working Paper Series.

Kendall, J. (1999). Axial coding and the grounded theory controversy. *Western Journal of Nursing Research, 21*(6), 743–757.

King, K. M., & Borders, L. D. (2019). An experimental investigation of White counselors broaching race and racism. *Journal of Counseling & Development, 97*(4), 341–351. https://doi.org/10.1002/jcad.12283

Kissil, K., Davey, M., & Davey, A. (2015). Foreign-born therapists: How acculturation and supervisors' multicultural competence are associated with clinical self-efficacy. *Journal of Multicultural Counseling & Development, 43*(1), 38–57. https://doi.org/10.1002/j.2161-1912.2015.00063.x

Kissil, K., Niño, A., & Davey, M. (2013b). Doing therapy in a foreign land: When the therapist is "not from here." *American Journal of Family Therapy, 41*(2), 134–147. https://doi.org/10.1080/01926187.2011.641441

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology, 50*(4), 466–481. https://doi.org/10.1037/0022-0167.50.4.466

Larrison, C. R., Schoppelrey, S. L., Hack-Ritzo, S., & Korr, W. S. (2011). Clinician factors related to outcome differences between Black and White patients at CMHCs. *Psychiatric Services, 62*(5), 525–531.

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings, 24*(3), 187–210. https://doi.org/10.1007/s10880-017-9510-2

Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 85–98. https://doi.org/10.1037/0033-3204.43.1.85

Miller, J. B. (1976). *Toward a new psychology of women*. Beacon Press.

Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Beacon Press.

Missinne, S., & Bracke, P. (2012). Depressive symptoms among immigrants and ethnic minorities: A population-based study in 23 European countries. *Social Psychiatry & Psychiatric Epidemiology, 47*(1), 97–109. https://doi.org/10.1007/s00127-010-0321-0

Mollen, D., & Ridley, C. R. (2021). Rethinking multicultural counseling competence: An introduction to the major contribution. *The Counseling Psychologist, 49*(4), 490–503. https://doi.org/10.1177/0011000020986543

Neville, H. A., & Mobley, M. (2001). Social identities in contexts: An ecological model of multicultural counseling psychology processes. *Counseling Psychologist, 29*(4), 471–486. https://doi.org/10.1177/0011000001294001

Owen, J. J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research, 27*(1), 102–111. https://doi.org/10.1080/10503307.2015.1078517

Owen, J. J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). "No-show": Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology, 59*(2), 314–320. https://doi.org/10.1037/a0027091

Owen, J. J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011b). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology, 58*(1), 1–9. https://doi.org/10.1037/a0021496

Pew Research Center. (2015, September 28). *Modern immigration wave brings 59 million to U.S., driving population growth and change through 2065* [Report]. https://www.pewresearch.org/hispanic/2015/09/28/modern-immigration-wave-brings-59-million-to-u-s-driving-population-growth-and-change-through-2065/

Pieterse, A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education: A review and analysis of a sample of multicultural course syllabi. *The Counseling Psychologist, 37*(1), 93–115. https://doi.org/10.1177/0011000008319986

Pitner, R. O., & Sakamoto, I. (2005). The role of critical consciousness in multicultural practice: Examining how its strength becomes its limitation. *The American Journal of Orthopsychiatry, 75*(4), 684–694.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Ponterotto, J. G. (2010). Multicultural personality: An evolving theory of optimal functioning in culturally heterogeneous societies. *Counseling Psychologist, 38*(5), 714–758. https://doi.org/10.1177/0011000009359203

Price, C. S., & Cuellar, I. (1981). Effects of language and related variables on the expression of psychopathology in Mexican American psychiatric patients. *Hispanic Journal of Behavioral Sciences, 3*(2), 145–160.

Prilleltensky, I., & Gonick, L. (1996). Polities change, oppression remains: On the psychology and politics of oppression. *Political Psychology, 17*(1), 127–148.

Rogers, M. R., & O'Bryon, E. C. (2014). Multicultural training models and curriculum. In F. T. L. Leong, L. Comas-Díaz, G. C. Nagayama Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA handbook of multicultural psychology: Applications and training* (Volume 2, pp. 659–679). American Psychological Association. https://doi.org/10.1037/14187-037

Sam, D. L., & Berry, J. W. (2010). Acculturation: When individuals and groups of different cultural backgrounds meet. *Perspectives on Psychological Science, 5*(4), 472–481. https://doi.org/10.1177/1745691610373075

Schmitt, M. T., Branscombe, N. R., Postmes, T., & Garcia, A. (2014). The consequences of perceived discrimination for psychological well-being: A meta-analytic review. *Psychological Bulletin, 140*(4), 921–948. https://doi.org/10.1037/a0035754

Sehgal, R., Saules, K., Young, A., Grey, M. J., Gillem, A. R., Nabors, N. A., Byrd, M. R., & Jefferson, S. (2011). Practicing what we know: Multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity & Ethnic Minority Psychology, 17*(1), 1–10. https://doi.org/10.1037/a0021667

Smith, T. B., & Trimble, J. E. (2016). Multicultural education/training and experience: A meta-analysis of surveys and outcome studies. In *Foundations of multicultural psychology: Research to inform effective practice* (pp. 21–47). American Psychological Association. https://doi.org/10.1037/14733-002

Solheim, C., Zaid, S., & Ballard, J. (2016). Ambiguous loss experienced by transnational Mexican immigrant families. *Family Process, 55*(2), 338–353. https://doi.org/10.1111/famp.12130

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372–1380. https://doi.org/10.1177/1049732307307031

Stockdale, S. E., Lagomasino, I. T., Siddique, J., McGuire, T., & Miranda, J. (2008). Racial and ethnic disparities in detection and treatment of depression and anxiety among psychiatric and primary health care visits, 1995-2005. *Medical Care, 46*(7), 668–677.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques*. Sage.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *Counseling Psychologist, 10*(2), 45–52.

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). John Wiley & Sons.

Ticho, G. R. (1971). Cultural aspects of transference and countertransference: Discussions by Charles Chediak, M. D. and Tetsuya Iwasaki, M. D. *Bulletin of the Menninger Clinic; Topeka, Kan., 35*(5), 313–334.

Tikhonov, A. A., Espinosa, A., Huynh, Q.-L., & Anglin, D. M. (2019). Bicultural identity harmony and American identity are associated with positive mental health in U.S. racial and ethnic minority immigrants. *Cultural Diversity and Ethnic Minority Psychology, 25*(4), 494–504. https://doi.org/10.1037/cdp0000268

Tribe, R., & Tunariu, A. (2009). Mind your language: Working with interpreters in healthcare settings and therapeutic encounters. *Sexual and Relationship Therapy, 24*(1), 74–84. http://dx.doi.org/10.1080/14681990802666023

Tummala-Narra, P., Singer, R., Li, Z., Esposito, J., & Ash, S. E. (2012). Individual and systemic factors in clinicians' self-perceived cultural competence. *Professional Psychology: Research & Practice, 43*(3), 165–174. https://doi.org/10.1037/a0025783

Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist, 33*(4), 449–478. https://doi.org/10.1177/0011000004269058

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31*(3), 253–272. https://doi.org/10.1177/0011000003031003001

Villalobos, B. T., Bridges, A. J., Anastasia, E. A., Ojeda, C. A., Hernandez Rodriguez, J., & Gomez, D. (2015). Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients. *Psychological Services, 13*(1), 49–59. https://doi.org/10.1037/ser0000051

Vinson, T. S., & Neimeyer, G. J. (2003). The relationship between racial identity development and multicultural counseling competency: A second look. *Journal of Multicultural Counseling and Development, 31*(4), 262–277. https://doi.org/10.1002/j.2161-1912.2003.tb00354.x

Wilcox, M. M., Franks, D. N., Taylor, T. O., Monceaux, C. P., & Harris, K. (2020). Who's multiculturally competent? Everybody and nobody: A multimethod examination. *The Counseling Psychologist, 48*(4), 466–497. https://doi.org/10.1177/0011000020904709

CHAPTER TWO

REVIEW OF THE LITERATURE

The following provides a brief history of the multicultural counseling movement in psychology, as well as a description of relational-cultural theory (RCT; Miller, 1976) and an ecological theory specifically tailored to address systemic issues of power, the ecological model of multicultural counseling psychology processes (EMMCPP; Neville & Mobley, 2001). Within the discussion of EMMCPP, an overview of the racialization of systems is included, specifically as it pertains to the racialized system of immigration in the United States. Chapter two continues with a review of the theoretical and empirical literature regarding the experiences of immigration and the racial and ethnic minority (REM) client, as well as the experiences of the REM therapist.

Multicultural Competence in Psychology

Multicultural competence is a movement, a framework, and the subject of much research and inquiry that seeks to address what it looks like for psychologists to practice multicultural counseling competence (MCC), building upon the ongoing scholarship that addresses what MCC means. The first American Psychological Association (APA) *Multicultural Guidelines* defined *multicultural* as "interactions between individuals from minority ethnic and racial groups in the United States and the dominant European-American culture" (APA, 2003, p. 378), reflecting the widely held conceptualization that multicultural competence is mostly a need for White clinicians. Emerging research demonstrates, however, that factors above and beyond therapists' racial identity accounts for mental health outcome disparities for REM populations. The work of illuminating therapist-level factors and behaviors, as well as relational processes that lend themselves to most effectively working in cross-cultural relationships, is ongoing.

While *multicultural* has been expanded to included broad identity groups (e.g., age, gender, disability, religion/spirituality, sexual orientation and gender diversity, social class), for the purpose of this inquiry, the current discussion will be limited to MCC as they regard the identity factors of race and ethnicity. Additionally, the terms *multicultural* counseling and *cross-cultural* counseling will be used interchangeably to reflect a "helping dyad or group consisting of at least one person who perceives him or herself to be culturally different" (Vontress & Jackson, 2004, p. 76).

Historical Foundations and Impact

The multicultural competency movement was born out of the Civil Rights movement of the 1960s wherein counseling and psychology professionals began to advocate for systemic change, including inclusivity, sensitivity, and shared power (Arredondo et al., 2008). This movement was also in response to emerging research demonstrating that REM experienced mental health disparities relative to their counterparts (APA, 2003). Disparate mental health associations that were representative bodies of cultural groups began to emerge (e.g., the Association of Black Psychologists, 1968; the Association of Non-White Concerns, 1970s, which later became the American Counseling Association; the Asian American Psychological Association, 1972; National Hispanic Psychological Association, 1979; The Society of Indian Psychologists, 1970), whose initiatives coalesced around the need to develop professional counseling competencies that could guide mental health professionals to work ethically and effectively with clients from culturally different backgrounds (Arredondo et al., 2008). In both positing the need for cross-cultural counseling competencies in training programs and answering criticisms of those who resisted the idea, Sue et al. (1982) pointed out that social sciences had generally ignored certain ethnic groups and, in doing so, had reinforced negative and

pathological views of minority populations. The contemporaneous empirical evidence demonstrated that Asian Americans, Blacks, Hispanic, and American Indians terminated after one session at a rate greater than 50% (compared to 30% for White clients) and this disparity, Sue et al. (1982) argued, was in part a consequence of the "inappropriateness of interpersonal transactions" in therapy. The authors further charged that continued rendering of services as usual would implicate counseling and psychotherapy as "handmaidens of the status quo" whereby minority individuals would "believe that the mental health profession is engaged in a form of cultural oppression" (Sue et al., 1982, p. 46).

As an answer to the charge to create a set of competencies that could be used as a template for conducting cross-cultural therapy, Sue and colleagues (1992) included in their seminal paper, "Multicultural Counseling Competencies and Standards: A Call to the Profession," 31 competencies, with an accompanying document that described 119 operationalized behavioral statements (Arredondo et al., 2008). The American Counseling Association (ACA) formally endorsed MCC in 2002, and in 2003, the APA followed with the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003). Multicultural frameworks have been incorporated into both the APA and ACA professional codes of conduct and ethical guidelines such that MCC is considered both a foundational skill and ethical imperative (APA, 2017a). Additionally, MCC components have been incorporated into all areas of psychological sciences, including research, practice, and teaching as requirements and guidelines for institutional accreditation (APA, Commission on Accreditation, 2018).

Empirical Support and Differing Views

The most widely used conceptualization of MCC is the tripartite model proposed by Sue et al. (1982), which consists of (1) awareness of one's biases, values, and assumptions; (2) knowledge about cultural values and background of others; and (3) skills and techniques to use when working with diverse populations. This framework has guided more almost four decades of training and research in what is referred to as the "fourth force" in psychology (Pedersen, 1999) and continues to frame professional aspirational guidelines (e.g., APA, APA Task Force on Race and Ethnicity Guidelines in Psychology, 2019). Some scholars have also suggested a shift from a focus on measuring a counselor's multicultural competence, which is an assessment of a counselor's competency in implementing cultural awareness, knowledge, and skills, towards a focus on measuring a counselor's multicultural orientation (MCO; Owen et al., 2011c), or a "a way of being" that is concerned with "how the cultural worldviews, values, and beliefs of the client and the therapist interact and influence one another to cocreate a relational experience that is in the spirit of healing" (Davis et al., 2018, p. 90). The MCO framework suggests that therapists encompass cultural humility, conceptualized as having respect for others while maintaining an accurate view of oneself without the perception of oneself as superior to others (Hook et al., 2013). Relatedly, the disposition of openness is espoused as fundamental to multiculturalism (Fowers & Davidov, 2006) and has been suggested that such a focus can facilitate the shift from emphasizing a therapist's competence to a therapist's values. In addition to the three factors of the prevailing tripartite model, Sodowsky and Taffe (1994) argued for a fourth factor, the multicultural counseling relationship, in their creation and analysis of the Multicultural Counseling Inventory. The discourse regarding how to conceptualize MCC has also been supplemented by those who argue that traditional views of MCC fall short of guiding

providers to become change agents for social justice issues, which are inherently multicultural issues (Ratts et al., 2016; Vera & Speight, 2003).

Differing definitions aside, the most recent meta-analysis of two decades worth of MCC in therapy research (Tao et al., 2015) reveals that while the magnitude of impact varies, client perspectives of MCC matter. For example, as it concerns REM clients' satisfaction in feeling therapy expectations were fulfilled (i.e., client satisfaction), those who perceive their therapists to have higher MCC also feel that therapy services met their expectations (e.g., Constantine, 2002a, 2007; Fuertes et al., 2006; B. S. K. Kim et al., 2009) and perceive a more positive working alliance (e.g., Constantine, 2007; Fuertes et al., 2006; Owen et al., 2012). Research also demonstrates that the relationship between clients' perceptions of their therapists' MCC and therapy outcomes ranges from small (e.g., Owen et al., 2011a), to moderate (e.g., Owen et al., 2011b), to large (Hook et al., 2013). Meanwhile, clients who perceive their therapists to be lacking in MCC, as measured by the extent to which clients perceive racial microaggressions from their therapists, reported overall less improvement in psychological symptom distress (Owen et al., 2011a).

Presumptions Regarding Race and Ethnicity

Two presumptions have loomed large in parallel with the MCC movement. The first presumption was that matching clients with therapists of the same race would result in stronger therapeutic relationships (Harrison, 1975; Sue, 1977). This notion was guided by findings from social psychology wherein it was posited that individuals are not only attracted to and find connection with those who are similar (Newcomb, 1961), but that individuals perceive similar individuals to be more credible (Simons et al., 1970). Therefore, the assumption for psychologists was that those therapists and clients with the same racial and ethnic matching

would be able to foster more trust based on perceived similarities (Cabral & Smith, 2011). In the most recent meta-analysis concerning racial and ethnic matching in dyads, Cabral and Smith (2011) found results that echo prior meta-analyses (Coleman et al., 1995; Maramba & Hall, 2002; Shin et al., 2005): While African American clients strongly prefer therapists who are also African American and evidence mildly better outcomes as a result of this match, Asian American clients have mild preferences, and Hispanic and Latino American clients have moderately strong preferences. Overall, matching clients with therapists of the same racial and ethnic background does not produce differences in therapy outcomes (Cabral & Smith, 2011).

The second presumption that has cast the work of MCC researchers and scholars is that REM therapists are more culturally competent due to their identities as minorities. More recently, Berger and authors found (2014) that while REM therapists reported increased multicultural awareness and multicultural counseling relationships in comparison to White counselors, this increased awareness is a function of their increased community involvement by way of social and interpersonal interactions with REM individuals and groups rather than a function of their racial identity. Several early studies by way of collecting therapist self-report data seemed to support the claim that REM providers may have more cultural competence (e.g., Pope-Davis & Ottavi, 1994; Sodowsky et al., 1998). Be that as it may, while clients' perceptions of therapists' MCC matters in relation to perceived satisfaction, alliance, and outcomes, how therapists perceive their own MCC may matter less as it has been shown that therapists' perceptions of their MCC are unrelated to how their own clients perceive the multicultural competence (Fuertes et al., 2006; Worthington et al., 2000). Therapists' self-perceptions of their MCC are also unrelated to client symptom improvements, and thus therapy outcomes (Larrison et al., 2011). Yet, individual, therapist-specific factors *beyond* racial identity account for

differences in outcome between REM and White clients. In an analysis of a dataset from the Center for Collegiate Mental Health, which included 161,335 clients of 3,599 therapists from 122 counseling centers in the United States, Hayes and authors (2016) found that while therapists' demographic factors were not significant to therapy outcomes, individual therapists' differential effectiveness was related to clients' race and ethnicity. In other words, some therapists, whether REM or White, did not differ in their outcomes with both their REM and White clients. However, some therapists evidenced better outcomes with their REM versus White clients, while other therapists had better outcomes with their White versus REM clients such that clients' race and ethnicity was shown to be a function of therapists' effectiveness. That a client's racial status accounts for significant variability within a therapist's caseload was also demonstrated in prior studies of therapists at college counseling centers (Drinane et al., 2016; Hayes et al., 2015), as well as among a diverse sample of mental health professionals treating those with serious mental illness (Larrison et al., 2011) and adolescent cannabis use disorder (Imel et al., 2011). In their examination of client rates of unilateral termination, or the act of dropping out of therapy without plans to do so, Owen et al. (2012) found that while REM clients were significantly more likely to terminate compared to White clients, unilateral termination rates within therapists' caseload differed such that the difference was a function of *clients'* racial identity status, rather than the therapists' identity. In a related study, Owen et al. (2017) found that in addition to clients' racial identity, therapists' racial and ethnic comfort were related to unilateral termination rates.

The presumption that REM therapists may be more culturally competent has also influenced MCC research and institutional training curricula. Since the APA adoption of the first MCC guidelines (APA, 2003) and the subsequent wide acceptance of similar aspirational

guidelines, MCC research—which in part informs these guidelines—has mostly been conducted using White therapists (Dickson et al., 2010; Vinson & Neimeyer, 2003). Important inquiries regarding MCC and relational processes, such as developing self-awareness of privilege (Akins et al., 2017; R. C.-L. Chao et al., 2017) and broaching the topic of race and racism with clients (King & Borders, 2019), have been conducted with exclusively or predominantly with White trainees or therapists (e.g., Constantine, 2002b, 2007; Dickson et al., 2010; Gelso & Mohr, 2001; Utsey et al., 2005; Vinson & Neimeyer, 2003), and this trend continues presently (e.g., Castillo et al., 2007; D. F. Chang & Berk, 2009; Day-Vines et al., 2018; Hayes et al., 2015; King & Borders, 2019; Wilcox et al., 2020). Historically and presently, the majority of therapists have been White, and this has framed the exigence of studying this particular dyad (i.e., White clinicians and REM clients; Singer & Tummala-Narra, 2013). Admittedly, this was also based on the assumption that counseling students from REM groups are already more knowledgeable about cultural issues (D'Andrea et al., 1991; Neville et al., 1996; Sue & Sue, 2016). As it concerns multicultural competence, D. Sue of D. W. Sue & D. Sue (2016) reflected in their seminal work, *Counseling the Culturally Diverse*:

> I have always been aware that my teaching and training were more directed at educating White trainees and counselors to their own biases and assumptions about human behavior. I operated from the assumption that people of color knew much of the material on oppression, discrimination, and stereotyping. After all, I reasoned, we were members of the oppressed group and had experiential knowledge of how racism harmed us. (p. 57)

Dickson and authors (2010) point out that studies that examine the effectiveness of MCC training components in reducing racial prejudice among counseling students (Castillo et al., 2007; Constantine, 2002b) are based on predominately White students' attitudes toward African

Americans, which undermines the reality that people from all racial and ethnic groups are "subject to the socialization of prejudiced and biased attitudes" (p. 249).

Therapists and Differential Outcomes

Research regarding the *therapist* have mostly been conducted looking at distal, surface-level demographic and professional variables, such as gender and race. Therefore, while it has been established that therapists are one of the primary sources of racial and ethnic disparities in mental health outcomes, more can be said about what does *not* account for those differences than about therapist skills, strategies, or actual behaviors that do account for differences. Researchers (e.g., Hayes et al., 2016) surmise that this gap exists due to the complexity and difficulty of studying process-related constructs that may be more valuable in informing effective therapy work with REM clients. Such processes include managing therapists' emotional reactions due to countertransference when working with REM clients (Comas-Díaz & Jacobsen, 1991; Gelso & Mohr, 2001), addressing cultural misunderstandings, impasses, or other ruptures in the therapeutic relationship (Gaztambide, 2012), effectively broaching the topic of race and racism with REM clients (Day-Vines et al., 2018; King & Borders, 2019), or therapists' use of self-disclosure (Solomonov & Barber, 2018).

Additionally, research shows that there is a gap between therapists' attitudes toward MCC and the actual application of culturally competent practice. For example, Hansen et al. (2006) revealed via a national survey of psychologists that while clinicians recognized competencies such as "using racially/ethnically sensitive data-gathering techniques" and "preparing a cultural formulation" as very important, they were not as likely to put knowledge into practice. For example, 27% of respondents rarely or never made referrals to other providers despite knowing that doing so would be in the clients' best interest, and 39% of participants

reported that they did not seek professional consultation regarding multiculturally competent care when working with REM clients (Hansen et al., 2006). This gap between knowledge and action was echoed in later findings that illuminated significant differences between what trainees and psychologists believe they *should* do and what they *would* do, as per multiculturally competent practice (Sehgal et al., 2011). The difference was significant among even among practicing psychologists with an average of 10 years of experience, suggesting that this gap persists even with the added benefit of more education and professional experience (Sehgal et al., 2011). What was decried more than two decades ago among researchers, that the relationship between MCC and actual counselor behaviors has largely been unidentified (Fuertes et al., 2002; Sodowsky et al., 1998; Vera & Speight, 2003), continues to ring true.

Lenses of Analyses: Relational Cultural and Ecological Models

Relational-cultural theory (RCT; Miller, 1976) centers the need for all individuals to participate in growth-fostering relationships while accounting for the myriad sociopolitical factors that act as barriers to opportunities to engage in such meaningful interactions. The therapeutic relationship, or *alliance*, is conceptualized as being influenced in part by therapists' authenticity (Duncan, 2014), as well as mutual collaboration and rapport (Orlinsky et al., 2004). Such components share overlap with core RCT constructs, such as empathy, mutuality, authenticity, engagement, and empowerment, which have been studied across diverse populations and client contexts to add support for the use of RCT as both a conceptual and practical intervening framework (Lenz, 2016). As such, RCT provides a meaningful framework to investigate the experience of individuals in a relational dynamic that, thus far, has received little attention. Additionally, an extended lens of Bronfenbrenner's ecological model—the ecological model of multicultural counseling psychology processes (EMMCPP; Neville &

Mobley, 2001)—has been added to specifically contextualize how social identities are nested and interact within systems of power and oppression that impact individuals at the very level of relationships.

Relational-Cultural Theory

As humans, we both grow *through* and *toward* relationships rather than separate from them (Comstock et al., 2008). That the fundamental developmental goal for all people is the ability to mutually and authentically participate in increasingly complex relationships is key to relational cultural theorists. At its core, RCT is about the inevitable need for interconnectedness for *all* throughout life (Jordan, 2017).

Historical Underpinnings

Rooted in feminist thought and the work of Jean Baker Miller (1976), RCT queries commenced in 1977 with informal meetings among four women—Jean Baker Miller, Irene Stiver, Janet Surrey, and Judith Jordan—who shared and discussed their own experiences as mental health counselors. In their conversations, they recognized that their trainings in teaching hospitals were "distinctly patriarchal and doctrinaire" (Jordan, 2017, p. 232) and that traditional theories about human psychology did not accurately represent the experiences of women and other marginalized populations. Rather than being motivated and acting on self-interest and gratification, RCT theorists contend that people develop, grow in complexity, and heal by engaging in and creating connections in growth-fostering relationships (Comstock et al., 2018).

Key Assumptions and Theoretical Tenets

RCT tenets are built from a contextual assumption that all forms of oppression, humiliation, marginalization, and other "relational violations" are necessarily characteristic of patriarchal, dominant-subordinate systems, and that these experiences perpetuate human

suffering and trauma (Comstock et al., 2008). While the "power-over" framework is systemic and institutionalized, all interpersonal, relational contexts are "raced, engendered, sexualized, and situated along dimensions of class, physical ability, religion or whatever constructions carry ontological significance in culture" (Walker, 2002, p. 2, as cited in Comstock et al., 2008). As such, all individuals experience violations in relational contexts. The resulting breaches can only be restored through healing relationships (Comstock et al., 2008).

Connections in growth-fostering relationships lead to growth by way of mutual empathy and mutual empowerment—as in, both parties are affected and have the power to affect the other (Jordan, 2017). Mutuality, in the context of RCT, does not mean sameness or equality, but rather is "a way of relating in which each, or all, of the people involved are participating as fully as possible" (Miller & Stiver, 1997, p. 43). Mutual *empathy* is defined as a process of active engagement that involves "joining together based on thoughts and feelings in the situation" (Miller & Stiver, 1997, p. 43).

Miller posited that people "experience pleasure if they can respond to another person's feelings with feelings of their own, regardless of what the feelings themselves are. We experience pleasure in this, per se—the feeling of being in the flow of human connection rather than out of it" (Miller & Stiver, 1997, p. 35). Connections, then, are marked by what Miller (1986) called the "five good things": (a) each experiences *zest,* or vitality and energy; (b) each is empowered into *action* during the immediate exchange so that they can impact the other; (c) each gains *knowledge* that more accurately represents themselves, the other, and the relationship; (d) each gains an enhanced *sense of worth* regarding their own thoughts and emotions due to the others' responsiveness and recognition; and (e) each gains a *desire for more connection* and caring for the other with motivation and energy to have other relational connections. RCT

theorists posit that all relationships can be understood in the context of relational movement, or the way in which relationships move through connections and disconnections.

Relational Movement from Disconnections to Connections

Disconnections, or those experiences in relationships that are not mutually empathic or empowering, can accompany feelings of shame, frustration, fear, humiliation, self-blame, and—the most powerful and destructive of all—psychological isolation (Comstock et al., 2008). Relational disconnections accompany a sense of "being cut off" from another and can vary from minor feelings of being out of touch with another, to violent abuse and traumas (Miller & Stiver, 1997). The experience of disconnections happens in early development such that *relational images*, which portray patterns of an individual's relational experience, can be constricted by negative beliefs constructed about the self and others in order to make sense of the prevailing relational images. In the process of trying to stay in connection, individuals who have less power and cannot change the relationship change *themselves* or change how they construct their experiences internally in order to "twist herself into a person acceptable in unaccepting relationships" (Miller & Stiver, 1997, p. 73). RCT theorists assert that even as an individual builds increasingly restrictive relational images, they continue to seek connections, but can only do so by using strategies that result in further disconnection or isolation, referred to as the *central relational paradox.* Chronic disconnections can lead to a sense of *condemned isolation*, which is described as "the feeling that one is locked out of the possibility of human connection and of being powerless to change the situation" (Miller & Stiver, 1997, p. 70).

Relational movement makes possible an opportunity for disconnections to resolve into reconnections, which can become new, transformative connections when one is able to make their experiences known, and when the other in the relationship is able to effectively respond

(Comstock et al., 2008; Miller & Stiver, 1997). Both conditions rely on *authenticity*, or the ongoing ability for one to be able to represent their experiences truly and fully, while also being able to respond to others' experiences truly and fully (Miller & Stiver, 1997). The capacity to *move* and *be moved* is a creative process wherein both participants can gain new awareness and energy, and neither is in control. Power differentials do not preclude the possibility for mutuality as each can engage and interact by authentically acting on thoughts and feeling so that each can benefit mutually (Miller & Stiver, 1997). RCT theorists posit that such a process is predicated on replacing the concept of domination in power, as in "power over," with an alternative model of "power together" (Miller & Stiver, 1997).

Those for whom disconnections are most painful are the ones who are more vulnerable in the relationship—such as clients in a therapy relationship—or for those who are from marginalized and devalued cultural groups (Comstock et al., 2008). The role of the therapist as the "expert" in mental health in a counseling context makes power differentials inherent in the therapy relationship. RCT relational concepts, such as empathy and authenticity, make it particularly fitting to use as a lens to explore REM therapists' experiences of cultural connections and disconnections with their REM clients.

The Ecological Model of Multicultural Counseling Psychology Processes (EMMCPP)

The EMMCPP is a model that directs attention to the role of differential structural and individual power on psychological processes (Neville & Mobley, 2001). The EMMCPP is an explicitly multicultural revision of Bronfenbrenner's ecological model (1979), which frames human interactions as influencing—and influenced by—five interrelated, nested systems: (a) individual and their characteristics, such as genetic make-up, ethnicity, age; (b) microsystem, or immediate interpersonal interactions in a given environment; (c) mesosystem, or interactions

between two microsystems; (d) exosystem, or the interactive influence of two subsystems; (e) macrosystem, or the overarching societal values and norms that define social roles and expressions of identity. Specifically, the EMMCPP expands the macrosystem as encompassing not just values, but also sociocultural forces of institutional racism, sexism, classism, ableism, and any other social processes that marginalize and oppress groups of people based on socially stratified differences. Thus, the EMMCPP model allows for contextualization of the therapy relationship by considering the interaction of all client- and provider-related systems (Neville & Mobley, 2001).

The "contextual therapeutic relationship" was termed by Anderson and colleagues (2000) as a way to examine "ecological disruptions," which are defined as "external deviations that threaten the nature of the therapeutic relationship" (p. 109). Contemporary U.S. politics and policies manifest explicit forms of anti-immigrant perceptions and acts that impact the macrosystem milieu. Tummala-Narra (2020) noted that the growing visibility of racial minority immigrants has spawned a collective anxiety "where dissociative defenses maintain emotional distance and identification with groups perceived to be threatening" (p. 50). An ecological frame, such as EMMCPP, is a useful lens through which to examine REM immigrant therapists' experiences as they are uniquely positioned to be both perceived to be a threat, and as a part of the collective, may also perceive threat from REM immigrant clients.

For the purpose of this study, I will discuss the historical conditions and present-day elements that encompass the macrosystem. In concordance with the EMMCPP, I will extend the macrosystem beyond the discussion of values and norms and discuss the overall historical and present-day societal structure of race.

Racialized Systems

In the therapeutic relationship, the therapist and client are impacted not only by biases and assumptions owing to differences in culture, but also by perceptions and feelings shaped and influenced by their differing locations within a social structural system (Ainslie et al., 2013). Such "differing locations" is the function of enduring oppression and inequity rooted in the historical policies and conditions of colonization (Prilleltensky & Gonick, 1996). While a complete and comprehensive examination of all the related constructs of oppression and colonization is beyond the scope of this dissertation, *racism* will be discussed throughout, and thus deserves a definition:

> [The] transformation of racial prejudice into individual racism through the use of power directed against racial groups and their members, who are defined as inferior by individuals, institutional members, and leaders, which is reflected in policy and procedures with the intentional and unintentional support and participation of the entire race and dominant culture. (Carter, 2007, pp. 24-25)

Additionally, Speight (2007) added that racism is "a process, a condition, a relationship that violates its victims physically, socially, spiritually, materially, and psychologically" (p. 127).

Racial systems function as a mechanism to classify and stratify individuals and groups with differential, intergenerational implications for access and opportunity, or lack thereof (Bashi & McDaniel, 1997). In the United States, individuals are racially classified based on skin color: Black, brown, or darker-skinned individuals are placed in the lower levels of the racial hierarchy (McDaniel, 1995). This ideology is rooted in European colonization of Native American Indians in North America and the forced migration and enslavement of African people, wherein differences in physical features between the White master and African slave were what

defined—and continues to be a largely defining factor—otherness (Bashi & McDaniel, 1997). In a letter to his Black, adolescent son, contemporary writer, Ta-Nehisi Coates (2015) penned:

> Race is the child of racism, not the father. And the process of naming "the people" has never been a matter of genealogy and physiognomy so much as one of hierarchy. Difference in hue and hair is old. But the belief in the preeminence of hue and hair, the notion that these factors can correctly organize a society and that they signify deeper attributes, which are indelible—this is the new idea at the heart of these new people who have been brought up hopelessly, tragically, deceitfully, to believe that they are white. These new people are, like us, a modern invention. But unlike us, their new name has no real meaning divorced from the machinery of criminal power. The new people were something else before they were white—Catholic, Corsican, Welsh, Mennonite, Jewish. (p. 7)

Coates' latter thesis reflects the fact that immigration is inextricably linked to the racialization of America. Immigrants do not come to the United States with racial classifications, but rather are placed into categories that reflect a racial social order (Jasinskaja-Lahti et al., 2006; Wimmer, 1997; Yakushko, 2009). In other words, immigrants "become differentially racialized" (R. Chang, 2000; Sanchez & Romero, 2010) based on their physical features such that those who physically resemble the dominant group (i.e., White individuals) are more likely to experience privileges akin to their White counterparts, while those who look non-White are relegated to a class with less power (Jaynes, 2008; Wimmer, 1997; Yakushko & Chronister, 2005). Categories and labels such as "Black," "Hispanic," and "Asian" are assigned in such a way that individuals and groups are forced to assimilate into a system of racial stratification not formerly assigned to them in their countries of origin (Bashi & McDaniel, 1997). Immigrants

from Europe who are English, French, Irish, Scottish, and others are assimilated also as "White," while those who come to the United States as, for example, Chinese, Japanese, Indian, Mexican or Cuban are monolithically prescribed as "other" (Bashi & McDaniel, 1997; McDaniel, 1995). Herein lies the difference between race and ethnicity: whereas the former is a social construction that functions as a mechanism to stratify and rank individuals (Carter, 2007), the latter is a subset of people who share common cultural, national, religious, ancestral, and other characteristics (McDaniel, 1995). For European immigrants, ethnic differences largely dissipate in the process of assimilation so that it is race, *not* ethnicity, that characterizes and maintains divisions in the United States (McDaniel, 1995). Many racial minority groups, even when native-born in the United States and regardless of citizenship status or length of stay in the United States, are presented and seen as immigrants and foreigners (McDaniel, 1995; Moradi & Hasan, 2004). This kind othering, also known as foreigner objectification, occurs especially for those who are of Asian and Latino descent (C. C. Lee, 2018).

Conflating race with ethnicity undermines the magnitude of implications owing to the unequal distribution of power, resources, and *access* to those resources that is inherent in these divisions (McDaniel, 1995). As McDaniel (1995) wrote, while the "withering" of ethnic differences among European-origin immigrants creates opportunity for socioeconomic mobility and advancement, for immigrants from elsewhere—and especially for African Americans—the passage of time creates an "underclass of people who are disaffected and disconnected from the fruits of society at large" (p. 673). In the United States, foreign-born individuals earn significantly less than native-born counterparts, and foreign-born women experience the largest earning gap (Green & Lin, 2002; Yakushko, 2018). Income gaps continue to persist for REM individuals as compared to their White counterparts (Kochhar & Cilluffo, 2018).

Coates' thesis also reflects the notion that as a concept, race necessarily involves two or more distinct races so that racial groups are always a part of a system of race, whereby racial classification occurs through social interaction (McDaniel, 1995). Unequal outcomes, such as the kind stated above, are the result of institutional racism, which is an inherent feature of racialized social systems and is manifested in systems of education, health, occupation, and politics (Carter, 2007; Crenshaw, 1995; Delgado et al., 2000). The most apt illustration of the historical racialization of systems in the United States is the legally sanctioned use of race to define who can and cannot be citizens, dating back to the 1790 Naturalization Act, which specified that only "free Whites" could apply for citizenship (Gee & Ford, 2011). Additionally, the racialization of the U.S. border and immigration policy can be traced back to the Chinese Exclusion Act of 1882 that barred Chinese laborers from immigrating to the United States for a period of 10 years, while also prohibiting any Chinese immigrants from being able to become citizens (E. Lee, 2002). Ensuing rhetoric has continued to reflect an institutionally racialized sentiment of exclusion with the use of terms such as "foreigner," "undesirables," "diseased," and most recently, "illegals" and "terrorists" (E. Lee, 2002). Such rulings and policies are viewed as the impetus of a race-based gatekeeping ideology intended to preserve American whiteness and the racial hierarchy (E. Lee, 2002; Segal et al., 2010). Indeed, while citizenship had largely been granted to White European immigrants since 1790, REM immigrants were the first group of people to become naturalized citizens in 1952 (Daniels, 2002).

Racialization of Immigration and Xenophobia

Xenophobia, or the fear and dislike of foreigners (Yakushko, 2018), has been noted to occur when individuals are threatened by changing demographics due to increasing racial and ethnic diversity (Segal et al., 2010). Of the approximately 59 million immigrants (i.e., foreign-

born) who arrived to the United States since 1965, half (51%) of all immigrants have been from Latin American countries (i.e., Central America, the Caribbean, and South America) of origin, while one-quarter of immigrants have been from Asian countries of origin (Pew Research Center, 2015). This trend in immigration can largely be accounted for by the Immigration and Nationality Act of 1965, which abolished national-origin quotas that had favored immigrants from European countries (Batalova et al., 2020). In light of this trend, the overall demographic of the population is expected to shift such that the non-Hispanic White demographic will become less than half of the U.S. population (46%) by 2055 (Pew Research Center, 2015). Such shifting demographics are not only presented as threats to the majority population, but also to U.S.-born racial minority individuals when, for example, newly arriving immigrants are scapegoated for social and economic problems (Munro, 2006; Yakushko, 2009, 2018). The long-standing myth of the Asian "model minority" has been perpetuated to idealize Asian immigrants as exemplary owing to generalized depictions of Asian academic achievement and economic advancement, which has been compared and contrasted with prevailing stereotypes of other "lazy" and "unenterprising" minority groups, especially African American and Latino populations (Espenshade, 2000; C. J. Kim, 2000; Merskin, 2011; Yakushko, 2018). These "intentional efforts" (Yakushko, 2018), it has been argued, are strategies used by the majority to distract attention from the system of privilege and oppression that hurts all groups (Johnson, 2006). Furthermore, that the characteristic of racial identity is tied to feelings of threat renders xenophobia and racism as mutually supporting and interrelated forms of oppression (Yakushko, 2009)

Xenophobia and Racism Between and Within REM Groups

Xenophobic attitudes and treatment of immigrants by native-born marginalized groups have been studied and documented in more depth and breadth than is possible to capture here. For the purposes of this study, only select examples as discussed in the recent literature will be provided. Examinations of xenophobic attitudes have been noted, including African Americans' negative views towards Black immigrants and Asian immigrants (Hovey & Magaña, 2002; C. J. Kim, 2000; Thornton & Mizuno, 1999) as well as native-born Latinos' negative reactions towards new Latino immigrants (Basáñez et al., 2019). Xenophobia is a reflection of not only the attitudes of the host country, but also involves fears that immigrants themselves might harbor from their own host countries (Tummala-Narra, 2020). This may be particularly true for immigrant individuals from countries that were formerly colonized by Western Europeans, "which are plagued by age-old colonial processes and institutional practices" (Jayawardene, 2016, p. 352). For example, Latin American individuals and groups experience a "Mongrel complex" as they are apt to compare themselves unfavorably to White Europeans (Yakushko, 2018; R. J. C. Young, 2005). For such groups, persisting feelings of inferiority based on skin color is the lasting inheritance of the system of stratification imposed on Latin American populations by Spanish colonial rule, whereby skin color and other "emulated Whiteness," such as cultural, ideological, economic, and aesthetic qualities, were used as determinants for placement in a social caste hierarchy (Hunter, 2007). For South Asian individuals and groups, the history of British colonialism and ensuing racialization of Indians and Sri Lankans has been consequential, not only for the ways in which fair, light skin is upheld as the standard of ideal beauty, but also for the ways in which colorism, or the ways in which privilege and power are accorded based on the lightness or darkness of one's skin (Burton et al., 2010), is associated with high and low caste groupings (Jayawardene, 2016). For other Asian societies without direct

European colonial histories, colorism may intersect more with classism, as dark skin is associated with manual laborers and the working class, whereas light skin is associated more with leisure (Hunter, 2007; Rondilla et al., 2007). Colorism differs from racism mainly by the way in which distinctions of skin color are made *within* a racial group instead of between groups (Hochschild & Weaver, 2007).

It has been argued that many African Americans, Latinos, and Asian Americans have internalized the colonial racial hierarchy and have come to uphold and valorize light skin and other White features (R. Hall, 1994, 1995, 1997). Such manifestations of cultural imperialism, or the "universalization of a dominant group's experience and culture, and its establishment as the norm" (I. M. Young, 1990, p. 59, as cited in Speight, 2007), is at the root of *internalized racism* (Speight, 2007). In arguing that internalized racism is "the most damaging psychological injury," Speight added that experiences of shame and humiliation lead to negative images of one's own inferiority "serve to colonize and recolonize them. Through its internalization, oppression becomes self-sustaining" (2007, p. 130). While the discourse on internalized racism and oppression can be traced back to the works of post-colonial scholars (e.g., Freire, 1970), most of the psychological literature—approximately 90%—is from the last two decades, with the overwhelming majority published in the last 10 years (74%) and a large proportion of the literature focused on the experience of African Americans (45%; David et al., 2019). According to David et al. (2019) in their systematic review of the literature, those who experience more racism have higher levels of internalized racism, and internalized racism perpetuates racism by creating conflicts within and between racial minority groups (David et al., 2019).

Notably lacking in this domain of research is an exploration of the relationship between REM groups who have historically been oppressed through slavery, genocide, and colonialism

and expression of anti-immigrant sentiment (David et al., 2019). This echoes what was noted almost a decade earlier by Pyke (2010) in their observation that as it relates to internalized racism, both sociological and psychological research had largely ignored "the consequences for immigrants of color who arrive having already imbibed in their homeland an ideology of White (Western) supremacy dispensed through military, economic, religious, and cultural colonialism and imperialism" (p. 556).

Relational Cultural and Ecological Lenses: What's at Stake in the Therapeutic Relationship?

Coates' assertion that White America functions inseparably from the "machinery of criminal power" is an indictment of the systematic and unsanctioned use of control that RCT theorists contend are at the root of relational violations. Non-mutuality is the engine of societies that treat power as a limited commodity, which necessarily follows that mutually empowering relationships would not be encouraged on all levels of relationships, from the global to the most intimate (Miller & Stiver, 1997). Disconnections are the result of overall functions and values of a culture in which one group of people has more power than another group in a power-over way such that "cultures built on dominant-subordinate relationships based on gender as well as class, race, and other characteristics have created a nonmutual model that permeates all relationships," adding, "We *all* have developed within this framework" (Miller & Stiver, 1997, p. 50).

By extension, clients and therapists alike all grapple with the central relational paradox. RCT's support of the assertion that societal and institutional oppression is enacted in interpersonal relationships is especially important for therapists, given that the counseling relationship is inherently encompassed by a power differential—by virtue of the role of the therapist as "expert"—and given that larger racialized dynamics are to bound to become

"organizing principles" in the therapy room, which acts as a microcosm of the larger racialized societal context (Sue & Sue, 2003). In relationships where one person has more power, they can exert much more influence and control over the interaction and, therefore, the potential for danger and harm are increased (Miller & Stiver, 1997). It has long been established that the therapeutic relationship is one of the key predictors of therapeutic outcomes (Bordin, 1979; Safran, 1993); the same is echoed by RCT theorists who assert that the relationship "is key to the process of therapy, not just the backdrop" (Jordan, 1990, as cited by Miller and Stiver, 1997, p. 135). Therefore, understanding the sources of cultural disconnections and making efforts to move from disconnections to connections is imperative for therapists (Miller & Stiver, 1997), both REM and White alike.

Ecological Time and Context

Coates' assertion is rendered a more meaningful frame when placed in the context of U.S. contemporaneous events: He wrote to his 15-year-old son in 2014, the same year that many were witness to police brutality and killings of unarmed African Americans for the first time on national media, such as Eric Gardner and Tamir Rice, while convictions and justice for those who were killed, such as Michael Brown, were elusive. Ensuing research shows that over the course of their lifetime, Black men are 2.5 times more likely to be killed by police than are White men in the United States (F. Edwards et al., 2019). Time, as it relates to context, matters. Solomonov and Barber (2018) noted that most psychotherapy studies that investigate the therapeutic encounter do so without giving the necessary historical context or addressing the particular political climate during which the data are gathered. Furthermore, the authors pointed out that studies that do address a particular historical-political event are subsequent to wide-

ranging traumatic events in which it is assumed that the therapist and client share similar worldviews (Solomonov & Barber, 2018).

In a similar vein, understanding relational aspects of a therapeutic dyad requires sociopolitical context. The year 2016 was a year in which the U.S. presidential election proved consequential for most Americans, as 57% indicated that ensuring political climate was a significant source of psychological stress, and 49% of the representative sample of 3,440 Americans stated reported that the outcome of the election was a significant source of distress (APA, 2016). Additionally, for nearly half of Americans (48%), immigration-related issues were cited to be a prevalent source of stress with the highest majority reported from Hispanic (66%) and Asian adults (52%; APA, 2019). Within months of his inauguration, President Donald Trump signed several executive orders that initiated an anti-immigrant agenda to increase deportations of unauthorized immigrants, to commence plans to build a wall along the U.S. Southern border, to ban Syrian refugees along with others from seven predominantly Muslim and African countries from entering the United States, and to stop granting asylum to victims fleeing their home countries due to domestic abuse or gang violence (Torres et al., 2018). In 2017, it was also announced that the administration would end the Deferred Action for Childhood Arrivals (DACA), a 2012 Executive Order that granted legal work authorization and protection from deportation for 2 years (Siemons et al., 2017). Public opinion on the current reality and future direction on the topic varies: one-third (35%) of U.S. adults incorrectly believed that most immigrants were in the United States unlawfully, despite the fact that lawful immigrants make up the vast majority (76%) of the immigrant population (Gramlich, 2019). Moreover, while 82% of Democrats felt that it is important for policies to establish a pathway for unlawful immigrants to remain in the country legally, under half (48%) of Republicans felt the same (Radford, 2019).

Concurrent with vastly changing policies on immigration, the United States saw a rise in hate groups (940 in 2019, compared to 917 in 2016), including White nationalist groups that increased 55% from 2017, as well as continued rise in hate crimes, including those involving anti-immigrant sentiment (Southern Poverty Law Center, 2020b). As was expressed by Tummala-Narra (2020) with respect to her work with immigrants, many immigrants fear that their legal status in the United States no longer protects them. In the midst of the COVID-19 (coronavirus) pandemic that was first detected in Wuhan, China and spread globally within months, the U.S. political response was wrought with xenophobic sentiment, starting first with the President's reference of the "China Virus," followed by other politicians who vocally claimed that "cultural practices" made it unsurprising that COVID-19 had its origins in China (Southern Poverty Law Center, 2020a). These sentiments harken back to a rhetoric akin to "medicalized nativism," or the explicit racialization of diseases based on assumptions tied to certain "immigrant menace" groups (Kraut, 1995).

Immigration and the REM Immigrant

Currently, it is estimated that more than 44.7 million immigrants are in the United States, accounting for 13.7% of the overall population (Batalova et al., 2020). Over time, various terms have been used to define those who migrate. In the literature, terms such as migrants, international, transnational, non-natives, and foreign-born have been used. Additionally, distinctions are made between lawful permanent residents, legal residents who are in the United States on temporary visas, refugees, and asylum seekers (Batalava et al., 2020). There are marked differences in both the access and restrictions granted to different groups based on their immigration status, as well as in the experiences of those who relocate based on each group and individual circumstance. As such, the term "immigrant" will be used to describe an overarching

category of individuals who relocate in this section to highlight both shared concepts as well as distinct differences, particularly as it concerns the REM immigrant experience, when relevant. Additionally, the term "foreign-born" will be used to honor fidelity and consistency with the original inquiry where studies are referenced.

Immigrants and Waves

The history of migration is inextricably linked to present-day U.S. demographics and sociopolitical character, especially as it regards the designation of the term *minority*. The first wave of immigrants (1700-1803) who have acquired the status of "original inhabitants" were mainly White, English-speaking protestants from Western European (Akhtar, 2014). The second wave of immigrants (1804-1924) who were "darker" Europeans and mostly non-English-speaking from countries such as Italy, Greece, and Russia have assimilated to the culture established by the first wave. The third wave of immigrants (1925-present) are mostly darker-skinned Asian, Caribbean, and Hispanic, and are those for whom struggles to fit into the mainstream still persist, especially for those who are from a lower socioeconomic class. While U.S. immigration is generally accounted for by the preceding three waves, this naturally overlooks the forced migration of slaves from Africa from 1519-1808 (Akhtar, 2014). In the United States, a group is a "minority" not based on quantity or chronology of arrival, but rather a distinctive location of its relative weakness in social power that also invokes unjust and unequal treatment from the majority (Akhtar, 2014).

Loss and Acculturation

The physical, social, and emotional uprooting for immigrants is one that can be painful and consequential. The change from what one used to know to a new environment where one must adjust quickly may induce a "culture shock" (Ticho, 1971). Garza-Guerrero (1974)

described this process as a "confrontation" that accompanies stress and anxiety, akin to a "violent encounter" that prompts mourning for what has been a profound loss and a subsequent "threatening, transforming, and remodeling force" to one's identity (Garza-Guererro, 1974, p. 414). While most migration is in the context of a search for more opportunities and advancement, benefits acquired through the process may even be viewed by an immigrant individual within the context of loss (Rose & Hiller, 2007) that spans multiple domains, including loss of family, loss of language and culture, loss of homeland and belonging, and loss of social status (Garcini et al., 2019; Solheim et al., 2016). Separating from one's home country, family, customs, and language may create a kind of "ambiguous loss"; that is, while not physically present, such elements are continuously present in the psyche, prompting uncertainty about such losses (Boss, 2009; Solheim et al., 2016).

The manifold factors that impact immigrants' experiences—spanning from the degree of choice one has in leaving their country of origin, the age at which one relocates, to the degree of receptivity the new culture has towards the immigrants—makes no two immigration experiences the same (Akhtar, 1995; Yakushko, 2009). This holds true for the ways in which immigrants may have available to them or decide to utilize coping strategies while managing their intercultural post-migration experience. In recognition of these salient differences, as well as the possibility for positive processes and outcomes, the acculturation model was proposed by Berry (1997) and has been used widely to conceptualize how immigrant individuals manage difficulties when adapting to a different cultural context. Acculturation is a neutral term that accounts for cultural change in either one or both the non-dominant group and the dominant group when coming into "continuous first-hand contact" (Sam & Berry, 2010). In the process of acculturation, adaptation may include shifts in behavior, attitudes, and identity as one experiences psychological (e.g.,

self-esteem) and sociocultural (e.g., acquiring a new language) changes (Sam & Berry, 2010). As opposed to phasic, reactive conceptualization of immigrants' experiences that starts with a cultural encounter and ends with an outcome of a new identity formation (e.g., Garza-Guerrero, 1974), the acculturation framework recognizes that in the process of adapting, individuals vary greatly in both how they choose to engage and are able to have access to participate in the process. Four "strategies" are posited with respect to how individuals acculturate, depending on their attitude and orientation toward their original culture and the host culture: (a) assimilation, which is characterized by a wish to relinquish aspects of the original culture and a wish to interact with other cultures; (b) separation, which is characterized by a desire to retain their original culture while avoiding interactions with other cultures; (c) integration, which is characterized by a desire to both maintain the original cultural identities while also interacting with other cultural groups; and (d) marginalization, which is defined by a lack of interest or having little possibility in retaining their original culture or interacting with others (C. L. Williams & Berry, 1991). With experiences of marginalization, discrimination, exclusion, and other forms of oppression, the strategy is not a chosen one but often times one that is "enforced" (Sam & Berry, 2010).

Discrimination and acculturation strategies are inextricably linked: Not only is discrimination the most powerful predictor of poor psychological and sociocultural adaptation for immigrant individuals (Jasinskaja-Lahti et al., 2006; Missinne & Bracke, 2012; Schmidt et al., 2014), but those who encounter and experience higher rates of discrimination are also likely to avoid interacting with other cultures (i.e., separation), akin to a kind of "mutual rejection" (Berry, 2006). Experiences of hostile attitudes from those of the host country, such as pressure to assimilate and adopt the dominant language, beliefs, and customs, are also factors that can

exacerbate psychological distress (Yakushko, 2009). While most immigrant individuals prefer an integration strategy—that is, individuals prefer to hold onto salient attachments of country of origin while also acquiring new ones of the country of residence, others may not have choice in the matter, especially when dominant groups, by way of attitude, practice, values, and xenophobic policies may prevent immigrants from gaining access to communal resources (Berry, 2006). When immigrant individuals are constrained in their choice of strategy, a lack of "fit" between personal preference and actual strategy results, and the accompanying acculturative stress may lead to a host of mental health challenges, including depression, anxiety, and other serious mental illness (C. L. Williams & Berry, 1991). Constraints and barriers to adjustment are often exacerbated for those who may not have legally authorized documentation status, as well as for those who are racial minority immigrants.

Documentation Status

There are approximately 11 million immigrants who live in the United States who are living either temporarily or permanently without proper documentation by way of having a permanent resident visa or temporary work visa (Garcini et al., 2019). The U.S. government formally recognizes those without documentation as "illegal aliens," which is dehumanizing and inaccurate (Autin et al., 2018). While 67% undocumented immigrants in the United States are from Mexico and Central America, individuals from all parts of the world may lack legal documentation (Migration Policy Institute, 2020). Without legal documentation status, individuals lack access to basic necessities, such as a social security number and driver's license, which renders them unable to legally work (Autin et al., 2018). Such constraints can render undocumented immigrants more vulnerable to exploitation and economic hardship, including poverty (M. Hall & Greenman, 2015).

Lacking the possibility of daily social protections and safety, the uncertainty and fear of retribution, including being detained and deported, serve as existential threats that immobilize, limit, and restrict their daily lives, experiences which are consequential for immigrant individuals' mental health (Garcini et al., 2016; Solheim et al., 2016). Restrictions and limitations are sometimes exacerbated by state-level laws that target and are more hostile towards immigrants, such as that requires police officers to check the documentation status during an unlawful stop, should status be perceived as suspect (e.g., Senate Bill 1070 in Arizona, Toomey et al., 2014). These macro-level policies are consequential for psychological health and well-being, as demonstrated by Hatzenbuehler et al. (2017) who examined the relationship between the climate of state-level policies and Latino/a mental health in 31 U.S. states and found that those who lived in states with more restrictive and exclusionary laws (e.g., immigration, health care) experienced worse mental health than those who lived in less restrictive states (Hatzenbuehler et al., 2017). Further, a recent study found that almost 20% of Asian Americans experienced "legal acculturative stress," or stress owing to legal status and fears of being deported (Singh et al., 2017). This stress is not limited to the individual, as family members of undocumented individuals also experience the increased psychological burdens of worry, fear, and mistrust (Dreby, 2015; Torres et al., 2018).

As a highly stigmatized and hidden population, those who are undocumented live with a sense of "voicelessness" and invisibility that is further exacerbated by their relative lack of reprieve or access to support and resources (Garcini et al., 2016; Torres et al., 2018). Documentation status, which is considered a "concealable" stigma, may also impact the level of supports one has, as those with concealable stigmas are shown to have less social support while also more likely to internalize negative attitudes about themselves (Chaudoir et al., 2013). Fear

of retribution also makes research on this subpopulation difficult, and is therefore limited (Heckathorn & Cameron, 2017). Among relevant inquiries available, it has been shown that for undocumented Mexican immigrants, the magnitude of loss, particularly in the realm of loss of home, friends, and family experienced by those who do not have the prospect of returning to their homeland is extremely high (Garcini et al., 2019). Additionally, those who are undocumented also experience longer separation from their homeland, friends, and family with no pathway to freely return to the United States once they leave (Garcini et al., 2019).

Access to mental health is particularly challenging for undocumented individuals; as such, they are far less likely to utilize mental health services despite equal or greater need compared to nonimmigrant individuals (Derr, 2015). Given that most undocumented individuals are from a lower socioeconomic status and that many are uninsured—45% of those who are undocumented are uninsured (Kaiser Family Foundation, 2020)—disparities have and continue to exist. When in treatment, a unique challenge that accompanies this concealable stigma is the decision to disclose. Fear of consequences can be a powerful influence for undocumented immigrants, who may decide not to seek or utilize mental health care, leading to delays in diagnoses and worsening mental health (Singh et al., 2017).

Documentation is a matter of social policy that has direct, deleterious consequences for those who are constrained from access to opportunities and resources that are otherwise accessible to others. While this issue is conceptualized as binary—as in, one either does or does not have the requisite legal status—Hatzenbuehler et al. (2017) posited a "spectrum of citizenship" in order to capture even the insidious, indirect harm of laws that disseminate "a language of social exclusion that generates stigma and discrimination, and undermines feelings of belongingness, a core human need" (p. 170).

REM Immigrants and Mental Health

Racial and ethnic minority immigrant individuals make up 80% of the first-generation, U.S. adult immigrant population (Pew Research Center, 2015; Tikhonov et al., 2019). REM immigrants experience discrimination on account of their physical or language traits that are based on stereotypes in the host country (Singh et al., 2017). As such, they endure the harmful psychological impact of racism in greater magnitude than do White immigrant individuals (APA, 2012; Tummala-Narra, 2020). Indeed, a meta-analysis of studies regarding perceived discrimination and well-being revealed that effect sizes were significantly moderated by racial groups such that the well-being of those belonging to racial minority groups (i.e., Blacks, Asians, Arab/Middle Eastern, Latino) were impacted by perceived discrimination (Schmitt et al., 2014). Furthermore, longer time spent in the United States does not mitigate, but rather seems to exacerbate such discrimination-based distress, as manifested through higher rates of anxiety and depression (Perreira et al., 2015).

While visible racial differences render REM immigrants more likely to experience racism and xenophobia (Espenshade, 2000; Wimmer, 1997), language fluency and quality of accent are also often signifiers for the same (Yakushko, 2010a; 2010b). Studies show that regardless of immigrants' education level or accomplishments, accents are used to make judgments about both their intelligence (Bresnahan et al., 2002; J. Edwards, 1999; Gluszek & Dovidio, 2010) as well as quality of character, including credibility, integrity, and trustworthiness (Hosoda & Stone-Romero, 2010; Lev-Ari & Keysar, 2010). While U.S., racialized perceptions of what is deemed appropriate has created privilege for the U.K. English accent, accented language from elsewhere has been used as a basis for discrimination in employment, education, and health care, among other services (K. W. Jones, 2001; Yakushko, 2018).

REM immigrant individuals are less likely to utilize formal mental health services than nonimmigrant individuals, instead turning to other resources such as family, friends, or religious leaders for support (Derr, 2015). Structural barriers such as language, high cost of services, and lack of health insurance have been identified as impediments to access (Bridges et al., 2012; Derr, 2015). Although immigration status (i.e., foreign-born versus U.S.-born) was not specified, a review of epidemiological studies that included adult Latino refugee populations (Cabassa et al., 2006) demonstrated a similar significant trend in underutilization. Additionally, an aggregate study of multiple large-scale studies—one of which included interview translations for respondents in Spanish, Mandarin, Cantonese, Tagalog, and Vietnamese (Alegría et al., 2008)—showed that REM clients are far less likely to receive any mental health treatment for depression. A review of the accompanying qualitative data found that some respondents also reported mistreatment and experiences of social exclusion from their providers, signaling mistrust and lack of cultural sensitivity (Alegría et al., 2008).

For REM immigrants who are not proficient in the English language, communicating with a therapist can be a barrier to service. While approximately 22% (67.3 million) of the U.S. population reportedly speak a language other than English at home (Batalova et al., 2020), only 10.8% of U.S. health service psychologists are able to provide services in a language other than English (APA, 2016). Albeit there are very few studies regarding the impact of the use of language interpreters in therapy, what inquiries have been conducted have shown its potential to lead to inaccurate assessment and diagnosis without appropriate bilingual interpreters with bicultural sensitivity. For example, Price and Cuellar (1981) found that when their bilingual/bicultural mental health professionals reviewed videotaped interviews of 32 Mexican American participants—each of whom were interviewed in both English and Spanish

separately—the reviewing raters found that participants disclosed more and expressed significantly greater amounts of symptomology in Spanish rather than in English, as had been demonstrated by other studies of their contemporaries (e.g., Marcos et al., 1973). The difference, the authors surmised, could be accounted for by the use of bilingual/bicultural raters for both language interviews, versus the use of Spanish-speaking raters and English-speaking raters separately for their respective interviews. While the therapeutic relationship does not seem to be impacted by the use of an interpreter, clients seem to express a greater preference to be treated by a bilingual mental health provider (Villalobos et al., 2015).

Moreover, REM clients may manifest culture-specific conceptualizations of distress that could be misinterpreted or misdiagnosed if clinicians do not properly attend to culturally sensitive assessments (Sue & Sue, 2016). At the same time, over-relying on stereotypes or generalized knowledge about REM groups without attending to within-group variation can lead to "diagnostic overshadowing," or the practice of overemphasizing diversity characteristics at the cost of attending to important individual, client-level attributes (Vontress & Jackson, 2004).

Immigration and the REM Therapist

As opposed to classic psychoanalytic theory, wherein immigration status has been treated as more of an environmental condition that serves as context and is less significant than the mind that is embedded within (Ainslie et al., 2013), the APA recognizes the psychological importance of immigration and delineates practice recommendations as "psychologists are, and increasingly will be, serving immigrant adults and their children in a variety of settings" (APA, 2012, p. 3). Psychologists, also, are immigrant individuals. Even though immigration as an identity factor was not captured, REM psychologists accounted for 16% of the psychology workforce in 2016, which was a 92% increase since 2007 (9%; Lin et al., 2018). While Immigration status and

experience as it relates to *therapist* are equally salient as they are to the client, little has been inquired about how this impacts the therapist or the therapeutic relationship.

The Immigrant Therapist and Psychotherapy

In their discussion of the challenges of immigrant psychoanalysts, Akhtar (2006) pointed out the notable lack of writing capturing the *immigrant* psychoanalyst perspective emanating from formidable figures (e.g., Sigmund Freud) who immigrated to the United States from European countries during the Second World War. The author (Akhtar, 2006) surmised that the "reluctance" to consider sociocultural factors on one's work as a psychotherapist was in part a function of prevailing notions that largely attributed distress to unresolved childhood conflict. Others (Ainslie et al., 2013) posited that given that the impetus for leaving their homeland was due to the need to flee the Nazi Holocaust, such silence on the topic may reflect efforts to cope with their "traumatic dislocations" and the "vicissitudes of the experience of immigration" (p. 664). This coping may have involved a desire to deny differences between themselves and their clients as a way to assimilate professionally (Akhtar, 2006).

The interpersonal, co-constructed "intersubjective space" (Ainslie et al., 2013, p. 665) that marks the therapeutic encounter necessitates that therapists also engage in self-understanding of all identity factors, including the psychological importance of one's immigration experience and status. Kissil et al. (2013b) posited that the experience of being "not from here" is qualitatively different and a domain of a therapist's identity that cannot be wholly accounted for by variables such as race, ethnicity, or even the experience of being a minority. Similarly, Akhtar (2006) wrote that "being human and coming from a particular racial, religious, linguistic, and political group, the immigrant analyst undeniably has a cultural dimension to his or her personality, and this is indeed normal and healthy" (p. 25).

Very little exists in the way of inquiries of therapists as immigrants and how it impacts the therapeutic encounter. Thus far, it has been shown that foreign-born therapists who feel more fluent in the English language perceive themselves to be more clinically self-efficacious (Kissil et al., 2013a). Perceived self-efficacy is also impacted by the degree to which foreign-born therapists perceived their clinical supervisors to be multiculturally sensitive, as those who rated their supervisors to be higher in multicultural competence also had greater clinical self-efficacy (Kissil et al., 2015). Additionally, immigrant therapists who perceive prejudice from their environments on account of their skin color, accent, or being a foreigner perceived themselves as having weaker clinical skills compared to their counterparts (Kissil et al., 2013a; Kissil et al., 2015). These two studies are the only known quantitative studies that have investigated the clinical experiences of immigrant therapists.

Several unpublished dissertations have explored the topic of therapists who are immigrants, including a study of couples and family therapists who identify as first-generation immigrants in the United States (Niño, 2013). Participants (self-identified, one Black therapist, one Hispanic therapist, one mixed-race therapist, one White/Semitic therapist) noted that as immigrant therapists, they occupied simultaneous positions of power and marginalization for being both the subject of prevailing societal stereotypes, as well as for being the professional providing therapy for clients in their time of need and vulnerability (Niño, 2013). Some participants also noted that when working with clients who are immigrants, therapists found that they were acting as "cultural brokers" between their client and their systems. A term first used by anthropologists, cultural brokering as used in the medical and mental health fields is the act of both bridging individuals of different cultural backgrounds, as well as advocating on behalf of an individual (Fadiman, 2012; Jezewski, 1995). In a separate study that examined immigrant

therapists' experiences working with White clients, participants identified broaching the topic of differences as important for their work, with some speculating that increased comfort with engaging in such discussion was a function of changes in their own acculturation level (racial and ethnic identities of participants were not specified; Isaacson, 2002). Both aforementioned dissertation studies focused on immigrant therapists who arrived in the United States after the age of 18. In a different dissertation study that focused on immigrant therapists' bilingualism and the use of language in clinical work with immigrant children, the author found that for immigrant clinicians who worked with immigrant children, being an immigrant invoked transference responses (e.g., admiration and identification in placing the immigrant clinician in a role model position). It also served as a salient catalyst in invoking strong countertransference responses characterized as personal, "empathic relatedness," and "empathic recognition, attunement and identification" when clinicians remembered or reconnected with their own experiences, including feelings of loss (Sella, 2006, p. 277).

Akhtar (2006) noted the same potential for a finer, "intuitive empathy" for immigrant therapists who work with immigrant clients while he also warned of the possibility for "nostalgic collusion" for immigrant therapists who had not fully engaged in a self-examination of their own experiences of immigration-related loss. In a case study of three immigrant clinicians in Israel—two from Ethiopia and one from Russia—providing therapy to immigrant adolescent clients from their respective countries of origin, Yedidia (2005) illustrated that the clinicians either overidentified with their clients' distress or had difficulty managing elements of their own distressing experiences of adapting to their new country that were represented in their clients.

The influence of ethnic and cultural identity as core projective identity features of the both the client and therapist was emphasized by Comas-Díaz and Jacobsen (1991) in their

discussion of what they termed "ethnocultural transference and countertransference," wherein the authors posited that interethnic and intraethnic transference and countertransference are the direct influence of cultural, social, and political experiences of both the therapist and the client. Among the interethnic countertransference experiences are (a) a denial of ethnocultural differences, or a belief that all patients are the same; (b) the "clinical anthropologist syndrome," or an overly curious stance at the expense of the needs of the patient; (c) feelings of guilt and pity, particularly for those with lower social position; (d) feelings of aggression, especially for those who repeatedly evoke guilt; and (e) feelings of ambivalence, which can be a reflection of the therapist's own ambivalence towards their own ethnocultural identity (Comas-Díaz & Jacobsen, 1991). Comas-Díaz and Jacobsen (1991) also gave particular focus to intraethnic countertransference experiences that can occur for ethnic minority therapists who perceive a shared history of oppression and discrimination with their client. Among these are (a) overidentification, in "us and them" mentality renders the therapeutic space a "shared fortress" against perceived common threats; (b) distancing, which may be a strategy used to prevent overidentification; (c) ambivalence, as a result of intensified feelings regarding the therapists' own experiences oppression and discrimination; (d) anger, as a reflection of painful issues that may be uncovered; (e) survivor's guilt, for those therapists who overcame economic hardships; (f) alternating feelings of hope (for improving the lives of clients) and despair (for lack of guilt); and (g) "cultural myopia," or an obscuring of things as they are due to an "unconscious collusion" (Comas-Díaz & Jacobsen, 1991). The potential vulnerability for this "shared ethnic scotoma" (Shapiro & Pinkster, 1973, as cited in Akhtar, 1995) is one that Akhtar, a first-generation, Indian psychotherapist echoed when delineating the potential challenges that he and other immigrant therapists face in intraethnic dyads.

Some clinicians have written first-hand accounts of their own experiences as immigrant therapists working with ethnic minority immigrant clients and have touched on some of these theorized transference and countertransference elements. As a first-generation immigrant therapist from Iran, Mirsalimi (2010) reflected that their Iranian clients seek advice or a cure, likely due to cultural projections of the role Mirsalimi encompassed as a wise elder. More recently, in response to the divisive 2016 U.S. presidential election and the heightened collective fear of immigrants that has precipitated, Tummala-Narra (2020) added to the existing literature that argues for the preeminent salience of attending to sociopolitical contexts within the therapeutic encounter as xenophobia and racism are "key aspects of clients' and therapists' identity and relational life, and critical to physical, psychological, and spiritual self-preservation." As it relates to practice of therapy with clients, the author posited that therapists must reexamine the multiple layers of their lived experience:

> [U]nresolved personal conflicts with sociopolitical conditions, accompanying feelings of guilt, shame, envy, rage, and fear, histories of sociocultural trauma, internalized stereotypes and prejudice, and more broadly, public discourse on issues of race and immigration, and how these various layers manifest in the clinical process. (p. 51)

In their own examination of their work as a first-generation REM immigrant therapist from India, Tummala-Narra (2020) presented a case vignette that accompanies her own emotional reflections as she works with an Asian Indian female client's ambivalence regarding her own dark skin tone and internalized messages regarding caste, class, and gender. In the process of "bearing witness" to the client's account, Tummala-Narra (2020) related experiencing sadness and anger with her client's expressed disdain toward other Indian immigrants of a different caste,

empathy towards her experience with colorism in India, and curiosity regarding their own role as the therapist:

> I wondered about my particular role as a therapist in exploring what I view as the pathology of racism and casteism, and whether my personal wish to stand against racism and casteism interfered with knowing more fully their experiences of race and caste. I continued to reexamine my own life history with regard to xenophobia, racism and casteism, and my identity as an Indian American immigrant. (p. 59)

Summary

This chapter included an overview of the historical racialization of immigrant individuals and groups in the United States insofar as it is inseparable from present-day sociopolitical dynamics that impact relationships between and within groups and relationships. A contextualized overview was provided through the lens of RCT, a relational framework, and EMMCPP, an ecological framework. In the field of psychology, researchers and scholars alike have illuminated the importance of attending to the racial and ethnic identities of clients, while recognizing that the psychological and physical effects of racism impact REM immigrant individuals, in addition to the multiple stressors that accompany the experience of immigration. The present discussion has also highlighted the gaps in psychological research as they regard both the *scholarship for* and the *perspective of* non-White therapists, and especially those who are REM immigrant therapists.

CHAPTER THREE

METHOD

This chapter will articulate the principles of grounded theory (GT) research, starting with a brief discussion of the paradigmatic roots. Additionally, a rationale for why GT is a good fit to explore REM immigrant therapists' perceptions of their experiences with REM immigrant clients will be provided. A detailed discussion of procedures, participants, method of data collection, interview questions and format, as well as method of data analysis will follow. Finally, the positionality of the researcher will be discussed, consistent with fundamental GT practice of acknowledging and locating the researcher's generalizations and standpoint (Charmaz et al., 2018).

Grounded Theory

This study employed a constructivist paradigm using a qualitative, inductive GT design. The constructivist approach contrasts sharply from the positivist paradigm, which rests on the view that there is one true, objective reality that is knowable through explanation, prediction, and control (Ponterotto, 2005). Positivism undergirds strict reliance and adherence to the scientific method, whereby systematic observations render an a priori hypothesis, which is verified through a controlled experimental study, results of which are statistically analyzed to confirm or reject the hypothesis (Cacioppo et al., 2004). Rather than an "externally singular entity," constructivism holds that multiple and equally valid realities are constructed by individuals (Ponterotto, 2005). Therefore, the aim is to understand the "lived experiences" of the phenomena being investigated (Starks & Brown Trinidad, 2007).

GT was first developed by Glaser and Strauss (1967) with the primary intent to expose new insights and understanding from the participants' complex and lived experiences. GT

methods and strategies have been adopted widely in a variety of fields and is deemed as the most influential paradigm in social sciences research (Fassinger, 2005). The GT approach allows for an in-depth examination of participants' experiences, delineates strategies for flexibility and adaptability as the research unfolds, and makes explicit that no research is purely inductive—that is, coding, conceptualizing, and creating theoretical categories are the researcher's "renderings of a reality" (Charmaz, 2014). Throughout the GT research process, an iterative, constant comparison method is undertaken by way of collecting data, coding, categorizing, and comparing categories with each new data until new properties of categories cease to emerge (Charmaz, 2014). GT methods and tools are especially apt for uncovering the roots of "implicit meanings, actions, and larger social processes of which people may be unaware" by centering individuals' experiences and connecting them to macro-level structures and processes (Charmaz et al., 2018).

The current qualitative study is a response to Singer and Tummala-Narra (2013), who gathered the narratives of White therapists' perceptions of their experiences working with REM immigrant clients in order to understand the therapeutic relationship with regard to this specific therapeutic dyad. The current research inquiry aims to explore REM immigrant therapists' perceptions of their work with REM immigrant clients with a particular focus on how systemic issues of power and race are addressed and experienced in the therapeutic relationship. Relational-cultural theory (RCT; Miller, 1976) and the ecological model of multicultural counseling psychology processes (EMMCPP; Neville and Mobley, 2001) were chosen to contextualize the therapeutic relationship and to use as explanatory frames. That is, given the multiple, interacting, therapist-relevant and client-relevant systems, which are all influenced and encapsulated by an overarching, racialized macro-level milieu (EMMCPP), how does the REM

immigrant therapist in working with the REM immigrant client experience relational opportunities and challenges as they experience connections, disconnections, and attempt repairs? Due to the unexplored nature of the present research question, GT's methodological flexibility and structured analytic procedures allow for the possibility that while initial design will inform data, emerging data may also inform design. Additionally, given that these relational processes have been so understudied—and even less so from the viewpoints of REM immigrant therapists—generating contextualized, explanatory categories that are as "experience-near" (Fassinger, 2005) as possible is critical for adding to and advancing an inclusive conversation of what therapists know, and how they practice culturally competent care.

Data Collection

Participants

Quality GT design is based on a set of criteria that first includes a sound rationale for selecting the original sample of participants (Strauss & Corbin, 1998). My initial goal was to interview 12-14 REM immigrant therapists currently licensed as psychologists and practicing in the United States. Because the number of interviews is predicated on the saturation of emergent categories (discussed in detail in procedures; Charmaz, 2014), the exact number of interviews were to be informed during the data-gathering and coding process so as not to exceed 14 interviews. All self-identifying, non-White, racial, and ethnic minority individuals who also self-identified as immigrants (i.e., first-generation and later immigrants) were considered and included to account for experiences unique to REM immigrant individuals. That is, even when native-born in the United States and regardless of citizenship status or length of stay, REM individuals are perceived as immigrants and foreigners (C. C. Lee, 2018; Sue & Sue, 2016). Additionally, while past research questions that explore the acculturative process and changing

identities of immigrant therapists have narrowed the scope to first-generation immigrants who located to the United States as adults, the present study, which aimed to explore the perceptions of relationships, relied on therapists' own perceived self-identity and social locations owing, in part, to their subjective experiences. Rich accounts as it pertains to the present inquiry may also be more fully gleaned from those therapists who perceive that their immigrant identity is a salient factor that influences the therapeutic relationship.

Instruments: Demographic Questionnaire and Semi-Structured Interview Guide

Participants were asked to complete a demographic questionnaire (Appendix A) regarding general information, immigration experience, and clinical work. Participants were asked to self-identify their racial/ethnic identity, immigration status (e.g., first-generation, second-generation, etc.), age at emigration, and reasons for immigration via open-ended questions. Additionally, information regarding participants' clinical training practice were gathered, including the type of training, emphases of training, years of clinical experience, and language(s) used.

Grounded theorists often use intensive interviews to capture lived experiences, which in turn are the data to be analyzed. Charmaz (2014) defined intensive interviewing as a "gently guided, one-sided conversation that explores a person's substantial experience" (p. 56) and noted that interview guides should start with broad, open-ended, non-judgmental questions that simultaneously focus a topic while leaving open the opportunity for unanticipated stories to emerge. Interview questions should be relatively short and facilitate conversations with purpose (Morrow, 2005). Additionally, Charmaz (2014) provided specific questions for researchers to utilize in vetting for quality and appropriate interview questions, some of which include:

- To what extent does the interview guide elicit the research participant's views, concerns, and accounts of experience?
- To what extent does the interview guide reflect my views and interests instead of the participant's experience?
- Will the interview guide address the purpose of the research?
- How will these research questions sound to someone who has had this experience?
- Have I worded the questions in terms that the research participant would use or understand?
- Are the questions clear and concise?
- Have I thought of probes that will follow up on the general questions? Are any of my probes too intrusive? (p. 65)

The central aim for the present study sought to explore the experiences of REM immigrant therapists who work with REM immigrant clients, specifically utilizing relational-cultural and ecological theories as orienting lenses. Theoretical perspectives provide a frame for the qualitative researcher to guide formulation of questions as well as the approach for collecting and analyzing data (Creswell, 2009). Utilizing RCT and the EMMCPP lenses as points of inquiry and analysis, I was specifically interested in addressing the following questions in relation to the experiences of REM immigrant therapists in their practice with REM immigrant clients:

- How do REM immigrant therapists perceive their relationships with REM immigrant clients?
- Do they address issues of race, racism, and power and, if so, how?
- What behaviors and processes lead to successful relational connections? How do they know?

- What behaviors and processes lead to relational rifts, and how do they attempt to repair relational ruptures, rifts, and disconnections? How do they know?
- How do they perceive their professional roles, and what contributes to their perceptions? Does this shift and, if so, why?
- What strategies, resources, and practices (both personal and beyond) do they perceive to be most helpful in their practice with REM immigrant clients?

After careful review of the original interview questions used by the first author of Singer and Tummala-Narra (2013) in the original dissertation study (Singer, 2012), I opted to start with mostly all of the original interview questions as was used by the researcher (Appendix B). The set of questions satisfied the criteria listed by Morrow (2005) and Charmaz (2014) and addressed the purpose of the present inquiry. Two additional questions were added (where indicated) and only minor modifications were made to wording as appropriate. As recommended by Fassinger (2005), I conducted a pilot interview with a participant who fit the participant criteria but was not included in the study as a way to ascertain the fit and adequacy of the interview questions and to revise as needed.

Participant Recruitment

Initial participants for this study was recruited by utilizing a mixed approach of chain sampling and network sampling to identify psychologists who had interest to partake in the study. I started asking faculty members of the Radford Counseling Psychology Department, as well as clinicians from the local university counseling center, for suggestions in recruiting currently practicing psychologists who fit the initial sampling criteria and may have an interest in taking part in the study. In order to preserve validity and prevent "contagion" between the researcher and the researched (Davies & Dodd, 2002), second-degree contacts were sought by

asking suggested contacts for participant recommendations whenever possible. Additionally, recruitment announcements (Appendix C) were emailed to mental health facility directors to distribute to clinicians in their facilities. Saturation of theoretical categories supersedes sample size (Charmaz, 2014); as such, my goal was to interview 12-14 participants, or until theoretical saturation was reached, but no more than 14.

Prior to the initial interviews, participants were informed of the purpose of the study (Appendix D), expected length of time (60-90 minutes) for the interview, and the possibility that they may be contacted for future follow-up interviews. Upon agreement to participate, interviews were scheduled to be conducted via telephone or video due to schedule or travel constraints. All interviews were recorded using the data recording software, Otter.ai, while transcribed data were analyzed line by line using Excel spreadsheets. Additionally, participants were given an opportunity to review their transcripts in order to ensure accuracy and maintain rapport.

Data Analysis

Data Transcription and Analysis: Open, Axial, and Selective Coding

Interviews with each participant were recorded and transcribed using the software, Otter.ai. I engaged in a simultaneous process of collecting data and conducting analysis towards the goal of creating successively abstract categories; that is, those groups of data that share conceptual properties were subsumed under new, general categories (Fassinger, 2005). Specifically, data were compared (a) from different individuals; (b) from individuals to their own data at distinct and separate points in their own narratives; and (c) from conceptual categories to other categories (Fassinger, 2005). As the "bones" of analysis in grounded theory, coding is the process of defining what the data is about with names, giving particular focus to actions and processes. These names show how I select, separate, and sort the data to commence an analytic

account (Charmaz, 2014). Three levels of coding—initial, axial, and selective—were undertaken in both a phasic and recursive manner, as opposed to a strict sequential format, in following with the constant comparison method (Fassinger, 2005). At the initial level of coding, each transcribed interview was examined from units of meaning as they arose from my interactive analysis of them, ranging from as small as a word to whole paragraphs (Fassinger, 2005; Morrow & Smith, 2000), I looked for sensitizing concepts, or points in the data that indicate "action, meaning, process, agency, situation, identity, and self" (Charmaz, 2014, p. 117) and whenever possible, utilized gerunds to help give meaning to implicit and latent concepts. At this level of coding, I analyzed the data using questions such as the following: What process is this illuminating? How do I define this process? How does this participant think, feel, and act during this process? How does this process develop? How does this process change, and why? (Charmaz, 2014, p. 127).

At the axial level of coding, properties and dimensions of categories are identified so as to ascertain relationships among categories (Strauss & Corbin, 1998). At this level of coding, categories were compared and links between categories were developed by utilizing Strauss and Corbin's (1998) organizing scheme to think about the conditions under which interactions or processes take place; actions and interactions, or the participants responses to problems and events; and consequences or outcomes of the interactions. Categories were also compared to new data to determine whether categorical saturation was reached. Saturation of categories is achieved when categories are "robust" because no new properties of existing categories are found (Charmaz, 2014). While some have criticized axial coding for being too structured and proscriptive, Fassinger (2005) contended that this step is crucial for delineating context and conditions under which interactions and consequences ensue.

The final level of coding entailed a focused coding process in which central categories are selected to integrate all other categories into an assembled, explanatory whole (Fassinger, 2005). As with the other levels of coding, the emerging theoretical categories were compared to the data to ensure that it is grounded in experiences of participants while also compared to the existing literature to ensure explanatory power (Fassinger, 2005).

Memo-Writing and Reflexivity

In order to document and monitor the ways in which researchers engage with and analyze the data, GT researchers stress the importance of interacting with one's thoughts and ideas as they occur early and often by way of writing informal, spontaneous memos (Charmaz, 2014). To this end, I engaged with an interactive journal to track methodological dilemmas, decisions, and rationale for making these decisions. Additionally, I engaged in memo-writing during and after data collection, as well as through each level of the coding process in order to make explicit reasons and rationale for making comparisons and connections between data, between data and categories, and between categories and categories. Reflexivity, or engaging in self-examination of the researcher's own ideas and judgments (Davies & Dodd, 2002), is a core feature of GT research. Memo-writing facilitated this process, as well as ongoing discussions with team members and key advisors (e.g., research chair and coding team members).

Positionality and Expectations of the Researcher

Charmaz (2005) contended that no analysis is neutral: "We do not come to our studies uninitiated" (p. 510). As such, both the imperative and utility of positioning oneself as the researcher is to admit that "what observers see and hear depends upon their prior interpretive frames, biographies, and interests … the questions we ask of the empirical world frame what we know of it" (Charmaz, 2005, p. 509).

My own immigration story, education and training, clinical experiences with clients as an emerging counseling psychologist, and experiences of occupying marginal and privileged spaces all inform my worldview on the topic of what it means to be a racial and ethnic minority immigrant in the United States. In 1992, I was 6 years old when my family immigrated from South Korea to the suburbs of Ohio. While I was initially glad to trade in routine familiarity for all that I had gained, including new friends and the joy of acquiring a new language, I observed the toll of loss and stress that draped over the daily experiences of my other family members, as well as other adults in the small circle of immigrants in my community. My two older sisters and I took turns translating for my parents in all aspects of life—car repairs, doctor's visits, job interviews, parent-teacher conferences, and even racial epithets that were spray-painted on our house siding. By the time I became a naturalized citizen at the age of 12, othering experiences had become features of my daily interactions. As an undergraduate student at the University of Michigan, I was surrounded by a sizeable minority of Asian Americans, including Korean American and international students. While it was the first time that I experienced the joy of kinship and belonging when speaking my mother tongue with friends, it was also the first time that I felt an unexpected otherness based on socioeconomic and educational differences between me and my parents who were manual laborers, and my Korean peers, whose parents were not. These experiences have been formative to the ways that I attend to issues of power and privilege, as have been my experiences interacting with racial and ethnic minority students and their immigrant parents as a New York City public school teacher. In this setting, I observed the insidious impact of colorism when my students teased others with explicit remarks that incurred valence on the darkness or lightness of one's skin. How and to what extent I should intervene

was complicated by my own Asian identity and the fact that our lived experiences were very different.

Very early in my counseling psychology practicum experience at the local university counseling center, I worked with a client whose status as a REM immigrant added to questions I was already grappling with as an emerging clinician. Their status as a DACA recipient added to the layers of questions; specifically, how do I address issues of race, racism, and power with my non-White clients when I myself am not White? When I initiate these conversations, where am I locating myself in terms of my identity, and where am I assuming I belong? When I perceive power differentials that are not wholly accounted for by my role as "expert," from where does it emanate, and why? Additionally, how do I make sense of my perceived shifting role from session to session, and how does this impact the therapeutic relationship? These same questions loomed in my successive interactions with other REM students, including with Asian American students.

Amid this experience, I came across the published research article, "White Clinicians' Perspectives on Working with Racial Minority Immigrant Clients" (Singer & Tummala-Narra, 2013) and contacted the main author upon learning that it had been the topic of their dissertation. Rachel Singer, who is now a practicing licensed psychologist, stated that while her initial sample had been all clinicians, the data-gathering process had illuminated vastly different narratives and accounts between White clinicians and REM clinicians. Singer related to me that with the advice of their dissertation chair, the study was narrowed to focus on the experiences of the former group, while reassured that future research would tackle the latter (Singer, personal communication, February 27, 2020). My conversation with Singer was encouraging and came at

a time when I was unsure about whether my ponderings were simply anecdotal or may have reach and relevance for others.

While these personal experiences are important, my educational experiences are equally relevant to my positioning. My social work training and research activities with professors have been instrumental to solidifying a social justice lens in my outlook and worldview, specifically as they pertain to the question of *whose voice is not being heard?* This means that I naturally gravitate towards relational-cultural and ecological theories of human development. Additionally, the continued emphasis on social justice and diversity as core tenets of counseling psychology have prompted me to continue to ask this question in my personal, academic, and professional life and engage in critical discussions of the same with advisors, supervisors, and colleagues.

Rennie (2004) added to the definition of reflexivity as "self-awareness, and agency within that self-awareness" (p. 183, as cited by Morrow, 2005). Bracketing these experiences and influences are done with the goal of making the implicit explicit to myself and to others. Throughout the process, I engaged in reflexivity by asking myself the following questions: How does my worldview impact the research process and, specifically, whose perceptions are being described in the findings? I engaged in memo-writing and continued to reflect and keep notes in a methodological journal. Additionally, I consulted regularly regarding my findings with my research chair, committee members, and coding team. At the outset, my expectation was that REM immigrant therapists would have different experiences from what was captured by Singer in 2012. The present inquiry was an attempt to glean answers to the ways in which they differ.

Conclusion

In an attempt to explore the perceptions of REM immigrant therapists and their experiences of working with REM immigrant clients, a constructivist GT design was employed using strategies outlined by Charmaz (2014) and Fassinger (2005). While a new, substantive theory is the ultimate goal, the unexplored nature of the current question leaves room for the possibility for a "constructed interpretation of a list of categories" (Fassinger, 2005), or what Strauss and Corbin (1998) referred to as interrelated, "well-developed categories" that explain the "who, what, when, where, why, how, and with what consequences an event occurs" (p. 22). This kind of theoretical frame that may fall short of substantive theory still has utility in advancing a representative, inclusive conversation for future researchers to build upon.

CHAPTER FOUR

FINDINGS

The present exploratory study is grounded in constructivism and aims to present the lived experiences of racial and ethnic minority (REM) immigrant therapists who work with REM immigrant clients at this contextual, temporal juncture in the United States. This chapter presents a discussion of the resultant codified and categorized data that was derived from grounded theory (GT) framework and tools for analysis. Based on 12 individual, in-depth interviews, the discussion of these results answers the main research question: "How does the REM immigrant therapist in working with the REM immigrant client experience relational opportunities and challenges as they experience connections, disconnections, and attempt repairs?"

Characteristics of the Participants

Twelve REM immigrant psychologists completed the interview for this study. Not all respondents expressed interest in participating in the interview. This was due to a variety of reasons, which potential participants identified, including lack of fit with regard to the defined criteria as well as scheduling conflicts for interviews. Preliminary information regarding participants' demographic information as well as immigration history and clinical experience was gathered via a uniform demographic form; results will be presented here in aggregated format in order to preserve the privacy of participants. Additionally, self-identified terms were preserved in the exact ways that participants described themselves and their experiences (Table 1).

Table 1

Demographic Characteristics of Participants

Demographic Characteristics	n (%)
Age	31 – 45
Gender Identity	

Female	6 (50%)
Male	6 (50%)
Racial Identity	
Asian	8 (67%)
South Asian	2 (17%)
Asian American	1 (8%)
Asian and LatinX	1 (8%)
Ethnic Identity	
Chinese	3 (25%)
Chinese American	2 (17%)
Southeast Asian	1 (8%)
Southern Chinese American	1 (8%)
Chinese/Pakistani	1 (8%)
Filipino	1 (8%)
Korean American	1 (8%)
Latina	1 (8%)
Years Lived in the U.S.	9.5 – 30
Age of Immigration	4.5 – 22
Immigrant Status	
First-generation	7 (58%)
1.5-generation	2 (17%)
Expat	1 (8%)
No terms used	1 (8%)
Type of Psychology Graduate Training	
Ph.D. Counseling Psychology	5 (42%)
Ph.D. Clinical Psychology	3 (25%)
Psy.D. Clinical Psychology	2 (17%)
Psy.D. Counseling Psychology	1 (8%)
Languages Used in Psychotherapy	
English	7 (58%)
English, Spanish	1 (8%)
English, Urdu	1 (8%)
English, Mandarin	1 (8%)
English, Cantonese, Mandarin	1 (8%)
Current Clinical Setting of Practice	
Private Practice	4 (33%)
Group Private Practice	2 (17%)
Medical Hospital	2 (17%)
Community Mental Health	1 (8%)
College Counseling Center	1 (8%)
Region of Practice	
Urban	8 (67%)
Urban/Suburban	2 (17%)
Suburban	1 (8%)
Rural	1 (8%)

Note. $N = 12$

Participants' ages ranged from 31 to 45, and the mean age of participants was 36.5. Six participants identified as male (50%), while six participants identified as female (50%). Eight participants (67%) identified their race as Asian, two participants (17%) identified as South Asian,

one participant (8%) identified as Asian American, and one participant (8%) identified as Asian and LatinX. With regard to participants' ethnic identities, three participants (25%) identified as Chinese, two (17%) participants identified as Chinese American, one participant (8%) identified as Southeast Asian, one participant (8%) identified as Southern Chinese American, one participant (8%) identified as Chinese/Pakistani, one (8%) participant identified as Filipino, one (8%) participant identified as Korean American, and one (8%) participant identified as Latina.

Years lived in the United States ranged from 9.5 to 30. Age of immigration ranged from 4.5 to 22 years old, while seven participants (58%) identified as first-generation immigrant, two participants (17%) identified as 1.5 generation immigrant, one participant (8%) identified as an "Expat," and one participant (8%) did not use any terms to identify their immigration status. Reasons or impetus for immigration to the United States included education (n = 6), economic reasons (n = 2), economic opportunities (n = 1), and financial (n = 1), while two participants did not respond (n = 0).

All participants received their psychology graduate training in the United States. Five participants (42%) received training from a Ph.D. Counseling Psychology program, three participants (25%) received training from Ph.D. Clinical Psychology program, two participants (17%) received training from a Pys.D. Clinical Psychology program, and one participant (8%) received training from a Pys.D. Counseling Psychology program.

Finally, with regard to the language clinicians use to conduct psychotherapy with their clients, six participants (50%) identified only English, one participant (8%) identified English and Spanish, one (8%) participant identified English and sometimes Urdu, one participant (8%) identified English and Mandarin, and one (8%) participant identified English, Cantonese, and Mandarin. Four participants (33%) identified their current clinical setting as private practice, two participants (17%) identified their setting as group private practice, two participants (17%) identified their setting as a medical hospital, one participant (8%) identified their setting as community mental health, one participant (8%) identified their setting as a college of medicine, and one participant (8%) identified their setting as a college counseling center. Seven participants (58%) identified their region of locale as urban, two participants (17%) identified their region as urban/suburban, one participant (8%) identified their region as suburban, and one participant (8%) identified their region as rural.

Procedures

Prior to commencing with interviews, a pilot interview was conducted with one participant, after which questions on the semistructured interview guide were altered for clarity. Interviews were conducted over the course of approximately 13 months in the participant's chosen format of audio-only or video and ranged from 50 to 90 minutes in length (M = 77). With the prior expressed and documented consent of each participant, interviews were recorded using the data recording software, Otter.ai. Before commencing in the data coding process, all identifying information of participants were excised from the data. In order to preserve confidentiality, participants were asked to choose a pseudonym to be used for direct quotations. Additionally, a copy of the cleaned transcript was sent to each participant in order to ensure

accuracy and to invite participants to add, modify, or delete data for the purpose of preserving their and their clients' confidentiality.

Data Analysis

In order to initiate the process of becoming intimately familiar with the data, I listened to the recordings and transcribed all interviews before sharing the transcripts with my graduate coding team members, which included a coding partner and a debriefer. Both team members identified as White, female, counseling psychology graduate students who have and continue to work with clients who identify as REM immigrant individuals. To optimally prepare for the coding process using the grounded theory approach, I prepared a guideline that was shared with my team members and also engaged in a norming process with the first three pages of the transcribed interview. This norming process entailed a brief study of GT rationale and coding methods, initial engagement with the transcribed interview as independent coders, after which the team met to discuss how and why initial interpretations diverged, as well as strategies and rationale for keeping codes succinct and active. During this meeting and meetings thereafter, I engaged in reflective dialogue with my team members regarding my role, my identity factors, and the possible power dynamics that might interfere with an objective and systematic process of analysis. After individually coding the entire interview of the first transcript, we had extensive meetings to examine and engage in dialogue line by line, code by code, while keeping detailed process notes until we reached complete consensus. To ensure fidelity and accuracy of the coding process, the finished codes of the first transcript were also reviewed by the chair of my dissertation committee.

In the process of individually coding the first three transcripts, I met weekly with my coding partner to engage in ongoing reflexive discussions to clarify conceptual depth and verify

emerging categories, all towards the end of improving the coding analysis. After the third transcript was coded and analyzed collaboratively in this manner, it was determined that a satisfactory level of consensus was achieved such that we agreed that ongoing systematic meetings for discussion were no longer necessary such that I compared and contrasted my and my coding partner's individual codes, only to contact my coding partner to clarify where interpretations were in conflict.

Coding Process: Grounded Theory

In keeping with the GT (Charmaz, 2014) inductive approach to data analysis, a constant, recursive, and interactive process of defining, comparing, categorizing, and contrasting ensued from the first line of the first interview. During the initial coding phase, I analyzed line-by-line each participant's narrative account while giving attention to the participant's chosen language—the granularity of difference in words and phrases, to start the definition and interpretation from the participant's perspective rather than my own. Given the focus of the present research topic, accurate intensity of how participants feel, think, behave, and experience their interactions were preserved and examined closely for what was stated and unstated. Memo-writing after interviews and initial re-reading of transcripts functioned as a critical element to my reflexive interaction with my thoughts, ponderings, and ideas (example memo, Appendix E). With each subsequent interview, data was compared (a) from different individuals; (b) from individuals to their own data at distinct and separate points in their own narratives; and (c) from emerging conceptual categories to other categories (Fassinger, 2005). As larger categories seemed to subsume initial codes, I analyzed the categories for "thick descriptions" (Morrow, 2005)—that is, the multiple layers of culture as well as context (e.g., conditions, consequences, and responses) under which the described phenomena occurred in order to determine the relationship between categories (i.e.,

axial coding). Throughout the process, the question of "[w]hat larger analytic story does this indicate" (Charmaz, 2014) was constant and key to eventually raise and create abstract conceptual categories that accurately represent the phenomena under study (i.e., selective coding).

Quotations

In order to preserve authenticity of language and verbal style of the participant, verbatim direct quotations were preserved whenever possible. To enable fluidity and easier readability, repetitions of words were deleted, as were certain utterances including "like," "sort of," "um," and "you know." Additionally, I utilized guidelines from the 7th edition of the American Psychological Association Style Manual when using ellipsis to indicate omitted words within a quotation. Relatedly, a period and an ellipsis were used to indicate a sentence break within omitted words. Explanations within quotations that were added were included using brackets. Finally, quotes are followed by participants' chosen pseudonyms and their line of code as indicated in the research teams' coding manual.

Overview of the Data

The collective, coded narratives yielded an analytic framework comprised of 13 open categories and six axial categories across four selective categories (Table 2). The first focused category illuminates the person of the REM immigrant clinician with regard to participants' voiced aspects of their immigration and acculturation experiences in the United States, as well as broad and specific elements of their work as clinicians that participants regard as overwhelmingly positive. The second focused category, which is the largest and most significant, explores participants' views of the clinical relationship as they relate to three domains. The first domain in this category encompasses clinicians' descriptions of their felt and sensed connections

with their REM immigrant clients; strengths, skills, and what is enabled in the therapy room by virtue of the identities and experiences of the dyad, as well as participant's use of disclosure and broaching that contribute to trust and rapport building. The second domain explores participants' attention to intersections of identity and experiences, particularly as they relate to their and their clients' assumptions and aspects of power and privilege in the therapy room. The third domain highlights participants' experiences of relational challenges, as well as their perceived sources of such challenges. The third category captures participants' views of their and their clients' navigation of intercultural and intergenerational tension as they intersect with systemic and institutional challenges and barriers. Included in this category are also discussions of the ways participants viewed as helpful for their ongoing navigation and work. Lastly, the fourth category illuminates the role of reflexivity in the REM immigrant clinicians' work with their clients, including *in vivo* reflections of tensions and insights, as well as explicit acknowledgement of the interview, the researcher, and the research in providing yet another space to engage in reflection.

Table 2

Focused, Axial, and Open Categories

Selective	Axial	Initial
I. Person of the REM Immigrant Clinician	A. Before and Beyond the Room: REM Immigrant Identity as Backdrop	1. To be a REM Immigrant in the U.S. 2. To Be a REM Immigrant and Clinician in the U.S.
II. Experiences of the Relationship	B. "In Our Own Living Room": Experiences of Connections	3. "More Than What's Visible": Feeling, Sensing, Perceiving Connections 4. What is Enabled: Knowledge, Skills, and Strengths as REM Immigrant Individuals 5. "Two Well-Practiced Individuals": Broaching and Disclosure

		C. Attending to Intersections of Identities and Experiences	6. Guarding Against Assumptions 7. Power in Role, Privilege in Identities
		D. Relational Challenges and Ruptures	8. Difficult Emotional and Psychological Reactions
III.	Navigating Barriers, Negotiating Tensions	E. "Contextually Driven" Clients and Clinicians	9. Clients, Cultural Tension, Conceptualization and Clinician's Role as Intertwined 10. Where Barriers are Embedded in Systems and Institutions 11. Ongoing Navigation: Helpful Sources and Resources
IV.	Reflection as Catalyst; Catalyst for Reflection	F. Ongoing Reflection	12. Past, *In Vivo*, and Future Reflexivity to do "Good Work" 13. Views of the Researcher and Research in Relation to Self

The following is organized with detailed discussions of initial codes in subsections as a function of their axial and focused categories. Each category will be explicated with illustrative quotes and references to literature, where available and relevant.

I. Person of the REM Immigrant Individual and Therapist

A. Before and Beyond the Room: REM Immigrant Identity as Backdrop.

1. *To Be a REM Immigrant and Therapist in the United States.*

All participants in this study invoked aspects of self, vis-à-vis their immigration story and acculturative experiences—both positive and negative, as well as awareness of self in the eyes of others, mainly their REM immigrant clients. Given that some participants voiced sensitivity to confidentiality of themselves and their clients, the degree and detail to which participants described such personal accounts varied. Nonetheless, this category emerged as particularly

important as it illuminates the ways in which participants experience connections and empathy with their REM immigrant clients, feel empowered, knowledgeable, or skillful to utilize strategies in the therapy room, as well as the ways in which participants view themselves in relation to their work in the larger macro context.

Several participants invoked experiences and illustrations of navigating identity development and acculturation as immigrant individuals in the United States. One REM immigrant participant cited their own difficulty navigating adolescence in the added context of immigration as formative for their decision to pursue psychology: "There is a rich experience that I've gone through myself that really contributes into understanding more kind of deeper experiences without my clients having to explain every single detail if I were to be a White clinician, for example. (Heather, 6)Like Heather, another participant acknowledged that "operating in the background" of who they are and what they do as a clinician is the feeling of a broad "common experience" with their REM immigrant clients insofar as "[t]he people who have come here trying to build a new life or are seeking a better life, just like me and my family did" (Charlie, 41). With more detail, another participant recounted a core narrative experience as a young immigrant child while living with their grandmother in the United States:

> I was the one with my grandma and my sister, I was the one doing all the interpreting with my grandma. I was the one who had to be responsible and make sure I did all my homework. So, I was pretty much alone and had to be self-driven, because there was not a lot of people to guide me because my family wasn't here…Because I know how hard that was for me not to have anybody telling me what to do or giving me information to say, hey, this is an option for you, or have you thought about that? Giving me ideas or

> opening up my world a little bit more. I feel like I can do that for them [clients]. (TM, 423)

This participant further elaborated their view of experiencing a reflection of themselves in their clients, noting, "I see myself in them. So, it's, like I'm helping an earlier version of me. Does that make sense?" (TM, 421). The invocation of an early version of self was similarly voiced by another participant, who recounted their sense of feeling "isolated," "marginalized," and remembering a time when they were "looking forward to when I can get married and marry someone named Smith and I would not have to deal with people mispronouncing my name all the time" (Esmy, 225). For this participant, the specific act of doing psychotherapy in Mandarin with their clients who voiced their preference to do so was described as—among other things—a "healing" process:

> I think that each one of those moments has been a healing experience for me as a Chinese American immigrant child. And I use child very intentionally because a lot of times the wounds that we have on identity are childhood wounds, especially when you come in childhood. … When you go through that in therapy … a process of, over and over, you're telling yourself, it's okay to be me; It's okay to be you. It's okay to be Chinese. It's okay to be Chinese American. It's okay for you to speak Chinese in this way. And it's useful, and it's worthwhile, and it's powerful. And you are you, and that is great. (Esmy, 210)

Further illustrations of identity development as immigrant individuals in the United States were described by other participants in the added context of experiences of discrimination, hostility, or xenophobia. One participant spoke of their fear of "developing an accent," such that they stopped speaking the language of their country of origin at a young age, as well as their perception in the eyes of others as a perpetual "visitor" who also has and continues to experience

microaggressions as they relate to a denial of their ability to own their identity as a "Southern Chinese American" due to their racial identity (Esmy, 8). The notion of being perceived as a "perpetual foreigner" (Michelle) was echoed in various ways by participants, who noted that they had to learn to "read the room" (Heather)—a strategy that they now view as a nuanced skill for therapy—as well as "walking in the skin of otherness" (Vanessa) or their "sense of otherness" as a linchpin of their sense of self that is "never going away" (Charlie). As noted by Vanessa:

> I'm not part of the majority culture and also I'm part of the LGBTQ community, so you know, I'm kind of a double threat [laughs]. And I also look the way I look. I think if I was one of these sort of very feminine looking women, it would be different and I would pass as straight, but I don't. I'm kind of built like a tank and I wear collared shirts. You see me walking and I often get misgendered. And so, I look like that … and I walk in the skin of otherness and that's what I've chosen to do, and I'm [age of participant] years old and I've been doing it a while. (Vanessa, 161)

This participant expressed their awareness of "what I bring to the therapy room when people walk in and shake my hand" such that their style is "pretty open and direct" (Vanessa, 162). The awareness of self in the eyes of others—that of what is visually and audibly perceived by others—was invoked by four other participants (Leslie, Raymond, Yasmin, Stephen) who described, in various ways, their cognizance of "how they look," how they talk or do not talk with "an accent" or, for one participant, the fact that they do not wear a "hijab" (Yasmin). This aspect of awareness—at times noted as the reasons for which their REM immigrant clients "seek them out" specifically—was especially influential for how they viewed race and culture as always "salient" in the therapy room, as well as if, when, and how participants chose to make self-disclosures to their REM immigrant clients to assess for fit, assumptions, and to build

rapport, topics which will be addressed in more detail in later sections. Still yet, another participant's awareness of their phenotypical presentation was salient not just for the therapy room, but for the ways in which their Asian presentation affords social and cultural privileges in the context of an academic and professional institution, in contrast to the "offensive" and "stereotypical" perceptions that their Black colleagues suffer due to the persistent milieu of "anti-Blackness" (Esmy) in America. Such awareness also had implications for this participant's perception of their role in the macro setting.

Beyond specific illustrations, experiences of navigating intercultural and intergenerational challenges by virtue of having immigrated to the United States at specific points was voiced as especially meaningful and powerful for two REM immigrant family therapists (Jack, Yasmin). Yasmin, who moved transnationally multiple times throughout her childhood, articulated their own perception of self as having a "complex identity and upbringing" with "firsthand experience of what it's like to move and start over, and try to fit in" as well as the added experience of being the "eldest of four" children such that they could deeply empathize with the perspectives of both the immigrant parents and their young children and teenagers (Yasmin, 177).

Still yet, two other participants who came to the United States at later ages to pursue their own graduate training noted slightly different aspects of their awareness of self and how such awareness informs their clinical approach with REM immigrant clients. One participant noted their experiences and observations in their country of origin, such as the existence of a meta-narrative in their country of origin that is cast upon all who immigrate to the United States as "exotic" and "can't fail" (Stephen, 273), of having "absolutely hated military service" experience (Stephen, 177), and observing their parents, who still reside in their country of origin, as "docile

Asian parents" who give all authority to medical doctors (Stephen, 155)—all of which influences and informs the ways in which they empathize, check for assumptions, or build rapport with their REM immigrant clients. Further, while identifying minority psychology literature (e.g., David Eng, professor and scholar of Asian American studies, among other topics) as a resource for them, by virtue of how "growing up has been sort of complicated," this participant also expressed their perception that "I don't feel like I fit in those books, either … I wish it could be more helpful" (Stephen, 285). Notably, another participant described viewing it as "weird" to call themselves an "immigrant" due to how the word is "associated" for them:

> I guess for me, it, it always is really associated with like, I'm moving my whole family or I'm moving to the U.S. for better opportunities and so on and so forth, and my current circumstance from where I'm coming from is not doing so. For me I just saw, well I have to go to grad school, and psychology is better recognized in the States. So, I'll come here. So that was after Bachelor's, which I did in [name of country]. (Raymond, 18)

The preceding quote captures this participant's perceived dimensions of unit (i.e., "whole family" versus the individual) and function (i.e., "better opportunities") as particularly salient for what it means to label oneself or another as "immigrant." As well, this same participant articulated that they are also "currently going through acculturation issues with some of the social expectations in the States versus places I've been to," which is a point of identification and connection with their clients, further elaborating:

> The sort of focus on sort of identity theory and that's something that I definitely feel a difference at times. It's not something I see very heavily. You know, I've never been made so aware of my identity and my cultural values as since I've been to the States. (Raymond, 56)

The preceding quote is compelling as the participant seems to vocalize a loss of agency, similar to an imposition on their identity such that it is illustrative of the process by which individuals who come to the United States "become differentially racialized" (R. Chang, 2000; Sanchez & Romero, 2010). That is, categories and labels such as "Black," "Hispanic," and "Asian" are assigned in such a way that individuals and groups are forced to assimilate into a system of racial stratification not formerly assigned to them in their countries of origin (Bashi & McDaniel, 1997).

Finally, two participants described their felt sense of their role and purpose that emanated from what it means personally for them to be a REM immigrant individual in the United States. While describing the way in which they navigate their various roles in and outside of the clinical context, one participant acknowledged that "the work I do as an Asian American clinician" is "backdrop" and "doesn't necessarily escape" such that "who you represent as a clinician is embedded in who we are, extension of the personal understanding of who we are" (Michelle, 106). Similarly, another participant articulated their hopeful sense of "being a positive example" for their clients as an individual and member of a community who also "immigrated, who adapted to living here, who found a place, and made friends and created a family" (Charlie, 218).

2. Positive Views of Self in Relation to Work.

Overwhelmingly, REM immigrant participants articulated positive views of their work, themselves, and their REM immigrant clients, at times alluding to the depth of personal value and regard by the use of the word "love," invoked by five participants (Michelle, Leslie, Jack, Yasmin, TM), at times invoked multiple times. Jack articulated, "I love working with immigrant families … I can identify with some of the struggles, some of the successes, some of the accomplishments" (4). Relatedly, another clinician voiced, "I get to do what I love. This is the

blessing that I get to work with these people, that we have this shared experience" (TM, 493), while another also invoked their desire for future work by articulating, "I want to see even more REM patients" (Leslie, 337). Participants also articulated a sense of what is returned or gained for themselves by virtue of their work with their REM immigrant clients by way of invoking such words as "exciting," "fulfilling" (Yasmin, 324), "blessed," and "rewarding" (TM, 187), especially in the context of experiencing congruence between purpose and practice, as in, "this is the population that I really wanted to work with, serving my people. So, it's wonderful that I'm able to do exactly what I planned to do, that I worked so hard for" (TM, 484). A similar sense of feeling that their work is "rewarding" (Jack, 60) and feeling "amazed" (Vanessa, 62) was invoked as especially so when observing improvement in their clients' well-being and functioning.

Several participants also voiced their perception of viewing their work as "important" and "meaningful" (Jack, Michelle, Heather), while for one participant, this sense of meaning was also connected to their sense of feeling "useful" to be able to offer an aspect of self to others that is *unique* to who they are:

> I feel very useful that there are people that I can offer something, and it's something that needs to be through me and my identity, me as a person. Let's say, other White clinicians wouldn't be able to do this, so that's very empowering. I hold it as this kind of special and unique gift that I can share. (Heather, 56)

This participant voices recognition that the sharing of the gift is by virtue of the other half—the REM immigrant clients—specifically that which is shared between themselves and their clients. Said another participant, "We have endured changes and we've also in some ways proven our

resiliency through those changes. And there's almost a sense of, we're grounded in this strengths-based perspective" (Michelle, 11).

The sense of sharing and joining in was invoked as well by three participants, who all voiced a feeling of "pride" (Leslie, Charlie, Michelle) in their shared identities and backgrounds, as well as the "versatility" and the need to be even more "adaptable" for immigrant individuals.

Several participants voiced their appreciation of the "multifaceted," "nuanced," and "complicated" and "complex" parts of their REM immigrant clients and their work (Stephen, Raymond) such that they also appreciated their work broadly (Yasmin) or specific elements of their work (Jack) as simultaneously "challenging" or "not the easiest" (Heather, 7). Relatedly, these nuances and challenges were cited as having been a "very positive experience" in recognizing "what I don't know" (Stephen, 305), a "humbling" experience to be reminded of "the amount of things that I need to keep knowing and understanding" (Jack, 119), and "a good reminder" for the "work I need to do to stay up to date in terms of the literature, techniques and resources" (Yasmin, 71).

Finally, several participants voiced equally intense sentiments toward their work in reaction to certain aspects or behaviors of their REM immigrant clients. Notably, TM articulated similar sentiments of feeling "blessed" to be able to work with their REM immigrant Haitian, whom they also described as "resilient" and "strong" and from whom they feel they "learn and grow" in addition to their felt sense that "they accept me, which is great" (TM, 192).

II. Experiences of the Relationship

B. "In Our Own Living Room": Experiences of Connections.

3. "More than What's Visible": Feeling, Sensing, Perceiving Connections.

All participants spoke at length about how they feel, sense, perceive, and experience themselves in connection with their REM-I clients with regard to both broad generality as well as specific moments. Participants described feeling "instantly closer" (Michelle, 7; Leslie, 58), experiencing "immediate connections" (Michelle, 34) or perceiving "instant credibility" (Jack, 6) and "automatic" safety (Michelle, 71) or "automatic presentation that shifts" even within the clinician (Heather, 20) as they perceive a "sisterhood" with their clients by virtue of shared immigrant experiences. One participant described the connection as one that is "bidirectional" and felt mutually that they cherish and value highly:

> I love being able to instantaneously have that point of connection with my clients, in the sense of, despite all the other demographic characteristics that might be different between us, we can have the shared experience from the get-go. … We can kind of agree that that experience in many ways shapes us, sometimes even outside of our own awareness. (Michelle, 7)

Michelle's description of the felt "point of connection" that transcends demographic identity differences was echoed by another REM immigrant clinician who described feeling as if "the match is faster, or better, or stronger" at times when working "especially with immigrant students that are not from my same ethnic or racial, cultural background" by virtue of shared immigrant identity (Esmy, 40).

Specific "moments of connection" or "points of connection" were described similarly by participants with context for how they, for example, "identify with" (Jack, 10) and "relate to"

(Yasmin, 172) their clients' struggle of navigating intergenerational, intercultural tensions, "relate to" acculturation issues (Raymond, 202), "relate to the challenges" of being separated from family (Leslie, 62), "resonate" and "connect" with the immigrant individual's "sacrifice" and difficult emotions of REM immigrant clients who express "anxiety" or "sense of otherness" (Charlie, 46).

Several participants described moments of connection felt in the absence of "what's visible in the space or being articulated" such that they experience a "specific affinity" for those who without having to say much, get it" (Michelle, 12), a moment of understanding that is sensed in the form of an "unsaid, 'you get it moment'" (Yasmin, 249), or a "touchpoint" moment of "Oh, you get it" (Esmy, 51), exemplified by a moment of interaction with their REM-I client by another participant:

> And we were finishing up our session and I said, well, you have to really do me a favor and have longoniza sausage for me because that is amazing. And her eyes lit up and she said, you know longoniza? And I said, oh man, I've got a bad habit for it, but I can't get it here. And she was like, I'll have a double helping. And I was like, Great, thank you. And we laughed about it. But in that moment there was clearly some connection, and she didn't probe further, you know? She didn't ask me how I knew about it. Because it wasn't what she needed, but there was this moment of like, okay cool. You know what I'm talking about. (Vanessa, 89)

REM immigrant participants' descriptions of such moments seem to allude to sensed connections that emanate specifically from what is *not said*, similarly to the descriptions of connections that are "automatic," "immediate," or "instant" that are sensed from time that is *not passed* such that the experiences of connections between REM-I clinicians and clients may be

innate and inherent in the shared identity and experiences of immigrants themselves. To this point, two REM-I clinicians expressed the challenge of describing the felt sense of connection. Michelle described the relational experience as encompassing an "intuitive component" (61), at times connected to—among other things—the shared understanding of "implicit" messages and meanings of phrases and words, while also adding, "I can't quite explain it and can't quite put my finger on it, which is what I think your study's about" (45). Similarly, Esmy described a "touch moment" that is accompanied by "when the rapport is there on the immigrant level, there is always that kind of like, you know, ET-phone-home kind of moment [laughs], where you touch something" (45).

> Because we have a moment. I don't know what I would call this like, maybe in your research, you'll come up with a term for it. There's a moment of like, uh, of like identity connection. There's a moment of like when you touch fingers in a way that often is on that immigrant level. And I think it can come from any little thing. It also comes from like a shared immigrant experience. (Esmy, 41)

The sense of challenge, difficulty, and even allusiveness of words that the preceding two participants expressed are notable. In their work about the ways in which immigrant individuals discuss personal stories via online forums, a philosophy and communications researcher noted that the meta-narrative of migration as "happy movers" has compromised the ability to discuss or express certain emotions: "The mythologization of migration effaces its difficult parts and also the formulation of affective descriptions of this experience. Perhaps not fortuitously, English words such as nostalgia or homesickness did not exist before the seventeenth and eighteenth century, respectively" (Chitoiu & Cogeanu, 2021, p. 183). While not exactly in the realm of nostalgia or homesickness, what Michelle and Esmy seem to desire to label is the presence of

something in the context of *loss*, perhaps also evoking an emotion that contains both positive and negative valences.

Several participants expounded upon the experience of connection by describing their internal emotional experiences in the moments of connection. The felt internal emotional experience of these connections was described by two REM-I clinicians as being one of a "nice" and "quite pleasant" sense of "familiarity" (Michelle, 7; Raymond, 57) and also is simultaneously felt with "hopefulness and a solidarity" (Raymond, 55) when working with especially those families who are "not rooted in the States." Another participant expounded upon this notion of familiarity as "joy in recognition" that elicits "smile, laughter, softness, warmth" (Esmy, 64) for the clinician, which could be compared in the following way:

> And this does feel a bit like, accidentally encountering an old friend on a road and having a bit of that surprise joy and soft wave of like, hey, Oh, that's so nice to see them walking down. … And you see on the other side, maybe even if you can't reach them, or can't cross the road to say hi, you see an old friend from college or something. And you just see some recognition, that joy work that comes over as you say hi, and then move on. That's kind of the feeling that you get. (Esmy, 70)

The observed and articulated impact on their REM immigrant clients was commented on by several participants who cited observing a "sense of relief and astonishment" (Charlie, 166) and a "sense of relief and joy" (Esmy, 67, 82) as well as a "sense of being understood" communicated via "unspoken" behaviors, such as a "knowing laugh, change in posture, or a nod" (Michelle, 52) from their clients when they feel heard and connected.

4. What is Enabled: Knowledge, Skills, Abilities, and Strengths as REM-I Individuals in the Room.

Both universal and specific experiences of being a REM immigrant individual renders specific elements of "understanding," "knowing," "having," "recognizing," "anticipating," and being able to "use," "contribute," and "include" that REM immigrant clinicians describe as being consequential for how they experience themselves, their clients, and ultimately, what is "enabled" in the relationship, including further credibility, rapport, and trust building.

By virtue of their bicultural identities, three participants described their ability to "share knowledge" (Michelle, 117), which was described as a matter of "checking in with them as to what their understanding of the situation or the cultural artifact that they were having challenges with. And then really trying to correct for misunderstanding or filling in gaps" (Michelle, 122). Another clinician described it as a "blessing" to be able to use the "knowledge power" they have to give their clients "education, like why are you feeling this way, this is depression, anxiety, this is normal, this is not normal, this is what you can do about it" (TM, 287). As a clinician who works with children and families, one participant described their awareness of and ability to help a young Asian family and "give knowledge to understand" a mental illness and behavioral implications as it occurs for a young child. The family's gap in knowledge was recognized as a potential function of lack of exposure or awareness in their own country of origin: "And being able to give them you know, the knowledge to understand what that's like was great" (Jack, 59). For this REM immigrant participant, knowledge capacity was also supplemented by their nuanced ability to observe the family's "high context" communication style:

> Asian cultures in general, you just don't rely on what they say because Asian families definitely—their communication style is very high context. You don't just listen to what

> they say, but what they do and how they say it. And so, if you're not really careful in being observant of that, you might miss something. And I'm sure I have missed certain things. I think with this family, I had a pretty good working relationship and I think I'm fortunate enough to be Asian and to be immigrant that I was able to use that to maintain my credibility with this family but think that that can be a challenge with non-ethnic minority therapists or psychologists. (Jack, 31)

The participant theorized that knowing, observing, and understanding yet another layer of the "emotional" challenge that the young family faced—that of the potential high expectations that immigrant parents may have—were strengths and skills that were just as important as their identity factors to maintain credibility in the eyes of the family in being enabled to help the parents "set realistic expectations," which ultimately proved to be helpful for the family and "rewarding" for the REM immigrant participant. In their work with a REM immigrant parent, another REM-I family clinician described being able to "anticipate," "verbalize," and "articulate the rationale" for the differential expectations and rigor in the U.S. schooling system, compared to that of their country of origin, such that what they were able to "contribute" an element beyond simple validation for building rapport: "I felt that because of that, there was an understanding that she knew where I was coming from and that I had some experience and some understanding of what she was trying to communicate" (Raymond, 77).

Communicating specific emotional challenges by way of being able to "recognize," "name," and "reflect" were described by two participants, who also described the process as occurring simultaneously with deepening of empathy for their clients. Leslie described their interaction with a REM immigrant client who disclosed their inability to be with their family overseas after they had experienced a loss.

> That's something I've experienced myself too. … And I think that was helpful for me to provide validation and support for the patients. And also again, validate their feelings of perhaps guilt, which I felt in myself in the past as well. I think my experience of being an immigrant definitely helped me to better connect and understand, possibly the emotional experience of the client. And I was better able to name that emotion in the room with the patient. (Leslie, 79)

Another REM immigrant clinician described a moment of understanding in an encounter that allowed them to reflect back to their client the specific emotions of "sadness" and "disappointment" such that it was perceived by the participant that the client "felt heard" and was able to feel more "comfortable":

> When she would talk about the challenges that she had, and the things that made her sad in her life, which was really … how she lived here—losing her husband and being estranged from her children—that really resonated with me. Because I've grown closer with my own family, but I think when I was younger and sort of struggling with my own identity as an immigrant here as well, trying to acculturate and assimilate in a different way, I could resonate with her sadness, in terms of that lost connection with our children, especially when you come from a culture where family is so important. (Charlie, 134)

The experience described by Charlie seems to indicate that the emotional recognition transcended the need to identify with a specific parallel experience and may, rather, be contingent on a lived emotional understanding of the overarching themes of the immigrant experience or, as one participant labeled it, an understanding of the "common constellation" of the "emotional impact that those experiences have on the individual" (Michelle, 49).

To further elucidate this point, Michelle and several other participants described specific moments of experiencing mutual access to a "common language" that enables the clinician to understand and use "shorthand," "mnemonics" and "heuristics" without having to "explain and give a dissertation":

> A statement like "mama issues, I'm having mama issues" encapsulates so much from an immigrant's perspective. There are moments like that where just simple phrases become a lot more available for examination because those kinds of things really start to speak to a lot more layers underneath them. (Michelle, 41)

In addition to the general sense of "shared experiences" enabling trust building "much, much quicker" (TM, 412), Michelle described such moments as helping "a great deal with trust building" as "it's sort of like you get the sense that they get the sense that you get them, and vice versa" (Michelle, 50). What this participant insinuates is that what is positively enabled by the clinician is a function of what is known, understood, and shared together, between the REM immigrant clinician *and* REM immigrant client, a sentiment echoed by another participant who noted mutual access to the same "shorthands" regarding temporary visa labels and feeling that "it's so awesome to not have to explain it; they can just say the acronym, and I'm like, Oh yea, that's the one where you have to apply for that" (Stephen, 269). Such identification of mutual access to and "joining in a mental schema" regarding immigrant parental expectations for their careers was described by another participant, who highlighted moments of being able to "start counting together" when their clients evoke a common phrase, "my parents say you have to be," which also enables the clinician to "start to chant along" with their REM-I clients—"I'll be like, lawyer, doctor, engineer, right?" (Esmy, 51). This same participant recounted another joint

recognition of a "mental schema" they experienced with their immigrant client from Europe who was preparing to go back to their country of origin to visit their family:

> She was talking about something, and she was like, "Oh yeah, I have to have this suitcase," and kind of was looking at me with like, is she going to understand, because you look like you're an immigrant, but I don't know. And so, she was like, yeah, so I have a suitcase full of just like chocolates. And I was like, "Oh, yeah, I know that. I'm like, you know, you fill it with like chocolate and other "American" things, and you bring it back. And that whole suitcase is just gifts, right?" And she had a moment of like, Ah, Yes, right? [laughs]. And I was like, yeah, yeah, girl we have two when we travel. When we go back, you have your like "gift suitcases" and you have your "clothes suitcases" and those are different suitcases. And having that like laughing moment of like, yes, you understand the chocolate suitcase phenomenon, that opens a door. (Esmy, 43)

This moment of joint recognition of the "chocolate suitcase phenomenon" was perceived by Esmy (43) as creating "immediate trust … a sense of like, I don't have to explain certain things to you; you won't think that I'm exotic, you won't think that I'm weird." (Esmy, 43). This participant, along with two other clinicians, further theorized that what they perceive as enabling trust is not just by virtue of what is shared in the room but also from what the room spares and protects that is "out in the world" (Michelle, 66), specifically for REM individuals whose "racial and ethnic identity stems a lot from this immigrant identity, and that immigrant identity is so founded and stuck in this idea of, you are the perpetual foreigner. You are the perpetual sideline visitor; this does not belong to you" (Esmy, 89):

> We oftentimes are required to put on this kind of exterior of assimilation and whatnot when we go out and you're holding yourself on the sidelines, you've learned how to be a

> visitor. And there's something about like that chocolate suitcase story of when you can laugh about it, then suddenly, you are no longer visiting someone's home or you're like visiting someone's therapy office. I think there's this experience of, we've both packed a chocolate suitcase in our own living room, so we can talk about it together. Now the therapy space is our own living room. (Esmy, 81)

Michelle cited the "classic example" of the oft asked, "Where are you from" as just one of the many questions that "lends itself to having to explain more of who we are, the perpetual questions that make us feel like we're foreigners all the time that automatically puts a guard up for us, in the sense of, it triggers in us, this sense of not fully belonging in the spaces we find ourselves" (66).

> And so, when that guard is down, when we are with individuals who we know to be similar to us in our experiences and our worldviews, we don't have to necessarily give a recitation every single time. And so, there is a fluidity that comes with not having to present in a specific way and using language that others in the majority groups understand. It's like there's less catering to and more of just human connection that comes with engaging in a conversation with someone who we know understands us or gets us. (Michelle, 67)

Perceiving the space as a "two-way street" in which "guards are lowered" was similarly echoed by Heather (32), who also explicitly contrasted this experience from what is felt with their White clients.

What is enabled by mutual recognition and understanding had further implications beyond simply sensing belonging, including some participants' use of self-disclosure as well as

mutually enabled abilities to broach conversations—strategies that are intricately connected—as described in the next section.

5. "Two Well-Practiced Individuals": Disclosure and Broaching.

All REM immigrant participants discussed self-disclosure, which was, for the most part, intricately connected with the topic of broaching discussions regarding race, identity, culture, and context, and the similarities and differences between. The content and nature of disclosures were mostly related to the REM immigrant clinician's identity factors and immigration experiences, while two participants (Leslie, Heather) also gave mention to the disclosure of the clinician's felt emotions. This section will start with a continuation of the preceding category—that is, the ways in which participants perceived both topics as enabled by virtue of immigrant identities and experiences. Participants also articulated the general judgment and conditions under which discussions occur, with varying degrees of descriptions regarding the impact on clients and the relationship.

Three participants (Heather, Leslie, Michelle) explicitly described themselves as using more self-disclosure when working with their REM immigrant clients. Michelle described themselves as feeling "psychologically safer" to be themselves, which includes the ability to engage, "where appropriate," in more self-disclosure: "There is more of self-disclosure related to … I understand where you're coming from. I've been there. And I think that comes with more of a sense of, I can be assured that this person isn't going to negatively critique my credibility as a psychologist as a result" (Michelle, 73). While the fear of being negatively critiqued was not echoed by other participants, a similar need for discernment that emanates from a perceived judgment of interpersonal safety, or lack thereof, were described by other participants under more specific conditions. Heather, an East Asian-identifying clinician, described themselves as

being "more cautious" about using self-disclosure when working with their non-East Asian clients, while Leslie described themselves as being "more comfortable" (Leslie, 100) with disclosing their felt emotional experience as well as information about their own immigration challenges when specifically with clients they know are experiencing similar challenges.

Related to the notion of interpersonal safety, two participants (Heather, Yasmin) described self-disclosure as frequently initiated by their REM immigrant clients who, in most cases, specifically sought out the clinician by virtue of their REM immigrant identity factors such that discussions regarding race, ethnicity, and culture are present at the "outset" (Yasmin, 307). Additionally, one REM immigrant clinician perceived their client's curiosities as connected to "stigma":

> There's still that kind of stigma. So, when they're looking into or start working with me, there's so much more cautiousness and kind of testing the water and a lot of questions and, along with it—I see this as a very culturally relevant factor, like I said most of my REM clients are East Asians or of Korean descent—they ask me for a lot of my personal experiences, opinions, and really pull for the personal side of me. (Heather, 31)

Two other clinicians described the act of self-disclosing and engaging in conversations regarding identity differences and similarities as occurring "all the time" with their REM immigrant clients. For one participant who works primarily with REM immigrant clients, the discussion always starts with asking their clients, "English or Spanish? And if they say neither I ask Creole? And right away, like the fact that we're different is right there up and out in the open" (TM, 233). "I'm coming off with the idea of like, I need to help you, tell me how you came here" (309) and also entails disclosing, "I know the struggle, I know what they're going through because I've been through it, so we have this like, shared experience even though we've

never met before," which creates trust and rapport (TM, 305). The clinician described their setting as a known "sanctuary" in the community, complete with legal resources to protect against ICE being on their grounds (299): "I know that doesn't happen everywhere … So, getting some information about past trauma I ask like, how did you get here? Did you come by plane? Did you come by bus? Did you walk go through the desert? How did you get here? So, they tell me their stories" (TM, 295). For another participant, disclosure was enacted by direct questions from their REM immigrant clients who "were looking for a provider who was of color, or an immigrant background, or Muslim" (Yasmin, 308) such that the clinician's identity is the "first things that the client will typically talk about":

> They want to know what my background is. If they have an immigrant identity, they want to know a little bit more about where I'm from, how long I've had been here what other countries do I have experiences living in. So that's just standard like, "Hi, how are you," conversations for me. (Yasmin, 241)

This participant seems to theorize that both primacy and frequency of conversations regarding identity differences, which may also closely be related to what is traditionally known as broaching "difficult conversations," is not difficult, but rather engaged with a sense of automaticity and ease. Relatedly, for one participant, the awareness that race, identity, and culture are salient and "always in the room" (Jack, 45) was cited as that which also enabled them to broach conversations regarding cultural differences and tensions:

> I think one of the advantages or benefits of being a racial and ethnic minority, you know, health care provider or psychologist is that you can bring that up. … Your [REM-I] families are like, okay, yeah, let's talk about that. Whereas if you're not a minority, they

> might not know how to talk to you about that. They might not be open. Because maybe there's an assumption that you wouldn't understand" (Jack, 70).

Jack appears to insinuate that to "bring that up" is not a solitary, directive act but one that is made possible, in part, by the REM immigrant client's willingness to engage, a willingness that is rooted in an assumption that the REM immigrant clinician has intimate knowledge of what it is to negotiate cultural tensions. Relatedly, Michelle described conversations regarding identity differences as the coming together of two "well-practiced" individuals whose REM immigrant experiences render a need "to negotiate and actually develop those skills in your interactions with people who are different from you in your day-to-day life" (Michelle, 61). The result, according to this participant, is a conversation with their REM immigrant client that is "easy breezy," which was contrasted with their felt sense of having "more trepidation" to broach with their White clients.

While explicitly stated as more enabled by some participants, the clinical judgment to self-disclose or to broach topics of identity differences or similarities was described also by others—including those same participants cited above—as an ongoing "mental process" (Leslie, 97), which sometimes involves "self-monitoring" and self "query" in the form of, "is this self-disclosure for the client or is it for me?" (Yasmin, 243). One participant described their additional consideration of the contemporaneous sociopolitical milieu that may impact their decision:

> So, for instance with these days, there's just been a lot of conversations around racial trauma, and also around what it's like to be a person of color going into the healthcare system. So, I think in some of those scenarios, it's been helpful for clients to sometimes

> hear that I can relate to something that they're saying, based on a minimal self-disclosure. (Yasmin, 243)

Yasmin further commented that discussions of race and identity that are helpful for some REM immigrant clients are also a source of distress for others, specifically for the reasons regarding racial trauma:

> I have had clients of color talk about how sometimes they hate having that question asked, but they've placed it in the context of race and racism in America and wondering if that's being asked to label them a certain way to be treated poorly, versus when I've explained to them like, there's usually cultural pieces that come into play and I'm just asking about what's important in terms of your identity as that helps me figure out how to move forward as well. (Yasmin, 315)

Similarly, another participant described a process of weighing "contextual" factors, which includes a judgment of "when relevant and sometimes, if necessary" (Vanessa, 88) to disclose and broach. Vanessa described their ongoing work with one REM immigrant client who is "whip smart," "very insightful," and as one where "we talk more and more and more about race":

> And our conversations this last year has been, really, the most we've ever had, because she finally feels like she can look around with everything that's happening in the United States right now, politically—Black Lives Matter movement, crazy political situation with the last election—she can finally go, oh yeah, other people feel like this too, it's not just me. She says she's [laughs]—these are her words, okay? She says she's got more woke with each year of therapy. So, I think that is a win. (Vanessa, 63)

With regard to this participant's decision of broaching the topic of race, they added that "when they [clients] are very visibly struggling with issues about race and ethnicity and you're sitting across from someone who looks like me? I mean, you know, to not talk about it would be hypocrisy" (Vanessa, 69). For this REM immigrant participant, discussions of race and ethnicity are stated as imperative in their effort to be honest and sincere, which is also intertwined with an acute awareness of themselves in the eyes of their REM immigrant clients *within* the context of wider systemic challenges that occur outside of the therapy room. Including the above cited potential of the fear of making therapy "more about me and less about the patient," awareness of self in the eyes of their clients was also illuminated as a potential reason for why one REM immigrant clinician does not engage in conversations regarding race and ethnicity: "A lot of times, I kind of assumed that patients know because I look very Asian and I speak with an accent, I assumed that most people would assume that I'm not from this country. And they will know that I'm Asian" (Leslie, 204).

Finally, discussion of self-disclosure of the therapist's felt emotional experiences was explicitly noted by two clinicians. One participant described themselves as frequently "torn" and the decision to disclose as one that is a "dance" that accompanies a question of, "do I share with the patient, or do I not with the patient?" (Leslie, 109). Leslie described their decision to disclose their felt "sadness" and the aftermath of second-guessing, clarifying with their patient, "this is not about me," and eventually concluding, "By them showing empathy or understanding to my experience, I think we were probably sharing some emotions together in that relationship … I definitely think having these disclosures probably brought us even closer in this therapeutic relationship (Leslie, 109). This participant surmises that the act of letting the client know of their

emotional impact on the clinician was one that allowed for "sharing" that enhanced the relationship, despite the lingering tension that seemed to ensue even after the disclosure is made.

A similar initial tension was described by another participant, whose decision to explicitly disclose to especially their Asian immigrant clients, "I'm proud of you, I think you're great. I'm proud of the work that you've done" was in conflict with their supervisor's stance that clinicians should say only "proud for you":

> I remember that moment saying that I don't know if I agree with that. I think that there are times especially when I'm working with my Asian clients that I feel like it's okay to say I'm proud of you because we see ourselves as part of a whole. The best way of understanding our individual selves comes from how we relate to other people. And that may not be damaging, to have an experience of the people around me are proud of me. … A lot of clients I think felt very touched by that and saying, thank you, thank you for giving that to me. Because having to go pull that for myself feels so foreign to me. That's not me, that's not my culture, and it feels wrong, it feels unvirtuous in a Confucian sense. (Esmy, 124)

The above quote seems to indicate that for this REM immigrant clinician, the nuanced understanding of their Asian clients' Confucian values renders the clinician to permit themselves—against prevailing institutional values—to "give" access to a positive emotional experience, which may not be accessible to their clients for themselves. In turn, self-disclosure of the clinician's felt emotional also renders a "giving" back from their REM immigrant clients in the form of gratitude.

C. Attending to Intersections of Identity and Experiences.

6. Guarding Against Assumptions.

For REM immigrant clinicians who work with REM immigrant clients, the awareness of the "ever-present" (Yasmin, 328) potential "hazards of being too similar" (Michelle, 143), that while "differences might make it [therapy relationship] difficult … very close similarities can make it difficult as well" (Stephen, 167) such that REM clinicians need to engage in a "constant work of checking in" (Michelle, 143), was voiced by almost all participants in varying ways. One participant acknowledged their "constant struggle" of "countertransferences" and imposition of their own values that may occur (Heather, 7), while another participant voiced the many occurrences of realizing, "my gosh, me too. I've had that experience too" that demands a "constant staying on top of it" (Yasmin, 321). Yet another participant commented, "I find it's really important for me to not make assumptions, even more than usual," while adding that it is also "the hardest challenge for me as a therapist" (Vanessa, 15). Several participants voiced the importance of "assuming I don't know everything from the start" (Jack, 35), described also as a "humble" stance of "I still don't know. Just wait for this person to tell me their story; I still don't know" (Vanessa, 15). Another participant voiced themselves as requiring "a great deal of humility" to be "okay with not getting it the first time" (Michelle, 57).

"Introspection" and "reflection" were strategies cited by REM immigrant clinicians to discern whether their own "bias" is taking over (Leslie, 352) and "whether or not you're responding to your own stuff, or that of your clients" (Michelle, 143) by virtue of shared identities and experiences. REM immigrant clinicians also voiced an explicit invitation to clients to correct false assumptions (Michelle, Charlie) as well as leading with an acknowledgment of a

"common collectivistic background" before asking, "tell me more about that" (Michelle, 42; Charlie, 123) to "verify" clinicians' understandings.

As well, awareness and attention to intraethnic and intracultural variability—that is, "recognizing even within Asian cultures, even within Chinese cultures, there's a lot of variability. And so, the challenge is really understanding how this family experienced being Chinese" (Jack, 27), for example—served particular salience for how participants safeguarded against assumptions. Another clinician's attention to regional and religious variability was described as that which "warrants a further investigation" when their REM immigrant client states that they identify as Filipino:

> But it depends which island in the Philippines they come from because there's so many different subgroups within the Philippine Islands. So, I have to ask, can you tell me a little bit more about which group you feel matches you more closely? Or—because certain subsections are Muslim, and some are Catholic—and to not assume that they're Catholic because the majority of Philippines is Christian. (Vanessa, 15)

The attention to intracontinental and interracial variability served especially important for three (Esmy, Yasmin, Stephen) additional REM immigrant participants due to, as one participant described it, the "historical and cultural divides" that may ultimately compromise a sense of perceived "safety" (Esmy, 323) for the client. Indeed, one participant described it as "more hurtful" for them as clinicians to harbor assumptions about "what you think they might understand or identify with" such that the need to "center" was noted in the context of their appreciation of the intracultural variability that exists within:

> So even though I look Chinese and that's, you know, that's unavoidable, I think even within Chinese there are so many nuances. There's Malaysian Chinese, there's China,

> there's Taiwan, there's Hong Kong, and there's crazy stuff that's happening now with Hong Kong and China. And I was born in Hong Kong right, and my parents migrated to Singapore. And do I know fully the historical sort of context and trauma of all that? My parents certainly don't talk about it. (Stephen, 166)

This REM participant's inner monologue touches on both what they know—that differences exist—and what they possibly *do not know*—the repercussions of regional historical and ongoing tensions that could possibly impact the relationship between them and their clients in the room. Yet another participant, who identifies as a Pakistani individual, noted their attention to the possibility that their clients who are Indian "may pull back a little bit" such that—though "rare"—the clinician engages the client in conversation:

> With India and Pakistan, it's always interesting because there's like the political divide within the subcontinent. And that India versus Pakistan piece. So, I know with some of my Indian clients, we've never really talked about politics, necessarily, but it is something that has, that may come up at some point … if there has been anything specific going on, for me to remind them that this is about them and it's really not about me and my feelings." (Yasmin, 278)

Another participant described as an ongoing "struggle" their assumption that the clinical "match is going to be phenomenal" by virtue of shared background, noting that clinical match "always depends" and warrants special sensitivity to separate nation's historicity and imperialistic accounts:

> When we have Vietnamese clients, sometimes I feel disaggregation is to recognize, like, yes, we're both Asian, but I'm East Asian and you're Southeast Asian, and your culture may have a lot of history around—I'm the imperial power in the room with you, right?

> It's not going to feel the same. I don't want to make the assumption, like, *girl, we're both Asian*. On one hand, we might. And on the other hand, I want to be respectful of where are those power differentials. (Esmy, 323)

Historical and ongoing accounts of power that may impact a client's sense of perceived safety included, for one REM immigrant clinician who identifies as a Chinese individual, an explicit attention to colorism as it intersects with imperialism:

> I think less so with Black patients and more so with Singapore and Southeast Asia—generally, they're not that great in terms of how they view people with darker skin colors, like how there are Southeast Asians with darker skin colors. So, if I do get someone who's Filipino or Vietnamese or basically anyone who isn't ethnically Chinese, that is something that I mention, that I put out there in the beginning. That even though we are both meeting in [name of American city] in what tends to be a very liberal city, that I do want to acknowledge that my parents may not actually like you. (Stephen, 136)

For REM immigrant clinicians, safeguarding against assumptions of a client's safety not in spite of but *because* of shared identities seem embedded in their own knowledge and awareness of the historical tensions, conflict, and ensuing prejudices that follow and reverberate between two people in a room in a new country, perhaps generations apart from the original source of conflict. But does this matter? And if so, to what degree? Additionally, safeguarding against assumptions seem closely related to attending to clinicians' power and privilege, both by virtue of their roles and their social identities, which will be discussed in more detail in the following section.

Attention to the differences that occur *within* were also identified as important to safeguard against not only the held assumptions of the clinician, but also those that REM

immigrant clients initially come to therapy with. One participant, who also cited their appreciation for the vast regional "nuances" within the Indian subcontinent, described the frequent experience of REM immigrant clients who will say in the first moments of interaction "before I even say anything, 'But you understand, right?'" (Yasmin 254):

> Within the Muslim clients—which encapsulate such a diverse array of ethnic groups and nationalities that come through the door—it sort of like they just put me in that umbrella of, well, we're both Muslim so you get it. … They want that similarity. (Yasmin, 256)

This clinician stated their desire to "want to welcome that" but also needing to clarify, "hey, I may not be as similar to you as you're thinking. What is that going to do for us?" (Yasmin, 252). This same clinician described the need to "monitor" assumptions and expectations of parents of young female Muslim clients who wear a hijab, especially when the presenting concern is related to their religious identity development and even more so when considering that their clients "tend to be much more religious than I am … how would that fit? Is that still going to be comfortable for them, or not?" (Yasmin, 277). With challenge and tension, this participant appeared to voice a level of concern regarding the trajectory of the therapy relationship should the clinician neglect to explicitly clarify what is assumed by the client.

Past the moment of initial contact to assess fit, clients—much like clinicians—have moments of assumptions that occur throughout the therapy relationship. One participant referenced the importance of the connection and rapport of the "dyad" immediately preceding their recounting of feeling "uncomfortable" with a REM immigrant client's assumption regarding their identity:

> I remember one instance—I know this gentleman did not mean to make a comment the way he did—but he made an assumption and I said, "You know, I'm not sure if you

> remember, but I'm married to a woman". And he said, "Oh my god, I totally forgot. That was such a stupid thing to come out of my mouth. I'm so sorry". And I said, "No, we're good. I just wanted to remind you". And he said, "Yeah, sorry about that". You know, and then we moved on. (Vanessa, 165)

The description above seems to touch on the importance of the clinician's comfort just as much as that of the client's comfort in order to maintain connection and rapport of the therapeutic space, maintenance of which involves correcting a client's assumptions about the therapist's identity factors and ultimately depends on the clinician's direct intervention at the moment of perceived misunderstanding.

7. Power in Role, Privilege in Identities.

All REM immigrant clinicians spoke to varying length about perceived power dynamics, conditions under which clinicians leverage which strategies to shift the power, and perceived impact on clients or the relationship. Relatedly, some participants commented on the awareness of their power due to the privileged aspects of their identities.

REM immigrant clinicians viewed power differentials as "always existing" and "always salient" in the room by virtue of their role as the clinician (Yasmin, Raymond, Jack, Stephen, TM) as well as the medical setting, where power is "inherent" (Charlie, Jack). For one participant, awareness of their power occurred simultaneously with an awareness of the power of the REM immigrant parents in the room as having agency to "follow through" with their given advice. This clinician described their "forthcoming" disclosure of saying "you're an expert in this. I don't have my own kids. And I have helped a lot of kids, so I know how to help kids. So, let's work together" (Jack, 49). Relatedly, awareness of a client's agency (e.g., "They have a choice, you don't have to come here, you don't have to trust me"; Jack, 471), simultaneous with

the desire to recognize their "dignity," was cited by another participant as reasons for engaging in intentional mention of gratitude by way of "thank you, thank you for trusting me. Thank you so much for telling me your story" (TM, 467) such that the participant perceived their clients to feel "valued and respected." Two clinicians (Leslie, 310; Vanessa, 100) noted their intentional effort to "empower" the clients and encourage "self-advocacy" whenever possible. Another clinician noted their intentional decision to defer from wearing a white coat as well as engaging in nonverbal behaviors, such as "shaking hands and engaging in small talk" to create more "equity" (Charlie, 116). Beyond small talk, another participant, who works predominantly with REM immigrant individuals, described their intentional and explicit ways of thanking migrant farmworkers who, especially during the COVID-19 pandemic, did not have the luxury of work from home:

> I do specifically tell them how appreciative I am for their job. Because they feed America …. I definitely make it known to them that even though we work in different areas, different occupations, their job matters, their job is very important … And their work needs to be recognized because through all the hardships, they're still out there picking food for us. (TM, 273)

To further illuminate strategies, for three participants, an awareness and acute sensitivity of themselves in the eyes of their REM immigrant clients, particularly for how clients may be curious of their own immigration stories given perceived shared ethnic backgrounds but may not perceive full authority to ask, gave way to their own practice of being "transparent" and giving plentiful space for clients to ask any questions they might have "about me or how I'm in the United States" (Stephen, 152), or during intake, especially, to "provide space for the client to ask me anything they would like to know" (Yasmin, 248), and to be "forthcoming" about "why I'm

in the States and a bit about my family background. It's sort of a nod or an acknowledgement that I understand that we are here for different reasons … That, you know, we are sort of similar in ethnicity but there is a difference in our positions in the States" (Raymond, 150). This act of disclosure, both preemptive and in response to questions, was described as being essential to assess whether clients are "really comfortable" with the clinician (Yasmin), "really important for rapport" (Raymond), and an avenue towards creating "safety": "In my view the therapy really works best when you feel like you can feel emotionally safe" (Stephen, 157).

Where power differentials are perceived, not all participants felt the need to act to modify or rebalance the dynamic. For one REM immigrant participant, power was perceived—particularly from their first-generation REM immigration clients—as an "automatic labeling of authority figure, and I'm going to listen to this person. They're going to tell me what to do" such that the clinician avoids making "a great attempt to rebalance the power differential in therapy":

> And I do that because I do believe that some of these parents prefer it the way it is. They enjoy that they're seeking an expert … they're seeking a doctor to tell them what to do and they're able to sort of defer their concerns and considerations to me. There's a level of safety that they think that they experience. So, depending on their resistance, I don't try to reinforce this idea that we're on equal playing field. (Raymond, 177)

Similarly, this sentiment was echoed by another participant who perceived their REM immigrant clients as sometimes lacking understanding regarding the "role of psychologists, or they don't respond as well to Western perspectives about, what do *you* want? What are *your* goals?" and, preferring an "authority figure where you just learn and absorb information" (Leslie, 321). In such cases, Raymond described their attempt to "encourage" clients to "assert themselves," and "make decisions" about treatment without "trying to modify the dynamic" between, while Leslie

described their increased comfort and ongoing desire to be "flexible" and to "take the lead" when clients' cultural background and preference necessitates it.

Where power dynamics appear to elicit a reaction from their REM immigrant clients, participants also described various engagement strategies. One participant described sensing "hesitation" at times that seemed to communicate "fear of upsetting or offending me" so that "I have said whatever you have to say it's not about me, the space is about you" (Yasmin, 318). Another participant engaged in more "regular check-ins" with their REM immigrant clients and readily answered their clients' personal questions, who, at times, would vocalize, "I feel like it's this is a one-way thing, and it feels very uncomfortable for me. So, I want to be able to know what you're doing, I want to know you as a person" (Heather, 40). This same participant engaged in giving "verbal permission" for REM-I clients to disagree with them: "I'm not always right so you need to let me know and inviting [them] to take that power, share that power with me" (Heather, 227).

Awareness of privileged elements of identity invoked reactions and shifted strategies for some clinicians. Three participants acknowledged their awareness of privilege owing to their own legal status, relative to their undocumented REM immigrant clients, which deepened their sense of empathy (Charlie, TM), informed their decision to avoid "advice-giving" (Leslie, 113), and gave way to general discernment to "ease" into questions about documentation status only when "pertinent" to the presenting distress and "rapport" was evident (Charlie, 114).

Viewing their own acculturation by virtue of "language fluency" and ease with which they know how to "navigate systems" was recognized as privilege, privilege that demands for this clinician that they own all elements of their "Americanness," including elements of

"arrogance and hubris and self-confidence" when their East Asian clients express self-criticism for not being able to access an "American personality":

> Sometimes, I put myself out there like, I grew up American. So, I have some of that American arrogance, right? And for you to kind of own the negative traits that people might see of Americans sometimes can be helpful. (Esmy, 113)

Such acknowledgement was described by this participant as rendering opportunity to "validate" the clients for who they are, as well as to "open a door" for clients to express potential dissatisfaction with elements of American culture.

Finally, several participants described explicitly the ways in which they navigate the spoken language of the therapy session in an attempt to attend to the power dynamics. When working with intergenerational families in the room where the parents may speak Mandarin to each other, one clinician described the way in which they have "respectfully asked them if we can keep our conversation in English … this is a situation where I felt I can understand enough that I didn't need any translators or anything, and maybe requesting for a translator may be insulting as well" (Jack, 30). Another clinician described their way of apologizing and asking their REM immigrant clients to have "patience" with them for not being able to speak their language, that "it's not their fault that they can't communicate with me" (TM, 237). Yet another participant described giving their Mandarin-speaking clients the choice to speak Mandarin in therapy, a process that was described as a "reverse power dynamic" due to their client's higher level of fluency and one that was always met with the client's expression of gratitude. The process by which another REM immigrant clinician "gave power back" was described as occurring after they recognized that they had misgendered their client:

> I apologized, and I checked in … and then I kind of knew that I had to give client a sense of agency and power in that moment, so then I apologized. And then I asked the client, how is this conversation going? What are you feeling? How is this experience? And I misgendered you, and I'm apologizing and I'm checking in with you and making you talk about your experience. Is this something that you want to do? (Heather, 91)

The consequence as expounded upon by this participant was the client's expression of gratitude and identification of this moment as "when they felt like I can really talk to you. You're not like an authority figure robot" (Heather, 92).

D. Relational Challenges and Ruptures.

8. Difficult Emotional and Psychological Experiences.

While REM immigrant participants reported as overwhelmingly positive their experiences in their work with REM immigrant clients, when participants experienced relational challenges, participants described with varying degree their emotional and psychological reactions, perceived sources of challenges and emotions, and short- and long-term consequences for themselves and their work with their REM immigrant clients.

What many described as the point of connection and joy—the moments of "getting it" without saying much—was cited by one REM immigrant participant as potentially triggering feelings of being "trapped" and feeling at times "invisible" when the clinician remains silent about what the client may wrongly assume that the clinician understands by using phrases like "Well, you know what I mean, or, I think you know how it is" or paraphrasing in Mandarin, a language that the clinician did not fully understand: "And I remember my concern at the time was, the more I wait, then the more she'll realize maybe I just wasn't on the ball the whole time"

(Stephen, 175). This participant described the way in which they were able to finally broach the subject with the client and reach clarity and understanding.

Two REM immigrant clinicians described varying degrees of "frustration" regarding what may have been a miscommunication regarding what the client perceived as the clinician's role. One participant recounted the experience of feeling "frustration and sadness" after being "fired" by their client, who was undocumented, had a disability, and also had four young children:

> He was obviously very depressed about not being able to work … So, we tried to work together to try to get him to reduce some of that depression through behavioral activation. And he just didn't understand like, why going out for a walk was going to help them get a job … my job is not a job agency, so, I can't give you jobs. I can only teach you ways that kind of help you feel better until you are able to find a job. (TM, 346)

This participant pondered afterwards whether "I wasn't doing a good job explaining it, or he just wasn't ready to listen, I don't know what was going on," long after the rupture occurred. One participant described as ongoing the "challenge" of REM immigrant parents of young clients frequently expecting and desiring that the clinician will "side with them" and their view, when conflicts arise between them and their children, such as when the parents perceive that the "misbehavior" of their teenaged children is due to their being too "American":

> This is what American teenagers do—and that's code for White teenagers, White Americans do … and this is what our kid is learning. So can you please just tell our kid, ABC and D, and we'll be through with this, because there really is nothing wrong. And, and for me the challenge has then been to say, I respect you. I understand what you're

> saying. I cannot tell your child this because it's not true. And I really need you to understand how this works. So, there's been a few yelling matches there." (Yasmin, 227)

For this same REM immigrant participant, having "much needed," albeit "frustrating conversations" with their REM immigrant parents regarding the legitimacy and seriousness of their child's mental health disorder left them feeling doubtful that there was positive impact:

> And even though they were like okay, we kind of understand what you're saying, it was still really hard to for me to walk away from that feeling like they actually did. I feel like I just added a little bit of this dent into the conversation into their understanding of, oh our daughter will need long term care for this. This is not going to go away tomorrow. (Yasmin, 228)

Occasional feelings of "impatience" and "exasperation" were cited by another REM immigrant clinician who described the impact of persisting "cultural scripts" for one client who experienced the death of their mother but was not able to process their emotions of loss and, rather proceeded by way of, "I'm gonna go home to the funeral—she was in college at the time—and now I'm going back to classes because that's what I need to do because that's my job. You know, and so much of that is in that cultural script that cuts across lots of different groups of people, especially immigrants" (Vanessa, 40).

For another REM immigrant participant, the emotional experience and source of rupture was not readily made apparent for themselves until they engaged in reflection after the rupture and therapeutic relationship had ended such that repair was not possible. This participant described remembering having "a lot of unconscious and conscious feelings about" the client's identity factors and their own, including "socioeconomic status, client's generational status, client's kind of level of acculturation or slash assimilation almost, and the differences in our

ethnic identities" such that the clinician identified something that was "embedded or ingrained within me somewhere that I couldn't even access it until later that I really had to do a whole sit down reflection for like a week":

> This is such a vague way that I'm explaining this, but all of those intersections of identities … really triggered me to not have interest in the client, or I couldn't really connect with the client's pain point. Because I was thinking, you're privileged in all of these different areas. And, yes, we have shared experiences or identity as a woman of color, but I'm not even sure she identifies as a woman of color … so I had a lot of resentment towards that because of all these privileged identities that client holds that I don't identify with or feel really resentful towards. So then that kind of ultimately led into like, I'm not really interested in you, like, why do I have to offer my service to someone who … is privileged? (Heather, 119)

This clinician touches on a topic seldom addressed, that of clinicians perceiving less power and privilege in the room *in relation to* the client by virtue of their social locations. As an "undertheorized" topic in psychotherapy literature, one researcher wrote of their own experience of privilege favoring the patient that resulted in "confused subordination," which, "in the absence of the two parties' addressing the issue of aggression, this previously fruitful therapy got stuck, and the patient dropped out" (Fors, 2021). For this participant, the consequences of their inability to "connect with the client's pain point" and feelings of "resentment" can hardly be qualified as benign, for themselves, the client, and the relationship. This participant recalled feeling "very nervous … I didn't know how the client was going to react, didn't know if this is a good thing or a bad thing to do … but in a way, I knew in a way it had to be done," such that the disclosure of "how difficult it had been for me to form connection" with the client toward termination gave

way to a reaction from the client akin to "what are you talking about? I thought we were having a good time, almost like a betrayal" (Heather, 111). The participant added that this was "a very interesting dynamic … I did feel that there was some, I'm not sure if I can describe it as a threat, but almost" (Heather, 131).

Perhaps what this participant is verbalizing is the given that where privilege owing to social identity and location threatens the psychological safety of the client, such is bidirectional; as in, that which is harmful for the client is also harmful for the clinician. This sentiment was addressed more directly by another REM immigrant participant who noted the familiarity of their surname as one impetus for why their REM immigrant clients assume that they are "South Indian" and seek them out, and what "unfortunately has happened enough times now that I kind of look for it":

> By the time they make it to my office, and they see a butch lesbian in front of them, they freak out. There's a lot of freaking out. And I've encountered some difficult homophobia [laughs]—there's easy homophobia and then there's difficult homophobia. And I've had to say, you know, no thank you, I don't think I can work with you. Let me get you some resources of some other people who might be a better fit. Because I just don't need that. I don't want that. I don't need to work through that. I just feel like, no thanks. Doing therapy is plenty hard for everybody. I don't need to be carrying a weight of that kind of aggression in my face every session towards me. (Vanessa, 124)

With a hint of apprehension—"This is the part where I have to keep myself honest with you" (Vanessa, 122)—this participant seems to voice yet another topic that is seldom addressed, that of blatant acts of aggression that arise from clients, by virtue of ingrained, and at times, violent, homophobia that persists in the values and beliefs that travel with immigrant individuals and

communities from their own countries of origin. While Vanessa emphatically voiced their clinical judgment to assess REM immigrant clients' worldviews, biases, and judgments very early based on harmful experiences and judgment of their own safety, how might this best be addressed if such acts of aggression occur past the point of initial contact?

Switching slightly to a different topic, several participants described an intensity of emotions for what they wanted or longed for themselves, for their clients, or both that also followed matched intensity of challenging emotions and reflections regarding themselves.

One participant described their work with a REM-I client who identified as gay and struggled to find acceptance from their conservative Catholic, South American family members as a rare interaction in which "an intersection of factors pulled on a number of things internally" (Charlie, 118). The participant described themselves as having "wanted to make sure" the client had ample resources "specifically for his situation," but also transpired into moments when the clinician wondered if they were "too enthusiastic," "overreaching," or "overstepping" through the course of their therapeutic work.

> You know some members of his family, he shared were accepting of him. The major figure, his mother, was not, even though she loved him and was supportive of him he felt like he had to keep that part from her. And I sort of went through that myself. But my family ended up being a lot more accepting than I thought. So, when I did come out to them, it was sort of like, oh we already knew. That was a pleasant surprise for the most part, like, most family members. So, when I heard his story, you know that really resonated with me, where he was a person who was an immigrant and had the added disadvantage, or challenge of being undocumented and was also gay. (Charlie, 61)

This clinician described an ultimate sense of "guilt" and lingering internal questions of "Am I pushing this subject too much for him? … Am I pushing my own agenda more so than what he feels he needs?" which could not be quelled by the REM-I client's expressions of being "very appreciative" (Charlie, 106). Awareness and consideration of the client not only as an immigrant individual with marginalized identity factors, but also awareness of the clinician's own privileged experiences in relation to the REM-I client seems to be just as salient in the "intersection of factors" that Charlie describes as connected to their felt intensity of emotions.

The desire for "wanting to almost help their dream come true" (Leslie, 346) was felt by one participant, who also described a "strong desire" and "sense of urgency" as well as "really, really, really" wanting to help their REM-I client achieve what they longed to do before their impending death. Such longings were contextualized by the participant before describing their felt sense of "frustration," which transpired into a rupture.

> I remember the last session we had, I think I got pretty frustrated, and I raised my voice. I don't remember the details of our conversation, but afterwards I felt terrible. And I talked to my supervisor, and then we actually processed that about why I felt so frustrated because I think I was just really in a problem-solving mode … and I think in a way I recognized the challenges about their immigrant background, and how it's hard for them to move back to the country at this time, and how they don't have the finances and resources to support them. (Leslie, 347)

This participant voiced that they perceive that their "own bias kind of take over and then let it kind of get into the relationship" due to the influence of their own cultural background and how they might approach end-of-life: "If I know if I'm approaching the end of life, I'm not going to stay in this country. I'm moving back to my own country and spending time with my family"

(Leslie, 352). Leslie's description seems to insinuate that for some REM-I clinicians, the source of felt intensity of both *wanting* and that which transpires from its absence encompasses more than a consideration of challenges and intersecting identities. Leslie's explicit reflection of the therapist's self as an immigrant individual renders Leslie to conclude that their own "bias" for what they would have wanted for themselves were they in the client's shoes, was in part, to play for both their increased sense of wanting—which was perhaps not the same as what the client wanted for themselves—and challenging, layered emotional responses they experienced, first of "frustration," then of feeling "terrible" for acting on what Leslie described as having created their own "narrative" about what would be "meaningful" for the client.

For two participants, the impact of difficult experiences as a result of perceived ruptures appeared to reverberate beyond the single rupture or interaction that are connected not only to longing, but also expectations for self in regard to context and role. For one REM-I client, Michelle described the client encounter as presenting as "still mysterious," but starting with a felt sense of "eagerness" to correct cultural misunderstandings and a "yearning to be as helpful as possible" (Michelle, 88) that might also invoke for them a sense of "pride" in being able to effectively help the client:

> There's some stigma associated with Asian Americans going into treatment and going to therapy, and perhaps admitting to some mental health or emotional health struggles and so I thought I was making headway there with regards to an unfreezing of that stigma and being able to provide as much psychoeducation about the process as possible to change their minds on that … And then when they abruptly left, I felt I not only let this person down … I can't help but go into this kind of generalized sort of self-criticism, like if I

> can't do this work, how are we supposed to get other Asian Americans to treatment? (Michelle, 89)

Heather described herself as being "shaken" by the experience of misgendering their client in the context of, among other salient elements, what the participant "wanted" for their client and also for themselves:

> I'm their counselor and I'm supposed to be the healing space and I further reinforced this systemic oppression and seeing this person as a gender that they don't identify with, I further harmed them. What is this going to do with my counseling, all of those things. And it was especially significant for me because of the intersection of this client's identity, of not only being identifying as a member of the LGBTQ plus community, but also having this double whammy kind of identity, being a Korean descent, immigrant and colored person, and also being a part of the gender and sexual minority community and how that has been so hard for clients to kind of claim and be respected and appreciated and celebrated and that's what I wanted to, that was part of the work that I wanted to do with clients. So, when I misgendered them, I immediately thought, Oh, this—I suck. (Heather, 74)

III. Navigating Barriers, Negotiating Tensions

E. "Contextually Driven" Clients and Clinicians.

10. Clients, Culture, Conceptualization, and Clinician's Role as Intertwined.

REM immigrant clinicians recognized that their REM immigrant clients' distress was intertwined with culture and or "navigating" (Michelle, Leslie, Jack, Yasmin) elements of cultural tension or conflict within their families, regardless of whether their clients explicitly voiced it as such. One participant described their "first inclination" to be an assessment of the

"mismatch" between clients' upbringing in their country of origin, and that of the United States, irrespective of the referral reason such that the clinician asks, "How is this [problem] dealt with back at home?" (Raymond, 48, 54). Another clinician described their young adult REM immigrant clients' reasons for coming to therapy as "contextually driven" by transitions to new stages of life (e.g., finding romantic interests, finding job prospects) such that the intergenerational and intercultural tensions experienced by their clients was described as "significant" to their conceptualization that with clinician's "probing" for factors related to initial symptoms of "presenting depression and anxiety" demonstrated an emerging, "surfacing" process of "more evident roots" tied to "family stressors as well as issues related to enculturation as well as acculturation" (Michelle, 20). This same participant highlighted one client example that demonstrated their "struggle between expectations set by their family of origin, and what they are expecting of themselves and for themselves in a romantic partnership, and what it means to really fall for someone that your parents perhaps wouldn't have selected for you" (Michelle, 34):

> With this client in particular, the mom was more averse to the idea of her daughter dating without having the partner declaring his intentions, in the sense of having a plan to eventually marry her daughter. And so, there was sort of tensions about you know whether or not a daughter can be free to just explore her relationship further without having to commit to marriage … whether or not dating is something that will have a negative connotation with the daughter, and social connotation in the sense of, is she giving up her sense of pride or civility or whatever it is by just engaging in premarital sexual relations? (Michelle, 36)

This same participant described further the distress for the client that was rooted in not only intergenerational tensions, but also religious and intertribal tensions such that the conceptualization was voiced as "whose life is the daughter able to let live for? For her own, or for her parents?" (Michelle, 20).

For REM immigrant clinicians who work with families, the tension played out *in vivo* between REM immigrant parents and their children. One participant described broadly the children of immigrant parents who have anxiety and depression as having the added difficulty of being "trapped in two worlds" (Jack), while the parents may perceive their children and their proclivities as being "too American" (Michelle, Yasmin), a tension that is also intertwined with religious identity development for the children, adding yet another layer of religious tension (Yasmin, 289). One clinician who identifies as "1.5 generation" described their conceptualization of immigrant families in the following way:

> I can understand the immigrant parents' struggles of raising children here in the US, especially having grown up and really have a different value system from the country that they were born and raised in and then navigate raising a child here in the US—it's kind of nerve racking for a lot of parents and, of course, they're navigating how to do that as their kids grow up. So, I can definitely understand some of their concerns … But I can also appreciate and understand the struggles of the kids having to navigate being at home and abiding by their parents' rules and values and being enculturated in their home culture and then having to go to school and facing a different set of standards, a different set of value system and view of how things "should be." (Jack, 10)

This same participant also described the ways in which interparental differences in acculturation levels—that is, when one parent may be more acculturated by way of language and value

systems than the other—adds another layer to the complexity of navigation: "Just because two parents are both immigrants, it doesn't mean that their level of—what's the word that I'm looking for?—It doesn't mean that they have the same identification with their culture of origin" (Jack, 29).

REM immigrant participants who conceptualized their clients' presenting concerns as navigating intercultural and intergenerational tensions bracketed their own intimate knowledge, appreciation, and understanding of living through the experiences of both the younger and older generations, which informed their roles as one who is a "cultural broker" (Michelle, Yasmin), "arbiter" and "cultural concierge" (Michelle), or one who is a "collaborator" and "mediator," as well as an "observer" who is also almost like a "surgeon, trying to piece together this complex system without having to create additional ruptures so that I can put them together as a functioning family system" (Jack, 145):

> And help them and their parents be able to meet in the middle and readjust expectations and maybe value the culture of the family but also being able to value the culture of the context that they live in. Because I also think it's unrealistic to keep your own culture only because it doesn't really prepare you or your kids to what's out there. (Jack, 13)

The idea of "forming a bridge" and "pulling" together members of a family to avoid further ruptures (Yasmin, 294), while invoked by family clinicians, was also invoked by another participant who works with REM immigrant individuals, who also described themselves as having moments of "riding two worlds" when engaging with clients who may not be as aware of how cultural influences impacts their way of life, as exemplified by an illustration of a client who had suffered a "terribly traumatic" death of her mother, who was "carrying around all this anxiety because people in the family just don't do feelings" (Vanessa, 38). The participant

further described the client to have adopted the mindset of "Okay, I'm going to go to the funeral … and now I'm going back to classes because that's what I need to do because that's my job," an example of a persistent "cultural script that I think cuts across lots of different groups of people, especially immigrants" (Vanessa, 40). The participant described their inner dialogue and their strategy with clients in the following way:

> I frequently have those moments because they take a different form with each person, but there always comes a moment where I am in this weird position of having to ride two different worlds … And this moment of being like, wow … this is really touching something very painful in this person or it is making them anxious, and it is making them upset. And I have to hold the two. So, for me it's usually a moment of like, I have an inward sigh, like okay, here's that moment. Okay, got it. Alright, just hang here and be patient, and I convey as many ways as possible that I'm not trying to attack them in this moment by saying, yes, the culture you come from is important, but there are some things that are important that have been lacking for you in particular that you chose to seek out in therapy. Obviously, that's why you're here. It's not either or—it's and. (Vanessa, 55)

REM immigrant clinicians noted other ways in which their clients' distress was intertwined with culture, as well as various ways that they viewed what their role was in that moment. One clinician spoke of the REM immigrant client's distress navigating the conflict between staying in the United States for the medical care they needed against the wishes of their family in their country of origin who desired for the patient to move back home, which was also complicated by the lack of ease with which the patient could travel due their immigration status. The participant spoke of the client's sense of "guilt" and the clinician's felt sense to "just listen," give "support," and just be "stuck with them" such that they felt that it "really helped them to see

that it's okay for them to make the choice that makes the most sense for them and then to know that they are again doing everything they could to be supportive of their family" (Leslie, 141).

Where REM immigrant clients need instruction and guidance for knowledge gaps, several participants spoke as being most helpful the role of "teacher," "educator," or "advisor." One participant noted that East Asian international clients tend to experience their highest level of distress when navigating the job search, but feeling "extremely marginalized like, I know I have an accent, I know I'm not familiar with certain systems, I'm trying to convince someone to sponsor me. What a huge pressure" (Heather, 101), such that the participant feels that the most helpful strategy in the room is to provide "interview skills." For someone who is less acculturated than the clinician, another participant described their mindset as one who is a "teacher" and the client as a "willing student" (Michelle, 121). Still others, by virtue of the nature of their role and medical setting, voiced their general perception of themselves as an "educator and advocate" (Leslie, 322), an "educator, because I tell them about different things, different resources. I teach them about their health … I see myself primarily as a teacher and then also as a helper connecting them to whatever they need that's in my reach" (TM, 417), which was also echoed by Charlie who voiced their role as "inherently multifaceted," including a "healthcare coach, medical educator … oftentimes, I'm a social worker" (239). Still, another participant described their general role when working with REM immigrant families to be different than when working with others, such that they perceive themselves to be "less of a psychologist" and more of "a teacher or an advisor … I feel like I come with more roles, maybe as a social worker or maybe as a close friend of the family. A child's teacher" (Raymond, 226).

Another participant described the frequent "somatization" of stress that is present in their East Asian clients, while also noting that most of their clients' distress as "embedded in systemic

inequality" (Heather, 183) who also are in need of a space "where they can just be who they are" such that the participant sees their role as one who can "provide that space where they can be who they are and be understood. I think that's at the core of what I think is helpful" (Heather, 333). This participant voiced what many others touched on, which is that while cultural tension, conceptualization, and the clinician's role is interconnected, so too is the impact of systemic barriers such that the current treatment of separating categories may belie the inextricable nature of participants' views on systemic impact. Nevertheless, the next category further illuminates REM immigrant clinicians' views of the macro context.

11. Where Barriers are Embedded.

REM immigrant participants described to varying degrees the way in which they "appreciate" and view as "valid" their REM immigrant clients' systemic barriers as they intersect with each other and with their cultures such they add "layers" (Leslie, 136) to their clients' distress and treatment in the following ways: racism and discrimination (Stephen, Leslie, Esmy, Heather, Vanessa, Michelle), low socioeconomic status (TM, Leslie, Charlie, Yasmin, Jack), lack of documentation status or limitations on visa status (Stephen, TM, Leslie, Charlie), high cost of insurance and/or lack of providers who take insurance (Yasmin, Stephen, Michelle, Jack, Vanessa), lack of access to decent jobs (Jack), the persistence of the stigma of mental health (Yasmin, Michelle, Heather, Charlie, Jack, Vanessa), and lack of REM psychologists and other mental health providers (Michelle, Charlie, Leslie, TM, Yasmin, Leslie, Vanessa). Several participants also discussed barriers and shortcomings of psychological training and institutions. In this regard, clinicians discussed how they and their clients experienced these barriers and, for some, how they impact their role in the macro context.

Two REM participants (Vanessa, Jack) described their sense of being "humbled" by their work with their REM immigrant clients, especially so for one participant who noted the "extra obstacles" that their clients encounter along the way:

> Because all kinds of other stuff happened to them before they decided to come to therapy. It's so much harder. I think there's so many other obstacles that stand in the way. I mean there's obstacles to going to therapy, period. Even if you are a White American who believes and understands the science of therapy. But I just feel that when people come from different groups, they've got to overcome extra, extra, extra. (Vanessa, 8)

Among the perceived obstacles, this participant seems to allude to the stigma of mental health that persists for REM immigrant communities and informs a "reluctance of certain racial or ethnic immigrant families to seek help" (Jack, 108), a stigma that informs client's "cautiousness" and testing the waters" (Heather, 30), as well as "hesitation" and sense of "I'm not sure if I actually want to do this but I'm going to give it a try" (Michelle, 85) and, for one participant, leaves them feeling "most impressed with their openness to seeking help" (Yasmin, 194). For this same family clinician, the stigma had repercussions for how their young client's parents denied and had "no acknowledgement" of what was perceived as "inherited mental health" on most members of the family (Yasmin, 216). While persistent, two participants also noted their observations of the generational differences of their REM immigrant clients, in terms of observing that "emerging millennials and Gen Zs are much more open to seeking and receiving counseling and utilizing them" (Heather, 29), teens and young adults having a "level of awareness that they bring with them … of taking care of their mental health" (Yasmin, 195).

Concurrently, many of these same participants noted their acute awareness of "being the only" or "being one of a very few" REM providers (Charlie, Stephen, Leslie, Yasmin, Vanessa)

or Muslim providers (Yasmin) in their setting, community, region, or city, with varying consequences. One East Asian participant noted, "I haven't been able to find a therapist that is East Asian either, right?" (Stephen, 290). Others noted the frequent expressions of gratitude when clients meet them for being able to meet a REM provider (Michelle, Charlie, Leslie, TM) that also allows one participant to "feel more encouraged that I can be a REM person in the medical field" (Leslie, 291). Other participants described feelings of tension as well as roles they undertake outside of the therapy room. One participant described experiencing a sense of "pressure" and a "set of expectations that are self-imposed" to serve a bigger purpose and role to destigmatize mental health in the Asian American community, and "for all that we feel is lacking in the community that they come from, or that we represent together" such that a perceived failure in a clinical encounter sets into motion an "overall emotional response to it [that] becomes a lot more personal" (Michelle, 114). Similarly, two participants voiced their reactions to similar sentiments expressed by Michelle. Regarding their "unfortunate" frequent act of having to "turn away quite a number of people," Stephen voiced, "It feels less like a burden because I know that I'm just the one person and I can't see everybody," while also adding, "And maybe that's some kind of a defense in sort of making me feel better about not carrying the burden" (312). Yet another participant voiced their sense of feeling "connected" to a "part of all who feel badly about not being able to meet the needs of the community," as well as a similar sense of "pressure" and added "burden" with moments of a "bit more of a level of anxiety where I feel the pull to really have to perform well, because I know they [clients] haven't had other possible positive experiences or maybe this may be their first experience with a clinician" (Yasmin, 337). As well, Yasmin voiced their role as one that has been part "educational" and "alerting" administrative staff that to apply a blanket system of waitlisting clients, especially

when they have "certain linguistic needs, certain cultural, religious needs, and have one to three people to choose from in our entire region" is "not fair" (Yasmin, 189). Yet another participant voiced their sense of being "torn" to stay within their setting, by virtue of the lack of REM providers, and leaving to pursue other opportunities (Leslie, 337).

Participants who explicitly noted racism and discrimination as interconnected with clients' sense of distress described, for example, their tendency to explicitly "label experiences of discrimination and oppression":

> When a system is fucked up, the system is fucked up. Like hey, look at this this, we're not going to kind of beat around the bush … every person in your leadership at your school or your workplace is a White person. And when they say certain things to you, that's racism. (Heather, 228)

Another participant described their REM clients as voicing their past experiences of racist interactions with medical providers (Leslie, 174) as well as the participant's personal experience of their medical team labeling a Black, male patient "as really aggressive when the patient was just trying to advocate for themselves for the type of treatment they wanted to receive" (171), such that, after supervision and some discussion, they presented in their multidisciplinary meeting and "tried to make it clear that when the providers feel attacked or feel the patients are being violent toward them, either based on their implicit bias or stereotypes … it's oftentimes very hard for us to feel empathy or try to understand the patient's perspective" (Leslie, 176). Relatedly, this participant described advocating that the client be seen by a psychologist outside of the medical team as the relationship had already been compromised and "if they have negative feelings, well not if, *when* they have negative feelings with these other providers, it could be harder to trust me [because] we share records and work together as a team" (Leslie, 190).

Another participant voiced their practice of "acknowledging the systemic oppression that does take place, that psychology has been implicated in that as well" (Stephen, 215), noting that "the system," which is rife with mental health disparities, "can gaslight you into thinking you're less than" (Stephen, 229), represented by none other than the fact that "I'm the only Asian male psychologist in all of [urban U.S. city]" (Stephen, 232). In their work with one Black female client who experienced frequent microaggressions in their doctoral program, they described "putting out there" and discussing:

> What could it have been like for you if I was a Black woman? Would that feel different, better, worse? Just, I guess the lack of financial privilege and just being able to pay out of network therapy … I think it helps … It's a sense of, the system is such that your options are kind of limited at this point. Is there a way to acknowledge it? And also, maybe acknowledging it allows you to make the best of it. (Stephen, 243)

At the root of this participant's assumption seems to be that racial and ethnic representation in providers is significant. From there, what this participant seems to insinuate is a connection between systemic disparity—as represented by and experienced first-hand by the lack of REM mental health providers—and the impact of such disparity at the micro, individual level that transmits a message of being "less than" deserving of care, as represented by the dearth and lack of availability of providers who share similar racial and ethnic identities.

Yet another clinician, whose role also encompasses training others in their setting, described their role in honoring, training, and engaging in intentional practice the uniform reference to all providers in the setting with doctor honorifics in reference to their awareness and acknowledgment of their "privileged elements of being Asian in America" in the context of the

racialized history of the United States as they also intersect with their Confucian value of modesty:

> But when that intersects with our immigrant status of being Asian in America, and America has a history of anti-blackness that functions in this way, how do we then even accidentally piggyback on a form of kind of subtle anti-blackness by leveraging our privilege to turn down a doctor honorific? … We all adhere to whoever wants the highest honorific … making sure that we are giving honor to the other people who have earned it. And is it stressing a power dynamic? Yes. But it's stressing a power dynamic that has to do with other power dynamics. And sometimes that makes sense. (Esmy, 291-302)

Given the timing of this study, several participants gave mention to the ways in which the "turmoil of the last four years"—in specific reference to the sociopolitical impact of the 2016 Presidential Election—impacted their clients and themselves. One participant voiced that the "past four years have been horrible. So much anxiety, like anxiety so high people are scared of being separated, being sent back. Not refusing resources," while also adding the impact on themselves and their effort to "not dwell on all the things that Trump administration was doing so I could just breathe and manage my anxiety to be able to help them manage theirs" (TM, 445). This participant further elaborated:

> Early on, like 2017 … there were these ICE officers all over town. They were stopping people left and right. So our patients weren't able to come to their sanctuary or clinic, because they were stopping people left and right for stupid things. Like, let me check your windshield wipers or let me look at your car, it seems like it's not running well, like stupid reasons, and to ask for their documentation. So, there was just so much fear in our patients. It makes me so sad. So sad. (TM, 440)

Another participant described their sense of "disappointment" in not perceiving a space in their setting to discuss sociopolitical events, such as the shooting of Black men, such that they felt their own need to "forge a space" to "bring up" these issues themselves (Leslie, 277). Yet another participant described feeling a "greater sense of pride in who I am and a need to speak my own experiences into the void and just be able to be more cognizant as to how I carry myself in the world" (Michelle, 154). This participant further added:

> There's this sense of, I need to be able to help move these individuals to higher grounds. And there is a sense of wanting to protect them against all the downs of the world as well. And to kind of encourage them to be more resilient against all of the discriminatory assaults that they may have been experiencing. So, in other words, I feel this work being more and more important for myself. And so that is sort of a statement and a reaction against all of the backlash that we as a group have experienced. (Michelle, 156)

Insofar as it impacts REM immigrant clients' treatment, some REM immigrant clinicians voiced ways in which the system of psychotherapy (e.g., therapeutic frame) or the institutions of training—including literature, supervisors, and "what we're told" to do and not do—serve as barriers to treatment, directly contradicts or challenges their own experiences, or ways in which they fail to address what they perceive are important elements in providing treatment to their REM immigrant clients. For example, one participant voiced their perception that "colonized concepts of traditional old school therapy" that include abstaining from certain emotional disclosures as well as assumptions that all clients are aware of the parameters of the traditional "therapeutic frame"—that is, that all clients "understand confidentiality, they understand what a 50-minute session looks like, they understand this process of, what the hell are we doing here?" (Esmy, 132)—serve as barriers for REM immigrant clients to not only seek therapy, but to

adhere to medication referrals, to build rapport, and to sustain treatment. Yet another participant described recognizing their perceived "internal pressure" to use "evidence-based approaches" as proscribed by their "training in counseling" against the grain, experience, and intuition that "it's more helpful if I can just be in this moment, hear the patient and see what's going on" (Leslie, 128).

Several participants voiced their perceptions of institutions of training. One participant voiced their perception that the "multicultural piece" of psychological training was a "short form for, how do you work with a Black client? And how do you work with Asian client? But I think even within that ethnicity, there's so much more nuance that doesn't get talked about" (Stephen, 288). Similarly, another participant described feeling as if psychological training did not prepare them for their perceived role with working with REM immigrant clients as the "classes on cultural understanding and cultural identities of families" were "prescribed and superficial, like, these types of parents are more family-oriented or these families are more authoritarian in their family dynamics … and not a lot of ... dialogue, in terms of ... discussing why you would approach this way" (Raymond, 238). This same participant described the way in which training contradicts their decision to self-disclose:

> In grad school you're taught almost like a hard rule not to disclose any personal information, always deflect. The longer I have been away from grad school, it's only understandable that these individuals, these parents would like to know something about you. And they're connecting with you and they're discussing very private matters at home, and they would like to know something about you. So, I would provide some information about my background, and talk about certain dynamics between me and my Chinese family that they appreciate. (Raymond, 156)

Related to the topic of disclosure, another participant voiced their perception that "our training hasn't always advocated for" the kind of "transparency" that they feel is helpful when, for example, correcting clients on their assumptions (Vanessa, 165). Insofar as attending to how best to serve REM immigrant clients, Jack noted, "I think grad school programs need to have this more because I think that is reality because the U.S. is becoming even more diverse by the day, by the minute" (78). This participant seems to allude to training curriculums that give attention to a growing, diverse U.S. population:

> Because I think that is reality because the US is becoming even more diverse by the day, by the minute, you know. And so not facing that head on, actually disadvantages the program or the students in the program if they don't really work on that. (Jack, 78)

One participant described the feeling of being "burdened" by virtue of their leadership role of a psychological association that, while they "put out a statement" in support of the Black Lives Matter movement, "all the things that keep Black people out of the program are still in place" (Stephen, 319).

Another participant described the dearth of opportunities to have more training in conducting psychotherapy in Mandarin such that direct translation of psychotherapy concepts was perceived as "awkward" for this clinician (Leslie, 250). While voiced by only one participant, this point seems salient for what another clinician described as most influential in their development as a REM immigrant clinician.

12. Ongoing Navigation: Helpful Sources and Resources.

What parts of training or institutions lacked, all REM immigrant participants voiced aspects as helpful, or "seeking out" other sources and resources that were "helpful" to "grow" and to be "encouraged." Training supervisors were perceived to have been helpful for four

participants, two of whom described themselves as intentionally "seeking out" REM supervisors (Vanessa, Heather). Vanessa described seeking out and being trained by a "wonderful clinical psychologist of color" whose style of "transparency" was congruent with theirs (Vanessa, 166). Relatedly, Heather voiced that they "sought out" East Asian supervisors who were helpful in the ways in the "parallel" ways that many clients voiced as helpful:

> I don't have to worry, like are you going to understand? Or do I have to explain every detail in order to make you understand? … with my East Asian supervisors, I've never had to do that and that has been a very liberating experience" (Heather, 262).

As well, another REM immigrant clinician described their "grateful" experience of feeling as if their REM supervisor and bilingual supervisor not only rendered intimate understanding and resources but helped them to recognize areas of discomfort and "recognize the power dynamics in relationships" with "candid" and "upfront" conversations, such that they felt that they modeled what it looked like to "comfortably" broach difficult topics with their clients (Leslie, 228). Contrastingly, one participant described the ways in which their White supervisor "was very, very affirming" and who "was intentionally touching on and soothing of, and taking care of" aspects of their racial and ethnic immigrant identity factors such that it was a "shock": "That was incredible for me, and I did not expect to get it from my White, older generation, Southern supervisor. So, it was a shock, but a most wonderful shock" (Esmy, 35).

Where psychological training may have had shortcomings, REM immigrant participants were able to identify aspects that lingered for them as "useful" long after the fact. One participant acknowledged that learning about the way in which multicultural classes during graduate training was helpful to maintain "this level of self-awareness" to try to abstain from "making assumptions" (Charlie, 210), which was echoed by another participant who voiced, "To

sum it up, I think the only prevailing advice we were given as trainees, or grad school, is to be sensitive. I think it's important, but I also think that was only one aspect of it" (Raymond, 238).

As important, two participants voiced specific, "pivotal" ways in which graduate training was an "eye opener" (Leslie) such that they were "woke" (TM). One participant, who moved from China to the United States to pursue graduate training, voiced the ways in which "multicultural counseling class in my first year of doctoral training was, in a way eye opening":

> When I first moved to the US, I don't even know what people mean about social justice very honestly. But then once I got into my program and took that class, it really made me reflect more and become more interested in learning more about the history and how race plays such a big part in American history. (Leslie, 223)

Another participant described the way in which learning the term "White privilege" was "illuminating" and "life-changing" such that it reframed the way they saw themselves and their world:

> I remember this topic specifically. And it was just in grad school. And it was the first time that I've heard of the term "white privilege." I had never heard of that before. And when this particular Professor explained it to us, she was a professor of color—she explained it to us, and I remember, almost like, what's that term? Woke. Yeah, I remember being woke like, Oh my gosh, like, I could see everything now in such different lenses. And it made me so sad and angry. … That experience with that Professor really helped shape the way I treat my patients and the way I help them see their situations because I talk a lot about systemic racism and about how the system works against you; this is not your fault. This is the system. … It all makes sense now. It's inequality. (TM, 501-511)

Being members of psychological associations and subscribing to listservs for resources were identified as helpful by several clinicians (Yasmin, Jack, Vanessa), as were ongoing trainings specific to topics such as cultural awareness, racism, microaggressions, and marginalized populations (Vanessa, Leslie). Additionally, self-driven education by way of texts, journals, empirical studies, fiction and non-fiction texts, and texts that go "beyond just the individual … to me history is important, not just a personal history but the history of a country, the history of a society, a particular culture, or ethnic group because those also play into what a person brings to the therapy setting" (Charlie, 178) was identified by several participants. One participant described their need to have to build more "self-knowledge" with regard to the "strong history of psychology within Islam" to compensate for what is often "missed":

> We had like the first psychiatric hospital was within the so called "Muslim world" in like the 9th or 8th century, and that often gets missed. So, I know for my own self-knowledge and especially working with clients who are more religious, I've had to do more reading of some of those texts and, for instance, the text of from back in like the 9th or 10th century that essentially is cognitive behavioral therapy but was talked about back then with a Muslim scholar who laid out how it would work. So, bringing those examples is helpful. (Yasmin, 303)

Another participant described "gravitating" especially towards memoirs and biographies, such as those of David Chang and Barak Obama, that illustrate cross cultural relationships as well as immigrant experiences:

> They just make a lot of sense to me. I see a lot of myself in these characters or in these writers. And oftentimes, there is a through line on what it means to be an American immigrant or an immigrant in America. And there's some comforting aspects to it. And

> oftentimes it's stories of triumph over lots of failures so it's inherently uplifting. (Michelle, 138)

Relatedly, authors such as Zadie Smith, Colson Whitehead, Malcolm Gladwell and popular podcasts such as This American Life were identified as resources for themselves as well as for what they would pass on to their clients (Vanessa, 113).

Other individuals, including work colleagues and peer supervision and consultation, were identified to be helpful and important by several clinicians (Vanessa, Yasmin, Heather, Stephen, TM) who identified their supports as helping to "build the bridge" for them and their clients when they could not speak the language of their clients (TM), or giving opportunity for the participant to "center" themselves wherever they deemed to be *their* center (Stephen) without feeling the pressures to conform to mainstream, heteronormative standards. Still others identified their work with their REM immigrants as helpful as they served as catalysts to engage in ongoing reflection (Yasmin, Heather, Michelle, Jack), and where even ruptures were perceived as "a really good learning opportunity" for realizing among other things, the clinician's "role," their limitations, and ways what they would do differently if "I was given an opportunity again" (Leslie, 354).

IV. Reflection as Catalyst; Catalyst for Reflection

F. Ongoing Reflection.

13. Past, In Vivo, and Future Reflexivity to "Do Good Work."

Self-reflection is an especially requisite practice for therapists when working with immigrant individuals, where the frame and orientation of that work is influenced and typically embedded in Western values (Sue & Sue, 2003). Critical self-reflection is a process that entails active engagement with the goals towards "increasing awareness of one's privilege, power,

strengths, weaknesses, cultures, values, biases, assumptions, and worldviews" (Yakushko & Chronister, 2005, p. 296). Almost all participants acknowledged to some varying degrees the importance of engaging in self-reflection to do "good work" with their REM immigrant clients, that despite, for example, "having a keen sense of who you are, I think there's always different layers and textures that still need to be considered" (Michelle, 152). Relatedly, two participants noted their work with their REM immigrant clients as the broad impetus to engage in self-reflection (Heather, Yasmin), including for one participant constant reminders to be "aware" of their blind spots:

> Knowing that I have all these prejudicial thoughts how my background kind of affords me different privileges and power, those are also helpful in kind of like, okay I need to be aware of this, and I need to be aware so that I don't harm people. (Heather, 327)

Still, another participant described their ongoing process of "sitting" with their own experiences of "race, immigration, class language," intersects with the experiences of their clients as most helpful (Stephen, 282).

Two REM immigrant participants explicitly described their experiences of having engaged in reflection after difficult experiences, which the clinicians described as leading to challenging reflections about themselves as well as what they would do differently if given the opportunity to work with their clients again (Leslie). One participant voiced that engaging in reflexivity after-the-fact gave rise to the realization that they should have voiced their difficulty connecting with the client "much earlier" than they did, but also expressed difficulty while they "tried to understand" the client, the presenting concern, and themselves:

> And it helped to a certain extent, but I think my unconscious or subconscious was so strong at that time and moment that it really kind of hindered me from getting in there.

> And, like I said, that reflection didn't happen until the very end of our relationship. And I think that's also telling of how I felt about this client. (Heather, 144)

Heather's reflection seems to insinuate a connection between the absence or felt resistance of the clinician to reflect and negative/complicated feelings the clinician may have towards the client.

Relatedly, three participants had *in vivo* reflections, which were voiced by way of invoking the present "talk" and what participants were feeling, questioning, or realizing, as demonstrated by one participant who, in the midst of voicing what they perceived as barriers to the relationship, added:

> And, you know, now that you mentioned it, I have to now go reflect and think whether or not those like two cases, I'm kind of like, what happened there? I wonder if there wasn't as much time because it was so professional and formal, maybe I didn't spend enough time kind of setting up the frame of like, what are you needing? I think, in both those cases, it was difficult to pull for, you know, what are your goals and things in therapy. (Esmy, 133)

Yet another participant voiced curiosity of their own decision to withhold self-disclosure of their own identities and privileges while working with one client, speculating aspects such as, "I want to be also be mindful of not bringing, I guess not bringing my privilege too much in the room," as well as, "I think maybe part of it is also my own anger toward the system," and adding, "I think maybe I also have some discomfort of not wanting to, perhaps, ask the patient to educate me too much about this situation" (Leslie, 148). Later, this same participant acknowledged the interview as a "good opportunity" to, among other things, "reflect on what I've learned, what I've done, the areas I've grown, and the areas I should continue to seek resources or seek learning opportunities," further elaborating:

> Because I think a lot of your probing questions also got me thinking more about, why did I not choose to say those things in therapy? And I imagine those discomfort will not necessarily go away. And I may not necessarily change my practice in the future, but at least it's helpful for me to be aware of the existence of those feelings and the reasonings or rationales behind a lot of my decisions in therapy. (Leslie, 332)

Another participant voiced that they realized that they had "denied" either "articulating or acknowledging the felt sense of pressure that I have towards the work of destigmatizing mental health and the use of psychotherapy in our Asian American community … I just didn't know the emotional toll that that sometimes has on me" (Michelle, 160). This same participant elaborated:

> You know, I think that now that we're talking about it, I mean this person symbolized for me sort—I'm not quite sure how to put it, but this this sense of duty I suppose to the community I belong to in the sense of providing more insight into the need for caring for one's mental health that perhaps isn't as salient or accepted by our Asian American community. (Michelle, 93)

Further, Michelle voiced their need to continue "to really think a little bit more about for myself, you know, am I taking on too much there, or am I perhaps doing not enough" (Michelle, 166).

Acknowledgement that topics during the interview are not usually topics that participants engage in reflection were voiced by several participants, including Charlie who reflected the way in which having the opportunity to "step back" and reflect on their experiences as a REM immigrant clinician: "These are things that I don't really normally think about actually. I'll think about it here and there" (Charlie, 251). For another participant, reflection served as a potential catalyst for future action:

> The cultural brokering piece, thinking about that a little bit more deeply and giving that some space. I think for me it's very much like, oh yeah, I've been doing this for a while and my "work hat" goes to, like, what would that mean … what could that look like as a community workshop for the parents and the kids in the mosque? Because I get called on to do some stuff like that. What programming could I create? And then also thinking about what that means for me and how I approach the role. So, I think that was really one of the highlights for me of diving into this conversation with you today. So that was pretty cool to think. Because I didn't realize like, wow, like a lot of what's salient has been those clients where it's the immigrant parents and the child who has predominantly been brought up here, but that whole unit is my client. (Yasmin, 354)

Relatedly, two participants voiced the way in which the interview served as a reflection catalyst for future reflection. One participant noted:

> You make me think of things that I haven't really thought about before, that becomes almost automatic that I don't really think about it. And I think it it's a positive experience in that it allowed me to reflect on my experience, which after having done this for a long time, I think we always need to do that and I think it just reminds me that I need to do that a bit more. I'm aware of the minute things that might be happening in the therapy room or in the therapy context, but I don't put as much time kind of just stepping back and, you know, kind of seeing the pattern in what I do. (Jack, 167)

Another participant echoed similar sentiments regarding the way in which the interview "made me think," adding that the reflection will continue:

> It will continue to happen, reflection will continue to happen, but it was helpful for me to kind of think about what is it that I think is important? What am I doing? [laughs] How

> do I want to do my work and what kind of clinician … How do I want to live my life and you know, have therapy? And also thinking about within group differences … I have mostly Korean East Asian clients; however, I do have REM immigrant clients who don't identify as such so, am I different? Am I not? What is the reason behind it? (Heather, 347)

Lastly, another participant viewed the "opportunity to reflect" as an avenue for validation of the work they do:

> It helps me keep going, this reminder, like, hey, you're doing something, like you really care about your patients. And sometimes it's hard to do that when you're constantly going, going, going. But it's, it's nice to reflect, especially after this year, these four years. (TM, 495)

13. Views of the Researcher and Research.

Several participants voiced how they felt and responded internally when they first encountered the initial recruitment flyer, which included a note on their motivation to participate in the research itself. Said one participant:

> I am so excited that I was able to even contribute a tiny piece. When I saw this come across my desk, I thought, oh my god, this means, this was my thought Jenn, and I said it to my wife … oh my god there's enough of us now that someone's doing a study! And by "enough of us now," I meant enough of clinical psychology PhDs who come from different ethnic groups who maybe even have an immigration situation. Like, what? Because certainly, let me tell you when I was in graduate school, nobody was doing any kind of research on that. Yeah, so the numbers right? Numbers. So, I was super psyched to participate, and thank you for doing it. (Vanessa, 182)

This quote alludes to several salient components of REM immigrant therapists' sentiments, including the reaction of positive joy and enthusiasm to both the idea of the research and their ability to "contribute," awareness of both the lack of REM immigrant therapists and the subsequent lack of research for and about "us," and expression of gratitude for the researcher. Similarly, another participant voiced that "it's just good to be reminded of how far the scholarship has come in just the last decade" (Yasmin, 344), while another said, "There's probably limited research on how to best work with REM therapy clients from either, you know, a REM or non-REM therapist's perspective, so, I'm glad you're doing this research and I'm glad you're doing it from a qualitative perspective" (Leslie, 264).

On the point of awareness of the dearth of REM immigrant therapists and scholarship, another participant added:

> I mean just reading the title and I was like, oh my god, you're not gonna get any participants, so I think I should probably do something … America is only going to get more diverse and clients are only going to get more diverse, and yet, therapists are as White as ever … It's nice to see people of color in the community. I hope you get your PhD and go do the same things. (Stephen, 326)

Yet another participant expressed their desire to "contribute," in addition to their reactions:

> When I saw the ad I thought it resonated with me. I wanted to contribute, maybe add my experiences to it as well. If this helps guide—well, one, helps you get your degree, but also helps guide the development of our field, in general, that would be a worthwhile contribution. (Charlie, 247)

The awareness and acknowledgement of their own story and voice as represented by "my experiences" so as to shape the collective "contribution" was similarly noted by two other participants. One participant expressed, "Thank you for your research. It's really important to have our voice heard and to show that we bring value to the table, this work is important" (TM, 496). Gratitude for space to "have our voice heard" was similarly expressed by yet another participant:

> I'm so excited that you're like doing this work. … I really want to say thank you for giving me the space to be able to hear my own thoughts and to be able to validate that sometimes being a research participant can be so validating and saying that, like, my story does matter, my opinions do matter … I'm a Chinese American, first generation, immigrant, Southern woman, and whatever I experience and my perspective of that exists. That story is now there, my existence is there, and it cannot be erased. And it deserves to be there. And I think that has been a really affirming process to experience. And you giving so many psychologists this opportunity to reflect and think about that, I think is giving us a gift. (Esmy, 352)

Conclusion

REM immigrant psychologists' experiences in the current study indicate that relational experiences, including opportunities, challenges, and how REM immigrant clinicians view their roles in their work, are varied and richly influenced by a multitude of internal and external factors rooted in prior experiences and future wishes and desires in the context of extant barriers and challenges. At the time of interview, participants demonstrated ongoing navigation and reflection regarding the potential dynamism for both healing and harm owing to their

appreciation for the complexities in each of themselves, their clients, and the macrosystemic environment under which all relationships are encapsulated.

REM immigrant psychologists invoked and referred to their own immigration and acculturation experiences as reference points for that which informs their sense of deep understanding and empathy for their REM immigrant clients as individuals and families embedded with histories and futures embedded in a larger context of narratives and systems. Participants' intimate knowledge of creating a new life in a new land that is constantly "operating in the background" was also a source for how therapists experience themselves as knowledgeable, or skillful to use certain strategies to build trust, rapport, and continued connection in the therapy room. Just as perceptible was the appreciation of challenges clinicians experience especially when attempting to safeguard against their and their clients' assumptions about shared understandings and experiences that could potentially bias and undermine the clinical work. REM immigrant clinicians reported a constant curiosity about what it means for a client's values, worldview, and beliefs when they identify as a certain racial minority individual or to identify as their home country as one outside of the United States—even when clients' and clinicians' stated identities were similar—which demonstrated nuanced understandings of intraracial, intraethnic, and intracultural variability that exists across and within all individuals. REM immigrant clinicians' understandings were at times amplified by their identification with experiences of navigating struggles and obstacles at times distinct in nature and scope depending on factors, such as age and developmental period of immigration. Such experiences were seen as formative and invaluable parts of self as REM immigrant therapists first for how they perceive themselves as individuals and as psychologists in the United States and their role and purpose both in and outside of the therapy room.

CHAPTER 5

DISCUSSION

Introduction

In this final chapter, I will examine in further detail the four selective categories that arose (Table 2), while also referencing key conceptual tools from the ecological model of multicultural counseling psychology processes (EMMCPP; Neville & Mobley, 2001) and relational-cultural theory (RCT; Walker, 2002) to help frame the results as they relate to the main question of inquiry in this study: "How does the REM immigrant therapist in working with the REM immigrant client experience relational opportunities and challenges as they experience connections, disconnections, and attempt repairs?" Throughout the discussion, I will identify similarities and differences between the results of the current study and prior research findings where available or relevant. Additionally, I will identify strengths and limitations of the current study as they regard both content and process. Finally, I will discuss implications for future training and practice, as well as future directions for research.

Table 2

Focused, Axial, and Open Categories

Selective	Axial	Initial
I. Person of the REM Immigrant Clinician	A. Before and Beyond the Room: REM Immigrant Identity as Backdrop	1. To be a REM Immigrant in the U.S. 2. To Be a REM Immigrant and Clinician in the U.S.
II. Experiences of the Relationship	B. "In Our Own Living Room": Experiences of Connections	3. "More Than What's Visible": Feeling, Sensing, Perceiving Connections 4. What is Enabled: Knowledge, Skills, and Strengths as REM Immigrant Individuals

			5. "Two Well-Practiced Individuals": Broaching and Disclosure
		C. Attending to Intersections of Identities and Experiences	6. Guarding Against Assumptions 7. Power in Role, Privilege in Identities
		D. Relational Challenges and Ruptures	8. Difficult Emotional and Psychological Reactions
III.	Navigating Barriers, Negotiating Tensions	E. "Contextually Driven" Clients and Clinicians	9. Clients, Cultural Tension, Conceptualization and Clinician's Role as Intertwined 10. Where Barriers are Embedded in Systems and Institutions 11. Ongoing Navigation: Helpful Sources and Resources
IV.	Reflection as Catalyst; Catalyst for Reflection	F. Ongoing Reflection	12. Past, *In Vivo*, and Future Reflexivity to do "Good Work" 13. Views of the Researcher and Research in Relation to Self

Findings in the Context of Research Theories

The grounded theory of REM immigrant psychologists' experiences indicates that relational experiences, including opportunities, challenges, and how REM immigrant clinicians view their roles in their work, are varied and richly influenced by a multitude of internal and external factors rooted in prior experiences and future wishes and desires in the context of extant barriers and challenges. At the time of interview, participants demonstrated ongoing navigation and reflection regarding the potential dynamism for both healing and harm owing to their appreciation for the complexities in each of themselves, their clients, and the macrosystemic

environment that all relationships under which all relationships are encapsulated. REM immigrant psychologists invoked and referred to their own immigration and acculturation experiences as reference points for that which informs their sense of deep understanding and empathy for their REM immigrant clients as individuals and families embedded with histories and futures embedded in a larger context of narratives and systems. The expressed love, joy, excitement, and deep sense of gratification that REM immigrant psychologists experience in their work with their REM immigrant clients was substantial. That which is shared between clinician and client was more than just what is visible. When words could not adequately capture the ways in which REM immigrant psychologists feel, sense, perceive, and experience connections with their REM immigrant clients, participants invoked imagery and analogies in their efforts to capture their sentiments of what it feels to be in connection both generally and in specific moments. Participants' intimate knowledge of creating a new life in a new land that is constantly "operating in the background" was also a source for how therapists experience themselves as knowledgeable, or skillful to use certain strategies to build trust, rapport, and continued connection in the therapy room. Just as perceptible was the appreciation of challenges clinicians experience especially when attempting to safeguard against their and their clients' assumptions about shared understandings and experiences that could potentially bias and undermine the clinical work. REM immigrant clinicians reported a constant curiosity about what it means for a client's values, worldview, and beliefs when they identify as a certain racial minority individual or to identify as their home country as one outside of the United States—even when clients' and clinicians' stated identities were similar—which demonstrated nuanced understandings of intraracial, intraethnic, and intracultural variability that exists across and within all individuals. REM immigrant clinicians' understandings were at times amplified by

their identification with experiences of navigating struggles and obstacles at times distinct in nature and scope depending on factors, such as age and developmental period of immigration. Such experiences were seen as formative and invaluable parts of self as REM immigrant therapists first for how they perceive themselves as individuals and as psychologists in the United States and their role and purpose both in and outside of the therapy room.

According to EMMCPP, human interactions are influencing and influenced by five interrelated, nested systems: (a) individual and their characteristics, such as genetic make-up, ethnicity, age; (b) microsystem, or immediate interpersonal interactions in a given environment; (c) mesosystem, or interactions between two microsystems; (d) exosystem, or the interactive influence of two subsystems; (e) macrosystem, or the overarching societal values and norms that define social roles and expressions of identity. Building on Bronfenbrenner's ecological model (1979), Neville and Mobley (2001) expanded the macrosystem as necessarily encompassing sociocultural forces of institutional racism, sexism, classism, ableism, and any other social processes that marginalize and oppress groups of people based on socially stratified differences. Complementary to the EMMCPP lens, RCT also facilitates understanding of interactions with first and foremost a key underlying assumption that the "power-over" framework is systemic and institutionalized such that all interpersonal, relational contexts are "raced, engendered, sexualized, and situated along dimensions of class, physical ability, religion or whatever constructions carry ontological significance in culture" (Walker, 2002, p. 2, as cited in Comstock et al., 2008). RCT theorists contend that given such violations that transfer to all relational contexts, breaches can only be restored through healing relationships (Comstock et al., 2008).

Person of the REM Immigrant Individual and Therapist

Participants' invocation of their experiences and illustrations of navigating and struggling with identity development and acculturation as immigrant individuals in the United States echoes the literature that exists regarding the distinct experience of being a REM immigrant individual in the United States (e.g., Berry, 1997; Singh et al., 2017; Tummala-Narra, 2020). Further illustrations of identity development as they intersect with discrimination, hostility, or xenophobia as immigrant individuals in the United States were described in ways that are not only formative but also, at times, ongoing such that one "can't get over this sense of otherness" (e.g., Charlie, 45), reiterating the distinct phenomena of being looked upon and treated as a "perpetual foreigner," otherwise noted as foreigner objectification (C. C. Lee, 2018).

Overwhelmingly, positive views of self in relation to their work were highlighted through the depth of value and for how much participants love and feel gratified through their clinical work with REM immigrant clients, families, and communities. Much of what REM immigrant psychologists identified as reasons for their deep regard and gratification seemed to allude to a sense of identification and understanding, understanding that emanates from first-hand, intimate knowledge of experiencing that echoes the "intuitive empathy" pointed out by Akhtar (2006) and again reiterated via participants of a dissertation study who identified their sense of experiencing empathic attunement and identification with their immigrant clients (Sella, 2006).

While the current study and associated questions largely veered from directly asking participants about their own immigration experiences, the fact that all participants invoked personal experiences with varied detail is a critical attestation to the importance of the individual as a nested part of all human interactions, as indicated by the EMMCPP model (Neville and Mobley, 2001). In the current study, REM immigrant psychologists recounted in various ways

salient identity factors, such as gender, age, sexual identity, SES, proficiency of languages, personality traits, strengths and limitations as professionals, as well as their motivations, desires, and goals, all in the context of illustrating their relational experiences with their REM immigrant clients. As critically, the *awareness* of these parts of self is illustrative and again emphasizes the multicultural counseling competence (MCC) literature that invokes awareness of one's biases, values, and assumptions (Sue et al., 1982) as the first of the tripartite model of MCC, the latter two being knowledge and skills. The language of this selective code, *Person of the REM Individual and Therapist*, was partially borrowed from the language of Abernethy and Eriksson's (2021) inaugural section entitled "Person of the Trainer," which is included in the explication of their 13-year long multicultural training program. Abernethy and Eriksson, as it turns out, also borrowed this term from Kirmayer (2013), who illustrated the emphasis placed on the awareness of the "person of the clinician" as key and center to one model of cultural competence training in psychiatry, which is celebrated and taught at McGill University in Canada. The foci are arranged by four key tensions, one of which is to "reflect the ways we are all (intentionally or unwittingly) vehicles for collective identities, carrying these identities into the arena of the health care system and playing out versions of larger political conflicts in the microcosm of the clinical encounter" (Kirmayer, 2013, p. 368). Inherent in the training model originators' assumptions is a rejection of "the delusion of neutrality" in order to "highlight the sense in which, given what is a stake in any clinical encounter, the clinician has no choice but to take a stance—indeed, the attempt to display neutrality at times can be the most biased and provocative stance imaginable" (Kirmayer, 2013, p. 370). What Kirmayer pointed out, and what participants may also be echoing by virtue of the narrative parts of selves that were evoked through the interview process, is an affirmation of the adage that the personal is political or, as one participant put it, the person of the REM immigrant

individual is always "embedded in who we are" and always operating "in the backdrop" (e.g., Michelle, 106). Such was the reason for why REM immigrant psychologists in the current study felt that race and culture were always salient in the room, emphasized first via an awareness of self in the eyes of others, that which is visibly and audibly perceived by their participants that was remarked as a number of salient therapy factors, including reasons for why their REM immigrant clients have sought them out specifically. Awareness of such reasons for why their REM immigrant clients are in the room gave way to sensitivity and urgency to be aware of assumptions; that is, the shared initial perception of "getting it without saying much" seemed to function as a double-edged sword that could at times strengthen and enrich rapport and trust but also create an allusion of understanding and relating that feeds off of assumptions, assumptions that can at times be bidirectional. Notably, it was relayed by REM immigrant participants that such awareness could be counteracted best by using self-disclosure, broaching topics of similarities and differences, and being direct when misunderstandings seemed to arise, all of which were salient topics related to experiences of the relational encounter.

Experiences of the Relationship

Given that the relational experiences of REM immigrant clinicians were center to the research question, it was not surprising that the most robust category of findings was in the participants' descriptions of the relational experiences with their REM immigrant clients with both depth and breadth of description of participants' experiences. The selective code was broad so as to encompass the felt and perceived emotional connections and disconnections, the strengths and skills that present as opportune for relational trust- and rapport-building by virtue of the identities and experiences of the dyad, and the perceptions and safeguards against harmful

power dynamics, and the ways in which clinicians do or do not repair ruptures in the therapy process.

Echoing the position of Kissil and others (2013b) and perhaps adding a very important dimension to MCC scholarship for what it means to continually be reflective and to build self-awareness that impacts the intersubjective, therapeutic space (Ainslie et al., 2013), REM immigrant participants iterated their distinct experiences of being "not from here" *as well as* recognition and appreciation of their REM immigrant clients' experiences of being "not from here." These important and distinct experiences seemed to align with the view that what it means to be an immigrant individual in the United States is a unique domain of a therapist's identity that cannot be wholly accounted for by proxy factors, including race, ethnicity, or experiences of being minoritized (Kissil et al., 2013b). It might be said that what participants felt and perceived as mutually "grounded in a strengths-based perspective" (i.e., Michelle, 12) was connection in an inherently disconnected space due to factors above and beyond racial and ethnic match, perhaps contributing to an explanation for what Cabral and Smith (2011) found, which was that racial and ethnic background do not produce differences in therapy outcomes.

REM immigrant psychologists in the current study expressed their sense of feeling closer, resonating with their REM immigrant clients' lived experiences, and appreciating specific aspects of both hardships and successes of their clients. RCT theorists contend that connections are marked by what they term the "five good things": (a) each experiences *zest*, or vitality and energy; (b) each is empowered into *action* during the immediate exchange so that they can impact the other; (c) each gains *knowledge* that more accurately represents themselves, the other, and the relationship; (d) each gains an enhanced *sense of worth* regarding their own thoughts and emotions due to the others' responsiveness and recognition; and (e) each gains a *desire for more*

connection and caring for the other with motivation and energy to have other relational connections (Miller, 1986). Participants' descriptions of how they feel, sense, perceive, and experience themselves in connection with their REM immigrant clients, how they feel enabled and skilled to further build connections and disclosing aspects of self are all interconnected and seem to echo RCT tenets. Importantly, while the participants seem to reiterate Comas-Díaz and Jacobsen's (1991) conceptualization of ethnocultural countertransference as important aspects to safeguard against, especially that of overidentification, participants seem to illustrate the potential capabilities and possibilities of strengths that can also be leveraged and utilized for the enhancement of the relationships and therapy outcomes in general. Specifically, participants' illustration of what they feel enabled to do in the room by virtue of their shared identities is another way of illuminating the ways in which REM immigrant therapists feel permitted and empowered to utilize knowledge, skills, and parts of self to strengthen the relationship. For example, the descriptions of knowing without saying, the ability to identify, recognize, and explicate complex emotional experiences, and the availability and use of shorthands and heuristics to engage in rapid rapport building were just some of the aspects of strengths and skills that were enabled in the room. While counseling and psychology literature have identified several strategies and tools to build working alliances, including enthusiasm, openness, unconditional positive regard, and empathy (Ackerman & Hilsenroth, 2003), as well as accurate and careful attention to pre- and post-migration narratives, clients' understanding and sensitivity regarding confidentiality, short-term and long-term goals and needs (Yakushko & Chronister, 2005), REM immigrant psychologists in the current study identified nuanced ability and ease to both broach difficult topics related to racial, ethnic, and cultural differences and similarities and relatedly, to self-disclosure. Similar findings were echoed in an unpublished dissertation that

examined immigrant therapists' experiences wherein some participants speculated that increased comfort with engaging in such discussion was a function of changes in their own acculturation level (racial and ethnic identities of participants were not specified; Isaacson, 2002).

Notable for the ways in which sharing and divulging about oneself as a REM immigrant individual appeared consequential and linked to other categories, self-disclosure appeared to be one of the most significant categories to arise from relational experiences. For example, discussions of cultural similarities and differences, the broaching of discussions regarding race and ethnicity, or sharing one's emotional reactions were perceived by participants as easier and at times always relevant. Therapist's disclosure is described by Miller and Stiver (1997) as an "extremely complicated question" and one that the therapist "has to be exquisitely sensitive to":

> Our judgment about what to share with the patient needs to be guided primarily by what we believe will move the relationship, rather than what will relieve the therapist's discomfort, or allow the therapist to express herself … nondisclosure may at times have as significant a consequence for the therapeutic process as would disclosure. Sometimes the therapist's silence may have a very negative effect in working with patients who struggle with authenticity and vulnerability—they may interpret the therapist's lack of response as disapproval or as their own failure to relate well. Also, to "not tell" a patient some important reality about the therapist, which might have an impact on the therapy, might easily result in a serious disconnection in the treatment. (p. 145)

REM immigrant psychologists seem to appreciate the importance of self-disclosure regarding their personal experiences, including values and beliefs (e.g., Yasmin, 277), emotional reactions (e.g., Esmy, 124), as well as broaching topics that may be considered difficult or uncomfortable, such as that of racial and ethnic differences or cultural similarities (e.g., Vanessa,

91) or divergences (e.g., Stephen, 130) for a multitude of reasons, including client-clinician appropriateness and fit (e.g., Yasmin, 277). The ascertainment of fit was especially important given the appreciation and recognition of the intersectionality of identity factors and experiences of, for example, the REM immigrant psychologist who is a female, Pakistani and Muslim-identifying individual who has made a personal decision to no longer wear a hijab or who is conscious of explicitly checking in with their Indian-identifying clients when intracontinental political and cultural tension arise.

The importance and ability to self-disclose was relevant to how REM immigrant psychologists initiate repair in the face of recognizing a relational rupture. The ability to comment on the process, whether it be an apology of the therapist, or the explicit acknowledgement of an assumption made by their client, were all framed in the context of desiring clarification and repair; said in another way, they seemed to desire what RCT theorists state as "movement in relationship":

> Therapist and patient are in this movement together—they are both *moving in relationship*. The therapist too has the experience of being opened up; both are mutually engaged in the process. Each time such movement occurs, the patient mobilizes more of her empathic capacities. So does the therapist. (Miller & Stiver, 1997, p. 130)

It was noted as feeling safer and easier to do with their REM immigrant clients due to what one participant described as the coming together of "two well-practiced individuals" who have had to navigate being the minority in White, heteronormative spaces. Be that as it may, on the discussion of broaching, why some participants feel safer or inclined to do so is unclear. That is, while Knox et al. (2003) found that Black counselors are more likely to bring up topics of race and ethnicity and Utsey et al. (2005) found that White counselor trainees felt more anxiety and

were more reticent to bring up topics of race and ethnicity in cross-cultural dyads, for example, the fact that the current results seem to also align with prior findings does not confirm whether such ease is due to shared ethnic and racial identities or due to the shared experience of being "not from here."

The awareness of self and others as "not from here" has another very important, nuanced implication shown through participants that is echoed in several authors' writings, that of awareness of power in identities and social locations not just by virtue of the disorienting process of *"being raced"* (Ainslie et al., 2013) in the United States. That is, immigrant individuals do not come to the United States with racial classifications, but rather are placed into categories that reflect a racial social order (Jasinskaja-Lahti et al., 2006; Wimmer, 1997; Yakushko, 2009). Awareness of differential power was also acknowledged by virtue of the sociocultural and historical contexts and narratives within and between their countries of origin and that of their clients. REM immigrant clinicians voiced appreciation for awareness of "who is the imperial power in the room" based on intergroup historical traumas. These participants echoed Ainslie and colleagues' (2013) commentary on therapeutic variables as they pertain to contemporary psychoanalytic views of the experience of immigration:

> Ethnic/racial and religious identifications direct our attention specifically to intergroup relations, particularly histories of social struggle, oppression, and conflict. The key proposition here is that both parties in the analytic encounter, as subjects embedded in social structural systems, are consciously and, more importantly, unconsciously impacted in their perceptions and feelings by their participation and (relative) position in those systems. (p. 674)

Navigating Barriers, Negotiating Tensions

In light of the literature that highlights how migration and post-migration adaptation processes look different for each immigrant individual and that experiences of discrimination or systemic barriers, such as documentation status, can add unique challenges to exacerbate distress, the findings of the current study are in line with much of the literature. REM immigrant psychologists mentioned their own experiences navigating such obstacles as well as an appreciation of their own clients' navigation of such barriers and their attempts to facilitate and support them in the process. In this discussion, participants also illustrated their shifting roles, especially that which mirrors their understanding of what a mediator, navigator, negotiator, or teacher would do rather than what their understanding of a clinician or psychotherapist is, by virtue of their own training and what psychologists should or should not do. What is missing in the literature and what is remarked upon most by the participants are the intergenerational experiences of immigrants and families. In fact, Ainslie and colleagues (2013) commented on this directly by stating that few have studied or written about "the common occurrence of intergenerational conflicts within immigrant families, and tensions between first-generation parents and their second-generation children" (p. 675). Systemic barriers, such as the stigma of mental health, were even discussed in terms of intergenerational divisions such that some participants celebrated and appreciated the changing landscape of mental health among Asian communities and individuals in the younger generation.

Given that REM immigrant psychologists are REM immigrant individuals first and foremost, the longstanding macrosystemic barriers, such as racism, discrimination, xenophobia, and policies that create inherent challenges were readily identified and treated with an intimate appreciation and understanding as if they were the participants' own. As importantly, there were

undeniable "ecological disruptions" (Anderson et al., 2000) in U.S. and global sociopolitics that were relevant throughout the process of data-gathering, such as the COVID-19 (coronavirus) pandemic that was first detected in Wuhan, China and spread globally. The U.S. political response was wrought with xenophobic sentiment, starting first with the president's reference of the "China Virus." As mentioned by Anderson and colleagues (2000), ecological disruptions are conceptualized as "external deviations that threaten the nature of the therapeutic relationship" (p. 109). Rather than treated as threats, REM immigrant participants in this study tended to view the heightened xenophobic policies and attitudes of U.S. sociopolitical milieu as catalysts and reminders for their own purpose and role as REM immigrant psychologists and as needing to do more, learn more, and serve more to reach out and meet the mental health needs of their REM immigrant communities.

Reflection as Catalyst; Catalyst for Reflection

The last category emphasized REM immigrant psychologists' engagement with intentional, ongoing self-reflection, which continued through the interview process and was highlighted by some as necessary to do "good work" with REM immigrant clients. The findings reiterate the sixth guideline of APA's guidelines on Race and Ethnicity in Psychology (2019) and their stance that "ongoing self-reflection of one's own positionality and biases along with maintaining one's knowledge-base with current research on race and ethnicity are key to psychologists' ability to practice, teach, consult, and conduct research consistently" (p. 33). REM immigrant psychologists noted past reflections after client encounters that were critical to their own development and growth, particularly in the areas of developing self-awareness of their own privilege, power, and role for how to best serve their REM immigrant clients, as mentioned in the literature (e.g., Atkins et al., 2017; R. C.-L. Chao et al., 2017).

Additionally, Morrow (2005), in their oft cited writing, "Quality and Trustworthiness in Qualitative Research in Counseling Psychology," gave attention to the issue of researcher's subjectivity in qualitative research, especially so when the researcher is an "insider" whose culture and familiarity of a phenomenon may be consonant with that which is being studied. The steps advised to ensure researcher *fairness* to monitor researcher's subjectivity, however, is not fully appreciative of the subjectivity of the researched, nor, therefore, of the created intersubjectivity between and within. Morrow pointed out that others have rejected the subjectivity-objectivity split, instead illuminating the principle of *participatory consciousness,* or an "awareness of a deeper level of kinship between the knower and the known" (Heshusius, 1994, p. 16, as cited by Morrow, 2005). Such awareness elevates *feelings,* as "emotion is seen as an integral part of the human relationship between the knower and the known, and 'being with' the participant replaces mere observation" (Morrow, 2005, p. 255). This point is particularly salient to the current study as almost all REM immigrant participants voiced their own sentiments and reactions before, during, and after with regard to what they hoped for the researcher, the research, themselves, and to the field of psychology.

Strengths and Limitations of the Current Study

The aim of this study was not to arrive at a generalizable theory, but rather to illustrate rich experiences of a therapeutic dyad that is rarely mentioned in the multicultural counseling literature, a reality that undermines the fact that people from all racial and ethnic groups are "subject to the socialization of prejudiced and biased attitudes" (Dickson et al., 2010, p. 249). In fact, in a recent review of the counseling psychology literature spanning almost two decades, Hawkins and colleagues (2022) found that topics that are critical to the work of counseling psychology and counseling professionals including therapy process and outcomes, techniques

and therapy models, and supervision, training and education, were much more understudied in REM-focused articles, compared with non-REM focused articles. Even existing research regarding therapists have mostly been conducted looking at distal, surface-level demographic and professional variables, such as gender and race. Therefore, while it has been established that therapists are one of the primary sources of racial and ethnic disparities in mental health outcomes, more can be said about what does *not* account for those differences than about therapist skills, strategies, or actual behaviors that do account for differences. Researchers (e.g., Hayes et al., 2016) surmise that this gap exists due to the complexity and difficulty of studying process-related constructs that may be more valuable in informing effective therapy work with REM clients. Such processes include managing therapists' emotional reactions due to countertransference when working with REM clients (Comas-Díaz & Jacobsen, 1991; Gelso & Mohr, 2001), addressing cultural misunderstandings, impasses, or other ruptures in the therapeutic relationship (Gaztambide, 2012), effectively broaching the topic of race and racism with REM clients (Day-Vines et al., 2018; King & Borders, 2019), or therapists' use of self-disclosure (Solomonov & Barber, 2018). As they regard REM immigrant psychologists, the current study illuminated aspects of each of the aforementioned therapy processes with varying degrees; however, these results cannot yet be generalized but may give indication for future qualitative research. For example, future research could examine the differential attitudes of REM immigrant psychologists in their comfort, propensity, and goal for broaching and using self-disclosure, as well as consequences for the relationship and clinical encounter. Whether these factors owe to age of immigration, therapy orientation and training, personality traits, or something else entirely different is not yet discernable. Such examinations could have implications for training and views of psychologists in their own hesitation or sense of

navigating tension between what is taught in training and what they experience as impactful and therapeutic in their clinical encounters.

There were several limitations of the current study that should be addressed in future research. While grounded theory allowed for the depiction and appreciation of thick descriptions to arise, the therapist's account of the relationship between and within a dyad is not a complete substitute for what might be illuminated by accounting for the clients' experiences, as well as the therapist's. Therefore, a limitation of this study is the unidirectional perspective of only the clinicians' perspectives on a relational experience. In fact, RCT is explicit in how connection is accounted for as "each experience" the "five good things." The current study can only attest to one and the perception of how they experience their clients in connection or disconnection, when mentioned.

Secondly, while the aim of the study was to gather the perspectives of psychologists who identify as racial and ethnic minority immigrant psychologists, broadly, the racial identity of participants was overwhelmingly Asian-identifying such that it can hardly be said that the results can be generalized to be true of the all psychologists who identify as such, given the multitude of racial and ethnic minority individuals and backgrounds of immigrant REM immigrant individuals in the United States. There are several possible explanations for how candidates self-selected themselves to participate or not participate based on the language of the recruitment flyer. For example, just as one participant noted, the individual's conceptualization of what means to be an "immigrant" individual in the United States may be informed by their own personal objectives and understandings for who and for what individuals and families decide to move to the United States. Additionally, given the history of slavery and forced migration of Black individuals, it may be the case the case that the term "immigrant" may undoubtedly invoke

a sense of autonomy, volition, and intentionality, none of which can be considered to be valid in the case of enforced slavery. Future research on this topic may first warrant a deeper investigation into self-descriptors in order to delineate how specific REM populations view themselves as adequately or not adequately captured by the term "immigrant" in order to clarify the voices of the study sample. Additionally, a future separate study that examines the experiences of Black immigrant psychologists may yield results that illuminate important similarities or differences with regard to their experiences with their REM immigrant clients.

Additionally, given the dearth of REM immigrant psychologists in the United States and given some of the participants' own explicit proclamation of enthusiasm and excitement, it is possible that the perspectives of the participants are biased with regard to their sense of passion and positive experiences as they describe their work with REM immigrant participants. This particular bias could as well be influenced by the fact that I, the main researcher, also identify as a REM immigrant psychologist in training, such that social desirability—including the desire to motivate—may have clouded the extent to which participants described negative or challenging experiences, relative to the overwhelmingly positive sentiments and occurrences.

While not entirely related to the question of inquiry, there may be potential for research regarding the difficulty and challenge some participants experienced when relating their emotional experiences of connection with their REM immigrant clients. Such challenges elicit the constructivist theory of emotion as posited by Lisa Feldman Barrett (Barrett, 2017), whose work on emotion research contends that emotions are culturally constructed, and that having knowledge and attenuating to "emotional granularity" is key to wellbeing (Barrett, 2017). That the experience of being "not from here" may encompass a culture within a culture experienced within the therapy room where the REM immigrant therapist is sitting together with the REM

immigrant client that creates the potential for an emotional experience that requires new semantics is not entirely impossible or improbable, given Barrett and colleagues' research. Relatedly, participants in this study seem to allude to a notion of acculturation and identity formation as interminable, never-ending processes that are revisited and revised throughout the lifespan. In this regard, future research might examine how REM immigrant clinicians may, for example, engage in strategic and intentional separation from the English language that allows for healing and restoration of parts of the immigrant individual that were lost in the process of assimilation.

Implications for Practice and Training

Mollen and Ridley (2021) argued that while multicultural counseling competence has been elevated to a prominent status in professional psychology, lack of clarity and confusion around the construct still persists such that now there exists an "impasse" that is exacerbated by leaving unanswered inquiries echoed by graduate student trainees that span the following:

> After amassing all this multicultural information in our courses, I still am uncertain in how to proceed in my counseling with culturally diverse clients. I learned about the values, attitudes, and beliefs of various cultural and racial groups, but when I counsel a client from one of those groups, I still feel stuck. There must be more to multicultural counseling than what I learned in class. (p. 497)

The findings in the current study offer implications for trainees and practitioners who work with REM immigrant clients who may have similar inquiries and whose identities as REM immigrant individuals may yield nuanced reflections. For example, sharing racial and ethnic markers of identity may indicate a greater need to safeguard against not only therapists' assumptions, but also the REM client's assumptions such that self-disclosure is not only warranted, but also may

be imperative in order to clarify expectations and goals for therapy. When REM immigrant trainees and practitioners feel stuck with their REM clients, a part of the therapeutic essence of what it means to provide a connective, healing space may be for the clinician to be to utilize aspects of identifying and resonating with the struggles and hardships to not only offer empathy, but to tolerate and accept the difficult feeling of being "stuck with them," as one participant pointed out (e.g., Leslie). On the latter reflection, REM immigrant psychologists seem to voice that indeed, there is much more to multicultural counseling than what is taught in an academic setting, which has some implications for clinical training. First, educators and supervisors should first recognize, be sensitive to, and familiarize themselves with the nuanced aspects of intracultural, intraracial, and intraethnic variability across all groups. Such awareness and acknowledgement may be consequential for curriculum design and the choosing of literature and texts from which educators fundamentally iterate and influence how trainees, including REM immigrant trainees, view as valid or invalid their own tensions and perceptions that arise in the therapy dyad as well as skills, knowledge, or even roles they feel pulled to utilize but may question the viability or legitimacy of their perceptions. In other words, as iterated by Mollen and Ridley (2021), rather than assume that general training materials and scholarship is an adequate representation of People of Color, training programs, supervisors, and other leadership should seek out resources and research that are specific to REM immigrant individuals and populations.

Conclusion

REM immigrant psychologists who work with REM immigrant clients experience relational opportunities and successes that are at times profound for themselves and their clients. By virtue of their own REM backgrounds and intersectional identities, REM immigrant

psychologists also contend with a complex array of cultural and systemic dynamics—some of which they are aware of, and some of which are outside of their purview until a catalyst for reflection occurs. In revisiting Mollen and Ridley's (2021) last point of lingering reflections, REM immigrant psychologists seem to indicate that there is more to multicultural counseling than what *can be* taught in the classroom. Akin to the way in which there is no substitution for the first-hand experience of relocating, acculturating, and cultivating a new life to appreciate aspects of what it means to be an immigrant individual in the United States, there is no substitution for the first-hand gains of knowledge, experience, and nuanced awareness therapists gain with each new relational success and challenge that is experienced in the therapy room. More critical than content, what participants in this study seem to emphasize and what may be consequential for training programs is the rigorous and recursive act of self-inquiry and reflexivity that requires intentionality and, at times, tolerance and acceptance of challenging emotions and tensions that, when harnessed, may have a profound impact on future practice.

References

Abernethy, A. D., & Eriksson, C. B. (2021). The power of relationships for bridging difference. *Training and Education in Professional Psychology, 15*(1), 62–69. https://doi.org/10.1037/tep0000292

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1-33. https://doi.org/10.1016/S0272-7358(02)00146-0.

Ainslie, R. C., Tummala-Narra, P., Harlem, A., Barbanel, L., & Ruth, R. (2013). Contemporary psychoanalytic views on the experience of immigration. *Psychoanalytic Psychology, 30*(4), 663–679. https://doi.org/10.1037/a0034588

Akhtar, S. (1995). A third individuation: Immigration, identity, and the psychoanalytic process. *Journal of The American Psychoanalytic Association, 43*(4), 1051–1084.

Akhtar, S. (2006). Technical challenges faced by the immigrant psychoanalyst. *The Psychoanalytic Quarterly, 75*(1), 21–43. https://doi.org/10.1002/j.2167-4086.2006.tb00031.x

Akhtar, S. (2014). The mental pain of minorities. *British Journal of Psychotherapy, 30*(2), 136–153. https://doi.org/10.1111/bjp.12081

Alegría, M., Álvarez, K., & DiMarzio, K. (2017). Immigration and mental health. *Current Epidemiology Reports, 4*(2), 145–155. https://doi.org/10.1007/s40471-017-0111-2

Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C.-N., Takeuchi, D., Jackson, J., & Meng, X.-L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*(11), 1264–1272. https://doi.org/10.1176/ps.2008.59.11.1264

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377–402. https://doi.org/10.1037/0003-066X.58.5.377

American Psychological Association. (2012). *Crossroads: The psychology of immigration in the new century. Report of the APA Presidential Task Force on Immigration* [Report]. https://www.apa.org/topics/immigration/report.aspx

American Psychological Association. (2016, October 13). *Stress in America: U.S. Presidential Election 2016*. https://www.apa.org/news/press/releases/2016/10/presidential-election-stress

American Psychological Association. (2016). *2015 survey of psychology health service providers* [Report]. https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf

American Psychological Association. (2017a). *Ethical principles of psychologists and code of conduct.* https://www.apa.org/ethics/code

American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality, 2017*. https://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2019). *Stress in America*. https://www.apa.org/news/press/releases/stress/2019/stress-america-2019.pdf

American Psychological Association, APA Task Force on Race and Ethnicity Guidelines in Psychology. (2019). *Race and ethnicity guidelines in psychology: Promoting responsiveness and equity*. https://www.apa.org/about/policy/guidelines-race-ethnicity.pdf

American Psychological Association, Commission on Accreditation. (2018). *Standards of accreditation for health service psychology and accreditation operating procedures*. https://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

Arredondo, P., Toporek, R., Brown, S. P., Sanchez, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling & Development, 24*(1), 42–78. https://doi.org/10.1002/j.2161-1912.1996.tb00288.x

Arredondo, P., Tovar-Blank, Z. G., & Parham, T. A. (2008). Challenges and promises of becoming a culturally competent counselor in a sociopolitical era of change and empowerment. *Journal of Counseling & Development*, *86*(3), 261–268. https://doi.org/10.1002/j.1556-6678.2008.tb00508.x

Atkins, S. L., Fitzpatrick, M. R., Poolokasingham, G., Lebeau, M., & Spanierman, L. B. (2017). Make it personal: A qualitative investigation of White counselors' multicultural awareness development. *The Counseling Psychologist*, *45*(5), 669–696. https://doi.org/10.1177/0011000017719458

Autin, K. L., Duffy, R. D., Jacobson, C. J., Dosani, K. M., Barker, D., & Bott, E. M. (2018). Career development among undocumented immigrant young adults: A psychology of working perspective. *Journal of Counseling Psychology*, *65*(5), 605–617.

Barrett, L. F. (2017). The theory of constructed emotion: An active inference account of interoception and categorization. *Social Cognitive and Affective Neuroscience*, *12*(1), 1–23.

Basáñez, T., Sussman, S., Clark, J., & Unger, J. B. (2019). Intragroup xenophobic attitudes, ethnic identity, and substance use among Latinx adolescents. *Journal of Ethnicity in Substance Abuse*, *19*(3), 1–18.

Bashi, V., & McDaniel, A. (1997). A theory of immigration and racial stratification. *Journal of Black Studies*, *27*(5), 668–682. https://doi.org/10.1177/002193479702700505

Batalova, J., Blizzard, B., & Bolter, J. (2020, February 14). *Frequently requested statistics on immigrants and immigration in the United States*. https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states

Berger, L. K., Zane, N., & Hwang, W.-C. (2014). Therapist ethnicity and treatment orientation differences in multicultural counseling competencies. *Asian American Journal of Psychology*, *5*(1), 53–65. https://doi.org/10.1037/a0036178

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review*, *46*(1), 5–34. https://doi.org/10.1111/j.1464-0597.1997.tb01087

Berry, J. W. (2006). Mutual attitudes among immigrants and ethnocultural groups in Canada. *International Journal of Intercultural Relations*, *30*(6), 719–734.

Bhugra, D., & Gupta, S. (2011). *Migration and mental health*. Cambridge University Press.

Birrell, P. J., & Freyd, J. J. (2006). Betrayal trauma: Relational models of harm and healing. *Journal of Psychological Trauma, 5*(1), 49–63.

Blanco, C., Patel, C. S., Liu, L., Jiang, H., Lewis-Fernández, R., Schmidt, A. B., Liebowitz, M. R., & Olfson, M. (2007). National trends in ethnic disparities in mental health care. *Medical Care*, *45*(11), 1012–1019.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Boss, P. (2009). *Ambiguous loss: Learning to live with unresolved grief*. Harvard University Press.

Bresnahan, M. J., Ohashi, R., Nebashi, R., Liu, W. Y., & Shearman, S. M. (2002). Attitudinal and affective response toward accented English. *Language & Communication*, *22*(2), 171–185.

Bridges, A. J., Andrews, A. R., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-Southern United States. *Journal of Transcultural Nursing*, *23*(4), 359–368. https://doi.org/10.1177/1043659612451259

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Burton, L. M., Bonilla-Silva, E., Ray, V., Buckelew, R., & Freeman, E. H. (2010). Critical race theories, colorism, and the decade's research on families of color. *Journal of Marriage and Family*, *72*(3), 440–459. https://doi.org/10.1111/j.1741-3737.2010.00712.x

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health*, *33*(3), 316–330.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4), 537–554. https://doi.org/10.1037/a0025266

Cacioppo, J. T., Semin, G. R., & Berntson, G. G. (20040517). Realism, instrumentalism, and scientific symbiosis: Psychological theory as a search for truth and the discovery of solutions. *American Psychologist*, *59*(4), 214–223. https://doi.org/10.1037/0003-066X.59.4.214

Cantor-Graae, E., & Selten, J.-P. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry: Official Journal of the American Psychiatric Association*, *162*(1), 12–24. https://doi.org/10.1176/appi.ajp.162.1.12

Carter, R. T. (2007). Racism and psychological and emotional injury. *Counseling Psychologist*, *35*(1), 13–105.

Castillo, L. G., Brossart, D. F., Reyes, C. J., Conoley, C. W., & Phoummarath, M. J. (2007). The influence of multicultural training on perceived multicultural counseling competencies and implicit racial prejudice. *Journal of Multicultural Counseling & Development*, *35*(4), 243–254. https://doi.org/10.1002/j.2161-1912.2007.tb00064.x

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Chang, R. (2000). *Disoriented: Asian Americans, law, and the nation-state*. NYU Press.

Chao, M. M., Okazaki, S., & Hong, Y. (2011). The quest for multicultural competence: Challenges and lessons learned from clinical and organizational research. *Social & Personality Psychology Compass*, *5*(5), 263–274.

Chao, R. C.-L., Paiko, L., Zhang, Y. S. D., & Zhao, C. (2017). Service-learning: A training method to enhance multicultural competence toward international students. *Scholarship of Teaching and Learning in Psychology*, *3*(1), 28–42. https://doi.org/10.1037/stl0000078

Charmaz, K. (2005). Grounded theory in the 21st century. Applications for advancing social justice studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 507–537). Sage.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage.

Charmaz, K., Thornberg, R., & Keane, E. (2018). Evolving grounded theory and social justice inquiry. In N. K. Denzin & Y. S. Lincoln. (Eds.), *The Sage handbook of qualitative research* (5th ed., pp. 576–599). Sage.

Chaudoir, S. R., Earnshaw, V. A., & Andel, S. (2013). "Discredited" versus "discreditable": Understanding how shared and unique stigma mechanisms affect psychological and physical health disparities. *Basic & Applied Social Psychology*, *35*(1), 75–87. https://doi.org/10.1080/01973533.2012.746612

Chitoiu, D. (2021). Faces and Surfaces: A Phenomenology of Intercultural Encounters. *The Role of Intercultural Encounters*, p. 183).

Chung, Y. B. (2013). Presidential address: Immigrant counseling psychologists. *The Counseling Psychologist*, *41*(1), 152–169.

Chung, R. C.-Y., Bemak, F., Ortiz, D. P., & Sandoval-Perez, P. A. (2008). Promoting the mental health of immigrants: A multicultural/social justice perspective. *Journal of Counseling & Development*, *86*(3), 310–317. https://doi.org/10.1002/j.1556-6678.2008.tb00514.x

Clauss-Ehlers, C. S., Chiriboga, D. A., Hunter, S. J., Roysircar, G., & Tummala-Narra, P. (2019). APA multicultural guidelines executive summary: Ecological approach to context, identity, and intersectionality. *American Psychologist*, *74*(2), 232–244. https://doi.org/10.1037/amp0000382

Coates, T.-N. (2015). *Between the world and me*. Penguin Random House.

Coleman, H. L. K., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. *Journal of Counseling Psychology, 42*(1), 55–64. https://doi.org/10.1037/0022-0167.42.1.55

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*(3), 392–402. https://doi.org/10.1037/h0079267

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G., II. (2008). Relational-cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development, 86*(3), 279–287. https://doi.org/10.1002/j.1556-6678.2008.tb00510.x

Constantine, M. G. (2002a). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*(2), 255–263. http://dx.doi.org/10.1037/0022-0167.49.2.255

Constantine, M. G. (2002b). Racism attitudes, White racial identity attitudes, and multicultural counseling competence in school counselor trainees. *Counselor Education & Supervision, 41*(3), 162–174. https://doi.org/10.1002/j.1556-6978.2002.tb01281.x

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16. https://doi.org/10.1037/0022-0167.54.1.1

Crenshaw, K. (1995). *Critical race theory: The key writings that formed the movement*. New Press.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development, 70*(1), 143–150. https://doi.org/10.1002/j.1556-6676.1991.tb01576.x

David, E. J. R., Schroeder, T. M., & Fernandez, J. (2019). Internalized racism: A systematic review of the psychological literature on racism's most insidious consequence. *Journal of Social Issues, 75*(4), 1057–1086. https://doi.org/10.1111/josi.12350

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Van Tongeren, D. R., Worthington, E. L., Jr., & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy, 55*(1), 89–100. https://doi.org/10.1037/pst0000160

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12*(2), 279–289. https://doi.org/10.1177/104973230201200211

Day-Vines, N. L., Booker Ammah, B., Steen, S., & Arnold, K. M. (2018). Getting comfortable with discomfort: Preparing counselor trainees to broach racial, ethnic, and cultural factors with clients during counseling. *International Journal for the Advancement of Counselling, 40*(2), 89–104.

Delgado, R., Stefancic, J., & Press, T. U. (2000). *Critical race theory: The cutting edge*. Temple University Press.

Derr, A. S. (2015). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services, 67*(3), 265–274. https://doi.org/10.1176/appi.ps.201500004

Dickson, G. L., Argus-Calvo, B., & Tafoya, N. G. (2010). Multicultural counselor training experiences: Training effects and perceptions of training among a sample of predominately Hispanic students. *Counselor Education & Supervision*, *49*(4), 247–265. https://doi.org/10.1002/j.1556-6978.2010.tb00101.x

Dreby, J. (2015). U.S. immigration policy and family separation: The consequences for children's well-being. *Social Science & Medicine*, *132*, 245–251. https://doi.org/10.1016/j.socscimed.2014.08.041

Drinane, J. M., Owen, J., Adelson, J. L., & Rodolfa, E. (2016). Multicultural competencies: What are we measuring? *Psychotherapy Research*, *26*(3), 342–351. https://doi.org/10.1080/10503307.2014.983581

Duncan, B. L. (2014). *On becoming a better therapist: Evidence-based practice one client at a time*. American Psychological Association.

Edwards, F., Lee, H., & Esposito, M. (2019). Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. *Proceedings of the National Academy of Sciences of the United States of America*, *116*(34), 16793.

Edwards, J. (1999). Refining our understanding of language attitudes. *Journal of Language and Social Psychology*, *18*(1), 101–110.

Espenshade, T. J. (2000). Immigrants, Puerto Ricans, and the earnings of native Black males. *Immigration and Race: New Challenges for American Democracy*, 125–142.

Fadiman, A. (2012). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. Macmillan.

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology*, *52*(2), 156–166.

Forte, A., Trobia, F., Gualtieri, F., Lamis, D. A., Cardamone, G., Giallonardo, V., Fiorillo, A., Girardi, P., & Pompili, M. (2018). Suicide risk among immigrants and ethnic minorities: A literature overview. *International Journal of Environmental Research and Public Health*, *15*(7), 1438. https://doi.org/10.3390/ijerph15071438

Fowers, B. J., & Davidov, B. J. (2006). The virtue of multiculturalism: Personal transformation, character, and openness to the other. *American Psychologist*, *61*(6), 581–594. https://doi.org/10.1037/0003-066X.61.6.581

Freire, P. (1970). *Pedagogy of the oppressed*. Continuum.

Fuertes, J. N., Mueller, L. N., Chauhan, R. V., Walker, J. A., & Ladany, N. (2002). An investigation of European American therapists' approach to counseling African American clients. *Counseling Psychologist*, *30*(5), 763–788. https://doi.org/10.1177/0011000002305007

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy*, *43*(4), 480–490. https://doi.org/10.1037/0033-3204.43.4.480

Garcini, L. M., Murray, K. E., Zhou, A., Klonoff, E. A., Myers, M. G., & Elder, J. P. (2016). Mental health of undocumented immigrant adults in the United States: A systematic review of methodology and findings. *Journal of Immigrant & Refugee Studies*, *14*(1), 1–25. https://doi.org/10.1080/15562948.2014.998849

Garcini, L. M., Galvan, T., Peña, J. M., Klonoff, E. A., Parra-Medina, D., Ziauddin, K., & Fagundes, C. P. (2019). "A high price paid": Migration-related loss and distress among undocumented Mexican immigrants. *Journal of Latinx Psychology*, *7*(3), 245–255. https://doi.org/10.1037/lat0000127

Garza-Guerrero, A. C. (1974). Culture shock: Its mourning and the vicissitudes of identity. *Journal of the American Psychoanalytic Association*, *22*(2), 408–429.

Gaztambide, D. J. (2012). Addressing cultural impasses with rupture resolution strategies: A proposal and recommendations. *Professional Psychology: Research & Practice*, *43*(3), 183–189. https://doi.org/10.1037/a0026911

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old issues, new directions. *Du Bois Review: Social Science Research on Race*, *8*(1), 115–132. https://doi.org/10.1017/S1742058X11000130

Gelso, C. J., & Mohr, J. J. (2001). The working alliance and the transference/countertransference relationship: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists. *Applied and Preventive Psychology*, *10*(1), 51–68. https://doi.org/10.1016/S0962-1849(05)80032-0

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Aldine.

Gluszek, A., & Dovidio, J. F. (2010). Speaking with a nonnative accent: Perceptions of bias, communication difficulties, and belonging in the United States. *Journal of Language and Social Psychology*, *29*(2), 224–234.

Gramlich, J. (2019, January 16). *How Americans see illegal immigration, the border wall and political compromise*. https://www.pewresearch.org/fact-tank/2019/01/16/how-americans-see-illegal-immigration-the-border-wall-and-political-compromise/

Green, N. W., & Lin, A. C. (2002). *Immigration*. CQ Press.

Hall, R. E. (1994). The "bleaching syndrome": Implications of light skin for Hispanic American assimilation. *Hispanic Journal of Behavioral Sciences*, *16*(3), 307–314. https://doi.org/10.1177/07399863940163008

Hall, R. E. (1995). The bleaching syndrome: African Americans' response to cultural domination vis-à-vis skin color. *Journal of Black Studies, 26*(2), 172–184.

Hall, R. E. (1997). Eurogamy among Asian-Americans: A note on Western assimilation. *The Social Science Journal, 34*(3), 403–408. https://doi.org/10.1016/S0362-3319(97)90038-0

Hall, M., & Greenman, E. (2015). The occupational cost of being illegal in the United States: Legal status, job hazards, and compensating differentials. *International Migration Review, 49*(2), 406–442. http://dx.doi.org/10.1111/imre.12090

Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., Burke, C., Kershner-Rice, K., & Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research & Practice, 37*(1), 66–74. https://doi.org/10.1037/0735-7028.37.1.66

Harrison, D. K. (1975). Race as a counselor-client variable in counseling and psychotherapy: A review of the research. *Counseling Psychologist, 5*(1), 124–133.

Hatzenbuehler, M. L., Prins, S. J., Flake, M., Philbin, M., Frazer, M. S., Hagen, D., & Hirsch, J. (2017). Immigration policies and mental health morbidity among Latinos: A state-level analysis. *Social Science & Medicine, 174*, 169–178. https://doi.org/10.1016/j.socscimed.2016.11.040

Hawkins, J. M., Bean, R. A., Smith, T. B., & Sandberg, J. G. (2022). Representation of race and ethnicity in counseling and counseling psychology journals. *The Counseling Psychologist, 50*(1), 123–144. https://doi.org/10.1177/00110000211041766

Hayes, J. A., McAleavey, A. A., Castonguay, L. G., & Locke, B. D. (2016). Psychotherapists' outcomes with White and racial/ethnic minority clients: First, the good news. *Journal of Counseling Psychology, 63*(3), 261–268. https://doi.org/10.1037/cou0000098

Hayes, J. A., Owen, J., & Bieschke, K. J. (2015). Therapist differences in symptom change with racial/ethnic minority clients. *Psychotherapy*, *52*(3), 308–314. https://doi.org/10.1037/a0037957

Hays, P. A. (2016). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (3rd ed.). American Psychological Association.

Heckathorn, D. D., & Cameron, C. J. (2017). Network sampling: From snowball and multiplicity to respondent-driven sampling. *Annual Review of Sociology*, *43*, 101–119.

Hochschild, J., & Weaver, V. (2007). The skin color paradox and the American racial order. *Social Forces*, *86*(2), 643–670.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. https://doi.org/10.1037/a0032595

Hosoda, M., & Stone-Romero, E. (2010). The effects of foreign accents on employment-related decisions. *Journal of Managerial Psychology*, *25*(2), 113–132.

Hovey, J. D., & Magaña, C. G. (2002). Psychosocial predictors of anxiety among immigrant Mexican migrant farmworkers: Implications for prevention and treatment. *Cultural Diversity and Ethnic Minority Psychology*, *8*(3), 274–289. https://doi.org/10.1037/1099-9809.8.3.274

Hunter, M. (2007). The persistent problem of colorism: Skin tone, status, and inequality. *Sociology Compass*, *1*(1), 237–254. https://doi.org/10.1111/j.1751-9020.2007.00006.x

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study

of cultural competence. *Journal of Counseling Psychology*, *58*(3), 290–298. https://doi.org/10.1037/a0023284

Isaacson, E. (2002). *The effect of evolving cultural identities on the experience of immigrant psychotherapists* [Unpublished doctoral dissertation]. http://search.proquest.com/docview/305458861/abstract/D357F090E00E467CPQ/1

Jasinskaja-Lahti, I., Liebkind, K., & Perhoniemi, R. (2006). Perceived discrimination and well-being: A victim study of different immigrant groups. *Journal of Community & Applied Social Psychology*, *16*(4), 267–284. https://doi.org/10.1002/casp.865

Jayawardene, S. M. (2016). Racialized casteism: Exposing the relationship between race, caste, and colorism through the experiences of Africana people in India and Sri Lanka. *Journal of African American Studies*, *20*(3), 323–345. https://doi.org/10.1007/s12111-016-9333-5

Jaynes, G. D. (2008). *Immigration and race: New challenges for American democracy*. Yale University Press.

Jezewski, M. A. (1995). Evolution of a grounded theory: Conflict resolution through culture brokering. *Advances in Nursing Sciences*, *17*(3), 14–30.

Johnson, A. G. (2006). *Privilege, power, and difference*. McGraw-Hill.

Jones, C. T., & Welfare, L. E. (2017). Broaching behaviors of licensed professional counselors: A qualitative inquiry. *Journal of Addictions & Offender Counseling*, *38*(1), 48–64. https://doi.org/10.1002/jaoc.12028

Jones, K. W. (2001). *Accent on privilege: English identities and Anglophilia in the U.S.* Temple University Press.

Jordan, J. V. (1999). *Toward connection and competence* (Work in Progress No. 83). Stone Center Working Paper Series.

Jordan, J. V. (2017). Relational-cultural theory: The power of connection to transform our lives. *Journal of Humanistic Counseling*, *56*(3), 228–243.

Kaiser Family Foundation. (2020, March 18). *Health coverage of immigrants*. https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/

Kendall, J. (1999). Axial coding and the grounded theory controversy. *Western Journal of Nursing Research*, *21*(6), 743–757.

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2009). Client adherence to Asian cultural values, common factors in counseling, and session outcome with Asian American clients at a university counseling center. *Journal of Counseling & Development*, *87*(2), 131–142. https://doi.org/10.1002/j.1556-6678.2009.tb00560.x

Kim, C. J. (2000). *Bitter fruit: The politics of Black-Korean conflict in New York City*. Yale University Press.

King, K. M., & Borders, L. D. (2019). An experimental investigation of White counselors broaching race and racism. *Journal of Counseling & Development*, *97*(4), 341–351. https://doi.org/10.1002/jcad.12283

Kirmayer, L. J. (2013). Embracing uncertainty as a path to competence: Cultural safety, empathy, and alterity in clinical training. *Culture, Medicine, and Psychiatry: An International Journal of Cross-Cultural Health Research*, *37*(2), 365–372. https://doi.org/10.1007/s11013-013-9314-2

Kissil, K., Davey, M., & Davey, A. (2013a). Therapists in a foreign land: Acculturation, language proficiency and counseling self-efficacy among foreign-born therapists practicing in the United States. *International Journal for the Advancement of Counselling*, *35*(3), 216–233. https://doi.org/10.1007/s10447-012-9178-0

Kissil, K., Davey, M., & Davey, A. (2015). Foreign-born therapists: How acculturation and supervisors' multicultural competence are associated with clinical self-efficacy. *Journal of Multicultural Counseling & Development, 43*(1), 38–57. https://doi.org/10.1002/j.2161-1912.2015.00063.x

Kissil, K., Niño, A., & Davey, M. (2013b). Doing therapy in a foreign land: When the therapist is "not from here." *American Journal of Family Therapy*, *41*(2), 134–147. https://doi.org/10.1080/01926187.2011.641441

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology, 50*(4), 466–481. https://doi.org/10.1037/0022-0167.50.4.466

Kochhar, R., & Cilluffo, A. (2018, July 12). *Key findings on the rise in income inequality within America's racial and ethnic groups*. https://www.pewresearch.org/fact-tank/2018/07/12/key-findings-on-the-rise-in-income-inequality-within-americas-racial-and-ethnic-groups/

Kraut, A. M. (1995). *Silent travelers: Germs, genes, and the immigrant menace*. JHU Press.

Larrison, C. R., Schoppelrey, S. L., Hack-Ritzo, S., & Korr, W. S. (2011). Clinician factors related to outcome differences between Black and White patients at CMHCs. *Psychiatric Services, 62*(5), 525–531.

Lee, C. C. (2018). *Multicultural issues in counseling: New approaches to diversity*. John Wiley & Sons.

Lee, E. (2002). The Chinese exclusion example: Race, immigration, and American gatekeeping, 1882-1924. *Journal of American Ethnic History, 21*(3), 36–62.

Leech, N. L., & Onwuegbuzie, A. J. (2011). Beyond constant comparison qualitative data analysis: Using Nvivo. *School Psychology Quarterly, 26*(1), 70–84.

Lev-Ari, S., & Keysar, B. (2010). Why don't we believe non-native speakers? The influence of accent on credibility. *Journal of Experimental Social Psychology*, *46*(6), 1093–1096.

Lenz, A. S. (2016). Relational-cultural theory: Fostering the growth of a paradigm through empirical research. *Journal of Counseling & Development*, *94*(4), 415–428. https://doi.org/10.1002/jcad.12100

Lin, L., Stamm, K., & Christidis, P. (2018). *Demographics of the U.S. psychology workforce: Findings from the 2007-16 American Community Survey*. https://www.apa.org/workforce/publications/16-demographics/report.pdf

Maramba, G. G., & Hall, G. C. N. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity & Ethnic Minority Psychology*, *8*(3), 290–297.

Marcos, L. R., Alpert, M., Urcuyo, L., & Kesselman, M. (1973). The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients. *The American Journal of Psychiatry*, *130*(5), 549–553. https://doi.org/10.1176/ajp.130.5.549

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, *24*(3), 187–210. https://doi.org/10.1007/s10880-017-9510-2

Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training*, *43*(1), 85–98. https://doi.org/10.1037/0033-3204.43.1.85

McDaniel, A. (1995). The dynamic racial composition of the United States. *Daedalus*, *124*(1), 179–198. JSTOR.

Merskin, D. L. (2011). *Media, minorities, and meaning: A critical introduction*. Peter Lang.

Migration Policy Institute. (2020). *Profile of the unauthorized population: United States*. [Table]. https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/US

Miller, J. B. (1976). *Toward a New Psychology of Women*. Beacon Press.

Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Beacon Press.

Mirsalimi, H. (2010). Perspectives of an Iranian psychologist practicing in America. *Psychotherapy: Theory, Research, Practice, Training*, *47*(2), 151–161. https://doi.org/10.1037/a0019754

Missinne, S., & Bracke, P. (2012). Depressive symptoms among immigrants and ethnic minorities: A population-based study in 23 European countries. *Social Psychiatry & Psychiatric Epidemiology*, *47*(1), 97–109. https://doi.org/10.1007/s00127-010-0321-0

Mollen, D., & Ridley, C. R. (2021). Rethinking multicultural counseling competence: An introduction to the major contribution. *The Counseling Psychologist*, *49*(4), 490–503. https://doi.org/10.1177/0011000020986543

Moradi, B., & Hasan, N. T. (2004). Arab American persons' reported experiences of discrimination and mental health: The mediating role of personal control. *Journal of Counseling Psychology*, *51*(4), 418–428. https://doi.org/10.1037/0022-0167.51.4.418

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Morrow, S. L., & Smith, M. L. (2000). Qualitative research for counseling psychology. *Handbook of Counseling Psychology*, *3*, 199–230.

Munro, N. (2006). The immigrant numbers game. *National Journal*, *38*(25), 48.

Neville, H. A., Heppner, M. J., Louie, C. E., Thompson, C. E., Brooks, L., & Baker, C. E. (1996). The impact of multicultural training on White racial identity attitudes and therapy competencies. *Professional Psychology: Research and Practice*, *27*(1), 83–89. https://doi.org/10.1037/0735-7028.27.1.83

Neville, H. A., & Mobley, M. (2001). Social identities in contexts: An ecological model of multicultural counseling psychology processes. *Counseling Psychologist*, *29*(4), 471–486. https://doi.org/10.1177/0011000001294001

Newcomb, T. M. (1961). The acquaintance process as a prototype of human interaction. In T. M. Newcomb, *The acquaintance process* (p. 259–261). Holt, Rinehart & Winston. https://doi.org/10.1037/13156-015

Niño, A. (2013). *Experiences of immigrant couple and family therapists clinically active in the United States* [Unpublished doctoral dissertation]. https://idea.library.drexel.edu/islandora/object/idea%3A6139

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–390). Wiley.

Owen, J. J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research, 27*(1), 102–111. https://doi.org/10.1080/10503307.2015.1078517

Owen, J. J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). "No-show": Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology, 59*(2), 314–320. https://doi.org/10.1037/a0027091

Owen, J. J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011a). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling & Psychotherapy Research, 11*(3), 204–212. https://doi.org/10.1080/14733145.2010.491551

Owen, J. J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011b). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology, 58*(1), 1–9. https://doi.org/10.1037/a0021496

Owen, J. J., Tao, K. W., Leach, M. M., & Rodolfa, E. (2011c). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*(3), 274–282. https://doi.org/10.1037/a0022065

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage.

Pedersen, P. (1999). *Multiculturalism as a fourth force*. Brunner/Mazel.

Perreira, K. M., Gotman, N., Isasi, C. R., Arguelles, W., Castañeda, S. F., Daviglus, M. L., Giachello, A. L., Gonzalez, P., Penedo, F. J., Salgado, H., & Wassertheil-Smoller, S. (2015). Mental health and exposure to the United States: Key correlates from the Hispanic Community Health Study of Latinos. *Journal of Nervous and Mental Disease, 203*(9), 670–678. http://dx.doi.org/10.1097/NMD.0000000000000350

Pew Research Center. (2015, September 28). *Modern immigration wave brings 59 million to U.S., driving population growth and change through 2065.* [Report]. https://www.pewresearch.org/237ispanic/2015/09/28/modern-immigration-wave-brings-59-million-to-u-s-driving-population-growth-and-change-through-2065/

Pieterse, A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education: A review and analysis of a sample of multicultural course syllabi. *The Counseling Psychologist, 37*(1), 93–115. https://doi.org/10.1177/0011000008319986

Pitner, R. O., & Sakamoto, I. (2005). The role of critical consciousness in multicultural practice: Examining how its strength becomes its limitation. *The American Journal of Orthopsychiatry, 75*(4), 684–694.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137–145. https://doi.org/10.1037/0022-0167.52.2.137

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Ponterotto, J. G. (2010). Multicultural personality: An evolving theory of optimal functioning in culturally heterogeneous societies. *Counseling Psychologist, 38*(5), 714–758. https://doi.org/10.1177/0011000009359203

Pope-Davis, D. B., & Ottavi, T. M. (1994). The relationship between racism and racial identity among White Americans: A replication and extension. *Journal of Counseling & Development, 72*(3), 293–297. https://doi.org/10.1002/j.1556-6676.1994.tb00937.x

Price, C. S., & Cuellar, I. (1981). Effects of language and related variables on the expression of psychopathology in Mexican American psychiatric patients. *Hispanic Journal of Behavioral Sciences, 3*(2), 145–160.

Prilleltensky, I., & Gonick, L. (1996). Polities change, oppression remains: On the psychology and politics of oppression. *Political Psychology, 17*(1), 127–148.

Pyke, K. D. (2010). What is internalized racial oppression and why don't we study it? Acknowledging racism's hidden injuries. *Sociological Perspectives, 53*(4), 551–572. https://doi.org/10.1525/sop.2010.53.4.551

Radford, J. (2019, July 17). *Key findings about U.S. immigrants*. https://www.pewresearch.org/fact-tank/2019/06/17/key-findings-about-u-s-immigrants/

Ramirez, S. Z., Wassef, A., Paniagua, F. A., Linskey, A. O., & O'Boyle, M. (1994). Perceptions of mental health providers concerning cultural factors in the evaluation of Hispanic children and adolescents. *Hispanic Journal of Behavioral Sciences, 16*(1), 28–42. https://doi.org/10.1177/07399863940161003

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling

profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. https://doi.org/10.1002/jmcd.12035

Rennie, D. L. (2004). Reflexivity and person-centered counseling. *Journal of Humanistic Psychology*, *44*(2), 182–203.

Rogers, M. R., & O'Bryon, E. C. (2014). Multicultural training models and curriculum. In F. T. L. Leong, L. Comas-Díaz, G. C. Nagayama Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA handbook of multicultural psychology: Applications and training* (Vol. 2, pp. 659–679). American Psychological Association. https://doi.org/10.1037/14187-037

Rondilla, J. L., Spickard, P. R., & Spickard, P. P. (2007). *Is lighter better? Skin-tone discrimination among Asian Americans*. Rowman & Littlefield.

Rose, S., & Hiller, S. (2007). From migrant work to community transformation: Families forming transnational communities in Periban and Pennsylvania. *Oral History Review*, *34*(1), 95–142.

Safran, J. D. (1993). The therapeutic alliance rupture as a transtheoretical phenomenon: Definitional and conceptual issues. *Journal of Psychotherapy Integration*, *3*(1), 33–49. https://doi.org/10.1037/h0101190

Sam, D. L., & Berry, J. W. (2010). Acculturation: When individuals and groups of different cultural backgrounds meet. *Perspectives on Psychological Science*, *5*(4), 472–481. https://doi.org/10.1177/1745691610373075

Sanchez, G., & Romero, M. (2010). Critical race theory in the U.S. sociology of immigration. *Sociology Compass*, *4*(9), 779–788. https://doi.org/10.1111/j.1751-9020.2010.00303.x

Schmitt, M. T., Branscombe, N. R., Postmes, T., & Garcia, A. (2014). The consequences of perceived discrimination for psychological well-being: A meta-analytic review. *Psychological Bulletin*, *140*(4), 921–948. https://doi.org/10.1037/a0035754

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 221–259). Sage.

Segal, U. A., Elliott, D., & Mayadas, N. S. (2010). *Immigration worldwide: Policies, practices, and trends*. Oxford University Press.

Sehgal, R., Saules, K., Young, A., Grey, M. J., Gillem, A. R., Nabors, N. A., Byrd, M. R., & Jefferson, S. (2011). Practicing what we know: Multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity & Ethnic Minority Psychology*, *17*(1), 1–10. https://doi.org/10.1037/a0021667

Sella, E. (2006). *Countertransference and empathy: The perceptions and experiences of polyglot immigrant clinicians, who, working with monolingual or bilingual immigrant children, are practicing in a language that is not their mother tongue* [Unpublished doctoral dissertation]. New York University.

Shin, S.-M., Chow, C., Camacho-Gonsalves, T., Levy, R. J., Allen, I. E., & Leff, H. S. (2005). A meta-analytic review of racial-ethnic matching for African American and Caucasian American clients and clinicians. *Journal of Counseling Psychology*, *52*(1), 45–56. https://doi.org/10.1037/0022-0167.52.1.45

Siemons, R., Raymond-Flesh, M., Auerswald, C. L., & Brindis, C. D. (2017). Coming of age on the margins: Mental health and wellbeing among Latino immigrant young adults eligible

for Deferred Action for Childhood Arrivals (DACA). *Journal of Immigrant and Minority Health, 19*(3), 543–551. https://doi.org/10.1007/s10903-016-0354-x

Simons, H. W., Berkowitz, N. N., & Moyer, R. J. (1970). Similarity, credibility, and attitude change: A review and a theory. *Psychological Bulletin, 73*(1), 1–16. https://doi-org/10.1037/h0028429

Singer, R. R. (2012). *The experience of clinicians who work with immigrants: Challenges and opportunities* [Unpublished doctoral dissertation]. http://hdl.handle.net/2345/2581

Singer, R. R., & Tummala-Narra, P. (2013). White clinicians' perspectives on working with racial minority immigrant clients. *Professional Psychology: Research and Practice, 44*(5), 290–298. https://doi.org/10.1037/a0034299

Singh, S., Schulz, A. J., Neighbors, H. W., & Griffith, D. M. (2017). Interactive effect of immigration-related factors with legal and discrimination acculturative stress in predicting depression among Asian American immigrants. *Community Mental Health Journal, 53*(6), 638–646. https://doi.org/10.1007/s10597-016-0064-9

Smith, T. B., & Trimble, J. E. (2016). Multicultural education/training and experience: A meta-analysis of surveys and outcome studies. In *Foundations of multicultural psychology: Research to inform effective practice* (pp. 21–47). American Psychological Association. https://doi.org/10.1037/14733-002

Sodowsky, G. R., Kuo-Jackson, P. Y., Richardson, M. F., & Corey, A. T. (1998). Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control racial ideology, and multicultural training. *Journal of Counseling Psychology, 45*(3), 256–264. https://doi.org/10.1037/0022-0167.45.3.256

Sodowsky, G. R., & Taffe, R. C. (1994). Development of the multicultural counseling inventory: A self-report measure of multicultural. *Journal of Counseling Psychology, 41*(2), 137–148. https://doi.org/10.1037/0022-0167.41.2.137

Solheim, C., Zaid, S., & Ballard, J. (2016). Ambiguous loss experienced by transnational Mexican immigrant families. *Family Process, 55*(2), 338–353. https://doi.org/10.1111/famp.12130

Solomonov, N., & Barber, J. P. (2018). Patients' perspectives on political self-disclosure, the therapeutic alliance, and the infiltration of politics into the therapy room in the Trump era. *Journal of Clinical Psychology, 74*(5), 779–787. https://doi.org/10.1002/jclp.22609

Southern Poverty Law Center. (2020a, March 24). *Hate group leaders, antigovernment extremists push anti-China coronavirus rhetoric*. https://www.splcenter.org/hatewatch/2020/03/24/hate-group-leaders-antigovernment-extremists-push-anti-china-coronavirus-rhetoric

Southern Poverty Law Center. (2020b). *The year in hate and extremism 2019*. [Report]. https://www.splcenter.org/sites/default/files/yih_2020_final.pdf

Soto, A., Smith, T. B., Griner, D., Rodríguez, M. D., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology, 74*(11), 1907–1923. https://doi.org/10.1002/jclp.22679

Speight, S. L. (2007). Internalized racism: One more piece of the puzzle. *The Counseling Psychologist, 35*(1), 126–134. https://doi.org/10.1177/0011000006295119

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372–1380. https://doi.org/10.1177/1049732307307031

Stockdale, S. E., Lagomasino, I. T., Siddique, J., McGuire, T., & Miranda, J. (2008). Racial and ethnic disparities in detection and treatment of depression and anxiety among psychiatric and primary health care visits, 1995-2005. *Medical Care, 46*(7), 668–677.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques*. Sage.

Sue, D. W. (1977). Counseling the culturally different: A conceptual analysis. *Personnel & Guidance Journal*, *55*(7), 422–425. https://doi.org/10.1002/j.2164-4918.1977.tb05281.x

Sue, D. W. (2016). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race*. John Wiley & Sons.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *Counseling Psychologist*, *10*(2), 45–52.

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). John Wiley & Sons.

Thornton, M. C., & Mizuno, Y. (1999). Economic well-being and Black adult feelings toward immigrants and Whites, 1984. *Journal of Black Studies*, *30*(1), 15–44. https://doi.org/10.1177/002193479903000102

Ticho, G. R. (1971). Cultural aspects of transference and countertransference: Discussions by Charles Chediak, M. D. and Tetsuya Iwasaki, M. D. *Bulletin of the Menninger Clinic; Topeka, Kan.*, *35*(5), 313–334.

Tikhonov, A. A., Espinosa, A., Huynh, Q.-L., & Anglin, D. M. (2019). Bicultural identity harmony and American identity are associated with positive mental health in U.S. racial and ethnic minority immigrants. *Cultural Diversity and Ethnic Minority Psychology, 25*(4), 494–504. https://doi.org/10.1037/cdp0000268

Toomey, R. B., Umaña-Taylor, A. J., Williams, D. R., Harvey-Mendoza, E., Jahromi, L. B., & Updegraff, K. A. (2014.). Impact of Arizona's SB 1070 immigration law on utilization of health care and public assistance among Mexican-origin adolescent mothers and their mother figures. *American Journal of Public Health, 104*(S1), S28–S34.

Torres, S. A., Santiago, C. D., Walts, K. K., & Richards, M. H. (2018). Immigration policy, practices, and procedures: The impact on the mental health of Mexican and Central American youth and families. *American Psychologist, 73*(7), 843–854. https://doi.org/10.1037/amp0000184

Tribe, R., & Tunariu, A. (2009). Mind your language: Working with interpreters in healthcare settings and therapeutic encounters. *Sexual and Relationship Therapy, 24*(1), 74–84. http://dx.doi.org/10.1080/14681990802666023

Tummala-Narra, P. (2020). The fear of immigrants. *Psychoanalytic Psychology, 37*(1), 50–61. https://doi.org/10.1037/pap0000245

Tummala-Narra, P., Singer, R., Li, Z., Esposito, J., & Ash, S. E. (2012). Individual and systemic factors in clinicians' self-perceived cultural competence. *Professional Psychology: Research & Practice, 43*(3), 165–174. https://doi.org/10.1037/a0025783

Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist, 33*(4), 449–478. https://doi.org/10.1177/0011000004269058

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31*(3), 253–272. https://doi.org/10.1177/0011000003031003001

Villalobos, B. T., Bridges, A. J., Anastasia, E. A., Ojeda, C. A., Hernandez Rodriguez, J., & Gomez, D. (2015). Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients. *Psychological Services, 13*(1), 49–59. https://doi.org/10.1037/ser0000051

Vinson, T. S., & Neimeyer, G. J. (2003). The relationship between racial identity development and multicultural counseling competency: A second look. *Journal of Multicultural Counseling and Development, 31*(4), 262–277. https://doi.org/10.1002/j.2161-1912.2003.tb00354.x

Vontress, C. E., & Jackson, M. L. (2004). Reactions to the multicultural counseling competencies debate. *Journal of Mental Health Counseling, 26*(1), 74–80.

Wilcox, M. M., Franks, D. N., Taylor, T. O., Monceaux, C. P., & Harris, K. (2020). Who's multiculturally competent? Everybody and nobody: A multimethod examination. *The Counseling Psychologist, 48*(4), 466–497. https://doi.org/10.1177/0011000020904709

Williams, C. L., & Berry, J. W. (1991). Primary prevention of acculturative stress among refugees: Application of psychological theory and practice. *American Psychologist, 46*(6), 632–641. https://doi.org/10.1037/0003-066X.46.6.632

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5*(3/4), 243–268.

Wimmer, A. (1997). Explaining xenophobia and racism: A critical review of current research approaches. *Ethnic & Racial Studies*, *20*(1), 17–41. https://doi.org/10.1080/01419870.1997.9993946

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competencies: Verbal content, counselor attributions, and social desirability. *Journal of Counseling Psychology*, *47*(4), 460–468. https://doi.org/10.1037/0022-0167.47.4.460

Yakushko, O. (2009). Xenophobia: Understanding the roots and consequences of negative attitudes toward immigrants. *Counseling Psychologist*, *37*(1), 36–66. https://doi.org/10.1177/0011000008316034

Yakushko, O. (2010a). Stress and coping strategies in the lives of recent immigrants: A grounded theory model. *International Journal for the Advancement of Counselling*, *32*(4), 256–273.

Yakushko, O. (2010b). Working through interpreters with limited-English proficiency clients: A phenomenological investigation. *Professional Psychology: Research, Theory, and Practice*, *41*(5), 449–455.

Yakushko, O. (2018). Hatred of strangers: Defining xenophobia and related concepts. In O. Yakushko (Ed.), *Modern-day xenophobia: Critical historical and theoretical perspectives on the roots of anti-immigrant prejudice* (pp. 11–31). Springer International Publishing. https://doi.org/10.1007/978-3-030-00644-0_2

Yakushko, O., & Chronister, K. M. (2005). Immigrant women and counseling: The invisible others. *Journal of Counseling & Development*, *83*(3), 292–298. https://doi.org/10.1002/j.1556-6678.2005.tb00346.x

Young, I. M. (1990). *Justice and the politics of difference*. Princeton University Press.

Young, R. J. C. (2005). *Colonial desire: Hybridity in theory, culture, and race*. Routledge.

Zayas, L. H., Torres, L. R., Malcolm, J., & DesRosiers, F. S. (1996). Clinicians' definitions of ethnically sensitive therapy. *Professional Psychology: Research and Practice, 27*(1), 78–82. https://doi.org/10.1037/0735-7028.27.1.78

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

This questionnaire is an accompanying survey to your interview. The below questions ask for information regarding your general identifying information, information about your immigration experience, and your clinical experience as a psychologist. All identifying information will be secured and remain confidential.

General Information

Age	
Gender	
Sexual Orientation	
Race	
Ethnicity	
Primary Language Spoken at Home	
Religious Affiliation	

Immigration Experience

In what country were you born?	
If you were born outside of the U.S., at what age did you immigrate?	
How, if at all, would you describe your immigrant status[1] (e.g., first-generation, second-generation, third-generation, etc.)?	
What was the reason or impetus for immigrating to the U.S.?	
How many years have you been living in the U.S.?	

Psychology Training and Clinical Work

What type of psychology graduate training did you receive to become a psychologist	

[1] First-generation immigrant status is designated for an individual who was born outside of the U.S. Second-generation immigrant status is designated for those born in the U.S. to immigrant parents. Third-generation and higher status is designated for an individual who was born in the U.S. to U.S. -born parents.

(e.g., Psy.D, Ph.D, clinical psychology, counseling psychology)?	
In what country did you receive your training?	
How much training did you receive in multicultural competence (Please indicates with hours or number of semesters.)?	
How many years of licensed clinical experience do you have?	
In what language(s) do you conduct psychotherapy or other clinical work?	
How would you describe your current place of employment (e.g., college counseling center, community mental health clinic, VA, private practice)?	
How would you describe your current region of practice (e.g., urban, suburban, rural)?	
In what state are you currently licensed?	

APPENDIX B

SEMI-STRUCTURED INTERVIEW GUIDE

1. Experience of working with REM immigrant clients

    - How many racial minority clients have you worked with? Describe their cultural backgrounds? What is it like to work with racial immigrant minority clients?

2. Counseling relationship

    - I'd like to ask you about one or two specific clients: thinking about a client (or two), who was also a racial and ethnic minority immigrant, tell me about their immigration background and when they first moved to the U.S.?

    - Can you describe a memorable, critical moment when working with these clients, or a time when things did not turn out well? What emotions or responses did you have?

    - Can you tell me about a time when you had a more positive experience with one of your racial minority immigrant clients? What emotions or responses did you have?

    Possible probing questions:
        - How did issues of race/ethnic identity arise in your clinical work?
        - Were you aware of issues of power that played out in the relationship with your client? If so, how?
        - What areas of differences do you discuss between you and your clients (e.g., race, immigration status, documentation status, language, social class)? How (precise language) do you discuss these differences?
        - What resources have been helpful in your work with racial minority immigrant clients?
        - What do you think are barriers in your work with racial minority immigrant clients?

3. Views of Self
    - How does working with racial minority immigrant clients influence your perception of yourself?

    Possible probing questions:

        - How do you perceive your role when working with racial and ethnic immigrant clients?

4. Final Questions
    - What was it like for you to participate in the interview today?
    - Is there anything you would like to add to the interview today?

APPENDIX C

RECRUITMENT EMAIL

Dear Training Director,

Please consider forwarding this to your professional staff.

For the purpose of a qualitative research study, we are seeking practicing psychologists who identify as racial/ethnic minority immigrants who are interested in sharing their perspectives in working with racial/ethnic minority immigrant clients.

Requirements for Participation:

- Currently licensed, practicing psychologist in the U.S.
- Self-identifies as a racial/ethnic minority individual
- Self-identifies as an immigrant individual
- Have provided psychotherapy/counseling services to racial/ethnic minority immigrant clients within the past 12 months

Your participation in this study will entail one in-depth video or phone interview with the possibility of a follow-up interview. The interview is expected to last 60-90 minutes.

Upon completion of the interview, a $20 donation will be made to the Immigration Law Center on behalf of the participant.

The Institutional Review Board at Radford University has approved this doctoral dissertation research project. For more information, please contact Jennifer Oh at Radford University's Counseling Psychology Department at joh8@radford.edu.

Please pass this invitation to other clinicians who may be interested in sharing their experiences and participating.

APPENDIX D

INFORMED CONSENT

RADFORD UNIVERSITY

Informed Consent

Title of Research: Racial Minority Immigrant Therapists' Perspectives Working with Racial Minority Immigrant Clients: Challenges, Opportunities, and Relational Experiences

Researcher(s): Tracy Cohn, Ph.D. (tcohn@radford.edu); Jennifer Oh, MSW, MA (joh8@radford.edu)

You are asked to be a volunteer in a research study designed to explore racial and ethnic minority immigrant therapists' perceptions of their work with racial and ethnic minority immigrant clients.

Purpose:
This research study is being conducted by Jennifer Oh, a doctoral candidate in Counseling Psychology at Radford University. The purpose of the study is to understand racial and ethnic minority immigrant therapists' perceptions of their work with racial and ethnic minority immigrant clients, with a focus on the ways in which therapists experience successes and challenges in their therapeutic relationships, among 12-14 U.S.-based licensed and practicing psychologists.

Procedures:
If you decide to be in the study, you will be asked to participate in a 60-90 minute video or telephone interview and a shorter follow-up interview. During the interview, I will ask questions such as: 1) Can you tell me what it was like to work with a racial and ethnic minority immigrant client?; 2) Can you describe a memorable, critical moment when working with these clients, or a time when things did not turn out well? What emotions or responses did you have?; 3) Can you tell me about a time when you had a more positive experience with one of your racial minority immigrant clients? What emotions or responses did you have?; and 4) How does working with racial minority immigrant clients influence your perception of yourself? All interviews will be audio recorded. Approximately 12-14 people who are licensed psychologists and are currently practicing in the U.S. who identify as racial and ethnic minority immigrants will be asked to participate in the study.

Risks or Discomforts:
The interview is not expected to cause any harm or pose more risk that you may encounter daily. Some of the questions I will ask may make you feel uncomfortable. Should you decide not to answer any or all the questions, or should you want to opt out of your participation in the research at any point in the process, you are free to do so.

Compensation to You:
Your participation in this research is completely voluntary and greatly appreciated. There is no compensation from being in this study.

Benefits:
This interview may add new insights into your role as a practicing psychologist. Additionally, information from the study could add existing research and inspire new research ideas.

You can choose not to be in this study. If you decide to be in this study, you may choose not to answer certain questions or not to be in certain parts of this study.

If you decide to be in this study, what you tell us will be kept private unless required by law to tell. If we present or publish the results of this study, your name will not be linked in any way to what we present.

Confidentiality:
The data collected in this research study will be kept confidential. Participation in research may involve some loss of privacy. I will do my best to make sure that the information about you is kept confidential, but I cannot guarantee total confidentiality. Your personal information may be viewed by individuals involved in the research and may be seen by people including those who are advising me on the study (i.e., chair and committee members). I will share only the minimum necessary information for the research. Your personal information may also be given out if required by law, such as pursuant to a court order. While the information and data resulting from this study may be presented at scientific meetings or published in a scientific journal, your name or other personal information will not be revealed.

I will collect your information through interviews, which will be audio recorded to be transcribed at a later time. When the interview is transcribed, no identifying information will be attached as I will ask you to choose a pseudonym to be used during the interview instead. This information will be stored on an encrypted cloud-based system where personal identifying information will be separated from the data. Because all data collected from this study will be presented as a group, no individual interviewee will be identifiable through the presentation of this data. When directly quoted, I will use the chosen pseudonym without mention of any other identifying information.

The audio recordings will be destroyed promptly after the interview has been transcribed. The recordings may be shared with members of the research team, but it will not be shared with the general public or any other researchers. You do have to agree to be recorded in order to participate in this study.

Costs to You:
There are no foreseeable costs to you as a result of participating in this study. You should not be in the study if you have any physical or mental illness or weakness that would increase your risk of harm from the study.

Questions about Your Rights as a Research Participant:

If at any time you want to stop being in this study, you may stop being in the study without penalty or loss of benefits by contacting Dr. Tracy Cohn at 540-230-5958 or tcohn@radford.edu.

If you have questions now about this study, ask before you sign this form. If you have any questions later, you may talk with Jennifer Oh or Tracy Cohn.

If this study raised some issues that you would like to discuss with a professional, you may contact Jennifer Oh at 513-545-2773 or joh8@radford.edu for a list of resources and recommended providers.

This study was approved by the Radford University Committee for the Review of Human Subjects Research. If you have questions or concerns about your rights as a research subject or have complaints about this study, you should contact Dr. Ben Caldwell, Institutional Official and Dean of the College of Graduate Studies and Research, bcaldwell13@radford.edu, 540-831-5724.

It is your choice whether or not to be in this study. What you choose will not affect any current or future relationship with Radford University.

You will be given a copy of this information to keep for your records.

If all of your questions have been answered and you would like to take part in this study, then please sign below.

_____	_____	_____
Signature	Printed Name(s)	Date

We have explained the study to the person signing above, have allowed an opportunity for questions, and have answered all of his/her questions. We believe that the subject understands this information.

_____	_____	_____
Signature of Researcher(s)	Tracy Cohn	Date
_____	_____	_____
Signature of Researcher(s)	Jennifer Oh	Date

I do □ or do not □ give my permission to the investigators to quote me directly in their research.

The investigators may □ or may not □ digitally record this interview.

Participant Name (printed): _____

Signature: _____ Date: _____