Working with Other Immigrants Brings the Parts That I Lost Back To Me: The Experiences of Latin American Immigrant Therapists Working with Latin American Immigrant Populations

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Working with other immigrants brings the parts that I lost back to me:
The experiences of Latin American immigrant therapists working with Latin American immigrant populations

Elizabeth Paola Rivera Morazán

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Lastly, thank you to the participants of this study. You brought parts that I lost back to me too.
Dedication

To my sun, Rocky Santiago Rivera-Ottman

May you choose radical love at every turn

And, to all the necias, the insufferables, the ones that are too much, the buzzkills:

I see you. I am you.

I honor the love that fuels your rage.

Thank you for radicalizing me.

i am not brave, but sometimes
i am made brave by my friends which is to say
i am made brave by love
@kafka

In solidarity with oppressed peoples everywhere
Abstract

Therapists who work with traumatized populations are vulnerable to experiencing trauma indirectly. This experience may be exacerbated for those who have experienced trauma themselves. As LatAm immigrant populations have often experienced trauma at the various migration phases, therapists who are LatAm immigrants and work with LatAm immigrant clients may also experience secondary traumatization as an inherent part of their work. While the research on secondary trauma spans decades, there is a dearth of literature on the experiences of LatAm immigrant therapists specifically. This qualitative dissertation study begins the conversation of what the lived experiences of LatAm immigrant therapists are via interviews with eight participants. Findings analyzed through an Interpretative Phenomenological Analysis (IPA) method indicate that LatAm immigrant therapists consider aspects of their identities (e.g., being LatAm) and lived experiences (e.g., being immigrants) as facilitative and, at times, hindering to the therapeutic treatment. Regarding their experiences with secondary trauma responses (STRs), the participants describe how listening to their clients' migration trauma stories takes a toll on them and simultaneously provides opportunities for redemption. Lastly, factors influencing the participants' experiences reveal that while several factors increase their risk of experiencing problems at work (e.g., being the only Spanish-speaking therapist at an agency), they leverage protective, mitigating, and sustaining factors to continue engaging in the work. Such factors include grounding their work in a sense of purpose, embracing practices of care, and finding meaning in contributing to changing the mental health system.
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Chapter 1. Introduction and Specific Aims

Statement of the problem

The following dissertation project is an exploratory study of Latin American (LatAm) immigrant therapists working with LatAm immigrant populations. As LatAm immigrant populations have often experienced trauma at the various migration phases, the therapists who work with them are vulnerable to experiencing trauma indirectly. Research on indirect trauma exposure indicates that professionals who work with traumatized clients are at risk of secondary traumatization. Studies also indicate that there might be an increased risk when there is more exposure to trauma material, when the therapist has a personal trauma history, and when there is a shared trauma context. While the research in this area is vast, there is a dearth of literature on the experiences of LatAm immigrant therapists specifically. This dissertation study seeks to fill that gap by asking: What are the lived experiences of immigrant LatAm therapists working with immigrant LatAm populations?

This dissertation study examined the lived experiences of LatAm immigrant therapists to gain a better understanding of potential secondary trauma responses (STRs) when working with populations exposed to traumatic migratory experiences. Specifically, this research identified the risk, protective, mitigating, and sustaining factors of engaging in trauma work, as well as important implications to clinical work that STRs present. The guiding research questions of this study include:

1. How do LatAm immigrant therapists describe the experience of working with LatAm immigrant populations?

2. How do LatAm immigrant therapists make sense of secondary trauma responses when working with LatAm immigrant populations exposed to traumatic pre-, peri-, and post-migratory experiences?

3. What are the associated risk, protective, mitigating, and sustaining factors experienced by LatAm immigrant therapists?
Brief rationale for the study

While there has been growing research conducted with LatAm immigrants over the last two decades, there has been far less research exploring the experiences of the therapists who support them and even less with those who hold similar identities and backgrounds to those of their clients. Because we know that the risk of secondary trauma may be high, we must learn from this population to identify how they experience working with traumatized clients of a similar background. Identifying the various factors (i.e., risk, protective, mitigating, and sustaining) associated with their work will help inform our understanding of the etiology of secondary trauma responses. A better understanding of STRs is essential for developing interventions to safeguard the well-being of therapists that work with traumatized clients.

Overview of study approach

This qualitative research study aimed to understand the lived experiences of LatAm immigrant therapists who work with LatAm immigrant populations. In alignment with the general guidelines for recruitment of the interpretive phenomenological analysis (IPA) framework, I recruited eight LatAm immigrant therapists for open-ended interviews about their experiences working with LatAm immigrant populations. The interviews were audio-recorded, transcribed, and analyzed utilizing the software program, ATLAS.ti to identify and interpret themes that emerged from the data relating to the experiences of the participants.

Definition of project-specific terms

Immigrants

In this study, immigrants refer to people who have left their home country to reside in another country. It encompasses people with documented and undocumented statuses, as well as refugees (i.e., a status that denotes state acknowledgment of the harms incurred at the hands of the country of origin; McDermott & Ainslie, 2021), and asylum seekers (i.e., people who have left their country and have applied to be legally recognized as a refugee in the new country; Mishori et al., 2016).
**Latin American (LatAm)**

In this study, *LatAm* refers to a heterogeneous group of people from Latin America, encompassing a wide range of nationalities, races, ethnicities, and traditions, and who nevertheless may share a similar set of worldviews and values, geographical location, and history of colonization and exploitation (Arredondo et al., 2014). The terms *Latinx/e/o/a*, and *Hispanic* were used when LatAm people are referred to as such in the literature.

**Secondary trauma responses (STRs)**

In this study, *STRs* refers to the spectrum of responses to secondary trauma exposure that therapists can experience. It encompasses both negative and positive experiences and experiences within and outside psychiatric conceptualizations of trauma. I adapted the term from van Dernoot Lipsky and Burk's (2010) concept of *trauma exposure response* that describes the ways that witnessing the suffering in the world – from the suffering caused by climate change to the suffering caused by interpersonal violence – impacts all of us, particularly those on the frontlines and in the helping professions. As their concept refers to the negative alterations of exposure to trauma, I decided to refer to all experiences – negative, positive, neither, or all – as STRs to honor the myriad ways trauma exposure may alter people.

**Therapists**

In this study, *therapists* refer to mental health professionals who work therapeutically with clients and who possess at least a master’s degree in psychology or a related field (e.g., psychologists, social workers, marriage and family therapists). The terms *clinicians, mental health professionals, counselors*, and *analysts* will be used when therapists are referred to as such in the literature.
Chapter 2. Critical Literature Review

Introduction

There are no studies specifically examining the experiences of LatAm immigrant therapists who work with LatAm immigrant populations. For this reason, I turned my attention to the various aspects of the research questions. First, I present a review of the literature on the impact that being an immigrant has on the therapist as well as the therapeutic relationship. The research in this area has primarily focused on the clients’ experiences, not the providers who work with them (e.g., Tummala-Narra, 2019). The limited literature that has focused on the therapists’ experiences primarily consists of studies with international students (e.g., Mittal & Wieling, 2006), personal reflexive accounts of immigrant therapists describing their work (e.g., Khouri, 2012), and two exploratory dissertation studies on how an immigrant identity influences the therapeutic work (e.g., Bass, 2015). However, the corpus of literature on immigrant therapists refers to immigrants in general, not LatAm immigrants specifically. For this reason, I then describe the literature on the experiences of LatAm therapists, regardless of migration background. The focus of research in this area has consisted of aspects of LatAm identity in therapy such as bilingualism and biculturalism (e.g., Engstrom & Min, 2004), the effects of LatAm cultural values on the therapeutic relationship (e.g., Cofresí, 2002), and how LatAm interactional styles of communication are utilized in therapy (e.g., Arredondo et al., 2014). Of the studies reviewed, none focused on the experiences of LatAm therapists providing therapy to LatAm or immigrant populations, though in some of the studies, this appeared to be an assumption (e.g., Mendez, 2017).

This led me to explore the literature on experiences of service provision to LatAm immigrants. The literature on this topic explores the experiences of therapists who work in cities along the Mexico-United States border as well as professionals (e.g., interpreters and lawyers) working with immigrants in their asylum-seeking process. Because LatAm immigrant populations often experience trauma at pre-, peri-, and post-migration phases that impact their
mental health, research exploring the experiences of the therapists that work with them is critical. Just as lawyers and interpreters are impacted, exposure to clients’ trauma material can also affect the therapist via secondary traumatization. This is the crux of the current study: how do therapists who have experiences with migration to the U.S. from Latin America work with people who potentially share similar traumatic stories, being LatAm immigrants themselves?

To attempt to understand this question, I then focused on secondary traumatization, which has been studied for several decades. Research on the effects of the indirect traumatization that can occur when exposed to clients’ trauma material is vast, encompassing concepts of secondary traumatic stress (e.g., Armes et al., 2020), compassion fatigue (e.g., Fernando & Consedine, 2014), and vicarious trauma (e.g., Armes et al., 2020; Fernando & Consedine, 2014; VanDeusen & Way, 2006). There is also evidence of positive effects that can occur as a result of exposure to trauma material, such as vicarious posttraumatic growth, compassion satisfaction (e.g., Craig & Sprang, 2010), and vicarious resilience (Michalchuk & Martin, 2019). The plethora of research on the various secondary trauma responses (STRs) stresses the impact that being exposed to clients’ trauma material has on therapists, the therapeutic relationship, and the settings they work in. The corpus of STR research, however, lacks consensus on definitions of concepts and on the instruments utilized to measure them. Additionally, research on STRs has consisted primarily of white samples, and migration nor migration status have been studied. Lastly, many risk factors have been studied in connection to STRs (e.g., Hensel et al., 2015). Of particular interest to the current study is the therapist’s personal trauma history (e.g., Pearlman & Mac Ian, 1995), and the client-therapist shared trauma (e.g., Ali et al., 2021). Both of these factors involve an increased vulnerability to experiencing the deleterious effects of direct and indirect exposure to trauma.

**Experiences of immigrant therapists**

Examinations on the impact of being an immigrant have primarily focused on the clients’ experiences, not on the therapists who work with them (e.g., Kissil et al., 2013). Systematic
investigation on the impact of immigration experiences on therapists is an underdeveloped area of research (Kissil et al., 2013). What limited research has been conducted has focused on examining the experiences of international students in clinical training, academic experiences of international professors, and the supervisorial relationship with international supervisees (Kissil et al., 2013). There have also been several think pieces in the psychoanalytic literature that describe the impact of migration on the psyche (Akhtar, 1999b, 1999a), as well as immigrant therapists’ personal accounts of their experiences (Boulanger, 2004; Khouri, 2012). Thus far, there are two dissertation studies that focus on examining the experiences of immigrant therapists, how their cultural identities influence their experiences (Isaacson, 2002), and the impact that being an immigrant therapist has on transference-countertransference dynamics (Bass, 2015).

Findings from research with international trainees suggest that the therapist’s foreignness is a risk factor for professional efficacy and personal well-being (Bass, 2015). In their qualitative study of international students in Marriage and Family Therapy (MFT) programs, Mittal and Weiling (2006) found that their participants (n=13 from India (4), Mexico (2), Malaysia (2), Germany (1), Canada (1), Japan (1), Iran (1), and South Africa (1)) expressed feelings of not belonging, inferiority, and difficulties assimilating to U.S. culture (Mittal & Wieling, 2006). Immigrant therapists, like minoritized clients, may experience xenophobic encounters in their personal and professional lives (Kissil et al., 2013; Mittal & Wieling, 2006). In discussing their clinical work, the participants shared their experiences of discrimination with clients who preferred American therapists, and supervisors who expressed xenophobic apprehension at pairing international students with clients. The participants recounted their supervisor’s dilemma that they are “from a different country, and think what will you understand about their culture?” (Mittal & Wieling, 2006, p. 377). These students’ accounts highlighted the barriers their foreignness presented to their clinical training. The idea that foreignness is a challenge to immigrant therapists is supported in Akhtar’s (2006) writings on the technical issues concerning
immigrant analysts. While non-immigrant analysts may experience similar challenges to these, Akhtar (2006) proposes that they are of greater importance to immigrants as they are more likely to arise in the therapeutic exchange. These challenges include having to monitor for transference material regarding the therapist's foreignness and ethnic background, linguistic and cultural nuances that arise from providing therapy in a second language, and maintaining cultural neutrality when clients' worldviews collide with the therapist’s (Akhtar, 2006).

Akhtar’s (2006) technical challenges highlight an important tendency in the research scholarship on immigration—that immigrant identity is often conflated with identity classifications of foreignness/otherness such as race, ethnicity, and culture (Kissil et al., 2013). In other words, to fill in the gap on the experiences of being an immigrant, explanations have been pulled from research on the experiences of minority populations from the fields of inter-, cross-, and transcultural psychology (Bass, 2015; Kissil et al., 2013). Few investigations have considered the immigration experience as a contextual factor that exists alongside and indeed intersects with, other identities (Boulanger, 2004). Even fewer investigations exist that explore these dynamics in relation to the therapist (Kissil et al., 2013). Reasons for the lack of attention to immigration-as-context can be found in classical theories of psychoanalysis. A foundation of psychoanalysis is that psychological issues are rooted in intrapsychic factors (e.g., dreams, fantasies, memories, and identifications) and are thus, the proper focus of the therapy encounter (Boulanger, 2004). These intrapsychic phenomena are considered durable and not easily uprooted by external forces such as the migration process (Boulanger, 2004). Thus, context is often ignored because the person’s internal workings are thought to be constant, regardless of circumstance (Akhtar, 1999a, 2006; Boulanger, 2004). This notion has been questioned in immigrant therapists’ accounts of the impact that migration has on their identity.

Accounts of therapists’ experiences of “being not from here” and its effects on the therapeutic relationship can be found in more recent psychoanalytic writings (Kissil et al., 2013, p. 135). These accounts demonstrate that therapists often realize the impact their migration
history has on their therapeutic work while working with immigrant clients. In their review of the literature on immigrant therapists, Kissil et al. (2013) highlight the therapist's privileged position to develop a cultural meta-perspective as the result of their encounters with at least two cultures, and their experiences making sense of and integrating various realities. The researchers posit that by way of their immigrant identity, the immigrant therapist has the “possibility of looking at cultures from the outside and becoming aware of their relativity and fluidity as human creations” (Kissil et al., 2013, p. 139). For example, in her narrative of providing group therapy to Arab immigrant adolescents, Khouri (2012), an immigrant from Jordan, states:

At the time, I did not realize that as I accompanied the boys on their journey of settling and adjusting to life in the United States, they would bring me back to where I came from and force me to contend with losses that I had tucked away for 23 years. I thought I would be the bridge that symbolized the integration of the East and the West. Instead, I was another pedestrian on the bridge between the two, and it was they who helped me embrace the various aspects of my immigration experience. The three years left me more aware than ever of the pain of mourning a time and space lost forever, yet undying in my mind. (p. 215)

Having an immigrant therapist can provoke similar strong reactions in clients as well, especially when they are from the same country (Kitron, 1992). This may result from perceiving the therapist as knowing an aspect of themselves without having disclosed it (Boulanger, 2004). Likewise, immigrant therapists have shared accounts of feeling vulnerable with immigrant clients from the same country. Boulanger (2004) shares “What I did not know when I accepted that referral was that I was inviting into my office and into my psyche someone who also knew where I came from. She knew where a part of me waited” (p. 367). While the experience of “being fully known” can feel threatening to immigrant clients and therapists, it can also facilitate rapport via “contextual continuity,” the tacit understanding that comes from being from the same place
(Boulanger, 2004, p. 357). This position is advantageous as it can increase the therapist’s ability to connect with clients who feel othered and marginalized themselves (Isaacson, 2002; Kissil et al., 2013). However, Akhtar (1999) warns this is another one of the immigrant therapist’s challenges as they have to monitor the ways one might be tempted to over-identify with clients’ material, leading to implicit biases (e.g., blind spots) and collusions with transferential dynamics (Akhtar, 1999b; Bass, 2015). Other challenges that immigrant therapists may experience include managing themes of alienation, loss, and mourning (Isaacson, 2002). Participants in Bass’ (2015) study described immigration as a “lifelong layer of identity” (p. 122) suggesting that experiencing such difficulties may also be a lifelong challenge. Findings from the two qualitative dissertations (Bass, 2015; Isaacson, 2002) describe the impact that immigration has on the immigrant therapist’s identity. Participants shared that their identity had “been infused by and become intertwined with their immigration experience [and] how the deepest layer of their identity remained attached to their country of origin” (Bass, 2015, p. 123). These findings underscore the importance of examining immigration as a variable that impacts the person of the therapist, their identity, and subsequently their therapeutic practice.

Notably, of the limited scholarship that exists on the experiences of being an immigrant therapist, no studies have focused on LatAm immigrants specifically. The present study addresses Bass’ (2015) suggestion that focusing on a more homogenous subset of immigrant therapists may serve to deepen understanding of the impact of immigration, as individual characteristics that influence the data may be minimized. While the present study includes a more narrow focus than including immigrants from anywhere in the world, I acknowledge that even focusing on LatAm immigrants encompasses a wide range of nationalities, races, ethnicities, and traditions; in other words, by no means is this a homogenous group (Arredondo et al., 2014). However, for the sake of attempting to minimize heterogeneity and gain a deeper understanding of immigrants’ experiences, Latin Americans in this study are conceptualized as a group of people who share a set of worldviews and values, geographical location, and history
of colonization and exploitation (Arredondo et al., 2014). As the population of focus in the proposed study is LatAm immigrant therapists, this review will now turn to the literature of LatAm therapists regardless of migration background to illuminate their experiences.

**Experiences of LatAm therapists**

Similar to the literature on immigrant therapists, examination of the experiences of LatAm therapists, foreign- or U.S.-born, is an underdeveloped area of research. While LatAm therapists’ identity as immigrants has not been studied, other aspects of LatAm identity have been examined in relation to therapy provision. Such aspects include bilingualism and biculturalism in therapy (Engstrom & Min, 2004; Peters et al., 2014; Teran et al., 2017), the effects of LatAm cultural values (e.g., familismo, machismo and marianismo, spiritual outlook) on the therapeutic relationship (Cofresí, 2002; Lauricella et al., 2021), and how LatAm interactional styles of communication (e.g., dichos y refranes) are utilized in therapy (e.g., Pérez-Rojas et al., 2019). Of the studies reviewed, none explicitly focused on the experiences of LatAm therapists providing therapy to LatAm or immigrant populations. However, this appeared to be an assumption in many of the studies despite not capturing client demographics.

LatAm clients who prefer to communicate in Spanish lack culturally and linguistically proficient mental health providers with whom they can communicate effectively (Peters et al., 2014). Long lists of LatAm Spanish-speaking clients awaiting mental health services emphasize the need for therapists who can provide culturally and linguistically competent services. Yet data indicate a significant shortage of LatAm Spanish-speaking mental health professionals that can serve the ever-growing population. According to Census data, there are approximately 8,000 Spanish-speaking psychologists in the U.S., representing only 7 percent of all psychologists (APA, 2020). In a nationwide survey of the American Psychological Association (2015), only 5.5% of psychologists (of any race or ethnicity) reported being able to provide services in Spanish. The shortage of LatAm mental health professionals is attributed to the combination of low levels of LatAm students seeking degrees in the mental health field (Peters et al., 2014) and
low retention rates of LatAm students once in school (Olcoń et al., 2018). In fact, the mental health field has been reported to be one of the least attractive careers among Latino students (Manoleas et al., 2000). LatAm students encounter multiple barriers to achieving the required degrees to work in the field (Manoleas et al., 2000; Peters et al., 2014). One such barrier is that many are first-generation college attendees who experience various factors that negatively impact their overall success in schools, such as disparities at social and economic levels, limited access to resources, and psychosocial difficulties resulting from discrimination, poverty, and immigration (Arredondo et al., 2014; Peters et al., 2014). In graduate schools there is also a lack of education, training, and supervision tailored to providing services to LatAm populations, leaving LatAm students in the mental health profession ill-prepared upon graduating (Peters et al., 2014). To address this, LatAm therapists report needing to secure independent learning of cultural and clinical issues related to LatAm populations (Teran et al., 2017).

Upon entering the workforce, LatAm therapists are often tasked with a slew of additional roles related to providing therapy to LatAm clients (Engstrom & Min, 2004). One such role is acting as language brokers to Spanish-speaking clients, despite being formally trained and supervised in English (Delgado-Romero et al., 2018). While language brokering is a common practice for its convenience, it is contraindicated by governing bodies because therapists are neither trained or compensated to provide interpretation services (American Psychological Association, 1993; Delgado-Romero et al., 2018). Yet time and again, this practice was reported by LatAm therapists across studies (Teran et al., 2017). Engstrom and Min (2004) conducted a study with bilingual social workers in San Diego. Participants (n=26) reported having to do a lot more for clients for whom English is not the first language in order to help them navigate the system of social services. LatAm therapists are also tasked with educating others at the agency about diversity issues, carry higher caseloads because of the shortage of therapists who can work with LatAm clients, report feeling isolated, are undercompensated and overworked,
experience inadequate supervision, and rely on alternative supervision to meet their needs (Delgado-Romero et al., 2018; Verdinelli & Biever, 2009).

**Sources of Trauma among LatAm Immigrant Populations**

In 2019, there were approximately 60.6 million LatAm-descendant people in the United States with about 34% of them being foreign-born immigrants (Pew Research Center, 2020). Making up 18% of the total U.S. population, LatAm people are the largest ethnic minority, significantly contributing to the country’s cultural, economic, and socio-political fabric (Walsdorf et al., 2019). While a review of the extensive history of U.S. immigration is beyond the scope of this literature review, it is imperative to contextualize the following review of the sources of trauma among LatAm immigrants (Sheehi & Crane, 2021). U.S. immigration history is marked by colonial and territorial practices, and characterized by destabilization through foreign policies and military occupation of historically exploited countries (Chomsky, 2014). Changes in the interactions between economic developments, foreign policies, and political practices impact the experience of immigration (Chomsky, 2014). In order to de-pathologize the experiences of historical and intergenerational sociopolitical trauma experienced by LatAm immigrant populations, it is imperative to acknowledge the centuries of oppressive practices and to conceptualize people’s responses to trauma as normative within this context (Walsdorf et al., 2019).

**Migration Trauma**

Despite diverse backgrounds and migration experiences, many immigrants from LatAm countries experience traumatic events at the various phases of migration (Comas-Díaz, 2021; Torres et al., 2018). This exposure to trauma has a negative impact on the mental health of immigrants. Therefore, it is essential for therapists to apprise themselves of the factors associated with their clients’ pre-, peri-, and post-migration experiences. In a study examining whether pre-migration trauma exposure predicted post-migration acculturative stress, findings suggested that the Latino immigrants who reported pre-migration trauma were more likely, than
those who did not, to report traumatic experiences in the post-migration period (Li, 2016). These findings are consistent with the literature on stress proliferation, a process in which additional stressors arise and accumulate due to having experienced an initial stressor, leading to health detriments (Li, 2016). This process can occur as a result of any stressful event, with traumatic events being of note for their particularly noxious effect (Li, 2016). In another study with undocumented Mexican immigrants, Garcini et al. (2018) found an increased vulnerability to experiencing psychological distress among the participants that reported a comorbid history of trauma (e.g., interpersonal discrimination, in general, and for being undocumented, specifically) as opposed to those who did not report a trauma history. Additionally, not only are people with a history of trauma particularly vulnerable to further traumatization, but they are also more likely to display a heightened psychological response (Garcini et al., 2018).

**Pre-migration phase.** The experiences of LatAm immigrants at the pre-migration phase will vary depending on the country they are migrating from; however, there are similar themes of economic insecurity, physical and sexual assault, natural disasters, extreme poverty, crime victimization, war, gang violence, extortion, increased drug trafficking activity and political oppression (Li, 2016; Torres et al., 2018). Central America, for example, has been impacted by increasing levels of violence, rates of homicide, and gang activity (Torres et al., 2018). In one study, Mexican and Central American immigrant women (n=28) reported migrating to escape the combination of violence at the domestic, community, and political levels (Kaltman & Hurtado de Mendoza, 2011). Very often, it is exposure to these traumatic experiences that prompt the migration to the U.S.

**Peri-migration phase.** While some experiences of migration to the U.S. might be relatively simple (e.g., arriving via airplane with visas), many LatAm migrants embark on the more complex journey via land, often crossing various borders without authorization (Torres et al., 2018). The journey via land often includes utilizing the services of a coyote (i.e., a person who smuggles people across the Mexico-United States border) and traveling in overcrowded
vehicles with limited provisions (Comas-Díaz, 2021). Unfortunately, peri-migration experiences are fraught with violent crimes such as sexual assault, kidnapping, robberies, murders, accidents, physical abuse, witnessing violence towards others, as well as other organized crime (APA Presidential Task Force on Immigration, 2012; MacLean et al., 2019; Torres et al., 2018). In a study with Latina immigrant women, Rios Casas et al. (2020) found that participants (n=58) in all four of their focus groups described themes of heat exposure, exhaustion, sexual assault, and threats of violence. The participants shared that even years after having migrated, they experience hypervigilance, sleep disturbances, and recurring sadness related to their peri-migration experience (Rios Casas et al., 2020).

**Post-migration phase.** The trauma experiences continue once migrants arrive in the U.S., with many being held in detention centers by Immigration and Customs Enforcement (ICE; Comas-Díaz, 2021). Immediate post-migration experiences while in ICE custody include physical and sexual abuse, lack of medical care, inadequate provisions, cold temperatures, neglect, uncertainty about the duration of detention, limited access to legal services and representation, ongoing separation from family, and death (Li, 2016). Long-term post-migration stressors include factors in the socio-economic, social and interpersonal, and acculturative realms, as well as factors regarding immigration policies, practices, and procedures. These factors include 1) *socio-economic factors* such as financial and housing insecurity, lack of work opportunities, and lack of access to education (Garcini et al., 2017), 2) *social and interpersonal factors* such as discrimination based on gender, race, ethnicity, authorization status, social class, religion, disability status, and sexual orientation, family separation, and changes in social roles (Updegrove et al., 2020), 3) *acculturation factors* such as social isolation, sense of guilt about leaving their family in their home country, culture shock, communication difficulties, and language-based discrimination (Li et al., 2016), and 4) *immigration policies, practices, and procedures* such as legality status stress, detention, deportation, limited access to health and social services, and higher levels of exploitability (Lyubansky et al., 2013). Undocumented
LatAm immigrants are also ineligible for postsecondary education and work-related benefits (e.g., health insurance, workers’ compensation; Delgado-Romero et al., 2018).

**Impact of multiple identities on migration experiences.** I would be remiss to neglect the effects of intersectionality (Crenshaw, 1989) on immigrants’ experiences. Following intersectionality theory, those who hold multiple marginalized identities would suffer the brunt of the oppressive systems in the U.S. and their countries of origin (Chavez-Dueñas et al., 2019). As such, it is important to account for location within these systems as they relate to the experiences of trauma (Sheehi & Crane, 2021). In other words, the effects of trauma are heightened for immigrants that hold membership in various marginalized identities (e.g., racial-ethnic minorities, having an undocumented status, belonging to a lower socioeconomic status). For example, undocumented immigrants from a lower socioeconomic status are less likely to obtain documentation due to the high cost of the process (Walsdorf et al., 2019). Additionally, unlike documented immigrants, federal law limits undocumented immigrants from accessing services, such as social security benefits, food stamps, public housing, and healthcare. The services they can still incur are limited to emergency medical care, as well as public elementary and secondary education (Lyubansky et al., 2013). This lack of financial help for undocumented immigrants makes it more difficult for them to afford to undertake the process of gaining documentation. Moreover, holding an undocumented status may worsen people’s mental health as they are more likely to experience discrimination. In a cross-sectional study examining the prevalence of interpersonal discrimination among immigrants. Garcini et al. (2018) found that not only was there an increased prevalence of interpersonal discrimination among undocumented participants (n=246), but they also described the discrimination experience as more stressful when compared to their documented counterparts.

**LatAm Immigrants and Mental Health**

The cumulative effects of the aforementioned migration dynamics have a significant damaging effect on the mental health of LatAm immigrants. Traumatic events such as those
experienced in the pre-, peri-, and post-migration phases, are associated with a higher risk for deleterious mental health effects such as depression, anxiety, somatic complaints, sleep difficulties, hypervigilance, substance use, hopelessness, and PTSD symptoms (Garcini et al., 2017; MacLean et al., 2019). McDermott and Ainslie (2021) posit that “any one of these sources of violence constitutes a significant psychological stressor. Together, however, they represent an enormously complex challenge for migrants [...] multiple exposures to adverse or traumatic events are linked to poor mental health outcomes” (p. 44). The impact of the aforementioned stressors may also be exacerbated by various contextual factors. In a qualitative study with 28 Latina immigrants, Kaltman et al. (2011) found that the level of brutality in the trauma material appeared to amplify the impact of the participants’ traumatic experiences. The researchers posit that exposure to trauma that consists of higher levels of brutality may worsen mental health outcomes, a finding supported in the literature on trauma theory (Vila & Pomeroy, 2020).

**Prevalence of mental disorders**

Keller et al. (2017) studied Central American migrants from Guatemala, Honduras, and El Salvador who were awaiting court hearings to determine whether they had credible fear of returning to their country of origin (one of the criteria for obtaining asylum). In their mixed-methods approach, the researchers interviewed and surveyed 234 adults via semi-structured interviews and standardized questionnaires that assessed: exposure to pre-migration trauma, reasons for having migrated, as well as PTSD and depressive symptoms (Keller et al., 2017). The majority of the participants cited violence as a reason for migrating, about 70% shared that they did not report it to the police for fear of retaliation, and 90% reported feeling fearful of returning. The researchers also found high levels of psychological distress among the participants, with about a third endorsing clinically significant symptoms of PTSD, and a quarter endorsing symptoms of major depressive disorder (Keller et al., 2017). These findings are consistent with other studies that have also found a marked increase in PTSD and depression among this population (Perez Foster, 2001).
In a study with undocumented Mexican immigrants, Garcini et al. (2017) aimed to assess the prevalence of mental disorders, comorbidities, and sociodemographic, immigration, and contextual vulnerabilities among this population. Utilizing a cross-sectional approach in a sample of 248 participants residing near the California-Mexico border, the researchers found that a quarter met the criteria for one or more of the assessed disorders, which included somatization disorder, major depressive disorder (MDD), panic disorder, generalized anxiety disorder (GAD), posttraumatic stress disorder (PTSD) and substance use disorder (Garcini et al., 2017). Of these, the most prevalent disorders among this sample were MDD (14.4%) and anxiety-related disorders (6.6%). The prevalence of having a substance use disorder was nearly 4%, a comparable rate to that of the general population. The prevalence of PTSD among this sample was low (3%) vis-à-vis the rates of traumatic events that were reported (83% of participants reported a history of trauma). While the prevalence percentage is comparable to that of the U.S. population, the researchers noted having expected it to be higher given the histories of trauma. The researchers postulated the low percentage may be due to the PTSD criteria not capturing the psychological distress and presentation of trauma symptoms among non-Western cultures, a finding corroborated in the research scholarship (and discussed further on p. 41 of this literature review; Sheehi & Crane, 2021).

**Mental healthcare utilization practices**

While LatAm immigrants experience high levels of psychological distress associated with traumatic events at the pre-, peri- and post-migration phases, studies have shown that they are not as likely to seek the help of mental health professionals (Olcón & Gulbas, 2020). Instead, LatAm immigrants are more likely to seek support from religious leaders, alternative healing practitioners, family members, and friends (Barrera et al., 2016). They are also more likely to seek access to primary care than mental health services, and more likely to access emergency services than primary care (Eisenman et al., 2003; Lyubansky et al., 2013). This may be due to LatAm immigrants’ tendencies to demonstrate somaticized presentations of mental health
concerns, which may lead them to seek medical care over mental health care; however, studies have shown that even when LatAm immigrants seek primary care, they are not likely to disclose their mental health concerns to physicians (Eisenman et al., 2003). Long waitlists in mental health settings, rigorous eligibility requirements for receiving services, coupled with the stigma associated with experiencing emotional and psychological issues, and the stigma of discussing such issues outside the home, are all contributors to LatAm immigrant’s mental health-seeking practices (Olcón & Gulbas, 2020).

Secondary trauma responses

Professionals that serve people who are traumatized are at risk of experiencing secondary trauma. As LatAm immigrants have often experienced trauma at the various migration phases, therapists who work with them are exposed to trauma material, leaving them vulnerable to experience trauma vicariously (Lusk & Terrazas, 2015). This researcher’s efforts in finding studies that examine secondary trauma responses (STRs) among LatAm immigrant therapists, specifically, yielded no results. However, there are studies that look at STRs among people from various professions who work with LatAm immigrants, four of which focus on LatAm therapists (not necessarily immigrants themselves; Harris & Mellinger, 2021; Lor, 2012). This dearth of studies regarding STRs among LatAm immigrant and nonimmigrant professionals is not reflective of the large research scholarship on the impacts of doing trauma work. In fact, decades of research on indirect exposure to trauma have yielded a variety of conceptualizations for STRs, all seeking to describe the pervasive impact of caring for those who experience trauma (Branson, 2018). The STRs encompass both the detrimental and beneficial effects of trauma exposure: vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout refer to the negative consequences, and compassion satisfaction, vicarious posttraumatic growth, and vicarious resilience refer to the positive ones.
Negative STRs

The negative effects of secondary exposure to trauma have been studied for several decades with a variety of concepts used, often interchangeably, to describe the detrimental change experienced by those who care for others in various aspects of their identity, functioning, and symptomatology (Branson, 2018). Such changes in the care person’s structure have been conceptualized as vicarious traumatization, compassion fatigue, secondary traumatic stress, and burnout. While these concepts all point to the adverse effects of being exposed to high stress and traumatic material, they refer to different yet interconnected experiences.

**Burnout.** While burnout does not occur as a result of indirect trauma exposure, it is understood that increased stressors at work and working with vulnerable populations increase the worker’s susceptibility to it (Newell & MacNeil, 2010). Burnout is described as the gradual development of negative psychological experience related to work that occurs along three dimensions: “overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment” (Maslach & Leiter, 2017, p. 37). Risk factors for burnout include experiencing minimum support, large caseloads, low salaries, difficulties in the provision of client services, powerlessness over the organization’s policies, and inadequate training (Newell & MacNeil, 2010).

**Secondary traumatic stress (STS).** One of the terms used to describe possible reactions to high stress is STS, which is considered to be acquired from exposure to individuals who are traumatized rather than from exposure to a traumatic event itself (Mordeno et al., 2017). STS refers to the symptomatology realm of STRs, with symptoms similar to those of posttraumatic stress disorder (PTSD). Such symptoms include intrusions of traumatic material, avoidance of potential triggers, reactivity and hypervigilance, and alterations in cognitions and mood (Sprang et al., 2019). STS may occur after one encounter with secondhand trauma whereas vicarious traumatization symptoms develop cumulatively, over several sessions and from several therapeutic relationships (B. H. Stamm, 2002).
Compassion fatigue (CF). The concept of CF evolved from the theory and research scholarship of STS, and in its simplest definition is described as the "cost of caring" for those who are suffering (Figley, 2002, p. 2). Whereas STS refers to symptomatology, CF refers to the behavioral and emotional consequences of knowing about another's suffering (Adams et al., 2006). CF is described as the reduced capacity or interest in engaging empathically with the suffering of clients. Figley (2002) describes CF as "a more user-friendly term" compared to STS, that minimizes stigma, and which has been conceptualized as a form of burnout (p. 3).

Vicarious traumatization (VT). Whereas CF refers to the behavioral and emotional responses to secondary trauma, VT refers to the "transformation of the helper’s inner experience, resulting from empathic engagement with clients’ trauma material" (Pearlman & Saakvitne, 1995, p. 40). The repeated exposure to traumatic material can shift the way in which therapists view and interact with themselves, others, and the world (Pearlman & Mac Ian, 1995). The effects of vicarious traumatization manifest cognitively as disruptions to schemas: people's beliefs, assumptions, and expectations about themselves, others, and the world (McCann & Pearlman, 1990). Disruptions in schemas of trust, dependency, power, independence, safety, esteem, intimacy, control, and frame of reference, have been identified (Neumann & Gamble, 1995). These changes to the person's worldview are considered to be permanent and untreatable, happening over time and in a cumulative manner (Harrison & Westwood, 2009).

Positive STRs

Professionals may also experience positive responses to being exposed to secondary trauma such as: experiencing a profound sense of caring for their clients, joy and deep satisfaction in bearing witness to their clients’ healing processes, honor for being part of someone's recovery, and fulfillment in "knowing we are working to counter the effects of interpersonal violence" (Neumann & Gamble, 1995, p. 347). The literature is scarcer regarding the positive STRs as the benefits of indirect exposure to trauma are mainly mentioned tangentially within the larger research on the negative STRs (Arnold et al., 2005). The positive
changes of secondary traumatization have been conceptualized as vicarious posttraumatic growth, compassion satisfaction, and vicarious resilience (Hyatt-Burkhart, 2014).

**Vicarious posttraumatic growth (VPTG).** VPTG refers to the positive changes of being indirectly exposed to trauma. Similar to the changes that occur in posttraumatic growth with survivors of direct trauma, those who experience secondary traumatization may undergo changes in self-perception, interpersonal relationships, new possibilities, and life philosophies (Tedeschi & Calhoun, 2004). Such changes in self-perception include viewing themselves as more tolerant, open-minded and flexible (Hyatt-Burkhart, 2014). Improvements in interpersonal relationships include increased levels of empathy, closer and more meaningful relationships (Arnold et al., 2005). VPTG may also involve a change in life philosophy characterized by a deepened appreciation for survivors’ resiliency (Arnold et al., 2005).

**Compassion satisfaction.** Stamm (2002) presented the term compassion satisfaction in relation to her professional quality of life model that covers the negative and positive experiences workers can have with their work. Compassion satisfaction refers to the increased pleasure, motivation and satisfaction that workers in the helping profession can experience in their work (Butler et al., 2017).

**Vicarious resilience.** Another term that is used to describe the positive effects of secondary traumatization is vicarious resilience. Evolving from grounded theory observations and Bandura’s (1986) theory of vicarious learning, vicarious resilience refers to the change that occurs when witnessing clients’ strengths and recovery process (Hernandez-Wolfe et al., 2015).

These positive and negative phenomena capture the cognitive, behavioral, emotional, and symptomatologic consequences of working with traumatized people in high-stress environments. Additionally, the various concepts of STRs are not mutually exclusive and can interact with each other and serve to exacerbate or moderate each other’s effects (Pearlman & Saakvitne, 1995). For example, studies show a positive correlation between STS and VT, as well as STS and burnout (Furlonger & Taylor, 2013; Sodeke-Gregson et al., 2013).
Unaddressed, VT may also precede experiences of burnout as it can lead to emotional exhaustion, depersonalization and decreased feelings of accomplishment, the components of burnout (Neumann & Gamble, 1995). Findings on the relationship between compassion satisfaction and STS are mixed, with some finding a negative correlation between them (Sodeke-Gregson et al., 2013), while others finding that they are not significantly related to each other (Samios et al., 2013). It was observed, however, that compassion satisfaction served as a moderator between anxiety and STS in a study of therapists who work with survivors of sexual violence (Samios et al., 2013). Of note, Samios et al. (2013) also found a relationship between STS and higher levels of depression and anxiety. Moreover, STS significantly predicted anxiety and depression (Samios et al., 2013). Unaddressed VT may also precede experiences of burnout as it can lead to emotional exhaustion, depersonalization and decreased feelings of accomplishment, known components of burnout (Neumann & Gamble, 1995). Together, the STR concepts describe the impactful change to the identity, functioning and symptomatology of those who work with traumatized populations (Branson, 2018).

**Working with immigrant populations**

While there are no studies examining the experiences of LatAm immigrant therapists working with LatAm immigrant populations, there exists research examining the experiences of therapists and other professionals working with this population (Piwowarczyk et al., 2009). Research in this area has primarily focused on the experiences of professionals who work in cities along the Mexico-United States border (e.g., MacLean et al., 2019) as well as professionals working with immigrants in their asylum-seeking process (Fennig & Denov, 2021). LatAm immigrants face psychological distress as a result of exposure to various traumas at the pre-, peri-, and post-migration phases, impacting their mental health (Torres et al., 2018). Therefore, therapists and other professionals who work with LatAm immigrant clients are at risk for experiencing occupational stress and secondary trauma responses (Mishori et al., 2016).
STRs among professionals working with immigrants

Lor (2012) conducted a qualitative study investigating the experiences of immigrant interpreters (n=4) who work with immigrant clients within mental health settings. Findings indicated that a majority of the interpreter participants experienced 1) physical changes such as trouble breathing; 2) psychological changes such as nightmares as well as trouble with sleeping and concentration; 3) behavioral changes, such as difficulties setting boundaries and separating their personal life from their work; as well as 4) changes in how they viewed themselves and the world as evidenced by feelings of helplessness in their ability to create change and questioning their purpose as interpreters (Lor, 2012). Of note, the majority of the interpreter participants experienced triggers via intrusions of client trauma material, and half reported experiencing triggering of their own immigration trauma (Lor, 2012).

Likewise, studies examining the experiences of lawyers who work with asylum seekers report high levels of burnout, secondary traumatic stress, and vicarious trauma (Harris & Mellinger, 2021). Researchers posit that the necessary steps of extracting and reviewing traumatic material to complete the necessary documentation for asylum claims combined with the lack of training on the effects of stress and trauma, and techniques to manage it, leave asylum lawyers vulnerable (Piwowarczyk et al., 2009). Findings from research among human services providers highlight that the workforce serving immigrants is too insufficient and overextended to address the needs of the expanding immigrant population (Lanesskog et al., 2015). Interestingly, in a study that examined the experiences of traumatized refugees, their therapists, and interpreters, Mirdal et al., (2012) found that when interpreters also have a refugee background, they face unique and critical challenges in the realms of confidentiality, boundaries, and overidentification with the clients. Both the therapists (n=16) and the interpreters (n=16) reported on themes relating to burnout and secondary victimization as a result of their work (Mirdal et al., 2012).
In a qualitative case study conducted by Olcón and Gulbas (2021), the researchers sought to learn about the experiences of social service providers (n=17) who work with Latino families in Texas, and capture how burnout is shaped by structural barriers. The researchers utilized the concept of moral distress to document the ways that macro-level barriers impact clients and the providers who work with them. They operationalized the concept of moral distress as: “(1) the structural barriers that limit providers from delivering services in ways they deem as ethical and (2) the emotional ramifications of experiencing those barriers” (Olcón & Gulbas, 2020, p. 6). Their study stemmed from a larger one where they noticed that the behavioral health providers, including mental health counselors and social workers, seemed to experience a different form of burnout compared to the larger group. They conducted qualitative interviews with behavioral health providers (n=17) regarding their perceptions of how immigration impacts the experience of psychosocial adversity and the barriers and solutions to working with Latino immigrant families. The study revealed four emerging themes that describe the experiences of burnout among this subset of providers who work with LatAm immigrants: (1) “the system has failed them; (2) compromised service quality; (3) ‘who really can help?;’ and (4) individual solutions to structural problems” (Olcón & Gulbas, 2020, p. 7).

**STRs among LatAm therapists working with LatAm immigrants**

As previously mentioned, there are only five studies that focus on the experiences of LatAm therapists working with LatAm immigrants. Of note, there are no studies that examine positive STRs in this population though themes of vicarious resilience and VPTG arose tangentially in the discussions. In the first study examining secondary trauma among caregivers who work with LatAm immigrants, Lusk and Terrazas (2015) explored the nature and severity of experiencing secondary trauma for those who work with traumatized refugees in El Paso, Texas. The study consisted of 31 professionals and paraprofessionals from a variety of settings including shelters, legal aid offices, and counseling centers. The majority of the sample was Hispanic (67.7%) and female (77.4%) and all of the respondents spoke Spanish regardless of
ethnicity. The researchers utilized structured interviews and two self-administered measures, the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004) and the Professional Quality of Life Scale 5 (ProQOL-5; Stamm, 2010). The STSS is a 17-item self-report measure that assesses three areas of traumatic stress related to secondary exposure to trauma: intrusion, avoidance, and arousal. The ProQOL is a 30-item that measures the professional quality of life via three subscales: Burnout, Compassion Fatigue, and Compassion Satisfaction. Quantitative findings showed that all participants reported experiencing intrusive thoughts, most reported having trouble sleeping and concentrating, and more than half reported at least occasionally feeling emotional numbness and being easily annoyed (Lusk & Terrazas, 2015). These findings were corroborated qualitatively, with all the participants responding that their clients’ situations were difficult, tragic, and overwhelming. The researchers noted that “none of the participants were unaffected by their encounters with migrants” (Lusk & Terrazas, 2015, p. 264). The participants also reported experiencing nightmares, crying, feeling horrified, sad, frustrated, and helpless. Approximately half of the participants reported feeling burned out, and many reported feeling they needed to “shut down” their emotions to put distance between themselves and the clients (Lusk & Terrazas, 2015, p. 266). The participants also reported positive reactions in relation to their work. Quantitative findings showed that 60% of participants reported compassion satisfaction, 86% reported feeling happy with choosing the career they did, 90% reported gaining satisfaction from helping people, and all the participants reported feeling proud of their work (Lusk & Terrazas, 2015). These findings were also consistent with their qualitative responses in which the participants shared their work is rewarding and are impressed by their clients’ resiliency and strength. Additionally, the researchers noted culture as a protective factor, with all of the participants reporting on themes of familism, collectivism, religiosity, and faith.

Teran et al. (2017) conducted the first study to measure burnout among bilingual Latina/o clinicians. The study consisted of 66 bilingual English-Spanish Latina/o clinicians. The majority of the sample was female (76%), and all of the respondents spoke Spanish regardless
of ethnicity. The researchers utilized the Maslach Burnout Inventory—Human Services Survey (MBI-HSS; Maslach et al., 1996), a 22-item self-report questionnaire that assesses the three aspects of burnout, emotional exhaustion, depersonalization, and personal accomplishment. They found that a majority of their sample (75%) endorsed moderate to high emotional fatigue, low cynicism, and high personal satisfaction. Endorsements in the latter two areas were different from those found among the normative sample suggesting that, compared to their English monolingual white counterparts, LatAm therapists fare better (Teran et al., 2017). The researchers posit this may be due to LatAm cultural values such as colectivismo (prioritization of the group over the self) and personalismo (preference for close and personal interaction) that impact their work—perceiving the work as more rewarding because they are helping their communities (Teran et al., 2017). The findings that job satisfaction is influenced by cultural factors echo the findings in Manoleas et al.’s (2000) exploratory study examining what factors were most important to experienced Latino therapists in the San Francisco Bay Area. The participants reported that working with other Latino staff, helping clients identify and utilize cultural strengths, and contributing to “el bienestar de mi gente” (my people’s well-being) were among the most important (Manoleas et al., 2000, p. 387). LatAm therapists have also reported feeling a sense of pride, connection, and satisfaction in having served their communities (Estrada et al., 2023).

In 2017, Mendez examined the experiences of clinicians who work with unaccompanied children at the Mexico-United States border. While the inclusion criteria did not include a particular race or ethnicity, all seven of the participants were described as Hispanic. Mendez identified themes regarding 1) the rewarding experiences in the participants' work, with many reporting that the rewards outweigh the stresses and frustration; 2) professional and personal development (e.g., feeling more adept to doing trauma work and experiencing humility, gratitude and kindness as a result of working with unaccompanied children); 3) the role of culture in which the participants reported that their similar backgrounds assisted them in establishing rapport; 4)
symptoms of burnout (e.g., experiencing desensitization and depersonalization) or measures utilized to avoid it (e.g., engaging in activities they find enjoyable such as going to the gym, gardening and watching television); and 5) precursors to vicarious trauma including prolonged exposure to their clients’ trauma and experiencing strong reactions as a result (Mendez, 2017).

Additionally, Castellon (2020) studied the experiences of counselors who work with unaccompanied children in detention facilities at the Mexico-United States border, finding that six out of ten participants believed they had experienced vicarious trauma or burnout. While all the participants were Spanish speakers, their racial/ethnic backgrounds were not reported. The reported vicarious trauma responses included experiences of numbness, problems with cognition, recurring nightmares, and hypervigilant behaviors (Castellon, 2020). Regarding burnout, the participants expressed not having free time and taking work home with them, reporting that not working slows down the process of getting the children out (Castellon, 2020). Participants also reported experiences of feeling unprepared to work with immigrants and refugees, questioning protocols and ethics, the importance of their work-family and supervisors as support, improvement of their counseling skills, viewing their job as a humbling reward, and how their work led them to explore their cultural identities (Castellon, 2020).

Factors impacting STRs

Efforts have been made to identify factors that relate to the various STRs. While such efforts have been limited, they have included quantitative, qualitative, and mixed methods approaches. Despite the breadth of approaches, studies have not equally covered the STRs, and as a result, our understanding of risk and protective factors is extensive for some of the concepts and limited for others (Mordeno et al., 2017). Similarly, there is no consensus among the research findings. This can be partly explained by methodical inconsistencies such as variations in definitions and operationalizations of the terms, variability in the instruments used, variations in trauma-related variables, and the breadth of professions being studied.
Gender. Some studies found that female-identified therapists were more likely to report higher levels of secondary traumatic stress than their male counterparts (Ivicic & Motta, 2016). One study found this to be true even when the participants did not differ in terms of their personal trauma histories (Ivicic & Motta, 2016), while another found no such association with regard to gender, personal trauma history and secondary traumatic stress (Rzeszutek et al., 2015).

Age. Some studies found that older therapists reported increased levels of compassion satisfaction and vicarious posttraumatic growth (Brockhouse et al., 2011), while no such relationship was found between age and vicarious trauma (Doric et al., 2012).

Therapeutic experience. Some findings suggested that more experienced therapists reported lower levels of secondary traumatic stress than their less experienced counterparts (Robinson-Keilig, 2014), others reported no relationship between these variables or between therapeutic experience and vicarious trauma (Doric et al., 2012), and yet others report that having more experience correlated with higher levels of compassion satisfaction (McKim & Smith-Adcock, 2014).

Training and education. Sodeke-Gregson et al. (2013) reported no relationship between years of training and education and vicarious posttraumatic growth.

Caseloads. Studies have found a positive relationship between secondary traumatic stress and caseload (Robinson-Keilig, 2014). Findings also suggest that increased exposure to trauma was predictive of higher compassion fatigue levels (McKim & Smith-Adcock, 2014), though this was not corroborated in other studies (Dhinse, 2017). Regarding the positive STRs, some studies have found that higher exposure is predictive of higher levels of vicarious posttraumatic growth (Brockhouse et al., 2011), while others have not found relationships between compassion satisfaction and caseload (Sodeke-Gregson et al., 2013).

Perception of control over work activities. Some studies found that the perception of having less control over work activities (e.g., having control over the what and when of their
work) predicted higher levels of compassion fatigue and decreased levels of compassion satisfaction (McKim & Smith-Adcock, 2014).

**Private vs. public practice.** Brockhouse et al. (2011) reported findings that public work was associated with increased levels of spiritual change, contributing to vicarious posttraumatic growth, as opposed to private practice.

**Supervision.** Studies have found no relationship between secondary traumatic stress and supervision (Ivicic & Motta, 2016), or compassion fatigue and supervision (McKim & Smith-Adcock, 2014). Others have also found no relationship between supervision and vicarious posttraumatic growth. Sodeke-Gregson et al. (2013) found that perceived high levels of supervisorial support were predictive of higher compassion satisfaction levels though this was not corroborated in other studies (Dhinse, 2017). Moreover, Sodeke-Gregson et al. (2013) also found that more time spent in supervision was associated with higher secondary traumatic stress levels.

**Social support.** Studies have found that a higher perception of social support is associated with lower secondary traumatic stress (e.g., MacRitchie & Leibowitz, 2010; Rzeszutek et al., 2015).

**Personal trauma history**

Of particular interest for the current dissertation study is the factor of the therapist’s personal trauma history. There is limited research on the topic of the therapist’s personal trauma history. When it is addressed, it is done so parenthetically within the main focus of secondary traumatization (Chaverri et al., 2018). The limited literature on the topic yields mixed results regarding the impact of the therapist’s personal trauma history (Bell et al., 2003). Whereas some studies have found that the therapist’s personal trauma history is a factor that increases the likelihood of therapists experiencing an STR (Linley & Joseph, 2007), others have found there is no link between these factors (Salston & Figley, 2003). Findings from cross-sectional studies have found positive correlations between secondary traumatic stress and the personal
trauma history of the therapist (Sodeke-Gregson et al., 2013), as well as personal trauma being predictive of increased levels of secondary traumatic stress among substance use treatment providers (Cosden et al., 2016). Higher levels of vicarious trauma have also been found to correlate with personal trauma history (MacRitchie & Leibowitz, 2010). Some studies have found that compassion fatigue scores were higher for participants with a history of trauma than for those without (Ray et al., 2013). Researchers posit this may be due to therapists identifying more with clients with trauma histories, which increases their risk for compassion fatigue (Ray et al., 2013). Additionally, it is also possible that the therapist’s personal trauma history can be a positive factor that contributes to personal growth (Linley & Joseph, 2007). However, findings related to therapist personal trauma history and the positive STRs are mixed, with some finding that personal trauma history is predictive of increased compassion satisfaction while others finding no significant relationship (McKim & Smith-Adcock, 2014; Sodeke-Gregson et al., 2013). While the results are mixed regarding the impact of the therapist’s personal trauma on secondary traumatization, according to stress-proliferation theory, having experienced trauma increases the likelihood of further traumatization; thus, it is likely that if a therapist has experienced trauma, then they are at increased risk for adverse effects (Li, 2016).

**Shared trauma**

Another factor that may increase the therapist’s vulnerability to experiencing psychological distress is being exposed to the same traumatic events as their clients (Saakvitne, 2002). This phenomenon has been conceptualized as shared trauma and double exposure to trauma (i.e., experiencing trauma for oneself and learning about it from one’s clients; Tosone et al., 2012). It has generally been used to refer to single traumatic events of all sorts, from natural disasters to terrorist attacks, and is described “as highly unusual and extraordinary” in the literature (Ali et al., 2021, p. 5). Similar to other trauma concepts, there is no consensus on the definition or organizing framework for shared trauma (Baum, 2010). More recently, researchers have begun to view shared trauma in relation to other such traumatic
events that are not limited to singular occurrences but instead constitute a broader contextual backdrop (Ali et al., 2021). Issues of poverty, persecution, mass violence, migration, and the current Covid-19 pandemic, have underscored the importance of understanding the collective experiences of ongoing traumatic events (Ali et al., 2021). Saakvitne (2002) writes that “with a shared tragedy, the frame of our work shifts [...] we are forced to remain consciously aware of our own vulnerability” (p. 444). Similarly, Ali et al. (2021) posit that shared trauma consists of aspects of both primary and secondary trauma and, as such, can have an impact on the therapist’s beliefs about themselves, others, and the world (Ali et al., 2021). Shared trauma may also include therapist lapses in empathy, therapist’s immersion in their professional role, and blurred boundaries in the client-therapist relationship (Ali et al., 2021). Moreover, as is the case with secondary traumatization, a client-therapist shared trauma context may also contribute to shared resilience and growth (Ali et al., 2021).

**Broadening Conceptualizations of Trauma**

Diagnostic classifications have inevitably influenced our conceptual understandings of mental disorders. The concepts that we have available to capture the phenomenon of indirect traumatization (e.g., compassion fatigue and secondary traumatic stress) are based on diagnostic understandings of direct trauma, namely PTSD criteria (Branson, 2018; Molnar et al., 2017). The criteria for disorders in the Diagnostic and Statistical Manual of Mental Health Disorders often locate the sources of psychological suffering within people, leaving out the influence of ideological, social, political, military, and systemic conditions (Comas-Díaz, 2021). Researchers and scholars urge that an intersectional macro-level lens must be utilized when considering the experiences of LatAm immigrants, as an individual-level view is unlikely to capture the extent of the impact of social inequalities on the health of immigrant communities (Olcón & Gulbas, 2020; Viruell-Fuentes et al., 2012). Various conceptualizations have been put forth to describe more collective experiences of trauma, such as *historical trauma* (Heart, 1999) and *soul wound* (Duran et al., 1998) used to describe the trauma experienced by Indigenous
Peoples of the Americas through colonization; *posttraumatic slave syndrome* (Degruy-Leary, 2017) used to describe the experiences of those whose African ancestors were enslaved through chattel slavery; and *complex posttraumatic disorder* (C-PTSD) used to describe prolonged and repeated trauma (Herman, 2015). Similarly, Palestinian clinicians and researchers posit that the experiences of trauma among Palestinian communities need to be understood within the context of the effects of ongoing settler colonialism – that there is no *post* to the trauma response and, thus, PTSD is ill-fitting a diagnosis (Sheehi & Crane, 2021).

As the trauma experiences of LatAm immigrant communities may be different than those captured by the available diagnoses, the subsequent STRs that LatAm immigrant therapists experience may also be different. It is a truism that trauma exists and that its effects reach far and wide, impacting more than just the direct victim (Pearlman & Saakvitne, 1995). Likewise, secondary traumatization affects more than just the therapists that work with traumatized communities, it affects the organizations and communities they inhabit (Herman, 2015). Understanding *how* secondary traumatization manifests and is experienced by different communities, particularly LatAm immigrant communities, is an area ripe for investigation.

**Summary of Chapter 2: Literature Review**

The research on the impact of being an immigrant on the therapy process has primarily focused on the clients’ experiences, not the providers who work with them. The limited literature that has focused on the therapists’ experiences shows that foreignness is a risk factor for professional efficacy and well-being due to experiences of xenophobia with clients and supervisors. Understandings of being an immigrant therapist have come from research regarding other identity positionalities (e.g., race and ethnicity), which have shown that immigrant therapists might have to monitor for transferential material related to their ethnic, linguistic, and cultural backgrounds. In other words, the immigration experience has not been systematically studied as a contextual factor that interacts with other identities. Writings regarding immigration as context have come from personal accounts highlighting that therapists
often manage themes of alienation, loss, and mourning related to their migration. Some potential benefits of being an immigrant therapist include developing a cultural meta-perspective due to navigating two cultures, which can increase the therapist's ability to connect to their clients. It can also be challenging because one might over-identify with clients' material, leading to potential implicit biases and colluding transferential dynamics. Because the body of literature on immigrant therapists regards immigrants in general, not LatAm immigrants specifically, I also looked at LatAm therapists' experiences, regardless of migration background. The research on LatAm therapists has covered bilingualism and biculturalism in therapy and how LatAm cultural values impact therapy. Studies focusing specifically on LatAm therapists' experiences show a shortage of LatAm Spanish-speaking therapists to meet the high volume of LatAm Spanish-speaking clients. As a result, they are often tasked with performing additional roles (e.g., language and cultural brokering), having higher caseloads, educating others about diversity issues, are under-compensated, feel isolated, and experience inadequate supervision.

Professionals who work with traumatized clients are at risk of experiencing secondary trauma. Decades of research on indirect exposure to trauma have yielded a variety of conceptualizations that describe the pervasive impact of caring for those who experience trauma. The STRs encompass trauma exposure's detrimental and beneficial effects on the therapist and capture the cognitive, behavioral, emotional, and symptomatologic consequences of working with traumatized people in high-stress environments. While the research scholarship on the impacts of doing trauma work is extensive, no studies have examined STRs among LatAm immigrant therapists, specifically those who work with immigrant clients. However, five studies focus on therapists working with LatAm immigrants (particularly at the Mexico-United States border) though the therapist participants are not necessarily immigrants or from Latin America. Findings from these studies identified themes of burnout related to structural barriers, intrusive thoughts, trouble sleeping and concentrating, and more than half reported at least occasionally feeling emotional numbness and irritability. Participants reported that their
experiences were difficult, tragic, and overwhelming. They also reported positive reactions related to their work, such as feeling happy having chosen the career they did, gaining satisfaction from helping people, feeling proud of their work, finding the work rewarding, and being impressed by their clients' resiliency and strength. For the participants that happened to be LatAm, culture has been identified as a protective factor, with all participants reporting on themes of familism, collectivism, religiosity, and faith. These findings were echoed in two recent dissertation studies with therapists who work with unaccompanied children at the border.

Research on migration trauma has been consistent with theories of stress proliferation that show that exposure to trauma at an earlier migration phase (e.g., during pre-migration) predicted trauma at later phases (e.g., post-migration). Migration trauma is often multilayered and ongoing, including trauma at various phases. Traumatic events, such as those experienced in the pre-, peri-, and post-migration phases, are associated with a higher risk for deleterious mental health effects, such as depression, anxiety, somatic complaints, sleep difficulties, hypervigilance, substance use, hopelessness, and symptoms of PTSD. While LatAm immigrants experience high levels of psychological distress associated with migration, studies show that they are not likely to seek the help of mental health professionals. This may be due to long waitlists in mental health settings, eligibility requirements for receiving services, the stigma associated with experiencing emotional and psychological issues, and the stigma of discussing such issues outside the home.

Many factors have been studied concerning STRs, such as gender, age, training, caseloads, and supervision. Of particular interest to the current study are factors related to the therapist's personal trauma history and shared trauma context. Regarding the therapist's personal trauma history, findings are mixed and depend on the STR concept utilized. Similarly, with the positive STRs, some studies have found that a personal trauma history correlated with increased compassion satisfaction, though this has not been corroborated. So, while the results are mixed regarding the impact of the therapist's personal trauma on secondary traumatization,
according to stress-proliferation theory, having experienced trauma increases the likelihood of further traumatization. Thus, it is likely that if a therapist has experienced trauma, they are at increased risk for adverse effects from indirect trauma exposure.
Chapter 3. Methods

In this chapter, I review the methodology for this dissertation study, the rationale for employing qualitative methods and interpretative phenomenological analysis specifically, as well as my reflexivity statement. I continue the chapter with a review of ethical considerations to protect the participants and ensure their confidentiality and the procedures employed to recruit participants and collect the data. The chapter concludes by explaining my data analysis process, utilizing the IPA steps for individual and cross-case analysis.

Methodology

The rationale for qualitative methods

Qualitative research methods are employed when variables regarding a particular issue are not measured easily, when a dearth of information requires further exploration, or when voices that are usually silenced need to be amplified (Creswell & Poth, 2016). The proposed study falls into all three of these criteria as highlighted in the review of the literature:

1. There are few studies concerning the experiences of therapists who work with LatAm immigrant populations and none of therapists who are LatAm immigrants themselves.
2. Studies examining STRs have been inconsistent in operationalizing concepts and have confounded STRs, utilizing instruments for one concept to measure another.
3. As trauma responses may manifest differently in LatAm populations, so might the manifestations of STRs in LatAm immigrant therapists, and thus the current literature, comprised of primarily white therapists, may not adequately capture these experiences.
4. Similar to the communities they work with, immigrant LatAm therapists are marginalized in society and underrepresented in research efforts, particularly those concerning STRs.

For these reasons, qualitative methods were selected to address the research purpose of learning of the experiences of immigrant LatAm therapists working with immigrant LatAm populations. A qualitative approach allowed this researcher to gain an in-depth understanding of the effects of working with populations exposed to traumatic migratory experiences, particularly
when the therapist shares a similar background to their clients. A solely quantitative approach would not have adequately captured the complexities of such experiences. Additionally, qualitative research is compatible with interactional styles found among LatAm communities, such as testimonios (testimonies), dichos (folk sayings), refranes (proverbs), and cuentos (stories; Delgado-Romero et al., 2018). By engaging the LatAm immigrant therapists via interactional styles they already use, I tried to facilitate a rich sharing of experiences.

**The rationale for interpretative phenomenological analysis**

Interpretative phenomenological analysis (IPA) is utilized when researchers are looking to gain an in-depth understanding of how people experience a certain phenomenon. The researcher chose IPA for several reasons, including flexibility that allows for creativity and exploration in the interview and analysis process, and for its complementary fit with psychological paradigms such as cognitive and constructivist traditions (Larkin et al., 2006; Smith, 2017). IPA is based on three theoretical orientations: phenomenology, hermeneutics, and idiography. The first theoretical basis of IPA, phenomenology, is concerned with the unique aspects of a certain phenomenon that make it distinguishable from others (Smith et al., 2009). Phenomenology is concerned with how people perceive a phenomenon instead of how a phenomenon is described theoretically or categorically (Pietkiewicz & Smith, 2014).

The second theoretical basis of IPA, hermeneutics, takes phenomenology into the existential realm. Beyond merely perceiving and describing experiences outside of already-established concepts, the participants are prompted to describe how they make sense of their experiences (the phenomenon) (Larkin et al., 2006). Thus, the IPA researcher strives to understand what it means to that person to have experienced the phenomenon. Furthermore, the analytic process of IPA employs a double hermeneutic approach in which the researcher’s perspective shapes the interpretation of a phenomenon: “as [the interpretation] interacts with the phenomenon in question, [it] is open to revision and elaboration, as the perspective and
understanding of the interpreter, [their] biases and blind spots, are revealed and evaluated” (Tappan, 1997, p. 651).

The third theoretical basis of IPA, idiography, concerns the singular and particular rather than the general. The idiographic aim of IPA is to provide an in-depth exploration of each participant’s experience. When a study consists of multiple participants, the idiographic approach is to analyze each case in detail, applying the same attentive exploration to each one (Smith et al., 2009). This in-depth exploration of each case allows for the later comparison of experiences, understanding the ways the experiences converge and diverge, extrapolating themes, and seeing how each person experiences the phenomenon for themselves (Pietkiewicz & Smith, 2014; Smith et al., 2009). Such in-depth insight into how immigrant LatAm therapists experience their work with immigrant LatAm populations could have important implications at the clinical, training, and supervisorial levels and contribute to the understanding of trauma manifestations as they relate to LatAm communities, potentially informing intervention, and supportive practices.

**Researcher reflexivity statement**

Grounded in an IPA approach, it is critical for the researcher to examine their positionality vis-à-vis the participants and the phenomenon itself (Creswell & Poth, 2016; Ponterotto, 2005). Because IPA operates from the standpoint that "interpretations are [...] bounded by the participants’ abilities to articulate their thoughts and experiences adequately, [as well as] by the researcher's ability to reflect and analyse," (Brocki & Wearden, 2006, p. 88) the researcher's own lived experiences, identities, background, and biases, are meant to influence the research findings while maintaining the integrity of the participants' accounts (Alase, 2017). Thus, the essence of IPA is the utilization of the researcher's interpretative abilities in the analysis portion of the research; however, during the data collection portion, the researcher must strive to mitigate the influence of their perspectives to empower the participants to express themselves and "make their claims on their own terms" (Smith et al., 2009, p. 42).
achieve this, the researcher must utilize a bracketing technique to set aside their preconceptions and return to the bracketed material afterward for reflection (Smith et al., 2009). IPA also necessitates the researcher to engage in a cyclical reflective practice to make sense of the bracketed information and any reactions from the various research stages (Shinebourne, 2011).

To position myself in relation to the current study, I assert that the inspiration for this dissertation arose from my personal experience as an immigrant from Central America to the United States. My clinical work with LatAm immigrant clients, who discussed trauma material from pre-, peri- and post-migration experiences, led to my interest in the topic. I found myself having strong reactions to specific migration stories similar to my own and those of people in my life. I experience similar STRs and often feel frustrated at the lack of resources, long waitlists, and continued anti-immigrant rhetoric and policies that target my clients and my community. My interest in the topic solidified when hearing how other LatAm immigrant therapists described their experiences in informal conversations - mainly in the breakroom! Time and again, these stories spoke about the impact the work had on them and how their experiences might differ from those of non-LatAm and non-immigrant therapists.

As I am part of the study population, I needed to remain aware of the possible implications that sharing identities and backgrounds creates, such as the possibility of conflating my experiences with the participants. I reflected on my identities as they related to this study and positioned myself in the areas where I hold privilege (e.g., access to higher education, light-skinned) and experience oppression (e.g., immigrant, from low SES). To engage the work with integrity and accountability, I utilized the bracketing technique through journaling and speaking to colleagues, my dissertation chair, and my therapist. In this way, I attempted to set aside my biases and preconceptions to allow the participants to share their stories freely. I also engaged in a cyclical reflection practice throughout the project by making art when trying to process the experience and centering myself by recalling my research questions and the study's goal. I
found all of these strategies necessary to ground the project on the experiences of the eight LatAm immigrant therapist participants while living as a LatAm immigrant therapist myself.

**Procedures**

**Sampling**

As IPA calls for depth over breadth to elicit a “full appreciation [of] each participant’s account” (Pietkiewicz & Smith, 2014, p. 9), the focus was to examine a phenomenon rather than producing a theory that will generalize to the entire population. Thus, I recruited and interviewed a small sample of eight participants. In order to participate in this study, the participants had to 1) have immigrated to the United States from a Latin American country and 2) work providing psychotherapy to LatAm immigrant communities.

**Recruitment**

Following IPA’s idiographic aim to provide rich accounts of participants’ experiences of a phenomenon, I recruited a small and relatively homogenous sample of people for whom the phenomenon in question is relevant and significant (Pietkiewicz & Smith, 2014). I employed purposive and convenience methods to recruit such a sample and posted in the National Latinx Psychological Association (NLPA) listserv. One of the responses to that initial recruitment call was an invitation to post the flyer on a closed Facebook group page for Latinx therapists. I recruited five participants in this first round. Three months later, I posted to the listserv again to recruit the last three participants. In total, there were twelve respondents, three did not meet the eligibility criteria, and the fourth did not respond to the follow-up email. The listserv post contained the flyer and the study letter (see Appendix B), and the closed group post contained only the flyer due to the platform format. People who were interested in the study were prompted to click on the embedded link that led to a Google Form with the eligibility questions:

1. Are you an immigrant from Latin America?
2. Do you work providing psychotherapy to Latin American immigrants?
3. Do you hold at least a master’s degree in psychology or a related field (e.g., MFT, MSW, PsyD, PhD)?

The respondents were given further information about the study’s aims, procedures, and any benefits and risks they could incur (see Appendix A). The questions in the Google Form were determined using branching so that only participants who answered affirmatively to the eligibility questions above continued to the informed consent and demographic questionnaire. There was also an opportunity to ask questions before signing the informed consent and the demographic questionnaire. One participant utilized this question function to ask whether they would qualify if their primary focus now is conducting immigration evaluations rather than therapy. The respondents who signed the informed consent and demographic questionnaire gave their availability for scheduling purposes. I then contacted them to offer interviews based on the days and times they indicated. I proceeded to schedule the 60 to 90-minute interview and sent the Zoom link via email. I also sent them reminders via email the day before the interview.

**Informed consent**

At the beginning of the interview, I reviewed the nature of the study and the interview timeframe and asked the participants if they had any questions. I also reminded them that I would record the interview and could stop the recording at any time at their request. Additionally, I reminded them that they could withdraw from the study at any time. Then, I confirmed their consent to proceed and began the interview. Immediately after the interview, I emailed them a copy of the informed consent (Appendix A) and a note that they would receive the e-gift card soon. The email asked them to confirm receipt of both items, and all eight participants responded affirmatively.

**Data collection**

I collected demographic information (see Appendix C) to describe the participants and provide context for their accounts. I also recorded field notes of my observations to adhere to IPA’s hermeneutic stance of making meaning from the interaction between researcher and...
participant (for example, see Appendix D). In these field notes, I captured the feel of the interview and other non-verbal information that may not be obvious from the transcript alone (e.g., if participants appeared hesitant, ashamed, or excited). These interviews, along with the field notes, were audio-recorded with a digital recorder, and transcribed by a confidential transcription service.

**Protection of the participants**

This study involved minimal risks to the participants' psychological well-being. While some of the interview guide questions evoked distressing emotions due to the nature of the subject matter, I did not ask the participants to recount traumatic events. Nevertheless, to help manage any distressing emotions that may have come up, I informed the participants before the interview that the questions may cause distress and that we could pause the interview for a break as needed or stop altogether. Additionally, the researcher did not ask about sensitive topics, such as authorization status. Participation in this research study was voluntary and the participants were allowed to withdraw at any time during the process. None of the participants withdrew. Lastly, I offered to provide them with resources as needed.

**Confidentiality**

Confidentiality measures consisted of de-identifying the transcriptions, utilizing pseudonyms, and protecting documents with passwords for safekeeping. Furthermore, I will destroy all audio recordings of the interviews and field notes upon the completion of the dissertation defense.

**Interview Guide**

IPA calls for an open and flexible interview approach to encourage rich, narrative, and expansive responses (Pietkiewicz & Smith, 2014). For this reason, the interview guide (Appendix C) consisted of open-ended questions and a semi-structured approach. The open-ended questions allowed the participants to share their experiences as freely as possible. The
semi-structured approach allowed the interview to flow to new discussion areas, following the participants’ lead (Smith et al., 2009).

**Data Analysis**

I started the analysis by listening to the audio the day after each interview while I waited for the transcribed files. I began by listening to the field notes to re-contextualize the atmosphere of the interview, followed by listening to the interview itself to immerse myself in the data and "try to step into the participants' shoes as far as possible" – an essential step in IPA (Pietkiewicz & Smith, 2014, p. 11). This step helped me acquire a holistic understanding of each interview. Once I received the transcript, I read through it while listening to the audio to ensure accuracy. This step was especially crucial in the segments of the interview when the participants switched to Spanish because the transcription service did not capture those accurately. This line-by-line reading helped cement the interview structure in my mind and allowed me to identify where richer data exists (Smith et al., 2009). The meticulous line-by-line reading also helped me immerse into the participant's account to make it the focal point of the analysis. After this careful review ensuring the transcripts were accurate, I uploaded them to ATLAS.ti, a qualitative data analysis software.

**Single-case analysis.** After all the interviews were transcribed, reviewed for accuracy, and uploaded to the software, I began the IPA steps for single-case analysis. IPA's idiographic approach is to analyze one interview at a time. I have included examples of the various IPA steps in Appendix D.

*Step one: Reading and exploratory notes.* I began by listening to the recording again while reading the transcripts, highlighting, and commenting on words and phrases that stood out to me using the ATLAS.ti software (see p. 198). Based on the most recent iteration of the IPA process (Smith & Nizza, 2021), the first step consists of a slow and in-depth reading of the interview, staying close to the participant's words, and reflecting on them. The primary aim of this step is to look for potential meanings, not to gain an ultimate understanding of the
participant's experience. As IPA involves exploring the participants and the researcher’s sense-making, the analysis consists of moving between the subject's perspective to the perspective of the observer (Smith et al., 2009). Taking the observer's perspective entails looking at the data via a psychological lens and applying psychological theories and concepts to shed light on the phenomenon (Pietkiewicz & Smith, 2014). To balance this out and avoid psychological reductionism, the researcher also analyzes from the subject's perspective, which entails attempting to see the world as they do (Pietkiewicz & Smith, 2014). With this goal in mind, I took descriptive and exploratory notes guided by the following questions, which I formulated based on the principles outlined by Smith and Nizza (2021):

1. What are the motivations behind the choice of words?
2. What do these words mean to the participant?
3. What things matter to the participant? (e.g., objects, events, experiences, processes, locations, principles, relationships, values)
   a. What is the meaning of these to the participant?
   b. What are these important things like for the participant?
4. What is being assumed?
5. What is being emphasized?
7. What are the different meanings that this can take?
8. What is the participant's standpoint?
9. What is their context? Their lived world?
10. What does this mean to me (the researcher)?
11. What was expected? What was unexpected?

Step two: Formulating experiential statements. The next step entailed transforming the initial descriptive and exploratory notes into experiential statements. Whereas the focus of the initial step was a line-by-line analysis of the data, the second step consisted of reviewing the
notes. In other words, the notes became the focal point of the analysis. The idea is that if the researcher stays close to the data in the initial stage, the notes should reflect the source material well (Pietkiewicz & Smith, 2014). To develop experiential statements from the notes, I aimed to create concise phrases that captured the essence of what was said more abstractly or conceptually. At this stage, the goal is to reduce the volume of detail while maintaining the complexity of the experiences, considering how they relate, and identifying patterns in the notes (Smith et al., 2009). The experiential statements reflect both the participant's words and the researcher's interpretation—the double hermeneutic characteristic of IPA. I formulated the following questions to guide myself in this step of the process:

1. What have I learned about the participant's experience?
2. Which aspect of the experience should be brought forward?
3. What are the relationships between exploratory notes?
4. How do the exploratory notes connect?
5. What patterns do I see?
6. What is the claim I am making about the meaning of the participant's experience?
7. What psychological processes are present?
8. What is the context of that psychological process?

Moving from the descriptive to the conceptual, I attempted to interrogate the text with these questions to open up various provisional meanings of what was being said (Smith et al., 2009). The guidance is that the experiential statements must be "dense and rich – pointing to both the important psychological process and the context or content of that process being invoked by the participant's response" to capture what we have learned about the meaning of the experience for the participant (Smith & Nizza, 2021, p. 39). As I developed experiential statements, I color-coded them based on their purpose in the analysis. For example, if the experiential statement was answering a specific question or depending on the emotional valence of the experience.
Step three: Finding connections and clustering experiential statements. The analysis continued with looking for connections between the experiential statements and identifying a structure that could bring them together (Smith & Nizza, 2021). The main goal of this step is to see more clearly the aspects of the participant's experience and how they made sense of it.

There are many ways to identify patterns and synthesize experiential statements, such as:

➢ Abstraction: grouping themes into a larger category consisting of like-with-like themes;
➢ Subsumption: similar to abstraction, but in this case, individual themes become the larger category;
➢ Polarization: grouping themes by their oppositional relationships;
➢ Contextualization: grouping themes according to temporal, cultural, or narrative threads;
➢ Numeration: clustering the themes based on the frequency in which they emerged; and
➢ Function: grouping themes based on the function they serve in the interview.

These grouping strategies are not mutually exclusive, so I combined them as needed to answer the research questions. For example, to get a jumpstart, I utilized abstraction and subsumption to identify the beginnings of a group. When I had a cluster of experiential statements, I color-coded them to keep track. Over time, I moved the experiential statements around to other clusters when the other grouping strategies (e.g., function, contextualization) helped me to better understand the participant's experience. For example, I utilized polarization to compare and contrast an experience, which led to a richer conceptualization of the experience.

Step four: Compiling the table of personal experiential themes. Once I established such connections between the experiential statements, the fourth step entailed creating a graphic representation of how they fit together to see the gestalt of the interview (Smith et al., 2009). I did this via a table of personal experiential themes (PETs) meant to express how the clusters converge and relate to each other. I utilized a table in Word to compile the various PETs (see p. 200). At this stage, I refined the PETs further by combining them when there were redundancies
or repetitions (Smith & Nizza, 2021). For example, I merged several PETs that served the same analytic function, chose the ones that better captured the essence of the interview, or took out those that were not contributing to the analysis. Lastly, I recolor-coded the various PETs to get a glance at the extent of the themes and see which were particularly prominent for the participant.

Once I completed these four steps for a single interview, I moved to the following interview and repeated the process. The guidance is that the researcher must treat all subsequent interviews as free-standing so that previous interviews do not influence the analytic process. While this may be inevitable in totality, there were steps that I took to reduce the effects of influence. For example, I bracketed the ideas that emerged from each interview and took time between analyzing the interviews to create distance between them. Once I completed all four steps for each interview and created a PET table for each participant, the analysis moved to the cross-case stage.

**Cross-case analysis.** I started the cross-case analysis by reviewing all of the PET tables, reordering, and recolor-coding the personal experiential statements to make the comparison process more manageable (step 1). After reviewing and reorganizing them, I printed all of the PET tables and positioned them on a flat surface for an at-a-glance feel of the data (see example on p. 201). This step aims to identify where there are differences and similarities, and overall connections among the participants (step 2). Because of the idiographic and inductive IPA approach, the individual PET tables often had different structures and wording (Smith & Nizza, 2021). It was not until reviewing them all together that it became apparent which ones regarded similar concepts with different words or how the themes showed up in different analytic orders (e.g., a concept that was an experiential statement for one participant, was a theme for another). The purpose is to develop group experiential themes (GETs; step 3). I utilized the following questions (derived from Smith et al., 2009; Smith & Nizza, 2021) to develop the GETs:

1. What are the connections between these themes across cases?
2. Which themes applied to all the cases?
3. Which ones were more idiosyncratic?
4. How does a theme from one case illuminate a different case?
5. What are the key aspects that explain what the phenomenon is like for the participants?

Engaging in this process gave way to a push-and-pull experience in which I tried to identify what was shared among the participants while honoring what was unique to each one. This process is grounded in IPA's theoretical underpinning of idiography, which seeks to find commonality in unique human experiences despite, and indeed because of, the range in variability. The tension between honoring the idiosyncratic and witnessing the shared experiences made way to several GETs. At the end of the cross-case analytic process, I created tables of the GETs (step 4). Additionally, I utilized various art forms (e.g., poems and traditional and digital mixed media) throughout the entirety of the analysis to think through and process the participants' experiences (see Appendix D).

Lastly, qualitative research methods, and IPA specifically, engage in iterative processes throughout the data collection, analysis, and writing process. Thus, while the PET and GET tables were finalized at the various points of the analysis to make way for the next steps, my understanding and interpretation of the participants' experiences and subsequent conceptualizations of the GETs and subthemes continued to evolve throughout. Thus, while I presented the analysis stepwise, it was anything but linear (as thinking processes often are). The analysis was slow, frustrating, and evolved in ways I could not have predicted. The analysis happened when I was actively working on it at my desk and in the in-between moments when life was happening. Therefore, capturing the process as it happened was a challenge and may still not thoroughly represent how it developed, despite the copious notes I took. The ongoing engagement with the data, re-listening to interviews, conversations with colleagues and
dissertation chair, reading the literature, and simply sitting with all I learned, all influenced the iterative process. In the next chapter, I present the results of this project.
Chapter 4. Results

This chapter includes an overview of the participant demographics, age of migration, and general location for contextual purposes. Table 1 follows with information regarding the participants’ education, years of experience, populations worked with, percentage of caseload consisting of LatAm immigrant traumatized clients, treatment modalities, and theoretical orientation. Next, Table 2 gives an overview of the themes and a breakdown of how many participants endorsed each theme. The chapter ends with an in-depth exploration of the themes with illustrative excerpts from the interviews.

The Participants

The participants in this study were eight LatAm immigrant therapists who worked with LatAm immigrant clients across the United States. I recruited them via two emails sent to the listserv for the National Latinx Psychological Association (NLPA) and by posting the flyer on a closed Facebook group for Latinx therapists, as suggested by a respondent of the NLPA listserv email. The participants’ ages ranged from 25 to 75 years old. They held educational degrees at the master’s and doctorate levels in psychology, counseling, and social work. At the time of the interviews, the participants worked in community mental health, private practice, and school counseling. Their years of experience providing therapy to LatAm immigrants ranged from 2 to 50 years. All eight participants reported that they utilize Spanish and English in their work. In this study, the participants chose their own pseudonyms. Consequently, there is variability among them, with some numerical, nominal, and alphanumeric names. The eight participants are described below and listed in the order in which the interviews took place.

❖ RR96 (she/her pronouns) is a 25-year-old Mestiza cisgender female psychologist trainee. She immigrated to the U.S. when she was 18 years of age as an international student. At the time of the interview, she was located in the South Atlantic region of the U.S.
❖ Paciencia (they/them pronouns) is a 38-year-old mixed race genderqueer psychologist. They immigrated to the U.S. at age 21. At the time of the interview, they were located in the West region of the U.S.

❖ Bovi (he/him pronouns) is a 34-year-old Afro-Latino cisgender male psychologist. He immigrated to the U.S. at age 13. At the time of the interview, he was located in the West Mountain region of the U.S.

❖ Maria (she/her pronouns) is a 35-year-old Latina cisgender female mental health counselor. She immigrated to the U.S. at age 24 with a work visa. At the time of the interview, she was located in the South region of the U.S.

❖ Faholo (she/her pronouns) is a 51-year-old Latina cisgender female social worker. She immigrated to the U.S. at age 35. At the time of the interview, she was located in the Midwest region of the U.S.

❖ Mexicana (she/her pronouns) is a 61-year-old Latina cisgender female psychologist. She immigrated to the U.S. at age 24 with a student visa. At the time of the interview, she was located in the Midwest region of the U.S.

❖ Dr. Luz (she/her pronouns) is a 75-year-old Hispanic cisgender female psychologist. She immigrated to the U.S. at ages 7, 15, and 25. At the time of the interview, she was located in the West Coast region of the U.S.

❖ 503 (he/him pronouns) is a 38-year-old Latinx cisgender male licensed counselor. He immigrated to the U.S. at age 8. At the time of the interview, he was located in the South region of the U.S.
Table 1 Participant information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Degree</th>
<th>Years of experience with LatAm immigrants</th>
<th>% Of caseload consisting of LatAm immigrant traumatized clients</th>
<th>Client populations worked with</th>
<th>Treatment modalities provided</th>
<th>Theoretical orientations</th>
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</thead>
<tbody>
<tr>
<td>RR96</td>
<td>MS¹ and pursuing PsyD²</td>
<td>2</td>
<td>75%</td>
<td>OA,³ adults, adolescents</td>
<td>Individual, group, couples</td>
<td>Integrative, CBT⁴</td>
</tr>
<tr>
<td>Paciencia</td>
<td>PhD⁵</td>
<td>10+</td>
<td>75%</td>
<td>Adults, adolescents</td>
<td>Individual, group, family, couples</td>
<td>Integrative, CBT, psychodydynamic, transpersonal</td>
</tr>
<tr>
<td>Bovi</td>
<td>PhD</td>
<td>16</td>
<td>100%</td>
<td>OA, adults, adolescents, children</td>
<td>Individual, group, family, couples</td>
<td>Trauma-focused CBT/IPT⁶/AC T⁷ ecological model and multicultural feminist theory</td>
</tr>
<tr>
<td>Maria</td>
<td>MS</td>
<td>9</td>
<td>75%</td>
<td>Adolescents</td>
<td>Individual, family</td>
<td>CBT, humanistic</td>
</tr>
<tr>
<td>Faholo</td>
<td>MSW⁸</td>
<td>17</td>
<td>75%</td>
<td>OA, adults, adolescents, children</td>
<td>Individual, group, family</td>
<td>Integrative, psychodynamic</td>
</tr>
<tr>
<td>Mexicana</td>
<td>PhD</td>
<td>25</td>
<td>75%</td>
<td>Adults</td>
<td>Individual</td>
<td>CBT</td>
</tr>
<tr>
<td>Dr. Luz</td>
<td>PsyD</td>
<td>50</td>
<td>100%</td>
<td>OA, adults, adolescents, children</td>
<td>Forensic evaluations</td>
<td>Psychodyynamic</td>
</tr>
<tr>
<td>503</td>
<td>MS</td>
<td>5+</td>
<td>75%</td>
<td>Adults, adolescents, children</td>
<td>Individual, group, family, couples</td>
<td>CBT, psychodynamic, person-centered</td>
</tr>
</tbody>
</table>

¹ Master of Science  
² Doctor of Psychology  
³ Older adults  
⁴ Cognitive-Behavioral Therapy  
⁵ Doctor of Philosophy  
⁶ Interpersonal Psychotherapy  
⁷ Acceptance and Commitment Therapy  
⁸ Master of Social Work
<table>
<thead>
<tr>
<th>Domains</th>
<th>Group Experiential Themes</th>
<th># Of Participants who endorsed the theme</th>
</tr>
</thead>
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<td>1. LatAm Immigrant Therapist-Client Relationship</td>
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<td></td>
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<tr>
<td>1A) Dynamics of Connection and Overidentification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Faster, easier, and deeper therapeutic engagement</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>b) Navigating more permeable boundaries</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>1B) Duty as Cultural Liaisons Contributes to De-Stigmatization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Working with a trauma-aware approach</td>
<td>7</td>
<td></td>
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<tr>
<td>b) Being “the only one” leads to sense of obligation</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. Experiences of Secondary Trauma Responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A) The toll of the work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Experiencing mixed emotions</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>b) Taking the work home</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>c) Own trauma becomes triggered</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2B) Opportunities for redemption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Recognizing their strengths</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b) Healing own trauma</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3. Factors that Impact the LatAm Immigrant Therapists’ Experience</td>
<td></td>
<td></td>
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<tr>
<td>3A) Risk Factors</td>
<td></td>
<td></td>
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<tr>
<td>a) Micro-level risk factors</td>
<td></td>
<td></td>
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<tr>
<td>(i) High exposure to trauma content</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>(ii) The therapist’s disposition</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b) Mezzo-level risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Shortage of Spanish speaking therapists</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>(ii) Lack of appropriate resources</td>
<td>5</td>
<td></td>
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<tr>
<td>(iii) Lack of supervision support in agencies</td>
<td>4</td>
<td></td>
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<tr>
<td>c) Macro-level risk factors</td>
<td></td>
<td></td>
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<tr>
<td>(i) Low pay and limited job opportunities</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>(ii) Lack of training</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>(iii) Microaggressions</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3B) Protective Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Grounding in sense of purpose</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b) Leveraging resourcefulness</td>
<td>5</td>
<td></td>
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<tr>
<td>3C) Mitigating Factors</td>
<td></td>
<td></td>
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<tr>
<td>a) Developing a protective membrane</td>
<td>8</td>
<td></td>
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<tr>
<td>b) Embracing practices of care</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>c) Bringing others in by venting things out</td>
<td>5</td>
<td></td>
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<tr>
<td>3D) Sustaining Factors</td>
<td></td>
<td></td>
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<tr>
<td>a) Feeling empowered</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>b) Witnessing clients’ small victories</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>c) Contributing to changing the system</td>
<td>4</td>
<td></td>
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</tbody>
</table>
Domain 1. LatAm Immigrant Therapist-Client Relationship

This domain captures the participants’ perspectives regarding mental health service provision to LatAm immigrant clients with a particular focus on the LatAm immigrant therapist and client relationship. All of the participants expressed that the work was simultaneously challenging and rewarding. More specifically, in response to the questions about how their immigration experience and shared ethnic backgrounds affect their work with LatAm immigrants (RQ4 and prompts), the participants spoke of the duality of how having shared lived experiences (e.g., having migrated) and identities (e.g., being from Latin America) both facilitated and created challenges in the therapeutic relationship. Their experiences are captured in two group experiential themes: 1A) Dynamics of connection and overidentification and 1B) Duty as Cultural Liaisons Contribute to De-stigmatization.

Group Experiential Theme 1A) Dynamics of Connection and Overidentification

All eight participants talked about the relational dynamics that arise when working with LatAm immigrants. They shared how being immigrants from Latin America was facilitative to therapeutic treatment because it created a deeper connection with their clients and made therapeutic engagement occur faster and more effortlessly. The participants also reflected on how the same factors that facilitated treatment also created challenges because the high relatability could lead to overidentification. Overidentification was seen as a challenge because it necessitated navigation of more permeable boundaries.

a) Faster, easier, and deeper therapeutic engagement. Seven of the eight participants talked about the notion of having a deeper connection with their clients because of their shared migration background. In the words of Maria:

“There’s that deep understanding of “I get it” ... When I tell [the clients] “I immigrated as an adult, I understand that this can be hard,” it’s kind of like relief. So, I don’t think I could have achieved that kind of connection if I hadn’t immigrated. So, it’s a different, understanding, a different experience. Only the people that immigrated know how pain in
the ass it is, ... because they have lived it in their bones ... I don't think that unspoken understanding would happen if I weren’t an immigrant ... Clients can tell when you deeply understand something. (Maria)

Similarly, RR96 reflected that she “probably [would] not have that insight enough to care as much as I do right now ... I probably would not feel those emotions, or maybe not as deep as I do now if I wasn’t an immigrant myself.” Mexicana shared that, for her, there was a strong connection despite having entered the U.S. with a student visa, unlike many of her clients:

Well, maybe because even though I might have come by plane and I was not having financial struggles, ... there still is separation from the family, there still is separation from your culture, from your language, from your food. And that’s where I felt that I relate. So, I think that helped me connect with them at a level that ... to relate to them, to be more understanding about how difficult it can be here ... So definitely for them it was much better to work directly with a bilingual therapist than to work with interpreters. So that is definitely an advantage from their point of view and a privilege for us to be able to connect using not only our language but also our culture. (Mexicana)

So, while the mode of migration was different from those of her clients, Mexicana identified that the point of connection was their shared language and culture, which made engagement more effortless. She also brought forth a prominent sentiment among the participants – that of reciprocity from having such shared experiences. Mexicana described the reciprocity of connecting via language and culture as an advantage for the clients and a privilege for the therapist. Maria also mentioned this sense of reciprocity between her and her clients, commenting on their agreement that the relationship is easier and more enjoyable:

I love the fact that we can connect and that they feel very comfortable ... I don’t need a lot of extra information that they usually have to give to other people. So, we kind of understand each other in a different level and I can understand the sayings, I understand the words, I understand the culture, I understand like all the expressions, I understand
how they grew up. I know where they’re coming from. So, it’s this understanding that people enjoy, I enjoy as well, and I really want people to thrive … because they’re here with a lot of effort and it’s hard … If I can help, yes, I love it. (Maria)

In addition to the impact of their migration backgrounds, the participants reflected on how their ethnic background, and specifically their shared language, not only deepened the connection but also expedited the treatment. For example, Faholo explained that some of her characteristics (e.g., her appearance and accent) make it apparent to her clients that she is an immigrant, whether she verbally discloses the information or not. She explained that these unintended disclosures allowed her to “avoid the introductory part [in a way that her clients] don’t have to do a lot of explanation” (Faholo) because there was unspoken understanding.

Similarly, Bovi spoke about the verbal and nonverbal disclosures that facilitated treatment:

I think it’s an incredible tool, … an incredible bridge or point of connection when you’re trying to do immigrant work. It’s hard to … explain to someone what it’s like to be undocumented or … What it’s like to have a hidden identity … So, in some ways it’s a blessing … I can say I’m originally from somewhere else and I also lived an undocumented life for a long time … I can understand the hesitancy that might come with that … just naming it creates comfort and I’m able to start working a little bit faster than if I was a white psychologist. … When I work with Spanish speaking Latino folks, we already started a couple steps ahead, right? They’re able to see across the screen and they see my brown skin … and automatically there’s a connection. (Bovi)

b) Navigating more permeable boundaries. While the participants remarked on the ease of connection and ability to expedite treatment, five of the eight participants also described instances where having shared backgrounds caused challenges to the therapeutic treatment because it led to overidentification. RR96 shared an instance in which she perceived a client as being too comfortable, which led her to engage with RR96 more as a friend than a therapist:
Sometimes [clients] were too comfortable ... I practice CBT, and they would not do their homework assignments. They would just be like “oh, you know how it is” ... So, it kind of became an issue, the fact that they ... felt too comfortable with me and did not feel like they were going to be held accountable in session, or ... like they were just here to chat with a friend. So that’s when I actually started talking to my supervisor and [she] told me you have to make it very clear that you are a therapist, and you are not a friend. (RR96)

Bovi shared how he has to hold back his reactions because what his clients share might be similar to his own experience, and he does not want to impose his reactions onto the clients:

Sometimes, it can be difficult. I think that there is a lot of people that carry a lot of shame with being an immigrant or being undocumented. I think there’s a lot of pain with even saying, “I’m an illegal,” right? And then my response immediately being like “ah, don’t call yourself that!” [and having] to pull back my own reactions because of some of the work that I’ve had to do in relation to my immigrant identity. (Bovi)

Faholo identified that because the therapeutic engagement is more effortless, she has to be more careful not to disclose her own immigration trauma:

For me, engaging [with the clients] is super easy because they know for the way, ... la forma como me veo, de que no soy de aquí.⁹ So, they can see I am immigrant, ... There are things that are self-explanatory, like I cannot hide that I’m a Latina, this is what I look like, and I speak their language ... this is not even a disclosure ... So, the engagement is easier. I just have to make sure that I don’t reveal my own ... immigration trauma, but I feel I have been able to process for years in therapy ... I can share with them my story. I don’t see those clients as parting from my own story at all. (Faholo)

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⁹ Translation: the way I look, that I am not from here
While Faholo remarked that she does not see her clients as parting from her own story, she stressed how imperative it is that she be mindful of places where there might be distance between her and her clients. Such distance arose from places where she holds privilege:

For the Latino immigrants, [they] see me in a professional setting, ... they can see that I am a citizen or at least I have an immigration status because I have a professional title. There are people who see me like a very privileged person. There are people who say “well, what do you know of our life? You are just sitting there in your chair; you don’t know about life.” (Faholo)

Along these lines, the participants stressed the importance of being careful to not assume they understand their clients because of the shared experiences and identities:

It’s different, depending on where they’re coming from. I always tell people yes, we’re all Latino, but we’re also different in so many ways. So also trying to understand that, you know, the experience of someone who maybe came here that actually walked here and went through the border and saw all these things, is different from someone like me who came here with a visa, right? So not just assuming I got this, I completely know what they’re going through just because I’m a fellow immigrant. (RR96)

503 shared how he utilizes the dynamics of overidentification to close potential distances:

It’s a humbling experience. Like, “this is how far I’ve come, and this is how far they can come” … Because sometimes I remind clients that their children could be where I am today, their children could be there too. Because sometimes they feel like it’s so far away, like there’s a huge distance between us, like professionally and educationally and things like that ... So, connecting that we’re not that far away in that sense. (503)

RR96 went on to reflect that the high relatability can lead to higher investment in the clients and can potentially cause her to do a disservice:

So, I think it’s also a matter of, I’m Latina, so I understand how important it is for me as a Latina, to be respected, to be understood … and I’m going to get invested, but I cannot
RR96 shared that she does not often notice instances of overidentification in session with her clients until her supervisor brings them to her attention:

*I have noticed … when I’m in supervision that I tell my supervisor that “oh, this person was held at gunpoint” … And then I’ll start talking about my own experience … and then my supervisor will break in and be like, “are you psychoanalyzing your patient or are you psychoanalyzing yourself?”* (RR96)

RR96 discussed how her supervisor manages such situations in supervision, mainly by encouraging boundary-setting and reminding her of her role vis-à-vis her clients:

*That’s something that I learned with one of my earliest patients, because they were also a first-generation, international student from Central America and I was like, “oh my god, this is going to bring a lot of countertransference.” But I had a really great supervisor, who helped me navigate those things and say “well, they’re now your patients. You’re not here to self-disclose” … We’re here to use theories, strategies, and interventions and figure out the best way to help them [so] they can help themselves.* (RR96)

**Group Experiential Theme 1B) Duty as Cultural Liaisons Contributes to De-stigmatization**

The participants discussed how their positions, as oftentimes the only LatAm immigrant Spanish-speaking therapist at their jobs, presented them with a duty to be liaisons for their LatAm immigrant clients who may not otherwise receive the services they need. The participants expressed that their migration background and ethnicity allowed them to work with a trauma-aware approach which de-stigmatized mental illness and mental health services for their clients. Moreover, being “the only one” who could speak Spanish and could provide trauma-aware therapy, meant that they felt a heightened sense of obligation. This presented a challenge because the participants found themselves performing additional roles.
a) Working with a trauma-aware approach\textsuperscript{10}. Seven of the eight participants reflected on their ability to approach care in a trauma-aware manner to LatAm immigrant clients because of their own experiences with migration. Their stories of providing therapy spoke of attunement to the experience of migration trauma that allowed them to believe their clients and normalize their experiences. In this respect, Pacienicia remarked:

\textit{At least there was never a point that I didn’t believe them [the clients], … a lot of the therapists that were around me didn’t believe how bad it was … they felt like they didn’t understand … how traumatizing it is, because a lot of them weren’t immigrants … I think that at least it was easier for me to be like, “I do believe that has happened to you and I understand this was what you experienced before you came here” … I think it helped me to be more patient, because … sometimes I would get people transferred to me where the clinician before was … way too forceful trying to have people talk about things. And lots of the way they were going about it felt very like white and western, right? Like … you have to divulge every detail of everything that’s happened to you … Like there’s other ways to work through trauma that’s not … trauma dumping … or trying to force clients to talk about things too soon.} (Pacienicia)

The participants spoke about their ability to help clients feel safe to open up with them because they had gone through similar experiences. RR96 shared that in addition to the shared migration background, her clients expressed relief because of how they perceive her ethnicity: “I see that shift where [the clients say] ‘I feel so much more comfortable talking to you’ [and] ‘oh, you’re brown like me.’ So, I may transfer some sense of security just because of my

\textsuperscript{10} I am not describing the participants’ approach as Trauma-Informed Care (TIC) because TIC implies the provider was informed of such practices via education and training, and that the issues are understood and addressed systemically, by the organizations. I am intentionally using the term trauma-aware to capture the participants’ approach to their work outside the systemic requirements and in spite of the lack of trauma training. TIC also necessitates that the provider is empowered via support and resources to then empower their clients, a matter that is not a reality for the participants of this study. A trauma-informed practice “requires a philosophical and cultural shift within an agency, with an organizational commitment to understanding traumatic stress and to developing strategies for responding to the complex needs of survivors” (Hopper et al., 2010, p. 81).
The participants described their ability to provide this safe space as particularly important within the context of anti-immigrant rhetoric, policies, and practices in the U.S. In the words of Faholo,

*I have been very successful in that they can feel safe and not judged ...* So, *that really helps for them to be more open ... in the first session. And they have, I don’t know how many therapists before that, and they don’t feel safe to share what their experience are ... I mean especially with everything that’s happening in the last four or five years, all the political environment, so they don’t want us to know that, for example, they don’t have legal immigration status. They don’t want to disclose. They feel like they’re scared to say everything that happened.* (Faholo)

Bovi echoed this sentiment and compared how his approach to therapy may be different from that of a therapist who does not have a migration background, particularly by using migration stories as an intervention. He reflected that “migration stories is not something that psychologists ... usually integrate into their work. But I think, because of my past identity as an undocumented immigrant, ... that opens the door where we’re able to share some of those experiences” (Bovi). He reflected that having a shared identity as an immigrant helps him provide a different therapeutic experience to his clients:

*I think that in one way, it helps normalize the experience ... that maybe a white person or someone that has never migrated might not understand ... Our just being able to provide a different response and like, you don’t have to tell me all the trauma for me to believe it, right? And you don’t have to come to explain to me what it’s like to be an immigrant in a classroom, right? The trauma experiences don’t have to be like the big scary things. It can be the everyday things.* (Bovi)

This idea of providing a different therapeutic experience to their clients includes the types of questions the therapist asks, how they conceptualize their cases, and the resources with which they connect their clients. For example, Mexicana shared,
So si yo no tuviera ese\textsuperscript{11} common thing with them. Most probably I would not be sensitive, and I wouldn't even ask the questions about what experience they had when they came to the U.S. ... ni si quiera se me hubiese ocurrido preguntar:\textsuperscript{12} “What were your losses? How is the language a barrier for you, if any?” … y cuestiones de aculturación, como: “¿Cómo has podido manejar el idioma? ¿Cómo has podido manejar la música? … ¿Cómo pudiste conseguir un lugar para rentar? ¿Tú sabes cuáles son tus derechos como inmigrante? Y luego peor, si no tienes documentación, ¿Qué derechos tienes como inmigrante? ¿La gente tiene derecho a pegarte? ¿A abusarte simplemente porque no tienes papeles? No, ¿Qué recursos tienes tu como persona inmigrante y sin documentación?” Esas son las cosas que I would say would make a difference si yo no tuviera una historia de inmigración.\textsuperscript{13} (Mexicana)

Such questions as these posited by Mexicana are one of the ways that the participants differentiated their approach to working with LatAm immigrants from non-immigrant therapists. The importance of providing a more attuned therapeutic experience is emphasized by the stories the clients told regarding their previous experiences with mental health services. RR96 shared that one of the reasons her LatAm immigrant clients do not feel comfortable sharing their experiences is because of their previous negative experiences with mental health services. The clients’ experiences consist of instances in which they felt unsafe disclosing sensitive information about themselves for fear of being reported to ICE by their therapist:

[The client] had a history of not really trusting her previous patients and just feeling like therapists are just out to get them or find a reason to deport them. So, when I actually

\textsuperscript{11} Translation: If I didn’t have that
\textsuperscript{12} Translation: It would not even have occurred to me, when I see someone, to ask
\textsuperscript{13} Translation: And matters of acculturation, like “How have you managed the language? How have you managed the music? It’s not the same, it’s all in English. How were you able to find a place for rent? Do you know what your rights are as an immigrant?” And then worst if they didn’t have documentation, “What rights do you have as an immigrant? Do people have the right to hit you? To abuse you simply because you don’t have papers? No. What resources do you have as an immigrant without documentation?” These are the things that I would say make a difference if I did not have a migration history.
heard her story I kind of wanted to reassure her like ‘no, I am your therapist. I’m kind of like on your side. I’m not going to be trying to find a reason to report you.’ (RR96)

RR96 shared that her clients are also afraid of disclosing because their experiences with previous therapists consisted of not being asked about their immigration story or not being understood: “Most of the times, my patients tell me, ‘Oh, yeah, my previous therapist never, never asked me about how my immigration status affects me. They didn’t understand the fear of being deported’” (RR96). Along the same lines, Bovi shared that his clients were apprehensive about sharing their stories because of how the therapist might respond to the migration trauma material:

I also fear that when it comes to our providers, they hear our stories, and their reaction is one of two. It’s either “ah, pobrecitos,” 14 And we’re broken and we’re victims. Or “wow, that is incredible,” and now we are inspiration porn. But neither one is great. So, I think some of that could be some of the differences … My partner is also a psychology trainee, and there are times where she’ll come home and be like “oh my gosh, can I process something with you?” And she’ll tell me something that happened with one of her immigrant clients, and my response is like “well, yeah, probably.” Where to her it’s more … this heavy thing that she has to carry back home, and to try to release, to be able to continue through her day, [to me it’s more] “I hear you, I see it and I can recognize the strength that has come from it.” Without having to, like her, feel bad for the things that have happened or make you a superhero to be able to receive your humanity. (Bovi)

Paciencia posited that it might be difficult for non-immigrant therapists to have empathy if they do not understand the immigrant experience and identified that their experience gave them a foundation from which to start learning about the areas they did not know about:

14 Translation: “aw poor them”
I really think it would be difficult, right? Because even though my [migration] experience was very different, I think it at least gave me the ability to understand that it was hard in the first place ... Some people who had no experience at all didn't seem to have much empathy or understanding about it, which was really weird ... Because at least I knew the areas that I wasn't familiar with so I could learn more about them. (Paciencia)

One of the qualities that RR96 identified as contributing to her ability to make clients feel safe was that she tends to be more accepting of LatAm immigrants because she understands their situations. She reflected on her experience with cases of potential malingering during psychological evaluations:

Even in those times, I don’t really judge the clients ... Because I ... understand why they’re doing it, like of course they want to leave their country. Their country is this country, it’s just as bad mine. So, I think I’m a little bit more accepting. That’s just a bias I have, of accepting fellow Latino immigrants when they tell their stories or when they tell me that they did something, I am not so judgmental to [say] “this person’s doing something wrong” immediately, because yeah, ... you want to leave the hell. (RR96)

This acceptance due to having a shared experience was echoed in 503’s story regarding the misperceptions of immigrants that contribute to xenophobic rhetoric:

I understand why they came here, that it is not a choice ... A lot of times people look at it ... from the white perspective, we’ll hear things like “oh, why do they come here? Why can’t they stay in their country?” ... And it’s like, when you think about it, who would not leave their country if they knew that by leaving their country they could survive? To what degree would you go to survive? Because that’s what they’re doing, ... [it’s a] traumatic experience, no one would put themselves through that if they didn’t have to. (503)

Dr. Luz’s take provides one perspective on why therapists, particularly non-immigrant therapists, may be ill-equipped for working with LatAm immigrants and migration trauma content:
It’s hard, because I certainly saw my colleagues that had no experience with immigrants just be totally flabbergasted by the stories that I would bring up. So, I don’t know how you get in touch with that if you don’t have an interest in learning about them. I think [for] those people ... there’s like an interest in learning about different people other than yourself. If you don’t have that, it’s really hard to relate to immigrants. So, there’s that cultural insensitivity if you don’t have an interest in the immigrant experience. (Dr. Luz)

b) Being “the only one” leads to sense of obligation. Five of the eight participants shared that a challenge to treatment is the sense of obligation they experience from often being the only immigrant or the only Spanish speaker at their jobs. For example, RR96 shared that she feels responsible to use her insight as an immigrant to assess aspects of the clients’ experience that a previous therapist may have overlooked:

> When it has that extra layer that they’re also Latinos, Latinas and also immigrants, yes. I am definitely more invested. I feel that I have to use the insight that I have. Like, this person’s going through these different things, ... that probably their previous therapist did not target because they lacked that insight. So, I feel like it’s my responsibility to try to assess how much of their past trauma, immigration status, immigration story, is playing a role in their current symptomatology ... because it may be the first time someone asked them. And most of the times it is. (RR96)

The participants remarked on how their insights as immigrants from Latin America allowed them to understand their clients’ views regarding mental illnesses – an insight that positioned them as liaisons between their clients’ concerns and mental health services:

> In my culture specifically, we do not really believe in mental illness ... So, when I have those conversations, I understand el ataque de pánico, those culture bound syndromes ... more maybe than other people who are from a different culture, or I understand that the patient’s concerned [because] they don’t want to be diagnosed ... because they don’t want their family to think that ... they’re crazy or God’s not with them. I can break
down those challenges a little better because I kind of have that insight … So being able to also change that mindset from patients that therapy is “para los locos, la terapia es brujería”15 to “wow, this was actually a health service, and it was helpful.” (RR96)

There was consensus among the participants that the sense of obligation arose from the expectation that if they could not work with the Spanish-speaking LatAm clients, they would either not receive services or have to work with someone who did not speak their language.

Paciencia shared:

*It helped me to be much more patient, and to put in the effort to get people more sessions because [the limited number of sessions] was kind of a problem ... It wasn't that hard to get it approved, I think a lot of [therapists] didn't do it, but I would try to see people as long as I could because otherwise, they may not be able to get services elsewhere.* (Paciencia)

Bovi shared that in addition to these external expectations, he felt internal expectations of wanting to offer his clients the type of support he would have wanted to have:

*I think we're giving so much sometimes because we're the only ones that maybe speak Spanish at the agency. You might be the only brown person at the agency ... and I'm hearing people's stories and then I'm like ... “who's working with your kids?” Because they also need to be in services ... So, you take all this extra responsibility that often no one but your clients is going to notice, right? No one but your clients is going to be like “yo, I know you put in extra time because you're a part time mental health provider, part time caseworker,” even though it wasn't part of the title, or it's not paid work. But maybe we give that much harder because we understand what it's like to ... have few points of connection in this system ... I think a lot of us that are immigrants, Latino psychologists ... came to this work because we saw that lack of someone that understood us, and*

15 Translation: “Therapy is for the crazies, therapy is sorcery”
looked like us, that came from lived experience to help us, and that was part of my story.

So, in part it’s kind of like paying back, the fact that I was able to make it this far. (Bovi)

RR96 echoed Bovi’s sentiment of wanting to provide the type of support she would have liked to have and added that the sense of responsibility also comes up with her identity as an immigrant:

*The sense of duty and responsibility that I’ve been given this opportunity … I have to pay my dues and earn my accomplishments and be grateful that I’m able to do that, not so much complain that … I’m facing these challenges. In the sense that sometimes I even see the challenge and I’m like “well, I’m grateful I have the challenge.” … Because these are problems that not many people have in my home country. It’s like the phrase: “first world people’s problems.” Right? Because that’s an opportunity that’s not provided or affordable for everyone. (RR96)*

Similarly, Paciencia attributed their openness and ability to work from a stance of *meeting the clients where they are* to the shared migration and ethnic backgrounds with their clients.

Paciencia reflected on how this helped them understand the stigma regarding receiving mental health services and adapting their therapy approach for their clients:

*I’m also an immigrant and mental health isn’t seen as something good where I’m from either, so I think that’s … why for me, when there’s that type of stigma, it doesn’t really bother me at all. It’s like “yeah, we can do whatever you need,” not talk therapy or not manuals. I mean, that works for some people, you know, but not everybody. (Paciencia)*

Bovi shared that one of the ways he addresses the mental health stigma within the LatAm immigrant community is by connecting to cultural practices they may already engage in:

*Something that I try to do to help break some of that “we don’t do that [therapy],” is trying to reconnect that most of what psychology does has been reappropriated from a lot of things we did before … like plática.*16 *We’ve been doing that forever. Right? I think that*

16 Translation: *chat*
once we’re able to do that they’ll probably be like “ooh, I’m ready for my plática,” [laughs] which is a way in which they can connect to [therapy] differently. (Bovi)

In this way, Bovi described bridging the gap between mental health services via cultural practices. Similarly, Paciencia shared that a strategy for connecting with clients included providing case management services (e.g., connecting clients with resources and filling out immigration paperwork). In this way, the clients were more inclined to engage in therapy:

Because [the clients would say] “oh, you’re actually helping me with something that I need” [or] “I don’t know what I’m being referred for.” And I’d be like “OK, let’s figure out like the actual stressors that are going on in your life and see what we can do about it.” ... Because a lot of the referrals ... didn’t really understand what [therapy] was ... So that buy-in was definitely needed ... there was a lot of people who had stigma against mental health [services], so I think it was helpful just to acknowledge that and just do whatever made more sense for them. (Paciencia)

Domain 2. Secondary Trauma Responses

This domain captures the participants’ experiences when exposed to their LatAm immigrant clients’ trauma material – their secondary trauma responses (STRs). I categorized their answers into two group experiential themes: the toll of the work – to capture the negative impact experienced by the therapist, and opportunities for redemption – to capture the positive impact experienced by the therapist.

Group Experiential Theme 2A) The toll of the work

All eight participants expressed that it was difficult to hear stories that contain such high levels of violence and hardship as migrations stories often do. They described various negative reactions from listening to their LatAm immigrant clients’ stories. Such reactions included a) experiencing mixed emotions, b) taking the work home, and c) their own migration trauma becoming triggered.
a) Experiencing mixed emotions. Six of the eight participants shared that their reactions to their clients’ stories consisted of experiencing mixed emotions, including sadness, anger, and powerlessness. For example, Mexicana talked about the reactions in her staff and emphasized the difficulty in remaining neutral when they have experienced similar situations as their clients:

Well, sometimes you have to be very sensitive about not crying when you are listening to some of their stories ... It is important you show empathy and that is hurting you too, ... but therapists need to check in themselves in terms of if a therapist also suffered something similar, they might react a little bit different ... And they have to be careful as to how not letting their own emotions interrupt the therapeutic relationship. (Mexicana)

Similarly, Maria reflected on the emotional impact that her clients’ stories have on her:

There are lots of reactions. I start from compassion, sadness ... it makes me sad to hear how unfair ... things are for people that immigrate. I've heard stories of students that they had to cross the border, and they’re children ... and they were either detained in these centers, ... or crossed the desert. It's hard, so I feel compassion. I think, of course it impacts me, ... absolutely, because it hurts ...I don’t know if these will hurt me as much if I was not an immigrant. I don’t know if I would get as mad if I was not an immigrant, or as happy. Because I don’t know that reality. But it does affect me, does make me mad, ... because of my own trauma from immigrating. (Maria)

She highlighted a story from her experience in a school setting during the 2016 presidential election – a time when anti-immigrant sentiments were particularly pronounced in the U.S.:

I get sad because I hear ... minors ask, “why do they hate us so much?” I almost lost it. He was sobbing, “we have done nothing,”... Around the same time, there was a child, ... the parent got pulled over by the police before dropping her off. So, this child got extremely concerned, ... she started throwing up ... I could smell the acid of her stomach and she was like throwing up of fear, and she said, “what is going to happen if I go home
“and nobody’s there?” My stomach also went up and down, right? Like I almost vomited my stomach with her. And not because of the smell, because ... I work with teenagers. I’m very strong in the stomach with smells and everything. But when she said, “what if my mother is not there anymore?” That almost broke me. I mean, after she left, I had to take a minute and not cry … Like feeling this great anger and sadness. (Maria)

Paciencia described feelings of anger that arose from learning of the mistreatment of their clients in various areas of life:

It was the frustration of not being able to do more or having all these barriers that didn’t make any sense ... Seeing the blatant racism against the same people over and over and over again ... It’s just really frustrating, to say the least ... I feel like that anger was mostly at the different systems, right? School, work, the government. (Paciencia)

The participants also described feelings of powerlessness as a result of the high need for resources and the limitations on their clients who had an undocumented immigration status:

Many of the people I saw before were undocumented ... and that caused a lot of issues. I would often [see] the kids who were citizens, but the parents weren’t, so there was a lot of anxiety and stress because they were worried that something bad was going to happen to them ... Trying to get them services was really difficult. So, I had families that wanted to do the best with their kid, but they literally couldn’t because they didn’t have the resources. It was stressful in that sense, where I wish I could do more. (Paciencia)

Faholo described her feelings of powerlessness as contributing directly to her vulnerability to experiencing traumatic stress:

Especially [with] the clients that I work for coming from very disadvantaged populations or situations, … it’s hard because you feel powerless to really help many of the clients ... You are very vulnerable to have posttraumatic stress, you know, after hearing their immigration stories. So, it’s hard, it’s really hard. (Faholo)
b) Taking the work home. Five of the eight participants talked about the impact that hearing their clients’ stories has on their lives. Mexicana shared that she has noticed her staff tends to take the work home, and “then they cannot sleep, and that is something that we need to provide them the guidance so that they don’t feel powerless over not being able to help a client, and then are not able to sleep.” 503 shared that the “degrees of distance are small” between him and his clients and that their stories “often hit home”:

It takes a lot of energy. Sometimes when I have like a really heavy session, I really feel like it takes a toll on me. So, I do have to make sure that I take time to process for myself what’s going on ... I’ve had moments where a client will say something and I’m thinking about it at night and trying to go to sleep. I’m still processing that trauma. (503)

Similarly, Bovi shared that he has experienced physical and emotional exhaustion to the point of questioning whether he can continue with the work on a daily basis. He added that it is difficult to separate from the job, a feat that became more difficult with the Covid-19 pandemic:

Sometimes it could be like taking things home with you, especially during the pandemic times, right? Like this office is my work office, so it happens my living room is right there. So, when you talk about not bringing clients home with you or their problems with you, like it gets a little bit more tricky, in that sense. I mean, I might have just finished a session with a client, and I’m going to go and make myself dinner because it’s that time of the day and having that [story] replaying in my head. (Bovi)

The impact on the participants’ personal lives included shifts in their sense of safety. For example, RR96 shared that working with LatAm immigrants “started this fear that I was going to be followed around and get attacked [laughs] … I would literally be driving home and looking both ways. It was interesting to see how that went into my personal life.” Maria also shared her preoccupation with potential danger for her family:

Their stories draw a lot of trauma ... Ooh, complex trauma. Generational trauma … Of course, it touches me as a person, and I start worrying about my family … When I hear
the horror stories, I’m like, “when is my family next?” … Because usually [the clients] are moving because the place they were leaving, it was very violent and I’m afraid for my family because they’re still there. I’m the only one who immigrated. (Maria)

Along with the change in their sense of safety, RR96 and Maria expressed feelings of guilt that arose from their travel privileges compared to their LatAm immigrant clients:

A little bit of guilt sometimes because I have a visa. So, I can travel. I can go see my parents. So, sometimes I have to tell them “Hey, I’m not going to be here, I’m going to travel to Mexico and see my family.” And they cannot do that. They haven’t seen their parents in like 20, 30 years and that makes me guilty that I do have the privilege. (Maria)

This sentiment was echoed by RR96, who shared that she often finds herself thinking about her clients’ stories outside of work and how closely they connect with her and her family’s story:

I’ve also had to work this in therapy, the feeling of guilt that I have felt … my family is still back home and I’m here in the U.S., the land of the American dream, and they’re stuck in a country that right now is going through elections and … people are going to riot and kill each other … so the things that happen to our patients we just keep them turning in the back of our mind. (RR96)

c) Triggers own traumas. Five of the eight participants shared that their own traumas become triggered when they learn about their clients’ stories. Bovi shared: “it can be a source of vicarious trauma because it brings up my own pain, [and] history, depending on the population … If they mention something similar, having my own traumas surface and replay in my mind.” Similarly, Paciencia explained that they did not experience re-traumatization from clients’ stories. Instead, their own migration trauma would become triggered, which they would process with their therapist. They did not believe this affected their work:

Not that things don’t affect me, but I don’t think I was retraumatized by them. I think the issue is that I have my own story that’s traumatizing, and so what would usually happen is that sometimes what they said would be too close to home for me, and then that
would trigger my stuff. But I don’t know that I was having a reaction to what [the clients] were saying, you know?... I think the issue was more “oh no, this is bringing up some of my own stuff,” which means I should work on that more. (Paciencia)

Faholo shared that early in her career, she experienced hypervigilance, muscle tension, and physical exhaustion from how similar her clients’ stories are to her own. Similarly, Maria shared:

It hurts, and of course it makes me relive some things, right? And that makes me question, like “what am I doing here? My parents are far away and what if something happened to them and I cannot be there for them?” Like all these questions that some immigrants have, I have them as well. So, when they question, I mean, I’ll be a liar if I told you that I never think about it. (Maria)

**Group Experiential Theme 2B) Opportunities for redemption**

All eight participants also expressed that there are opportunities for redemption that come with the heaviness of trauma work. They described the positive impact of listening to their LatAm immigrant clients’ stories which included opportunities for a) recognizing their strengths and b) healing their own trauma.

a) **Recognizing their strengths.** Five of the eight participants described that working with LatAm immigrants with migration trauma helped them recognize their own strengths:

*The clinic where I work at, we do 100% trauma all day, every day. We know these things to be true. Vicarious trauma is real, and you feel it. But I think I’ll say with the trauma there’s also this idea of vicarious resilience. And being able to also appreciate that. So, I don’t want to make it sound like it’s all bad. Right? Like within the trauma, I think that you’re also able to recognize a lot of your own strength, and the strength of the community itself. (Bovi)*

RR96 shared recognizing similarities between the way her clients talk about their trauma and how they continue to move forward despite the hardships and how she relates to her own trauma:
I was shocked because people usually told stories and they obviously are crying, … but at the same time they just show this level of resilience. They’re like “oh yeah, but the next day this is what I did.” And it’s … not so much shocked as how can this happen, because like I said, I come from a very dangerous country, so, I have seen similar things growing up … So, [it’s] more me trying to understand the mindset of “that’s just how it is.” I also have my own traumatic experiences in my home country, and when I tell them I also say, “that’s just how it goes back home.” (RR96)

Bovi shared that through working with LatAm immigrants, he recognizes the cultural strengths that he holds because his clients are a reflection of him. He went on to share how he uses those strengths in therapy to instill hope in his clients:

Eventually getting to a point where I see the … psychological strengths of undocumented students and I know that’s me too, right? And being able to connect … personalismo17 being a strength, … creative resourcefulness – we make things up as we go, we work it out … Optimism – no matter how hard things are right now; things do get better tomorrow. Right? And like that being the thing that pulled me for a long time. So being able to pass some of that on to other folks, … In some ways, it is a good reminder … for me now as, still an immigrant, … but now holding citizenship, … Working with [LatAm immigrants] puts the mirror in front of you and you’re able to see yourself reflected, maybe at a different point, maybe a little bit farther back, … before all the privilege that goes with education … being able to [say] “man, yeah, you’re going to be OK, … we are going to be OK.” And we have to believe that regardless of what you’re hearing, otherwise you don’t do this work. (Bovi)

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17 Translation: personalism
Mexicana discussed that whether a therapist is affected by their clients’ stories depends on whether they have worked through their own trauma – that it could be a strength if they have processed it or a potential source of further traumatization if they have not:

*It’s going to be either “oh, I understand what you’re going through and I’m going to try to help you doing this and that,” or I’m reacting to a point that “no, I don’t want to work with that client, [they] remind me a lot of what happened to me.”* ... Depending on how you perceived your immigration story is how you might feel that the story of your client is traumatic or not. ¿Si me explico? Si yo lo veo como una oportunidad y un aprendizaje, *mi historia de immigration,*¹⁸ is going to be a different reaction … than if I see my story of immigration as super traumatic and I still carry that with me, then my reaction to the client telling me something similar is going to be different. (Mexicana)

**b) Healing own trauma.** All eight participants reflected on the question, “what is the potential for healing for the therapist?” Their answers highlighted that offering their clients an experience different from theirs contributes to healing their own migration trauma. Mexicana explained this by saying she “would heal by knowing there is hope, that I was able to help someone else that experienced the same things as I did.” Similarly, Paciencia added:

*To be able to try and support other people going through similar stuff, because I definitely didn’t have that support when I came over at all. So, it was nice to be able to, I actually at this point, know the resources and I actually know where you can go to get things … that people wouldn’t even think about.* (Paciencia)

Even at the time of the interview, when Paciencia was not working with LatAm immigrants directly but working with 2nd and 3rd-generation Latinx clients, they shared that “it feels more like I’m helping people that would potentially be my kids in the future … Because the difference

¹⁸ Translation: *Am I explaining myself? If I see it as an opportunity and as a teaching, then my immigration story*
in generation is really noticeable, so … I feel like this will help [to] heal family trauma"

(Paciencia). Maria also spoke of the healing qualities of working with LatAm immigrant clients:

> I have PTSD from immigrating and I’m still working with my therapist through it, right?

> But it is a way of like redemption, kind of thing. It’s like let me help others not go through the same things I went through … I didn’t experience other things like crossing the border undocumented. I did not experience that. But I did experience racism … and I still do because I live in a very racist place … So, it’s a redemption, right? I went through this, let me help others not to go through it. Or I can see how people see you as less than, let me not do that. Let me help them feel normal and comfortable. So, yeah, that makes me heal as well. (Maria)

For Faholo, the healing aspects of the work result from having had the opportunity to develop a more resilient migration story for herself through self-reflection and witnessing her LatAm immigrant clients’ stories:

> I have been able for myself to create a more resilient narrative about my own experience. I have a more realistic view of my own story. I have been able to do a lot of self-reflection in my own privilege … And in my own story having created a lot of healing for myself when I see success in their stories … If I see 200 clients and just one is going well, I just touch one people’s life … I don’t blame myself for the others. (Faholo)

For Bovi, the healing aspects come in tandem with the heaviness of providing therapy to LatAm immigrant clients:

> I think there’s a lot of healing from doing this work. So, it’s hard to describe both … There’s a heaviness that comes with it that we’re not going to be able to just get rid of, but there’s also many gifts … Being reminded in different ways of your own resilience, of the things you’ve gone through. You don’t get to hear the hard things without getting a lot of the strength that comes from that … Being able to have a front seat to witness
immigrant hope and immigrant resilience, it’s beautiful and it’s a good reminder of why we do the work that we do every single day. (Bovi)

Maria also spoke of the heaviness of the work and described her immigrant experience as a process of grieving the various parts of herself that she lost:

*I think, immigrating, as any grieving process, will never be healed completely. It’s always going to be there … It’s just like a grieving process. You lose part of your history, your story, your place, you lose your food and family. You lose, lose, lose, lose. It’s a very complex grieving process. So, I don’t think it’s healed. Fully healed? No. I don’t think, no, not at all. And I actually think that that passes to the next generation, a little bit of that trauma … I think there can be a functional healing, as with any loss. Yes, we can thrive and use that to produce better. So, I will call that healing ... Healing in my perspective, as I see it, is when you’re aware of your pains and you’re functional in your life, and then you do something good about it. That, yes, is very possible. That it’s going to hurt? Always … to the very last day of our life. Absolutely. And especially if we’re working with immigrants and they keep showing the same wound … like, you know, it’s a mirror … But that’s grieving, and humans grieve all the time. (Maria)*

And that working with LatAm immigrants helps bring those parts back:

*I had to grieve parts because it was hard, and now it’s like a process of putting those pieces together … I also think it’s like redemption, working with immigrants, it’s healing, very healing … But yeah, there are parts of me that are gone and it’s sad. And I guess working with immigrants it’s good because they bring those parts back ... I have some kids that are immigrants and they’re so Mexican, they’re very new to the country, and they’re so Mexican or Latino, and I adore it ... They’re so fricking cute because they have those parts. But you do lose them … They start to fade. (Maria)*

Along the same vein, Bovi shared that working with LatAm immigrant clients is “a constant reminder to … practice mindfulness and … enjoy the little things and remember what it was like
when those things felt huge, … and reconnect with that part of me.” These sentiments were echoed by 503, who spoke about his experience working with LatAm immigrants as being a connection to his ancestors:

My heart is with the immigrant community … I came to the U.S. when I was eight years old, and so there’s always a part of me that has that connection to the immigrant experience … I find it very rewarding … I feel like this is a connection to my ancestors. That’s how I feel about it, because for example, my parents came to the U.S. undocumented … and they went through these same challenges and frustrations that … my clients go through right now … leaving their home country because of different challenges, whether it’s war or because they can’t afford to make a living … So, a lot of times when they tell their story, … it’s almost like it brings you closer to home. (503)

Domain 3. Factors that impact the LatAm immigrant therapists’ experience

In this domain I present the factors identified as risk, protective, mitigating, and sustaining. Risk factors consist of the elements associated with an increased likelihood of experiencing problems at work. Conversely, protective factors consist of the elements associated with a decreased likelihood of experiencing such problems. Mitigating factors consist of the elements that minimize the negative impact of the work on the therapist. Lastly, sustaining factors consist of the elements that allow the participants to engage with the work in a long-term capacity despite its difficulties.

Group Experiential Theme 3A) Risk factors

This theme encompasses the elements associated with an increased likelihood of experiencing problems at work. I organized the risk factors into the micro, mezzo, and macro societal levels for ease of presentation.

a) Micro-level factors. This level encompasses the risk factors relating to intra- and inter-personal dynamics, which include: (i) the therapist’s high exposure to a wide range of trauma and (ii) the therapist’s disposition.
(i) **High exposure to trauma content.** Five of the eight participants expressed concern regarding trauma exposure, which included the quantity and breadth of trauma content. They shared that their clients’ stories involve trauma at each phase of the migration process. Paciencia, for example, shared that they “hear the same type of story over and over again from different people of a similar background to me, and that’s always going to be harder than somebody who has a different background.” This notion of there being repetition to the clients’ stories was echoed by Maria, who shared that she could recite “the script of the stories [she] hears … trauma, emotional abuse, like abuse, abuse, abuse. Especially towards women.” Another experience shared between the participants regarded the consecutiveness of the trauma exposure. RR96 recounted, “Coming from one patient who left their country because they were gang raped to another … who left their country because their [family was] shot … it was a lot of heavy, emotionally charged sessions.”

The participants also spoke about the disproportionate exposure to trauma. For example, Bovi underscored that the imbalance in trauma cases assigned to him was inherent to the demographics of his caseload:

*If we are trying to give every … provider a case of … 25, and I’m the person that’s working with all the Spanish speaking, immigrant, and Latinx folks, that means that disproportionately I’m seeing more trauma, more casework … than maybe some of my colleagues that are dealing with middle class white women. We’re starting in different places. You’re not working to make sure your client has a place to sleep tonight. So, sometimes there is this idea of … equal work for all folks … eh, not so much.* (Bovi)

Bovi shared that the exposure is such that he has difficulty going from one session to the next. The impact of the breadth of trauma material on the therapist was echoed in Faholo’s account:

*What I have to fight more with myself, it’s compassion fatigue. Trying to avoid burnout because you usually can get there … It’s come to the point especially [when] you see the*
same pattern ... I have to be more attentive [so] I can engage, more than engage, clinically engage, so I can validate and understand the client’s feelings more. (Faholo)

Paciencia shared that not only did their caseloads have more trauma content, but their exposure to trauma material increased when they had to translate for other therapists:

_Often it would be [that I was] working with sibling A and sibling B is with a therapist who doesn’t speak Spanish. So, I’d have to ... go through the whole thing again which is difficult. And of course, the family is going through the whole thing again too. So that was really tough [and] way too much ... that’s one of the reasons I left._ (Paciencia)

**(ii) The therapist’s disposition.** Five of the eight participants talked about dispositional factors that negatively impacted their work, such as their own trauma history. RR96 told a story about a traumatic event for which she needed support because it resembled her clients’ stories:

_The last time I was in my home country, I was held at gunpoint. They were trying to ... mark me. And that’s the reason why I actually went to counseling services, because ... I immediately knew that I’m not going to put it behind me and make it go away ... So, for me, one of the biggest factors was my previous trauma history, because I don’t want to be triggered … because those are the stories I hear in sessions._ (RR96)

Likewise, Paciencia saw their own immigration trauma as a risk factor:

_I think the issue is that I have my own story that’s traumatizing … Because the way that I came over was so difficult, I thought I would somehow handle [the work] better because it didn’t surprise me … I sometimes saw other clinicians have a really hard time understanding that bad things happen to people. And I never had that problem … I think the issue was more that it was bringing up my own stuff … And there’s not much else to do except like, try to process it on your own time, you know?_ (Paciencia)

Another dispositional factor was the therapist’s mental health. Mexicana, RR96, and Bovi posited that the therapist’s mental health status plays a role in how they experience the trauma material. Bovi went on to highlight factors that are more particular to the immigrant experience:
I think time of the year makes a difference for me, right? When it’s closer to when I migrated versus when I’m working farther away. Also, holidays can be hard when you’re an immigrant, right? Like being an immigrant means that you leave parts of your heart in many different spaces and in many different places. You have many homes, but also belong nowhere. I think that can also be a risk factor. (Bovi)

b) Mezzo-level factors. This level encompasses the risk factors associated with dynamics at the organizational level. These include (i) shortage of Spanish speaking therapists, (ii) lack of appropriate resources for clients and (iii) lack of support from agencies.

(i) Shortage of Spanish speaking therapists. All eight participants described matters related to language as risk factors. The issues included translating documentation and acting as interpreters for non-Spanish speakers. RR96 shared that despite living in a predominantly Spanish-speaking city, the common practice was to “grab an English cop and translate as you go.” Maria described having to engage in roles outside of her job description simply because she spoke Spanish:

I get used on call for other things that are not my job, but just because I speak Spanish. So, then all of a sudden, I’m translating all the documents. Who else is going to do it? The agency doesn’t want to pay for it if they have a Spanish speaker. Oh, but they will pay for another language. I mean, I get it, I get it, it’s a strength that I bring. Everybody else brings some strength, this is mine. So, “OK,” but it’s a little abusive. (Maria)

This was a shared experience among the participants, who reflected that speaking Spanish was one of the reasons agencies hired them, which made them feel as though they had no choice but to take on tasks outside their job descriptions. Paciencia shared how having to perform additional tasks impacted them and their work:

What was hardest was [that] I was one of the few Spanish speakers there. And because of that, I kept getting way too many cases and they’re all really high trauma, complicated cases, well, more than not. And so, I was getting really burnt out. So, language was a
big issue ... the need was really high, but they weren’t hiring enough people who spoke Spanish ... In the end, all of us left. Nobody stayed even though one person had been there for a long time. Because we can’t keep burning out at this place. (Paciencia)

Contrastingly, Paciencia also reflected on the positive impact that having therapists who spoke the language had on their work and on the provision of treatment:

For a while there were only two of us, which I remember very clearly [laughs] and when we finally got two other people consistently, it was like “This is great!” We’re still burnt out, but that’s one of the reasons I was able to stay longer ... That’s probably the most people I worked with at the same time ... When we worked with bigger [Spanish-speaking] families, who had a really high level of trauma ... we could plan it so that all of us saw different members instead of one of them going to somebody who didn’t speak Spanish ... So, there was a lot of collaboration and planning ... It made it easier for [the family] to be able to come to the clinic at one hour ... And it was nice to know that even when we [the Spanish-speaking therapists] couldn’t talk to each other about the case, that the family was better off. (Paciencia)

When there was a lack of Spanish speakers, Paciencia noticed that one of the detriments was that cases were assigned based on language rather than on other client-therapist fit characteristics:

It could be that if the other therapist spoke Spanish, they’d actually be a better fit and it’d make more sense. But they can’t, so I would be the one. It’s so tiring ... I think that that happened to all of us where it’s not that it would be bad, it’s more that I can see that what this person needs and the kind of personality they need and specialty, is not my specialty... but, too bad! Because there’s no one else who speaks Spanish. (Paciencia)

Mexicana highlighted that the shortage of Spanish-English bilingual therapists is a systemic issue in many places, including cities that are typically diverse:
We have several openings right now and it has been a challenge to fill those positions. I think it’s a nationwide crisis right now ... I’m not exaggerating, there’s a lack of bilingual staff right now ... it’s happening all over the place, yes. I have been in meetings with people mostly from California, Texas, Florida, and I consider those states even bigger with Latinos, ... and they were struggling. So, if they’re struggling, can you imagine right now for us here in [the Midwest]? (Mexicana)

Dr. Luz highlighted that the shortage also impacts the availability of therapists that can provide culturally responsive services in the area of immigrant evaluations:

The problem is that I’m one of few people who do it, but there’s such a great need. If an attorney contacts me and I’ve got three weeks to hand this in, the chances of [them] being able to get somebody else to do that is slim to none ... Because there are Anglo clinicians that try and do this work, and they miss the boat ... And so, the attorney will say, “I contacted this psychologist, and they didn’t understand this person’s story.” So, my biggest worry is teaching people to do this work ... because there’s going to be so many immigrants that need this. (Dr. Luz)

While issues regarding language-appropriate services were a prominent risk factor reported by the participants, RR96 described recent changes she witnessed at her site:

We actually got standardized forms in Spanish for intake sessions. We did not have those before. We got standardized tests in Spanish, not just translated ... I was the only Spanish speaking person in the hospital where I’m working. We just got someone else and I’m training them, so that’s good ... because sometimes they were forcing Spanish speakers to do the psychological testing in English because there was just me. (RR96)

(ii) Lack of appropriate resources for clients. Five of the eight participants expressed that the lack of appropriate resources available for LatAm immigrants is a risk factor for experiencing problems in their work. For example, Faholo talked about the additional labor needed from her because of the lack of resources:
If I work with a client who has legal immigration status, there’s things from different sources … but when it’s the undocumented population because they don’t have the access to that, it’s hard … and you feel like you have to work like two times more …

Even when they have [legal] immigration status, they are not familiar with the resources.

So, imagine that I have to refer a client for hospice. Hospice is something that’s new for a lot of clients. Even though they have the access to the services, I have to go like three more steps trying to explain why hospice would be a good option for them. (Faholo)

Paciencia’s account also told of the additional strain placed on the therapist:

The best I could help them with was to get them on Medi-Cal that was for emergencies, but that doesn’t include mental health. And so, then you had all these adults who needed therapy but couldn’t get therapy… It was complicated. And I would say the biggest reason is because so many people weren’t able to be citizens … I think because I worked with that community so long, it’s what helped me get the parents services a lot of the times. Because there was ways for you to basically use the kids’ status to … sometimes get stuff covered for the parents. But it’s so much paperwork and so complicated … So that part, it was just difficult for everyone involved. (Paciencia)

RR96 added that even when her clients had insurance, there were limitations to the number of sessions she could provide:

Some of the patients that I’ve seen, they’re only allowed to do three sessions, four sessions, five sessions. They don’t have insurance and that’s it. And they’re not allowed to come back to services, and they need them … How do we reach that population if they’re not even allowed to have the services? (RR96)

Mexicana in turn, added how language barriers exacerbate the dearth of resources:

What makes it difficult is that sometimes even if they want to progress and do better, their migration status might not help that … Or, if [the therapist] wants to refer clients out, if they don’t have bilingual people in the other places, they end up being the ones
making the connection or act as interpreters. How many times have we had therapists being the interpreter too? (Mexicana)

Paciencia shared that the most challenging aspect of the work for them was the insurance- and immigration-related paperwork. This was the case because it was often complex, time-consuming, required them to translate information, and the outcomes were uncertain:

The trauma work is difficult but manageable. I think the paperwork part is hard because you never know if anything’s actually going to pay off or not. And it’s just so disheartening, you know? … Often, it would take so much to even convince them to try, right? Then it doesn’t work, and I put all this effort into this, and so did the client because they’re also doing all this stuff … and then see it being rejected for the millionth time. So, I think that that was harder than the content of the sessions. (Paciencia)

Further, the threat and fear of deportation of their undocumented clients was a challenge for treatment as it was difficult to address other psychosocial stressors. Paciencia shared:

At least with the content it’s like “well, we can talk about this and work on it and process it, but we can’t [do that] if you don’t have a home to live in or if people keep trying to kick you out of the country” … I had a lot of people [when I worked] with domestic violence victims, almost all of them were undocumented immigrants … and it’s like, we could work on this better if [they] could stay in the country and not be scared that [they’re] going to get kicked out … So, I feel like that was the worst part. (Paciencia)

503 echoed these sentiments regarding the lack of resources for LatAm immigrants and highlighted the unfairness in the stereotype that undocumented immigrants exhaust resources:

With immigrants a lot of times, especially undocumented, there’s not a lot of resources for them. That’s why it’s heartbreaking when you hear people talking about “oh, they’re getting food stamps, they’re getting healthcare.” I’m like, “According to who?” Because they don’t qualify for that stuff. If they do get food, it’s through organizations that help, but not state and government funding. (503)
(iii) Lack of support in agencies. Four of the eight participants expressed that one of the risk factors was the lack of support in the agencies where they worked. The lack of support included not receiving adequate supervision to work with LatAm immigrant populations.

Regarding supervision for matters related to immigrants or migration trauma, Maria shared:

> Here where I live, there are not a lot of professionals that immigrated in this profession, so they have no clue. I have trained them … I don’t want to sound like, that I’m more than them because I’m not, I learn a lot from them. But in this topic, they have no idea. Something as basic as somebody that will speak the language. They couldn’t check me because they couldn’t understand what I was saying. And somebody that works with this population would have been great, so they can tell me how to start. (Maria)

Faholo shared similar views regarding supervision and compared it with more recent experience:

> In the last seven years I been having supervisors who are immigrants themselves. So, that really changed everything, because I receive a very good individual supervision. But [with non-immigrant supervisors] I have to explain more. I mean, it can be good, but I have to explain how I feel. With [immigrant supervisors], we know it’s hard. So, “how hard it was for you and what are the things that impact it?” So, you don’t need to talk through everything … you can start at the same level. (Faholo)

The participants also described a lack of support for matters of secondary trauma.

Paciencia shared that it was not a topic in supervision: “I will say, none of them have ever asked me to talk about it in supervision. I don’t think there was ever a ‘hey, do you need support? Do you want to talk about this?’” Additionally, Paciencia reflected that their experience with burnout had to do “more because the agency was so unsupportive” regarding these matters than because it was difficult to work with the trauma material itself. From their own experience as a supervisor, Paciencia shared:
When I was in a supervisory role, there were a few supervisors who agreed with me [regarding support around secondary trauma]. But the bulk I don’t think did, and the problem was that the higher ups definitely didn’t. So those of us who were trying to get the trainees to have a better work-life balance because it’s what you should do, had to do it on the down low and not make it obvious to the higher ups. (Paciencia)

Further, regarding their trainees’ experiences with secondary trauma specifically, Paciencia shared that if the trainees were having a strong reaction, they were not encouraged to disclose:

My sense was that when ... new clinicians were having a really strong experience, I think they often didn’t feel safe to tell people … Going back to stigma in the mental health field … like you shouldn’t have any mental health problems and you definitely shouldn’t have vicarious trauma, because you shouldn’t have any feelings ... I saw that a lot. And I think it was really hard to get some of my students to talk about it, … to go to therapy and to take breaks. Because all those things are related. (Paciencia)

c) Macro-level factors. This level encompasses the risk factors associated with systemic dynamics that impact the participants’ work. These include (i) low pay and limited job opportunities, (ii) lack of training, and (iii) xenophobic microaggressions.

(i) Low Pay and Limited Job Opportunities. Four of the eight participants discussed that receiving low pay and having limited job opportunities contributed to experiencing adverse effects at work. For Paciencia, the low pay in community mental health caused them to leave and open their private practice:

I actually liked the other work better. But I don’t think it’s sustainable for my mental health. I did enjoy the families and clients I had in community mental health much more than the ones now. It’s so weird saying that while in my private practice ... but I think I could relate to people better and I felt like I was having more of an impact on the community ... Even when I left, I felt very conflicted about it, and I think it was mostly because I was burnt out and because the money was so bad that I literally … can’t live
in the Bay Area and work in community mental health. It’s just not sustainable.

(Paciencia)

Faholo shared that she “usually get[s] less pay than other people” and that she has to “fight really hard” for her salary. She attributed this hardship to the underfunding of programs for immigrants:

You get tired easily. I workplaces that probably are not safe places, physically are not the best places. I had jobs that I had to go 20 miles to get to the places from where I live, you know? ... I have been in places that they closed the programs because they don’t want to serve immigrants ... So, I lost my job ... I had to go to another place. And they’re very unstable ... There is a recession and with all the anti-immigrant rhetoric, they close the programs, they don’t want to put money there. (Faholo)

Additionally, Faholo shared that it has been challenging to find jobs outside of working with Spanish-speaking and LatAm communities:

For me as a clinician, it’s so difficult to find a job ... [other than] Spanish-speaking clients or immigrants because ... it’s going to be so hard that someone hire me because my accent, because of the way that I look like, for serving populations that are different than who I am ... So, it’s hard to find a job outside of what I’m doing right now. (Faholo)

503 shared a similar experience, describing being niched into working with Spanish-speaking clients regardless of the work setting:

When I worked with at-risk youth, if the parents only spoke Spanish, it was usually me who would be the therapist working with them. Same thing in the substance use rehabilitation center, same thing. If they spoke Spanish, the agency was like, “[503] is going to be their counselor.” (503)

Maria discussed another facet of experiencing limited job opportunities as an immigrant who migrated with a work visa:
I don’t know how many people you’re going to have like this but immigrating with a visa is a fricking pain in the ass, … because it ties you to your employer … And you cannot do like others and change jobs and get better. No, you’re there. So, they basically own you. So, it’s like “keep adding things for the burnout, please!” And also, if I get burned out, I don’t have a way out. If I get burned out, I better deal with it and get better fast because I don’t have the luxury of “let me just quit and get another job” … I cannot do it. I don’t have that privilege of quitting because … for me [it] means going back to my home country, which I love, … but the problem is that I have a life now here. So, it’s not an easy decision, it’s goodbye to the last ten years … That is very hard because it limits, it kills any motivation … and it puts that pressure … Like a pressure pot … and then it’s like putting on a lid that will not open … So, being an immigrant, and then listening to immigration trauma all the time and not having a way out? “Ooh! That’s fun!” That puts a lot of pressure in the therapist, and we … tend to burn out. (Maria)

(ii) Lack of training. All eight participants shared that the lack of training regarding migration and secondary trauma in their graduate programs and training sites was a risk factor that negatively impacted their work.

Regarding training on matters of immigration and migration trauma, the participants veered toward talking about culture and diversity courses because it was the only subject in which content about Latinx and immigrant issues might be discussed. RR96 shared that despite living and working in a city that has a large LatAm population, she has not received formal training beyond basic information:

Not to try to crap on my program, but that’s the reality of it. My diversity class really didn’t touch base on … the intersectionality of diversity. We have a Latino man who’s also queer. We never talked about that in class … more than just stamping Latinos, familismo, machismo, marianismo, right? … What more about that? … How do we actually do that practice part, not just the theory part? When we talk about Latinos we
talk about, … “they don’t like mental health services.” Second [and] third generation Latinos sometimes do. You can’t just stamp the same thing around all of them. Sometimes my peers don’t know the difference between Hispanic, Latinx, BIPOC, Afro-Latinx … very basic information … Yeah, I would say no formal training, which is very sad, because I’m in [a predominantly Latinx city]. If a city has Latinos, it’s [here]. (RR96)

Similarly, Paciencia shared that despite having attended two graduate programs for their degrees, they did not receive training regarding migration trauma: “Received? None [laughs] I didn’t get anything formal … Neither program gave me that, which sucks … The diversity section, per usual, was just bad.” Faholo shared that, to receive training for matters of diversity, particularly about immigration-related topics, she has to travel out of the state. However, she shared that she has started to see more training regarding racial trauma in the Midwest state where she lives.

The exception to the shared experience of lack of training was Bovi, who discussed that he received specialized training on how to work with Latinx immigrants and Spanish speakers as part of his doctoral program. He emphasized:

I don’t want to oversell the fact that I got some training in this and make it sound like that’s the norm across the United States. When the reality is that in most places there’s zero to none. Like if you took a multicultural class and you talked one week about immigrant folks, I’m shooketh, right? Usually, you’re going to get thrown in with Latinx experiences and then that’s why everybody assumes that every Latino is an immigrant … I run into a lot of folks, … that have never done any formal training, even when working at a majority Latinx institution. A lot of people learn in the job. So, for the first three years as a provider, when I was still getting my master’s, I didn’t have any specialized training besides my lived experience being specialized enough. (Bovi)
Regarding training on secondary trauma, the participants shared that it had been minimal if it occurred at all. Bovi shared that he did “six years of a PhD and there wasn’t a class specialized in trauma, let alone secondary trauma.” This experience is echoed in Paciencia’s response:

*I think [training on secondary trauma] … would be even less likely, just because if they’re not even talking about the main trauma stuff, then vicarious trauma is not coming up at all. [The] few times it’s come up, I feel like people don’t think it’s real or don’t give it value … It’s very real, I’m sure that I’ve had that to a point too, … it’s not something that’s easy to point out. But I have seen it in my students, for sure … I wish there was training but I guess I have very little faith that there will be.* (Paciencia)

Faholo shared that while she has seen an increase in discussing matters adjacent to secondary trauma, such as burnout, she expressed that her “employers have not been understanding that it’s an additional layer when you are a clinician of color serving clients of color or clients of the same identities.”

To make up for the insufficiencies in training, the participants rely on their lived experiences regarding matters of migration and secondary trauma and often brings those experiences to the places they study and work:

*When I was in school, … I was the only Latina, and I was already a practicing clinician, so I could bring the stories of what I did … into the classroom and … their eyes would open, and they were like, “[we] could never do this kind of work,” and I’m like, “what’s the big deal?” It was the disbelief, the not wanting to comprehend that people had suffered … to many of them it almost sounded as if I was relating a movie … I still have people in the profession that when I’ve gone to APA to present on immigration, … the trials, and tribulations, … the trouble with adaptation, the conflicting roles … People don’t believe it. … In the last ten years, there’s been more exposure, … so there’s more of a sense … I can understand my colleagues who had no points of reference. So, I would bring it*
constantly, the stories of immigrants … And for most people, they couldn’t relate … it’s kind of a foreign concept. (Dr. Luz)

Bovi described some of the ways that he supplemented for the lack of training:

There is an organization [where] they do trainings on immigration evaluations, U visas, T visas, VAWAs. So pretty much anything immigration-related to where a psychologist could meter mano19 … They teach you how to do it. However, it is expensive … To attend one of those trainings is like $3,000. So, how do we do the work if they don’t allow us access to the knowledge? But luckily my agency paid for the class so I could attend it, which was part of my contract negotiation, … Because I said, “I’m not willing to help you build the Latinx program here if you’re not going to give me the supports I need to learn what I don’t know yet.” (Bovi)

(iii) Microaggressions. Five of the eight participants talked about their experiences with racial and xenophobic microaggressions and its negative impact on their work. 503 spoke about his experiences with microaggressions in a previous place of employment:

We had a lot of Latinx clients, and they were low income, and they would come in and sometimes the children would get loud. And I remember my office manager [said] “you’re not like them, … you’re different.” And for me it was hurtful because you realize, “hey, by saying that comment you just offended … my ancestors, because where those people are right now, that’s where my parents were twenty years ago” … So, things that we sometimes can’t say anything [about] … I’ve had a lot of experiences like that. (503)

During the interview, Faholo weaved between Spanish and English because she was worried about someone overhearing her speak about anti-immigrant sentiments:

So, [Midwest city] is a place that is just starting the process of diversity. La retórica anti-inmigrante me afectó mucho.20 So, it helps when people are willing to share the success

19 Translation: put their hands in
20 Translation: The anti-immigrant rhetoric really affected me a lot.
stories of resilience, like in my particular case, I am where I am right now because I received the help that I needed ... So, I feel like they can see that investment could be real and I am a more productive member of the society. I don’t need to rely just on government support programs. So that helps it shift esas ideas negativas, para que nos vean con una mejor luz.²¹ (Faholo)

Mexicana discussed the risk factors within the context of her intersecting identities, reflecting that while she experienced xenophobia due to her accent, she did not experience it as severely as someone with a darker complexion than her would:

La otra suerte que tengo es que … I’m light-complexed, entonces yo sé que a una compañera que quizás tenga su doctorado … pero que es más morena, no la van a tratar igual²² … I used to feel bad because I didn’t pay for school, I don’t have student loans … And they treated me like “oh, la novedad, es de México, habla español.”²³ And others it’s like “oh, un Mexicanito,”²⁴ I don’t care for you.” So sometimes I did feel that it was too good for me … that I haven’t experienced what [others] have. (Mexicana)

Bovi spoke of the impact that anti-immigrant rhetoric and practices have on his work:

Even as I was writing my dissertation, it was super difficult because part of it was focused on mistreatment of immigrants in the U.S. … So, I was reading article after article after article at the time 45 was president, and just having to deal with watching a lot of his videos … as I was writing the dissertation that was very close to my heart because of my identities and because of the community. And by the end of it, wanting to beat a couple of people up, right? [laughs] Super healthy. (Bovi)

²¹ Translation: Those negative ideas, so they see us with a better light.
²² Translation: The other luck I have is that I’m light-complexed, and so I know that a colleague, who perhaps has their doctorate but is darker, they’re not going to treat her the same.
²³ Translation: “Oh the novelty, she is from Mexico and speaks Spanish”
²⁴ Translation: “Oh a little Mexican”
To close out the risk factor’s theme, I present an excerpt from Maria’s interview, which captures the essence of the participants’ experiences. Maria’s words reflect the interconnection of these risk factors and how they increase the likelihood that LatAm immigrant therapists may experience problems in their work:

*The very lack of resources for people that immigrated without documents. There is complex trauma, a lot, … like the fact that they immigrated is like putting five more layers in the trauma, period … It’s hard. So, it’s more complicated because you’re dealing with a lot of variables including the language, right? … Where I live there are not a lot of Spanish speaking therapists. So, then I feel the obligation of keep serving more and more, and I get tired. I am tired. I get burned out. And my friends too. Working with this population, we get burned because … it’s never enough.*

*And sometimes it’s like, if I don’t see this client, nobody else can see them, so I have to see them. Like I have to make a space for them, and it’s like “please, I’m tired” … People that serve other people that are not immigrants, it’s like trauma whatever, but then we have to deal with like “oh, what if the police stop them? What if their parents died in the other country?” They have court of immigration. And then you cannot find resources. It’s hard. And then the resources that there are, sometimes they’re not good. So, it’s like limited and there’s nothing I can do about it. So, I feel very powerless, and I think that burns me out because … I feel a lot of weight and I cannot do it.* (Maria)

**Group Experiential Theme 3B) Protective factors**

This theme encompasses the elements associated with a decreased likelihood of experiencing adverse problems at work. The participants identified the following protective factors: a) viewing their work as their life’s mission and b) resourcefulness.

**a) Grounding in sense of purpose.** Five of the eight participants shared that viewing their work with LatAm immigrants as their life’s mission was a protective factor. Bovi shared that he views this work as more than a career as it aligns with his cultural values:
It is incredibly rewarding, like the work that you will get to do is soul work. There’s a profession and there’s a calling and I feel like in some ways … this is my calling, to work with Latinx folks, immigrant folks. Like this is above and beyond dysfunctionality, and I think that it is the intersection of who we are as people. Personalismo, familismo, respeto, right? These are values that regardless what Latinx country you come from, we will connect with, and we bring that into the work that we do. (Bovi)

RR96 described her career as being something she was “made to do,” that it gives her a sense of purpose, and that not many people from her home country get such an opportunity:

Having that sense of purpose, for me this career, and … the challenges, practicum, studying, for me feels like this is the one thing that I was made to do … I feel very blessed to be able to say this, because I’ve never felt like I’m going to quit this program, … I feel imposter syndrome for other reasons but not for that. So that would be a protective factor for sure … Also, you know, the sense that not everyone gets this opportunity. I’m pretty sure I’m one of the very few [nationality] little girls who grew up and dreamed of going to college in the U.S. and actually did it … someone in my family once told me, “That’s setting up an example for people in your home country that si se puede, they can do it too, that se vale soñar” … So, being proud of my heritage and … stamping that I am from [home country] and I’m proud of the things that I’ve accomplished, through the sacrifice of my family, of course. (RR96)

While Dr. Luz did not speak directly about the work as her life’s mission, her 50-year career working and advocating for LatAm immigrants indicates a dedication to this work:

It’s time and interest. I know a lot of people my age would probably be retired. I have no interest in being retired. I’ll die at my desk. I have no interest in stopping because I’m so fascinated by the work. Each case is so different … each one of them has such a

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25 Translation: Personalism, familism, respect
26 Translation: “yes, we can” and “dreaming is worth it”
different life experience. And that life experience just kind of invigorates me, just to know that they survived and that they’re here and that they’re going to move forward ... I guess I enjoy the whole storytelling ... the evolution of the decisions that they made, how they made them, what got them here. Because I know that it’s hard. (Dr. Luz)

b) Leveraging resourcefulness. Five of the eight participants also displayed resourcefulness in how they approached the challenges of their work. For example, in the face of limited resources, 503 explained that remaining flexible and trying different approaches is imperative:

As far as, protective factors, … I think one of the things is having that flexibility … if something doesn’t work, it’s OK. “What can I do differently?” You know? If a resource doesn’t work, what other resource is available? ... let’s give it a try. What is under our control? … Flexibility and trying something different, ... trying new things. (503)

Similarly, Faholo shared that “you have to be very creative to provide referrals. I had to kind of build my own network, people who knows what I’m talking about, … it’s hard.” Bovi reflected on how immigrants must be “scrappy” to make the most of limited resources and opportunities. He also shared his vision of LatAm immigrant therapists and allies creating spaces and resources that are missing from the system as a way to support their clients:

No one teaches you how to do … the business of psychology, [and] I think it is directly connected to the work we do with immigrant folks. Because we’re too expensive for the people that we want to work with to afford us. So how do we make that sustainable? … I think that private practice is a plan of liberation, especially as we talk about … what it is to do this work for so long for free … I think we have to get creative so that people we want to work with can access us … Nipsey used to say, “buy the block back, all money in, no money out.” And I think I’m in that mentality right now, like how do we, as a community, ... reclaim our services to be the vision of what we want it to be? (Bovi)
Bovi described some of the ways he utilized his scrappiness to obtain the support and training to provide services that were needed in his community:

*One of them was through my [graduate] program. A professor did [immigration evaluations] on the side. So, I was like “yo, what’s good? I’m your boy … this is what I came here to do!” [laughs] So, I roped him into doing some mentorship in exchange for free labor. You gotta be persistent, but hey, we out here doing it now! (Bovi)*

**Group Experiential Theme 3C) Mitigating factors**

This theme encompasses the elements that minimize the negative impact of the work on the therapist. The participants shared the strategies they utilize to deal with the challenges of working with traumatized populations. These strategies included: a) developing a protective membrane, b) embracing practices of care, and c) bringing others in by venting things out.

**a) Developing a protective membrane.** All eight participants engaged in strategies to deal with the difficulties and stress of their work. Dr. Luz shared her outlook that while working with LatAm immigrants can be negatively impactful, there are ways to manage:

*I’m not trying to minimize it. It does have an impact. But it’s almost like you can develop a membrane, a protective membrane, that doesn’t allow it to seep in all the time. But some of the stuff will stay. Dramatic stories where people have gotten severely hurt, you do remember those things. You don’t want to stew in them, because soon enough, another story will be right behind it, and you don’t have the brain to keep it all. So, you just deal with it at the moment and then you move on. (Dr. Luz)*

One way the participants minimized the impact of the work concerned their schedules. For example, RR96 shared that, “especially when [she] was seeing a lot of immigrant patients,” she would “try to leave 30 minutes between every patient to just unwind and decompress” despite her agency “scheduling back-to-back sessions” for her. Similarly, 503 shared that the back-to-back schedule left little space for reprieve and contributed to his experience of burnout:
Having someone with a traumatic experience in an individual session, … five minutes before I have to go up in front of 85 people to do a lecture … It was very draining for me, … draining paperwork, draining lectures, draining individual sessions. That’s one of the reasons I left, the burnout, and you’re doing the best that you can. (503)

Paciencia described a strategy where they intercalated their schedule depending on trauma content to balance out the heaviness from session to session:

I know that when I was able to, … which was not very often … I would try to have the next client not be as trauma heavy, if possible, like have various levels of what I was dealing with, if you know what I mean. Or even better, if I could have a little bit of a break between them … that’s how I managed it. (Paciencia)

All the participants stressed the difficulty of implementing these strategies because of full caseloads. Mexicana highlighted the role that agencies can take in supporting such practices:

I don’t like to just cargarle la mano a los que hablan español y que ellos hagan todo,27 I like to combine things. Like if a therapist [has] a different skill, let’s say IT or social media, then maybe 30 hours you can [do] therapy stuff and the other 10 hours you can do this other interest of yours. So, I think that helps the burnout … having some variety of activities, [it] makes them feel less stressed out … I have the freedom to do it, but it’s not a common thing in most places. If you’re a therapist, te quieren exprimir, y nada más vas a hacer eso porque28 we can charge the insurance companies. So, in our case we don’t deal with [insurance] right now. So, we are free to do those things. (Mexicana)

Other ways that the therapists tried to manage the stress of the work was by attempting to contain their work from other areas of their lives:

One of the things that I teach others is how to compartmentalize, because you can’t keep all this stuff. You can’t do this work, … where there’s trauma after trauma after
trauma, without learning to compartmentalize. So, the minute I close my door to my office, it stays here. I don't take it with me. But that comes over time. I say it as if it was easy to do and it's not. Because the tendency is to want to talk about what happened with X, Y or Z case, and you can't do that ... I know that what I do, I need to leave here, I cannot take it ... Because it's not helping me or anybody else. (Dr. Luz)

While most of the participants emphasized the importance of “separating what they are doing at work, so it does not affect [their] personal life” (Faholo). Paciencia shed light on the fact that it is not always the healthiest practice:

*I mean, for better or worse at the time, I was pretty burnt out because I was working a lot of jobs, so … I just put my energy into that. I didn’t have a lot of time to think about things … this was very early in my career, so they weren’t paying me almost anything at all. So, I was working other jobs, … and so for better or worse, that’s probably what my energy went into … it’s not the best way to process it, but that’s what I did.* (Paciencia)

b) Embracing practices of care. Six of the eight participants described care practices as mitigating factors because they helped distract them from the impact of the work. RR96 shared that she “learned the hard way that mental health matters and sometimes you just have to take the time off, even though my personality tells me just … keep pushing, just keep working. Now I take times off.” Bovi described it as “doing whatever it is that I need to do to get some of my own trauma out of the way.” Some of the activities included exercising, spending time alone, reading, and watching a favorite show.

Faholo shared that she had to learn to give herself “permission to rest” which took experience and time. Similarly, Dr. Luz shared that it took her many years and discipline to be able to disengage. She expressed that people “won’t last long in the profession” if they do not have “something else to occupy [the] time … an escape mechanism … You have to find that which will give you another direction to put your energy and focus away from it” (Dr. Luz). From
her role as director, Mexicana shared the importance of supporting her staff in managing the impact of burnout:

> Now, especially after COVID, … we encourage our staff to do self-care activities, because you saw a lot of burnout … So, we would do [Zoom] meetings where we [had] meditation, yoga, listen to music. Things that helped them relax at least for that hour that we were together … We want [the staff] to take care of themselves because they tend to be … working, working, working and “oh my client this or my client that.” We had to tell them “You have to take time for yourself. Take a whole hour lunch,” because sometimes they will eat at their desk. So, there’s things that we as an agency try to do so they wouldn’t feel that burnout and be in a better position to help others. (Mexicana)

c) **Bringing others in by venting things out.** Five of the eight participants also discussed the importance of having formal and informal outlets to let off steam and receive emotional support. Such outlets included therapy, consultation groups, supervision, and friends. Paciencia stressed that, for them, having other LatAm immigrant Spanish-speaking therapists was particularly helpful in receiving support at their agency, especially with frustrating matters such as when their clients' immigration paperwork was denied:

> [Case management] was hard, and the way that I managed it was trying to talk to other [therapists] who were working with similar populations who also came from a similar background. So, there weren’t many options [laughs] … but there was a few of us who could talk, … so, I was close to all of them. It was very helpful to be able to vent about it … And though I’m glad I left that agency, I did make a lot of really close friends there, probably because we were all stressed out at the same time. (Paciencia)

In addition to having people to vent to informally, the participants highlighted the importance of engaging in therapy to avoid doing a disservice to their clients:

> For me, it’s always, protect myself from being triggered and preventative counseling, [so I don’t] do a disservice to my patients by being triggered in session because I didn’t
process that, ... and then there’s no more therapy going on, or I was just trying to put a band aid to it ... So, we can either do a disservice, keep it to ourselves, and everything gets spiraled down, or we can process and talk to other people who have knowledge and who will guide us on how to handle the situation ... So, processing those emotions, and doing a lot of reflection ... outside the session to navigate, you know? (RR96)

Mexicana shared that she noticed a difference in how the current therapist trainees react to their clients' stories. She attributes this change to their engagement in therapy, which was not a customary practice when she was in school:

*I don’t think [seeing a therapist] was a requirement or even encouraged when I went to school ... Now, most of [the students we supervise] are encouraged, to have their own therapist. And that’s a big difference ... That has an impact on how they react to their clients’ stories, because they are in therapy themselves.* (Mexicana)

Paciencia remarked that despite their years of clinical experience and of processing their trauma in therapy, they still become triggered in their work with LatAm immigrants:

*I’ve had my own therapist for a very long time, ... I need to be able to check in with somebody else ... Especially if you’re an immigrant yourself, ... I think it’s really essential that somebody be doing their own work, because ... it’s not that I haven’t been doing the work, but it doesn’t mean that it’s done ... I have stuff come up randomly that ... I didn’t even know was bothering me, but apparently it is. So, it’s good to have somebody to check-in with so that you’re not accidently doing something with your client that you shouldn’t ... because you’re not looking at what you’re dealing with.* (Paciencia)

**Group Experiential Theme 3D) Sustaining factors**

This theme encompasses the elements that allow the participants to engage with the work in a long-term capacity despite its difficulties. Their stories spoke of sustaining factors such as: a) feeling empowered, b) witnessing their clients’ small victories, and c) contributing to changing the system.
a) Feeling empowered. Four of the eight participants shared their experiences of feeling empowered by their work with LatAm immigrant clients. Such experiences of empowerment included being one of a small number of Spanish-speaking psychologists in the U.S. RR96 reflected on how meaningful it is to her to be part of this statistic:

Learning that there are only 5,000 Spanish speaking psychologists in the U.S, ... like it’s one percent of psychologists. Knowing that I can be part of that statistic and, you know, make a contribution, that makes my work meaningful. And that’s kind of what makes me go into practicum, ... and even offer pro bono services because people in my home country, for example, don’t have access to those services. And they need them. (RR96)

Bovi echoed this experience and how this means that he is often the first therapist his clients have worked with who speaks Spanish:

The first thing that comes to mind is “empowering,” just to be able to work with your community. The amount of times that people tell you “I didn’t know we did that [therapy],” Or “I’ve been looking for someone that was Latino and Spanish speaking for about two years” ... They’re shocked at the fact that we become doctors or that psychology is something in which we have Latinx folks doing great work. (Bovi)

Mexicana expressed that utilizing her Spanish-English bilingual skills at work is a privilege:

That whole thing that we’re able to do here, I have friends that would say “oh wow, I don’t have the opportunity to speak Spanish at work. I don’t work with other Latinos,” and that is an advantage that we’re very aware of ... So, to me that is a privilege that I have had for a very long time, that I don’t take for granted because I know that not everybody is that lucky. (Mexicana)

b) Witnessing the clients’ small victories. Five of the eight participants shared that having small victories with their clients encouraged them to continue moving forward with their work. For example, Bovi and Dr. Luz shared that learning that their clients’ immigration cases were approved is meaningful and indicates that the immigration evaluations they provide make
a difference. Bovi shared that knowing that the clients “will be able to stay [in the country] and have access to different resources that weren’t there before” was a source of motivation for him. The small victories also included witnessing the “resilience of humankind” (RR96) through their clients’ changes in therapy. Faholo remarked on her clients’ resilience and ability to implement what they have learned in therapy:

> Oh, I love it, … they are so resilient that you can give like two, three tools and all of a sudden, they are giving therapy [laughs] It’s so nice. And you know, there are exceptions, but I just see they learn so fast … You can see like the transition from being, _como de la oruga a la mariposa_, \(^{29}\) in a super short time. (Faholo)

Mexicana shared a similar experience regarding what motivates her and her staff of LatAm Spanish-speaking therapists:

> I think we can see the difference, … I’m not talking just about the talk therapy and how it helps them to think differently, to see themselves in a … more positive way, to identify their skills, to see their progress, … the fact that we’re able to provide services in their own language with a cultural perspective is a tremendous satisfaction for us. Because we see someone that comes all sad and “I’m not worth anything,” to “I feel better, I know I have value, I know I can contribute. I am a better parent; I am a better listener to my partner … Now I can defend myself because … I know what my rights are.” … They feel that they have more worth and that there’s … hope. So, all those things … are a reason for feeling satisfied that what [we are] doing is meaningful. (Mexicana)

Likewise, Bovi shared that for him, the small victories include helping his clients move away from survival mode, and make shifts in relation to oppressive cultural perspectives:

> Being able to teach things that a lot of folks take for granted, but our community has not had access … or the privilege of time to think “how do I take care of myself?” Sometimes

\(^{29}\) Translation: _like from the caterpillar to the butterfly_
we’re in survival mode and we stay in survival mode for a lot of the time … So, “que breathing ni que coloring”30, I don’t got time for none of that shit” [laughs] Like all of a sudden, starting to see that change and shift, it’s powerful … Seeing young immigrant people feel pride in the fact that they’re immigrants instead of feeling shame, like reclaiming that part of themselves … And seeing that empowerment grow. (Bovi)

Dr. Luz shared that she moves forward by focusing on the client in front of her rather than thinking of the people that still need help. About one case, in particular, she shared:

I had a 12-year-old that walked all the way from El Salvador to find her grandmother. I’m amazed how she survived, but she survived! … Probably there are other kids that didn’t make it. I’m very much aware of that. But I tend to focus on “well, she made it,” and now we need to figure out what she needs to keep her here, and so I will work my ass off to make sure that that happens. (Dr. Luz)

While Maria shared that having small wins with her clients is one of the motivators to continue working, she also gave a “jaded” reason for engaging in this work – that she cannot leave her job due to visa limitations:

Moments … lots of small wins, like little victories with the kids. Smiles. When they keep coming back and say thank you, Ms. [Maria]. I guess it’s just a passion that I have, being a hopeless optimistic … [having] faith in humanity. And, being a little sarcastic, … the fact that I cannot change jobs, so my visa, [laughs] that’s a factor. [laughs] I keep doing this because I cannot do something else. Even if it gets bad, I have to do it, I have to overcome it. But that’s just me being jaded and sarcastic and tired [laughs]. But I mean, at the end of the day I do have a choice, which is leave, and I choose to remain because I deeply care about it, about people, and about my people. (Maria)

30 Translation: what breathing or what coloring
c) Contributing to changing the system. Four of the eight participants shared that contributing to changing the systems that LatAm immigrants engage in plays a crucial role in being able to continue to engage with their work. Bovi shared: “A lot of the times, systems are not built for us immigrant Latinx folks in mind, and you’re still part of that system … It can be difficult and frustrating.” One of the ways the participants contributed to changing the system was through diversifying mental health services. For example, RR96 shared: “we need more diversity and need more [Latinxs] mental health providers. And when we’re bridging that gap … we’re changing the system in a sense, one by one.” For Bovi, providing LatAm immigrants with a different experience is his way of changing the system by bringing social justice into his work:

*If I would’ve had someone that looked like me … or someone that at least knew where I was coming from and they said “hey, I’m sorry, this is hard. Like I get that you’re going through a hard patch,” instead of telling me “I know what this is like.” … I would have done … my own work way earlier in life. Instead, I had to go through a few more years of hardship and suffering … because of who the messenger was. So, I think I’m constantly connecting back to that, … and thinking “How do I pay that back? … That lets it be worth the while. It’s my own way of bringing social justice into the work that I do.* (Bovi)

Similarly, Mexicana shared that having the opportunity to provide LatAm immigrants with an experience in which they are valued and respected is sufficient motivation to continue to engage with her work despite its challenges:

*Being able to work with my own people … gives me that satisfaction and energy to keep doing what I do … I believe in justice, and I believe that our Latino community should have the same rights [and] opportunities as everybody else … Because we know that in other places they would not be as lucky as they might be when there are agencies and people that look at their best interests and treats them with respect and dignity and not like second class citizens. So, if I’m sticking specifically to those that are not documented, we know that they’re not treated with dignity and respect every place they*
go. So, the fact that we teach them to look at their own skills, qualities, … and values, to me that is enough to keep me going. (Mexicana)
Chapter 5. Discussion

This study was designed to explore the lived experiences of LatAm immigrant therapists who work with LatAm immigrant populations. This chapter discusses how the themes elicited from the participants fit within the existing body of research. The discussion includes the study’s main contributions and significance in broadening understandings of the LatAm immigrant therapist-client relationship, secondary traumatization regarding migration trauma, and the influence of several factors (risk, protective, mitigating, and sustaining) on the therapists’ experiences. The chapter ends with a presentation of the study’s strengths and limitations, implications, and recommendations for future research and practice.

Domain 1. LatAm Immigrant Therapist-Client Relationship

One of the aims of this study was to learn how LatAm immigrant therapists describe the experience of working with LatAm immigrant populations. All of the participants expressed that the work was simultaneously challenging and rewarding. More specifically, they spoke about the therapist-client relationship and how aspects of their identities (e.g., being LatAm) and lived experiences (e.g., being immigrants) either facilitated or created challenges to the therapeutic treatment. The participants spoke of a duality in relationship phenomena that emerged as: 1A) dynamics of connection and overidentification and 1B) experiencing a sense of duty as cultural liaisons to de-stigmatize mental illness and mental health services among LatAm immigrants. The interconnectedness of these phenomena is depicted in Figure 1:
**Group Experiential Theme 1A) Dynamics of Connection and Overidentification**

The relational dynamics of working with LatAm immigrants served as the framework from which the participants discussed their experiences as LatAm immigrant therapists. They shared how their insight as LatAm immigrants facilitated the therapy process because a) it made therapeutic engagement occur faster, more effortlessly, and connections more profound. Furthermore, the participants reflected on how the same factors that facilitated treatment also created challenges, such as experiencing overidentification from the high relatability, which b) necessitated navigation of more permeable boundaries.

**a) Faster, easier, and deeper therapeutic engagement.** The participants reflected on how their own migration and ethnic backgrounds allowed them to start steps ahead, bypassing the introductory part of the therapy process because there was an unspoken understanding between them. One way they could expedite engagement was by minimizing instances in which

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**Figure 1 Domain 1. LatAm Immigrant Therapist-Client Relationship**

[Diagram showing the dynamics of connection and overidentification]

1. **Faster, easier, and deeper therapeutic engagement**
2. **Navigating more permeable boundaries**
3. **Working with a trauma-aware approach**
4. **Being "the only one" leads to sense of obligation**
clients have to explain themselves, a finding that echoes those reported by Goode-Cross and Grim (2018) and Kokaliari et al. (2013), to name a few. Such facilitative effects on therapy have been documented in studies on racial and ethnic matching that demonstrate that the experience of familiarity between LatAm therapists and clients may reduce barriers in the therapeutic alliance (e.g., (Cabral & Smith, 2011; Nadathur, 2019; Ramos et al., 2020; Suero, 2018).

In addition to being able to start steps ahead in the therapy process, the participants expressed that the engagement with their LatAm immigrant clients was more effortless. They described the ease as providing relief to their clients, who said they finally found a therapist with whom they could connect. A characteristic of the therapist that made the engagement more effortless was their ability to use Spanish language skills in therapy. One way this was facilitative was by allowing them to engage with their clients without using interpreter services. This finding is supported by studies that indicate that the utilization of interpreters can hinder therapeutic engagement due to having a third person in the room and having the therapy process depend on the attributes of the interpretation that is provided (Fidan, 2017; Hale, 2019; Seto & Forth, 2020). Of course, in situations where the therapist may not speak the language, utilizing interpreters may be the best option when the alternatives are not to communicate at all or to provide ethically inappropriate services (Fidan, 2017; Santiago-Rivera et al., 2009). However, speaking directly to their clients means that the therapists can express familiarity with the clients’ sayings and values that may not be understood otherwise. The research scholarship on bilingualism in therapy highlights the ways that “cultural values are deeply embedded in language” (Kokaliari et al., 2013, p. 113), which is evident in communication practices of using dichos and cuentos to engage with people in and out of therapy. Beyond being representational, language can be used in therapy to facilitate space for clients to attach meaning to their experiences (Taylor et al., 2006). Having a shared language can facilitate the co-creation of meaning within the therapist-client relationship, destabilizing power dynamics and making the therapist more approachable and relatable (Castro, 2022).
The participants also reflected on how the shared experiences of migration and shared ethnic backgrounds not only expedited engagement and made it more effortless but also created a deeper connection with their clients. They hypothesized that they might not feel as deeply as if they did not have these shared identities and experiences. The deeper connection was underscored by the sense of reciprocity that created a more enjoyable relational experience. The importance of such reciprocity is emphasized by scholars in cross- and multicultural therapy research who advocate for the focus to be on the mutual and reciprocal nature of the therapeutic relationship rather than on prescriptive demographic characteristics just of the clients (e.g., Cabral & Smith, 2011; Lee et al., 2022; Verdinelli & Biever, 2009). These more recent studies on multicultural psychotherapy have documented the therapists’ and clients’ experiences of how shared race, ethnicity, and language act facilitatively in the therapeutic alliance.

The present study's findings are consistent with the seminal study by Verdinelli and Biever (2009), in which they interviewed 13 Spanish-English bilingual therapists who reported that they developed easier and faster connections with Spanish-speaking clients than with English-speaking ones. Additionally, their participants stated they were "more serious and detached when working with English-speaking clients" (Verdinelli & Biever, 2009, p. 238). While the present study did not ask the participants to compare the client populations they serve, we can presume that in expressing a deeper, easier, and faster connection, they are comparing instances in which that is not the case. Moreover, Verdinelli and Biever's (2009) participants attributed this quality of connection to their ethnicity, which they posited resulted in the therapists having more familiarity with LatAm culture and manifested in a more relaxed and humorous approach to the therapeutic relationship. Similarly, Engstrom and Min's (2004) participants reported that their therapeutic exchanges were grounded in their cultural insight and gave meaning to the relationship (Verdinelli & Biever, 2009).
The notion of faster, easier, and more profound connection due to shared racial and cultural characteristics was reported by Goode-Cross and Grim (2016) in their study on the experiences of 36 Black therapists working with Black clients. Their participants posited that their familiarity with cultural and racial experiences allowed them to engage with their clients with “heightened sensibility” and without having “to go to the literature” because they instinctively know (Goode-Cross & Grim, 2016, p. 38). The authors reported that regardless of years of experience, gender, and settings, their therapist participants reported connection faster and easier with Black clients than with non-Black clients and perceived their clients as being more comfortable. Additionally, the participants expressed a reciprocal positive experience that occurs when they can communicate with their clients in “more culturally congruent” ways by utilizing “cultural idioms and a shared vernacular” (p. 39). In another study with therapists who work with undocumented immigrants from Mexico, Baranowski and Smith (2018) relayed their participants’ perceptions that having a personal experience with immigration, providing services in Spanish, and having a shared ethnic identity, were assets to their work because it allowed them to build a strong therapeutic alliance. Nguyen (2014) reported that for the therapist participants in their study, being bilingual “brought an almost instant bond or closeness to the counseling couple” and became “a base for the working alliance” (p. 350). Similarly, Costa and Dewaele (2014) found that bilingualism had a positive outcome in the therapy relationship via attunement and identification that allowed the clients to feel “less dislocated and isolated” (p. 242).

This is anticipated by studies with therapists working with LatAm immigrant populations that have indicated the challenges that arise when the clients’ linguistic needs are unmet. For example, in their study, Taylor et al. (2006) found that of the therapists they interviewed, those who were LatAm and grew up in Spanish-speaking households reported having an easier time relating to their clients than the therapists who learned Spanish later. Additionally, the therapists reported that they believed their proficiency in the language and firsthand experience of LatAm
culture “facilitated greater understanding and empathy in their work with Latinos” (p. 436). Additionally, some of the therapists they interviewed who did not grow up speaking Spanish (unclear whether they were LatAm or not) expressed feeling as though their language proficiency limitations “held them back from greater cultural efficacy and competence when working with Latino clients” (Taylor et al., 2006, p. 437). The authors added that “despite the difficulties raised by conducting therapy in a non-native language, many of the therapists [...] felt a high level of acceptance, responsiveness, and appreciation among Spanish-speaking clients who otherwise would not be able to receive services” (Taylor et al., 2006, p. 437). It is critical to consider how receiving services that are not linguistically appropriate does not meet the practice standards of working with non-English speaking populations. Moreover, it is imperative that we do not equate clients’ manners and graciousness as an indication that we continue to provide subpar and ethically inappropriate services. The negative impact of not meeting the linguistic and cultural needs of LatAm immigrant clients in health services is well-known and well-documented in the literature (Altarriba & Santiago-Rivera, 1994; Baranowski & Smith, 2018; Biever et al., 2011). Research examining therapists’ experiences working with minoritized clients found that abrupt changes occurred when culturally important topics arose with racially different therapist-client dyads despite having good rapport otherwise (Lee & Horvath, 2014). This type of response to culturally relevant material presented a missed opportunity and negatively impacted the therapeutic alliance (Lee et al., 2021). These findings are corroborated by studies from the clients’ perspectives that reported that the participants who had non-Spanish speaking therapists explained that expressing themselves in their language would have improved the therapist experience (Sypolt, 2022).

The participants’ experiences of having faster, easier, and deeper connections with their clients because of shared identities and lived experiences can be explained via the cultural values identified for LatAm populations. One such value is personalismo which reflects adherence to “warm yet formal relationships” where interactions prioritize the person rather than
the task (French et al., 2020, p. 28). Another value is confianza which reflects adherence to “trust that takes time to develop” via mutual reciprocity (Padilla-Leon, 2017, p. 42). One example of how utilizing LatAm cultural values is facilitative to the relationship can be found in promotor/a/e-based grassroots projects in which community members are incorporated into various health services to bridge the sharing of knowledge and resources in their communities (Borelli et al., 2022). Their efficacy derives partly from their shared experiences and backgrounds that provide insight into the community values and practices.

While the general sentiment was that being able to connect via migration experiences, ethnicity, and language specifically was a facilitative advantage for therapeutic engagement, the participants also reflected that they need to be more mindful in their work because the characteristics that make the engagement faster, easier, and deeper, also create the conditions for more permeable boundaries.

b) Navigating more permeable boundaries. While the participants remarked on the speed, ease, and depth of therapeutic engagement, they also described instances where having shared backgrounds caused challenges to the therapeutic relationship via experiences of over-identification. The dynamics of overidentification described by the participants included feeling a higher level of emotional investment which necessitated they navigate more permeable boundaries. This included having to be more mindful of holding back their reactions to their clients’ stories, paying more attention to verbal and non-verbal disclosures, and not making assumptions based on their own experience – phenomena that have been brought forth as counter/transferential material in prior studies (e.g., Baranowski & Smith, 2018; Kokaliari et al., 2013), and considered to be “particularly evident in relationships where the counseling dyad shared the same language and culture” (Nguyen, 2014, p. 351).

The participants in the present study discussed the importance of being mindful of instances of overidentification because they can negatively impact service provision and decrease the effectiveness of therapy. The pitfalls of overidentification have been well-
documented in the literature. For example, Nguyen (2014) highlighted that the “possible collusion” (p. 351) between the therapist and client might prevent differences from being explored and may instead be replaced with assumptions by the other person. Other pitfalls of overidentification include the possibility to “trigger feelings of intimacy” (Kokaliari et al., 2013, p. 110), “boundaries being challenged by the client” (Nguyen, 2014, p. 351), confidentiality issues may arise, critical issues may be overlooked, and the therapist may become over-protective and overly involved. The therapist may also carry their “own ambivalence ... related to past country and culture,” which may make them “feel guilty for being in a better position than the client and may try to compensate for this by becoming overly active or gratifying” in the therapeutic relationship (Kokaliari et al., 2013, p. 102).

To avoid the pitfalls of overidentification, it is clear that the therapist must exercise vigilance in separating "what belongs to whom" (Nguyen, 2014, p. 351) because "undetected, or unaddressed, overidentification could impede the therapeutic process" (p. 351). The therapists in Taylor et al. (2006) expressed the importance of being mindful of the differences within LatAm populations and practicing "cultural sensitivity and clinical flexibility in light of the diverse experiences and perspectives presented by Latino clients" (p. 437). Costa and Dewaele (2014) reported that their participants expressed the importance of taking measures to address overidentification collusions and adopted strategies to deal with them (p. 240). However, the authors did not report what those strategies were. In their implications for practice, Nguyen (2014) included being mindful of boundaries and utilizing supervision to become aware of possible collusion. The present study’s participants echo these recommendations and further the discourse by describing strategies they use to mitigate the adverse effects of overidentification: working on establishing more balanced boundaries by focusing on the scope of their roles as therapists and relying on supervision for guidance.
Group Experiential Theme 1B) Duty as Cultural Liaisons Contributes to De-stigmatization

Through the relational dynamics of working with LatAm immigrants, the participants also reflected on their duty to utilize their positionality to serve as cultural liaisons. This sense of duty arose from their ability to a) work with a trauma-aware approach because of their lived experiences as immigrants and from often b) being “the only” LatAm Spanish-speaking immigrant therapist. The pressures of being in these positions heightened their sense of obligation to utilize their knowledge and experiences to liaise between their LatAm immigrant clients and the various systems they interact.

a) Working with a trauma-aware approach. Despite a lack of formal trauma training (discussed further on p. 147), the participants described an ability to provide trauma-aware services to their LatAm immigrant clients (explanation for use of “trauma-aware” can be found in footnote on p. 70). They described this ability as attunement to the clients’ trauma stories that led them to believe, validate, and normalize their experiences – central tenets of working from a trauma-informed approach (Hopper et al., 2010). Such an approach is key in creating safe spaces for traumatized people, especially given the anti-survivor tendency to doubt, question, and require proof of people’s experiences to determine their validity and worth (Herman, 2015; Rodriguez, 2016). While the “burden of proof” is a legal standard, it permeates the world we live in, and certainly the mental health profession – the sentiment being that survivors must disclose details of their trauma to mental health and other professionals in order to obtain services. The participants of this study compared their trauma-aware approach as diverging from what Paciencia called the “white and Western” norm of working with traumatized populations. This norm is marked by having clients talk about their trauma too soon and too quickly, a practice that is not only contraindicated by trauma-informed care (TIC) guidelines, but also displays a tendency of therapists, particularly therapists who are not immigrants, to engage in voyeuristic and self-serving behaviors when hearing their clients’ migration trauma stories. For example, they may ask for details of trauma without integrating the information into their therapy process,
begging the question of why clients would need to divulge their trauma experiences if it is not utilized as part of the treatment.

The practice of talking about trauma too soon and too quickly may be due to organizational procedures in which intakes and treatment plans need to be developed quickly in order to meet requirements for service provision (e.g., insurance coverage). The participants of this study described tension between working within the limits of what the system requires (discussed further on p. 141) and working based on what their insights as immigrants compels them to do to serve their clients. In the case of the participants of this study, they brought this approach via lived experiences. They described an ability to create relatively safer spaces for their clients that was rooted in their own experiences of having migrated. Some of the ways the participants worked from a trauma-aware approach included: allowing clients to take their time and tell their stories at their own pace, as well as naming things that their clients might find shameful (e.g., documentation status).

Other ways they were able to engage in a trauma-aware manner included the types of questions they ask and how they conceptualize their cases. Both the questions asked, and case conceptualizations, have implications for assessment, treatment, and the resources clients get connected with. While assessment and screening are important components of TIC, they are not necessary, meaning that providers and organizations can act in trauma-informed ways without requiring the disclosure of trauma material (Ellis, 2020; Hopper et al., 2010). It is imperative to consider how much is missed and dismissed about the client’s experience when therapists do not consider the contributions that migration dynamics have on the clients’ psychological, emotional, behavioral, and physiological presentation. Advocates of the importance of survivor-centered and lived experience-based service provision have emphasized that systems must be molded according to the clients’ and providers’ experiences to adequately meet the needs of the populations being served. The participants of the present study echo
these beliefs and describe these dynamics within the context of migration matters, a unique perspective from their work with immigrants.

**b) Being “the only one” leads to sense of obligation.** In addition to providing their LatAm immigrant clients with a trauma-aware therapeutic experience, the participants shared that they were often the only or one of few Spanish speaking, LatAm, and immigrant therapists at their agencies (discussed further on p. 139). Being the only one caused them to feel an obligation to serve the Spanish speaking LatAm immigrant clients who may not otherwise receive services that are culturally or linguistically appropriate or run the risk of not receiving services at all (Balderas, 2016, p. 198). The burden of their sense of obligation echoes those reported in other studies with immigrant therapists expressing that immigrants “need more than we can do. But if we don’t take them, who will?” (Balderas, 2016, p. 198). These experiences reflect those reported in several studies (e.g., Verdinelli & Biever, 2009), where participants described external pressures to provide services, such as the long waitlists, despite the lack of support at the agency level.

Another explanation for the heightened sense of obligation can be attributed to the very factors that facilitated therapeutic engagement and allowed the participants to work in a trauma-aware manner: their lived experiences as immigrants and their ethnic identities. These more internal factors caused them to feel invested and committed and therefore exert more energy and effort in their work with Spanish-speaking LatAm immigrants. Goode-Cross and Grim (2016) and Kokaliari et al. (2013) reported similar findings regarding therapists’ experiences working with populations racially and ethnically similar to themselves. The present study’s participants contribute their unique perspectives as immigrants working with immigrants, an area that has yet to be explored in the literature. This perspective includes the heightened sense of obligation that caused the participants to feel a duty to be cultural liaisons between their clients and the various systems they encountered. Some of the strategies they used to
liaise between their LatAm immigrant clients and mental health services consisted of the following:

⇒ Meeting the clients where they are by adapting their therapy approach based on their cultural knowledge regarding beliefs about mental illness. For example, the participants described spending time addressing negative rhetoric of mental illness as a weakness or an indication of a spiritual shortcoming. Studies of clients’ beliefs about mental health indicate that such rhetoric is rooted in cultural values of fatalismo – an adherence to the spiritual “belief that one’s life is predetermined, or subject to God’s will” (Flores et al., 2012, p. 32). Ascribing to this belief, LatAm immigrant clients may experience shame and guilt for seeking mental health services and may be fearful that others will think they are being punished or that they need only pray harder to get better (Nadathur, 2019).

⇒ Providing case management services to demonstrate to their clients the other ways the time could be used outside of traditional notions of therapy (e.g., connecting clients with resources, filling out immigration paperwork, and helping clients obtain housing). The therapists’ practices are considered the best (and humane) approaches to culturally- and trauma-informed care. Such practices are also highlighted in an executive summary released in 2022 that outlines the guidelines for working with low-income and economically marginalized populations, which immigrants often are (Juntunen et al., 2022). In their guidelines, the authors encourage psychologists and systems to implement concrete strategies, such as providing public transportation vouchers, offering reminder phone calls for appointments, childcare services for when parents and caregivers are in an appointment, flexing roles to include writing letters to support clients in accessing other services, flexing the typical 50-minutes therapy session, and flexing fees (e.g., via sliding scales; Juntunen et al., 2022). These strategies helped the participants de-stigmatize mental illness and mental health services for their LatAm immigrant clients – an experience they reflected on would have been helpful to them as
immigrants at an earlier point in life. Their sense of obligation can be understood via sentiments shared by immigrants (and children of immigrants) of having to work hard and make one’s sacrifices (and those of one’s family) “worth it.” This is reflected in writings of immigrants that emphasize that migrating is a sacrifice that often involves separating from family, country, and culture to survive or better one’s life (Abrego, 2014). Immigrant communities describe working hard to improve the family’s conditions as a way of proving that their sacrifices were not in vain and that there was a purpose despite the losses.

Summary of Domain 1 Discussion: LatAm Immigrant Therapist-Client Relationship

The burden of often being the only Spanish-speaking LatAm immigrant therapist whose lived experiences, as well as ethnic and cultural backgrounds, positioned the participants as liaisons for their LatAm immigrant clients. This role as liaisons both facilitates and hinders the provision of mental health services making their work simultaneously challenging and rewarding. Their heightened investment in their clients due to the ease of engagement and depth of connection created opportunities for boundaries to be more permeable, thus increasing their responsibility to be mindful of the potential dynamics of overidentification that arise. Their experience of being relationally closer to their clients and often being the only LatAm immigrant therapist at an agency also created conditions for this group of therapists to feel a sense of obligation to utilize their positionality to meet the needs of this traumatized population. The participants of this study described leveraging their firsthand cultural knowledge in service of their clients to provide them with the trauma-aware experience they wish they had experienced themselves.

Domain 2. Secondary Trauma Responses

Another aim of this study was to learn how the participants described their experiences of listening to their clients’ trauma content. More specifically, the focus of this study was to learn how LatAm immigrant therapists describe the experience of working with LatAm immigrant
populations in relation to migration trauma and their potential secondary trauma experiences. Their stories spoke of 2A) the toll of the work and 2B) opportunities for redemption. While these are categorized separately, it is vital to view the STRs as complex, often co-occurring, augmentative, and likely to change over time.

**Group Experiential Theme 2A) The toll of the work**

The participants reflected on how hearing their LatAm immigrant clients' stories impacted them. They spoke of the toll it took to hear stories so similar to their own or those of their loved ones. The toll of the work for these participants included: a) experiencing mixed emotions, b) taking the work home, and c) their own migration trauma becoming triggered.

**a) Experiencing mixed emotions.** The participants described their reactions to their clients' stories as emotionally heavy, especially when they shared lived experiences and identities with their clients. It was evident from their answers that being aware of and discussing their emotional experiences from the therapeutic work – specifically the experiences that result from trauma exposure – was not the norm at their places of employment. Bercier and Maynard (2015) explain that such experiences are "often surrounded in silence and shame as professionals avoid speaking up due to fears of being pathologized or labeled" (p. 84). Despite working within such contexts, the participants of this study described their reactions to their clients' stories as a mix of emotions – namely, sadness, anger, and powerlessness. They posited that these emotions arise in response to hearing their clients' migration stories, learning about their mistreatment due to anti-immigrant sentiments and practices, knowing about the high need for culturally and linguistically appropriate resources, and realizing the limits of their ability to help their clients. This study's participants stressed that they might not be as affected if they did not share migration backgrounds with their clients for the same reasons that they felt more connected to and invested in them (discussed further on p. 118).

The participants also spoke about the expectation that they should be able to move from client to client throughout the day despite the sessions' impact on them. They shared that not
only did they not have the opportunity to feel their emotions or talk about their experiences (discussed further on p. 136), but they were also expected to remain unimpacted enough to do the work. The participants described some of the ways that emotions are discouraged at their jobs: they are to hear trauma-laden content back-to-back, often without breaks; they do not often have decision-making abilities regarding their schedules; and they do not often have adequate supervision (these and other risk factors are discussed further in p. 136 - 148). For the participants, this expectation translated to demonstrating a level of neutrality, which they described as difficult to achieve because of the shared experiences with their clients and the heavity of the stories.

While remaining neutral has been equated with being a "blank slate," there is a distinction between remaining technically neutral (i.e., attending nonjudgmentally to clients without trying to sway them) and moral neutrality based on the belief that the clients' stories should not compel the therapist. Trauma theorist Judith Herman (2015) emphasizes the necessity of anyone who works with traumatized populations to take on a "committed moral stance" that is anything but neutral (p. 135). Instead, this moral stance is one of unwavering solidarity with the traumatized person and firmly against the conditions that degrade their existence. Nevertheless, the misunderstanding of what it means to remain neutral still plagues guidelines in the mental health field to resist being compelled by clients' traumatic stories. Such indications encourage the denial and repression of emotions to move on to the next client. While such an approach may work in the short term, it is not sustainable (van Dernoot Lipsky & Burk, 2010; discussed further on p. 136).

The pitfalls of taking a neutral moral stance include becoming desensitized and disconnected from the humanity of the person in the room. Not surprisingly, albeit ironically, desensitization and disconnection are also trauma responses – a signal of the profound moral injury that occurs when therapists are expected not to be affected by the stories they hear because there is no space or time to process the experiences. The present study’s participants’
mixed emotions indicate the tension that can arise in the therapist when they hear and hold story after story within the context of emotion-avoidant work environments. While this is a topic that has been written about in the literature (e.g., Bercier & Maynard, 2015), the present study’s participants contribute their perspective as immigrants working with other immigrants and how the shared contexts and histories create conditions for a toll to be taken on the therapist, particularly when there is no outlet to express their mixed emotions.

b) Taking the work home. The participants also shared the negative impact on their personal lives that listening to their LatAm immigrant clients’ experiences had, mainly because of the similarities to their own stories and the previously mentioned feelings of powerlessness. They expressed difficulty separating from the work, carrying the heaviness home, thinking about their clients outside the session, and experiencing difficulty sleeping. The sleep difficulties were brought on by the replaying of their clients’ stories at night, an activity that stirred up the feelings of hopelessness, impacting their ability to fall asleep.

Another way that the participants of this study described the impact on their personal lives, included experiencing shifts in their sense of safety. They gave examples of being preoccupied with the potential danger their families might experience at home, needing to check on their families to ensure their well-being, and questioning past decisions about their own migration (e.g., considering whether they had put their children in the type of danger that their clients described). Shifts in one’s sense of safety has been documented in the literature on VT from its earliest conceptualizations and included as a main concept in Pearlman and Saakvitne’s (1995) seminal book on VT. The authors present safety as one of the five core psychological needs (the others being trust, esteem, intimacy, and control) that are usually disrupted by trauma exposure (Pearlman and Saakvitne’s, 1995). Moreover, they explain that sense of safety is the most vulnerable need area because of the sequelae of disruptions to one’s frame of reference and worldviews.
The participants also reflected on their experiences of guilt that arose from their relative safety compared to their families back home and from their ability to travel in and out of the country to visit their family, whereas their undocumented clients cannot. Similar findings regarding guilt were reported by Padmanabhanunni and Gqomfa (2022) who framed their participants’ experiences through the constructs of survivor guilt and inequity guilt which consist of guilt from “being spared harm” and guilt from “having any form of advantage [...] compared to others” (p. 8), respectively. The present study’s participants add the perspective of how shifts in the sense of safety and experiences of guilt play out within the context of migration (e.g., being an immigrant working with immigrants). Furthermore, their stories describe the pervasive ways trauma work gets taken home – in a literal and figurative sense.

c) Triggers own traumas. Another toll of the work included experiencing triggers of their own trauma when listening to their LatAm immigrant clients' stories. The participants shared that their own pain surfaced when clients described experiences similar to their own. The surfacing of the pain came in the form of their own trauma replaying in their mind and subsequently becoming overwhelmed. These experiences are anticipated in the vast literature on STS, CF, and VT (reviewed in chapter 2). While the participants perceived their experience with trauma as something that facilitated a connection with their LatAm immigrant clients (discussed further on p. 118) and allowed them to provide services from a trauma-aware approach (discussed further on p. 125), they also shared how they were not expecting the triggers to be as negatively impactful as they were.

Paciencia specified that they did not consider the experience as re-traumatizing, but instead, viewed it as a trigger to their own trauma. For Faholo, her trigger responses changed over time, with hypervigilance, muscle tension, and physical exhaustion occurring earlier in her career and later on, experiencing more difficulty with remaining clinically engaged and curious. She posited that this was the case because of the repetitive patterns of the stories and the continual exposure to the trauma material (discussed further on p. 136) over the course of her
career. To date, the topic of how trauma responses (from either direct or indirect exposure) change over time, has not been broached in the literature.

**Group Experiential Theme 2B) Opportunities for redemption**

There was an overall sentiment that the heaviness of providing therapy to LatAm immigrants came in tandem with opportunities for redemption. These redemptive opportunities included being able to a) recognize their strengths and b) heal their own trauma.

**a) Recognizing their strengths.** One redemptive opportunity expressed by the participants was recognizing their own strengths by way of listening to their clients’ stories, so similar to their own. The participants explained that they could identify with how their LatAm immigrant clients moved forward despite the difficulties at the various migration phases. In identifying similarities, the participants discussed the overlap with their clients’ cultural strengths (e.g., creative resourcefulness and optimism in the face of challenges). These findings are consistent with the changes described by the concept of VPTG (described in chapter 2). In addition to increased personal strengths, the process of VPTG also describes increased wisdom, resilience, and a sense of purpose as the positive results from exposure to trauma content (Ali et al., 2021; Tedeschi & Moore, 2016). Identifying with the strengths of their fellow LatAm immigrants can help bolster the therapist's belief in their ability to cope and heal from their trauma, as well as promote the belief that the community can overcome the impact of trauma too (Ali et al., 2021). This outlook can help the therapist project hope back to the client and help them identify their strengths, further aiding in the therapy process.

**b) Healing own trauma.** Another opportunity for redemption was the potential for healing for the therapist. The participants shared that by helping their clients with tools and resources they did not have, they got to notice their own healing progress. Another healing aspect was witnessing immigrant resilience and hope, allowing them to develop a more resilient migration narrative. In their study, Padmanabhanunni and Gqomfa (2022) reported similar notions about healing among their female psychologist participants who worked with women
survivors of sexual assault. One of their participants stated that clients "bring something else that makes the trauma bearable for the listener. They bear this burden; you share in that load. It's not just left with you. It's the sharing of this load ... they give you some of how they managed to hold the [trauma], they give you some of that" (p. 7). Likewise, the current study's participants brought forth the notion that the therapist-client relationship is fertile ground for trauma processing and healing to occur.

The therapist-client relationship presents a unique opportunity for the LatAm immigrant to heal from the trauma of migration, which is often one of separation – separation from family, culture, and life as was known (Perez Foster, 2001). This study's participants described immigration as a process of continual loss. Maria described it as a process of grieving the lost parts of the self that begin to fade with time away from the home country. Thus, the trauma content that LatAm immigrants bring to therapy often concerns relational wounds due to the (often violent) separation from people and culture. The impact of the trauma is such that it permeates individuals and communities in pervasive ways. In her writings on trauma theory, Bonnie Burstow (2003) posited that "in traumatized communities, it is as if the tissues of the community had been torn asunder" (p. 1302). Understandings of trauma highlight that whatever the form it takes, "trauma befalls embodied individuals, and even when there is no explicit assault on the body, people become alienated from their bodies in some respect" (Burstow, 2003, p. 1302). Because the impact of migration trauma concerns injuries to relationships in various realms of life, healing must also occur in relationships. Thus, the LatAm immigrant therapist and client can find and connect with the parts they have lost in the migration process. Maria explained that while healing is never fully realized, functional healing can occur when the immigrant can learn to live with and move forward despite the heartache. Through the relationship with their LatAm immigrant clients, the participants' experiences told a narrative of reconnection to their lost parts, mirrored in their clients and their stories.
Domain 3. Factors that impact the LatAm immigrant therapists’ experience

The last aim of this study was to identify the factors – risk, protective, mitigating, and sustaining – associated with engaging in trauma work as a LatAm immigrant therapist. The risk factors consist of the elements associated with an increased likelihood of experiencing problems at work. The protective factors consist of the elements associated with a decreased likelihood of experiencing such problems. The mitigating factors consist of the elements that minimize the negative impact of the work, and the sustaining factors consist of the elements that allow the participants to do the work in a long-term capacity despite its challenges.

Group Experiential Theme 3A) Risk factors

The participants reflected on elements of their experiences that made their work particularly difficult (RQ5). They described difficulties that arose from within themselves, as well as difficulties from working at their agencies, within the mental health field at large, and from existing in this world. Because the risk factors spanned various realms, I organized them into the micro, mezzo, and macro societal organizational levels. It is important to note, however, that these risk factors are not discreet to one level; in fact, the various levels interact with and often exacerbate each other. Indeed, the risk factors are often a part of and a result of systemic racism that “creates chaos” and “disrupts the linear operations” of the various levels, bringing the distal issues (e.g., those from the macro level) closer to the person impacted – this is especially true for those further in the margins (Liu, 2022, p. 1235).

a) Micro-level factors. The risk factors at the micro level are related to inter- and intra-personal dynamics and include: (i) the therapist’s high exposure to a wide range of trauma and (ii) the therapist’s disposition.

(i) High exposure to trauma content. One of the interpersonal factors described by the participants of this study included high exposure to trauma content. They expressed that the exposure was due to the high number of cases and the wide breadth of trauma from every phase of the migration process (discussed in the literature review). The participants also
remarked on the similarities between migration stories that made the exposure to trauma material repetitive. The participants emphasized that there were similarities from client to client, as well between the clients’ stories and their own. Furthermore, the participants described the exposure as continual, explaining that they often have consecutive sessions without breaks, which makes it difficult for them to transition from one session to the next. Exposure to trauma has been one of the most consistent correlates of secondary traumatization documented in the extensive research scholarship (Ali et al., 2021). An aspect of this risk factor that was unique to the participants of this study was the reason for the elevated levels. The participants posited that their exposure to trauma was high because they were often “the only one” at an agency that could speak Spanish (discussed further on p. 127). Being the only, or one of few, that speaks Spanish means that the LatAm immigrant therapists were disproportionately assigned more trauma-laden cases by their agencies based on the demographic composition of the clients on their panels. Additionally, they reported that the expectation to translate and interpret for non-Spanish-speaking providers further increased their trauma exposure as they were exposed to their clients’ and other therapists’ clients’ stories. So not only were these LatAm immigrant therapists exposed to higher levels of trauma because of the demographic composition of their caseloads, but their experiences with having to translate and interpret increased the exposure. Therefore, having bilingual therapists carry out roles outside their scope (e.g., interpreting) is exploitative (discussed further on p. 139) and raises concerns regarding the heightened risk from higher exposure to trauma.

(ii) The therapist’s disposition. The therapists also talked about factors related to their disposition that negatively impacted how they experienced their work. One such factor was their own trauma history because of its similarities with their LatAm immigrant clients’ stories. The participants’ experiences are consistent with the research on STS, CF, and VT (reviewed in the literature in chapter 2). While findings on whether a personal trauma history can predict experiences of secondary traumatization are mixed, having a personal history of trauma is
generally considered "a noteworthy correlate to secondary traumatization" (Ludick & Figley, 2017, p. 116). The research thus far indicates that, especially for people with unresolved or unprocessed trauma, there is an increased risk for experiencing STS. The risk is heightened for people whose trauma more closely resembles that of their clients, with the data showing that this interaction prompts more distress than when the type of trauma content is of a different nature than that of the therapists’ (Ludick & Figley, 2016). Current understandings of how the therapist's history of trauma interplays with secondary trauma exposure is that it can exacerbate the responses to secondary trauma and eventually "become incorporated into their own trauma narratives" (Ali et al., 2021, p. 5). This experience can make the trauma experience more nebulous, with the impact of direct, indirect, and shared trauma exposure becoming increasingly intertwined.

The participants also identified that having a negative mental health state is a dispositional factor that increases the likelihood of experiencing difficulties at work. It is well-documented that experiencing negative psychological symptoms increases one's vulnerability and decreases one's capacity for coping (Garcini et al., 2018); within this context, it makes sense that if the therapist is experiencing symptoms that negatively impact their well-being, they would be more susceptible to additional adverse effects. Lastly, Bovi presented the last dispositional factor related to the immigrant experience that heightened the risk of experiencing problems at work. Such migration-related factors included the time of the year (e.g., when the person migrated), holidays, anniversaries, and other milestones. While these experiences have not been reported as risk factors in the scholarship on trauma or secondary trauma, they are topics of conversation among immigrant communities and reflected in anecdotal writing by immigrants (e.g., van Ecke, 2005), which shed light on the profound impact that the separation from land, people, and culture can have on the person. In her writings on the psychology of immigrants, van Ecke (2005) writes:
The longing when important life events such as births, new homes and anniversaries continue to take place back home without our presence, the sense of sadness when family back home become ill and we cannot be there to support them, and the grief when loved ones pass away before we have time to see them and say goodbye. For immigrants, this is the norm, not the exception, and despite email, [and] affordable phone service, ... life for an immigrant has a different quality marked by both opportunity and separation. No matter how great life in the new country is, at times we all miss the feelings of being surrounded with the people, sounds, smells and sights that constitute “back home” (p. 467-468)

Thus, from an attachment-theory perspective, "major separation and permanent loss pose a risk" for experiencing mental disorders (van Ecke, 2005, p. 474). For immigrants, the separation may be the departure from the home country and the cumulative losses over time which leave them vulnerable to experiencing problems, particularly around times when the separation is most salient.

**b) Mezzo-level factors.** The risk factors at the mezzo level are related to organizational dynamics and include: (i) shortage of Spanish speaking therapists, (ii) lack of appropriate resources for clients and (iii) lack of support from agencies.

**(i) Shortage of Spanish speaking therapists.** One of the main difficulties reported by all of the participants included the shortage of Spanish speaking therapists, which resulted in inappropriate services and limited referral opportunities (e.g., few providers that can conduct immigration evaluations in Spanish). The impact of often being the only or one of few Spanish speaking therapists at their agencies included being assigned all of the Spanish-speaking clients, having to act as interpreters for non-Spanish speakers, and translating documentation for the agencies (Duarte, 2020). The lack of language-appropriate services and resources available for both clients and their therapists is well-documented (and discussed further on pp. 141-144). Yet the participants of this study reported that the customary practice in 2022
continued to be to *translate-as-you-go*. This practice relies on the Spanish-speaking therapist to render translation and interpreter services without the appropriate training or compensation (Valencia-Garcia & Montoya, 2018). The participants of this study reported that while it is burdensome and against ethical guidelines, the expectation to engage in these practices are based on the sentiment that their agencies hired them *because* of their Spanish language skills – placing the Spanish speaking therapist in a precarious situation in which they can be more easily exploited (Biever & Verdinelli, 2009).

There is little doubt that bilingual providers improve access to services for linguistically diverse clients in the U.S., particularly for those who do not English (Estrada et al., 2023). Studies show better treatment outcomes when providers can incorporate trans-language strategies throughout the therapy process, as well as improved relational bonds and attunement (discussed further on p. 118; Kokaliari et al., 2013). Additionally, in a study that examined the differences in how therapists from various racial/ethnic backgrounds implemented evidence-based practices (EBPs) with racial/ethnic minority clients, Ramos et al. (2020) reported that Latinx therapists in particular, utilized their language and cultural competencies to serve traditionally hard-to-reach clients. They went on to state that the Latinx therapists expressed “more positive experiences implementing EBPs, making more adaptations to EBPs, and encountering fewer client-engagement challenges than therapists from other racial/ethnic groups” (Ramos et al., 2020, p. 9).

A common sentiment that arose from the participants of this study, was that they utilized disadvantaged situations (e.g., performing additional roles without proper compensation) and make the most out of them. For example, while the participants expressed that they took the situation of performing additional roles as an opportunity to obtain buy-in to treatment for their LatAm immigrant clients (further discussed on p. 149). Just because people adapt and make the most of things does not mean the negative impact is not profound. In addition to the negative impact that the shortage of Spanish speaking therapists had on the participants of this study,
they also talked about the detrimental effects on their LatAm immigrant clients. One such
detriment included being assigned a therapist based solely on language match, as opposed to
on other fit characteristics (e.g., therapist specialization match with client’s presenting concern).

(ii) Lack of appropriate resources for clients. Along with the language-related risk
factors, the participants remarked that the lack of culturally and linguistically appropriate
resources to connect their LatAm immigrant clients increased the likelihood of experiencing
problems at work. Not only does the lack of resources increase the therapists’ workload
because of the extra effort to find referrals, but they also experience disillusionment and
powerlessness. They expressed frustration that anti-immigrant rhetoric relies on the idea that
immigrants overuse and exhaust resources that are not their experience when trying to connect
their clients to services and inevitably contribute to the stigma their clients face. The reality the
study participants face is that their undocumented immigrant clients are often not eligible for
federal services, and in various states, they are ineligible for legal employment, postsecondary
education, and work-related benefits (e.g., workers’ compensation; Delgado-Romero et al.,
2018; Hernandez Vazquez, 2020). Moreover, undocumented immigrants may refrain from using
state services they are entitled to because it might render them ineligible for future immigration
procedures (Jimenez, 2021). Thus, resources are scarce, and the decision to utilize them does
not come without potential negative and punitive consequences. Additionally, Latinxs who are
migrating to new destinations (e.g., the Midwest or “The New Latino South”; Balderas, 2016)
encounter even fewer resources compared to those that migrate to traditional destinations (e.g.,
California; Lanesskog, 2018). This subpopulation of new-destination Latinxs is more likely to
seek free or low-fee clinics or emergency rooms where they may be met with even less
culturally and linguistically appropriate services (Lanesskog, 2018).

Moreover, the participants of this study discussed how the lack of appropriate resources
for LatAm immigrants means that they often have to help their clients with immigration and
health insurance-related processes and documentation (e.g., filling out applications, researching
what forms are needed, translating such forms). Similarly, Balderas’ (2016) participants described experiencing role strain due to external limitations in meeting the needs of their clients. Like the participants of the current study, they described difficulties with referring clients to other services because of restrictions on services for people with unauthorized documentation statuses and because of the potential for discrimination at organizational levels (Balderas, 2016). The participants also described spending “extra time and energy helping their clients with case management, advocacy in the community, managing a crisis, or accessing other services – even without getting paid for this time” (p. 178). While the study participants expressed that they were familiar with these processes because of their own experiences, they expressed frustration because doing so was not part of their job descriptions (which means it was often uncompensated).

Nevertheless, they felt obligated to help in this way because their clients needed it to access mental health and other social services. The participants described their experiences with immigration and insurance-related paperwork as a risk factor because of how complex and time-consuming it can be, how often it necessitates English-Spanish translation, and how uncertain the outcomes are (Duarte, 2020). The weight of the paperwork was made worst by the constant threat of deportation, which caused fear in their clients and made it difficult to address other psychosocial matters. While the paperwork was burdensome and hindered the therapeutic relationship when it consumed therapy session time, the participants emphasized their willingness to do it if their clients could receive the needed services. However, the rejections of their paperwork were disheartening and weighed heavy on the participants. Lastly, the study participants described that spending time in case managerial roles took away from the time they could spend with their clients working on therapeutic goals (e.g., processing trauma and reducing symptoms). Often the participants only had a couple of sessions with their clients (because of the same insurance-related limitations), and case management support took precedence over therapeutic support because of the urgency of the matters (e.g., figuring out
shelter for the night). However, the limits on sessions meant that clients might be left without at least coping strategies to manage their emotional and psychological symptoms.

**(iii) Lack of supervision support in agencies.** Another risk factor identified by the participants was the lack of support at their agencies, namely, inadequate supervision. More specifically, the participants reported not receiving culturally or linguistically appropriate supervision. Such experiences have been demonstrated in several studies on the experiences of Latinx and Spanish-speaking mental health (e.g., Estrada et al., 2023). Such studies have identified that while it is well recognized that clinical supervision is a “primary and key ingredient in graduate training and professional development,” the “supervision of bilingual trainees is both challenging and more complex when compared with the work with monolingual English trainees” (Valencia-Garcia & Montoya, 2018, p. 144). Some elements that make bilingual supervision complex are when the supervisors do not speak the language of the therapists and their clients, as sentiments may not be translatable, and thus, meanings may be lost. This may leave the bilingual therapist feeling unsupported in their endeavors to provide adequate therapy to their clients and holding a moral dilemma (Valencia-Garcia & Montoya, 2018). It may also cause the bilingual therapist to feel a heightened obligation to educate their supervisors and colleagues, which may present additional conflicts from power dynamics (discussed on p. 127).

The study participants also reported that they did not receive supervision support regarding secondary trauma, stating that it was not an area their supervisors broached. Not surprisingly, studies have shown that trauma-informed supervision is a protective factor for people working with traumatized populations (Padmanabhanunni & Gqomfa, 2022). Characteristics of supervision rooted in an understanding of how trauma manifests would include “attentiveness to specific types of vicarious trauma-related appraisals (e.g., clinician self-blame, sense of complicity, and inequity guilt), coping responses (e.g., adaptiveness of hypervigilance [...] ), and encouragement of clinicians to adopt a self-care plan and facilitate a safe and respectful collaborative relationship” (Padmanabhanunni & Gqomfa, 2022, p. 9). One
explanation for the lack of support from agencies for these matters can be gleaned from the participants’ experience in supervisory positions. They described pushback from the higher-ups at their agencies that discouraged them from providing person-centered supervision (e.g., encouraging students to prioritize work-life balance). They described the lack of support as deriving from organizational stigmatization of mental health, illness, and emotionality. Specifically, the participants described a general sentiment from their agencies and graduate programs that emotional experiences were not welcome. This rejection of emotional experiences prompted the participants to think that all they could do was deal with their experiences themselves and on their own time. Unsurprisingly, the mental health stigma that leads LatAm and immigrant communities to underutilize services also impacts the providers from the same community. An approach rooted in the knowledge that trauma responses (including STRs) are natural responses to human suffering would acknowledge and validate people’s experiences as clients and therapists (Cayir et al., 2021). As stated by Cayir et al. (2021), “organizational stigma may perpetuate self-imposed stigma” and may lead people to avoid broaching subjects with their supervisors, professors, managers, and peers (p. 11348). Leaders at organizations must adopt trauma-informed approaches (discussed further on p. 125) and foster a work environment that prioritizes the psychosocial needs of their workers, particularly those tasked with providing care to traumatized populations.

**c) Macro-level factors.** The risk factors at the macro level are related to systemic dynamics and include: (i) low pay and limited job opportunities, (ii) lack of training, and (iii) xenophobic microaggressions.

**(i) Low Pay and Limited Job Opportunities.** One of the systemic factors described by the participants included receiving low pay and experiencing limitations in job opportunities. The participants described being under-compensated relative to the additional labor required at their agencies (e.g., translating and interpreting and providing case managerial services – discussed further on p. 139). The low pay reflects the underfunding of programs for Spanish-speaking
LatAm immigrant populations and mental health services at large. In a study of the prevalence of mental health treatment facilities that offer services in Spanish, Pro et al. (2022) found that there was a decline of 17.8% (from 13,015 to 12,345) in facilities that offered Spanish-language treatment between 2014 and 2019, while the Spanish-speaking population increased by 4.5% (or 5.2 million people) during the same period. Though there is a shortage of providers that can render culturally and linguistically appropriate services (Delgado-Romero et al., 2018; Peters et al., 2014), and LatAm immigrant therapists fill gaps in services by carrying various roles at their agencies (Biever et al., 2011), they still experience difficulty finding work. This becomes even more difficult if they desire to serve populations other than LatAm immigrants and if they have work visa limitations (Cadenas et al., 2022). One of the results of receiving low pay was that the LatAm immigrant therapists might choose to leave community mental health and opt to go into private practice – contributing to the abovementioned shortage.

(ii) Lack of training. Another risk factor identified by the participants was the lack of training and education on migration trauma and secondary trauma. They expressed that this negatively impacted their work as they felt unprepared to work with LatAm immigrant clients. The narrative was that they did not receive training on “regular” trauma matters, much less on niche areas such as migration and secondary trauma. This is concerning on various levels, particularly regarding the interplay between the high prevalence of trauma among LatAm immigrant populations (Chavez-Dueñas et al., 2019; Sibrava et al., 2019) and the disproportionate number of cases with trauma content assigned to these Spanish-speaking LatAm immigrant therapists (discussed further on p. 136). When asked about their experiences regarding training about migration trauma, the participants veered toward talking about culture and diversity courses because these were the subjects in which content about immigration and Latinx communities was most likely to be discussed. The consensus was that said courses were insufficient as they often focused on theoretical concepts rather than on practical skills for working with Latinxs clients.
Evidently, it appears that to obtain a more robust training for working with LatAm Spanish-speaking immigrants, one must attend a specialized graduate program, programs that are often outside of the geographical and financial grasp of most graduate students (Delgado-Romero et al., 2021). Data gathered by the National Resource Center for Hispanic Mental Health and reported in a dissertation by Mezquita (2020), shows that in 2012, there were fifteen training and educational programs that focused on providing mental health services to the Latinx community. Mezquita highlighted that the same fifteen programs were reported six years later in a compilation by the American Psychological Association (APA, 2018) of programs with an emphasis on culture and language – the fact that there had not been an increase in programs highlights the “lack of emphasis and slow progress made toward the development of adequate training for bilingual mental health providers in the United States” (p. 9). Importantly, while these programs are filling a need to train providers to work with LatAm populations, this does not mean that they are providing training on matters of migration trauma, specifically.

The participants’ concerns also regarded the lack of training for treating trauma-impacted populations. Various calls to action to increase awareness and develop the competencies to meet the needs of traumatized populations have been made (e.g., Cook et al., 2017; Kumar et al., 2022; Moh & Sperandio, 2022; Rinfrette et al., 2021). In a national survey of doctoral programs in the U.S., it was found that only 1 in 5 programs offered a trauma psychology course and experiential training via practica (Cook et al., 2017). Scholars of trauma training advocate for the infusion of trauma considerations and multicultural competency development into existing program curricula to enhance the generalist approach (Cook et al., 2017; Houseknecht & Swank, 2019).

To make up for the lack of training the participants resorted to their own personal and professional experiences, they also utilized their resourcefulness (theme 3B, b) by seeking out opportunities to learn from people doing the work and negotiating trainings into their contracts. The latter was possible once they were done with school as they had more leverage to make
such requests. The participants also reported that to fill the lack of knowledge in their graduate programs and at their jobs, they would present cases of LatAm immigrants in a take-matters-into-your-own-hands approach. Similar experiences have been reported by other researchers (e.g., Balderas, 2016), highlighting how LatAm therapists who work with Latinx communities take on the responsibility of educating their peers and colleagues (discussed further on p. 127). In a study with survivors of gender-based violence in leadership positions, Marte (2021) posits the importance of considering that survivors inhabit positions at all levels of the organization and from this perspective, “clients are not strangers; they are part of our community” (p. 8). In her research she posits that her survivor participants, do not need more leadership trainings to help them manage the negative impact of the work, rather, what they needed is “a healing space that honored that social justice work is personal” (Marte, 2021, p. 8). It appears that much work needs to be done in the areas of cultural and linguistic competence and trauma, and much more work where these areas intersect – so that LatAm immigrant Spanish-English bilingual therapists can be prepared to work with the trauma-impacted LatAm immigrant population. Therefore, a trauma-informed approach that is responsive to the cultural and linguistic needs of LatAm immigrant clients and therapists is warranted (Sibrava et al., 2019).

(iii) Microaggressions. Another risk factor reported by the participants was racial and xenophobic microaggressions at their places of employment. Of course, such experiences with microaggressions are manifestations of the larger prejudicial context steeped in anti-Black and anti-indigenous racism (Sissoko & Nadal, 2021). Because of this, the people most affected belong to more marginalized groups (Cadenas et al., 2022). The negative impact of experiencing microaggressions is well-documented. Specifically, studies show increased mental health symptoms, increased vulnerability to further trauma, and re-traumatization due to continued exposure to discrimination (Sibrava et al., 2019). The nature of bias, microaggressions, and discrimination is insidious and makes it so that LatAm immigrant therapists and their clients navigate the same sociopolitical landscape. The LatAm immigrant
therapists in this study reflected on the heaviness of witnessing these prejudicial dynamics’ impact on their clients and pointed to the increased exposure to trauma responses from witnessing these microaggressions (as discussed on p. 136).

**Summary of Risk Factors.** The variety of risk factors identified by the participants of this study, demonstrate some of the conditions that increase their risk of experiencing problems at work, and place the LatAm immigrant therapist in a precarious position due to the “potential for being exploited that is inherent in this role and the challenges and demands of being the only Spanish-speaking therapist in the workplace” (Verdinelli & Biever, 2009, p. 237). The shortage of providers and therapist turnover reported by the participants of this study, and corroborated by others (e.g., Delgado-Romero et al., 2018), may be explained by these risk factors that present challenges for providers who are also part of the community they serve. Additionally, the reverberations of the impact of these conditions, on LatAm immigrants – therapists and clients – are reciprocal: that which impacts the clients, impacts the therapist, impacts the service provision, further compromises the mental health of both and perpetuates the cycle.

**Group Experiential Theme 3B) Protective factors**

The participants reflected on elements of their experiences that allowed them to do their work and decreased the likelihood of experiencing negative problems at work (RQ7 and 7a). Their answers included: a) grounding their work as their life’s purpose and b) leveraging resourcefulness.

**a) Grounding in sense of purpose.** Viewing their work with LatAm immigrants as their life’s mission was one of the protective factors identified. The participants expressed that the meaningfulness of their work made it feel more like a calling than a career. The notion of the work as their life’s mission influenced their therapeutic work and their mentorship with the next generation of LatAm immigrant therapists. It is no surprise that considering their work to have a higher purpose than merely a job acted as a protective factor. The protective properties of finding a higher purpose have long been identified (Aviad & Cohen-Louck, 2021; Frankl, 2006),
with numerous studies reporting inverse associations between meaningfulness and negative mental and emotional states (e.g., posttraumatic stress, depression, anxiety, and suicidality). In their work on stress and coping, and trauma and resilience, Keenan (2010) posits that our values "guide our responses to stress" because we not only "cope with stress," but we also "cope towards the values that are most important to us" (Keenan, 2010, p. 1043). Some explanations brought forth by the participants as to why considering their work to be their life's mission is a protective factor was that serving their LatAm immigrant community aligned with the LatAm cultural value of colectivismo, making their work feel more relevant and fulfilling (Gutierrez & Casas-Valdovinos, 2020). Particularly for cultures that hold collectivist values, resilience and growth may be experienced in a collective manner, and can include increased optimism, hardiness, a change of life philosophies, and greater awareness of possibilities (Ali et al., 2021). Another explanation was the immigrant experience of feeling the need to take advantage of opportunities (e.g., getting the chance to go to school and obtain a white-collar job) because they come from having sacrificed a life in their home country. Often, this experience is described as survivor's guilt (Padmanabhanunni & Gqomfa, 2022) which makes it so that the person feels internal pressure to not "waste" opportunities, as they result from personal and familial sacrifices. The participants in Balderas’ (2016) study also reported a commitment to serving the Latinx community and described it as a contributor to burnout prevention.

b) Leveraging resourcefulness. Another protective factor identified by the participants was their resourcefulness. The LatAm immigrant therapists expressed a tendency to make the most out of demanding situations, which involved getting creative and being flexible in how they approached their work, particularly considering the various risk factors stacked against them. The participants described often having to build their support networks to come up with ways to meet the needs of their LatAm immigrant clients despite, and indeed because of, the scarcity of resources and the lack of organizational and systemic support. Theories of resourcefulness
describe the personal and social components of the construct. People with high personal resourcefulness use internal processes to cope with stressful events (e.g., adaptability, positive self-talk, and active problem-solving strategies; Liu et al., 2022; Wang et al., 2015). People with high social resourcefulness seek help from others for emotional and practical support (Zauszniewski, 2016). Together, resourcefulness' personal and social components are understood to serve as a buffer against adversity and lead to better life satisfaction and mental health outcomes (Liu et al., 2022).

A few theories may explicate the resourcefulness described by the participants of this study. For example, these LatAm immigrant therapists may be engaging in the Latinx cultural value of colectivismo, which includes valuing and relying on one's social support and contributing to the collective's well-being (Gutierrez & Casas-Valdovinos, 2020). Their resourcefulness may also be explicated by the immigrant experience of having to be scrappy to survive in a new place and create their own opportunities. Immigrants and children of immigrants often learn to navigate systems in a foreign country, develop foreign language skills, utilize those skills to interpret and translate documents, and contribute to word-of-mouth approaches to seeking resources (Corona et al., 2012). This informal training on navigating systems places immigrants in a unique position to be a resource for their LatAm immigrant clients. Similarly, the Balderas' study (2016) participants reported that they draw from their firsthand experiences as immigrants or as descendants of immigrants in their work to make up for the lack of training and limited support. Developing their skills with a learn-as-you-go approach, and employing those skills to help their community, are characteristic of the LatAm immigrant therapists of this study and demonstrate some of the ways they might use their scrappiness to counter the adverse conditions of their work.

**Group Experiential Theme 3C) Mitigating factors**

The participants reflected on elements of their experiences that helped minimize the negative impact of the work with LatAm immigrants (RQ7 and 7b). Minimizing the negative
impact of the work is essential because, as captured in the risk factors section, the adverse conditions are complex and imposed at various levels. For this reason, factors that mitigate the negative impact on the therapist contribute to their ability to engage in the work despite the difficulties. These mitigating strategies consisted of a) developing a protective membrane, b) embracing practices of care, and c) bringing others in by venting things out.

**a) Developing a protective membrane.** The participants spoke of strategies that mitigate the impact of the work by developing what Dr. Luz called "a protective membrane." Some of these strategies included incorporating transitional periods between therapy sessions, intercalating cases based on the level of trauma content, and attempting to leave the work at work. The participants expressed utilizing these strategies as a way of reducing and balancing out the level of exposure to trauma content. Studies with trauma therapists have reported similar experiences (e.g., Day et al., 2017; Keyes et al., 2022), particularly the implementation of strategies "aimed at self-protection" that include modulating their exposure to trauma by limiting and distributing their cases, taking frequent breaks, and diversifying their caseloads (Padmanabhanunni & Gqomfa, 2022, p. 9). The participants of the current study emphasized how difficult it was to implement such strategies because of agency-based limitations and the high work demand. For example, some barriers to implementing these strategies included having full caseloads, not having decision-making ability regarding their schedules, and having to carry out additional tasks for their clients (e.g., case management). Not surprisingly, some of these barriers were also identified as risk factors (e.g., the heightened exposure to trauma due to being assigned cases with high levels of trauma, and back-to-back sessions without reprieve, both discussed on p. 136).

Some participants described these protective strategies as an attempt to compartmentalize various areas of their work and personal lives. Colloquial understandings of compartmentalization view it as separating various life areas from each other. Clinical conceptualizations of compartmentalization view it as a defense mechanism (e.g., Holmes et al.,
2005). From this perspective, compartmentalization is a short-term problem-focused coping strategy (e.g., to be used during a crisis; Day et al., 2017). Engaging in compartmentalization requires a degree of distancing from one’s emotional and psychological experience in order to focus attention elsewhere. Not being able to engage with or process one’s emotions because of the high demands of the work means that the therapists need to ignore their reactions in order to be able to serve the next client. However, there is a toll to ignoring or avoiding our experiences, and if not addressed eventually, it can have detrimental effects, even after the initial response (Day et al., 2017). Therefore, compartmentalization is unsustainable in the long term because often, “the impact of what [has] been heard crops up again” (Kiyimba & O’Reilly, 2016, p. 98). Paciencia called attention to the unsustainability of utilizing compartmentalization, sharing that their need for a second job due to receiving low pay at their primary job (discussed further on p. 144) made it, so they had to set aside their feelings from one job to shift their attention to the other. While processing one’s emotions may not be available or warranted in every situation, having the choice to sit with their experiences may serve as a way to move beyond merely modulating and adapting to the stressors of the work and toward a place of healing. However, this necessitates systemic changes (e.g., addressing the shortage of Spanish-English bilingual therapists and compensating therapists appropriately for their labor) to allow the therapists working with traumatized LatAm immigrants to process their experiences.

Furthermore, for therapists who work with populations similar to themselves, developing a protective membrane may not mitigate the impact successfully because their exposure to traumatic content is not limited to work. The difficulties of navigating a similar context as one’s clients is anticipated in the literature on shared trauma (discussed in the literature review on p. 40) which highlights that one of the main negative effects is the incessant nature of the exposure to trauma content. Moreover, for the participants of this study, much like the LatAm immigrants they serve, the exposure to trauma is not a single event or even a string of events; instead, it is constant, multilayered, and ongoing. The participants may very well develop a
protective membrane to mitigate their exposure to trauma content at work and still be exposed to similar situations in their personal lives (e.g., their loved ones back home may be in danger, or their friend may be in the midst of an immigration process).

b) Embracing practices of care. Another factor that helped mitigate the negative impact of the work was the participants' engagement in care practices. These consisted of activities that gave a break from the stress of the work, allowed them to disengage, served as a distraction, and helped get their "own trauma out of the way," as Bovi put it. Some care practices included exercising, spending time alone, reading, and watching a favorite show. These findings join those of others (e.g., Horvarth & Schofield, 2006) in emphasizing the importance of engaging in care practices to lessen the negative impact of the work and increase one's capacity to cope. The importance of care practices is evident by its inclusion in the ethics codes for various mental health professions (Barber-Rioja et al., 2022), yet professionals continue to report the same barriers to engaging in care practices that have been documented in the burnout, STS, and VT literature for decades. The barriers include “lack of time, denial of issues, shame, and lack of motivation” (Barber-Rioja et al., 2022, p. 112).

This study's participants further the conversation about the limitations of care practices by highlighting the limitations that may be more unique to the immigrant experience. They shared that engaging in activities to care for themselves does not come naturally because of their tendency to want to push through and continue working despite the difficulties. One explanation for this is the shared immigrant experience of feeling obligated to work hard, not waste opportunities, and improve one's circumstances to justify the sacrifices made for migration (discussed further on p. 148). Additionally, there is a tendency among immigrants to normalize mental strain because the chronic nature of stressors is such that the baseline for experiencing strain is higher (Cha et al., 2019). For this reason, it might not be readily obvious for LatAm immigrants to notice when they need support until a more serious condition happens. There was also an overall sentiment among the participants that there was a point where they
realized that they could not keep going with the work unless they engaged in activities that allowed them respite. Thus, the practice of caring for themselves arose from necessity. Additionally, they emphasized that engaging in care activities was a practice that took time to develop – highlighting the notion that the broader concept of self-care is not an easy nor innately available solution. To my knowledge at the time of this writing, there are no studies reporting such limitations about engagement in care practices.

c) **Bringing others in by venting things out.** Another factor identified as having a mitigating effect was formal and informal venting practices, including engaging in therapy, utilizing consultation groups, supervision, and speaking with colleagues and friends. The participants described these practices as ways to unburden themselves and receive support to minimize the negative impact of the work. Having outlets to do this was particularly important when dealing with complex matters, such as when their clients’ immigration applications were denied. The participants stressed the importance of having people who could relate to their experiences, such as other Spanish-speaking, LatAm, and immigrant therapists. Consultation groups and supervision were places to unburden themselves and receive advice from people who possibly have had similar experiences. Given that one of the risk factors identified in the literature for experiencing STS is isolation (Killian, 2008), it is evident that connecting with others would be an antidote.

Another important outlet for venting and a source of support was engaging in their own therapy, especially because of the possibility of becoming triggered in session due to hearing similar stories. The participants stressed the importance of being cautious and proactive about managing their triggers not to do a disservice to their clients. Furthermore, the participants who had been in the field longer shared their observations on how the younger generation of LatAm immigrant therapists engages with their LatAm immigrant clients, emphasizing shifts in therapy utilization among therapists. The participants talked about bringing others in as an essential part of minimizing the work’s negative impact because it allowed them to engage the other mitigating
factors better. For example, by letting off steam about a client's situation, the participants could move on to their next session or disengage via the care practices.

**Group Experiential Theme 3D) Sustaining factors**

The participants reflected on elements of their experiences that allow them to engage with their work in a long-term capacity (RQ6 and 6a). Their stories spoke of factors that brought meaning to them and thus, sustained them through the work: a) feeling empowered, b) witnessing their clients’ small victories, and c) contributing to changing the system.

**a) Feeling empowered.** One of the factors that sustained the participants in their work with LatAm immigrants included feeling empowered by their work. One such experience of empowerment came from being one of a small number of Spanish-speaking psychologists in the U.S. While being one of few that can provide services in Spanish increased their sense of obligation (discussed on p. 127) and the likelihood of experiencing a higher exposure to trauma content (discussed on p. 136), the participants expressed that it is meaningful to them to fill this gap in the mental health field. Furthermore, the participants expressed feeling empowered by utilizing their Spanish-English bilingual skills in a professional setting. The sentiment was that because few people have the opportunity to speak their language and be around fellow LatAm immigrants for work, the experience feels like a privilege.

Moreover, immigrants often learn the expected language, in this case, English, and translate and interpret between languages to help their families navigate and adjust to a new place. From the standpoint of this immigrant experience, the participants may feel empowered now to utilize their language skills for non-survival purposes. Feeling empowered as a sustaining factor can be explained by power-over dynamics that are often at the root of the types of traumatic experiences that LatAm immigrants experience at various societal levels (Alessi & Kahn, 2023; Herman, 2015). Within this context, feeling empowered about a part of themselves previously experienced as shameful (e.g., speaking Spanish) can be experienced
as a liberatory tool to regain some power for themselves and, in turn, promote it in their LatAm immigrant clients.

**b) Witnessing the clients’ small victories.** Another sustaining factor included bearing witness to their clients' "small victories," such as when they could connect their clients with housing or when their clients' immigration cases were approved. The participants expressed that this made their work meaningful and was a motivator because it meant they were making a difference in their clients' lives. The experience also included bearing witness to their clients' victories with their: resilience development, ability to implement what they had learned in therapy, live their lives beyond survival mode, shift their relationship to oppressive cultural perspectives (e.g., machismo), and embrace parts of themselves they were previously ashamed of (e.g., holding an undocumented legal status). Similar findings were reported by Padmanabhanunni and Gqomfa (2022), whose participants expressed sustaining themselves by "re-framing their work as a means to promote healing and as bearing witness to the capacity of others to overcome pain and adversity" (p. 9). The conceptualization of witnessing their clients' small victories as a sustaining factor echoes the concept of vicarious resilience that posits that "a higher appreciation for human resilience [can result] in the reinforcement of the therapist's innate optimism [...] increased sense of hope [and] belief in change" (Silveira & Boyer, 2015, p. 522). Moreover, for the current study participants, potentially contributing to the healing of intergenerational and migratory trauma aligns with their collectivistic values. From a collectivistic standpoint, it makes sense that witnessing changes in their LatAm immigrant clients – who remind them so much of themselves and their loved ones – would be experienced as a sustaining factor, as it serves to give these LatAm immigrant therapists hope and validates their efforts.

**c) Contributing to changing the system.** Another sustaining factor identified by the participants is their perception that they are contributing to changing the mental health system. Researchers of vicarious resilience (e.g., Michalchuk & Martin, 2019; Silveira & Boyer, 2015)
have reported similar findings in which providers who work with traumatized populations derive meaning from feeling that they are making a difference in people's lives and contributing to a higher purpose. Some of the ways the participants of the current study described contributing to systemic change include diversifying the mental health field and serving as a bridge between their Spanish-speaking LatAm immigrant clients and mental health services. The importance of being a Spanish-speaking LatAm and immigrant provider was particularly poignant for the participants, given the various risk factors discussed earlier (starting on p. 136) that demonstrate how mental health services (and healthcare and social services at large) are often not built with LatAm immigrants in mind and are consequently ill-prepared to serve them in culturally and linguistically appropriate ways and with a trauma-informed approach. For these reasons, the participants experienced their mere existence in mental health spaces and their social justice-based commitment to serve the LatAm immigrant community as changing the system.

Figure 2. Interplay Between the Protective, Mitigating, and Sustaining Factors
Strengths and Limitations of the Study

While this study offers important insights derived from the experiences of eight LatAm immigrant therapists, there are several limitations to consider in order to understand the scope of the findings. Below I explain the limitations and describe how I attempted to minimize their impact. This ultimately led to a more robust study, that remained focused on answering the research questions:

1. The relatively small and homogenous sample of participants limit the generalizability of the findings. Importantly, this study did not aim to provide generalizable theories. Instead, I set out to examine a phenomenon through the experiences of the people for whom it is relevant. That is, how do LatAm immigrant therapists experience their work with LatAm immigrant populations often exposed to migration trauma? This study was the first to examine the potential STRs that LatAm immigrant therapists may experience. Thus, generalizability was neither possible nor warranted at this stage.

2. I utilized the listserv for NLPA, the largest organization for Latinx mental health providers. This is a limitation because many LatAm immigrant therapists are not part of this organization. The limits include the type of mental health provider that would subscribe to such organizations, which is determined by factors such as having financial means to cover membership fees and identifying with Latinx as an identity, to name a few. I also posted to a closed Facebook group not associated with the NLPA. While this opens the potential recruitment pool, the same limitations arise.

3. Another limitation is that I did not contextualize the participants' experiences further in the analysis by utilizing their reported demographics to add depth to the data (e.g., how was the experience for a psychodynamic therapist similar or dissimilar to that of a behaviorist?). While I did consider their years of experience (e.g., when a participant with more experience reflected on how their STRs have changed over time), I did not consider this factor systematically, for every research question or for every participant.
4. Another limitation is having discussed the immigrant experience broadly. It is imperative to consider how the participants’ experiences are informed by the sociocultural, economic, and racial contexts that prompted them to migrate in the first place. Thus, while migrant therapists from anywhere in the world may resonate with some of the experiences presented here, there are likely differences in the manifestation of STRs and the subsequent impact on the therapy process and the therapist-client relationship.

5. I also did not conduct participant checks to receive feedback on the findings’ accuracy, validity, and resonance. One way I addressed this shortcoming was by returning to the data throughout the analysis and the writing of the results and discussion chapters. I also engaged in reflective practices, conversations with colleagues, and feedback from my committee chair to ensure I stayed close to the data and did not misrepresent the participants’ experiences.

6. Lastly, the participants’ stories are merely a peek into their experiences, as seen through the filter of who I am and what matters to me. Just as the analysis centered the things that might be meaningful to the participants (based on words they chose and the emotional valence of their narratives, for example), the final product is the combination of what was also meaningful to me and how I view and understand the world. For this reason, my own limitations bind the findings: limitations in my interpreting ability, the scope of my knowledge, my experiences as a LatAm immigrant therapist, and limitations to time and emotional energy to reflect on the data. For this reason, the participants, readers, and future researchers may have different interpretations and arrive at different conclusions. This is not a drawback but an invitation to exercise our imagination and consider the myriad ways the participants’ experiences can be interpreted. Furthermore, it offers fertile ground for new contributions to our collective understanding of what it is like to be a LatAm immigrant therapist and work with people with similar identities and experiences.
Implications of the Findings

While the experiences of these eight LatAm immigrant therapists may parallel those of many LatAm immigrants, it is imperative to consider how people in more marginalized positions (e.g., disabled, queer, trans, non-Spanish speaking LatAm immigrants, and those who hold an unauthorized immigration status) are not only impacted by the same conditions and situations that the participants broached, but that the effects are likely to be more detrimental. For example, as bad as it is that we do not have appropriate services in Spanish, the matter is significantly worse regarding the languages that Spanish violently tried to replace via colonization (e.g., Nahuatl, Miskito, Quechua). Thus, a LatAm immigrant whose first language is not Spanish will be harder pressed to find linguistically and culturally appropriate services than one that does. This is a crucial point when identifying actionable recommendations for training, practice, and research, as focusing on addressing such inequities in healthcare will undoubtedly benefit the care we provide to all clients.

The participants’ stories join the centuries-long calls for action against the systems that negate and degrade human dignity. This study helps document some conditions that result from living and working within oppressive systems which create and perpetuate traumatization (e.g., the mental health industrial complex). Such oppressive systems create high-stress environments, contribute to long waitlists, rush diagnostic and treatment processes, encourage grind culture (e.g., having back-to-back sessions), and discourage emotionality and investment in relationships. This study contributes to the knowledge of how exposure to direct, indirect, and shared trauma within such systems reverberates through communities – from the clients to the therapists that treat them. For this reason, an important contribution of this study is the focus on the therapist-client relationship as one place where we can answer the calls for justice. It was evident from the participants’ stories that an approach to therapy that centers the relationship can be healing and have a rippling effect in the community.
Furthermore, the participants’ experiences and my analysis are situated within a particular place and time. Our understandings may, and hopefully will, evolve over time. Rather than draw definitive conclusions, I hope the findings add a thread to the conversation about the experiences of LatAm immigrant therapists. I also hope that we push the conversation toward places that can disrupt the established systems and create accountability for the ways mental health providers also perpetuate harm. I hope academic conversations join those happening in the breakroom of agencies, on social media platforms, and in activist spaces – those about the roots of Latinidad being anti-Indigeneity and anti-Blackness, how Latinidad is weaponized against the most marginalized, how the mere holding of a legal migration status reinforces the nation-state, how xenophobia (and all the phobias!) are rooted in coloniality, how healing must happen as a collective, how our imaginations must push the bounds of what we have known while tapping into collective wisdom that center emotional, somatic, and relational experiences. I hope these conversations guide our policies and practices in and outside the therapy room.

**Recommendations for Practice and Training**

Some recommendations for clinical practice and training include weaving trauma- and grief-informed approaches into the core of curricula. It was evident from the participants’ experiences and what is reported in the literature that training regarding trauma is lacking, and therapists feel unprepared to deal with the impact of the work. We must incorporate trauma-and grief-informed approaches to the content we teach and how we teach it. Approaching courses and training in this way will model and normalize the practice. Because training regarding trauma should aim to de-pathologize trauma responses and contextualize them within larger systems of oppression, therapists must learn how to advocate within agencies, conceptualize cases and develop treatment plans in a trauma-informed and grief-informed manner, all of which could be discussed collaboratively within training programs. Such an approach can help prepare therapists to work with traumatized populations and can help reduce potential re-traumatization for both the clients and the therapists (Cayir et al., 2021).
Another recommendation is to incorporate experiential modes of learning in the classroom. While the uptick of virtual settings for training has increased access to information, opportunities to learn from instructors in-depth are imperative (Shannon et al., 2014). One-off seminars are ideal for presenting the current state of trauma interventions, yet having longer-term immersive experiences can serve as a way to experience the impact of trauma work in a relatively safer environment where there is support (Houseknecht & Swank, 2019). Additionally, the person can experiment with various practices for managing their STRs by engaging in practices of care built into curricula and modeled by professors and supervisors alike. Further, therapists can be encouraged to engage in posttraumatic growth promotive activities, such as advocacy engagement (e.g., Delgado-Romero et al., 2021). Developing experiential learning opportunities and providing proactive school and work environments that address the impact of trauma is crucial to improving the conditions that create high-stress environments that place therapists at heightened vulnerability for STRs.

**Recommendations for Future Research**

Some recommendations for future research include incorporating how various therapist factors (e.g., years of experience, treatment modalities, and theoretical orientations) may impact the experiences of working with LatAm immigrants. Beutler et al. (2016) found that therapist factors explain outcome variances in manualized treatments, highlighting the importance of considering therapists’ contributions to the therapeutic relationship. It also underscores that therapist factors are nuanced and dynamic and interact with the therapists' demographic characteristics, beliefs, perceptions, and environment (Lee et al., 2021). Taking it a step further, considering the impact of the whole of the therapist on the therapeutic relationship, parenthetically recognizes that healing happens in relationships, which further highlights the importance of creating spaces that are supportive of the clients and their therapists.

Another research recommendation is to elicit comparisons from the LatAm immigrant therapists about providing therapy to LatAm immigrant clients, non-immigrant LatAm clients,
and non-LatAm immigrant clients. It would be valuable to learn how LatAm immigrant therapists experience their work with various groups of people by shedding light on potential similarities and differences. This would not only give us new insight into therapy processes with distinct groups but also help us understand the work with LatAm immigrant clients better. Another area of exploration might be to ask the LatAm immigrant therapists whether their experience with secondary traumatization differs from other forms of trauma. Because migration trauma encompasses trauma from wide-ranging dynamics (e.g., from interpersonal to systemic dynamics), asking whether their experiences differ from other trauma contexts may expand our understanding of STR manifestations.
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Appendix A. Informed Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study conducted by Elizabeth Rivera, a graduate student in the Department of Clinical Psychology at the University of San Francisco School of Nursing and Health Professions. The faculty supervisor for this study is Dr. Michelle Montagno, a professor in the Department of Clinical Psychology at the University of San Francisco School of Nursing and Health Professions.

WHAT THE STUDY IS ABOUT:
The purpose of this research study is to further understand the lived experiences of Latin American immigrant therapists working with Latin American immigrant clients, and to understand the potential secondary trauma responses they might experience when working with populations exposed to traumatic migratory experiences.

WHAT WE WILL ASK YOU TO DO:
If you agree to be a participant in this study, the following will happen:

1) You will complete a brief demographic form.
2) You will be interviewed for 90 minutes by Elizabeth Rivera about your experience as a Latin American immigrant therapist working with Latin American immigrant populations.

DURATION AND LOCATION OF THE STUDY:
Your participation in this study will involve one 90-minute interview. The study will take place over Zoom at a time and day that is convenient for you.

POTENTIAL RISKS AND DISCOMFORTS:
The research procedures described above may involve minimal risk to you and your psychological well-being as some of the questions may evoke distressing emotions due to the nature of the subject matter (e.g., regarding identity as an immigrant). You will not be asked to recount traumatic events. Shall you disclose sensitive information during the interview (e.g., authorization status), it will be scrubbed from the transcripts. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

BENEFITS:
You will receive no direct benefit from your participation in this study; however, the possible benefits to others include contributing to the collective psychological knowledge of the experience of immigrants from Latin America. Information from this study may benefit the
development of interventions and resources for Latin American immigrant therapists in the San Francisco Bay Area.

PRIVACY/CONFIDENTIALITY:
Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will de-identify transcriptions, utilize pseudonyms, and protect documents via password-protected methods. Only the faculty supervisor and the graduate student (Elizabeth Rivera) will have access to the data. The only document that will have any identifying information is this informed consent form that will be kept in a password-protected place and destroyed after 3 years.

AUDIO RECORDINGS:
Interviews will be audio recorded for the purposes of data analysis. The audio files of each participant will be assigned a pseudonym and access to the audio files will be password-protected. Only the faculty supervisor, the graduate student (Elizabeth Rivera), and the audio transcriber will have access to the de-identified audio files. The audio files will be archived until completion of the research project and will be destroyed after 3 years.

COMPENSATION/PAYMENT FOR PARTICIPATION:
You will receive a $30 Visa gift card for your participation in this study. If you choose to withdraw before completing the study, you will not receive a gift card.

VOLUNTARY NATURE OF THE STUDY:
Your participation is voluntary, and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty or loss of benefits. In addition, the researcher has the right to withdraw you from participation in the study at any time.

OFFER TO ANSWER QUESTIONS:
Please ask any questions you have now. If you have questions later, you should contact the principal investigator: Elizabeth Rivera at (415) 806-4202 or eprivera@dons.usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

PARTICIPANT'S SIGNATURE DATE
Appendix B. Recruitment materials

Recruitment flyer

Participants needed!
Study on the experiences of Latin American immigrant therapists

Seeking participants for:
60-90 minute Zoom interviews about working therapeutically with Latin American immigrant clients

Eligibility criteria
1) Are you an immigrant from Latin America?
2) Do you work providing psychotherapy to Latin American immigrants?
3) Do you hold at least a master’s degree in psychology or a related field? (e.g., MFT, MSW, PsyD, PhD)

If you are interested in participating:
Click on this image for more information and next steps

Participants will receive:
One $30 Visa gift card for their time

For more information, see attached letter or email:
eprivera@usfca.edu

UNIVERSITY OF SAN FRANCISCO
Recruitment letter

Hello potential participants!

My name is Elizabeth Rivera and I am a doctoral student at the University of San Francisco. As part of my dissertation research, I am conducting interviews with Latin American immigrant therapists who provide therapy to Latin American immigrant populations. This study was prompted by my own experiences as an immigrant therapist from Nicaragua.

The purpose of this research study is to understand the lived experiences of Latin American immigrant therapists working with Latin American immigrant clients, what are the potential secondary trauma responses they might experience when working with populations exposed to traumatic migratory experiences, and what factors prevent or allow them to engage in this work.

I hope this study will lend itself to contribute to the collective psychological knowledge of the experience of immigrants from Latin America. Information from this study may benefit the development of interventions and resources for Latin American immigrant therapists.

To participate in this study, you must be an immigrant from Latin America, work therapeutically with immigrant clients from Latin America, and have a master's degree or higher in psychology or a related field.

If you agree to be a participant in this study, you will:

1) Complete consent form to participate in an audio-recorded interview
2) Complete a brief demographic form
3) Participate in a 60–90-minute interview over Zoom at an agreed-upon time

Participation is confidential and you may withdraw at any time. Each participant will receive a $30 Visa gift card for their time.

If you are interested in participating and would like to check if you meet eligibility requirements, please go to the following Google Form: [https://forms.gle/CLQWVLmR5nRtSD389](https://forms.gle/CLQWVLmR5nRtSD389) where you will find the eligibility criteria, read through the consent form, opt to participate, and fill out the demographic questionnaire.

You may contact me at any time. I am happy to provide further details regarding the process and content of the interview and answer any other questions you may have. Once you agree to participate, I will request written and verbal consent from you. My contact information is eprivera@usfca.edu or (415) 805-4202. I look forward to hearing from you!

Elizabeth Rivera, M.S.
Appendix C. Measures

Demographic questionnaire

1. Please choose a pseudonym:

2. What is your age?

3. How do you characterize your gender?

4. What is your racial/ethnic background?

5. At what age did you migrate to the United States?

6. What is your level of education?

7. What is your profession/degree?

8. Do you currently provide therapy to Latin American immigrant clients?

9. How long have you worked with Latin American immigrants?

10. What is your theoretical orientation?
    a) Systemic, b) Integrative, c) CBT, d) Psychodynamic, e) Humanistic, f) Other (if other, fill in:____)

11. What modalities of therapy do you provide? (circle all that apply)
    a) Individual, b) Group, c) Family, d) Couples, e) Other (if other, fill in:____)

12. What client populations do you work with? (circle all that apply)
    a) Older adults, b) Adults, c) Adolescents, d) Children

13. What percentage of your caseload would you say includes work with traumatized clients?

14. What languages do you speak in therapy?
Interview Guide

RQ1. Can you tell me about the work you do with Latin American immigrant clients?

RQ2. I’m curious, what is it like for you to provide therapy to Latin American immigrant clients?

  Prompt a: Can you tell me about any reactions you have had when listening to your
  clients’ stories?

  Prompt b: What about reactions after the session?

  Prompt c: Can you tell me a story that resulted in that reaction?

RQ3. What is it like for you to engage with your clients’ immigration trauma material?

  Prompt a: Is there a particular story that stands out to you that exemplifies that?

RQ4. How does your own immigration experience affect your work?

  Prompt a: How do you think your shared migration backgrounds influence how you
  experience their trauma material?

  Prompt b: How might this be if you did not share migration backgrounds with your
  clients?

  Prompt c: How might this be if you did not share racial/ethnic backgrounds?

RQ5. Is there anything that makes your work particularly difficult?

  Prompt a: What are risk factors that make it more difficult to do this work?

RQ6. Is there anything that makes your work particularly meaningful?

  Prompt a: What are factors that sustain the work you do?

  Prompt b: What is the potential for healing for the therapist?

RQ7. What allows you to do this work?

  Prompt a: What are protective factors that allow you to do this work?

  Prompt b: What are factors that mitigate the challenging impacts of the work?

RQ8. What has been your experience with training regarding migration trauma?

  Prompt a: What training would you have liked to receive in this area?

RQ9. What about training regarding secondary traumatization?
Prompt a: What training would you have liked to receive in this area?

RQ10. What has been your experience with supervision regarding migration trauma?

Prompt a: What supervision would you have liked to receive in this area?

RQ11. What about supervision regarding secondary traumatization?

Prompt a: What supervision would you have liked to receive in this area?

RQ12. What training or supervision would you like to receive in the future regarding these topics?

RQ13. What would you say to a therapist who is starting to do this work?
Appendix D. Examples of IPA Process

From interview with participant RR96

Single Case Step 1 – 4 Analysis

Example of field notes transcribed from recording:

as, there were times that she alluded to things, and I didn’t dig too much into it, mainly because they were things that are hard to talk about. I’m not her therapist, so I know I have to practice boundaries myself in terms of like, she was sharing reaction to a client’s story. I didn’t really want to necessarily dig deeper to understanding, and I think I tried to ask a few times in different ways, to ask a few times about it and when I maybe wasn’t being super candid, and it was clear that maybe this person didn’t understand where I was going with something. I kind of just let it be, because it is not something I necessarily want to have somebody unravel all this stuff that’s heavy and then just leave them like that.

So, I need to maybe figure out how to reword for clarity in a way that is maybe more containing of things that might come up. I guess I was just worried about poking at something that would maybe be too difficult to discuss. But there were times when I thought maybe if I had slowed down just a second and I had asked a little bit more it would have been different. But I guess that’s the case in any interview, really.

So, one of the things that stood out to me was the sense of responsibility or duty that this person feels when providing services, even when it’s hard for them, the sense of responsibility or duty because it’s your people that you’re working with. So, it’s something that I personally feel, and so sometimes those feelings can be really strong, almost like where I have to give back to my community. One of the things she was saying was like that to her, this is her passion and it’s really important to her, and so she wasn’t going to waste the opportunity. Like for example, one of things that she said was I’m not just going to go and party, like I need to be taking this seriously because it’s like, it’s not often that people from this country get to do this work and pursue a higher education. And so, there’s a sense of responsibility that perhaps other folks may not feel when they’re not immigrants or having to have migrated for difficult reasons.

There was also, so there’s aspects like being an immigrant yourself, being from a Latin American country, it’s like relating to people because you’ve been there too, so you can relate and connect with them at a different level than if you weren’t. And at the same time, it sounds like when she has to do neuropsych assessments for people, she notices they might be malingering, but there’s some sort of secondary gain like staying in this country if you’re more impaired because of something that occurred, more impaired than you actually are. And she has a hard time because she’s like well, I’m an immigrant too so I understand why somebody doesn’t want to go back to their country. And having maybe to manage, I just realized maybe I should have asked, like how do you manage those cases where the person might be malingering but as an immigrant you understand all the reasons that people might migrate. So maybe I should have asked more about that.
IPA Step 1: Reading and exploratory notes

Personally, I feel sometimes that transference. I feel very sad. I feel like I can relate to some level. I'm also an immigrant myself. I'm an international student here, so when I have family members, patients who haven't seen their family members in like a year or two, I can relate to that, right? I have family members I haven't seen for a couple of years now. During the pandemic, many people were telling me, many patients were telling me you know, I can't travel. My home country requires, you know, people to have X amount of vaccine doses or whatever, and my family member doesn't have it available so they can't travel. Sometimes it's not just the financial needs, it's just like the logistics. Sometimes people don't understand what it's like to actually be able to travel to the U.S. or out of the U.S. like the visa application and all that stuff.

So, I kind of related to that because I also have family members who were unable to travel during the pandemic, not just because they nature of the disease, but because of the regulations that were happening. There, I've also heard stories of patients who describe just very much political unrest in their countries, and I come from one of the countries that's most popular for having political unrest. So, I kind of see, I won't say myself, but I kind of see a lot of the circumstances that they're living as circumstances that I've also kind of experimented (I think was trying to say experienced) to some level. So, I think that definitely processing those emotions on my own therapy, because I have a counselor, and just doing a lot of reflection and processing all of those things outside the session, and just trying to navigate, you know?

IPA Step 2: Formulating experiential statements

But I also see the reaction of them when my patients get very excited because they ask me, are you Latina? And I say yes, and sometimes I disclose, and I say I'm from Honduras, and they hear my Spanish and they're kind of like, "oh, are you Central American?" And I see that shift where they're like oh, I feel so much more comfortable talking to you and that's just so much better. And they're like oh, you understand, you can relate to this. So I feel like it can kind of can go both ways. It can be very challenging for me to try to put that, OK, let's not get so invested on a personal level, but also I have that insight that can help me help them a little bit better, and they feel more comfortable, right? I have had people that told me oh, you're brown like me. So it's like OK, I may transfer some sense of security just because of also my background. So I think I'm still learning, it's a learning process, how to navigate between I'm a Latina therapist and that can be an asset, and that can also bring me some challenges just, you know, counter-trasference and translference-wise.

What are the motivations behind the choice of words?
- I'm curious about the choice to use a psychological term: transference in describing her reactions to her patients stories. It does this throughout the interview and I see it as a representation of how she has assimilated

What things matter to the participant? (e.g., objects, events, experiences, processes, locations, principles, relationships, values)
- Immigrant experience of not seeing family members - shared experiences
- Immigrant narratives presented by Covid-19 pandemic travel restrictions

What is being assumed?
- That patients are undocumented could very well be the case, it's just not explicitly stated

What is their context? Their lived world?
- Not an immigrant, she can relate to her patients' circumstances regarding travel and not seeing their family members
- The participant has knowledge of what is needed to travel as an immigrant. Later she talks about the insight she has as a "fellow immigrant" and I think some of the insight consists of understanding such things as travel dynamics/restrictions
- She is an international student, like her patients, the participant has gone years without seeing her family members
- The therapist comes from a culture that's most popular for having political unrest. Another point where she relates to her patients as they tell her stories of political unrest

What is the participant's standpoint?
- People not understanding travel dynamics faced by immigrants
- Travel requires more than just financial aspects
- Logistics of travel
- This is all insight that RRB6 has that others may not
- Can relate to her patients because she is also an immigrant
- "Can relate to some level" —> Is there a limit to how much she relates? What other levels of relating are there?

What does this mean to me (the researcher)?
- I have the same experience of not seeing family members for decades so this experience is particularly poignant for me
IPA Step 3: Finding connections and clustering experiential statements
**IPA Step 4: Compiling the table of personal experiential themes**

<table>
<thead>
<tr>
<th>Experiential Statements</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4a. Facilitators to the therapeutic relationship</strong></td>
<td></td>
</tr>
<tr>
<td>Shared migration background facilitates communication with LatAm immigrant clients</td>
<td>So, I kind of started noticing in the beginning they were very kind of like shy, didn’t want to talk about a lot. But then as we were moving on and they realized I was Latina and I was from [home country] and spoke Spanish, I saw they were very comfortable.</td>
</tr>
<tr>
<td>Transfers a sense of security to her patients by the shared background</td>
<td>I also see the reaction of them when my patients get very excited because they ask me, are you Latina? And I say yes, and sometimes I disclose, and I say I’m from [home country], and they hear my Spanish [...]. And I see that shift where they’re like oh, I feel so much more comfortable talking to you and that’s just so much better. And they’re like oh, you understand, you can relate to this. I have had people that told me oh, you’re brown like me. So it’s like OK, I may transfer some sense of security just because of also my background.</td>
</tr>
<tr>
<td>Insight about how immigration processes work helps normalize these for clients</td>
<td>I find it very helpful that I have some insight as a fellow immigrant on when they talk to me on like the legal aspects and they’re like trying to explain yeah, like you know, my family’s processing this visa, and because of this I’m not able to see my family member for X amount of years. I have some insight, and I actually have found it very helpful [...]. So, I feel like in one sense I can bring that knowledge and say “hm, is there something weird here?” or in therapy we can process the fact that their documentation is going to take X amount of years. And they’re like oh my god, this government, they’re like well, you know, actually that’s a common thing. That’s part of the law. So I think that in that sense it’s helpful for me.</td>
</tr>
<tr>
<td>Shared migration background deepens therapeutic connection</td>
<td>I think I would probably not have that insight enough to care as much as I do right now. [...] I probably would not feel those emotions, or maybe not as deep as I do now if I wasn’t an immigrant myself. So, I think it definitely like, well, my experience as an immigrant definitely plays a part in that.</td>
</tr>
<tr>
<td>More understanding of why patients may malinger when it comes to immigration matters</td>
<td>In a way I want to say that with my immigrant patients I’m always a little bit more nice, I do have to remind myself that there’s boundaries and confrontational skills that my supervisor always reminds me of. And especially when it’s the malinger cases I do feel bad. I genuinely feel bad that I have to cut it out and say, “you know, there’s a secondary gain”. But at the same time, that’s part of the job [...]. Even in those times, I don’t really judge the clients, and I’m like wow, how can they do this? Because I kind of understand why they’re doing it, like of course they want to leave their country. Their country is this country, it’s just as bad it is mine. So, I think I’m a little bit more accepting. That’s just a bias I have, of accepting fellow Latino immigrants when they tell their stories or when they tell me that they did something or that they had to sell all of this. I am not so judgmental to be like well, this person’s doing something wrong immediately, because I’m like, yeah, I mean, you want to leave the hell.</td>
</tr>
</tbody>
</table>

| **4b. Barriers to the therapeutic relationship**                                       |                                                                                                    |
| Therapy not as effective when there is overfamiliarity                                  | Sometimes they were too comfortable. Sometimes they would just, I practice CBT, and they would not do their homework assignments. They would just be like oh, you know how it is. Like you’re a student too so you know that it’s busy. So, it kind of became an issue, the fact that they kind of felt too comfortable with me and did not feel like they were going to be held accountable in session, or they just felt like they were just here to chat with a friend. So that’s when I actually started talking to my supervisor and my supervisor told me you have to make it very clear that you are a therapist and you are not a friend. |
| Burden to assess for immigration-related matters                                        | But when it has that extra layer that they’re also Latinos/Latinos and also immigrants, yes, I am definitely more invested. I feel like that Insight that I have, it’s OK, this person’s going through these different things and this person’s going through these other domains of issues, that probably their previous therapist did not target because they lacked that insight. So, I feel like it’s my also responsibility to try to assess how much of their past trauma, immigration status, immigration story, is playing a role in their current symptomatology or their presentation of problems, because it may be the first time someone asked them. And most of the times it is. |
| Overinvolvement due to shared backgrounds can be a disservice to her patients           | So, I think it’s also a matter of I’m Latina, so I understand how important it is for me as a Latina, as a person from our ethnic minority, to be respected, to be understood. So, because of that Insight, I want to respect and understand my patients a little bit better. And yes, I feel like at the same time it is OK, I’m going to get invested, but I cannot just be like thinking about the patient 24/7 and you know, letting go those emotions, also projecting because I can actually do a disservice. |
| No more therapy happening if she became triggered // shared trauma context              | [Being held at gunpoint] happened twice a week, and actually I promised myself I’m never going back to [home country], And a year later I was forced to go back because I had a funeral for a family member. After that I’ve never been there, and I honestly, every time I think about it, I think, “hell no”. But I had to process that because I did not want to get triggered, because those are the stories I hear in sessions. So, for me, one of the biggest factors was my previous trauma history, because I don’t want to be triggered in session and then just, there’s just no more therapy going on anymore. |
Cross Case Step 1 – 4 Analysis

IPA Step 1: Reviewing PET tables
IPA Step 2: Comparing and contrasting the PETs across participants
### IPA Step 3 and 4: Developing the GETs and creating the GET tables

<table>
<thead>
<tr>
<th>Participant</th>
<th>ES</th>
<th>Quotes</th>
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<tbody>
<tr>
<td><strong>RR96</strong></td>
<td>Shared migration background deepens therapeutic connection</td>
<td>I think I would probably not have that insight enough to care as much as I do right now. [...] I probably would not feel those emotions, or maybe not as deep as I do now if I wasn’t an immigrant myself. So, I think it definitely like, well, my experience as an immigrant definitely plays a part in that.</td>
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<tr>
<td><strong>Bovi</strong></td>
<td>Connecting with various parts of the client’s stories</td>
<td>So, there was parts of it that was, that I could connect with from his migration. There were parts of it I could connect with what it was like to get down or have to deal with gang violence as you’re growing up [...] different pieces felt personal in some ways [...] So, I can understand the isolation of being an unaccompanied migrant as a child, and kind of like all the things that that brought up for him. And of course, today I still think of them often. I don’t know what their life became, you know?</td>
</tr>
<tr>
<td><strong>Maria</strong></td>
<td>The connection is deeper when the therapist is also an immigrant and speaks the same language</td>
<td>I have another friend [...] she is Latina descend but she grew up here, she was born here, she grew up here. We think different. We do. And even though she’s super Mexican, there’s still that part that she’s not. We can tell, we do, among my friends, you know, who grew up here and who doesn’t. And that is different. That is like a different level of like connection. [...] There’s that deep understanding of I get it [...] When I tell them “no, I immigrated as an adult, I understand that this can be hard,” it’s kind of like relief. So, I don’t think I could have achieved that kind of connection if I hadn’t immigrated. So, it’s a different, understanding, a different experience. Only the people that immigrated know how pain in the ass it is. Like because they have lived it in their bones. And I don’t think I would have ever achieved something like that or made them feel like that [...] Clients can tell when you deeply understand something. [...] When clients come and they say “finally,” like when they breathe, when I start talking they immediately know that I was not raised here. Like immediately. It’s easy, [...] And they have like this “ah, I can tell you [...] I’m so glad you speak Spanish. I’m so glad you understand.” And that gives me energy, because I’m like yes, that’s what I’m here for, to give that relief because I understand how hard it is and now, we can communicate easier [...] So, it’s like this other level of understanding and of like, “I got you.”</td>
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**Faholo** Engaging the clients is easy for her because of her appearance and accent, and she needs to be careful about what she discloses because she does not see the clients as separate from her story

For me engaging [with the clients] is super easy because they know for the way, la forma como aparece, la forma como me veo, de que no soy de aqui. So, they can see I am immigrant. [...] There are things that are self-explanatory, like I cannot hide that I’m a Latina, this is what I look like, and I speak their language as a native speaker so [...] this is not even a disclosure, they know, they immediately ask, “where are you coming from?” “De donde eres?” [...] So, the engagement is easier. I just have to make sure that I don’t reveal my own trauma, [...] I have my own immigration trauma, but I feel I have been able to process for years in therapy [...] So I don’t do a lot of self-disclosure at that point, [...] be very careful about self-disclosure. I believe that is real necessary [...] unless that is something that’s needed, just to specific things. [...] I can share with them my story. I don’t see those clients as apart from my own story at all, if that makes sense to you.

**Mexicana** For the therapists, getting to speak directly to the clients is a privilege as it allows for connection with their language and culture

So definitely for them it was much better to work directly with a bilingual therapist than to work with interpreters. So that is definitely an advantage from their point of view and a privilege for us to be able to connect using not only our language but also our culture.

**Mexicana** While mode of migration may be different, there is a shared experience in being separated from family, from culture, language and food

Well, maybe because even though I might have come by plane and I was not having financial struggles, and they didn’t, there still is separation from the family, there still is separation from your culture, from your language, from your food. And that’s where I felt that I relate. So, I think that helped me connect with them at a level that [...] to relate to them, to be more understanding about how difficult it can be here.