The experience of clinicians who work with immigrants: challenges and opportunities

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THE EXPERIENCE OF CLINICIANS WHO WORK WITH IMMIGRANTS: CHALLENGES AND OPPORTUNITIES

Dissertation
by

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submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

May 2012
The Experience of Clinicians Who Work With Immigrants: Challenges and Opportunities

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Immigrants in the United States experience a unique array of mental health stressors related to their experiences of migration and acculturation. For immigrants who are also persons of color, additional obstacles and stressors may compound their experiences. Previous research indicates that while psychologists who work with this population may endorse multicultural competence, they may not actually carry out culturally sensitive practices. Additionally, much of the present literature on therapy with minority clients focuses on aspirational goals. However, analyses of the ways in which these tenets are applied to clinical work are few and far between. What are the barriers to implementing these practices? What resources support clinicians who are working with diverse immigrant populations?

The present qualitative study focused on the experience of clinicians who work with minority immigrant clients. Thirteen White psychologists responded to open-ended questions regarding their clinical experience with this population. Interview questions explored positive and negative clinical experiences, issues of power, and the ways in which the therapeutic relationship impacted clinicians’ views of themselves. Results of the study indicate that internal and external systemic factors influenced clinicians’ expectations for therapy as well as the manner in which they approached problematic relational outcomes. Analyses further highlighted the role of power and systemic influences on the therapeutic relationship. Participating psychologists painted a clear picture of the importance of collaborative, empathic relationships, which further highlights the consequences of neglecting to address
underlying tensions. A clear and consistent theme of deeply personal commitment to their work transcended individual interviews. Implications for researchers, clinicians, and training institutions were addressed.
Dedication

I would like to dedicate this treatise in loving memory of my grandfather, Max Singer. His vision of Tikkun Olam inspires my work, and regularly reminds me to seek ways of empowering those who are oppressed.

Acknowledgments

This dissertation would not have been possible without the support of numerous individuals, without whom I would have been hard-pressed to complete this endeavor.

I would like to extend my deep gratitude to my dissertation chair, Dr. Usha Tummala-Narra, whose calm presence, optimistic outlook, and collaborative style served as crucial resources throughout this process. Under her tutelage, I gained a deeper understanding of the research process while simultaneously developing my own professional identity as a psychologist. I am truly grateful to have had the opportunity to work with her. I also owe a heartfelt thanks to my dissertation committee: Dr. Belle Liang, Dr. Lisa Goodman, and Dr. Leigh Patel-Stevens. With their patient, thoughtful, and thorough guidance I gained valuable insight into the data analysis and presentation processes.

I was very fortunate to have had the opportunity to work with Jessica Esposito and Sarah Ash, graduate students who worked tirelessly to transcribe and analyze the data in the present study. Their presence brought much-needed laughter, sanity, and fancy pastries into this process. I would also like to extend a heartfelt thanks to Julie Woulfe, who provided essential feedback and editing support.

My colleagues at Boston College served as invaluable resources throughout my research process. Angela DeSilva, Sarah Weintraub, and Deirdre Brogande were kind enough
to share wisdom from their own dissertation experiences, and I appreciate their support. I am further grateful for the support of my cohort, whose sage and witty advice allowed me to find silver linings in dissertation clouds.

I would like to acknowledge my besheret, David Weinberg, for helping me to find my voice and for tirelessly supporting me during late nights and long weeks. My parents and family served as essential supports during this process, and I would express my gratitude to my mom for her willingness to proofread chapters. Thank you to my parents, my brother, my grandmothers, my aunts and uncles, my cousins, and my friends for believing that this was possible, and for your unfailing encouragement. Without all of you, this would not have been possible.
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Chapter 1: Introduction

*Personal Vignette*

I encountered one of my most challenging clinical cases during my first practicum placement as a Masters student. That year I was working in a therapeutic middle school for children on the autistic spectrum, though various other diagnoses prevailed. Early in the year, I began to co-lead social skills groups, and a few weeks later I was introduced to my first individual clients with whom I would meet once a week for thirty minutes. When I first met Michael, a young Latino man, I was told that my task would involve simply providing some structured time to play games. The hope was that we would engage in hands-on learning related to pro-social behaviors. However, the truth soon emerged that Michael was struggling with more profound difficulties than merely impaired social skills.

Within the first few meetings, my supervisor informed me that Michael’s behavior was becoming increasingly erratic in his classroom; he would oscillate quickly from a flat affect to a state of extreme emotional agitation. Upon meeting with his teachers and the principal of the school, I learned that Michael had been diagnosed with Psychotic Disorder, NOS. Michael frequently described seeing “the devil,” often with moderate levels of distress. His teachers informed me that they believed that he was not taking his anti-psychotic medication at home, and indicated that they thought his parents were negligent of his care.

Delving further into this issue, Michael’s teachers noted that his parents had never attended any meetings at the school, and that his older sisters served as the primary interpreters and bridges between the school and Michael’s mother, Rosa. Michael’s teachers

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1 Names and identifying information have been changed to maintain confidentiality
further expressed impatience with Rosa, particularly citing her lack of communication with the school as a lack of investment in her son’s life. No interpreters were present in the school aside from one of the teaching assistants who would frequently be called upon to interpret calls home and individualized education plan (IEP) meetings.

A month or so into the school year, after many calls between the school staff and Michael’s older sisters, it was arranged that Michael’s mother would attend the IEP meeting. When the meeting finally commenced, eleven women sat around an oblong table, including various teachers, the principal, the school social worker, the district special education coordinator, Rosa, and me. All individuals in attendance, with the exception of Michael’s mother, were White.

As the meeting began, I noticed an odd pattern of communication. Michael’s mother sat at one end of the table, and the special education coordinator at the other. All conversation took place between the school staff and the special education coordinator, while Michael’s mother looked down at her lap, neither making eye contact with anyone nor making any comments. The bilingual teaching assistant was present, and partially translated the meeting, though I noted that she left out comments when there was much back-and-forth conversation between the various clinicians and teachers in the room.

I spoke last in the meeting, due to my status as an intern. When it was my turn, I turned to address Rosa directly, and introduced myself in my limited Spanish. I apologized for speaking through the interpreter, but asked her permission to do so, given my limited skills. Rosa looked at me intently, and then began speaking very rapidly in Spanish. She asked me if I was Michael’s teacher, and why there were so many people in the room. The principal seemed surprised to see Rosa speak, and asked me to continue to address her
directly, despite my limited vocabulary. The teaching assistant offered to help should I need assistance. I introduced the various other women in the room, then introduced myself and asked Rosa how everything was going at home. She noted with great emotion that she was deeply concerned about her son, and was convinced that he was possessed by the devil. She indicated a plan for an exorcism at their Pentecostal Church, and confided that she thought their Anglo doctor was trying to poison her son with white pills.

The conversation continued for the duration of the meeting, and as the teaching assistant translated for the others at the table, an interesting shift took place. Chairs and bodies physically turned towards Rosa, and the school staff began to ask her questions directly. As the meeting drew to a close, it was decided that Rosa would be put in contact with a Spanish-speaking psychiatrist and that the school would send letters home in Spanish about her son’s progress. A month after the meeting, Michael’s behavior had changed quite dramatically. He no longer reported visual hallucinations, and was able to accomplish his work in class. When I called his home to check in with his mother, she cited the successful exorcism as the reason behind his calmer affect, though noted that she supervised his medication intake as well.

This was a pivotal case in my training experience, and extended far beyond the basics of diagnosis or interventions that I was learning from my supervisor. Prior to this series of events, my supervisor and I had never discussed my client’s racial background, save for brief conversations regarding how to contact the teaching assistant when I needed an interpreter. I know that I was not alone in this crisis, that my own insecurities about my ability to converse in Spanish paled in comparison to the suffering experienced by my client with his untreated psychosis and to Rosa with her many questions and fear about her son’s symptoms. While
the resolution we reached was a relatively satisfying one, the circuitous process may have caused unnecessary distress along the way.

My experience with this situation increased my desire to explore components of cultural competence in the clinical realm, both in my own experience and among other clinicians. However, it is difficult for me to ascertain whether I contributed to the power dynamics with this client, or with others. I am sure that part of me also felt unduly critical of Michael’s mother for her lack of involvement, and frustrated at the family’s lack of compliance with their psychiatrist. I was not well versed in providing care for Latino clients, let alone Pentecostal Christian clients. I may have contributed to the dilemma through my lack of self-knowledge or training. In my subsequent clinical training, I continued to experience self-doubt about my level of cultural competence. Even the most well meaning and seasoned of clinicians may engage in practices that impair the counseling relationship or undermine care.

Indeed, in my studies and research since this experience, I’ve learned that this was not an isolated incident. Previous researchers have suggested that clinicians engage in growth-fostering relationships when they engage thoughtfully on issues surrounding race and culture, whereas the absence of mindful practice can perpetuate cycles of mistreatment and harm (Worthington, Soth-McNett, & Moreno, 2007). Despite the enormity of this problem and the profound potential ramifications, there is a marked dearth in literature that actively explores present clinical practices of mental healthcare providers who work with immigrant persons of color.

Background Literature
Cultural Competence. The field of applied psychology has begun to shift towards acknowledging the necessity of engaging in clinical interventions that suit the particular needs of the client. This manifests through the recognition that race, culture, and other aspects of identity play a salient role in individuals’ experiences (APA, 2006; Helms & Cook, 1999; La Roche & Christopher, 2008). Clinicians’ particular strategies for providing care also impact the mental health outcomes of their clients. Thus, to achieve nonmaleficence, or to “do no harm,” mental health providers must strive to implement interventions that are culturally competent. Numerous definitions attempt to capture the essence of cultural competence (Atkinson, Thompson, & Grant, 1993; Sue et al., 1982; Sue & Sue, 2003; U.S. DHHS, 2005; Vera & Speight, 2003), and much of the literature in this area focuses on recommended strategies for implementing these objectives.

Yet when it comes to an actual analysis of the practical implementations of cultural competence, the literature is suddenly sparse (Hansen et al., 2006; Maxie, Arnold, & Stephenson, 2006; Worthington, Soth-McNett, & Moreno, 2007). Some researchers have begun to tap into the application of multiculturally competent care through case conceptualization exercises (Hansen et al., 2006), or self-report measures that focus on race-related discussions in the therapeutic room (Maxie, Arnold, & Stephenson, 2006). Yet while clinicians may support the notion that cultural competence is important, they do not necessarily engage in these practices to the extent that they endorse them (Hansen et al., 2006).

In the case of my own client, I happened to find a way of opening communication with his family. Perhaps some of the conversations I had in my graduate classes increased my awareness of issues related to culture or the manner in which non-dominant cultures are
marginalized. However, the dynamics between my client, his family, and the surrounding professionals illuminated the complexity of interactions regarding race, culture, and areas of difference. There were many breakdowns in communication; between my client’s mother and the psychiatrist, the school and the family, myself and my supervisor, and everyone and my client. Many well-meaning individuals acted in a way that produced harmful results and ultimately undermined the work they intended to accomplish.

Even after the “resolution” of this particular ethical dilemma, many questions and issues remained. How did the breakdowns in communication emerge, and what factors reinforced their presence? Had the school, hospital, or my own training program contributed to the underlying problem? Despite the fact that my client’s symptoms had improved, had he suffered undue psychological distress due to the missteps of those around him? What practices or assumptions had I myself initiated that had contributed to or enabled the lack of communication to fester? Finally, what information might my own account (or another clinician’s account) provide about the underlying dynamics, my understanding of race, or my training program? This question warrants theoretical lenses that address underlying relational and contextual issues.

Lenses of Analysis

Relational Cultural Theory. In the complex interactions between individuals and between an individual and his or her environment, Relational cultural theory (RCT) posits that the most growthful relationships occur when both parties are mutually engaged and empathic (Comstock, Hammer, Cannon, Parsons, & Salazar, 2008; Jordan, 2002, 2004; Miller & Stiver, 1997). In contrast to more traditional theories, RCT suggests that it is relationships and connection that foster growth, rather than individuation (Comstock et al.,
When empathy and mutuality are present, not only can a particular relationship flourish, but also both parties feel empowered to seek out further connections with others, perpetuating a cycle of healthy relating (Comstock et al., 2008).

However, when these factors are not present, or when various factors impede connection, disconnection emerges that can ultimately lead to negative inter- and intra-personal dynamics (Miller & Stiver, 1997). Disconnection may result from individual conflicts, or from larger societal factors. Differentials in power, particularly as enacted by inequitable systems, racism, or other forces of oppression, can result in “condemned isolation”: a sense of profound exclusion (Comstock et al., 2008; Miller & Stiver, 1997). For example, in the case of my client’s mother from the vignette, she was isolated through physical and metaphorical means. During the IEP meeting, everyone’s back was turned away from her, and she was excluded from the conversation due to both linguistic barriers and preconceptions about her inability to provide sufficient supports for her son. Her lack of adherence to the prescribed treatment was seen as neglect, rather than recognized as a source of disconnection and ill communication beyond her control. When the perception changed at the table, she was regarded as an essential source of support for my client, and empowered to go ahead with the church exorcism that provided great comfort to the family. This empowerment ultimately yielded positive outcomes for my client (e.g. symptom reduction), but also fundamentally changed the ways in which the family was able to access the school and the personnel therein.

Relationships may include permutations of larger societal dynamics (Adams, 2004; Birrell & Freyd, 2006), including internalization of “traumas that are at the core of human suffering” (Comstock et al., 2008, p.280). These factors likely play out in the context of
therapy, particularly in cross-cultural or cross-racial dyads between clinicians and marginalized populations, such as minority immigrant clients. This is not to say that therapeutic relationships will ever be without tension and disconnection. In fact, as with all relationships, these relational outcomes in therapy are inevitable. Repeated, empathic failures and disconnections can produce profoundly negative outcomes for clients. However, the key here is that such occurrences are handled in a manner that allows for further growth. Empathy, empowerment, and authenticity are key elements to promote a closer relationship. Thus, RCT represents a particularly apropos lens for exploring clinicians’ perception of their work with this population.

*Bronfenbrenner’s Ecological Model.* An additional lens for analyzing the impact of societal values on the clinical relationship is the ecological model, developed by Urie Bronfenbrenner developed to explore the experience of an individual within the larger context of complex, nested systems (Bronfenbrenner, 1979, 1986, 1994; Reifsnider, Gallagher, & Forgione, 2005). This approach to analysis explores various facets of an individual’s identity, including 1) *microsystems*, or the immediate interactions 2) *mesosystems*, the interaction between these micro systems, 3) *exosystems*, indirect systems and 4) *macrosystems*, contextual factors. Macrosystems particularly tap into aspects of culture or widely held beliefs of a particular society that serve as deep undercurrents to one’s own internalized principles. While the macrosystem may begin to identify societal influences, the overall theory may fall somewhat short when addressing underlying racial constructs and dynamics, or institutionalized racism (López, 1995).

*Systems of Psychologists.* Various external influences shape the training and practice of mental health clinicians. The American Psychological Association and American
Counseling Association have recognized the need of underserved populations (including persons of color and immigrants), but this is a relatively recent and hard-earned shift in overt policy (Toporek, 2009). Present-day training sites have the ability to train clinicians in culturally competent practices (Lee & Tracey, 2008) which can improve patient outcomes (Rajendran & Chemtob, 2010), but may shy away from doing so due to fears of “going against the grain” (Stovall, 2004, p.8) or “opening up a can of worms” (Willen, Bullon, & Good, 2010, p. 247). Indeed, some programs accredited by the American Psychological Association do not offer courses in multicultural competence (Arredondo, 2010). Yet while mental health psychologists may struggle with the notion of their own fallibility or inadequacies as a clinician, those who suffer most are the clients themselves.

With regard to the case discussed earlier, external systemic influences very likely impacted the individual interactions between my client’s mother and the staff at the school. The power differential between my client’s mother and staff likely emerged due to internalized expectations about cultural norms. What may have actually represented a strong adherence to her own culture was perceived as neglectful mothering when viewed in the context of a Western medical model. Additionally, a distinct power differential emerged through the school personnel’s use of the English language even though it was known that the mother was monolingual and spoke Spanish. These expectations shaped the very nature of interactions between these various parties, and serves as an example of the manner in which systemic influences may shape individual clinical interactions.

Mental Health of Minority Immigrants

A recent survey found that a vast majority of clinicians self-identify as White (Munley, Pate, & Duncan, 2008), yet only a miniscule 2% indicate an internalized sense of
responsibility to serving the needs of minority individuals (Delgado-Romero, Galván, Maschino, & Rowland, 2005). The healthcare disparities between persons of color and White individuals have been well documented (Alegria et al., 2008; CDC, 2005, as cited in Tucker, Daly, & Herman, 2010; Good, James, Good, & Becker, 2005; U.S. DHHS, 2001). Additional burdens of racism may enhance mental health problems for minority individuals (Carter, 2007; Clark, Anderson, Clark, & Williams, 1999; Thompson & Neville, 1999).

These problems may be compounded by additional struggles for persons of color who are also immigrants (Alvarez, 1995; Chi-Yung, Bemak, Ortiz, & Sandoval-Perez, 2008; Ponce, Hays, & Cunningham, 2006; Short et al., 2010; Struwe, 1998; Toole & Waldman, 1990; Vontress, 2001). The rapidly burgeoning immigrant population (American Community Survey Reports, 2010), specifically those who are persons of color, may encounter inferior treatment in mental health settings due to language barriers (Remy, 1995), limited understandings of culturally bound symptoms (Nicolas et al., 2007), or general cultural incompetence (Betancourt, 2003; Vontress, 2001). The implications for neglecting the needs of this population are quite profound, and calls for further study.

Rationale and Aims of Present Study

The perception of clinicians about their own practices and the climate of their clinical sites can provide essential data about the present-day treatment of minority immigrant clients in mental health contexts. This area is particularly under-studied, and thus warrants an exploratory approach devoid of pre-ordained hypotheses. Existing research tends to focus on ideal theoretical orientations or intervention strategies without assessing the actual implementation of these methods. Additionally, while some researchers have focused on patient outcomes or treatment of ethnic or racial minority individuals, the research related to
immigrant clients or specifically immigrants of color is quite deficient. To explore this issue, the present study explored the knowledge, perceptions, and experience of clinical and counseling psychologists who have at least five years of experience working with minority immigrant clients.

Building upon the relational cultural theory and the ecological systems perspective, the current study focused on clinicians’ perception of the counseling relationships they form with minority immigrant clients in order to examine factors that promote or inhibit culturally competent care. I am particularly interested in aspects of connection and disconnection as they emerge in response to differences or similarities in identity (racial, cultural, and immigrant factors) between clinicians and their clients. Elements of power and power over, as they are experienced or not experienced by clinicians also served as a focus for analysis. Interview questions highlighted clinicians’ perception of the role that race and immigrant status play in their relationship with their client, and reflections on challenging and successful experiences with minority immigrant clients. The results of this study may have implications for clinicians, training sites, academic institutions that train mental health psychologists, and perhaps other researchers who aim to extend the literature beyond the aspirational goals of cultural competence. In order to tap into the underlying functioning of this multitude of systems, the participant base included “seasoned” clinicians, or those with at least five years of clinical experience working with immigrant clients. Analyses were qualitative with a content analysis method.

The present study sought to begin a conversation about relational and power dynamics between clinicians and minority immigrant clients. In this given relationship, the clinician inherently has more power and privilege, given their status as the “expert” on
mental health. While the clients themselves are likely the primary authorities on the power differentials in this relationship, the view of the clinician is critical to understand both aspects of the relational dynamic. Indeed, this is one component of a much larger systemic issue that should include the client’s point of view as a primary voice. This study is intended to serve as a starting point in this research, rather than an end point or a comprehensive and summative view of the entire dynamic between minority immigrant clients and mental health clinicians.

Chapter Overview

Moving forward, the second chapter will strive to expand upon the existing literature briefly noted in the present chapter to explore the definition of cultural competence and various relational and systemic factors that influence connection between clinicians and minority immigrant clients. Chapter two will further elucidate the necessity for exploring the present topic, including ramifications for inadequate care or potential benefits of well-informed intervention strategies. Chapter 3 will highlight the methodology of participant selection, data collection, and data analysis. Methods will include a qualitative research approach, specifically tapping into constructivist and interpretivist orientations. Once data has been collected, transcribed and analyzed, Chapter 4 will entail a summary of the overall findings, including overarching coding categories and underlying codes. The fifth and final chapter will discuss the results and potential implications for the field, while addressing limitations of the study and areas of future research.
Chapter 2: Literature Review

Introduction

The field of mental health psychology has shifted focus in the past few decades to recognize the importance of providing treatment for diverse clients in a manner that is attuned with the unique needs and identities of each individual client (APA, 2006; La Roche & Christopher, 2008). Such explorations have emerged through the study of cultural competence, or the process of providing thoughtful, culturally salient care (Sue et al., 1982; Sue & Sue, 2003; Worthington, Soth-McNett, & Moreno, 2007; U.S. DHHS, 2005; Vera & Speight, 2003). Much of this literature has focused on aspirational goals of counseling, highlighting the importance of this approach while outlining potential styles of intervention to achieve multicultural competency. Yet literature that actually focuses on the lived experiences of psychologists who work with diverse populations, including immigrant of color, is quite sparse, signifying a critical gap in the present literature.

In order to fully understand the role and experience of clinicians, the various systemic factors that shape their identity (e.g. training and context) must be examined to gain a more complete analysis. Given this need, relational cultural theory (RCT) represents a particularly salient lens of analysis for examining the types of connections created between clinicians and clients. Highlighting a historical phenomenon of disconnection, RCT also serves to explain differences in power in relationships, both in terms of privilege and also with regard to one’s status (e.g. as a supposed omniscient professional) (Adams, 2004; Hagey, Turrittin, & Das Gupta, 2007; Jordan, 2004; Miller & Stiver, 1997). Bronfenbrenner’s ecological model provides an important framework for understanding the systems within which clinicians reside (1979, 1986, 1994). Bronfenbrenner’s (1979) lens and relational cultural theory
provide frameworks for analyzing the historical developments in the field of clinical and counseling psychology.

This realm of research is critical, as inequitable systems and institutionalized racism contribute to mental health stressors for persons of color (Helms & Cook, 1999). Immigrants experience an additional set of stressors on top of those experienced by persons of color, ranging from factors of the immigration process itself to challenges with acculturation post immigration. The present chapter strives to analyze the complex features that shape the experience of clinicians who work with immigrant clients with the ultimate goal of adding insight about ways to eliminate barriers to providing culturally competent care for this population. In theory, the results of the present study could have profound applications for seasoned clinicians, supervisors, mental health sites (e.g. community mental health centers), academic institutions, and psychology trainees.

Background

Promoting Optimal Treatment

The drive to promote optimal treatment in the field of mental health has been bolstered by the evidence-based practice in psychology (EBPP) movement. The primary goal of EBPP is to pinpoint treatments that have empirically supported efficacy for use in clinical settings (APA, 2006). In part, EBPP was developed in response to a critique of previously established empirically supported treatment. While EST similarly focused on treatment supported by research, there was a lack of focus on the particular needs of diverse clients (La Roche & Christopher, 2008). In order to provide the most appropriate and relevant care for ethnic and racial minority clients, it is clear that an empirical foundation can enhance fit between the client and the treatment. To address this question, EBPP focuses on the
treatment outcome and treatment utility through clinical observation, qualitative analyses of lived experiences, case studies, and meta-analyses (APA, 2006).

While most of these elements suggest that the client’s experience is paramount, there are also allusions to the clinician and the clinician’s experience. Specifically, APA’s Presidential Task Force on EBPP indicates that clinicians’ expertise (e.g. their level of competence) influences clinical outcomes (APA, 2006). The article further notes that clinicians can provide valuable information about their own methods of intervention, decision-making, self-reflective processes, utilization of research, and understanding of individual differences (APA, 2006). Yet this list seems incomplete. Given psychologists’ firsthand experience in the therapeutic relationship, it seems inevitable that they may also be able to provide information about their own experience within the therapeutic relationship.

**Focus on Psychologists**

In an infamous meeting between Allport and Freud, Allport was discomfited by Freud’s prolonged silence. Searching for a topic of conversation, Allport remarked that he had seen a little boy on the train ride to Vienna who seemed phobic of dirt accompanied by his “terribly clean and purposive looking” mother (Elms, 1994, p. 72). When Allport finished describing the incident, Freud “fixed his therapeutic eye upon [Allport] and said ‘Was that little boy you?’ ” Allport reportedly was surprised and taken aback by Freud’s statement, and it also made him uncomfortable, as he described feeling “guilty” (Allport, 1963; Elms, 1994).

This story highlights the deep ravines that separate distinct theoretical branches of psychology, but also touches upon a different issue: we psychologists are not used to having the lens of analysis turned upon ourselves. Most psychologists enter the field to “help
others,” with the mindset that their clients’ or subjects’ lives are paramount, though Albert Ellis does boldly state that he became a therapist to help *himself* overcome issues of anxiety (Ellis, 2005). One of my former supervisors told me that the hierarchy of needs that should guide my decisions at my training site were the needs of my clients, the needs of the system (in this case the school), then lastly my own needs and the needs of my supervisor. This makes sense, given the nature of our work, and responsibilities to our clients.

Yet questions remain unanswered about mental health clinicians’ own experiences, and further, their perception of their own experiences. It is only relatively recently, with the rise of alternative approaches to counseling and research such as feminist, relational, multicultural, and criticalist methods, that the lens has widened to include the specific reality and experience of clinicians themselves (Ballou & Brown, 2002; Brabeck, 2000; Brown, 1994; Goodman et al., 2004; Helms & Cook, 1999; Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2003). One particularly salient topic in recent research that focuses on the role and experience of clinicians is the concept of cultural competence, which harkens back to the culturally appropriate approaches lauded by EBPP researchers.

*Cultural Competence*

*An Aspirational Goal.* Cultural competence is a particularly salient area to explore when assessing mental health care for diverse populations. Some ethicists suggest that clinicians’ main goal should be that of nonmaleficence, or the act of doing no harm to clients (APA, 2002; Koocher & Keith-Spiegel, 1998). In order to avoid this major pitfall, clinicians are called upon to select suitable treatments that fulfill their clients’ particular needs. Utilizing the wrong tool, or an ill-fitting approach could potentially result in breaks in the therapeutic relationship (Miller & Stiver, 1997), or even further psychological or
interpersonal damage for the individual receiving care. At the core of appropriate interventions lies an assumption that the method recognizes individual differences, and characteristics unique to the client. At this juncture, the notion of cultural competence serves to address the clinician’s understanding of the client’s situation and ability to utilize the proper tools of intervention and assessment.

Daniels and Pack-Brown (2006, p. 5, as cited in Ellis & Carlson, 2009) define competence as “a set of skills or attributes that allow one to effectively intervene on the demands of a particular situation or circumstance.” In the past several decades, the clinicians and researchers have utilized this term to define cultural competence, or the particular degree of success in providing mental health supports that are sensitive to the identity and background of the client. Indeed, Sue et al (1982) first introduced the notion of *multicultural counseling competencies* over twenty-five years ago.

The U.S. Department of Health and Human Services defines cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (U.S. DHHS, 2005). Focusing more specifically on cultural competence as it is defined in mental health arenas, Sue and Sue (2003) offer one definition. Cultural competence is a three-tiered system, comprised of clinicians’ concerted efforts to 1) increase their awareness about their own values and biases; 2) understand the worldview of their clients, aiming to withhold judgment about areas of difference between themselves and their clients and 3) utilize intervention techniques and approaches that are salient or relevant to their particular clients.

Vera and Speight (2003) offer a similar definition of cultural competence, recommending that mental healthcare providers must cultivate an understanding of their own
worldview, systems of oppression and institutional barriers that impact their clients' lives, assessment strategies that are appropriate for diverse populations, and must move towards eliminating bias in their own work. Multicultural counseling competency theory further suggests that this work is based on attitudes and beliefs, knowledge, and skills (Atkinson, Thompson, & Grant, 1993; Sue et al., 1982). The message (or perhaps mandate) that clinicians should aspire to culturally competent standards is quite widespread (Hansen et al., 2006).

The focus of cultural competence builds on foundations of feminist and multicultural ideologies, and represents a marked shift from more traditional ideologies that often promote a "one size fits all" approach (Goodman et al., 2004). Indeed, the social justice focus central to this approach suggests adding a wide array of services to the traditional clinical roles, by providing services such as community outreach, advocacy, and macro-level interventions (Moane, 2003; Vera & Speight, 2003). As Atkinson, Thompson, and Grant (1993) suggest, clinician’s approach should fit the particular goals of counseling, the client’s locus of control, and the client’s level of acculturation. Counselors should adjust their actions to fit a client’s position on each of these three scales. For example, clients may need more of an agent of change, an advocate, counselor, advisor, consultant, therapist, facilitator of indigenous healing, or facilitator of indigenous support (Atkinson, Thompson, & Grant, 1993). As Toporek (2009) suggests, this is an ongoing process; shifting between roles requires clinicians to engage in a constant process of self-exploration and awareness.

Self-Awareness. Focusing on one’s own experience is central in the training aspect of mental health clinicians. The process of engaging in self-awareness, also called reflectivity, entails an internally oriented analysis of one’s own experiences, with the end goal of
“[producing] insight and fundamental shifts in . . . original beliefs” (Orchowski, Evangelista, & Probst, 2010, p. 51). In order to engage in deep self-reflection, one must recognize and accept one’s “human limitations” which include defenses and anxieties (Sarnat, 2010, p. 26). Exploring internal reactions to clinical work aids in the process of acknowledging and accessing elements of transference towards ones’ clients. Additionally, self-exploration through supervision represents a fundamental competency (Newman, 2010; Sarnat, 2010). This process transcends various training experiences, including divergent theoretical orientations (Newman, 2010; Sarnat, 2010). Fostering a sense of one’s own self-awareness may enhance levels of cultural competence, as clinicians may be able to address their biases and seek appropriate supports or trainings.

**Gaps in Cultural Competence Research.** Despite the fact that cultural competence has grown as an area of study in the past decade, there are still gaps in the research. Most studies focus on client outcomes or client perceptions of counselors, even though a majority of research in this field involves interviewing the clinician (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001; Worthington, Soth-McNett, & Moreno, 2007). Yet clinicians’ experiences are critical to the process of providing culturally competent care. An additional gap in the research is that a vast majority of studies (90.1%) in a meta-review of this area utilize a quantitative approach; only 4.9% of studies in this area utilize qualitative methods, a factor which may limit the type of information acquired, and the degree to which the clinicians can share their own subjective experiences (Worthington, Soth-McNett, & Moreno, 2007). Furthermore, as noted in Worthington et al.’s (2007) meta-review, much of the literature on culturally competent care focuses on the discussion of the problem rather than an actual investigation of how it is applied. Only a small number of studies actually
focus on the process of clinical work. Thus, it is critical to explore the nature of cultural competence in context.

*Cultural Competence in Context.* Clinicians who employ culturally competent methods tend to produce better outcomes for their clients (Worthington, Soth-McNett, & Moreno, 2007). The question is: how do they actually achieve this goal? The literature tends to focus on aspirational goals for competence, while there is a great dearth of research on clinicians’ actual practices in the psychotherapy context (Hansen et al., 2006; Maxie, Arnold, & Stephenson, 2006; Worthington, Soth-McNett, & Moreno, 2007). Maxie, Arnold, and Stephenson (2006) interviewed clinicians about the ways in which they discussed racial and cultural differences between themselves and their clients. For some clinicians, the direct approach felt more comfortable, such as stating: “I am wondering, given the problems you have encountered with White Males, how do you feel about me?” (Maxie, Arnold, & Stephenson, 2006, p. 92) For others, their own discomfort discussing issues turned clients away. Therapists described having clients who only came for one session, or even an instance in which clients walked out of the room after just a few minutes. Clearly, there are powerful implications for the manner in which clinicians address issues of difference and race.

Hansen et al. (2006) conducted a more general study of clinician’s experiences by interviewing 517 doctoral-level psychologists about their participation in culturally competent practices. Participants tended to endorse activities such as respecting client’s worldviews, fostering an awareness of their own biases, and establishing rapport in ways that were sensitive to clients’ racial and ethnic identities (Hansen et al., 2006). However, clinicians very infrequently endorsed behaviors such as seeking culturally-relevant consultation, including indigenous resources in their treatment models, utilizing multicultural
Experience of Clinicians

resources, and negotiating appropriate languages for treatment. More surprisingly, while participants often endorsed culturally competent practices, they were much less likely to actually engage in these practices in their clinical work, which may indicate an overestimation of their own cultural competency (Hansen et al., 2006). There are potential explanations as to why this might be the case. Perhaps clinicians are unwilling or unable to put out the extra effort required to engage in MCC, or they lack personal characteristics (e.g. perseverance, dedication) to carry out their plans (Hansen, et al., 2006). However these explanations seem incomplete, and are still in the embryonic hypothetical state. Additionally, Hansen et al.’s (2006) work contains other potential limitations, as the clients seen by the clinicians in Hansen’s work were mostly European American (64%). Thus, in order to more fully understand this issue, it is essential to explore the possible factors that might influence clinicians’ work with a diverse client population. To better understand clinicians’ experiences and practices, it is important to understand their multiple contexts.

For example, as noted by Tummala-Narra, Singer, Li, Esposito, and Ash (In Press), there are connections between clinicians’ abilities to access resources, their self-perceived cultural competence, and their orientation towards diversity. Specifically, clinicians who hold more open and positive attitudes concerning diversity are more likely to report engaging in culturally competent practices. Theoretical orientation and the extent to which individuals find multicultural workshops to be helpful can also impact self-perception of cultural competence. This latter finding may highlight the potential benefits of multicultural training that is tailored to clinicians’ particular needs concerning cultural competence (Tummala-Narra et al., In Press).
Relational Cultural and Ecological Lenses of Analysis

Relational Cultural Theory

*Origins of Relational Cultural Theory.* Nearly 35 years ago, Jean Baker Miller published her pivotal work, *Toward a New Psychology of Women*, a book credited with founding the relational cultural theoretical framework (Comstock, Hammer, Strentzsch, Cannon, Parsons, & Salazar, 2008). This theory emerged as a counterpoint to traditional theories that emphasized individual development over relational functioning, and which did not account for the experiences of Miller and her colleagues (Comstock et al., 2008; Miller & Stiver, 1997). The Stone Center at Wellesley College served as an additional sounding board for feminist clinicians who critiqued the notion that autonomy and separation were “markers of emotional maturity and psychological health” (Comstock et al., 2008, p. 279). In contrast, the dominant theory at the time belied a lack of understanding for the fundamental experience of women and minority groups alike, which explains the close relationship that later emerged between RCT and multicultural theories.

*Theoretical Tenets.* Relational cultural theory builds on the principle that individuals have a deeply ingrained desire for connection, and benefit from positive, sustaining relationships (Jordan & Hartling, 2002). Diverging from traditional theories, RCT postulates that growth occurs through relationships rather than individuation and that mutuality is an essential element of any “growth-fostering” relationships (Comstock et al., 2008). The most positive, fulfilling relationships also entail several key components, or as Miller (1986; Miller & Stiver, 1997) describes them, the “five good things”: 1) empowerment or zest; 2) action; 3) increased clarity; 4) sense of self worth; and 5) feelings of connection.
The first component, empowerment or zest, implies a sense of powerful connection of being “with” another person, or an energizing feeling of enjoying another’s company. When a relationship includes elements of empowerment, both individuals feel able to and are capable of taking action. Increased clarity in healthy relationships yields a more accurate understanding of oneself and of others. A sense of self worth, or esteem for oneself, is another critical component that allows for greater levels of one’s confidence and perceived competence. Finally, if one is engaged in a positive, growth-inducing relationship, these feelings of connection will lead to a heightened desire for further connections in other relationships (Miller, 1986; Miller & Stiver, 1997). For these elements to truly flourish, relationships must also contain aspects of empathy, mutuality, and growth. When these factors are present, individuals experience a sense of internal cohesion, which subsequently elicits feelings of relational competence that can emerge throughout many relationships and over time (Comstock et al., 2008).

Conversely, when forces serve as obstacles to mutuality, the result is a culture of disconnection. “Condemned isolation,” as disconnection is also described, is a result of differentials in power that emerge through the adherence to oppressive systems powered by racism and classism (Miller & Stiver, 1997). As a result of this system, certain groups become marginalized and disconnected from the dominant culture.

On a smaller scale, non-mutual relational patterns in families lead to parentification of children, secrecy about family dysfunction, and inaccessible parents. Those who encounter such unfulfilling and harmful relationships may try to change themselves rather than recognize that the source of the pathology stems from another source, which may lead to feelings of self-blame for failures in relationships (Miller & Stiver, 1997). RCT suggests that
individuals in these circumstances may experience the central relational paradox: despite the fact that they may crave connections with others, they may approach relationships with distrust due to a history of disconnection. In order to avoid further damage to one’s sense of self and to limit experiences of rejection or exclusion, one may preemptively cut short or sabotage relationships thereby perpetuating patterns of disconnections (Comstock et al., 2008). In this sense, resistance to relationships may serve as a coping or protective strategy (Jensen & Hoagwood, 1997; Miller & Stiver, 1997).

Moving from Disconnection to Connection. In order to break patterns of negative relationships and shift into healthier styles of relating, RCT prescribes a style of therapy that deviates significantly from more traditional therapeutic models. In this theoretical orientation, therapists are neither blank slates (Miller & Stiver, 1997) nor calculated instruments of therapy (Walker, 2004), because both of these approaches would decrease authenticity and undermine the fundamental purpose of co-creating a mutual relationship. In order to move from disconnection to connection, relational cultural therapists need to empathically resonate with both sides of the central relational paradox (Miller and Stiver, 1997). The benefits of establishing a mutually beneficial therapeutic alliance are multifold—fostering such a relationship allows for a partnership in which decision-making is shared (Halperin, 1988), creates a sense of mutual benefit, and an inherit valuing of the relationship (Deweese, 2004; Dixon, 2001; Kram, 1983; Kram & Isabella, 1985).

Refraining from judgment about a client’s negative patterns of relating allows the client to feel fully accepted and bring more of him or herself into therapy (Miller & Stiver, 1997). Through the acceptance of the central relational paradox, clinicians can recognize the protective nature of disconnection to thwart feelings of shame or rejection (Comstock et al.,
Furthermore, RCT indicates that clinicians must openly discuss the manner in which societal inequities and cultural contexts prevent healthy connections from forming, instead prompting profound disconnections to fester. Finally, mental health clinicians must describe the process of therapy as it can potentially foster authentic and mutually fulfilling relationships (Comstock et al., 2008). However, the relational process and movement towards connection may be further complicated by power differentials between parties in a relationship, or between an individual and the dominant group.

*Power and Relational Cultural Theory.* Within the field of RCT, power is defined as the capacity to produce change (Hagey, Turritin, & Das Gupta, 2007; Walker, 2008). “Power over” dynamics occur when power is inequitably distributed: “humanity is rank ordered according to perceived cultural value and is stratified into groups of greater than and less than” (Walker, 2008, p. 129). In this system, one group is privileged over another, which causes oppression, marginalization, and disconnections for members of the non-dominant group. This process may have profound internal ramifications for the marginalized individual:

“Chronic disconnections occur when, in an important ongoing relationship (particularly when it is characterized by inequal power distributions), the less powerful person is not responded to or is unable to represent his or her needs and feelings. The more powerful person may respond with avoidance, denial, shaming, or attack. In such interactions, the less powerful person is silenced, feels relationally incompetent (he or she cannot move or affect the other person or the relationship), and feels unable to bring him- or herself authentically into the relationship.” (Jordan, 2004, p. 23)
This definition of oppression, as a counterpoint to power and privilege, allows for clear parallels to be drawn between RCT and multicultural theories. There are various systemic areas of psychological study and research about factors that impact the therapeutic relationship that complement the RCT approach.

It is important to note that while RCT presents one particular viewpoint of power dynamics, it does not address every aspect of how power manifests. This lens will particularly serve to explore one aspect of how systemic factors are considered within the context of the relationship. Further limitations will be addressed in Chapter 5, as part of a discussion of the manner of data interpretation and of the utility and application of the resultant findings.

*Ecological Model: Systemic Factors*

In addition to the emphasis on interconnectedness of relationships described by RCT, the present study is concerned with systemic factors that influence interpersonal relationships. Systemic theories posit that each person functions within a complex web of interactions, groups, and systems. Urie Bronfenbrenner’s (1979, 1986, 1994) ecological model is a particularly salient supplemental lens for analysis, as it addresses development and functioning on a variety of different levels.

The ecological model entails the microsystem, mesosystem, exosystem and macrosystem. Each of these represent nested systems, encompassed by and related to the level before (Bronfenbrenner, 1979, 1986, 1994; Reifsnider, Gallagher, & Forgione, 2005). The *microsystem* represents one’s immediate environment, or the face-to-face interactions that occur directly with other people. These interactions may include relationships with family members, co-workers, classmates, etc. When particular people within the microsystem
interact with each other, Bronfenbrenner suggests that on a *mesosystemic* level, potential changes, linkages, or transformative processes may result. *Ecosystems* are settings that do not directly impact the individual, but that shape the immediate environment (e.g. a parent’s place of work) (Reifsnider, Gallagher, & Forgione, 2005). Finally, the *macrosystem* defines the larger societal context that shapes an individual. This level may include aspects of culture, deeply ingrained systems of belief, social functioning patterns, and various opportunities or barriers. This latter category is highly relevant when exploring the experience of counseling psychologists, as such macrosystem elements impact their training, clinical services, and community functioning. Exploring these areas provides additional insight for mental health clinicians, particularly when trying to understand or explain barriers to mental health (Arredondo & Rosen, 2007).
Figure 1. Bronfenbrenner’s nested structures of the environment (Reifsnider, Gallagher, & Forgione, 2005)

Relationships exist within the context of larger systemic factors. As noted by Walker, (2002, as cited in Comstock et al., 2008) relationships are inherently “raced, engendered, sexualized, and situated along dimensions of class, physical ability, religion or whatever constructions carry ontological significance in the culture” (p. 2). Larger societal dynamics play out within the context of individual relationships. Indeed, RCT “is based on the assumption that the experiences of isolation, shame, humiliation, oppression, marginalization, and microaggressions are relational violations and traumas that are at the core of human suffering and threaten the survival of humankind” (Comstock, et al., 2008, p. 280). Historical contexts of oppression lead to heightened sensations of shame, self-blame, and fundamental relational ravines that prevent growthful relationships from forming (Adams, 2004). Divergent issues of identity, including race, ethnicity, and country of origin complicate relationships, including the therapeutic alliance. Clinicians whose training has been steeped in Eurocentric tendencies may approach minority immigrant clients in a way that denies clients’ authenticity. Western clinicians may pathologize behaviors that are normative for clients (Adams, 2004). Indeed:

“People at the margin are defined as “objects:” They are seen as being at the margin because of some essential failure of character or effort. The myth of meritocracy and the myth of the level playing field support this distorted understanding of privilege. . . In fact, people at the margin are actively socialized to believe that they have failed. . . . The group at the center makes the rules and names the situations and conditions of privilege and disadvantage.” (Jordan, 2002, p. 2)
This process of marginalization is deeply inscribed within the historical contexts of race relations. Reviewing patterns of oppression may provide insight into the origins of present-day inequities.

Bell (1995) chronicles the potential ramifications of a supernatural event in which aliens land in the United States, promising an end to social problems if the U.S. is willing to trade its Black citizens for this knowledge. In the allegory, only Black Americans can see the true nature of the aliens, describing them as “old South sheriffs, mean and ugly,” “slave drivers and overseers,” and “in whatever guise they saw them Blacks all agreed that the visitors embodied the personification of evil” (Bell, 1995). This commentary exemplifies the tenet that racism is invisible to those with privilege, but very real and salient to those whom it disempowers. Bell (1995) further describes the conditions that prompted the U.S. government to agree to the trade, describing the cities as severely racially segregated. More than half of the Black population “were confined in former inner-city areas that had been divorced from their political boundaries . . . no one ever dreamed anymore that the mass of Blacks . . . would ever ‘overcome’” (Bell, 1995). While this story clearly contains fantastical elements, in actuality, the harsh conditions are not that far removed from present-day racial segregation, and from historically government-sanctioned racism.

Olivas (1995) cites particular events that predate Bell’s allegory: the Cherokee expulsion from their native land, and treatment of Chinese laborers in the 20th century. The Cherokee tribe in the United States was forced to relocate to a barren reservation from their native homeland, despite the fact that they tried to integrate themselves into American society. Indeed, “some refused to believe that the American people would let this happen,”
proclaiming their desire to remain on their homelands (Bell, 1995, p. 12). Despite their best efforts at persuasion, they were unsuccessful and were driven from their homes.

Chinese laborers were exploited for their cheap labor in the United States, working under horrific circumstances without adequate compensation for their time. Further, the United States Supreme Court validated the processes of the denial of rights for Chinese laborers.

“The power of exclusion of foreigners being an incident of sovereignty belonging to the government of the United States, as part of those sovereign powers delegated by the Constitution, the right to its exercise at any time, when in the judgment of the government, the interests of the country require it, cannot be granted away or restrained on behalf of any one . . . If there be any just ground of complaint on the part of China [or the Chinese immigrants], it must be made to the political department of our government, which is alone competent to act on the subject.” (Chae Chan Ping vs. United States, as cited in Olivas, 1995).

In this instance, it is clear that while the government could sanction the use of cheap labor, no protections or acknowledgements existed regarding inequitable practices. These historical examples of inscribed racism are crucial to understanding the context of present-day race relations, and more specifically, the context of mental health clinicians.

Relational Cultural: Focus on Therapeutic Dynamics. The lens of RCT with its foci on power differentials and areas of disconnection is particularly salient, given that a recent survey of 6,976 counseling psychologists found that 91.8% reported identifying themselves as White (Munley, Pate, & Duncan, 2008). With this high percentage of psychologists identifying as the racial majority, this clearly impacts potential race relations in the
counseling context for individuals working with persons of color and minority clients. As previously noted, while psychologists may strive towards cultural competency, there is a discrepancy between ideals for counseling and actual practice (Hansen et al., 2006). Further, in the realm of research related to counseling psychology, only a miniscule percentage of studies (2%) demonstrated a concerted commitment towards the concerns of racial or ethnic minorities (Delgado-Romero, Galván, Maschino, & Rowland, 2005).

Therapeutic relationships that take place with cross race or cross cultural dyads may embody these fundamental aspects of disconnection, as clients may re-experience the feelings of power differential and rejection by clinicians who deny their culture or operate on flawed assumptions based on a client’s race or identity. Thus, clients may censor themselves, or withdraw in treatment due to feelings of alienation or fear about not being fully heard (Garcia Coll, Cook-Nobles, & Surrey, 1997, as cited in Weintraub, 2008). In order to truly support and join with clients, Birrell and Freyd (2006) suggest that clinicians must “question a system that pathologizes suffering individuals while refusing to look beyond to the system that sees nothing wrong with objectifying others in the name of help, that rewards power dynamics. . . and that privileges individualism and rights over the bonds of human communities” (p. 60).

In order to understand the systems of psychology that perpetuate connection or foster connection, it is necessary to recognize the role of societal and system influences as they may infiltrate personal relationships while simultaneously exploring the external factors that shape clinicians’ cultural competence and adherence to racially sensitive interventions.

Professional Contexts of Psychologists

*Professional Associations*
One major source of influence for mental health practitioners is the organizations to which they belong. These institutions impact training, through the process of accreditation, foster practices through peer-reviewed journals, and shape research and clinical work. Thus, it is quite significant that the road to the inclusion of multicultural competencies within professional organizations was not an easy one. This process involved multiple proposals over several decades, and repeated revisions of the multicultural competencies by Sue & Sue (2003), Arredondo and Rosen (2007). The American Counseling Association did not endorse Multicultural Competencies until 2002. This process had taken 22 years from the initial proposal to the final endorsement (Toporek, 2009).

Division 45 in the American Psychological Association created a task force whose purpose was to construct a set of Multicultural Guidelines for psychologists (Toporek, 2009). The result included 6 main tenets designed to foster multicultural competencies (APA, 2002). Guidelines indicate the importance of engaging in a process of self-reflection and self-awareness regarding their own identity and the role that culture plays in their work: 1) psychologists’ culturally situated attitudes may negatively impact persons of color, and 2) multicultural sensitivity is an essential component of thoughtful care. Additional recommendations target the specific nature of practices in clinical, research, and policy levels: 3) multicultural issues and constructs must be addressed in training and educational settings, 4) researchers should seek out culturally sensitive methods of research 5) such practices should also extend to clinical work, and 6) psychologists should explore potential methods for implementing change on organizational or policy levels (APA, 2002; Constantine & Sue, 2005; Fouad, 2006).
Training

Systems of training further influence the work of mental health clinicians. Reviewing the literature on the degree to which training programs foster cultural competence serves as an additional gauge for the environment in which in which clinicians’ professional identities develop. This area is a crucial area to explore, given the dramatic way in which faculty and supervisors can shape clinicians with regard to their clinical skills and their learning (Arredondo & Rosen, 2007). Once again, the aspirational literature in this area highlights a series of guidelines for the manner in which cultural competence should be infused into a graduate program or a training site’s curriculum (Arredondo & Rosen, 2007). Fouad (2006) highlights several factors that graduate programs should include, such as strong efforts to:

1. Actively commit to diversity, and state this goal explicitly
2. Recruit a diverse student body
3. Seek out and maintain a diverse faculty core
4. Ensure that the process of selecting students is equitable
5. Promote students’ self-knowledge and awareness about their own background and culture, and the necessary tools to serve a diverse population
6. Critically explore the content of all courses to make sure that they shape cultural competence
7. Regularly assess students’ cultural competence

It is important to recognize, however, that the above goals are contingent on the presupposition that multicultural counseling skills can be taught (Arredondo & Rosen, 2007).

The effects of this training may be measured through client’s levels of satisfaction, or through the aforementioned process of EBPP. A number of researchers have also explored
mental health trainees’ effectiveness through studies of case conceptualization (Ladany, Marotta, & Musa-Burke, 1997; Lee & Tracey, 2008; Neufeldt et al., 2006). These various studies provide some insight about potential factors that increase cultural competence for trainees in psychology. For example, in one study, students’ actual cultural competence did not correlate to their self-assessment of their level of multicultural competence, perhaps due to the effects of social desirability (Ladany et al., 1997). Other studies found that greater levels of racist attitudes yielded lower levels of cultural competence (Constantine & Gushue, 2003), whereas higher levels of empathy and ethnic tolerance attitudes were positively correlated to cultural competence (Constantine, 2001, as cited in Lee & Tracey, 2008). In a survey of 91 graduate level trainees (both Masters and PhD level students), correlations were found between general skills in conceptualization and level of clinical training, and specific multicultural conceptualization skills and level of multicultural training (Lee & Tracey, 2008). Indeed, these trainings can have profound effects on mental health care, as the level of training in cultural issues improves patient outcomes, such as the use of mental health services (Rajendran & Chemtob, 2010).

There is a strong call for enhanced training in this area, as “classroom teaching of diversity is just a chore unless diversity is part of the student’s life” (Maxie, Arnold, & Stephenson, 2006). While most programs currently offer trainings or courses in multicultural issues, this has not always the case. In 1982, this was not a requirement, and 60% of programs did not have a multicultural course (Bernall & Padilla, 1982). In fact, even today, some programs that are APA accredited do not offer courses in this area, and those that do may be limited in scope (Arredondo, 2010). In order to truly foster multicultural competency, gaps in training programs must be addressed directly and thoroughly (Sue, Arredondo, &
Davis, 1992). To shape training programs, clinicians should be encouraged to recognize the role that racism plays in their own and their clients’ experiences. Such conversations are difficult to have, and thus psychologists and psychologists in training may shy away from openly discussing these critical issues.

Psychology trainees can in fact increase their level of multicultural competence, given the appropriate training, though training may not impact affective racial attitudes (Dickson, Argus-Calvo, & Tafoya, 2010). However, just as with the previous indication that clinicians don’t always engage in the culturally sensitive work that they also laud, present-day programs don’t necessarily provide sufficient training. As Stovall (2004) notes, “social justice agendas in schools are a hard sell. It’s considerably easier to do what you’re told. ‘Going against the grain’ is not received with accolades of achievement” (p. 8). While Stovall’s comment is intended to address the process of introducing social justice into elementary through high schools, the statement could just as easily apply to colleges and universities in which social justice is not a widely accepted goal. Indeed, for some programs, introducing the controversial topics of race or racism is like “opening up a can of worms,” and may cause more difficulty than schools are equipped to handle (Willen, Bullon, & Good, 2010).

Beyond academic institutions, clinicians are also shaped by their training experiences in the field and the organizations within which they work. Resistance to discussing areas of race or ethnicity may stem from either the trainee or from the supervisor. Indeed, in a majority of instances, the trainee is often the one who starts the conversation about race in supervision (Jernigan et al., 2010). This may be particularly uncomfortable, given potential power dynamics in the training settings (Tummala-Narrara, 2004); trainees may not want to
offend their supervisors, appear racist, or contradict their supervisors if they have different viewpoints. Additionally, the racial identities of the supervisor and supervisee matter as much as their race with respect to their experiences and worldviews (Jernigan et al., 2010).

In Paynter and Estrada’s (2009) article, they explore Paynter’s experience as a White clinician working with Mexican immigrant clients. The paper focuses on three particular cases, reviewing Paynter’s own background, assumptions, helpful resources, and climate of the training site. Factors that facilitated more culturally competent care included the “cultural immersion” of the training site, the supervisor’s Latina background, and the trainee’s ability to form strong empathic relationships with her clients (Paynter & Estrada, 2009). This article provides a starting point for conversation on systemic issues that enhance effectiveness for new clinicians who work with diverse, immigrant populations. In fact, much of the literature on multicultural competence and training focuses on new clinicians, as the goal seems to be to effectively shape present training programs. However, clinicians who were trained in a different era, in which different values or foci were paramount may have an entirely different experience. Indeed, as Constantine (1997, 2001, as cited in Tummala-Narra, 2004) noted, 70% of trainees have completed courses in multicultural education, whereas 70% of their supervisors had not.

This may come into play when considering the critical, central role of self-awareness within the supervision setting. If the supervisor has not considered issues of race and cultural competence, then it is unlikely that they will bring it up in supervision, thereby limiting the experience and continuing self-exploration of the trainee. As Orchowski, Evangelista, and Probst (2010) note, “supervisors must actively engage in his or her own personal self-reflection at the start of a new supervisory relationships” (p. 53) to enhance discussion of
issues related to race, culture, and identity. In the best of scenarios, supervision involves an in-depth training in the art of self-awareness so that fundamental shifts may take place.

“Supervision interrupts practice. It wakes us up to what we are doing. When we are alive to what we are doing we wake up to what is, instead of falling asleep in the comfort stories of our clinical routines and daily practice. We have profound learning difficulties when it comes to being present to our own moment to moment experiences. Disturb the stucknarrative. The supervisory voice acts as in irritator interrupting repetitive stories (comfort stories) and facilitating the construction of new stories.” (Ryan, 2004, p. 47, as cited in Carroll, 2010.)

When supervisees experience anxiety about engaging in self-reflective practices, it falls upon the supervisor to provide support and guidance in this area (Carroll, 2010; Orchowski, Evangelista, & Probst, 2010). However, if the supervisor does not have the skills to do so, no progress will be made and ultimately the client will receive less thorough or even potentially harmful treatment.

**Historical Context of Training**

The field of mental health psychology has only recently begun to shift from the traditional medical model in which the source for pathology resides within the individual rather than as a result of larger systemic or contextual issues (Arredondo & Rosen, 2007). The medical model of psychology further included a movement to streamline the classification of disorders so that the process of identifying and treating disorders could be streamlined (Rutter & Sroufe, 2000). This model suggested that individuals with the same diagnosis were subject to the same conditions, and exhibited the same manifestation of the disorder. Individual differences were minimized to enhance potential generalizability (Rutter
& Sroufe, 2000). Yet, as Developmental Contextual Theory noted, context is quite critical when exploring the unique experience of each individual (Cicchetti & Toth, 1998; Lerner, Walsh, & Howard, 1998; Rutter & Sroufe, 2000; Werner, 1957). An individual’s context, including factors related to neighborhood, family experience, race, and culture, can profoundly impact the etiology of mental illness, and also the potential outcome of mental illness (Black & Krishnakumar, 1998; Helms & Cook, 1999).

Previous models also utilized an approach that was particularly Eurocentric, ignoring differences in cultural considerations (Helms & Cook, 1999; Pedersen, Draguns, Lonner, & Trimble, 2002; Sue & Sue, 2003). When this model is applied, anyone who strays from the dictated “norm” is ill, when in reality they may simply to ascribe to a different set of behaviors or processes as illuminated by their cultural or ethnic identity. Indeed, symptoms may actually be adaptive response to a maladaptive system (Jensen & Hoagwood, 1997). Context is important to consider when evaluating the role of experienced psychologists who are several years removed from their training. These individuals may maintain consistent techniques with those learned during their training, thus deviating from potential present-day standards.

Why Are the Stakes So High?

The process of providing culturally competent therapy for diverse groups involves deep self-examination on the part of the therapist (Goodman, et al., 2004; Sue et al., 1998). This process is particularly critical, given that the counseling relationship serves as a microcosm of racial, ethnic, and social dynamics from the larger society (Sue & Sue, 2003). The potential harm that can arise from a therapist’s missteps is quite profound, and can negatively impact the therapeutic alliance. Specifically, the process of establishing a
therapeutic alliance is essential for clinical progress. Breaches in this relationship may result in lower levels of service utilization, negative treatment outcomes, and lower levels of patient satisfaction (Lu, Lum, & Chen, 2001). Additionally, counseling without careful assessment of one’s own values may lead to an imposition of cultural expectations onto one’s client (Remy, 1995).

As Martin-Baró, a famous liberation psychologist, notes, practitioners have a responsibility to their clients to discontinue biased practices and actively seek to change the existing, flawed system. More specifically, mental health clinicians need to 1) aid in the “recovery of historical memory” 2) critically examine the construction of individual experience; and 3) build on client strengths (Arredondo & Rosen, 2007). The first goal is particularly important, as the process of erasing histories of racism is so deeply ingrained in our society that most social studies textbooks fail to address anything related to race or racism (Gay, 2003). Fostering culturally competent practices is particularly essential when considering the mental health needs of underserved populations who have less visibility and potentially greater barriers to accessing care. Immigrant clients, specifically those who are also persons of color, represent a particular subset of the population whose needs may far exceed the resources they are generally granted.

Mental Health of Minority Immigrants

General Multicultural Counseling

The present gap in health care for underserved populations, including persons of color has been widely documented (Alegria et al., 2008; Good, James, Good, & Becker, 2005). The disparities manifest both in the availability of treatment, but also in health outcomes for individuals from racial and ethnic minority groups (Tucker, Daly, & Herman, 2010). The
Center for Disease Control recently reported that, compared to their White counterparts, ethnic and racial minority individuals tend to have earlier mortality rates, higher rates of various types of cancer, and greater rates of diabetes (CDC, 2005, as cited in Tucker, Daly, & Herman, 2010). Additionally, the Surgeon General’s Report indicated that persons of color are less likely to receive needed health care services, and the care they do receive is generally of poorer quality than that of their White counterparts (U.S. DHHS, 2001).

In addition to physical health problems, persons of color may also experience a variety of detrimental conditions that contribute to various mental health difficulties. Racism and discrimination impact persons of color in insidious and pervasive ways. More overt racist overtones have been replaced by subtler and yet more biting racial microaggressions. As Pierce (1974, as cited in Solorzano, Ceja, & Yosso, 2000) noted, “one must not look to the gross and obvious. The subtle, cumulative miniassault is the substance of today’s racism.” Microaggressions may emerge from individuals who do not intend to harm, but whose biting comments provide backhanded insults. The effects of racism are quite profound, as it may increase psychological distress, enhance physical distress, amplify other existing stressors, and impact one’s self-esteem or even academic success (Carter, 2007; Clark, Anderson, Clark, & Williams, 1999; Thompson & Neville, 1999). Compounding these experiences, persons of color who are also immigrants may face a host of additional stressors.

**Immigrants and Mental Health**

As of 2007, roughly 12% of the entire U.S. population, or 38.1 million individuals, were born abroad (American Community Survey Reports, 2010). However, this figure may in fact be a conservative estimate of the number of immigrants, as it does not encapsulate individuals who consider themselves second-generation immigrants (i.e. those who were
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immigrants often experience a variety of unique physical and mental health challenges. One study found that recent immigrants experienced earlier mortality than their native-born counterparts (Toole & Waldman, 1990). An analysis of 55,000 individuals in a recent California study found that participants who had limited English proficiency (LEP) had both a 68% increased risk of experiencing poorer health when compared to participants who were monolingual English speakers and an increased risk of feeling sad most of the time (Ponce, Hays, & Cunningham, 2006).

Immigrants may also present with a particularly complicated web of mental health symptoms, often stemming from a history of trauma and violence, experiences of bias, social isolation, racism, prejudice, or other environmental stressors (Alvarez, 1995; Chi-Yung, Bemak, Ortiz, & Sandoval-Perez, 2008; Short et al., 2010; Struwe, 1998; Vontress, 2001). Indeed, while immigrants of color have similar experiences of bias to their non-immigrant counterparts, they may be more likely to experience practices of discrimination from healthcare professionals (Lauderdale, Wen, Jacobs, & Kandula, 2006). Recent immigrants may also present or describe psychological symptoms in a manner that diverges from the Westernized framework of health (Gavagan & Brodyaga, 1998; Struwe, 1998). For example, individuals of Haitian descent may experience psychological trauma as physical symptoms, such as stomachaches (Nicolas et al., 2007). If their clinicians and healthcare providers are not well versed in non-westernized methods, they may misdiagnose or neglect treatment for these cases.

Additionally, the process of acculturation can be a particularly harrowing experience, compounding other mental health and situational difficulties (Rogers-Adkinson,
Immigrant individuals may have difficulty finding work in general and particularly work that is safe, may have limited access to upward social and economic mobility, and may have limited access to social support networks (Takeuchi, Alegria, Jackson, & Williams, 2007). In addition, immigrants may encounter the experience of racism for the first time, as they transition from majority to minority status in the United States, which has profound mental health implications (as documented above).

**Disconnection and Immigrants.** The experience of racism and discrimination compounded by stressors related to immigration may further lead to disconnection for minority immigrant individuals. Indeed, isolation is a fundamental stressor experienced by immigrants (Fu & Graff, 2009; Smith & Mannon, 2010). A qualitative study of Nigerian woman immigrants found that feelings of isolation were closely linked to perceptions of interpersonal and societal rejection, which contributed to feelings of depression (Ezeobele, Malecha, Landrum & Symes, 2010). This experience transcends racial and ethnic status for various immigrant groups (Sullivan & Rehm, 2005), as another study with Arab immigrants found that social isolation closely paralleled level of acculturation, with lower levels of acculturation equating to higher levels of social isolation (Ajrouch, 2008).

Social isolation may be further enhanced by a shift in roles within the family post immigration and by higher levels of unemployment; if one does not have a familiar familial context or a work community, this may lead to fundamental disturbances in one’s social network (Este & Tachble, 2009). Further, encountering a portrayal of oneself as “the enemy” (e.g. one group who experiences such a response is Arab Americans) may undermine any sense of connection to the dominant culture (Wray-Lake, 2008). This isolation ultimately
yields further problems in the mental health arena, as one study found higher rates of both psychoses and social exclusion for both first- and second-generation minority immigrants as compared to their non-immigrant and non-minority counterparts (Hjern, Wicks, & Dalman, 2004). Disconnection may also represent a barrier to accessing mental health services: individuals who feel isolated or disconnected may also feel inhibited from accessing healthcare resources (Harari, Davis, & Heisler, 2008).

**Barriers to Care**

The reality of providing treatment for diverse populations, including immigrants, includes many hurdles. Financial constraints and limited potential for upward social mobility represent major barriers to accessing healthcare, including mental health services. Compared to their native-born counterparts, an extraordinarily high percentage of recent immigrants live in poverty (71% of those who have lived in the United States for ten years or fewer years) (Camarota). Similarly, immigrants without American citizenship are far less likely to have access to medical insurance (Ku & Matani, 2001). Individuals with limited English proficiency are also more likely to lack access to healthcare (Ponce, Hays, & Cunningham, 2006).

For those individuals who are able to access healthcare, they may encounter inadequate care; as indicated above, disparities in healthcare services provided to ethnic minority clients have been well documented (Alegria et al., 2008). Sites may not provide necessary services, such as bilingual healthcare providers or interpreters (Remy, 1995). As previously noted, the call for culturally competent care has resounded throughout the field of counseling psychology. Yet, there still exists a shortage of healthcare professionals trained and willing to work with this population. Providers may not recognize the needs of
underserved families, or may lack general cultural competence to provide care (Betancourt, 2003). Counselors may fall prey to a “culture of niceness,” avoiding issues they don’t understand or deem too emotionally charged for fear of offending their clients (Chi-Yung et al., 2008), or may impose their own cultural standards on their clients, rather than incorporate traditional methods of healing requested by their clients (Vontress, 2001). Clients may also distrust their clinicians due to past experiences (Moore, Henfield, & Owens, 2008).

Present Study

Despite the mental health needs of immigrants of color and the theoretical emphasis on providing thoughtful care, little is known about the precise clinical process with this group. While numerous studies and conceptual articles highlight the importance of implementing a culturally competent approach in work with diverse populations, few have explored practical implementations or counselors’ experiences of such rhetoric. Researchers exploring cultural competence tend to focus on programs that train new clinicians, particularly highlighting the importance of careful supervisory relationships (Kaduvettoor et al., 2009; Ober, Granello, & Henfield, 2009; Pieterse et al., 2009). Additional research focuses on work with specific ethnic populations (Nassar-McMillan & Hakim-Larson, 2003). However, virtually no research explores seasoned clinicians’ practice with immigrants.

Addressing clinicians’ experiences necessitates a specific approach to the research process that highlights the clinicians’ narrative, or their particular story. Their voices and perspective provide a unique, insider window into the dynamics within the therapeutic realm, and also within the clinicians’ overarching contextual systems. As Olivas (1995) reflects, “the funny thing about stories is that everyone has one” (p. 9). Narratives are the processes through which individuals learn societal dynamics, and this is certainly the case for racial
constructions (López, 1995). Relational cultural theory, with an emphasis on systemic factors, is an ideal lens through which to explore the stories and experiences of mental health clinicians who work with marginalized groups, such as minority immigrant clients.

Utilizing this approach may elicit a clearer picture about the relationship between clinicians and minority immigrant clients. Furthermore, filling in this missing perspective can better inform the work of mental health providers, and perhaps provide additional information about the help-seeking behaviors of immigrants, barriers to care, information about the dynamics of therapy, and a perspective on particular issues that emerge during counseling sessions (Nassar-McMillan & Hakim-Larson, 2003).
Chapter 3: Methodology

Introduction

The goal of the present study is to explore the experience of counseling psychologists who work with minority immigrant clients. As noted in the previous chapter, while numerous researchers highlight the importance of engaging in clinical work that adheres to standards of cultural competence, the actual application of these methods is understudied. While some studies explore the experience of clinicians through case conceptualizations, this may not fully represent clinician’s approach to counseling in the context of their daily practices. Further, studies tend to focus on clinicians who have worked with primarily White clients. There is little research related to clinicians’ practices regarding treatment of persons of color or immigrant clients, and even less on clients who encompass both of these attributes.

Focusing on clinicians’ experiences and perception of the therapeutic relationship will provide information about the counseling relationship itself, the clinicians’ perceptions of their own cultural competence, systemic factors related to their particular clinical site, and insight into the training practices for emerging clinicians. Thus, the specific narrative methodology was selected to ensure that participants’ experiences were central, while reducing researcher bias by circumventing a priori hypotheses.

Method

The present study utilized a qualitative approach to explore the experience of counseling psychologists who work with immigrant clients, specifically employing a constructivist/ interpretivist lens and qualitative description/content analysis methods. Qualitative research is well-suited for this study because it builds on a naturalistic design, positing that: 1) reality is a subjective experience that is socially constructed, 2) researchers
are an integral and inseparable part of the research process, and 3) one must investigate a phenomenon within a natural setting and without prior hypotheses (Creswell, 1998, 2007; Lincoln & Guba, 1985; Sandelowski, Davis, & Harris, 1989). This process aims to limit the influence of prior biases by utilizing an atheoretical approach (Sandelowski, Davis, & Harris, 1989). Thus, qualitative research is designed to focus on participants’ subjective experiences as opposed to the predisposition of the researcher (Creswell, 1998, 2007).

**Paradigm**

Various paradigms or worldview constructions mesh well with qualitative methods, but the most relevant and appropriate for the present study are interpretivist and constructivist approaches. Whereas positivist and postpositivist paradigms suggest that there is one true reality (Creswell, 1998, 2007; Ponterotto, 2005), interpretivist and constructivist approaches propose that more than one reality exists, and that each is the product of social construction (Krauss, 2005; Ponterotto, 2005). Moreover, there is value in understanding the various perspectives of unique individuals (Golafshani, 2003). Once again, this places participants at the center of research through the assumption that these individuals have unique, insider perspectives of a particular phenomenon (Landrine, Klonoff, & Brown-Collins, 1992). Constructivist theories further focus on the context in which individuals live, in this case the direct experiences of the participants.

Thus, in order to understand the experience of mental health clinicians who work with immigrants, the clinicians themselves are essential. Their experiences and self-reports target the underlying question about their perspectives and processes within the counseling room, while simultaneously providing a particular perspective on systemic issues. Given the focus on the experience and narrative of the clinicians themselves, the interviews in the present
study may bypass some of the aspirational literature on cultural competence and will provide a clearer picture about actual processes and experiences of practicing clinicians.

Paradigms also clearly enumerate the role of the researcher within the research process. Unlike positivist and post-positivist methods in which the researcher represents an unbiased and analytic research tool, constructivist and interpretivist approaches acknowledge that the researcher’s values cannot be extricated from the research process itself (Ponterotto, 2005). Thus, researchers need to “position” themselves, or to communicate their own background, potential motives in the research process, and particular discipline (Caelli, Ray, & Mill, 2003). Researchers are an integral part of the process, and their background and expectations are intricately linked with their “positionality” (Creswell, 1998, 2007). Researchers must, therefore, identify themselves within their research. This process further involves an exploration of the dynamic relationship between the researcher and participant within the presentation of the data.

*Personal Expectations and Positionality.* My own position, as highlighted in Chapter 1, includes lenses of my training, position as a doctoral student and budding clinician, and my own personal biases. As a constructivist/interpretivist qualitative researcher, my lens of analysis provides very different results than a quantitative, positivist researcher. I have additional lenses related to my training as a counseling psychologist, particularly one who has received training in a program that emphasizes cultural competence and social justice themes (Goodman et al., 2004). As explicated below, I further explored my own responses to the research process through detailed journals during the data collection and analysis stages.

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2 Please see Chapter 5 for an additional analysis of the potential effect of response bias, particularly with regard to potential politically correct responses.
In particular, I kept a detailed reflective journal of my own biases and expectations prior to the data collection process, during data collection and analysis, and after the data analysis process.

I myself am the grandchild of immigrants, and our stories of immigration have impacted the ways in which we have adapted to and sought to distance ourselves from the dominant culture. As Falicov (1995) suggested, my own stories impact my interpretations of others’ histories of migration. These intersections, so called “cultural borderlands” represent the interaction of my background and expectations with those of my client. In terms of my theoretical approach, my training as a graduate student at Boston College was also steeped in a relational cultural context, an approach that further provides a lens for understanding this data set.

*Relational Cultural Theory.* Elements of connection or disconnection, central to Relational Cultural Theory, may ultimately predict the success of a therapeutic relationship. Therapeutic relationships are fraught with struggles about power—clinicians inherently possess more power, due to their status as the “expert” in the room, which may lead to distrust or non-mutuality between clinicians and their clients (Miller & Stiver, 1997). Furthermore, counseling relationships represent microcosms of the larger system, and may therefore contain the same foundation of inequity or marginalization for individuals from the non-dominant group, such as persons of color or immigrants. Exploring these through the eyes of the clinician may provide insider insight into factors that lead to breaks in the relationship.

*Attention to Ecological Issues.* Psychologists exist within a complex framework that may shape their experiences, and subsequently impact their clinical treatment when working
with minority immigrant clients. While the present study aims to explore clinicians’ individual experiences, it is hoped that these interviews and subsequent codes will also shed some light on supports or impediments to therapy. Thus, participants’ responses to the interview questions may also tap into their perceptions of available external resources.

**Qualitative Description & Content Analysis**

Beyond the theoretical positioning of a research study lies the methodological process of data analysis. Building on the selection of a naturalistic qualitative approach and a constructivist/interpretivist paradigm, qualitative description methods mesh well with the objective of the present study (Sandelowski, 2000). Indeed, the goal of research from a qualitative description or content analysis angle is to create a clear picture of a phenomenon as it occurs in a natural setting (Downe-Wamboldt, 1992; Elo & Kyngäs, 2007; Hsieh & Shannon, 2005). Qualitative description differs fundamentally from other prominent qualitative methods, such as consensual qualitative research (CQR; Hill, Thompson, & White, 1997) or grounded theory (Creswell, 2007; Strauss & Corbin, 1998) in a number of key areas. CQR in particular developed in response to the call for a qualitative method that adhered to more positivist tendencies than did other approaches. This process involves multiple researchers who collaborate to reach a consensus about the meaning of the data itself. As others have noted, this diverges from the constructivist position that the participants (rather than researchers) are essentially the experts (Neimeyer, 1995; Weintraub, 2008).

Grounded theory is a more appropriate theory for the present study than CQR, given its emic interpretation of the manner in which individuals experience a particular event or phenomenon (Strauss & Corbin, 1998)—but it still falls short of the objects of this study. Grounded theory involves an inductive creation of a theory from the ground up, based on the
data presented by participants (Creswell, 1998; 2007). Yet Sandelowski (2000) suggests that grounded theory adds additional elements to mere presentation of participant data, applying a certain “spin” or lens of interpretation, which occurs in the form of a “conditional/consequential matrix” (Strauss & Corbin, 1998). This adds an additional layer of the researcher’s own lens of analysis, while potentially shifting away from the direct words of the participants. The process of theory building in grounded theory also presumes that the phenomenon can be enumerated and understood through the process of data analysis. However, the present study strives to explore an uncharted area in research, and may therefore benefit from the less interpretive and more summative qualitative description process (Elo & Kyngäs, 2007). Content analysis serves as an even less interpretive analytic tool under the qualitative description umbrella (Sandelowski, 2000). This methodology will be further explicated under the data analysis section below.

Participants

In order to garner salient results, the process of selecting participants is crucial in the research design. In particular, care should be given to selecting participants who are especially knowledgeable in the present material and who can provide unique insight about their own experience as a counselor (Sandelowski, Davis, & Harris, 1989). My initial goal was to interview between 12-15 licensed, practicing psychologists who have worked with immigrant clients for at least five years in order to gain access to the perspective of clinicians who have some experience in the field. However, the number of participants ultimately depends on achieving a level of data saturation such that subsequent interviews would produce no new information. Once saturation is reached through this process, participant recruitment can be discontinued. The particular time frame of five years of clinical
experience was selected specifically because clinicians need at least five years of clinical experience in order to be able to supervise psychology trainees. Thus, their unique role as both a clinician and potential supervisor enables exploration of the needs of individual clinicians, training programs, and systems of mental health care.

Data Collection

*Participant Recruitment*

Participants identified through professional channels as having experience working with immigrant clients were recruited by phone and by email. Additional participants were contacted through a "snow-balling" method, by asking participants to recommend potential colleagues who fit the participant criteria and who may have an interest in engaging in this study. Potential participants were also be recruited by contacting mental health site directors and asking them to pass on recruitment fliers to the staff at their site. Prior to their participation in interviews, potential participants received a brief overview of the study. If they still expressed interest, interviews were scheduled approximately one to two months in advance of the actual interview dates, and participants received reminder emails prior to the actual interviews. Precise interview locations depended on the preference of the interviewees themselves, and were selected to provide the most geographic convenience possible (e.g. near to their place of work or home) that were also private enough to maintain confidentiality. Most participants who were available for in person interviews requested to be interviewed in their professional offices. Several participants who were interested in engaging in the study were not available in person, and elected to participate through phone interviews.
Format of Interviews

Interviews are a common method within the realm of naturalistic inquiry as they identify participants' own experiences as central to the resultant data (Sandelowski, Davis, & Harris, 1989). Semi-structured interviews also help to gain insight into little-studied phenomenon (Deluca, McEwen, & Keim, 2010). Interviews began with a review of the consent form (See Appendix II), which will be discussed in the Human Subjects Protection section of this chapter. Once participants indicated an understanding of the consent form and agreement to participate in the study, I began by asking some general questions about their clinical experiences. Interviews were recorded, with participants’ permission, and transcribed at a later date.

The specific research questions enabled participants to focus on the topic at hand to ensure their responses were not too broad, but allowed the participants to shape the content and direction of their own responses (Elo & Kyngäs, 2007). This process calls for semi-structured interviews with open-ended questions. When engaging in qualitative research, one must begin with a central, general line of questioning that aims to explain, describe, or serve an emancipatory purpose (Marshall & Rossman, 2006, as cited in Creswell, 2007). However, sub-questions are also necessary to break down the central question into more specific questions (Creswell, 2007).

The central question for the present study explored the experience of counseling psychologists who work with immigrant clients. In order to assess this issue, interview questions centered on several main areas, such as 1) clinicians’ perceptions of their own experiences working with minority immigrant clients; 2) successful or challenging experiences with specific minority immigrant clients; and 3) the ways in which working with
these particular clients has influenced the clinician’s view of him or herself. Additional questions (e.g. probes) were added to ensure that I accurately understood participants’ experiences, and to clarify their responses (See Appendix I) (Lincoln & Guba, 1985). The above interview questions were selected for their incorporation of elements of identity, such as race, class, and immigrant status, but also attempted to tap into clinicians’ perceptions of the connectivity/disconnectivity of the therapeutic relationship, and the potential power structure that is present within this dynamic.

Bronfenbrenner’s ecological model served as a framework in the selection of research questions for the current study. In selecting interview questions, I sought to address the issues delineated below, all of which are consistent with RCT and the Ecological Model:

- How do clinicians talk about their own systemic influences? Do they identify specific interpersonal relationships, larger societal systems, or internalized cultural systems as resources or barriers?
- What factors (e.g. familial, community-oriented, cultural, racial) do clinicians address in their client’s experiences? To what do they attribute the client’s strengths?
- Are clinicians identifying differences between their own ecological models and their clients? Do they attempt to bridge these differences? Discuss them openly? Utilize this information in therapy?

From a relational cultural perspective, when asking clinicians to describe specific clients, I wanted to move beyond generalities (e.g. aspirational ethics) to have clinicians really investigate their perception of the working relationship with their clients. I asked about specific emotional responses. I was curious what the positive relationships felt like (e.g. zesty, empathic, as described by RCT?) How did clinicians know when they had made a
positive connection? Also, to what do they attribute the source of their disconnection? Where are the problem areas, according to clinicians? I also wanted answers to the following questions:

- Do clinicians describe attempts to repair rifts in their relationships? What techniques do they use? Do they move from disconnection to connection?
- Do clinicians feel that they can bring their authentic selves into their relationships with their clients? Do they feel constrained by any factors?

Under the umbrella lens of RCT, I also sought to ask questions about power dynamics between clinicians and clients. These questions served both as underlying currents to shape the research questions, and as specific probes during the interviews.

- How are larger systemic forces playing out on the individual, interpersonal level between clinician and client?
- Do clinicians address issues of racism and discrimination? Do any of these elements permeate the therapeutic relationship?
- To what degree is the therapeutic relationship co-created by the therapist and the client?
- Does the clinician see him or herself as the director of cultural issues?
- Are there situations in which the clinician gets feedback from the client about their preference for therapy, and if so, how do they use this information?

Are disconnections related to power differentials, or to another source? During the interviews, I sought to focus on listening rather than interacting to avoid overly shaping or biasing the interview (Creswell, 2007). I did keep a detailed set of notes about my response to the interview process and the data obtained therein. I will further discuss how my own
responses shaped my understanding of the data in the reflexivity section in Chapter 5. Interviews were conducted until saturation was reached and no new incoming information (e.g. no new codes) arose with subsequent interviews (Deluca, McEwen, & Keim, 2010). This process generally takes more time than positivist approaches, as it warrants an immersion in the world of the participant (Ponterotto, 2005). After each interview, I engaged in a process of writing field notes or reflections about the interviews, which served to bolster the coding process during content analysis. I continued to add to these notes as I engaged in the process of data analysis as well, and encouraged my co-coders to do the same both in their own journals, and to openly discuss our responses during group coding sessions (Elo & Kyngäs, 2007). Additional measures included keeping an audit trail, or clear records of the process and procedure (Lietz, Langer, & Furman, 2006). As for the process of data collection, I took detailed notes during and after interviews and verified that my recordings of the interviews were of sufficient quality (Creswell, 2007).

Data Transcription

Once each interview was complete, I engaged in the process of transcribing by reviewing the audio recordings and converting them to text. I sought additional help with the transcription process from two graduate student collaborators who completed an appropriate human subjects course (See Human Subjects Protection). These research collaborators received examples of transcribed interviews on which to base their own transcribing process. Each transcription was carefully reviewed to ensure that it accurately reflected the content of the interviews. Further, the transcribed interviews were emailed back to each participant themselves to verify whether they felt I accurately captured their views and experiences in the text (Creswell, 2007; Lietz, Langer, & Furman, 2006; Sandelowski, Davis, & Harris,
Participants were informed during this process that they were welcome to add to or clarify any of their responses. Please see Chapter 5 for additional notes about participants’ responses to this component of the validation process, and to the interview process in general.

**Human Subjects Protection**

Prior to engaging in the recruitment and interview process, I obtained approval via Boston College's Internal Review Board (IRB). I ensured that my certification was valid to engage in work with human subjects. While this study should involve minimal risk, I strove to clearly enumerate potential benefits and risks to participants in the consent process (Sandelowski & Barosso, 2002). Landrine, Klonoff, and Brown-Collins (1992) suggest that researchers may engage in a variety of ethically faulty processes when recruiting participants, so it is important to be mindful of potential issues that may arise. For example, past researchers have exploited participants by making participation mandatory (Landrine, Klonoff, & Brown-Collins, 1992). I indicated during the consent process that participants could disengage from the research process at any time without penalty or coercion to complete the study. The consent form also outlined processes of confidentiality, such as the fact that no names or identifying information would be stored with the interviews (please see Appendix III). The interviews themselves were stored in locked file boxes, and in password protected electronic files.

When outlining potential risks of the study, I also noted that the interview process might trigger a range of emotions, including frustration or distress when recalling difficult clinical experiences. To this end, I offered to provide contact information for mental health clinicians or additional resources for participants who wished to continue to discuss their
experiences after the interview itself has concluded. No participants elected to follow up with additional resources, though several noted that they were interested in reading the results of the study. I also outlined potential benefits of participating in the study, such as possibly contributing to training materials for future counselors or expanding resources for counselors who work with immigrant clients. I further noted that participants might also feel positive emotions related to successful or growth-inducing experiences with clients.

Data Analysis

*Data analysis process: Content analysis*

As delineated by Elo and Kyngäs (2007), data analysis methods are essential to report, and I will attempt to do so here. However, processes potentially shift slightly between the planning and implementation stages of qualitative research, and any alterations will be clearly noted in the methods and results section. For the process of content analysis, the primary purpose of this research subset is to describe themes that emerge across multiple data points (Downe-Wamboldt, 1992). In exploring the output in a qualitative study, the general path of content analysis moves from specific units of data, to eventually creating larger overarching categories that serve to organize the individual points (Elo & Kyngäs, 2007).

Hsieh and Shannon (2005) identify three main types of content analysis: conventional, directive, and summative. The first type of content analysis, conventional, focuses on the main goal of describing a phenomenon. To this end, categories emerge from the data itself, rather than from pre-determined hypotheses. Interviews using conventional content analysis rely heavily on open-ended questions and subsequent probes to elicit further information and clarification from the participants themselves. The process of analyzing data
obtained in this fashion entails a careful, word-for-word review of transcripts. Through this review process, codes emerge (Hsieh & Shannon, 2005).

Directed content analysis is an appropriate method when a researcher wishes to test a preexisting theory or compare the present study to previous research. This method would not be appropriate for the present study, given the dearth of previous research in this area. Finally, summative content analysis focuses more on the specific words used by the participants in a study. The goal of this method is to explore the context of the words and language, and explore how participants describe a phenomenon through their particular verbalizations (Hsieh & Shannon, 2005). For this reason, a summative method does not fit the particular goals of the present study since it includes more of an analysis of specific word patterns rather than overarching exploration of a phenomenon. Thus, conventional content analysis is the most appropriate method of data analysis for the present study.

As outlined by Downe-Wamboldt (1992), there are eight steps to the content analysis process: 1) choosing the particular questions to explore; 2) selecting and describing overarching categories; 3) testing category definitions; 4) assessing reliability and validity; 5) revising codes; 6) testing revised schema; 7) coding data; and 8) assessing validity and reliability for a second time. Hsieh and Shannon (2005) suggest a slightly altered order of data analysis, though they include overlapping goals: reviewing the data word for word, creating categories from the participants’ own words, creating larger overarching categories, and finally clustering these categories into meaningful groupings.

The initial stage of content analysis involves reading and re-reading the individual interviews to get a sense of their overall flow and content (Hsieh & Shannon, 2005; Sandelowski, 1995 as cited in Elo & Kyngäs, 2007). After this review, the first level of
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analysis involved the process of creating individual codes. It is crucial to ensure that codes stem from participants’ own words, in order to limit imposition of bias or prior hypotheses when exploring the interviews (Hsieh & Shannon, 2005; Sandelowski, Davis, & Harris, 1989). I utilized a data abstraction sheet to keep track of individual codes, pulling relevant quotes from the individual interviews to ensure that I stayed close to the data itself.

The second stage involved sorting individual codes into larger categories or meaningful clusters of data in which the codes seem to address similar concepts (Hsieh & Shannon, 2005). In this stage, categories are intended to capture the essence of the data while exploring trends that transcend individual differences and those that are unique to individual participants (Downe-Wamboldt, 1992). The aim was to explore both patterns that occurred within one participant’s responses, but also trends or commonalities across the various transcripts.

Finally, one should analyze resultant categories to look for clusters of data that address similar issues, which allows for reflection on relationships between the various codes. This process entails reflecting on the data while reading and coding, essentially writing notes in the text of the transcribed interviews themselves (Elo & Kyngäs, 2007), while simultaneously comparing my data to previous work (Downe-Wamboldt, 1992).

As previously mentioned, several other trained researchers co-analyzed the interviews to create the first round of codes. Initially, I worked with the chair of this dissertation to code one interview, then I co-coded transcripts with two other graduate students until consensus was achieved regarding potential codes. This entailed creating equivalent codes for which there is no major discrepancy between researchers, a process that took several transcripts. After we established this level of joint processes, I jointly coded the remaining six interviews
with only one other collaborator (e.g. three interviews were co-coded with one graduate student collaborator, and the other three were co-coded with the other graduate student collaborator.)

These codes were then placed into categories, or overarching concepts. Larger domains were utilized to further group the categories. Regular meetings and oversight from an additional evaluator, the chair of the dissertation, were an integral component of this stage of analysis. The dissertation chair also served as an auditor, as this committee member was familiar with content analysis methods and with the overall topic of research. The graduate student collaborators further assisted in the review process of the data codebook, which included a summary of all of the codes (and the quotes associated with each code), the overarching categories, and the larger domains.

In addition to carefully following the methods of analysis outlined by content analysis methodologies, I strove to utilize quality research processes to ensure that my process and data analysis were rigorous and trustworthy.

**Good Research Processes**

*Rigor and Trustworthiness*

As Lietz, Langer, and Furman (2006) note, qualitative research may be “fraught with bias and reactivity”. One can limit these effects through strategies that enhance a study’s rigor. While the term “rigor” has not been well defined, researchers generally utilize it to loosely mean the practice of conducting “quality” research that adheres to certain standards of conduct and careful construction. In quantitative studies, the terms validity and reliability suffice to elucidate the fundamental guidelines necessary for rigorous research (Cohen & Swerdlick, 2002). However, qualitative research measures constructs and utilizes analytic
tools that are quite divergent from those associated with quantitative research and thus require a distinct set of criteria to ensure rigor (Meyrick, 2006). For example, as Davies and Dodd (2002) note, while qualitative researchers may strive for reliability, they are not expected to replicate their exact results in subsequent studies. The participant base of any qualitative study represents a small subset of the population with unique experiences that are framed within the context of the setting, time, etc. Thus, the following sections will address necessary practices for qualitative studies in regard to trustworthiness, ethical rigor, subjectivity, reflexivity, and additional procedures specific to the various components of the present study (Sandelowski & Barrosso, 2002).

**Trustworthiness**

The concept of trustworthiness encompasses the degree to which data closely represents the actual meaning intended by the participants (Golafshani, 2003; Lietz, Langer, & Furman, 2006; Lincoln & Guba, 1985). The researcher’s own biases may influence the data in a manner that decreases a study’s level of trustworthiness. Thus, to bolster this process, Rolfe (2006) suggests focusing on methods of credibility, dependability, transferability, and confirmability. Credibility roughly corresponds to the positivist notion of internal validity, or the degree to which a study measures what it is intending to measure, whereas transferability evokes external validity. Due to the small sample size and assumption that every individual has a unique world construction, it is not likely or assumed that qualitative studies will strive for external validity. The construct of dependability suggests relative reliability, while confirmability explores the strength of the relationship between the findings and the actual data (Lincoln & Guba, 1985).
To enhance trustworthiness, researchers can create a clear audit trail, or a description of the research process (Lietz, Langer, & Furman, 2006). This also entails a degree of reflexivity (defined below). Additional processes to bolster trustworthiness include member checks and consultations with other researchers (Lietz, Langer, & Furman, 2006; Rolfe, 2006).

**Ethical Rigor**

In addition to rigor, ethical guidelines further shape qualitative research processes by outlining decorous or desirable practices, which are “flexible and contextual” (Davies & Dodd, 2002, p. 281). Sandelowski and Barrosso (2002) propose that all processes involving participants must clearly state the manner in which researchers gained access to, supported, and protected these individuals during the process of the study. This includes clear articulation of human subjects practices, benefits and risks related to participation in the study as stated above, and further ensuring that discussion of data serves as a respectful and analytic process rather than as an objectifying or belittling process (Sandelowski & Barrosso, 2002).

In order to best adhere to ethical principles, researchers should engage in practices that are transparent, systematic (Meyrick, 2006) and guided by trustful, open, honest, respectful, and careful methods (Davies & Dodd, 2002). To enhance these qualities in a research study, researchers must locate themselves within the research process. My particular epistemological and paradigmatic orientations have been explicated at the onset of this chapter (Caelli, Ray, & Mill, 2003; Meyrick, 2006; Ponterotto, 2005). In order to thoroughly explore my position within and impact on the present research, I will explore the concept of subjectivity.
Subjectivity

The notion of subjectivity is thought to exist in utter contrast to the construct of objectivity (Ratner, 2002). Once again, this is an area in which qualitative research diverges dramatically from quantitative methods. The latter form of research strives for complete objectivity, suggesting that the researcher’s own biases cloud and undermine the research process (Davies & Dodd, 2002). Qualitative research, particularly constructivist and interpretivist methods, recognize that the researcher herself has a particular set of expectations and experiences that shape the lens of analysis in a given study. The researcher thus influences every aspect of the research process, from the choice of the research question to the participant selection, data analysis, and presentation of the data. This is not a hindrance to the data collection and analysis process, but simply warrants disclosure about one’s positionality.

Since the present study explores particularly uncharted territory and the data analysis method is content analysis, it was crucial to address subjectivity while also engaging in strategies that ensured that participants’ experiences were central. Thus, returning to Downe-Wamboldt’s (1992) question: “Whose reality is the most accurate relative to the research question?” Clearly, given the subjective nature of the material, the participants themselves are the experts. Thus, I sought to minimize my own interpretation and maximize the use of direct quotes and synopses of the data, as called for in the content analysis and qualitative description literature (Downe-Wamboldt, 1992; Hsieh & Shannon, 2005). Member checking was conducted as a way of ensuring the accuracy of the interview transcripts. I sent each participant a typed version of the transcript of their interview to ensure that they were comfortable with their responses. Participants were invited to make comments (e.g.
clarification or additional commentary) about responses to increase the accuracy of the interview. One participant, after reviewing the interview transcript, expressed discomfort about his or her response, which will be further elaborated in the discussion section. However, the clinician gave permission for the initial interview to be used in data analysis.

Reflexivity

Researchers possess their own perspectives and frameworks, which subsequently impact their interactions with participants. Reflexivity suggests that the nature of the relationship between participants and researchers is salient to the research process (Meyrick, 2006). This includes clearly articulating the expectations of the researchers, and potential factors that challenge these goals (Davies & Dodd, 2002). The relationship between participants and researchers is reciprocal—both parties have the potential to impact the other through the research process (Alvesson & Sköldberg, 2009). Engaging in reflexive processes should not merely represent an attempt to respond to “poor test results or ambiguous findings; rather, it involves a reflective self-examination of our own ideas and an open discussion and comparison of our research experiences” (Davies & Dodd, 2002, p. 286). Multiple strategies can potentially enhance the present study’s level of reflexivity. For example, collaborating on this project with a team or group of additional individuals allowed for verbal reflection with other collaborators, thus tapping into the process of inter-rater reliability (Downe-Wamboldt, 1992). I further maintained contact with a team of advisors (e.g. the members of my dissertation committee) with whom I discussed my own reactions to the research process.

I also engaged in reflection through journaling during the research process, an attempt to foster increased reflexivity. Prior to data collection, I wrote about my own biases and
expectations for the results. For example, due to my exposure to RCT theory, I anticipated that clinicians who engage in self-reflective practices would experience a sense of connection with their clients, whereas challenges to multicultural competencies might elicit disconnection in therapeutic relationships. In my clinical experiences, I’ve found that when working with supervisors for whom multicultural issues are not a priority or a deeply essential component of therapy, I find myself somewhat at a loss when working with my own minority immigrant clients. I have had clients who have left after a few sessions and with whom I felt confusion about how to connect on an authentic and culturally salient level. Some of my more successful or satisfying clinical connections have occurred when issues of difference were explicitly brought up in the course of counseling, though of course every counseling relationship has varying levels of success and challenge for a wide variety of reasons. I also expected that relationships might play out differently for clinicians who themselves had a family history of immigration or minority status. Perhaps those who identify with one of these groups might feel a greater sense of mutual connection or shared identity with their clients than a colleague who does not.

I am also aware that this is a topic that is personally salient for me, and it is important to understand how my own family history might effect my interpretation of results. I come from a family of immigrants who arrived in the United States at a time when Jewish individuals were not considered to be White. My grandfathers used to talk about their respective childhoods in Poland and Russia, in which they were not considered to be Polish or Russian citizens, but rather “Jewish”, a caste aside and less than full-fledged “citizens” of their countries of origin. Frank discussions about anti-Semitism in the United States shaped my own narrative about power dynamics. My father, for example, shared stories about how
my paternal grandfather’s other Jewish colleagues of Eastern European origin were fired from their government jobs because it was assumed that they were communists, and therefore a threat. My grandfather was not fired, because his job was too essential to the facility in which he was employed. He refused to work until his colleagues were reinstated several months later.

This story, an integral part of my family history and thus own identity, has sharpened my sensitivity to potential slights among other communities. Over time, my family has become part of the dominant racial group in the United States. This history and present day identity has heightened my interest in understanding the fundamental processes that emerge for minority immigrant individuals, particularly as they are framed by those in the mental health profession (another core aspect of my professional identity).

Throughout the research process, I recorded my own personal thoughts and responses, particularly reflecting on the manner in which the data did or did not match my preliminary expectations. I further discussed personal biases and inclinations with the larger research team to engage in collaborative reflection designed to understand our role within the research process. At times, we needed to code and recode particular quotes that struck one or more research members as biased. Our goal was to recognize our own personal triggers, record them, and try to code each particular quote in a manner that accurately represented the content (e.g. sticking closely to the actual words of each participant). The dissertation chair and committee members served as additional supports with whom I engaged in conversations about the research process and my own reactions to the data.

*A Note on Reflexivity.* For all qualitative analyses, reflexivity is an essential component of the research process. Researchers need to recognize the ways in which they
engage with the data, and the specific manner in which their own life experiences, biases, and expectations may influence data analysis. With regards to content analysis, this process is particularly critical. Content analysis calls for a more impartial restating and organizing of the participants’ own words with minimal interpretation. I sought consultation from my dissertation committee and fellow graduate level researchers to reflect on my own biases and assumptions. This enabled me to engage in active listening during the interview and coding processes while simultaneously noting my personal response to the resultant data. The primary purpose of this methodology, describing the experiences of participants without necessarily interpreting their responses based on my own personal experiences, required a consistent process of reflection and consultation.
Chapter 4: Findings

Introduction

The present study is an exploratory and qualitative analysis of the experience of psychologists who work with minority immigrant clients. Participants discussed their clinical experiences with this population through semi-structured interviews and through their written responses to the subsequent transcripts of these interviews. The present chapter will walk through the resultant data, as coded and categorized in a content analysis methodology.

Not all participants who initially expressed interest actually engaged in an interview. Additionally, partway through the data collection process it was determined that White clinicians and clinicians of color (particularly those who identified as immigrants themselves) presented unique narratives, and thus clinicians of color were not part of the present study. For these reasons, participant identification numbers do not necessarily relate to the overall number of participants, but rather serve to distinguish between participants’ responses. Throughout this chapter, participants will be identified by their participant i.d. number in order to preserve confidentiality.

Participants

Overall, thirteen clinicians completed the interview process for this study. Prior to the interview process, participants completed a demographic form regarding aspects of their personal identity. Their ages ranged from 30 to 85 years old, with a mean age of 56.54 years of age. Six participants identified as male, and the remaining seven identified as female. With regard to their ethnic background, six participants identified as Jewish. Participants also noted various ethnic backgrounds as combinations of Hungarian, Russian, German, Welsh, Swedish, Irish, Finish, “mixed” and “Anglo”. A majority of participants (n = 10) received
Ph.D.’s as their highest degree in clinical psychology (n = 6) or unspecified (n = 4), whereas the remainder had received EdD’s (n = 2) or PsyD’s (n = 1). The average number of years of experience since receiving their highest degree was 25.08, with a range from 6 to 53 years. Participants were roughly split between those who had received multicultural training in their graduate coursework (n = 6) and those who had not (n = 7). Slightly more clinicians received supervision that included a discussion of multicultural issues (n = 8) than those who had not (n = 5). Most of the clinicians (n = 10) had attended workshops after receiving their highest degree that addressed multicultural issues.

A vast majority of the clinicians noted that they did not speak a second language well enough to conduct therapy with clients (n = 11). The two clinicians who did speak a language other than English indicated that they both spoke Spanish. Participants worked with clients who immigrated from the following countries: Afghanistan, Armenia, Australia, Azures, Bosnia, Brazil, Cambodia, Cape Verde, Canada, China, Columbia, Cuba, Dominican Republic, Ecuador, Egypt, Ethiopia, France, Germany, Ghana, Guatemala, Haiti, Honduras, India, Iran, Iraq, Ireland, Israel, Italy, Jamaica, Japan, Kenya, Korea, Libya, Mexico, Morocco, Nepal, New Zealand, Nicaragua, Nigeria, Pakistan, Peru, Poland, Puerto Rico, Romania, Russia, Sierra Leone, Senegal, Somalia, South Africa, South Korea, Spain, Taiwan, Tibet, Trinidad, Uganda, Ukraine, Uruguay, Vietnam, and Zimbabwe. Three clinicians described working with clients from Central or South America without specifying particular countries. Two participants also indicated that they had worked with Jewish clients, and one clinician indicated working with Native American clients.

When describing the theoretical orientation of their graduate program, clinicians indicated exclusively psychodynamic or psychoanalytic (n = 4), cognitive behavioral (n = 2),
or integrative (n = 7) orientations. Only two clinicians noted their own present theoretical orientation as psychodynamic, whereas the remainder (n = 11) described themselves as integrative with influences ranging from cognitive behavioral, family systems, humanistic, existential, and biological to trauma and attachment oriented.

Interviews took place both in person and by phone for clinicians who lived out of driving range. The length of interviews ranged from twenty to sixty minutes in length. Two interviews at the shorter end of the time spectrum had to be cut short due to other work commitments of the participants. All participants expressed an interest in participating in the study in part because they remembered working on their own dissertations, or because they were particularly interested in the research question.

Saturation. Morrow (2007) suggests that saturation has multiple shades of meaning, and can be denoted into two genres, utilizing Lincoln and Guba’s (1985) and Strauss’s (1987) definitions. The first, redundancy of data, suggests that researchers strive to collect data until there is no new input received at all. However, as Morrow (2007, p. 217) notes, “True redundancy can never be achieved, of course, because of the uniqueness of each participant’s experience; indeed, additional data always add richness and complexity to the analysis.” Yet, it is possible to achieve a second sort of saturation, the theoretical saturation outlined by Strauss (1987, as cited in Morrow, 2007). Theoretical saturation implies a more practical completion of data collection, or a more general assumption of redundancy. In the present study, the process of determining saturation began with the interview process itself. Notes taken during the interviews, combined with initial rounds of coding indicated a general familiarity of concepts (e.g. participants described similar experiences, used similar phrases, etc.). Confirmation of saturation was obtained during the coding process itself. At a certain
point, though new codes emerged with each participant, no new categories or domains emerged.

Data Analysis

All interviews were recorded using a digital audio recorder and subsequently transcribed by myself and two other graduate student researchers. After the transcription process, the digital files were destroyed and the transcripts password protected. I provided the co-researchers with a sample of a transcript from one of the participants prior to their own transcription process. All identifying information, including names, geographic information, and other identifiers were purged from the data during the transcription process. The process of transcription allowed all researchers to engage deeply and develop familiarity with the data prior to the coding process itself. I reviewed all transcripts, including those typed by other students, in order to ensure that they were accurate. The participants themselves also reviewed their own transcripts before the analysis process. Two graduate student researchers and I completed a human subjects ethics data course prior to the entire research process.

In keeping with the conventional content analysis approach, I sought to move from specific components of data to larger, general categories (Elo & Kyngäs, 2007) with the ultimate goal of describing a particular phenomenon (Hsieh & Shannon, 2005), in this case clinicians’ perception about their relationship with minority immigrant clients. To this end, I incorporated prescribed methods endorsed by Hsieh and Shannon (2005) and Downe-Wamboldt (1992). I began by reading and re-reading each individual transcript word-for-word, as recommended by Hsieh and Shannon (2005), Sandelowski (1995), and Elo and Kyngäs (2007). This process, coupled with the process of transcription itself allowed for increased familiarity with each individual transcript.
Once I had completed this deep reading stage, I worked in collaboration with another expert coder (e.g. the chair of this dissertation) to code one transcript together. We started by coding on our own, then compared our codes, discussing and editing until we had reached consensus on every individual code. In this case, *codes* represent a short phrase used to describe a particular quote from a participant’s transcript. We sought to stick closely to the participant’s own words in the coding process (Hsieh & Shannon, 2005; Sandelowski, Davis, & Harris, 1989), often using their own words in the code itself. See below for examples of codes that emerged from the data:

<table>
<thead>
<tr>
<th>Code</th>
<th>Quote (Participant ID #, page number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician recognizes that s/he does not have first hand experience of immigration</td>
<td>But really [I] have no first hand experience of what it’s like to come from Somalia, or Bosnia and start over. (25, p. 1)</td>
</tr>
<tr>
<td>Clinician can’t relate to experience of migration</td>
<td>The experience of that I don’t relate to. (27, p. 5)</td>
</tr>
<tr>
<td>Being away from family allows client to work through issues</td>
<td>The sister was in a very very bad way, and is probably better off for it. You know, is probably better off for being away from her family, from having a place where she could be by herself and work through her issues (16, p. 8-9)</td>
</tr>
<tr>
<td>Immigrant clients accepting of White people</td>
<td>Mostly, the immigrant, mostly the immigrants are ready to accept White people, who are in their eyes, okay. (15, p. 4)</td>
</tr>
<tr>
<td>Cultural differences may be a barrier</td>
<td>I mean cultural differences, presumably differences that I’m not aware of, that- that- um interfere with our ability to do what we’re here to do. (24, p. 10)</td>
</tr>
</tbody>
</table>

Once I had completed the initial process of coding and reviewing one transcript with a faculty researcher, I reviewed these codes with the other graduate students. We then completed a similar process of individually coding a transcript and then reviewing codes as a group, talking through areas of difference between our respective coding until we were able to reach consensus on each code. After reviewing five transcripts in this manner, we found
that eventually when we compared our codes as a group they were identical prior to the process of our discussion. At this point, we divided the remaining seven transcripts such that I coded all of them, and each graduate student co-researcher coded one half of the remaining transcripts. I then met with each co-researcher separately, discussing any discrepancies between codes and subsequently reaching consensus on the final code. During this process I tried to maintain an awareness of power issues related to my status as the primary investigator. In discussing the codes, we alternated presenting our independent codes to each other so that we were able to maintain a sense of fairness and collaboration while remaining aware of any potential power differentials. My collaborators and I had regular discussions and check-ins about the process of coding and how it was experienced by each one of us.

Once the initial phase of coding was complete, I transitioned into the second phase of data analysis: sorting through the codes to determine clusters of data, or categories, that subsumed individual codes (Downe-Wamboldt, 1992; Elo & Kyngäs, 2007). To approach this stage of data processing, I started with one participant’s codes, looking for larger categories that encapsulated clusters of codes. I then reviewed each additional set of codes, revising and editing the categories as new codes were added. Through this process, categories emerged, shifted, and crystallized with each additional participant. Simultaneously, I began exploring the overarching categories to create larger domains that subsumed the categories themselves. See below for an example of the completed codebook. The following illustrates the domain (experiences of the therapeutic relationship), the category (barriers that limit relationship), and the sub-codes.

**III EXPERIENCE OF THE THERAPEUTIC RELATIONSHIP (Domain)**

**IIIA. BARRIERS THAT LIMIT RELATIONSHIP (Category)**
### IIIA1. SITUATIONAL BARRIERS

#### IIIA1a. TYPE OF COUNSELING ADDS LIMITATIONS

<table>
<thead>
<tr>
<th>Page</th>
<th>Code</th>
<th>Quote (Participant ID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Limits of competency and training make supporting particular clients challenging</td>
<td>He can do therapy, I can't do therapy with him here. I mean I'm not authorized to do real, intensive, internal system psychodynamic work with him, but it's very clear that he can go and find some of the stuff that's caused him to have the distress that he's has, and he's underserved (P 05)</td>
</tr>
<tr>
<td>5</td>
<td>Nature of role limits clinician’s ability to help client</td>
<td>And the other expectations that are asked of me, or requirements, prevent me from doing the kind of monitoring and individual work that I would like to do for him. So that leaves me at a disadvantage and disappointed that I can't offer him more time and attention. (P 05)</td>
</tr>
<tr>
<td>5</td>
<td>Neuropsychology involves more psychoeducation and therapist as expert than other therapy</td>
<td>Nowadays I'm doing feedback about neuropsych I've written and so it's very much about working memory's this, boom, and this means, and um you know the balance of talking is 70-30. (P16)</td>
</tr>
<tr>
<td>2</td>
<td>Clinician’s particular role fits in more with medical model</td>
<td>Uh, periodically they come up. But I'm not doing what you would consider traditional psychotherapy. I'm not working with a traditional clientele. I'm working with people who are not psychotherapy patients because they want to be. They've had a situation that caused them to have some kind of trauma or something like that and they've kind of been sent to me. They view me as part of their whole medical treatment. They're in – I don't know how to say this. They look at me more as a medical person rather than a psychotherapist. (P21)</td>
</tr>
</tbody>
</table>

A faculty mentor, the chair of this dissertation, served as an advisor throughout this process, and the graduate student co-researchers further reviewed and provided suggestions for the final codebook. Additional faculty advisors were also asked to review and provide feedback on the categories and domain component of the data. The resultant codebook will be outlined below.
Overview of Data

In its final form, the codebook that emerged from this process of evaluation, sorting, and organizing contained three overarching domains. Each domain contained several categories. Within each category, codes indicate specific examples illustrating these categories. The first domain explored the experience of the therapist him or herself, particularly with regard to the therapist’s orientation towards multicultural issues. This included participants’ descriptions of the ways in which they learned about multicultural issues and their own views on whether race and cultural issues are salient topics for exploration. Clinicians’ responses about their own identities were also included under this domain, and included descriptions of their self-perceived strengths and limitations as they impacted the realm of clinical work. Participants also described variations in access to their inner dialogue, which particularly included discussions about their comfort level discussing multicultural issues.

The second domain centered on clinicians’ perceptions of their clients’ experiences. Participants described a series of external systemic challenges that they believed impinged on their clients’ functioning, as well as perceived strengths that bolstered their clients’ experience. Various responses also touched upon the manner in which clients’ identities and values shaped their approach to the therapeutic process itself. The second domain also included clinicians’ descriptions of their clients’ characteristics, both in terms of the overall patient population with whom they worked, and aspects of individual clients. Individual clients were frequently compared to non-immigrant clients, while the struggle between “American” culture and that of the client’s country of origin was frequently depicted as the source of internal and familial strife.
Domain three explored various tenets of the therapeutic relationship, as understood by the therapists themselves. Barriers to therapeutic relationships, both external situational and interpersonal hurdles, were described in counterpoint to factors that enhance clinical relationships. Such positive, enhancing factors included descriptions of strategies for deepening relationships. Clinicians further outlined the ways in which they addressed differences between themselves and their clients, as well as their own expectations about the role that they should play within the therapeutic relationship.

Additionally, participants reflected on their experience of participating in the interview itself, a shadow fourth domain that will be discussed more in depth in Chapter 5. The following segments will explore each domain and underlying categories in greater detail, including illustrative quotations in an effort to include participants’ voices in the data analysis process (Sandelowski, 2000).

Domain I: Clinician’s Engagement with Multicultural Issues

In the first domain, clinicians addressed issues of their own identities as they related to their professional functioning. This discussion included outlining sources of information and resources through which the clinicians themselves learned about cultural issues. Additionally, clinicians discussed the degree to which they believed that racial and cultural issues are important areas to explore when working with minority immigrant clients.

How Does Clinician Learn About and Gain Access to Cultural Issues. It turns out that the clients themselves were a primary source of information, or “very personal, on the ground, sleeves rolled up” (P 16, 2) resources, both in terms of discussing their personal experiences, and in teaching clinicians about world issues.
Participants indicated that they would often ask very openly about their clients’ own experiences as a way of learning more about daily routines and social connections:

“Talking to the people—so who’s at home? Do you do your homework? If you do your homework, which is generally not true, who is there to help you? Is anybody there? Finding out about their kinship, who they see in their kinship network. Finding out who is important to them. Bottom line—asking them about their world (P01, 2).”

In this sense, one participant considered the client’s experience to be paramount, and the interplay of the therapeutic relationship as central to engaging with clients.

“And our patients themselves are the best resources, really. Um, just the general getting to know you process has to be more reciprocal, more open. There’s so much you don’t know when you sit down with someone. You learn things along the way but it’s never the same as a common experience of someone lives in your neighborhood. People have very very different experiences—our clients are our best teachers. Often they are the ones who say, oh you should talk to so and so.” (P16, 2)

In this instance, the client serves both as an expert into his or her own experience, but also as potential connections to external resources. Clients also served as informants about racial issues and dynamics, and “what it means to be whatever their specific culture might be” (P26, 3).

“He taught me all kinds of things I didn’t know. About his ‘races.’ . . . but he taught me about what it was like to be him in this world. Which I can appreciate. And I might not have had that experience had he not been my patient, so I might not have known. So to the extent that people come in and tell me all kinds of stuff, I— I— you
know I learn something about reality that I might not have otherwise bothered to find out”. (P24, 8)

Through their clients, clinicians gained access to viewpoints, worldviews, and information that had previously been lacking in their daily experiences. They even described this as opening doors to other parts of the world that the clinicians themselves “would never necessarily go to” (P24, 4). This process of information sharing subsequently shaped some clinicians’ approach to conceptualizing their clients’ experiences

“Um, it gives me a broader world view, for one. Since I’ve been doing this work in particular I think of- I think of Africa, I’m thinking of Asia, I’m thinking of South America in ways I hadn’t before. So my world is a larger world. Because the work that we do is about violence, and now I’m more aware of the different forms of violence that are taking place around the world and that are politically sanctioned around the world.” (P27, 8)

This newly expanded knowledge shaped clinician’s awareness and actions: “some of the people have convinced me I have to be more careful and seek out the differences, and not take things for granted” (P15, 11).

Colleagues, supervisors, and co-therapists similarly served as useful resources for clinicians in the present study, providing general consultation and further facilitating the therapeutic relationship between clinician and client, or even acting as a sounding board or a source of emotional support. “It just helps to be able to just go across the hall and say what do you think this is? (P16, 7).” Indeed, other staff members provided “expertise and cultural sensitivity” (P26, 7) that they themselves had garnered through their own clinical
experiences. One clinician was surprised at the degree to which colleagues had served as a critical resource.

“Actually the question that I thought was the most interesting to me that it was something I had never thought about before when you said what are some resources and my first thought was, you know gosh, I wish I had more resources, you know what I mean to point people in the direction, and then I realized that my biggest resources was just the other staff and you know colleagues that I work with and just being in a pretty diverse community both at the agency I work at and even more so at the school that I work at and that’s probably in the best just sort of working in a setting where diversity is accepted and kind of just kind of embraced is kind of the biggest thing” (P20, 8).

The identity of colleagues was particularly salient, as the aforementioned clinician noted that the agency’s diverse clinician population was its own resource. Another participant concurred, noting “Yeah, we hired an associate clinical director here, who herself is a refugee from Iran. She’s Bahai’, she’s been here for about 4 years now. So she’s my buddy and I’ve learned a lot from her” (P24, 11). Colleagues also served as sources of information if they had experience in other relevant fields.

“Well with this work in particular there’s a group of us who work pretty closely together with one another. This group includes lawyers and other people in the mental health field who do these evaluations and a physician who is very involved in trying to document any physical scarring and provide comprehensive care. And we’re lucky enough to be in an area where there are a fair number of immigrant resources, and people dedicated to trying to be helpful. And then working in the institution that tries
to bring an understanding— it’s not easy, to keep with the demands in the healthcare field, psychiatry, mental health, really bringing in revenue.” (P27, 7)

Supervisors and co-workers were not the only professional resource utilized by clinicians in the present study. In fact, trainees provided both new perspectives and kept multicultural issues at the forefront of conversations in particular clinical sites. In this case, trainees themselves served as the “squeaky wheels”, which was “helpful” and “sometimes annoying” (P27, 7-8).

“I teach behavioral medicine at [name of town], and I just did a whole thing on the family life cycle. And [the students] said to me- none of this applies. Because these people that they work with don’t have families. They are young unwed mothers, fifteen, sixteen, and they don’t have mothers around. They have multiple fathers for multiple children, they have no resources.” (P01, 1)

Beyond the process of providing information that shaped a clinical understanding of clients’ experiences, some colleagues also played a more active role in facilitating the relationship between clinician and client. Part of the facilitation entailed the more instrumental process of interpreting, though in a way this also blurred lines between interpreter and “co-therapy” (P16, 4). Other therapists helped to further facilitate the relationship between the primary clinician and the client’s family by “[making] a phone call home, make sure somebody speaks the same language, that kind of thing. That’s been really helpful” (P20, 4).

Interpreters or bilingual colleagues were also resources from whom clinicians requested information about manifestations of mental health and mental illness within particular populations. Colleagues served as “another pair of eyes, and someone who actually knows the Bosnian culture better than I do to help me figure out how to have a conversation
with these parents” (P25, 3). Another clinician noted, “um I still like having someone who’s fluent in the language to be able to provide consultation” (P05, 2). However, even colleagues who had expertise in working with clients from particular backgrounds were not always able to provide the final word on a particular client’s presentation.

“And I had an interpreter with me, only used the interpreter for direct questioning, little bit of context, because I kept saying- does this seem like-? . . . And so I kept turning to the interpreter saying- can you help me understand? Does it fit for you, how they’re presenting? And the interpreter wasn’t much help (laughs) either, couldn’t really tell.” (P27, 2)

To further enhance clinical work and subsequently relationships with clients, some participants also described processes of educating themselves by seeking out resources such as “peer reviewed articles” (P12, 5) or books such as “Spirit Catches you [and You Fall Down], books like that” (P01, 2-3). World travel added additional lenses, and for one clinician earlier college education also “clued me in to- this is not the world” (P12, 5). In other words, this clinician learned to recognize that one’s life experience does not necessarily encapsulate the experiences of everyone around them.

Trainings themselves presented a mixed bag of useful information and disappointing experiences. While one clinician described graduate training as a central process that expanded understanding of the “interface between how protective or dangerous their environment is and what’s their degree of emotional regulation” (P 16, 1-2), other clinicians outlined flaws in existing training programs. Though they might be “well-meaning” (P15, 11), workshops touched upon “what I already knew” (P01, 3). One clinician perceived trainings as condescending: “in other words, people preaching at you, sort of there’s this tone
of you don’t know what the hell you’re doing, you ought to be more sensitive without really
evaluating how sensitive you really are” (P24, 12). One clinician considered the trainings to
be biased by the experiences of those who led the workshops.

“Participant. I mean I understand where this is coming from. Probably from their
own wounds or whatever. For sure.

Interviewer: the- the people running the trainings?

Participant: Yeah. Um. . . but this quality of you ought to, you ought to, you ought
to- with this kind of ideological you know what. Maybe I’ve been to the wrong
trainings.” (P24, 12)

Where external resources fell short, clinicians also described their own internal life
experiences as another resource that better facilitated their understanding of multicultural
issues. This included exposure to diverse neighborhoods “where you’re kind of socialized
into being accustomed to being around kids who are different than you” (P16, 12).

“Being around them. Not just learning about them academically, but actually being
around them. I grew up in South Brooklyn, so I was pretty much around certain
minority groups and absolutely found out the difference between Puerto Rican . . .
instead of a Cuban. Which sounds really prejudiced, and probably is, but is really
true.” (P11, 4)

Personal experience extended to more direct relationships as well: “I have a lot of experience
with minorities in my personal life, my social life, my family life, and my professional life”
(P14, 5).

“I guess, you know, well I, you know, I guess I would like to think of myself as pretty
open minded, and accepting, and tolerant of difference. My family is kind of, kind of
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(laughing), I guess I don’t know how you would describe it, a mix of races and backgrounds. My husband is an immigrant himself actually from Korea and we have two birth daughters so they are Caucasian and Korean and we have an adopted son who is half African American and half Caucasian . . . So you know I think I’ve always been you know pretty aware of differences and you know accepting of differences so I think that my own immediate family has certainly shaped that as well. I think I am going in with my eyes wide open kind of thing.” (P20, 7)

The quote above touches upon both an ingrained desire to want to be seen as culturally aware, coupled with an indication that the clinician’s own life experiences included direct encounters with multicultural and multiracial issues. This clinician’s statement also seems to place potential value on lived experiences over other kinds of learning.

Clinician’s View on Race: Are Race & Ethnicity Important Factors in Clinical Progress? Regardless of which type of experience was valued as more educational in the multicultural realm, most clinicians addressed the question of whether racial and ethnic facets of identity should be included in the therapeutic process. Among respondents who indicated that race was not important, two primary explanations emerged. First, some participants indicated that all clients should be treated the same. “In that sense, it’s the same as anybody who comes here and sees me who grew up in Long Island just like I did” (P01, 2). This philosophy linked with a parallel notion that “the race is irrelevant” (P01, 3). Another clinician noted a belief that while one client spoke extensively “about his ‘races,’” I don’t think that’s a term that I believe represents anything real” (P24, 8). Another participant concurred:
“It’s been the same as work with other people. . . When I think of my patients I don’t think of them in terms of their ethnicity. . . and I have to tell you, that the issues that I see, that I work with people aren’t that different from anybody else. . . Just the same thing that helps me with anyone else.” (P14, 2, 5, 8)

Similarly, among clinicians who did not address racial or ethnic issues, another type of response seemed to emphasize that race and ethnicity are secondary to other issues. This might include a focus on the client’s stated reason for entering therapy, or as one clinician described it, “it’s really about what the problem they have much more than their background” (P12, 1). Particular foci of clinical work also limited discussions on race and ethnicity:

“Um, in the um evaluation when my role has to be . . . there’s a forensic quality to it. So I probably don’t bring in my Whiteness as much as I would if it was a therapy relationship, and the differences. . . I have to stay with symptoms. Forget the picture and stay with symptoms. Try to document it quickly, write it up.” (P27, 5).

Similarly, another clinician expressed how other aspects of the client’s identity supersede race and ethnicity. Specifically, this clinician emphasized the salience of developmental status over cultural differences. “Well, I guess…in my mindset I don’t ever…I mean I have to remind myself that they’re minority immigrant students, but I begin by thinking that they’re children, and that they are students and that we have to care for them in the same way regardless of their color . . . So, it isn’t really a cultural minority issue, it’s a child issue” (P05, 1, 7).

Several clinicians who reported wanting to address racial and ethnic issues were reluctant to do so because they were concerned that they would be imposing their own
agenda on clients who might not have a vested interest in exploring these aspects of their own identity. For example, one clinician articulated:

“I would almost worry that someone would feel that that was my agenda? They’re not here to talk about race, they’re here to get their kid tested, you know what I mean? . . . Like an imposition. Like, what? Why are you talking about race? I want to know if my kid can read. But I don’t know. You make me think about that in a different way, I don’t know.” (P25, 5)

Along similar lines, another clinician described feelings of frustration with a client whose cultural views violated the clinician’s own value system. However, the clinician chose not to bring this up in the context of therapy because “that wasn’t what he was coming in about. So I didn’t feel that it was my position to challenge his attitudes towards women” (P24, 10).

However, the issue of addressing race, ethnicity, and other aspects of cultural identity proved to be more complex, as some clinicians who indicated that it was not an important construct also identified race as a central component in their clients’ lives. Participant 1 noted:

“He was raised in the church, all the hopes of the church were pinned on his shoulder. So in that sense he was carrying his community with him when he went to [X University] and it hasn’t served him well as an adult. So his history as a Black person, Black culture, encased within a White culture in the south is important.” (P01, 4)

When describing the same client earlier, this participant suggested race was not important. Other clinicians suggested that race was “always in the room” (P25, 5), and “very, very important. It’s more important than what people know” (P11, 8). Another clinician
indicated that this is a mandatory area to explore with one’s clients, and fodder for discussions about the client’s identity and experience in the world:

“But I need to know- there’s an imperative, I need to know about the origins of where people come from, so there’s a mandate I have to do that, which is helpful. Tell me about who you are, about your country, about your tribe, about the differences, about what’s important to them, how you make (inaudible), about the vegetation, about the quality of the air.” (P27, 4)

In another case, the clinician’s own cultural knowledge was described as providing the foundation for clinical discussions about aspects of the client’s life experience. “My knowledge of U.S. intervention and my politics surrounding that makes it hopefully possible for clients to speak to me about what it’s like to come to the U.S. and be received in the way that they have been” (P26, 4). Other clinicians saw analysis about race and culture as central to understanding the client’s daily experiences: “since this is a small community, and she’s rather strikingly ebony in a White culture” (P15, 3). Addressing these issues carefully was seen as a way of avoiding the embarrassment so one does not have to “put your foot in your mouth” (P12, 1). Culture and racial factors were also viewed as salient, even for one clinician whose line of work usually ignores these features:

“And I got the idea that this evaluation was taking place in the context of someone coming from a culture that was not the culture of the suburban, White (name of town) parents whose kids I evaluate in (town) who are really open to looking for learning difficulties, learning challenges as positive information that’s gonna help them get the kid through the system. They don’t really- I think have the same kind- they have a different kind of cultural expectation about what it would mean to be less than perfect
in a neuropsych profile. So it was a different understanding, born of different education, born of different background I’m sure growing up. This woman never ever knew anyone in her cohort who was tested, whereas there’s so much of a different experience.” (P21, 9)

This wide array of responses on this issue highlights confusion about the need to address race, and how. “I guess academically people are more interested in- well, is it a real construct? And how do you deconstruct it?” (P25, 5). Beyond the complex question of how to discuss race, clinicians further described their clinical struggles and personal strengths.

Clinician’s Self-Perceived Limitations and Strengths Concerning Multicultural Competence. As one clinician reflected, “I think it’s important- I think it’s very important for therapists to know what they do well and what they don’t” (P01, 6). Some of these imperfections related to multicultural knowledge, and the manner in which culture impacts mental health.

“And I was supposed to evaluate his level of depression. And he was near mute, and not elaborative. . . And I had not worked with anyone from Tibet so I was really not familiar with what a presentation of depression in a monk might look like. What is silence, what is cultural sort of reticence, what was depression?” (P27, 2)

Another clinician similarly acknowledged a dearth of understanding about “families in India that accepted the caste system. People I had known from India had been political progressives who didn’t accept the caste system” (P15, 6). In these examples, lack of clinical or personal experience contributed to challenges on behalf of the clinician when working with unfamiliar cultural expectations.
In several instances, clinicians acknowledged that the nature of particular challenges led to problems with individuals from specific backgrounds. In the case of the Tibetan client mentioned above, the clinician referred the client to a colleague whose specialty is working with Tibetan clients because the participant determined “I’m not a good evaluator for him” (P27, 2). Two other clinicians indicated that they viewed themselves as unable to work with Asian clients. “There something about the language, there something about- it’s not that I haven’t, there’s something about. . . I subjectively don’t do well with people of Asian extraction” (P01, 3). While the clinician indicates an inability to clinically support Asian clients, there is a certain lack of clarity about why this may be the case. Another client suggested that the challenge may lie with the clients themselves.

“Oh I will say this, as far as Asians are concerned, I’ve only had a couple of Chinese people come to me and they never stayed. I feel like they could do better with someone else but I feel that they’re just not into the kind of intersection that’s involved in psychoanalysis and psychotherapy, it just doesn’t make sense to them, and they’ll come once or twice and that’s the end of it.” (P14, 7)

This perception of clients’ accessibility and receptivity to the clinical process will be further explicated under domain two when exploring clinicians’ responses about their perception of their clients’ experiences.

How do these limitations impact clinicians? Responses frequently manifested negative feelings of inadequacy and “frustration” (P25, 3) about their own ability to adequately address multicultural issues. One clinician confided that “I feel bad about myself sometimes” while adding “I got a headache from thinking about [this issue]” (P1, 8). Others suggested that working with immigrant clients highlights the fact that they themselves are
“very biased” (P11, 7), and that in their work with this population, “I think because I never assume that I am 100 percent sure of anyone else’s experience” (P26, 10).

Participants also described some self-perceived strengths related to working with minority immigrant clients, though in general this was less highly endorsed than comments about their limitations. One clinician described feeling more skilled than other colleagues at addressing multicultural issues, and the subsequent approval from one’s clients. “I just don’t have a lot of the same belief structures as many of my colleagues. To a fair extent I’ve learned to keep it to myself. It certainly loosens me up in terms of other people in terms of their culture, what they think is cool” (P12, 5). This perception of oneself as more fully developed (or perhaps just uniquely oriented) compared to one’s peers further ties into the notion of varying degrees of access to one’s inner dialogue.

Variations in Reflection and Dialogue on Multicultural Issues. The process of analyzing their own knowledge of racial and ethnic issues triggered similar responses among many clinicians, frequently eliciting a response that the clinicians were not used to discussing this material. As one clinician noted: “Well it was challenging because I don’t think about these questions as a separate- you’re asking me to open a window on the way I think about my work that I don’t usually open. It’s there, but it’s challenging” (P01, 9). A second clinician had a similar reaction, citing potential embarrassment that might arise from addressing this unfamiliar topic: “I can’t believe I’m on tape saying this” (P25, 6). Several other clinicians shared the experience of unfamiliarity, but expressed more positive sentiments with regard to the process of discussing their clinical work with minority immigrant clients.
“I mean it’s nice to have a chance to stop and pause and think about some of the things that I have to you know consider every day I mean I’m often so cemented in my thinking that I don’t step back often enough to remind myself of all the stuff that’s going on.” (P 05, 8)

Another clinician echoed this sentiment that while their work discussions typically focused on the client, this research interview provided a welcome opportunity to reflect on the clinician’s response to the clinical work:

“Um, I enjoyed [this interview] very much. It’s nice to be able to reflect on things you don’t have a chance to... You know, I haven’t really gotten to do this kind of talking- and really not in such a personal way when you’re on refugee trauma team, you’re talking more about how do we solve the issue, not how it’s affecting you but more in the transference countertransference way, not in the reflecting on. It’s a nice thing- thank you for the opportunity.” (P16, 13)

In this vein, clinicians described the process of reflecting on their work with minority immigrant clients as “enjoyable” (P16, 13) or “educational [and] surprising” (P25, 9). In other words, while the process may have exposed factors or challenges to which they as clinicians had not been exposed, they found some utility in engaging in these reflections.

Some participants indicated that they regularly thought about issues related to race, culture, and identity. “So much of it is just who I am that it’s kind of second nature at this point. So, I hear all the stuff that I’m saying and they’re the same things I would say to my friends when they ask me about the work that I do” (P05, 8). For this clinician, no new information was garnered from the interview process, and there was also a notation that this is a regular topic of discussion with peers. The clinical work served as one main source of
reflection for one participant. “It’s both opened me up- I feel that I am a more richer person, in terms of – it’s challenged me in ways in terms of- it’s really good for me to think in ways about who I am, who I want to be in the world, the impact that I have” (P27, 8). The challenge is considered to be a positive one, and deepens the clinician’s understanding of the world. Indeed, two other participants agreed that the clinical work provides “a whole different perspective on something I’m embedded in” (P24, 9), and “continually shows me that I’m looking at the world through a perspective of someone who’s Jewish growing up in South Brooklyn part of town” (P11, 7).

However, even for one clinician who indicated a process of self-reflection, the interview process itself may have stirred up negative emotions and triggered a response towards the interviewer. “Ok, before you do that, let me answer your question for what it’s like. Because I was sort of a little combative. Because I did think about it” (P24, 2). These same challenges emerged through a discussion about their own level of privilege. Participants experienced feelings of embarrassment, coupled with desire to want to understand and empathize more fully.

Clinicians acknowledged their privilege with regard to economic stability, status as an American-born individual, and White privilege. “It’s probably social, the social status piece, the being a White American woman piece that often times embarrasses me” (P26, 4). This disconnect between one’s personal experiences and those of one’s client were seen as factors that might ultimately undermine potential empathy, or perhaps just a lack of understanding about the day-to-day experience of one’s clients.

“Yeah, I think the barriers are that it can be just so hard no matter how hard you try to empathize with what their situation would look like from their point of view. As
much as you can try and try and try, that I don’t think that you can ever quite get there. And of course it’s true with any other person that you try to empathize with. But I think to have to- or maybe this is more with poverty than with race, that it is so, so hard to imagine what emotional life would be like if in addition to everything else that’s hard in your emotional life come out ok, if you were worried about how you were going to feed your kids, or [where] you were going to live that I just can’t even imagine.” (P25, 6)

The experience of privilege was also linked to a sense of frustration: even though one clinician viewed clients as having the means to change their situation, there was a sense of lack of agency. Perhaps this was linked to an inability to “play the system”.

“I mean since we’re including- only because they’re in my practice right now these two African American couples- there’s very little that- there’s very little that I would tell them that they don’t know, but they too can’t- they know it but they can’t do it. . . She just doesn’t feel enough of a sense of agency or authority even though she has the right she has the privilege, she just doesn’t- it’s not internalized the way she grew up.” (P01, 8).

Despite the fact that the clinician acknowledges privilege, there is still a sense of confusion about why the client does not simply rise up and alter her own situation. Privilege, for another clinician was seen as an indication of “luck”- that to have access to resources provides innumerable opportunities.

“And I’m also very aware that I’m lucky because I’m first generation, I’m not an immigrant. And I grew up in an era, because I’m old I grew up in the depression, when there was more passion for people and more resources available. I had a good
education in the public schools. The kids in New York City schools that are minority or immigrants, very few of them are getting educated, so I know I’m kind of lucky in that respect.” (P14, 8)

This feeling of luck was shared by another participant, for whom the process of working with clients is “positive in the sense that I’m reminded of how fortunate I am” (P24, 4).

Beyond reflecting upon the impact that privilege had on their own experiences, clinicians also described numerous systemic factors that they believed challenged their clients.

*Domain II: Perceptions of Client Experiences*

Shifting from the experience of the clinician to that of the client, a great deal of commentary in the interviews centered upon clinicians’ suppositions of various facets of their clients’ lives. Most clinicians provided information about their overall client population, particularly the percentage of their clients who were minority immigrants. Extensive analysis, transcending all of the clinicians, highlighted perceived challenges that undermined clients’ experiences. Somewhat less attention focused upon potential strengths fostered by particular clients, both internal and environmental supports connected to resilience. Using the lens of clients’ cultural frames of references, participating clinicians also provided their thoughts on aspects of clients’ identities that might impact the clinical realm. Commentary also turned to analyses of differences between the culture in clients’ countries of origin (and at times the expectations of their families) and either American cultural values or the clients’ shifting value system post-immigration. The present results section will focus on a more in-depth exploration of the categories that emerged within this domain.
**Characteristics of Clients.** Two of the clinicians indicated that minority immigrant clients represented a very small percentage of their client base, 5% (P27) and 15-20% (P20), respectively. For the first clinician, this number was small because the population specifically represented a side evaluation service exclusively for asylum seekers. Three other clinicians described minority immigrant clients as 25-50% of their client base (P14, P15 & P16), though this number tended to fluctuate based on the clinicians’ particular practice settings and geographic location. Of the remaining psychologists, two described their practice as mostly minority immigrant clients, ranging from 60-70% (P25 & P26).

**Challenges and Systemic Factors that Impact Clients.** Delving further into the identity and life experiences of their clients, participants enumerated a range of factors that provide hurdles for minority immigrant clients. These issues include socioeconomic and immigration status, prejudice or bias of others, trauma and other negative life events, familial stress, and general systemic challenges.

Many of these factors may in fact compound each other, as one clinician suggested. “This kid probably had- plunk a kid who was premobidly fragile into any family, it’s going to really stress that family. Plunk that kid into a family where there are very few financial resources, where access to a larger family system is missing. . .” (P01, 6). Other clinicians agreed that socioeconomic (SES) issues were as important as racial issues, though “less talked about” (P20, 3). When issues related to SES were addressed, it fell to the teenage clients to initiate the conversation through a discussion of “what kind of car people have and make different kinds of assumptions about that and that kind of thing” (P20, 2). When clinicians were not used to discussing economic issues, sometimes the conditions in which their clients lived appeared shocking and distressing.
“And I can remember (laughs) I went to a staff meeting, and I said- I’ve got this terrible problem, I’ve got this client who doesn’t have a home. People looked at me, (laughs) like, oh? And I realized that there’s a whole kind of- what that was, was sort of rebridging that cultural divide of coming back to (town) after having not been anywhere near being in a relationship with anyone who was homeless.” (P25, 6)

This particular clinician was surprised both by the lack of the client’s resources, but also by the lack of outrage from colleagues who seemed more acquainted with homelessness among their particular patient population. For this same clinician, another surprise came from expecting that a client would thrive in American culture because she did have material resources, and the subsequent repercussions in the clinical realm.

“I think looking back on it, this woman was a very hard-working Haitian immigrant who’d done really well for herself. . . and I think part of the reason I failed to perceive that was this was a very successful woman professionally, and I almost think had I been dealing with someone who I knew had just come from Haiti and had not had any experience in American culture that I would be more careful to explain and do a lot of psychoeducation initially about this is what we’re gonna do. . . that I would have put more effort into psychoeducation. I think because of the combination of class and ethnicity that I got my signals crossed. . .That again, the class bias of oh, she’s a professional, she’ll understand this, got in the way of understanding- no no no, it’s not that simple.” (P25, 2)

In this case, money is equated with power, and entrenched similarities between the clinician and the client (e.g. economic stability) led to false expectations about cultural similarities.
Socioeconomic status was inherently linked to other resources for another clinician, particularly educational attainment.

“And I don’t know if that’s typical of the people I work for- work with- who are from Trinidad . . . I see middle class people. Or maybe in their country they were upper middle class. The people that I see are not recent immigrants who were struggling and came over here. They are people with education. They are not people with jobs because of their education, but because of their education they were able to come here, take a city test, do what they needed to do to get into the system and work. So they learned the system. They know the system very well. They know how to get in there and they know when they can take their sick days and when they can’t take their sick days and what’s in the union contract and what their rights are, and they don’t fight against it, they work with it.” (P21, 5)

In the same vein, lack of educational status and subsequent financial difficulties are equated with disempowerment on behalf of one’s clients.

“Whereas I can’t say that about Mexican people that I’ve worked with because the people that I’ve worked with have not had any education. The women who- some of them never even went to school. And coming here they have a very hard time navigating the system.” (P21, 5)

“The system” was also considered much more difficult to navigate when immigration status was in peril. Clients who were afraid about their immigration status were seen as less trusting in the therapeutic context because they believed that sharing their undocumented status would mean that “then they’re going to be forced back to move back to their home country” (P05, 7) and concern that the clinician is “gonna have to you know turn them in,
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blow the whistle on them, that kind of thing” (P20, 3). Fear also arose in circumstances in which clients’ safety were threatened along other levels. For several clients, despite the fact that they were in serious physical danger or being harassed by others, they were “afraid to go to the police because she wasn’t sure if her own paperwork wasn’t totally in order” (P20, 5) and because “they were afraid of being deported” (P24, 7). These particular situations led to constant feelings of paranoia and fear.

Immigration was viewed as disruptive along multiple levels of experience. Particularly, clients “lost status” (P15, 11), needed to learn a “new system” (P21, 2), and had to break familial ties “from his child, his family, his country” (P27, 3) upon immigrating. Indeed, immigrants were described as living borrowed lives: “They have lost structure to their life, and they don’t have one here yet. They’re borrowing someone else’s who is kind enough to lend that to them, but there’s time limit to that” (P27, 5). Another clinician described an additional sense of transience for immigrant clients who generally are not able to complete long-term therapy because they “generally come, do a little piece of work, and move on” (P01, 5).

If immigration alone did not trigger problematic consequences, the process of immigration may have added the burden of exposure to new sets of prejudices and biases in the United States. “I think a lot of my immigrant clients suffer from discrimination um, ‘go back to your country’, you know, that kind of thing” (P21, 4). Another clinician agreed with this sentiment, noting: “Hispanics are very discriminated against in [X] County and they don’t get what they need, they’re not treated as equals, which they know, it’s just I want them to know that I know it” (P14, 8).
According to one interviewee, blame falls on immigrant clients from a number of different fronts. Prejudice and racism emerge through anonymous comments on police blogs in one town, suggesting that “it’s the immigrants that are a problem, it’s the Brazilians or it’s the- whatever group that they want to jump on to blame” (P05, 8). Blame for one individual’s actions could result in the labeling of an entire community as problematic, even though “sometimes you just do stupid stuff because you’re a middle-schooler and so when you act out, you could be doing the same thing as a White kid” (P05, 8). This same participant also mused that racism could be even more insidious and masked through policy in a particular school district. The clinician commented that colleagues had blamed the failing academics in a particular school on the fact that “we have fifty percent English Language Learners and fifty percent SES free and reduced lunch” which leads to the imperative of “breaking the mindset that it’s the kids’ fault” (P05, 3).

Compounding experiences of discrimination, general traumatic stressors included continuations of conflicts between religious groups from a particular country in the United States (P15, 9, 12), and general trauma that may particularly impact refugee clients (P16, 4). One clinician linked general stressors more along racial lines than immigration status.

“Well, I don’t have a single, I’ve never had a single White patient or Hispanic who had murder in their family. But it’s very common in Black Americans that I see. And I’ve moved to Harlem recently, so I get more Black people (Interviewer: Ok). I see more funerals and deaths. I see more incarcerated relatives that I never see in any other segment of society. It’s not just . . . even Black people who are relatively affluent and educated and professional, they have more of that in their lives than other people.” (P14, 5)
This is example indicates potential blurring of lines between persons of color and minority immigrant clients. Additionally, this quote harkens back to a previously noted comment that socioeconomic status itself is not seen as a substantial protective factor against negative life events.

Outside of race or immigrant status, clinicians also mentioned general familial stressors that negatively impacted their clients’ lives. These incidents ranged from “family demands” (P15, 6) that clients were unable to fulfill to trying to figure out how to discuss mental health issues with one’s children (P20, 7). These conflicts occasionally stalled the therapeutic process if a client’s family was unaccepting of mental health supports for the identified patient. “So mom threw up all kinds of roadblocks to bringing him to our center. Even though she basically lived up the street. She made it sound as though it was this onerous thing to get there” (P16, 9).

Other potential barriers emerged through general systemic challenges encountered by minority immigrant clients. Clinicians described frequent systematic “red tape” (P11, 6) and frustrations elicited by “bureaucratic” systems (P05, 1). School systems were frequently described as contributing to clients’ stressors, including cultural divides: “she was at war with the school- how can they expect these boys to sit still all day, you know, in Somalia kids can get up whenever they want to, this is crazy” (P16, 6); and general inadequacies “in New York City schools that are minority or immigrants, very few of them are getting educated” (P14, 8). The impact of systemic challenges was described as a major hurdle for both clients and clinicians. As one participant noted, “You could hear the trajectories of kids whose families were involved with the police versus kids who were connected to church and community” (P16, 1). When the system fails, clients also “fall through the cracks” (P24, 1).
which can lead to serious consequences. “He’s one that’s falling through the cracks. And may most likely fall out of school by the time he turns 16, not get his degree, and probably end up working at some kind of an auto-shop of some kind, or kind of low wage type manual labor, when he’s got more talent than that” (P05, 5).

External systemic challenges also weighed upon the clinicians themselves, who experienced a sense of “frustration, in an effort to sort of contact a million people to do one small thing” (P26, 2-3). One participant outlined the sheer amount of responsibilities linked with a single client:

“It was a hell of a case and it was an enormous amount of case work, we had to go through a lot of stuff together, I was dealing with his lawyer, and the Department of Children and Families, and his- his immigration attorney, his melt downs, his inability to understand the system, and his loss of insurance, bills from the insurance company, a $40,000 from the- from the hospital because he didn’t have health insurance when he was hospitalized. $40,000. Going to apply for health insurance, going over to apply for health insurance. He had two names, and there was some confusion as to which name it was.” (P24, 5-6)

In this particular case, it seems that the clinician is highlighting a sense of shared responsibility for the outcome of the case, but also a feeling of a shared burden. The challenges faced by the client had in turn become the challenges faced by the clinician.

**Strengths of Clients.** Though a lesser focus, participants also highlighted various strengths of their clients, both touching upon external resources through communities and support networks, and also internal strengths. Two clinicians in particular described various aspects of external resources that enhanced their clients’ lives. Participant 05 p focused upon
families as resources for minority immigrant clients, particularly as they allowed for connections with other members of the community. “It’s word of mouth like a lot of things in our community that the immigrant families I think create a network and within their network they know who to trust and how to work the system” (P 05, 1). Similarly, “caring parents” were labeled as a powerful resource for another client (P05, 5-6). Participant 16 suggested that immigrant clients tended to foster more egalitarian community hierarchies than most American community structures, and that this facilitated positive growth within communities. Indeed:

“A lot of our work was focused on shoring up relationships with community leaders. . . Talking to a grocer is pretty much one step away from their community leader. . . It’s just a very different kind of existence and it’s really nice in a lot of ways. I don’t think- I think we have an easier time in some ways helping the refugees who live here than we might helping people of our own culture living here because of how tiered it is.” (P16, 2, 4)

In this way, minority immigrant communities were viewed as more resilient and more collaborative than those of individuals born in the United States.

General inner resilience was a common refrain across interviews, and in most cases was viewed as a noble and admirable trait. This sentiment was often coupled with a sense of awe at the degree of hardship encountered by clients. “They have a lot of resilience because they had to go through so many changes” (P21, 1). Another participant concurred: “It’s been really rewarding and really humbling. I think it’s rewarding just because the – the admiration I feel for people who are brave enough to leave their own country and come here really try to start over is- is boundless. It’s so enriching to be close to that experience” (P25, 1). This
trend often induced positive reactions, and appeared to make the clinical work more appealing for the clinicians themselves. “They’ve been heroic people. I’m privileged to be a small part of their life” (P27, 1). Another clinician described a challenging situation in which a client was able to face animosity:

“He had two names, and there was some confusion as to which name it was. And when we went together to apply for insurance, the lady behind the counter says to him- “which name is it? Is it THIS name or is it THAT name?” That kind of stuff, you know. Um. . . and really to witness his- um. . . I mean his amazing demeanor in the face of that hostility. And insensitivity.” (P24, 6)

In this case, the clinician’s outrage on behalf of the client seems almost palpable, and appears to include a sense of amazement that the client was able to withstand this degree of hostility. Contrasting this attitude of acceptance in the face of negativity, several other clinicians highlighted what they described as a sense of acculturation and adaptation to norms in the United States.

This form of adaptation, and subsequent sense of value (or strength) attached to more Americanized behavior connected to a “willing[ness] to use her English more” (P26, 2), a process of “becoming more assertive” (P26, 2) and a sense of becoming more “acculturated” as a way of “becoming successful” (P26, 1). Another clinician indicated a value judgment of a client’s inability to adapt to American norms by not standing up for himself.

“Whereas people who are more American, I don’t know what I mean when I say more American, but they take on more American values. They understand that they can be more assertive. . . Yes, you are allowed to question the system. You’re allowed to question the system.” (P21, 6)
When a particular client did not stand up for himself, he was hospitalized against the judgment of the clinician, which “still bothers me. His flashbacks and things from the hospital have gotten fewer. This was about 6 months ago or so. Still wonder why I wasn’t able to communicate that with him. And I think that with maybe more with immigrant population I have a harder time communicating that part of the system” (P21, 6). This clinician viewed the adherence to the hospitalization process as harmful. Furthermore, the clinician expressed frustration that the client did not question the judgment of the hospital, and that the clinician was not able to teach the client how to refuse unnecessary treatment. Another clinician defined adherence to professional suggestion as acculturation, citing cultural differences along these lines.

“Mexican Americans would be more apt to take suggestions without- and follow through, it appears. Depending on you know, I guess what degree of acculturation, a lot of these variables. They are more apt to take direction than African Americans are. African Americans might not take direction like that. There might be some resistance that would come up.” (P11, 1-2)

It is less clear in this instance whether the clinician values the method of “taking direction” or “resistance” more, though perhaps for this participant, adhering to a clinician’s professional opinions might seem more helpful to the professional in the clinical realm.

Clients’ Approach to Counseling. Indeed, other participants also addressed the issue of the intersection of culture and expectations for counseling, which at times seemed at odds with the therapists’ own sense of the purpose of counseling. Culture and racial factors were described as determinants to clients’ receptivity to counseling, while other expectations, such
as the desire for problem-solving or expert advice seemed to conflict with clinicians’ sense of decorum.

Starting with the intersection of culture and clinical expectations, participants seemed to insinuate that particular cultures were either more or less responsive to mental health processes. There was some disagreement among participants about overall receptivity to counseling, with one clinician generalizing that “mostly, the immigrant, mostly the immigrant[s] are ready to accept White people, who are in their eyes, okay” (P15, 9), whereas another participant stated that “there’s relative degrees of wariness of the system, of the authorities” (P21, 4). Others concurred with the latter theory, “there is a large and growing number of people who are rela- who are immigrants and refugees who are not interested at least initially in psychotherapy, may not know what it is, who are coming here, and something shows up where we get involved in one form or another” (P24, 1). Various theories emerged about potential reasons for the range of responses to the therapeutic process. While the aforementioned Participant 11 believed acculturation contributed to clients’ acceptance of therapy (P11, 1-2), others argued that historical contexts and past exposure to racial conflicts might be important.

“It is much easier, in my limited experience, for a White therapist to work with someone from the Caribbean, a Black person from the Caribbean, or from Africa, than often times from inhabitants of big cities who are minorities. And the reason for that isn’t because White people aren’t any better, but because they have been limiting the contact with White people at home, and uh, and they haven’t felt dominated or get into any power struggles.” (P15, 9)
A spectrum of receptivity was also highlighted with regard to age and developmental status, with one theory that younger clients might be more open to counseling.

“Um, there’s another group of people who are immigrants or sons and daughters of immigrants who are sort of bicultural (mmhmm) who are more likely to come directly for psychotherapy. You know, may have been born in China and then moved here at 11, and so uh, those are more likely to self refer.” (P24, 1)

However, even for younger clients, the process of therapy seemed to take much longer than expected for one clinician for whom “we did in nine months what I’m accustomed to doing in the first couple of months with other patients I have in terms of that just getting to know ya- the connections, getting comfortable with talking, so much, much longer, and interrupted” (P21, 4). This longer time frame might be attributed to clinicians’ perception that minority immigrant clients “don’t trust as easily” (P01, 3).

Further challenges arose for clinicians when their clients’ expectations for therapy did not mesh with their own model of the clinical relationship. In particular, clinicians in the present study attributed challenges to clients’ expectations that their therapist would serve as problem solvers and the expert voice of authority. Participants described clients’ desires to “to just fix him” (P01, 6) and to “stop treatment” (P21, 8) when they had reached desired levels of symptom reduction. One clinician linked this approach to the client’s culture:

“Well look, some people come in and they’re not at all psychologically minded and I think in some cases it’s because of the culture they grew up in. So to even think that you have a self that you reflect on in some cultures is an utterly foreign concept. So those people will come in, and their symptoms will be somatic symptoms, and they’ll
just want some relief. So I suppose you could say it’s a barrier, because I’m psychologically minded, I want to talk about the self.” (P24, 10)

In this sense, “psychologically minded” refers to the clinician’s desire to “talk about the self” rather than to reduce symptoms, the client’s apparent goal for therapy. This deviation between expectations was attributed to the client’s culture, and appeared to irk the clinician in question.

Similar frustrations arose when the participants described various instances in which their clients appeared to desire a greater demonstration of hands-on “fixing” of problems, and clinicians’ judgment that this would ultimately be harmful for the clients.

“Someone’s coming to you to evoke power to help their kid at school. Um, but there’s a real danger of just saying this is what you need to do. Um, it’s in the room. It’s completely in the room. Um, and it’s a very strange thing when someone thinks they want you to take control of the situation, it’s actually negotiating what that’s going to look like.” (P16, 6)

Describing the same client, Participant 16 also indicated that the client might not have been aware of her actual desires even though the client appeared to request greater involvement, or a sense of “I want you to rescue me, but I’ll freak out if you actually do it” (P16, 6). It appears that there is a perception of conflict between what the client wants and the clinician thinks they actually need. In this sense, the clinician simultaneously rejects the role of expert while also indicating that he may have a better sense of the client’s needs than the client herself does. Another participant, grappling with a similar conflict, seemed more apt to take on the role requested by the client.
“Yeah, I worked with a, I guess an Asian American family and absolutely felt that way. They wanted it to feel that way, wanted to make sure it was that way. Otherwise they don’t want to use you as a therapist. . . They were very humble, and very just. . . they wanted to be around an expert (mmhm) to be helpful to them . . . I knew from experience that they were very big on that, going in. I knew that the mother and the father were going to be very, I don’t know, it’s almost like a rank in the military. You’re a doctor, they’re a person. That’s the way- I knew going in, it was just that way. I just presented myself as doctor, and said- usually I say, gee, would it be easier for you to call me doctor or to call me [first name], and I didn’t present it that way. I usually say that. But I didn’t say that to them.” (P11, 6-7)

This clinician’s response seems to reference a belief that Asian clients require a certain variety of clinical intervention, and that this may deviate from the clinician’s general process of relating to clients. Perhaps this further references, from the clinician’s viewpoint, a divide between Asian and other clients.

Differences Between Immigrants and American Born Clients. Other clinicians drew distinctions between all immigrant clients and those born in the United States, referencing both general life experience and conflicts between the clients themselves and their families or between adherence to customs in the United States and those in their country of origin. In addressing differences between clients born in the U.S. and those born in other countries, several clinicians described their experiences as entirely separate, with “different value systems” (P21, 4). “It’s a different- it’s a totally different mode. It’s a different world. They don’t live in the same world, respectively, in a lot of cases [that] White people live in” (P11, 1). Others addressed familial relationships, describing immigrant families as “more
authoritarian than typical suburban American parent might be” (P25, 4), or more respectful towards one’s elders (P15, 5). Another clinician posited that immigrant families tend to “have a far more extended family structure than Americans do. They have far more duties and responsibilities extending out from their nuclear families than we are accustomed to,” and thus “you wouldn’t want to say that they are enmeshed or anything” (P12, 1).

As Participant 12 suggested, the particular perceived cultural structures might impact the therapeutic realm. For example, Participant 16 described minority immigrant communities as less tiered than those born in the United States, which in turn might yield an “easier time in some ways helping the refugees who live here than we might helping people of our own culture living here because of how tiered it is” (P16, 4). In this sense, community connections are viewed as a resource that better facilitates the counseling process. One clinician also described manifestation of mental illness in a particular client: “his depression took the form of somatic complaints—pain in his head, heaviness, and a lack of faith in god which had been very strong for him” (P27, 3). These manifestations of depression fall outside the American Psychiatric Association’s definition of the disorder, but as another clinician pointed out about intervention techniques, “yeah, we call them alternate, to them our methods are alternate” (P21, 8). These two comments indicate a potential need for interventions that are salient and tailored to the particular needs of a client.

One clinician questioned the manner in which minority immigrant clients’ needs may be different than those of an individual born in the United States, particularly in terms of the response that these needs prompted from the larger community.

“Is this ok? To be resourcing one person so heavily when there are other people who needed— or resourcing heavily because of his asylee status. What about the people
who are living in [name of town], growing up in [town] who don’t have resources. We’re giving so much to one person because they’re identified as political violence survivor, and there was that. There was a lot of affect, and a lot of good will, a lot of wanting to help people when they’re coming from outside, and less so when they’re here.” (P27, 4)

This clinician postulated that while the need for support may be present in both communities, “the image of a country in civil war, or political physical violence” that impacts “a whole community” may receive more attention than the needs of an individual family who is struggling with a particular challenge (P27, 4).

Navigating the cultural divide was a common point of discussion among clinicians, both in terms of internal conflict and conflict between clients and their families. It seemed that most clinicians perceived this process as a challenge for their clients, as described by one participant: “he was just strung between cultures, strung between identities. There was no identity he could imagine for himself here. There was no way he could be present” (P27, 4). Another participant concurred, musing: “in just about every case there was conflict, internal conflict, in most of the people, um, between the culture they left behind, especially if they were adolescents when they left, and the new culture, and adapting to it” (P15, 7). The general consensus among clinicians seemed to be that in the case of a struggle between cultural expectations, one side “won out” against the other so that clients either rejected American cultural norms, or abandoned familiar practices in an attempt to acculturate.

“I used to volunteer at a place where there used to be a lot of Mexicans. Mexican immigrants. Um, new immigrants, old immigrants, some- most of them illegal, some of them legal. And that was different. The Mexican group wanted to not integrate.
They wanted to – they just really stayed within their own culture and society. They didn’t see the value of learning English. They didn’t want to. They didn’t want to eat other foods, they didn’t want to learn about other people in the community, they just really wanted to be together.” (P21, 4)

Participant 21 depicts Mexican immigrants’ process of maintaining a sense of continuity with the culture of their country of origin while living in the United States. The clinician’s hypothesis about why clients chose this particular balance within their communities is somewhat unclear.

Other participants referenced incidents in which their clients opted for more Americanized values, such as “[treating] people nice no matter where they, what their station was, this includes service people, like taxi cab drivers, clerks at the cleaners, every place she went. She felt bad that she wasn’t living up the family requirements by treating these people with a smile, and uh, a pleasant tone” (P15, 6). In addition to emotional consequences for choosing cultural values outside of those chosen by the family, there were other potential ramifications in the family setting.

“The content was uh, how he could make his own in this culture. Whether he could manage to make a living without his father’s money. Um, whether or not if would ever go back to Iran, where he had left most of his friends of childhood and young adulthood. Whether or not he had really been so bad as to make this first marriage with a person he now considered inappropriate. These were the kind of things.” (P15, 5)

In order to avoid direct confrontation, clients often adopted particular strategies for bridging cultural divides, such as “an example of it is a woman in this couple was a professional. She
had chosen not to wear the veil anymore. So, she her face was exposed to the world, but when she went back home, where she came from, where her mother still resided, she would wear the veil” (P15, 8). The relationship between parents and children in immigrant families produced challenging dynamics. Several other clinicians also mentioned cultural conflicts that arose between parents and children. In particular, “I guess the ones who have been born here, their parents were from another country, right? So they’ve had to figure out how to um, make American culture work for them when the culture in their household is very often much different” (P21, 1-2). Participants viewed the process of immigrating and acculturating as a pivotal in shifting dynamics in the family context for these clients.

Domain III: Experience of the Therapeutic Relationship

Beyond describing their own perspective on multicultural issues and discussing their perceptions of their clients’ experiences, participants in the present study also focused on various phenomena that emerge in the counseling relationship. Domain three consisted of four factors: 1) barriers that limit the therapeutic relationship; 2) factors that enhance the therapeutic relationship; 3) the ways in which clinicians addressed differences between themselves and their clients; and 4) participants’ perceptions of the particular role that clinicians should play.

**Barriers that Limit the Therapeutic Relationship.** Addressing barriers prompted detailed discussions for nearly all participants, who sought to thoroughly outline factors that undermined or complicated the clinical process. Many examples emerged that highlighted external systemic barriers that negatively impacted the relationship between clinician and client. Interpersonal barriers also included references to factors in the clients’ culture that were perceived as roadblocks to therapy. As a result of these hurdles, various consequences
included negative ramifications for clinicians and clients alike, including termination of relationships before clinical goals were achieved.

Despite the fact that recalling problems could potentially trigger painful memories of particular challenges, clinicians described extensive barriers in their relationships with minority immigrant clients. Most clinicians identified situational or systemic barriers. In particular, problems were attributed to the type of intervention, time, language barriers, and to other health characteristics of their clients.

Several participants described the particular nature of an intervention as one limiting factor. One clinician seemed to imply a desire to engage in deeper psychoanalytic therapy, but feeling restrained by the particular role. “He can do therapy, I can’t do therapy with him here, I mean I’m not authorized to do real, intensive, internal system psychodynamic work with him, but it’s very clear that he can go and find some of the stuff that’s caused him to have the distress that he’s has, and he’s underserviced” (P 05, 5). This left the clinician feeling “disappointed that I can’t offer him more time and attention” (P05, 5). This clinician worked within a school context, and felt tasked with focusing on academic issues. Other clinicians’ limiting roles included neuropsychology (P16, 5), court-based evaluations (P27, 2), and cases related to work injuries (P21, 2). These roles led to less psychologically oriented interactions, as described by participant 21: “I don’t know how to say this. They look at me more as a medical person rather than a psychotherapist” (P21, 2). The pressure associated with this role was intense enough for one clinician that it seemed like a less desirable form of treatment. “So I try not to accept those cases (laughs) where the pressure is so great, because it feels unfair to me and to the individual that they have to tell their story, which is generally a very painful story with that pressure and without the time to weave in
some intervention” (P27, 3). This participant’s experience bridges topics with another particular challenge: the frustrations of time-limited treatment.

One clinician described time as “the biggest challenge” (P05, 5). Another participant agreed, echoing the sentiment by suggesting that “you have to accomplish something, and you only have limited hours to do it, so there’s only so many hours that you can actually work. Depending on your curriculum, depending on what you want to accomplish I guess” (P11, 3). This constraint enhanced clinician’s sense of pressure to achieve therapeutic outcomes, and also shaped the content of the counseling sessions themselves. Participant 25 suggested that the nature of time prevents any discussion about race or identity.

“Um, so . . . it’s more likely that in psychotherapy when I’m gonna have a long term relationship with someone that I’m gonna bring it up very explicitly at the beginning—how do you feel about having a therapist with a different ethnicity? It evaluations, it’s less- it feels less appropriate. Yeah, I think because in a counseling session, it’s really the beginning of a long term relationship there’s going to be a lot more intimacy. And a lot more, you know, projection.” (P25, 5)

Short-term relationships are described as less intimate, and more goal-oriented in the sense that they do not have room for discussion about other elements of identity.

In addition to time, clinicians also addressed the issue of language barriers. Nearly every participant in the present study described language as contributing to the challenge of working with minority immigrant clients. Several clinicians went so far as to describe it as the biggest challenge: “Yes, indeed but the biggest one though is not race. The biggest one is language” (P15, 10). This barrier makes work with minority immigrant clients “harder” than with other clients (P14, 4). Language barriers made sessions with one client “so painful.
Experience of Clinicians

Because of the language I couldn’t join them. . . The language was a real obstacle and they understood the things I said they were doing wrong much better than anything else” (P01, 5). This same clinician found that language barriers contributed to a sense of “impatience” because clients are “so slow”, and that ultimately clients “experience my impatience” (P01, 4). For another clinician, clients had to be transferred to another clinician due to language barriers (P14, 4).

An additional layer of complexity surrounding language barriers relates to the role of the interpreter. Other than the mere shortage of interpreters (P16, 7; P26, 4), clinicians indicated that interpreters may miss the essence of a client’s meaning.

“And trying to get someone to translate what I want said and how they say it, it’s not the same thing. That’s one of the challenges at a psychologist. There’s certain ways to turn a phrase, and I think we in the field are often trained in a unique way in how to help invite people to have conversations about challenging things, and you…when I rely on somebody else to do it, I don’t think they’re doing it right. I can tell by the nonverbal expression of the people’s face the way the question’s being asked doesn’t quite capture it the way I want it to. So, that’s a challenge.” (P 05, 2)

From this clinician’s perspective, well-meaning interpreters may not convey the message exactly as the clinician wishes it to be presented, which may lead to other strains in the professional relationship between the clinician and interpreter. Miss- or partial-interpreting was also attributed to the interpreter’s own life experience “because if they come from a similar background who knows what hearing about another person from that background’s trauma has been, how that impacts that staff person” (P26, 5). Participant 27 recounts an example that fits with this perspective.
“I had an interpreter once with a man from Rwanda who was very, very sad, had- one parent was Hutu, one parent was Tutsi, and he was caught between these tribal wars. Felt like he’d been robbed of any pride in any sense of his identity and the interpreter- they were speaking French, was a common language. And the interpreter started crying. And so had to leave. She couldn’t be in the room. She actually had a history of her own and then I had to take care of the interpreter. It turned out that he and I could actually speak English well enough, to complete the evaluation. When the interpreter was interpreting, I realized once she started crying that I really couldn’t trust her interpretation because she was so full of her own affect and her own experience. I had to go back and start from the beginning and ask her those questions over again to see if what she was telling me was accurate to his experience. So those are some- that’s a huge barrier.” (P27, 6)

In this circumstance, not only is the clinician concerned about the validity of the clinical interview, but now the well-being of the interpreter (previously an impartial professional resource) is called into question.

The mental health of the clients themselves, both generally and more specifically with relation to particular cultural constructs, also served as a challenge for the clinicians in this study (P11, 4; P16, 4; P20, 5). Shame appeared to be a central aspect of the mental health process that required extra legwork on behalf of the clinicians. Participant 26 (1) described “an Iraqi middle-aged Iraqi man who has been self-medicating with alcohol and if I just describe with the effort to date has been unsuccessful for someone who speaks Arabic and is Muslim and feels ashamed.” This same clinician identified a problem recruiting and retaining male minority immigrant clients. “We understand less what of the men are experiencing
because few of them come into the health center. . . . So, we’ve never captured Somali men, we’ve got lots of Somali woman, Somali children” (P26, 4). The participant did not offer a theory about why this challenge existed.

One additional systemic barrier that emerged was addressed only by one client, but seems worthy of note in this results section. Participant 16 described the problem of “political correctness” in which the clinician “just felt that [the Department of Children and Family Services (DCF)] was just wrongly treating them with kid gloves in the name of they’re a different culture, they do things differently. Um, and by any measure this was outrageous. . . And she was hiding behind the Asian Psychiatry team, was hiding behind DCF” (P16, 8). While the clinician also noted that “it was two equally correct voices arguing” (P16, 8), the first statement seems to imply a sense of frustration with multicultural values as a potential impediment to the physical safety of clients.

Shifting topics to address interpersonal barriers reveals both some novel territory, and also significant overlaps with previously mentioned categories. Frequently these barriers were attributed to the client’s culture, though clinicians also described the general cultural gulf and power dynamics as influential in promoting rifts between themselves and their clients. In multiple instances, the cultural divide was attributed to clients’ negative perceptions of White individuals. Because they have been “screwed over in a lot of ways by White people” minority immigrant clients are more “afraid that something might harm them than might help them, for good reason” (P11, 2). Participant 12 suggested that Black clients might “perceive a Caucasian person such as myself to be arrogant” (P12, 1). Another clinician described a similar perception that minority clients experience anger and hostility towards White individuals.
“Well this guy had a lot to say about White culture. I mean about- American culture. He told me that ‘you guys are a bunch of liars’. I remember him saying- you guys are a bunch of liars. I mean watch the news. They tell you in a few minutes we’re gonna be giving you a report on this, and then an hour later they give you the report. So they’re lying to you. And that’s what this culture’s like. Everybody’s liars.” (P24, 9)

In this latter example, the clinician seems to be somewhat validating of the client’s viewpoint by providing a subsequent example that supports the statement that White people are liars, which echoes Participant 11’s comment about a client being critical of White people “for good reason.”

Several other clinicians described situations in which it seemed more difficult to carry out clinical interventions because of resistance attributable to culture, or general cultural complications. One female client did not want to “talk about sex with a third person who was also male” (P15, 3), whereas other clients were viewed as simply “not prepared to tell me anything about themselves. . . and I’m assuming again that that’s a cultural thing, once they saw that that was what I wanted, they just left” (P24, 9). A participant also described difficulty distinguishing between the client’s culture and pathology.

“And this was a child- a girl, about 12, from a family that came here from Bosnia. And she was evaluated because there was some question of Asperger’s. And it was really um difficult to sort out what degree of this girl’s oddness maybe kind of a spectrum related, versus what degree was coming from a different culture, having experiments- different experiences, um having some learning disabilities as well in a case that was kind of- probably borderline.” (P25, 3)
This example links to an ongoing discussion about cultural differences between clinicians and clients, which also subsumes examples of divergent expectations for the counseling process. At times, clients raised concerns about racial barriers between themselves and their clinicians. “Um, you know, sometimes they question whether I can understand their experience if I’m White and they’re a person of color” (P20, 2). Another client raised concerns about how racial and cultural conflicts in the community might play out in the therapeutic relationship. “And he came in, the first thing he said to me was you’re not going to want to see me because you’re a Jew and I’m an Arab” (P24, 11). Clinicians also expressed concern about how cultural gaps might impact the power dynamics in the relationship “She would come in completely unraveled, and what do I do, and this is terrible, and we all really had a hard time of not falling into the trap of just taking over. Because once you take over, then you are an oppressor too” (P16, 6).

Several other clinicians also identified power differentials between themselves and their clients as primary boundaries in relationships. “I mean I think that’s the biggest challenge is that for many of our immigrant children seeing me, kind of the 6 foot 1 White guy who’s wearing a tie, normally their association is an authority figure” (P05, 1). A clinician’s status as a mandatory reporter of abuse (P20, 7) and as the final voice in a clinical evaluation that may have legal ramifications also seemed to influence the relational dynamics (P27, 5). This dynamic was particularly uncomfortable for one clinician.

“One of my first supervisors here. . . said what you have to realize is that a good percentage of your clients are going to come in and look at therapists as gods and goddesses. And I heard that, and thought- ugh. And he wasn’t saying that it was a
good thing at all. And I think that that’s been a power dynamic that I’ve really looked for ways to dispel.” (P25, 8)

Additional factors, such as theoretical orientation of counseling or socioeconomic status were also seen to contribute to a difference in power between clinician and client. As Participant 25 noted: “I think that psychodynamic kinds of treatment that really don’t allow you to directly dethrone yourself the way more cognitive behavioral approaches do have been less compelling to me” (P25, 8). Socioeconomic factors were explored through the mere type of dress for clinicians and clients. “I’m dressed differently. These folks mostly have borrowed clothing on and sometimes it fits and sometimes it doesn’t. They don’t have homes, they’re living in someone else’s home. They don’t have- [they] have nothing” (P27, 5).

Though perhaps slightly peripheral to the discussion of power, clinicians also attributed rifts in relationships to aspects of themselves and the manner in which they approach the therapeutic relationship. Making an effort to understand clients is key, according to Participant 11. “It really impacts the clinical progress because if you don’t understand them, you don’t get where somebody is coming from. If you’re willing to do this, or not willing to do this- if you’re not willing to meet them where they are at, you are not going to get very far” (P11, 2). Participant 12 also described the nature of relationship as tenuous when there was a lack of positive emotion on behalf of the clinician. “If I like em I like em, if I don’t like em, they leave pretty fast” (P12, 4). This statement draws focus to a primary effect of interpersonal and systemic barriers: dropout among clients.

According to the participants in this study, the ramifications of barriers in the therapeutic relationship can have a profound impact on clients and clinicians alike. Since the present study includes clinicians only, their perspective is paramount in discussing the
outcome of therapy. Perceived frustrations on behalf of clients mainly manifested through the process of dropout, or termination prior to the achievement of therapeutic goals. This appeared to be a common problem for clinicians: “there are always people dropping out for one reason or another. So... I’m used to it” (P24, 4). While one participant indicated that clients dropped out after experiencing a reduction in symptoms (P01, 3-4), others indicated that counseling ended abruptly and unexpectedly: “she just stopped coming” (P25, 3). This form of dropout was described as a total failure of the therapeutic process. “I don’t know what happened to them. That’s an example of total and complete uselessness of therapy” (P01, 5-6).

The effects of dropout and other challenges on the clinicians themselves appeared quite profound. Clinicians often described powerfully negative emotions, such as in the case of one clinician who felt unable to connect with clients. “I tried to breach the distance between them and me and I just couldn’t. I was very frustrated. They were polite, but I think they were irritated” (P01, 6). Other clinicians described feeling “terrible” and “sorry about the outcome” (P15, 5), “upset with him... upset with myself” (P21, 7), and “dismantled- my skills were dismantled” (P27, 2). Working with minority immigrant clients appeared to invoke particularly powerful emotions for the clinicians, and several participants provided theories as to why this might be the case.

“So it’s interesting, it’s intense, it’s time consuming, the counter transference is wild. . . . What does it mean frequently in the types of cases you’re dealing with, you end up feeling that if you don’t do a good enough job this person might die. . . And you feel like what you’re- what you do, in an immigration- a forensic immigration case
might make a huge difference in terms of whether this person goes one way in their life or another.” (P24, 2)

For the clinician above, the stakes feel higher with minority immigrant clients than with other individuals, and the clinician’s role feels more important. Participant 27 described a similar sense of responsibility, and subsequent feelings of despair about the size of the problems facing minority immigrant clients.

“I have to be careful around not getting too depressed by it all, and feeling a sense of any change is- will genocide always be happening? Will we always misuse power? Why do we misuse power? What will really make the difference? But I can get a pretty bleak world view, and get into an existential morass that I have to be careful when I do that.” (P27, 8)

For all of these clinicians, the role seems to come with certain distressing burdens, or emotional reactions that reverberate long after the outcome in a particular clinical relationship. Yet just as the lows seem particularly low, the highs are also quite high.

Factors that Enhance Clinical Relationships. In addition to describing potential obstacles and factors that complicated their work with minority immigrant clients, clinicians also described various resources and strategies that supported successful relationships with clients from this background. Elements in this category also included various external factors that fostered positive environments thereby improving clinical connections. Finally, clinicians described the ways in which they themselves benefited from their relationship with particular clients.

When describing factors that enhanced therapeutic relationships, clinicians touched upon several primary examples of connectivity. They described experiences of feeling the
same emotions as their clients, feeling a sense of connection, exploring similarities between themselves and their clients, remaining open to their clients’ cultural values, and benefiting from their clients’ gratitude. In fact, two clinicians indicated the absolute absence of any negative experiences. One individual has had “very positive experiences with all of them. . . I’ve had very positive experiences with everybody” (P14, 5). When asked about challenging experiences, another participant indicated that difficult incidents “Never happened. Things were always more than well with him because he was very cooperative. This particular client was very, he was just really trying to do better. I didn’t get- there were no [negative events]” (P11, 5).

Though most of the codes in this category were generally “positive” in the sense that they enhanced the relationship, some of the connections involved sharing negative or distressing emotions with clients.

“I was very frustrated that I couldn’t – I would make a joke and they would look at me. Or . . . I tried to breach the distance between them and me and I just couldn’t. I was very frustrated. They were polite, but I think they were irritated. . . So there was a growing sense of impatience and irritation. The whole thing felt- I felt irritable and irritated.” (P01, 6)

The clinician’s frustration here appears to mirror the impatience of the clients, and both are described as “irritated.” A similarly powerful emotional connection affected another participant who described feeling dejected during particularly painful work with a depressed client. “At that point sitting with him was probably as painful as a process that I’ve had as with anybody. And I’ve sat with really depressed people before. But there was a quality to his feeling bereft which he- he was just strung between cultures, strung between identities”
Another clinician experienced a similar form of reflective emotion, though with a more satisfying outcome. “What kinds of emotions did I have to the positive outcomes? I was excited and I showed. I showed it. Mexicans as a whole are very expressive, very verbalish and they let their emotions out” (P11, 5). The clinician’s emotions seem tied to the clinician’s view of the client’s form of emotional expression, as with the first example.

Deepening of the relationship status also occurred through feelings of connection to one’s clients. Connectivity stemmed from a sense of having a “real human bond” (P26, 3) and being “let in on someone’s life” (P24, 4). The presence of connection “promotes trust, it promotes openness. It promotes collaboration. It promotes everything that needs to happen for therapy to work” (P01, 7). These feelings seemed powerful enough to shape the clinician’s entire sense of being, particularly with regard to the passage of time, as one participant suggested.

“There’s a warmth and an effortlessness and timelessness and a sense of connection. All of which [is] subsumed under connection, connectedness. You know there are patients when you glance at the clock and it’s 12 you glance at the clock and it’s 12:02. You think fifteen minutes have passed. And then there are people where it’s 12:30 and you go holy cow. I didn’t get to xyz just because the conversation is flowing, it’s connected. . . There are people that you look at the calendar and you think- that will be a great afternoon. That’s when work goes well. (Interviewer: people that you look forward to seeing?) Yeah. It’s not friendship but it’s the kind of connection that feels like a friendship.” (P01, 7)

To create this kind of warmth within relationships, participants also described a concerted effort to build the relationship through seeking out similarities with their clients. This process
could be as simple as striking up a conversation about a shared interest with a client, and using this casual conversation to shift into discussions about any difficulties the clients might be experiencing (P05, 5). Another participant described a client’s artistic endeavors, and added: “I’m also an artist so it’s like a collaboration. It’s exciting to me that she’s doing this” (P14, 7). Finally, one clinician drew similarities between the clinician’s culture and that of the client. “He was- I don’t know how accurate this is, but apparently, much like in Jewish culture you are a man at 13, it’s similar in China, at least in the way he conveyed it. . . There was a little bit of that stress management, coping stuff, but most of it was just you know sitting shiva is the closest I get to what that experience was like, sitting together, remembering this person” (P16, 9-10). For this latter example, it seemed that tapping into the clinician’s own culture served as a point of reference that allowed a deeper understanding of the client’s experiences.

Openness to clients’ culture seemed to be a point of contention for several clinicians, particularly when their clients’ values seemed at odds with their own. However, a number of participants described various strategies to reconcile these experiences by remaining open to their clients’ experiences. This process “required a lot of listening and . . . suspending some judgments” (P25, 4). For example, in case of genital mutilation, one clinician had to “hold back my own feelings of horror when that might not be what they’re feeling” (P27, 6). Another participant described two similar instances in which “I was pleased because I really did stick to my views and it had to be her decision based on her beliefs, not mine” (P15, 7) and a situation “that went well, even though it was against my values, but it wasn’t against the client’s” (P15, 7). The outcome was considered to be positive, even though the values
conflict elicited discomfort. Not every participant approached the process of openness in the same manner:

“Everyone is all on this diversity, and you’ve gotta be trained, and blah blah blah. I think that if you don’t have a rigid idea about how things are supposed to be in the world, and you’re not brainwashed by your culture, and you’ve really understood that you’re not supposed to be judgmental when you’re doing psychotherapy (mmhmm) it’s you know, people are very diverse. You don’t have to come from a different culture. Everyone’s who they are.” (P12, 5)

For this clinician, openness means the suspension of judgment even though notions of “diversity” are viewed as superfluous.

One additional aspect that appeared to enhance relationships was the degree of gratitude expressed by one’s clients. Minority immigrant clients were described as “welcoming and appreciative” (P27, 1) and enjoyable to work with due to their “gratitude” (P24, 4). This sense of appreciation seemed to stem from a feeling of relief at surviving particularly stressful experiences. “The enjoyable part is that most of the people that come here are very glad to be here. It’s high in their consciousness, by here I mean in the United States. Um, most of the people I’ve seen have gone in considerable hardship in order to be here and to feel relatively safe in their surroundings” (P15, 2). The sense of “the joy, the relief, the . . . complete sort of like, um- alleviation of like a sword hanging over their heads” (P24, 4) served as a strong motivator for clinicians working with this population.

\textit{Strategies for Building Relationships.} Beyond the mere experience of a satisfying connection, participants also brainstormed strategies for creating and maintaining relationships with their minority immigrant clients. Such methods included striving to break
down power differentials between clinician and client, working to increase empathy to deepen relationships, and focusing more on the clients experience rather than on the clinician’s expertise. The last sub-category could also be described as “listen more, talk less”.

The act of lessening power dynamics seemed to involve a concerted effort on behalf of the clinicians. Various strategies allowed entry to this more egalitarian style of interaction. One example entailed creating a mutually collaborative atmosphere in which both clinician and client served as experts. “And so there’s this back and forth of- I’m learning about their culture and their day-to-day experience and they’re also getting from me how I’m thinking through trying to diagnose what’s going on” (P16, 5). A further iteration of this strategy involved an acknowledgment of imperfection on behalf of the clinician, specifically reducing the clinician’s expert status by apologizing for poor language skills. Through this process, “sometimes what happens is someone who thinks they can’t speak English when they hear me speaking Spanish they realize that they can speak English” (P14, 4). Establishing “equal ground” means asking questions, and “asking the person come back in and read it with them. See does this . . . sound like you. I want to make sure that I capture things accurately” (P27, 5). Ultimately, the goal seems:

“. . . to be able have them feel at ease around me and to let them know that I can be their support, a resource, and to be able to advocate for them is huge because I think it helps model for them their worries at times that often kind of being the White person is the perception that they may be threatened by or worried by because we may be, you know White people in general and White males in general being the source of authority, may not always be perceived as being the friendliest people for them to be communicating with.” (P 05, 1)
One sub-strategy related to the power dynamic and the goal of increasing ease within a therapeutic relationship is the incorporation of humor and more casual styles of conversation. “And how’s your lunch, joking about how bad or good the food was and that kind of thing. . . And we could joke about, yeah this isn’t- we’d be in the cafeteria and there’d be the clattering of glasses or someone’s- the smell of tater tots (laughs) or something” (P16, 9, 11). The same clinician described similar strategies of initiating conversations by asking about daily experiences, or celebrations of holidays “to get to know him more” (P16, 5, 9).

A parallel process of concerted relationship building involved focusing on the immediate connection of empathy by focusing on being mentally and emotionally present for clients. “At the end of the day it really was about sitting with someone” (P16, 11). Another client focused on the value of empathy as a way of ensuring that clients feel heard and understood.

“The fact that I can offer empathy and appreciation for what they’re going through, it really, it sounds cliché, but it has always been able to help the people feel like someone’s heard them. And I think that’s really one of the most important things that I can give any of our recent immigrants, and even not recent immigrant families, the experience that someone understands their worries about their son or daughter and what goes on here at school.” (P 05, 7)

This relational process appears paramount for this participant who describes it as more important than any other aspect of counseling. Other clinicians choose to build connection by focusing more on the client’s experience than their own expertise, a process that similarly places the client in the forefront of the relationship.
The focus on the client’s experience can also be described as “listen more, talk less.” Participant 16 particularly lauded this approach, suggesting that this process entails being “quieter” and “more patient” (P16, 6).

“Some of my best sessions of me barely saying anything and being mostly in silence and asking the right question. And happening upon it. Um usually just because of something I could feel from the other person. When you are in silent your other senses get more attuned. And you might pick up on something you wouldn’t if you were chattering (laugh) away and just making sure their eyes weren’t glazing over.” (P16, 5-6)

Several other clinicians also emphasized the importance of asking questions in order to better understand clients meaning and to learn more about their culture (P20, 3; P26, 3; P27, 6). This has an added benefit in which “patients see that you are eager to learn about their culture and for them to teach you about those parts of themselves” (P26, 3). For one clinician who literally has difficulty hearing clients, “I have to ask, naturally I have to ask people to restate things (laughs). Have to sit close to hear, in addition to accents have a hearing loss in order to hear. The good thing is that brings me into close proximity with people, I’m comfortable asking questions and asking people to repeat themselves. I’ll explain that I don’t hear well” (P27, 6). Though perhaps unintended, the questioning allows for both increased clarification, and a literal “closeness”. This process also changes the pace of sessions, because as compared to working with English-speaking clients in which “it’s very easy with English speaking clients, especially if you live in the same neighborhood to um have a shorthand and a lot of assumptions that kind of whip through,” with minority
immigrant clients who are non-native speakers “I don’t want to put words into your mouth, I
don’t want to assume” (P16, 12).

Efforts to enhance clinical relationships through conscious strategies were also
bolstered by external, systemic factors. Clinicians identified non-traditional roles or settings,
the efforts of previous clients on current relationships, and a racial or cultural match as
further elements that allowed for close connections with clients. Two clinicians identified
school systems as particularly constructive environments in which to conduct counseling.
Schools allow for more regular contact, including informal check-ins. “I get to see him every
day. Like see him, I mean I pass him in the hallway, that’s an exchange. It’s different than an
office arrangement, which is you know, again, there’s a camaraderie that we have which is
nice” (P 05, 6). Participant 16 described a particular school that set aside space for a Spanish
immersion room for students to utilize for various purposes.

“And [Name of School] is amazing because they have a Spanish immersion room.
Like they have- they go to their home base, and it’s wonderful to see. And they’re
going in there, and they can just hang out and talk in Spanish, be themselves. And it’s
this nice little airlock to go into class. So kids are just coming in and out of there all
the time.” (P16, 10)

This particular room seemed to serve as a safe place of sorts in which clients could regroup
and connect with classmates and teachers. These examples of space, both in the literal and
figurative (e.g. time) exist in marked contrast to other varieties of counseling or other
settings. For example, Participant 16 describes the process of neuropsychology as one in
which “it’s very easy to get into this contracting mode- so we’re going to do this, and we’re
going to build this, and all of that” rather than moving at the pace of or targeting material raised by the clients (P16, 11).

In addition to factors related to external settings, clinician also received a boost in their credibility through word of mouth from previous clients. That is to say- previous clients paved the way for present clients through interactions such as the following. “I think the kids are more likely to seek me out and it translates when the kids . . . when the 8th graders tell the 7th graders or the 7th graders tell the 6th graders Dr. _____ is an okay guy, you can trust him, you can go to him and get help, and that happens a lot. . . But at least from the kids’ perspective, I think they know they can refer a friend if they need help” (P 05, 1). Similarly, Participant 24 reported a word of mouth approval process as a manner of facilitating relationships with new clients. “What ends up happening though as we end up getting a reputation for working with immigrants and refugees, word gets around, some of them will come themselves or people will know about us in other places and will refer them here” (P24, 1). This process also entailed an even deeper form of facilitation in a group context through which the clients themselves serve as an extension of the therapist, perhaps reaching clients with whom the clinician might not be able to connect.

“This one kid was extraordinarily bright and my co-therapist was sort of explaining to me how the kid picked up on what I was trying to say and came up with something brilliant to say to his friends. It wasn’t as if I’d given him the words to do to that . . . It felt as if basically what I wanted to say if I were saying in English it’s as if it somehow got to him without my being able to offer much at all (laughs) other than some broken ideas, shored up a little bit by my co-therapist. But this kid kind of took it and lights went on.” (P16, 10-11)
In this instance, the client was able to serve as a cultural, linguistic, and also an emotional mediator between the clinician and other clients. However, in other instances in which there is not such a catalyst, several participants indicated they believed that therapy might proceed more effectively if there were a cultural or racial match between client and clinician.

In some cases, the choice to transfer to a different clinician emanates from the client. “I think he told me that he felt uncomfortable and thought he’d better go see someone who’s Spanish instead of not” (P14, 4). In this case, it’s unclear whether the client is expressing a preference for someone who speaks the same language, or who shares similar cultural attributes. Whereas for Participant 16, one client’s needs seemed to be better suited by someone from the same background. “My patient ended up transferring to um a Chinese American clinician which it seemed like a corrective, right time to do that” (P16, 8). This issue did not always appear quite so clear to all clients. One clinician indicated that the imperative of matching a client to a clinician based on similar background characteristics might depend both on the availability of clinicians, and on the particular needs of the clients.

“I don’t think I do this with Asians. Because I think I feel like the cultural divide is not so- well, two things. I think maybe I feel like the cultural divide maybe isn’t so great, and that there’s not as much potential for a whole history of racial conflict to find its way into the room? Um, and I guess I feel like- well someone said yeah, I would really rather not have a White therapist, I’d rather have a Black therapist, that I’d know where to find a Black therapist.” (P25, 6)

The explanation for offering a cultural match for Black clients but not Asian seems twofold. The first involves a sense of cultural “distance,” or the theory that Asian and White
individuals share more in common than their Black and White counterparts. The second explanation is a more logistical lack of knowledge about where to locate Asian clinicians.

On a partial aside, Participant 14 also expressed consternation about the lack of minority clinicians in the field of mental health.

“I haven’t seen one Black person, I haven’t seen one Hispanic person, I haven’t seen one . . . um . . . Asian…they’re all White. . . And then I was always bothered that we just couldn’t keep Black people in the group . . . Well I’ll tell you the only thing I’m thinking of as I talk to you is how bothered I am, I don’t understand, I haven’t figured it out, why my profession doesn’t attract minority people. Even though they come as patients. And that bothers me a lot. And nobody addresses it, like they don’t even notice.” (P14, 3, 4, 9)

This lack of clinicians of color may be linked to the particular theoretical orientation of this participant, who identifies as psychoanalytic. Participant 14 offers another theory, namely that the clinicians themselves are their own limiting factor. “You know one colleague said she thought what it was about that it’s enough of a struggle for [persons of color] to get into the Master’s degree level in any field. To go beyond it is beyond their concept of what they can do. So that’s the only idea that I’ve heard” (P14, 9). This notion seems to indicate that clinicians’ inability to conceptualize themselves in this role, or perhaps an insinuation that other barriers impede progress towards advanced graduate degrees in psychology.

Transitioning to another subset of the category that addresses enhancing factors in therapeutic relationships, participants also outlined potential kickbacks for the clinicians themselves. In other words, what exactly does the psychologist “get” out of the relationship with minority immigrant clients? The two primary sub-categories that emerged in this area
included the dramatic effects of supporting minority immigrant clients, and positive feelings that emerged for the clinicians themselves (e.g. feeling good about themselves, and a general sense of well-being.)

Working with minority immigrant clients allowed one clinician to “feel like I’m making a difference on social, political and individual level. . . I know I’m making a difference in people’s lives” (P27, 1). For another clinician, working with a minority immigrant client “was a privilege. And it’s a deeply pain- it’s very sad and it’s very noble. And um, and it was nice for me to play a role in his getting legal status here in the United States” (P24, 5). Challenges associated with this population constituted the “pain” part of the work, whereas the dramatic effects seemed more “beautiful” (P24, 6). Connecting clients to needed resources also provided satisfaction for one participant.

“Yeah, I think the rewarding part of being able to do this is being able to hopefully serve as a bridge between people who have needs, they’re in a culture where they don’t know the ropes, they don’t have a lot of mentoring maybe from people who know how to negotiate systems. To be able to be part of helping those people to get the information, and the advantage, and the access to what’s out there for them is the best part.” (P25, 1)

Being able to support clients in this manner yielded very powerfully positive feelings for clinicians, who described the process as “a privilege” (P24, 8; P25, 1), “fulfilling . . . compelling” (P27, 1), “incredibly rewarding” (P26, 1, 2) and “gratifying” (P20, 6). This process also served as a source of self-esteem that was “congruent with my self image” (P26, 5), and as a tool for honing skills with other clients.
“I guess the thing that I would add to what we’ve been talking about is that working here has also made me a better therapist for people I see in other places too. I think that it’s a real exercise in humility in terms of understanding how to know that you don’t know. To question assumptions you have about anybody’s world view experience. I think that these larger gaps in background have made me maybe a little less vulnerable to making assumptions that are probably just as ill advised to people who share similar ethnic backgrounds. It’s a reminder working in a world like this to question yourself.” (P25, 9)

In this case, it appears that working with minority immigrant clients allows this clinician to face the challenge of “questioning assumptions” in order to focus more fully on the client’s experience rather than on the clinician’s perspective. A simultaneous effect seems to be a growing sense of efficacy on behalf of the clinician.

Addressing Differences. Another central aspect of the clinical relationship addressed by participants was the process of discussing differences between clinicians and their clients. Part of the exploration of this topic entailed a delineation of who initiates this type of conversation: the therapist or the client? Several clinicians indicated that this was not a challenge for them, and that they were able to discuss racial differences without difficulty (P14, 6; P21, 2). Others indicated that differences were addressed as a way of exploring a “gulf in understanding” or as a form of information exchange about the culture of the clinician and the client (P24, 9).

For one participant, both clinician and client could initiate race or culture-centric conversations (P20, 2). In other cases, the client served as the main catalyst for discussions in this area. “One of the boys said to me, “you know Dr. _____, you’re one of the only White
guys in this group. . .Well I’m the White guy. I know that, kids will remind me of that fact (Interviewer: They won’t let you forget it.) Nope, which is fine with me, and I know that too” (P 05, 3, 7). This issue also comes up when clients “want to make it clear, that people want to make it clear, that they are speaking from a different set of, different viewpoint, then they think I might be thinking” (P15, 9). For participant 15, client-initiated conversations usually progressed “in an affectionate way” (P15, 9).

Others described their own process of bringing up this topic. In one instance, this included a comparison of what it might be like for the participant to work with someone who shared cultural background with the client. “Usually it’s in terms of- obviously I’m White, um, what do you imagine that would have as pluses and minuses for you as opposed to having a Black therapist?” (P25, 5). Participant 20 also started this conversation as a way of opening up dialogue and leaving room for clients to ask questions about the clinician.

“Um, like I said I’ll raise the issue you know I’m a White person, I don’t know if you’ve worked with other White people before, I don’t know if there are questions you want to ask me, I just want to let you know if there are issues that come up and you’re curious about my perspective on things you can always ask, you know, that kind of thing.” (P20, 2)

This format of discussion served to deepen the relationship from the perspective of several clinicians. It was a way of addressing “the elephant in the room” right at the beginning of the therapeutic setting: “before we even talk about the project, let’s talk about who we are, what we’re here for” (P11, 3). Bringing this issue up at the onset of therapy “would begin the work of something that they would be willing to go deeper” (P11, 2).
For other participants, humor served as a tool to better facilitate conversations about differences. “Is anybody surprised that I’m White? (laughs) . . . me being White you guys are all Black. What’s up?” (P11, 3). This technique also transcended to conversations originally initiated by the clients.

“And I said, “yeah, we should get more White people in here, don’t you think so?” And all of the kids all started laughing, and yet it gave us a springboard for a conversation about what it means for both of them, for the boys to be Brazilian, to be Brazilian here in the community and what it’s like for them. And uh, me being again sort of very reminded, you know it was with affection when the boys were saying it, but also again a really concrete reminder of that I am of a different color.” (P 05, 3)

Again, this serves as a “springboard”, or an entry point into more challenging conversations, or perhaps sets the stage for additional conversations on the same topic. It seemed that for most clients in this area, once the topic had been broached, it was easier to discuss a second time.

*What is the Clinician’s Role?* The final category under domain three, the focus on the relationship, included an analysis of the various expectations about the particular nature of the role of the clinician. Very divergent viewpoints emerged in this context, ranging from the ultimate goal of shaping or changing the client and providing psychoeducation to fulfilling the client’s needs, helping the client navigate systemic challenges, and ultimately implementing systemic changes.

Changing the client included altering types of behavior, such as teaching the client particular coping mechanisms for life challenges (P11, 5), particularly when the clinician believed that the client’s strategies were faulty in some way. “And is that why they’re not
coping well now because they are still using that strategy, or are they not coping well because they are not using that strategy” (P21, 3). Other clinicians described trying to teach clients more appropriate behavior, particularly when the clinician deemed it was “not an appropriate behavior for a public situation” (P14, 2). For Participant 27, changing the client involved trying to teach him to accept his new life and role in the United States, and let go of some grief about what was lost in immigration.

“[I] also felt like he has to make a decision to be here, to say yes I am here, and to begin grieving um . . sort of happening in his life, and to be here. Or to say, I’m going to return. Because he still held that up as being a possibility. So the pivotal moment was I had to really be in there with him, and really sort of bring that conflict up in a way that wasn’t too much, that he could see it and I did, so I drew that to his attention. And it was like an epiphany for him. He got it. And he had to make a life here, and he had to let go, and grieve. And he started doing that. Came in, and . . . suddenly animated. . . He needed to recognize it. This was his life, claim it, and the really painful aspects of it.” (P27, 4)

Despite the fact that this seemed a particularly difficult process for the client, the clinician deemed that it would be helpful and ultimately it seems that it did provide some relief for this individual. A similar kind of instructive environment emerged for clinicians who felt it was important to provide some variety of psychoeducation, both to clients and others professionals.

Two clinicians described similar processes of working with other professionals, such as the immigration services and a judge to provide explanations about why a client would stay with an abusive partner (P24, 6) and about various processes of immigration.
“And it is generally a helpful addition to their asylum, and often makes a difference in helping the judge better understand their symptom picture, giving a cultural context for their system picture, understanding why how that symptom picture may differ from the judge’s neighbor might present themselves and also to really help educate the legal system about the amount of trauma.” (P27, 1)

In this example, the participant describes the clinician’s role as serving on the client’s behalf to ensure that others will work with the client in a beneficial and appropriate manner. Perhaps this might also increase the empathy for the client through providing a more detailed understanding of what their life experience might be like. The process of psychoeducation was also viewed as helpful for interacting with the client’s family.

“So I try to help and spend the necessary time, whatever length of time that may mean, to help the parents understand what this might imply…the implications of what the learning issue may have in regard to their son’s learning, and then to help the boy or the girl understand…this is what’s going on, this is what I think is causing you to have trouble, and helping the child to understand, cause they’re typically frustrated too.” (P 05, 2)

While this process seems to take more time, it is also seen as a crucial foundation for later work in which the family might serve as better supports for the client. Another active change-inducing role appeared to be the process of trying to implement systemic change. This also included educating other professionals, such as discussing the difference between a learning disorder and “an English language acquisition issue” (P 05, 2). Participant 14 described working with minority immigrant clients as “political . . . and I feel that I’m making a contribution by helping them” (P14, 9).
In contrast to the clinician as facilitator for changes, both within the client and the larger system, clinicians also mentioned approaches in which the client’s voice seemed more central. This warranted a “clients are the boss” comment from participant 14: “I always figure, I’m there- they’re the boss, they’re paying the money, they’re telling me what it is they want to get out of treatment, and it’s my job to see that they get it. If they don’t get it, I’m fired. And if they do get it, I’m laid off” (P14, 5). This also included a process of continuing treatment, because the client requested it even though the clinician deemed it was no longer necessary. “If this was a different practice, I might terminate her treatment. And I’ve even talked to her about it a few times, but she doesn’t want to. It’s become part of her coping” (P21, 9).

For several clinicians, the process of fulfilling the client’s needs meant focusing on symptom reduction rather than on other aspects of the relationship.

“It’s pretty clear we’re not establishing a relationship. Once the therapy is over, the therapy is over (ok). Thank you. I don’t get cards and letters and flowers or anything like that. It’s not a big gratitude, it’s just you know, this is what I needed at the time. You were there to help me, thank you. If I ever need to meet you in the future, you know I know you’re there, or maybe I forget you’re there. At the time, it’s um . . . it’s a successful relationship. It doesn’t have to be more than that.” (P21, 10)

It seems from the clinician’s perspective that clients aren’t looking for anything from the relationship other than a reduction in their level of stress. Similarly, another clinician focused on strategies that resulted in the client “feeling less helpless” (P26, 2).

Tailoring interventions to suit clients often included a shift in clinicians’ expectations about the therapeutic process. One clinician focused on the needs of a client’s family rather
than on the results of a neuropsychological exam, even though that was the original stated purpose of counseling.

“Being really careful about trying to shift the narrative to something that was going to be useful to them in their experience, that just made the outcome much better . . . We didn’t really try to analyze what was the score on the WISC, and how does that compare to the scores on the WIAT. That thinking about, or trying to think about what the questions were, what they were asking from their point of view was.” (P25, 4)

This included providing suggestions about “modifying behavior from within their frame of reference” (P25, 4), such as utilizing a more spiritually-based focus for a client for whom this orientation was particularly important (P27, 4).

A sub-category in this area seemed to be focusing on the client’s experience by helping them reconnect with the culture in their country of origin. For example, one clinician encouraged her clients to return to the country of their birth “to get some kind of grounding-to remember who they are, to come back to who they are outside of this situation. And then get on their feet and come back here and let’s build from there” (P21, 3). This process is “recharging. You know, it’s bringing you back to your roots (ok, great) it’s grounding you. You know, like anybody, go home to mom for a few weeks, she’ll give you some soup or something you know, just hot water, but it makes you feel better” (P21, 3). One client initiated this process himself by creating “a radio show, and he is devoted to the well-being of “my people” in Uganda,” which the clinician deems part of this client’s resilient behavior (P24, 5). Participant 27 sought to re-create aspects of the client’s home culture during the process of treatment.
“He calls to come in and we meet and do psychotherapy differently than I do with other people, which is more- we go on the computer together, we look up Uganda. He tells me what’s happening politically. Question what he’s doing here to support himself politically so he still feels connected because he is very political to Uganda. He brings in songs that are important to him, pictures. So we really create a little Uganda here (laughs).” (P27, 4-5)

For these particular clinicians, recreating aspects of home seems to fulfill various aspects of their clients’ needs. Perhaps they are referencing a form of identity stability, despite the larger instabilities of the immigration process itself.

Implications

How do these responses fit into Relational Cultural and Bronfenbrenner’s Ecological theories? What does this mean for individual clinicians and for larger training programs? How can this data inform policy with regard to minority immigrant clients and the various mental health systems that support them? These questions, along with further discussion about the limitations and scope of the present study will be further explored in Chapter 5.
Chapter 5: Discussion

Introduction

The goal of the present study was to explore the experience of psychologists who work with minority immigrant clients and to create a narrative of the supportive factors and barriers that impact their therapeutic alliance. This discussion also recognized the broader systemic context, emphasizing the role that internal and external factors played in the therapeutic relationship. Relational cultural and socioecological theoretical models are particularly apropos in this context, serving as useful lenses through which one can tease apart the complex dynamics of these interactions.

Participating psychologists painted a clear picture of the importance of collaborative, empathic relationships, which further highlights the consequences of neglecting to address underlying tensions. A clear and consistent theme of deeply personal commitment to their work transcended individual interviews. The rewards of working with minority immigrant clients seemed powerfully conducive to overcoming setbacks and frustrations. Utilizing the aforementioned lenses, I will review the study’s results in the present chapter. I will focus on outlining the external and internal factors that participants described as most salient, along with characteristics of problematic versus fulfilling therapeutic relationships. This will include reflections on power dynamics and participants’ descriptions of the ideal role of mental health clinicians. I will address the limitations of the present research as well as implications of the findings for research, practice, and training.
Integration of Findings and Research Literature

While many possible analytic tools exist to provide a context for the present data, two in particular integrate an overarching composite of internal and external factors that shape the alliance between clinicians and their minority immigrant clients. As outlined in chapter two, relational cultural theory highlights potential etiology and repercussions of connection and disconnection between individuals, and between an individual and a larger society. Bronfenbrenner’s socioecological model alludes to critical circles of influence that impact an individual, starting with close relationships and ending with cultural and environmental phenomena. Combined, these theories offer a useful basis for understanding the range of factors that shape the therapeutic dyad.

*Systemic Factors: Internal and External Influences*

Bronfenbrenner’s ecological model suggests that the unique attributes and experiences that clinicians and clients bring into the relationship profoundly impact the course of treatment. According to this theory, the personal experiences of an individual exist within nested circles of influence, as understood in the context of Bronfenbrenner’s systemic theory. The present study will focus on specific elements of Bronfenbrenner’s theory, including: 1) *microsystems*, or direct interactions with others 2) *mesosystems*, the interaction between these micro systems, and 3) *macrosystems*, contextual factors (Bronfenbrenner, 1979, 1986, 1994; Reifsnider, Gallagher, & Forgione, 2005). Participants in the present study described their perspective of the particular factors that contribute to each dimension for clinicians and clients, and further explicated the manner in which each individual’s identities informed the joint interactions and relationship.
Clinicians’ Influences. Starting with clinicians’ representations of their own experience, participants addressed internal and external factors that shaped their own expectations of therapy and impacted the course of conversations with clients. On a microsystemic level, the clinicians’ family experiences were presented as a particularly powerful influence. Several clinicians indicated that they perceived themselves as more open to conversations about race due to their identification with a minority group, either through family ties or through exposure to diverse groups early on in life. In this manner, family identity contributed to the worldview held by clinicians, their desire to have conversations about race, and in their interest in working with minority immigrant clients. In addition to reflecting on the influence of their family members, participants also identified their coworkers as prominent microsystemic influences. The impact of these relationships will be explored further when addressing factors that influenced the direct relationship between clinicians and their clients.

These microsystemic interactions also connected to macrosystemic influences, such as the infusion of larger cultural norms within psychologists’ worldviews. Though less directly stated than the influence of familial connections, it became clear through the data analysis process that clinicians’ culture and expectations of normative behavior profoundly impacted the ways in which they approached their clients. In particular, clinicians described “healthy” or “normative” behaviors and indicated that some of their minority immigrant clients did not conform to these standards. For example, assertiveness was described as a healthy form of standing up for oneself, whereas frustration blossomed when clients’ behaviors were incongruous with these norms. These responses also fit with traditional psychotherapy models. Clinicians varied in terms of the degree to which they were aware of
these values impacting the relationships and the degree to which they were concerned about imposing their values on clients.

Clinicians’ Views of Their Clients. Clinicians also described internal and external influences in their clients’ lives. Of course, as previously stated, the results of the present study solely represent clinicians’ analyses of their own experiences, as well as their perception of the experience of their clients. It is crucial to recognize that this may not in fact be how the clients see themselves. Participants described strengths and challenges that they believed were central to their clients’ experiences. A common refrain was the presence of inner resilience embodied by minority immigrant clients. Other factors that clinicians described as positive, protective traits included strong work ethic, an ability to adapt to novel situations, and strength in the face of difficult situations.

Despite these inner strengths, clients were depicted as battling powerful cultural conflicts between themselves and their country of origin or family. Clinicians who described these inner strengths often inserted their own particular values as to which side was more beneficial — families were sometimes depicted as meddling intermediaries who added complications in therapy. For example, clinicians talked about family members “hiding behind” their culture and “ducking an important issue” by choosing to adhere to their families cultural values that differed from the clinician’s own values. Another clinician described a client who was struggling with the choice between “freedom” (the clinician’s culture) and “restriction” (the client’s home culture). However, families and community were also described as powerfully supportive external factors that contributed to inner resilience. Regardless of the values associated with clients’ culture, it appeared that this aspect of identity powerfully shaped clients’ expectations for therapy.
The process of immigration itself interplayed with microsystemic family connections. Clinicians described the new expectations and new opportunities associated with immigration as a fundamental game changer that impacted the very core of family dynamics. Different family members were perceived as presenting different approaches to navigating the new system. These divergent methods were seen as further complicating familial relationships. Clinicians described their clients as grappling with changing familial relationships as a result of the immigration process. This finding paralleled previous studies, which highlighted disruptions to primary support networks as a result of immigration and acculturation (Este & Tachble, 2009). A different result emerged when discussing other external resources, such as community members who were presented as possible resources in navigating a new society. Indeed, some clinicians even incorporated this microsystemic support into their treatment by encouraging clients to reconnect with family members, cultural resources, or other strategies that included a recreation of aspects of clients’ home cultures.

On a macrosystemic level, clinicians depicted an enormous degree of discrimination in client’s lives as very distressing, with profound ramifications for clients’ health. This presentation echoes previous research that points to the pervasive and indelible impact of racism for the mental health of immigrants and people of color (Carter, 2007; Clark, Anderson, Clark, & Williams, 1999; Thompson & Neville, 1999). As one clinician noted, “they’ve been screwed up in a lot of ways by White people.” Discrimination, coupled with problems at the larger societal level, was depicted as a systemic shortcoming. Clients who had reported higher degrees of racism were described as less trusting or more resistant to therapy. This theme also taps into the relational cultural model’s notion of a “power over society” (Walker, 2008) in which discrimination and other inequities yield greater levels of
distrust for the recipient. Indeed, in the present study, societal inequities were portrayed as harmful to client’s very existence.

These complex internal and external elements impacted the relationship between clinician and client on a number of levels.

Relational Outcomes

Impairments and Disconnections. Relational and ecological theories would concur that individual conflicts, larger societal factors, and differentials in power can contribute to fundamental aspects of fractured or disconnected therapeutic relationships (Comstock et al., 2008; Miller & Stiver, 1997). In the present study, clinicians noted fundamental differences in cultural expectations between themselves and their clients.

One factor that contributed to tensions between clinicians and clients was the degree of trust and openness perceived by clinicians. Clients themselves were often depicted as the primary source of disconnection due to their “wariness of the system,” inability to trust the clinician, and past history of negative interactions with White individuals. Some clinicians described challenges of working with Asian clients. One clinician was unable to identify the source of the problem, but another described it as a cultural barrier: “they’re just not into the kind of intersection that’s involved in psychoanalysis and psychotherapy, it just doesn’t make sense to them, and they’ll come once or twice and that’s the end of it” (P14, 7).

Clinicians also emphasized the differences between minority immigrant clients and clients born in the United States. While these differences sometimes appeared to better facilitate care (e.g. having greater community resources), they also drove a wedge between clients and clinicians such as in the case of clinicians who described clients from particular backgrounds as non-receptive to treatment. Clients with norms that were further from those
of American-born clients were often depicted as difficult to work with, and as experiencing the most internal conflict between familial and societal expectations. Clinicians utilized more negative language when describing their work with clients whose cultural norms deviated from their own, describing their clients’ practices as “appalling” or “naïve”. They further indicated their own emotional response to clients with divergent viewpoints as “fearful” or “angry”.

In addition to cultural differences, linguistic differences posed a daunting barrier for nearly all of the participants in the study. Inability to communicate directly impacted their work with clients and in some cases prevented additional services, such as family consultation. As one clinician noted, this caused relational impairments: “because of the language I couldn’t join him.” Working with interpreters yielded further challenges through the addition of microsystemic and mesosystemic complications. Inviting a third party into the relationship sometimes led to more complex dual relationships, such as the introduction of a traumatized interpreter who herself had experienced a situation similar to the client. Further, participants suggested that interpreters could “have their own agendas” or simply provide additional shades of meaning that the clients themselves did not intend.

The aforementioned impairments produced clear consequences, such as clinical dropout, which clinicians associated with feelings of disconnection and a sense of failure. Obviously, the clinicians often did not have any information about what happened to clients who had dropped out and not returned (i.e. did they end up finding service elsewhere or connect with a clinician with whom they shared a common language?) However, several clinicians also provided examples in which planned termination ultimately led to more
positive consequences, as in the case in which a client was referred to a clinician who had more experience working with clients from a particular cultural background.

While the methodology used in the present study focuses on the narrative of the participant, and does not support the formulation of theory, it is important to recognize that the participants’ responses raise questions about the therapeutic process with minority immigrant clients. For example, if a clinician feels uncomfortable in his/her interactions with a client or deficient in a particular area, could this lead to an increasing desire or openness to learn more multiculturally competence practices? As noted by Tummala-Narra, Singer, Li, Esposito, and Ash (In Press), it is not mere presence at multicultural workshops that enhances cultural competence, but the degree to which clinicians find these workshops useful. Perhaps in order to grow professionally, one needs to feel an imperative to change on the basis of personal experience – and only then have access to a means for doing so. Since reflecting on one’s challenges may invoke feelings of embarrassment, this process may be an uncomfortable one for clinicians. These questions will be further explored in the implications component of this chapter.

Fostering Connection. In addition to dissecting causes behind relationship impairments, clinicians also described aspects of relationships that foster connection. Participants’ definition of a successful relationship paralleled relational cultural theorists’ definition in which the deepest form of relating incorporates mutuality and empathy (Comstock, Hammer, Cannon, Parsons, & Salazar, 2008; Jordan, 2002, 2004; Miller & Stiver, 1997). As postulated by previous theorists, empathy was indeed a central component of satisfying relationships for clinicians in the present study. Clinicians reported feeling connected through shared emotions, though this did not just include positive shared feelings.
In fact, powerful connections emerged through a sharing of negative feelings as well. Clinicians experienced client’s setbacks and losses in a deeply personal way— the highs were high, but the lows were low. Empathy was also established through the creation of a trusting relationship. From the clinicians’ perspectives, relationships shifted and deepened when it seemed their clients felt heard and listened to.

However, given the aforementioned struggles with differing cultural expectations, it appeared that in some instances clinicians needed to sacrifice their own sense of authenticity for the sake of better engagement, compromising their own cultural values in order to acquiesce to clients’ cultural needs. In the process of recognizing and working through one’s own value system and cultural biases clinicians found themselves reacting negatively when confronted with values that were contradictory to their own. One example of this is the case of genital mutilation described by one clinician. In order to support the client, this participant described the need to set aside feelings of revulsion at this practice. Accepting clients’ cultural norms involved “suspending judgment” in order to respect the client’s core ethical principles. Despite the inner turmoil that clinicians usually experienced during this process, clinicians expressed a sense of satisfaction when it was achieved. Addressing the discrepancy between one’s own values and that of one’s client in this manner often entailed conscious strategies of weighing the costs and benefits of adapting to another culture.

Other external factors and exosytemic elements, such as the presence of valuable colleagues, were also seen as promoting successful relational outcomes. Colleagues were presented as valuable resources, both in providing information and also serving as a kind of “cultural ambassador” between clients and clinicians. Being part of a team allowed clinicians to process their experiences and seek support when they were unfamiliar with a particular
cultural norm. One clinician specifically stated that the presence of diverse colleagues within their agency increased clients’ comfort level in therapy. It should also be noted that external supports were not always sufficient to facilitate a satisfactory relationship. As previously indicated, at times psychologists felt they needed to refer their clients to other clinicians who had more specific background when the cultural divide between clinician and client seemed too wide to bridge.

Central Relational Paradox: Power Lines. Despite clinicians’ desires to form successful therapeutic alliances, relational problems did emerge. The relational paradox in RCT suggests that despite an individual’s desire to form a strong connection, fears about negative relational outcomes actually lead an individual to pre-emptively reject the person with whom they would like to connect. It seemed that this paradoxical dynamic existed within participants’ conscious desire to serve their clients, and a more internal rejection of cultural norms that deviated from their own.

From the perspective of the clinicians in the present study, the processes of connecting were associated with generally more positive feelings (e.g. feeling gratified, feeling good about themselves), which suggests that it might represent particularly desirable outcomes. However, despite the best intentions of these participants, fundamental problems emerged and led to damaging clinical outcomes, such as a disruption in clinical service or negative emotions. How did participants explain the outcome of negative relational conflicts?

In part, clinicians attributed such conflicts to the client’s cultural values. Participants in the present study also identified power differentials as an inevitable manifestation that impacted their relationships with clients. In this case, clinicians generally identified themselves as the bearers of power and their clients as those without. As compared to the
clinicians themselves, clients were identified as having fewer resources. The multiple layers of minority identities such as the intersection of race and socioeconomic status, appeared to further complicate participants’ understanding of power. For example, one clinician had difficulty understanding why some of his wealthy minority clients had difficulty utilizing resources that he believed were at their disposal.

Another complicated power dynamic emerged when clinicians indicated a perception that their clients wanted their psychologists to be “more powerful” or “voices of authority” but the clinicians themselves did not feel comfortable in this role. In some instances in which clinicians chose to adhere to their clinical training rather than shifting to take on these newer roles, the clinical relationship ended when the clients simply stopped coming to therapy. As noted by Laura Brown, feminist relational psychologists may strive to create a more respectful relationship through the creation of egalitarian dynamics (Brown, 2007). However, some of the clients depicted in this study appear to be calling for a different type of relationship, one in which the therapists maintain a more distant role as the expert. These divergent values and contradictory expectations for therapy warrant further study.

In other instances, acknowledging and shifting the power dynamics in the clients’ favor allowed for a greater sense of connection. One strategy for accomplishing this success was to create a common goal, coupled by the mentality of “we’re in this together.” Several participants in the present study endorsed the strategy of reducing one’s own power or status as the expert. Clinicians also sought to acknowledge flaws, such as their own difficulty speaking clients’ native languages. Others utilized humor or sought out non-traditional models (e.g. setting up a “safe space” at a school where minority students could process stressful events) in order to step outside the traditionally reserved role of impassive therapist.
These strategies seemed to emphasize the clinician’s fallibility and elevate the client. This ties into the relational cultural construct of empowerment, which suggests that healthy relationships involve a sense of agency.

It is unclear whether clinician’s own identification as a minority individual impacted the power dynamics in a similar way. Although this study required that participants not be people of color, numerous clinicians cited their own personal affinity with an ethnic group, either through direct cultural heritage or simply through exposure to diversity. Often, clinicians cited this as way of feeling bonded with their clients or as an explanation for the imperative they felt to provide service to minority clients. However, several clinicians also acknowledged that despite this identification with minority status, they still had more power than their clients through access to material resources, a lack of a shared history of racism in the same forms or severity, or through having been sheltered from relevant traumatizing events. Given this continuing power differential despite the desire to find similarities, does identification with minority status also serve to limit the degree of conversation clinicians are able to have about their own privileges? For example, are there differences between clinicians who have family members who are persons of color versus clients who themselves are persons of color? Or are there differences between various minority statuses (e.g. those which are openly visible and those which can be hidden by choice?) Questions such as this one highlight the need for continuing exploration, research, and conversation.

Reflexivity

At various points throughout this dissertation I have touched upon the question of my own personal lenses of analysis: external, internal, and theoretical factors that influence my understanding of the data presented by participants. Due to the lack of previous research
addressing the practical experiences of clinicians working with minority immigrant clients, I employ a summative content analysis method for the present study. The goal of this approach was simply to provide a summation of the data utilizing an organized, nested system of codes, categories, and domains. Unlike grounded theory, this process is not designed to draw deep inferential conclusions about underlying theories. However, my response to the data and the particular content of the data may highlight underlying constructs that prove influential for the clinicians and clients themselves. In the present section, I will draw on my own observations of the data itself to raise questions about the potential implications of this study.

My family history and cultural background shape my own lens of understanding, and certainly contribute to my own biases. This, in turn, impacts the ways in which I analyze data, the values I attribute to the clinicians, and the conclusions I draw from the resultant information. In a way, I feel connected to the clinicians in this study. I, too, am a White clinician who was born in the United States. In this way, I found myself wondering if their experiences were similar to my own. I differ from these clinicians mainly due to my status as a trainee, as opposed to their more experienced perspectives (e.g. minimum of 5 years post licensure). This might also mean that I have been trained in different models than these clinicians, given the relatively recent shifts in graduate training regarding cultural competence and the particular foci of my graduate training. For this latter reason, I found myself feeling concerned about the experience of the clients.

As noted earlier, recognizing my own values forced me to identify moments in which I felt driven to label clinicians practices as culturally competent, or explore areas in which clinicians experienced negative outcomes. As a result, at many junctures throughout this process, I found myself wanting to identify more clearly with the clients themselves. In a
way, the content analysis component of the study forced me to try to focus very specifically on the actual words that clinicians were choosing. In seeking larger, overarching categories I was unable to simply utilize the participants’ words, but had to seek terms that fully encapsulated the underlying concepts. At several points, I sought consultation with the other graduate students, my dissertation chair, or other committee members in order to receive guidance about the coding process itself. One of the ways in which I sought assistance was in choosing the specific names for the domains and the categories themselves: specifically, how to consolidate the underlying categories in a way that rings true to the participants’ experiences, but that does not simply rely on my own biases. In other words, how do I give voice to the participants themselves?

At the same time, my own reactions to the data led me to wonder about what was not being said or stated directly. Beginning with the internalization of larger systemic factors, I found myself wondering about the manner in which clinicians did or did not acknowledge their own personal biases. Arredondo and Rosen (2007) suggest that the degree to which clinicians recognize their own biases might impact clinicians’ abilities to help clients recover “historical memory” by processing their brushes with racism and discrimination. Both relational and ecological perspectives highlight historical contexts of negative interpersonal experiences and the ways in which these might impact client’s approach to therapy. For example, clinicians described examples of discrimination on behalf of their clients, and these examples might account for some of the clients’ apprehension about working with their White clinicians. Some of the participants also described inaccessible cultural gaps between themselves and their clients, which might prevent open discussions from occurring and thus shut down dialogue between parties.
I also wondered about the degree of self-awareness fostered by clinicians in this study. When clinicians enumerated clients’ perceived strengths, were they also perhaps providing information about characteristics that the clinicians themselves valued as important and admirable? When clinicians talked about clients adhering to their family’s value system, perhaps they were also communicating something about their own sense of decorum and the value they place on individualism. Conversely, when clinicians described clients’ cultural factors as inhibiting therapy, I wondered about the presence of cultural biases among the clinicians themselves.

The case of the clinician who believed that Asian clients are simply unable to participate in therapy may be a key example of this assumption. Mainstream psychotherapy generally calls for dialogue in which clients verbalize their feelings and experiences. However, Asian culture oftentimes emphasizes other forms of communication, such as a greater emphasis on deference to authority and non-verbal communication, both of which might inhibit clients from expressing emotions in the more open and direct manner that White, American-born therapists might expect from their clients (Hsiao-Ying Kee, 2004; Kanishige, 1973; Uba, 1994). Clients in these instances might be seen as disconnecting, whereas in actuality they might simply be seeking quite genuinely to connect through a cultural model that suits their particular needs and expectations.

Another clinician described developmental stages as superseding racial or ethnic identity for young clients. In discussions with members of my dissertation committee, this quote came up as an example of a potentially objectifying and paternalistic view of the clients. Clinicians further described their sense that they were solely responsible for the fate of their clients, a role that may entail a very specific and detrimental understanding of the
power hierarchy (e.g. clinician as agent of change, client as passive recipient of services). The danger of this philosophy is that clinicians may indicate a lack of consciousness about their own White privilege, which may detract from the therapeutic process. This contradicts the relational tenets of empowerment, agency, and mutuality. In such instances, the clinicians ascribe to a fixed viewpoint of therapy that minimizes and therefore does not address cultural or racial identities. My training as a counseling psychologist in a social justice institution has informed me that these are essential, non-negotiable elements of therapy.

Indeed, fully addressing these paradoxes ultimately requires a broader set of tools than content analysis on its own can afford. Understanding the ways in which clinicians see themselves is important, but this finding points toward the importance – at least for future studies – of more directly examining the impact that these assumptions may have on minority immigrant clients. This is a conversation to continue beyond the present study and may involve a deeper analysis of the systemic institutions that maintain and shape clinicians’ approach to therapy with diverse clients. As I note below, critical race theory may be an especially useful tool for this important, subsequent endeavor. However, it lies beyond the scope of the present project, which is primarily summative and therapist-focused instead.

Limitations of Study

The results of this study represent a close analysis of the experience of thirteen psychologists who work with minority immigrant clients. In this regard, it offers an encapsulation of the experience of these individuals, at this particular time in their careers. It is possible that interviews in a different context might elicit different findings. At the same time, qualitative data is not intended to be universally generalizable, and therefore the results from this study are not intended to represent the experiences of all psychologists who work
with minority immigrant clients. Rather, the goal is to extend existing research on this topic by providing a thick description of the participants’ experiences and to initiate a dialogue about potential deficits in the training and support process for clinicians working with minority immigrants.

With regard to the process of data collection itself, the participants who completed interviews for this study all represented individuals who were very motivated to talk about this particular topic. This may indicate that they possess a vested interest in furthering their understanding of their own work, or that perhaps they are motivated to address the topic for other personal reasons. Clinicians for whom this work is less motivating, or who have had more negative experiences may have self-selected out of the research process. Given the time commitment necessary for completing an interview, others may have simply deemed themselves too busy to participate. The study may be biased toward the experience of clinicians from a particular geographic area and who have a certain amount of clinical experience.

It is also critical to note that the data represents clinicians’ perceptions of the relationship with their minority immigrant clients and does not substitute for a more objective or thorough analysis of the clients’ experiences themselves. It is possible that some clinicians may have responded to the questions of the interview with the hope of presenting an appearance of competence in working with their clients. They may have downplayed tensions and highlighted harmonious outcomes in an attempt to limit the possibility that they may be perceived as culturally incompetent.

Another potential limitation of the study relates to the scope of the particular lenses of analysis. Relational Cultural Theory and Ecological Theory may provide a context of
systemic inequities that impact minority immigrant clients. However, the use of content analysis in the present study does not fully allow for an interpretation of the participants’ responses in a way that represents the potentially negative effects of systemic inequities (e.g., racism, White privilege) in the psychotherapy process. Other lenses, such as critical race theory, might serve as more effective options for a study that seeks to explore inscriptions of race within systemic institutions as well as the impact that this ingrained racism has upon individuals in therapy who immigrants of color. Critical race theory suggests that practitioners have a responsibility to their clients to discontinue biased practices and actively seek to change the existing, flawed system. This theory would provide useful tools for documenting the consequences of many of the phenomena that are identified as findings in the present study. It would also provide opportunities to explore the experience of racism, systems that maintain privilege and oppression, and an exploration of the social construction of race (Abrams & Moio, 2009). Exploring these areas in future studies could potentially provide crucial insights about power dynamics for mental health clinicians, particularly when trying to understand or explain barriers to mental health (Arredondo & Rosen, 2007).

Suggestions for future research will be explored in the section below.

Implications for Practice, Training, and Research

Despite the limitations, the present study provides an array of information about the functioning of clinicians who are currently serving a minority immigrant population. Previous research and publications in this area highlighted theoretical, aspirational values, but it did not reflect on the degree to which these ideals were being implemented. This data may have potential implications for other clinicians who work with minority immigrant clients, and for the clients themselves. Further, given the clinicians’ status as potential
supervisors (i.e. their level of expertise and minimum of five years of experience, a criteria for potential supervisors), there are also potential ramifications for sites and academic settings that are currently training future psychologists. Finally, research implications will be addressed, particularly with regard to future directions.

Clinical Implications

Findings in the present study build on previous research regarding aspirational goals for psychologists working with underserved and minority populations. Participants’ responses provide possible insight on the racial and cultural roles that are enacted in the relationship between clinicians and this population of clients. Indeed, clinicians described the permeation of external discrimination and racism within their sessions, along with their own “defenses and anxieties” (Sarnat, 2010) about addressing cultural differences between themselves and their clients. This conundrum seemed to yield potential confusion, frustration, and even termination in the clinical relationship, which echoes findings from previous studies (Maxie, Arnold, & Stephenson, 2006). What does this imply for racial issues? Clinicians themselves may be uncomfortable addressing race due to insecurities about how they will be perceived or their own need to feel competent in their practices. There appears to be a strong need to explore this area further and perhaps provide training for seasoned clinicians about how to have these kinds of conversations successfully.

Building upon the challenges described by clinicians in the present study, it may be particularly useful to recognize the value of addressing negative outcomes. While premature termination and cultural incongruities yielded negative feelings for these clinicians, these experiences may also serve as a useful springboard for further development. For example, disconnection may be indicative of an issue that troubles a client, but it may also represent an
opportunity for deepening the relationship. Several of the participants in the present study expressed surprise at their own comments, suggesting that the mere act of discussing their experience providing therapy for minority immigrant clients may yield further insight about clinician’s practices.

It is also clear that most of the clinicians in the present study appreciated the opportunity to explore these issues. Perhaps continuing education in the area of multicultural competence should include interactive, self-reflective exercises. Additionally, perhaps psychologists might benefit from Balint type groups in which experienced clinicians are afforded an opportunity to discuss their experiences with colleagues. Indeed, Sue and Sue (2003) suggest that increasing an awareness of one’s own biases should be a fundamental goal of cultural competence. Discussing these issues in an unthreatening environment might minimize defensiveness and increase opportunities to increase one’s self-awareness about these key issues (Sarnat, 2010).

Some continuing opportunities for conversation might also center on the ways in which clinicians define their role in the therapeutic dyad. According to the results of this study, culture may play a central role in dictating the expectations of clinicians and clients alike. Previous research suggests that clinicians’ roles should shift to match various aspects of clients’ identities and situations (Atkinson, Thompson, & Grant, 1993), but there is room for debate whether discrepancies between the clinicians’ and clients’ expectations are best addressed through psychoeducation about the nature of the psychologist or through a more adaptive process of shifting roles depending on the client.

Relational Cultural Theory might suggest that an integrative approach through which the client is allowed to express his or her authentic self might be the most effective
intervention. Therapeutic relationships such as those depicted in the present study, likely entail divergent expectations for therapy between clinician and client. However, minority immigrant clients also may be among the clients most in need, the most inclined to terminate treatment if it is unsatisfying, and the most unable to invest scarce additional resources in extracurricular experiences to boost their returns to time in therapy. This does not preclude psychoeducation as a component of therapy itself, but it points to the essential nature of flexibility on the part of the clinician with regard to the cultural expectations of the client in order to achieve optimal mental health benefits. Further research may clarify the definition of a psychologist, and to better understand what it is that clients are seeking from their psychotherapists.

*Training Implications*

A majority of the implications for clinicians apply directly to the training context as well. A useful approach for explaining these implications begins with a brief consideration of the clinicians’ differences and similarities. Even among the small number of clinicians in this study, despite several shared characteristics (e.g. race and minimum number of years of experience), there were extensive individual differences. Some clinicians described themselves as comfortable discussing racial issues while others indicated that they did not perceive race and culture to be central to their work as therapists. However, changing requirements suggest that multicultural education may be much more central for today’s trainees (Fouad, 2006). For trainees who are seeking conversations about their own racial identity, working with a clinician for whom this is not a central aspect of training can be particularly challenging (Jernigan et al., 2010; Tummala-Narra, 2004).
This is especially telling given participants’ reactions to the present study. Responding to questions about their practices with minority immigrant clients yielded a vast array of responses. While some clinicians expressed appreciation for the opportunity, this did not preclude discomfort on their part during the interview experience. Comments included references to embarrassment and shame over their self-identified inadequacies in dealing with challenging situations. Other clinicians expressed a sense of distrust with the primary investigator, and one participant defensively questioned whether the transcript accurately reflected the actual interview despite a tape recording that supports my recollection of events. Such responses highlight the challenges of openly discussing racial and cultural issues and a critical need for ongoing training that supports the ability to engage in such dialogue.

Previous theorists highlight the importance of self-reflection for supervisors (Orchowski, Evangelista, & Probst, 2010). Supervisors may benefit from explicit trainings about ways in which to broach conversations about race with their supervisees, or perhaps ways of responding when supervisees initiate the topic. Perhaps clinicians can participate in an additional certification process when becoming a supervisor in case they have not had the opportunity to engage in their own multicultural competency coursework.

The insights of participants in the present study may also provide guidance for training programs for psychology trainees. For example, references to clients’ strong community connections may suggest the importance of incorporating external supports into therapy, rather than viewing them as a hindrance. Directors of training who have experience with this population may be able to tap into case examples from their own experience as a starting point for conversations about trainee’s own cultural expectations and approach to therapy.
Future Research

The present study is a beginning point for future research addressing culturally competent services for immigrant clients and the training of clinicians and supervisors. Several distinct avenues for research should be considered to further extrapolate on the factors that impact therapeutic dyads.

The present study involved interviewing White clinicians who worked with minority immigrant clients. Future research should examine the perspective of clients about their therapeutic work with White clinicians. Perhaps a dual study might include perceptions of dyads of clinicians and clients to explore any similarities or discrepancies between their experiences. Would they have the same expectations for therapy, perspective on outcomes, or response to any ethical dilemmas that might emerge during the course of therapy?

During the course of interviewing for the present study, it became very clear that clinicians possessed very unique and individualized definitions of the role of the psychotherapist. Exploration of clinicians’, clients’, and training institutions’ definitions of this role might shed light on potential gaps in communication between these bodies. Open-ended qualitative questions might address clients’ and clinicians’ expectations and hopes for therapy: what are they looking for from a psychologist? What is their level of (dis)satisfaction with the role that clinicians are currently embodying in their mental health experiences? This line of inquiry might provide a deeper understanding about factors that lead to termination in therapy. Additionally, it may illuminate the need for more psychoeducation about the role of therapists, a need to create more flexible roles for psychologists, or perhaps a combination of the two.
Expanding the population in question, it may also be beneficial to identify any similarities or differences between clinicians in the present study and clinicians who themselves are minority immigrants. A number of participants raised the idea that their clients might be better served by clinicians who matched some level of clients’ identities. Does this actually facilitate a better match? Are there advantages from meeting with a clinician from a similar background, and are there also distinct challenges? A quantitatively oriented study might also further distinguish between the experiences of clinicians from different theoretical orientations, clients from different countries of origin or cultures, and clients who have varying levels of acculturation. Do years of experience (or first and second generational identities) impact the processes of therapy?

Given the challenges described by seasoned clinicians in the present study, future research might also explore the efficacy of continuing educational programs. Are they able to help clinicians who were not exposed to cultural competency training? A study might also pair with a clinical outcome enhancement project by piloting a conversation group in which mental health clinicians are afforded an opportunity to reflect on their experiences working with minority clients. Questions might also center on the particular situations in which clinicians feel more inclined to discuss their successes and failures in therapy. For example, some clinicians may feel that they are expected to be experts rather than allowing themselves to struggle through thinking about complicated issues. Qualitative inquiry on this topic might shape future training programs and mental health institutions about the support provided for clinicians.

There are many remaining questions about the nature of cultural competency that might be addressed through additional research in this area. For example, is it possible to
learn cultural competency through one’s clinician experiences? Are there ethical problems that arise when a clinician is learning about multicultural competence *while* they are treating a particular client? For example, later clients may benefit from a clinician’s burgeoning knowledge, but would the present client experience harm through imperfect practices? Additionally, what factors, in addition to mere exposure, contribute to greater multicultural competence? There is a growing body of research in this area but many more avenues to explore.

**Conclusion**

In addition to the complex dynamics involved in any therapeutic relationship, clinicians who work with minority immigrant clients may encounter a host of additional dynamics and systemic factors. Navigating these complex relationships may involve a process of increasing one’s self-awareness to encompass one’s own identity and the factors that shape clients’ experiences as well. The potential ramifications for neglecting to address these elements directly are clear, both for the clients and the therapeutic relationship. Psychologists may require additional supports or techniques for processing these aspects of their identity. When these elements are in place, clinicians may feel a greater sense of competence but should also be able to accept a degree of uncertainty to foster a continuing process of development.

Results from the present study have implications for the field of mental health and potentially even for policy issues that address services provided to immigrant clients. It is clear that more research is required in this area, but the effects of thoughtful practices are clearly quite profound. Returning to the anecdote about Allport and Freud in which Freud suggested Allport was projecting when talking about a child on a train, self-introspection
may raise painful, self-conscious feelings (Allport, 1963; Elms, 1994). Even though the study brought up negative feelings for the participants, it also encouraged clinicians to engage in careful self-reflection in a manner designed to promote the clients’ welfare in the therapeutic relationship. Training future psychologists and supporting current ones to engage in a similar practice may enhance therapeutic outcomes. Such efforts may take effort and patience to implement, but the potential benefits are profound.
References


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Experience of Clinicians


Experience of Clinicians


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Appendix I: Interview Questions

1. Experience of working with minority clients

How many minority immigrant clients have you worked with? Describe their cultural backgrounds? Tell me what is it like to work with immigrant minority clients?

2. Counseling relationship

I’d like to ask you about one or two specific clients: thinking about a client (or two clients) who was also an ethnic minority immigrant. Tell me about the background of this person—when did they first move to the U.S.

Can you describe a critical moment working with your client or clients, or a time in which things did not turn out well?
   - What emotions/responses did you have?

Can you tell me about a time in which you had a more positive experience with one of your minority immigrant clients?
   - What emotions/responses did you have?

Probes:
   - How did issues of race/ethnic identity come in your clinical work?
   - Were you aware of any issues of power that played out in the relationship with your client? If so, how?
   - How did you discuss areas of difference between you and your client?
     ○ Race
     ○ Culture
     ○ Language
     ○ Social class
   - What do you think are some barriers that may interfere with your work with immigrant clients?
   - What resources have been helpful to you in your work with immigrant clients?

3. View of Self

In what ways do you think that working with immigrant clients influences your view of yourself?

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, anything that I have left out?
INFORMED CONSENT FORM: Counseling Immigrant Clients

Purpose. This research study is being conducted by Rachel Singer, a doctoral candidate in Counseling Psychology at the Lynch School of Education at Boston College. I want to understand mental health clinicians’ experience with ethnic minority immigrant clients. The information obtained in this study may help inform training programs, additional research, and other mental health providers’ work with this population.

Procedures. I would like to interview you to ask you what it was like to work with immigrant clients. During the interview, I will ask you questions like (1) “Can you tell me what is it like working with immigrant minority clients?”; (2) “Can you describe a critical moment working with your client or clients, or a time in which things did not turn out well?”; (3) “Can you tell me about a time in which you had a more positive experience with one of your minority immigrant clients?”; and (4) “In which ways do you think that working with clients from different backgrounds influences your view of yourself?” The interviews should each take about 60 to 90 minutes and will audiotaped. Interviews will take place at a location that is easiest for you. If you live in another state, the interview might take place by phone.

This study is completely your choice, and you are free either to not take part, or to stop the interview at any time.

Risks. There is a small chance that the interview may raise some personal or uncomfortable issues for you. If you feel upset or would like to talk more about the feelings you have, I will give you a list of places that you can call to do so.

Your participation in the research is completely voluntary. If you choose to take part in the research, you may stop at any time. You do not have to answer any question you do not want to answer.

Benefits. You may find that the questions I ask will help you think about your counseling experiences in new ways. Also, the information you provide will help clinicians and researchers understand more about advocacy programs and how to make clinicians’ experiences better.

Confidentiality. Your interview audiotapes will be kept strictly confidential. Although names might be used during the interview, when the interview tape is transcribed no names or identifying information will be recorded. I will ask you to choose a pseudonym to be used instead. This pseudonym will replace your name in the interview transcripts. This form and the audiotapes will be stored in a locked cabinet, and the audiotapes will be destroyed after they are transcribed. No names or identifying details will be used in any
experience of clinicians

180 publications or other documents resulting from this research. All data collected from this study will be presented as a group, so that no one can identify any one individual within the study. I may also quote you or other participants without identifying where the quotation came from. The information collected will be kept for five years after the results of the study are published. This consent form will be stored separately from the information you provide, and will also be destroyed by shredding five years after the results of the study are published.

Of course, as is the case in any research project, there are certain limits with regard to confidentiality. For example, if you tell me about a child who is being abused, or about your intent to hurt yourself or someone else, we may be required to inform the Department of Social Services or other appropriate authorities.

Questions. Should you have any questions about your rights as participants in a research study, please contact Christina Booth, Administrative Director, Office for Human Research Participant Projection at Boston College: (617) 552-4778 or boobeste@bc.edu. Should you have any other questions about the study, please contact Rachel Singer at 617-939-4468 or singerra@bc.edu.

Certification. I have read and I understand this Informed Consent document. I understand the purpose of the research project and all my questions have been answered satisfactorily. I understand that I may withdraw my participation at any time and that I can refuse to answer any question(s). I understand that I will be audio-taped and know that I will receive a copy of the transcribed document. I agree to participate in the study, and to allow the researcher to use my responses in scholarly publications. I understand that my name and any personally identifiable information will be kept confidential and will not be used in publications or in any other document. I expect to receive a copy of this document.

Participant Name:________________________________________________________
Signature: ___________________________  ______________________________________
Date:  __________________________________________________________________
Researcher Name:________________________________________________________
Signature:  _____________________________________________________________
Date:  __________________________________________________________________
Appendix III: Recruitment Flier

Are you a Licensed Mental Health Professional Who Works With Immigrant Clients?

You are invited to participate in a survey to help explore experiences of clinicians providing psychotherapy to ethnic minority immigrant clients.

Requirements for participation:
1. Licensed psychologist
2. Currently a practicing clinician
3. Have provided psychotherapy or counseling for at least 2 months to one or more ethnic minority or multiracial immigrant client(s) within the past 2 years

Your participation in this study will involve the completion of one in-person interview. The survey will take approximately one hour to complete.

The Institutional Review Board at Boston College has approved this research study. If you have any questions concerning this research study, please contact Rachel R. Singer at the Department of Counseling, Developmental, and Educational Psychology at singerra@bc.edu

Please pass this invitation to other clinicians who may be interested in participating in the study. Thank you for your consideration.