A Narrative Study of Immigrant Therapists' Experiences of Working Professionally in the Cultural Context of Aotearoa, New Zealand

Adriana Thomas

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology, The University of Auckland, 2019.

Abstract

There are increasing numbers of foreign-born therapists working around the world and also in Aotearoa New Zealand. The experiences of these immigrant therapists, however, have received almost no research attention, despite substantial research into experiences of immigration and a growing interest in cross-cultural therapy. This qualitative interview study was therefore designed to examine the experiences of immigrant therapists currently working in Aotearoa New Zealand who had undergone their professional training overseas. The study aimed to understand their experiences of cultural differences, the impact of migration on their experiences of working therapeutically and their sense of self as professionals, and how their experiences changed over time.

Fifteen therapists (14 registered psychologists and 1 registered psychotherapist) with a minimum of two years' work experience in New Zealand were recruited to take part in in-depth interviews guided by a narrative approach. Two types of analysis – a narrative thematic analysis and an analysis of the participants' narratives over time – were conducted. The results of the analyses revealed the initial challenges that immigrant therapists experienced while working professionally, the types of support they considered important, and the changes in their experiences over time.

Most participants experienced a range of minor initial challenges. These included the prevalence of Cognitive Behavioural Therapy approaches in their workplace in contrast to their previous experience outside Aotearoa New Zealand, unfamiliar processes and systems in their workplaces, and learning new policies, laws, or ways of working. Some participants experienced challenges in the initial stages with cultural differences (particularly when experiencing an awareness of their own difference), while other participants were initially unfamiliar with aspects of New Zealand and Māori culture. Therapists expressed a range of personal responses to some of these challenges, including surprise, frustration, worry, exhaustion, or shock. Over time, most participants gained access to support that was helpful

for them, made professional connections, and had more opportunities that allowed them to experience a sense of "familiarity" and "ease". Having a clinical supervisor, and personal or professional colleagues to connect with and process experiences were particularly beneficial. The results also demonstrate that the majority of the participants adapted over time, developing and gaining more confidence in themselves and experiencing a sense of professional growth.

The majority of participants also spoke of positive experiences with cultural training and supervision in working with Māori and other cultural groups. This included the benefits obtained from learning protocols and Māori practices. Many described a sense of growth in self as a professional and a realignment of their identity over time. Several therapists also reflected on what they considered as the advantages of being an immigrant when working therapeutically in New Zealand. Some therapists spoke of taking a naïve inquirer stance and being genuinely curious with their clients, using their language difficulties to decrease power discrepancies, and discussing their differences in therapy.

The study contributes to the international literature on immigrant therapists and supports the extensive literature on the processes of acculturation. In particular, the findings support the notion that the processing of identity is ongoing and for an immigrant experiencing acculturation and adaptation, the restructuring of identity is likely to develop and change over time. The implications of the study and future research directions are discussed.

Acknowledgements

I would like to acknowledge the migrant therapists who took part in this study, who gave their time and shared their experiences of moving to and working in Aotearoa New Zealand. As a migrant trainee psychologist, I have been privileged to hear their shared experiences despite the demands on their time. I am very grateful for this opportunity, their input, and feedback throughout.

Many of the topics and themes discussed resonate with my own reflections on learning about the culture in Aotearoa New Zealand. I have also questioned my knowledge and skills, progressed in my own sense of self as a migrant in New Zealand, and had the privilege of learning about indigenous health models. Further, I have also seen the value in discussing my experiences and the shared understanding of migration as an important aspect of many therapists' experience of work. Anecdotes, conversations with other clinicians and the interviews have reiterated the importance of having these discussions as part of practice and training. It has also helped shape how I envisage being a therapist, my own professional identity, and increased my understanding of the importance of cultural sensitivity when working cross-culturally, as well as the enriching experience these encounters can create.

I would like to thank my supervisor, Dr Claire Cartwright. Throughout my doctoral experience, you have provided consistent support, feedback, and guidance. I am truly grateful for your help and contribution to my development these last four years. Thank you to Margaret Dudley, my secondary supervisor, for your cultural input, guidance, and feedback throughout this doctoral clinical psychology programme. Acknowledgements to my professional colleague, Germaine Ingley-Cook and also to my classmates who have supported me throughout and provided some light moments and humour during more recent challenges and deadlines. We have worked beautifully as a cohort and sharing the tough and good times together has been a major part of my experience.

To my mother and father, Simah Etgar and Desmond Thomas, who have supported me emotionally, physically, and financially these four years! Thank you for continually being there for me, and your spiritual and academic encouragement, laughter, and support. I could not have done this without your love and guidance.

Thank you to my husband, Jose Daniel Arciniegas Contreras, who has stood by me and supported me every step of the way. Together we have been through our own acculturation experience in New Zealand and have both been accepted in this country we love. Thank you for being there with me, for believing in me, and for your patience. Our experiences are the experiences of many others around the world, adapting and changing our story throughout, and it has been all the more amazing with you.

Table of Contents

List of Tables

List of Figures

Chapter One: Introduction, Literature Review, and Purpose

Introduction to This Study

This study is a qualitative investigation of immigrant therapists' experiences of working professionally and therapeutically in Aotearoa New Zealand[1]. The number of people migrating to different countries has resulted in major changes in the demographics of industrialised nations (Akhtar, 2010). This has led to more culturally diverse client populations and more diversity among trainees in psychology, psychoanalysis, and other mental health disciplines (Akhtar, 2010). The number of skilled migrants and tertiary students living in and continuing to move to Aotearoa New Zealand is also steadily increasing (Ward & Masgoret, 2008). Many clinicians in Aotearoa New Zealand have trained overseas and are currently working as registered psychologists (New Zealand Psychologists Board [NZPB], personal communication, April 28, 2016).

Research on immigration has considered the processes and effects of migration and associated psychological factors (e.g., Berry, 2017; Gardner & Tang, 2014; Sam & Berry, 2006). Relevant research areas in therapeutic practice include cross-cultural therapy (Sue & Sue, 2013), cultural competence (NZPB, 2010), and the importance of the therapeutic relationship to therapy outcomes (Gelso, 2014; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011). These areas of research are highly relevant and important in the context of Aotearoa New Zealand and are prioritised in training programmes and workplaces. Most of the cross-cultural therapy literature places emphasis on advising therapists from dominant cultural groups on appropriate ways of working with ethnic minority clients (Boyd-Franklin, 2013; Pedersen, Crethar & Carlson, 2008). However, few studies have considered the relevance of immigration for migrant therapists,

[1] Aotearoa (the land of the long white cloud) is the Māori name for New Zealand.

and how this may impact on professional and therapeutic work (Kissil, Niño, & Davey, 2013; Niño, Kissil, & Davey, 2016). This study aimed to examine immigrant therapists' experiences of working professionally in Aotearoa New Zealand, and to gain understanding of their perspectives and experiences of working therapeutically and cross-culturally.

Chapter One of this thesis considers the relevant literature that provides the context for this study. The second chapter provides an outline of the methodology, while Chapters Three and Four present the results of thematic narrative and plot analysis of therapists' experiences of working professionally in Aotearoa New Zealand. Finally, Chapter Five discusses the central themes and findings, and considers the implications for clinical practice, limitations of the study, and implications for future research.

This current chapter begins with definitions of relevant terms, followed by an overview of the relevant literature on immigration and associated processes that immigrants experience, such as acculturation. The importance of the therapeutic relationship is then introduced, and the research relevant to immigrant therapists' experiences and the importance of cultural competence and cross-cultural therapy outlined. A discussion of the cultural context in Aotearoa New Zealand then follows. The gaps in the literature are observed throughout, then reviewed at the end of the chapter along with the study's research aims and questions.

Definition of Terms

Psychologist. A practising psychologist is a professional with a minimum of a master's or doctoral degree and an accredited postgraduate diploma (or equivalent qualification) in a specific area of psychology such as with a clinical or counselling scope. In order to lawfully use the title "Psychologist", individuals must also be registered with the New Zealand Psychologists Board (NZPB, 2012). A clinical psychologist, for example, applies psychological understanding and theory originated from research to the area of mental health

and wellbeing. They assist children, youth, adults and families with emotional, developmental, behavioural and mental problems through the use of psychological assessment, formulation, and diagnosis. These techniques and therapeutic interventions are derived from biological, social and psychological factors and are adopted using a scientist-practitioner approach (NZPB, 2012).

Psychotherapist. The term psychotherapist refers to a person who is registered as a psychotherapist with the New Zealand Psychotherapists Board of Aotearoa New Zealand (PBANZ). To lawfully use the title "Psychotherapist", individuals must be registered with the PBANZ, hold a current Annual Practising Certificate (APC), and have completed one of the two pathways to registration, the Tertiary Pathway or the Professional Development Pathway (New Zealand Psychotherapists Board of Aotearoa New Zealand [PBANZ], 2013).

Therapist. For the purposes of this study, a therapist includes practising psychologists and psychotherapists amongst other mental health practitioners. The definitions of psychologist and psychotherapist used in this research are purposely broad enough to include clinical psychologists, other psychologists registered with the NZPB, and registered psychotherapists. The term "therapist" will also be used throughout as it is often used in the literature and may include psychologists, psychotherapists, and other clinicians and practitioners.

Immigrant/migrant. The word "immigrant" in this study refers to individuals born in a foreign country who have immigrated to another country during their lifetime (Rumbaut, 2004). The term "migrant" will also be used interchangeably throughout the study as both terms are used in the research literature.

Immigration and Acculturation

Exploring immigration as a contextual aspect of the therapist's professional experience is important for several reasons. Firstly, immigration is relevant and is currently a significant

contributor to the demographic growth of Aotearoa New Zealand. Government policies aimed at attracting highly skilled migrants have led to increasing ethnic diversity in Aotearoa New Zealand over the last decade (Ward & Masgoret, 2008). This research recognises the vast diversity within the category "immigrant therapists", and acknowledges that other contextual aspects such as gender, age, and race can have a profound impact on their experiences. However, this study explores the concept of immigration as a distinct contextual feature, as suggested in an earlier study of immigrant therapists (Kissil et al., 2013; Niño et al., 2016). Although there may be a danger of overgeneralisation, it is important to note there are key commonalities amongst the diverse experiences of migrants that are embedded in the life altering experience of living in another country, such as Aotearoa New Zealand, when one was born and raised in a different cultural environment.

The salience of immigration to Aotearoa New Zealand can be exemplified with some recent figures. In 2016, almost 30,000 people were approved for residence within the skilled/business stream (Immigration New Zealand, 2016). Nearly one in five New Zealanders was born in another country, the ratio rising to one in three in Auckland, New Zealand's largest city (DeSouza, 2006; Pavagada & DeSouza, 2012). This is in comparison to the United States with one in eight immigrants and Europe with one in fifteen (DeSouza, 2006). In addition, demographic data supplied by practitioners following initial application for registration as a psychologist with the NZPB indicates there are a significant number of migrant psychologists practising in Aotearoa New Zealand. Of the 1086 individuals who provided information when applying in 2016 , the largest groups of registered psychologists and registered intern psychologists from overseas were from the United Kingdom (187), followed by South Africa (166), the United States (65), and Australia (62) (NZPB, personal communication, April 28, 2016). The largest increases in net migration to Aotearoa New Zealand during the year 2017 were from the United Kingdom and South Africa (Stats NZ, 2017). It is interesting to note that, despite immigrant psychologists in Aotearoa New

Zealand coming from a wide range of countries, the majority of immigrant psychologists are likely to be native English speakers according to their reported nationalities. Further, 64% of psychologists reported their nationality as other than New Zealander, which suggests a large number of registered psychologists may have been born outside of Aotearoa New Zealand (NZPB, personal communication, April 28, 2016).

Exploring immigration as a contextual aspect of the therapist's professional experience is also important as the rate at which migrants from various countries are arriving in Aotearoa New Zealand is steadily increasing, with a record figure of 72,400 for net migration for the July 2017 year and the total number of migrant arrivals reaching 132,100 (Stats NZ, 2017). The number of international students in Aotearoa New Zealand universities is also continuing to increase (Ward & Masgoret, 2004). It is possible that the number of foreign-born therapists in Aotearoa New Zealand will also increase, thus it is important to gain an understanding of their experiences of adapting to life in Aotearoa New Zealand and how this might play a role in their professional work.

Lastly, the topic of immigration and associated experiences such as acculturation, adaptation, and cultural identity have received a considerable amount of research attention (Berry, 2017; Berry, Phinney, Sam & Vedder, 2006; Phinney, 2013). In his review of the research on the psychology of immigration, Berry (2017) argues that the field of psychology has much to offer in terms of understanding migrants' experiences. The long-term consequences of acculturation vary between individuals and are influenced by many variables, such as personal and contextual factors and the environment of the new culture (Berry, 2017). For instance in terms of personal factors, the experience of immigration can have a significant impact on the sense of self and identity of the individual (Akhtar, 2010; Deaux, 2006). Therefore, it is important to review the literature on the psychological processes of acculturation and ensuing adaptation.

Acculturation and Adaptation. The term acculturation is defined as the process by which cultural and psychological changes occur following contact between cultures (Sam & Berry, 2006). Changes in social institutions and collective behaviours occur at the cultural level, and within the psychological level changes occur for the individual, such as daily rituals or experiences of stress. According to Deaux (2006), one of the processes that immigrants experience is a restructuring of their identity, whereby elements from their home country and from the host country are integrated. The contact experiences with the host community during acculturation usually have a much greater impact on the non-dominant immigrant group.

The processes and outcomes of acculturation are not straightforward according to Sam and Berry (2010). In addition, research on acculturation is extensive and synthesising the literature is not an easy task (Ward, 2001) as there are several different bodies of research. Sam and Berry's (2010) review on acculturation provides a universalist discussion which highlights the common experiences of acculturation and considers the likely shared psychological processes that underlie human activity. There are two major research findings in cross-cultural psychology regarding changes that occur at the individual level of acculturation. First, there is significant variation in how acculturation is experienced by individuals, and second, such heterogeneity is also present in how people adapt to acculturating. Berry (2017) states that individuals who engage in their home culture and within the larger society "integrate" and adapt more than individuals who acculturate by leaning more towards their own culture (separation).

A similar concept associated with acculturation is "adaptation", which Ward (2001) refers to as individuals' psychological wellbeing and ability to cope socioculturally (such as learning a new language). According to Sam and Berry (2006), adaptation is a result of acculturation. The terms assimilation, integration, marginalisation, and separation have also been used to describe the various ways of acculturating (Sam & Berry, 2010). Although the

concepts of assimilation and acculturation have been used synonymously, assimilation is more commonly associated as a phase or strategy within acculturation (Sam & Berry, 2010). More recently, as global migration increases, new terms such as globalisation, biculturalism, and integration have been used interchangeably with the term acculturation. This research mainly uses the term acculturation as, unlike other terms, acculturation recognises the reciprocity of the impact both cultural groups have on each other in the processes of acculturating (Berry, 2017). Another reason is the situational factors that can change acculturation processes; individuals can potentially have different outcomes due to their changing experiences.

Another important concept in this area of research and relevant to this study is psychological acculturation, which refers to the psychological changes and ensuing outcomes at the individual level that take place following people's experience of adaptation (Berry et al., 2006). This concept has received some criticism, however. It has been so widely used in cross-cultural psychology that gradually its original meaning has been eroded and it has become synonymous with the term assimilation (Berry, 2017). However, it provides an important distinction because of the various changes that occur at the two levels – individual and cultural, which are often different. In addition, differences in psychological acculturation are considerable, even amongst individuals from the same cultural background (Nauck, 2008).

Berry (2017) further discusses a framework for acculturation which consists of three features – changes that occur during acculturation, the ways individuals acculturate, and the extent they adapt once acculturated. Within the changes occurring in the process of acculturation, affective, behavioural and cognitive features known as the ABCs (Ward, 2001) can be considered, as well as personality factors (Kosic, 2006). With regard to the ways in which individuals acculturate, Berry (2017) presents the different strategies individuals use to acculturate, such as integration, assimilation, marginalisation, or

separation. The last aspect of the framework examines long-term outcomes of acculturation. As individuals' experiences of acculturation vary considerably, leading to different outcomes, it is worth using a framework to understand the complexity of the psychological factors involved in acculturation and how the processes of acculturation and ensuing adaptation might change over time.

Affective, behavioural, and cognitive changes. According to Ward's (2001) theoretical framework on aspects of adaptation and shock, changes that occur for individuals when acculturating include affective, behavioural, and cognitive features. Affective aspects of acculturation include the experiences of loss and mourning of the old and familiar whilst needing to adapt to unpredictable and unfamiliar environments. In his psychoanalytic paper, Garza-Guerrero (1974) notes these affective experiences of loss can lead to anxiety and excitement, where intense changes in the outer environment are mirrored in experiences of disruption in the identity of the individual. Akhtar (2010) reviewed the research and clinical observations of interdisciplinary fields. He discusses the psychological outcomes of immigration, explaining that the restructuring of identity that goes along with the process of immigration provides a threat to the strength of an individual's internal structure, but also an opportunity for development. Whether individuals experience growth or disorganisation depends partly on how they address loss and mourning of their country. It also depends on the processes by which they build a new concept of familiarity and regularity in the adopted country (Akhtar, 2010).

Behavioural aspects of acculturation involve actions such as behavioural shifts (Berry, 2001). These shifts occur as a result of acculturation and psychological change, and can include just about any phenomenon including "cultural shedding" or "cultural learning" (p. 621) as individuals change what they wear or what they eat and their greeting processes. It has been found that some individuals may want to assimilate through significant behavioural

shifts in order to avoid discrimination or marginalisation (Sam & Berry, 2010). Cognitive features of acculturation include changing evaluations and perceptions of stressful situations and events and cognitive coping strategies (Ward, 2001). The term "assimilation tactic" (Berry, 2017) applies when individuals lack the desire to maintain cultural identity and wish to interact more with other cultures. Having a good level of language proficiency is also associated with increased interactions with the new culture and a reduction in sociocultural maladjustment (Ward & Masgoret, 2004).

The ways in which individuals acculturate. Berry's (2017) discussion of the acculturation framework notes that the process of acculturation involves two main factors – cultural participation and maintenance. This bidimensional theory of acculturation considers the level of assimilation to the culture of the new country, and also the degree to which the culture from the original country is maintained. Studies have also examined the notion of acculturation attitudes, which considers the extent to which people either give up on or maintain their cultural characteristics (Berry et al., 2006; Deaux, 2006; Sam & Berry, 2006).

Preferences within these two levels of acculturation lead to the four strategies that Sam and Berry (2010) have termed assimilation, separation, marginalisation, and integration. The strategies chosen depend on the degree to which individuals balance the two notions of cultural contact and maintenance. The strategy of assimilation is adopted when individuals prefer to interact more with the other culture rather than maintain their cultural identity (Berry, 2017). The strategy of separation occurs when individuals avoid interacting with the other culture because they place a high value on maintaining their original culture. The strategy of integration is adopted when individuals choose to maintain their original culture whilst interacting with other groups and participating more in the larger groups' cultural practices. Marginalisation is conceptualised by a lack of desire for cultural maintenance (often because of imposed cultural loss) coupled with a lack of desire to interact with others

(often because of discrimination) (Berry, 2017). These strategies are neither outcomes nor static factors, and may change based on contextual factors. Sam and Berry (2010) use the example of Muslims renegotiating their identities in the aftermath of the September 11 attacks in the US. The notion of identity is thus an ongoing process and for an immigrant experiencing acculturation and adaptation, this restructuring of identity is likely to develop and change over time.

Attitudes to immigration. Most of the literature on immigration suggests the receiving society's view of immigration is based on psychological and contextual factors (Berry et al., 2006; Berry & Sam, 2016; Berry, 2017; Ehrensaft & Tousignant, 2006). The latter may be linked to the current unemployment rate, for example, or political factors such as the relationship between the receiving country and an immigrant's home nation (Sam & Berry, 2010). At the individual level, psychological factors lie within contextual factors such as views on immigration, opinions on who should be allowed in, prejudices, and threats to employment and the economy. The types of attitudes individuals within the receiving society have to immigrants can have an impact on the different strategies immigrants adopt when acculturating (Sam & Berry, 2010).

Based on their review of acculturation, Berry and Sam (2016) maintain there are multiple dimensions in individual attitudes towards immigration, which can range from attitudes concerning acceptable numbers of immigrants, to the types of migrants that are considered acceptable or unacceptable, to stereotypes individuals or societies may hold. Stening (2002) extends on this in a literature review of cross-cultural misunderstandings, arguing that stereotyping the other culture is more likely if the differences between the cultures are greater. As significant immigration has occurred as a result of sociopolitical factors, much of the literature has focused on the problematic nature of the experience of migration (Berry, 2017; Sam & Berry, 2006). However, there is also some discussion of the positive aspects of

migration on cross-cultural experiences and ensuing adaptation (Berry, 2017; Ehrensaft and Tousignant, 2006).

Adaptation following acculturation: separation, integration, and resiliency. The level of difficulty faced in the process of adaptation varies amongst migrants and is associated with the course and the outcomes of acculturation. When considering the question of how well people adapt, research has tended to focus on the long-term outcomes of psychological acculturation (Berry, 2017). Sluzki (2008) describes the obstacles immigrants encounter when changing environments and states that having social networks disrupted is one of the biggest stressors they face. He explains the importance of a social network as a fundamental aspect of an individual's life, which exists in a range of situations from the most ordinary every day activities to traditional celebrations and ceremonies. Attachment losses and challenges with building support networks in a new country can cause social isolation, health problems, and even affect the potential of survival and adjustment for the immigrant (Sluzki, 2008).

An important finding over the years is that discrimination against migrants plays a role in the processes of acculturation and ensuing adaptation. Research suggests that higher levels of discrimination experienced by migrants tend to result in the use of the separation strategy, while lower experiences of discrimination are linked to preferences for integration and assimilation strategies (Sam & Berry, 2006).

In addition, research has shown that discrimination is frequently the most significant predictor of poor sociocultural and psychological adaptation (Berry et al., 2006; Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006). For instance, in *Immigrant Youth in Cultural Transition,* Berry and colleagues discuss psychologists' work in a comparative study of acculturation and identity. Using data from more than 7,000 culturally diverse immigrant youth living in 13 countries, they explored different ways in which young immigrants

acculturate and adapt to their intercultural context. Participants in this international comparative study were aged between 13 to 18. Data collection involved a structured questionnaire evaluating acculturation attitudes, identity, ethnic language proficiency, national language proficiency, language use, and perceived discrimination among many other variables. Berry et al. (2006) explain the differences in both psychological adaptation and sociocultural adaptation, with most youth in the study adapting well over time.

The evaluations by Berry and colleagues (2006) suggest that the integration strategy predicts more positive adaptation and they provide some evidence that more successful intercultural relations potentially require a decrease in discrimination. They note that future research in cross-cultural psychology should be longitudinal in order to examine the psychological and cultural changes during the processes of acculturation (Berry et al., 2006). A study in New Zealand investigating the settlement and social inclusion of young migrants and refugees similarly found the level of discrimination experienced was associated with poor settlement and social inclusion (Sobrun-Maharaj, Tse, Hoque, & Rossen, 2008). Major barriers to settlement included negative host country attitudes such as racism, prejudice and non-acceptance of immigrant youth. Sobrun-Maharaj and colleagues' (2008) findings also noted that a sense of belonging and a supportive environment contributed to the integration strategy and youth migrants' interactions in New Zealand.

Berry (2017) and other researchers (e.g., Gardner & Tang, 2014) have commented that much of the research has placed emphasis on the needs and struggles of immigrants, suggesting that experiences of cultural difference are problematic. However, there has been some discussion on the positive aspects of migration. Ehrensaft and Tousignant (2006) argue that the experiences of acculturation can enable individuals to actively cope with the circumstances of life rather than become victims of events. These researchers describe resiliency in immigrants as a process, as opposed to a personal quality in individuals, which is built when individuals develop positively despite enduring stressors. Another positive

outcome of acculturation can arise from the process of adaption, where migrants develop cross-cultural sensitivity and hence empathy towards others (Bhawuk, Landis, & Lo, 2006).

The following sections will review the research and clinical literature related to immigrant therapists, cultural competence in therapy, and working therapeutically cross-culturally. Prior to this, it is important to briefly consider research into the therapeutic relationship as it is linked to therapy outcomes (Norcross & Wampold, 2011) and may be relevant to immigrant therapists' experience of working in Aotearoa New Zealand.

The Therapeutic Relationship

As part of understanding immigrant therapists' experiences, this study also aimed to understand the impact, if any, of being an immigrant therapist on working therapeutically and the therapeutic relationship. Researchers have concluded that the therapeutic relationship and therapeutic alliance between the therapist and client are central to positive outcomes in therapy, and therefore of vital importance to practising clinicians (Gelso, 2014; Lambert & Barley, 2001; Martin et al., 2000; Norcross & Wampold, 2011). Although there are several contributing elements to the success of therapy, clinicians of various orientations agree on this aspect: common factors such as warmth, empathy and the therapeutic relationship are the basis for growth and change (Norcross & Wampold, 2011).

Drawing on research and theoretical literature, Gelso and Carter (1994) propose an operational definition of the client-therapist relationship as "the feelings and attitudes that counselling participants have toward one another, and the manner in which these are expressed" (Gelso & Carter, 1994, p. 297). This definition is generally accepted, theoretically neutral, and broad but succinct (Norcross & Lambert, 2011). The therapeutic alliance reflects the strength and quality of the collaboration between the therapist and client (Norcross & Wampold, 2011) and has been described as the catalyst for therapeutic work (Gelso, 2014). This "working bond" between the therapist and client, where together they

agree, either implicitly or explicitly, on achievable goals in therapy and work on tasks to facilitate goal achievement, may be conceptualised as the working aspect of the relationship (Gelso, 2014).

Another concept known as "the real relationship" can be seen as the foundation of the therapeutic relationship and depicts the degree of realism and genuineness within the personal relationship between therapist and client (Gelso, 2014). Although there is virtually no empirical work on how to strengthen the real relationship, the term itself may provide an indication to therapists to be more authentic and work diligently to understand the client more realistically and accurately (Gelso, 2014). However, as Gelso (2014) explains, this notion of genuineness is one of the most challenging to understand and describe.

Another element that forms an aspect of the therapeutic relationship is the dynamic of transference and countertransference (Gelso, 2014). Transference can appear in everyday interpersonal situations, but the term is generally used to describe reactions that clients have to therapists (Cartwright, 2011). There are several definitions and conceptualisations of transference from various psychological perspectives that are beyond the scope of this thesis. Thus, at the risk of oversimplifying the concept, this general definition of transference is used throughout this research. However, given that attitudes to immigrants can be based on individual qualities such as stereotypes and cultural differences, it is important to understand the relevance of transference in terms of working therapeutically.

Countertransference, on the other hand, is commonly used to describe the therapist's reasoning and emotional responses to the client (Gabbard, 2004). The therapist's emotional responses or countertransference can be a valuable tool, and thus need not be seen entirely as a hindrance in terms of understanding clients (Cartwright, 2011). Rather, countertransference can be viewed as an important experience clinically and provide further insight into processes that are occurring (Akhtar, 2006; Cartwright, 2011). Countertransference has also received significant attention in the literature with considerable

disagreement on the concept (Norcross & Wampold, 2011), but a full discussion of this topic is also beyond the scope of this thesis. However, it is an important concept to consider and appreciate, particularly in terms of any countertransference that might occur with immigrant therapists and their clients in Aotearoa New Zealand.

In this research, the term therapeutic relationship is used as a general term to describe the working alliance, the real relationship and the transferences discussed above. The reason this term was chosen is because of the specific definitions discussed in the literature that denote detailed elements of interactions between therapists and clients. It is possible, however, that participants in the study have not adhered to these definitions in their descriptions and their explanations are less theoretical and more experiential, as was the case in a similar previous study (Niño, Kissil, & Davey, 2016).

Other components of the therapeutic relationship involve a positive regard, a degree of self-disclosure, repairing ruptures in the alliance, and managing countertransference (Norcross & Wampold, 2011). Given the probability of countertransference having a negative effect on the therapeutic relationship (Hayes, Gelso, & Hummel, 2011), it is important for therapists to view and consider countertransference in their reflection and supervision practice (Cartwright, 2011). Some problems that can occur in the therapeutic relationship, as noted in Norcross and Wampold, include confronting the client, therapist rigidity, using only one treatment method for all clients, and having rigid assumptions. The therapist needs to be flexible in their approach and assumptions about what is best for clients. The best practice is to respectfully inquire how the client perceives therapy and request feedback. This is likely to enhance the alliance and therapeutic outcomes (Norcross & Wampold, 2011).

Another related term when considering the therapeutic relationship is the idea that Gelso and Mohr (2001) introduced as cultural transference. Cultural transference refers to culture-related beliefs or behavioural responses to the therapist that are entrenched in the client's

understandings and experiences with members of the therapist's cultural group. Similarly, Foster's (1998) paper discusses cross-cultural countertransference as a web of interfacing cognitive beliefs and experiences about which the therapist has various levels of awareness, and within which exist the therapist's life values and subjective biases regarding their own ethnicity.

Foster (1998), a research and clinical psychologist with expertise in working cross-culturally, argues that often these cultural countertransference beliefs are denied or neglected by the clinician, but have a powerful impact on treatment and, although not expressed, are often perceived by clients. She adopts a psychodynamic and clinical approach to illustrate how cultural biases can shape and influence a clinician's viewpoint when working with clients whose cultural background is considerably different to their own. She claims that there has previously been a "delusion" on the part of therapists in assuming that the application of a psychotherapeutic framework can mask the clinician's subjectivities and worldview. Foster (1998) argues instead that such subjective reactions form part of our existence in everyday life.

Foster (1998) also notes that neglecting cultural countertransference can have negative implications when working therapeutically. Problems that arise will at the minimum be a rupture in the therapeutic relationship when the client recognises the clinician's unspoken beliefs, and in the worst case scenario an early termination of therapy. This view is supported by Gelso and Mohr's (2001) theoretical propositions and discussion following semi-structured telephone interviews with expert psychologists in the field of race and identity. These authors concluded that significant dropout rates have often occurred in the area of cross-cultural therapy as cultural countertransference is not noticed or ignored.

Gelso and Mohr (2001) also argue that when individuals are different, particularly in terms of race and sexual orientation, cultivating the working alliance may require increased effort. This is even more relevant when one individual in the dyad is from a minority group

and the other a majority group member. This may be because of culturally reinforced negative transferences associated with fear and assumptions of nonunderstanding (Gelso & Mohr, 2001). These transferences can then create initial obstacles to healthy alliance formation. Gelso and Mohr note that alliance formation can also be significantly impacted by the differences and similarities between therapist and client worldviews, cultural values, and styles of communication.

According to Sparks and Duncan (2010) in their review of evidence for the efficacy of family therapies, earlier research investigating the effects of therapist and client demographic matching is inconclusive. In a paper reporting their study of immigrant therapists, Niño et al. (2016) note in their literature review that there is some evidence that similarities in demographics between therapists and clients are linked to better working alliances and clinical outcomes. Previous studies have found that variables which appear to be positively affected by therapist-client demographic matches include the number of appointments attended, treatment modality, and satisfaction with therapy (Johnson & Caldwell, 2011; Zane, Hall, Sue, Young, & Nunez, 2004). However, Niño et al. (2016) also cite recent meta-analyses (Gaztambide, 2012; Zane et al., 2004) showing no significant associations between discordant or matched client–therapist backgrounds and the quality of the therapeutic relationship and therapy outcomes (Zane et al., 2004). On the other hand, therapists' empathy and warmth, competence, cultural sensitivity, and holding similar values to their clients have been found to be more strongly related to therapeutic outcomes than the social positioning of therapists and clients (Sparks & Duncan, 2010; Zane et al., 2004).

As the quality of the working alliance and relationship are seen as pivotal factors linked to health outcomes, most of the research on the therapeutic relationship discusses their impact on therapy outcomes (Norcross & Wampold, 2011). Gaining a better understanding of immigrant therapists' experiences when working therapeutically in Aotearoa New Zealand may therefore provide further insight into successful cross-cultural therapy. In

particular, a better understanding of their sense of self as professionals, and how this might develop and change over time, may be particularly informative and relevant to understanding how immigrant therapists experience the therapeutic relationship with their clients. A deeper understanding of their experiences could provide insight into their challenges and breakthroughs when working in a new setting and environment. Consequently, therapists could then be supported and encouraged to build on their self-awareness in terms of what they carry with them in the therapeutic setting, including cultural factors, and how to best use these factors for optimal therapeutic relationships (Kissil et al., 2013).

Cultural Competency, Immigrant Therapists, and Cross-cultural Therapy

It is important to consider the research and clinical literature on cultural competence, immigrant therapists, and cross-cultural therapy relevant to this study. According to the NZPB (2010), cultural competence is defined as demonstrating the knowledge, skills, and awareness needed to accomplish various psychological tasks. For therapists, this involves recognising the different views and actions of themselves and clients from different cultures (NZPB, 2010). Most of the international clinical literature on cultural competence places emphasis on advising therapists from dominant cultural groups on appropriate ways of working with ethnic minority clients (e.g., Boyd-Franklin, 2013; Durie; 1994; Lee, 2011; Pedersen et al., 2008; Sue, 2006). This includes being culturally aware and understanding clients' values and beliefs in order to avoid making assumptions about what is "normal" (Akyil, 2011, p.158).

In a review article on cultural competence theory and practice in the mental health field, Sue (2006) notes the "challenging and exciting movement" has led to the development of a number of guidelines by governments and national organisations (p.237). He also argues that a substantial body of research has been undertaken to raise awareness among therapists

about the cultural diversity of clients (Sue & Sue, 2013). Sue and Sue (2013) and other researchers (e.g., Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003) and therapists (e.g., Akhtar, 2006, 2010) suggest there are a number of resources available to provide clinicians with the tools and information required to offer therapeutic services which better fit the needs of clients from different cultures. These suggestions for research and training on effective therapeutic practice have focused on cultural competence and cross-cultural sensitivity in working with clients in therapeutic settings (Sue & Sue, 2013).

Although there has been extensive research on the processes of immigration and emphasis on the importance of cultural competence, there appears to be minimal research focusing on factors associated with the therapist's cultural background. The lack of research or clinical discussion on the impact of being a migrant therapist when working therapeutically (Akhtar, 2006) may suggest that this cultural element does not affect the therapist, or that the therapist is culturally neutral (Kissil et al., 2013).

In a web-based survey study of immigrant clinicians' acculturation, Kissil, Davey and Davey (2012) note that the influence of being an immigrant on a therapist's sense of self during therapeutic work has received little empirical attention, despite the increasing number of foreign-born clinicians in the United States. The researchers examined the associations between acculturation, clinician self-efficacy, and language proficiency in a sample of 258 foreign-born clinicians practising at the time. Their findings suggest that the level of perceived prejudice, rather than acculturation, is significantly linked to levels of clinical self-efficacy, which highlights the role of the host community's attitudes in immigrant therapists' experiences. These researchers also note that the concept of being "not from here" can be seen as a different, unique notion not presently discussed in research regarding ethnicity, race, and minority groups (Kissil et al., 2013).

One of the challenges immigrant therapists may face lies within the contextual factors of the new professional setting in relation to their sense of self as professional (Kissil et al.,

2013). One example from Kissil and colleagues' (2012) findings was that immigrant therapists reported feeling more connected to other internationals rather than therapists from the United States. Both studies by Kissil and colleagues (2012, 2013) highlight the challenge for immigrant therapists in understanding the professional environment in the host country whilst integrating the old and new professional cultures in order to achieve continuity in their professional identities. This challenge is also identified in earlier research by Basker and Dominguez (1984), who conducted case study interviews with 24 immigrant therapists (psychologists, psychiatrists, and social workers) who had moved to Israel. In this study, the researchers note that participants reported having a clear understanding of the effect of immigration and differences in culture on their personal lives, however they appeared not to have an equivalent level of awareness when considering their professional actions.

Another later study by Yedidia (2005) of three social workers working as therapists who had moved to Israel as adolescents discusses problems with identity that can either come from, or are exacerbated by, the process of immigrating. The author concludes that the processes of immigration can influence relations with clients and therapists' capacity to treat them. Despite having a deep familiarity and empathy with their clients' cultural codes, the clinicians expressed unresolved identity conflicts originating from childhood and struggled to better contain issues that occurred with their clients, such as an over-identification with client vulnerabilities. According to Yedidia, the cases in his study highlight the importance of assisting immigrant therapists to be familiar with their own identity conflicts and resultant countertransference, in addition to the identity problems of their clients. However, it is important to note that Yedida's study is limited by the small sample. On the other hand, in a paper discussing the challenges faced by immigrant therapists, Akhtar (2006) also suggests that this level of professional awareness is required not simply to prevent immigrant therapists' conflicts from intruding on the therapy process, but also so they can utilise the richness of their encounters to help their clients.

A more recent study conducted by Niño et al. (2016) examined ways in which immigrant therapists in the United States connected to their clients, and strategies the therapists used to create stronger cross-cultural therapeutic work. They conducted an interview study with 13 immigrant therapists about their experiences, concluding that the participants believed building a strong therapeutic connection and engagement is essential for optimal cross-cultural therapy. Although the 13 therapists in the study had different backgrounds, most believed they had transformed their cultural differences into assets in their therapeutic work (Niño et al., 2016).

As the working alliance is more complex when cultural differences exist between therapists and clients (Gelso, 2014), immigrant therapists may need to make more effort to cultivate the alliance. Niño and colleagues' (2016) study supports this conclusion as their participants found it particularly challenging when initially forming a strong working alliance; they reported feeling they were viewed less favourably by clients in comparison to other US-born clinicians. However, despite these initial challenges, once the relationship was established, their foreignness became less important and secondary to their work (Niño et al., 2016).

Another interesting finding from Niño and colleagues' (2016) study was that participants reported a shift in their perceptions about their status of being foreign. Despite feeling that their foreignness was an obstacle that could affect later clinical encounters, gradually they reframed these expected problems (worries about language difficulties and not understanding the culture). Over time, they reported feeling more comfortable with their identity and realised they were able to be effective as therapists (Niño et al., 2016). The immigrant therapists also reported numerous ways of using their immigrant status to better relate to clients, such as using language difficulties to assist in breaking down hierarchies and decreasing power discrepancies (Niño et al., 2016). They also took advantage of their foreign status by being genuinely curious and asking questions. This finding provides

empirical support for previous reports in the literature, including Kissil and colleagues' (2013) study which suggests the capacity to be genuinely curious is an advantage for immigrant therapists. Lastly, Niño and colleagues' findings support earlier research regarding the importance of the therapeutic relationship for therapeutic outcomes (Norcross & Wampold, 2011).

Akyil (2011), a therapist who discusses her experience of being a minority family therapist in the United States, explains she worked diligently to ignore her own cultural values and described feeling it was best not to impose her culture on her clients as it would be damaging and unhelpful. However, over time, she learned that if used appropriately, her cultural beliefs could be a tool in therapeutic work and intervention. As noted earlier, this realisation has been seen in research studies in which immigrant therapists express identity as an ongoing development (Isaacson, 2001), and also noted in the immigration literature describing the processes of acculturation as continuous (Berry, 2017; Poulsen, Karuppaswamy, & Natrajan, 2005).

Akyil (2011) supports previous views that minority therapists working in an unfamiliar context should consider the biases and stereotypes they have, and reflect on when it might be appropriate to discuss cultural values in therapy. She suggests that considering an individualist-collectivist dimension may be helpful to understanding therapists' awareness. This knowledge may then create new opportunities to discuss how different worldviews are brought to therapy, and how recognising them may change health outcomes when working with different cultures. Akyil's reflections also point towards the importance of future cross-cultural comparisons on this topic. As other researchers and therapists have suggested (Niño et al., 2016), Akyil proposes that it would be informative to see how therapists in other countries reflect on their cultural background in therapeutic settings.

Within this small body of research and clinically-based reflections, a number of researchers have pointed out that immigrant therapists provide a fertile ground for work on

client transference because of the risk of being stereotyped by clients (Akhtar, 2006; Gardner & Tang, 2014; Gelso & Mohr, 2001). Gelso & Mohr (2001) argue that when one member of the therapeutic dyad's race or sexual orientation is different from the other, and particularly if their minority group is one oppressed historically or presently, the therapist can be a "lightning rod" for transference. However, this need not be a drawback as mentioned earlier, but rather can provide an important platform to address cultural differences, and awareness of these dynamics can enrich therapists' work. Gelso and Mohr argue that it is therefore important that immigrant therapists bring up and explore these contextual factors with their clients, particularly when the transferences are negative (Gelso & Mohr, 2001).

At the same time, it is also essential to attend to alternative explanations of behaviours that clients present with that may initially seem transferential (Gelso & Mohr, 2001). It could be that the therapist is unaware of or unfamiliar with normative behaviours pertaining to some cultural groups and client behaviours could mistakenly be interpreted as transference when in reality their actions are in accord with culturally appropriate roles. One example provided by these authors is clients from cultures that place emphasis on respect for medical professions who might seem unusually passive to some therapists. This behaviour could be viewed as pathological rather than an expression of a socially accepted attitude.

It is also possible that immigrant therapists may have increased awareness of how clients perceive matters because of their experiences of dealing with difference (Akyil, 2011). Gelso and Mohr (2001) also contend that clients may identify with the therapist's status of being other and feel that the therapist is able to understand them. Similarly, Isaacson (2001) suggests that the profound feelings of otherness that immigrant therapists experience can help them connect better with clients who also go through experiences of marginalisation and disenfranchisement. This includes clients from ethnic or racial minority groups, other immigrants, and clients who are critical of their own culture (Kissil et al., 2013).

However, as the experience of being different can be emotionally challenging for immigrant therapists, it may lead to self-doubts about working therapeutically (Isaacson, 2001; Mittal & Weiling, 2006). Doubts can be even more pronounced when the therapist's native language is different from the host country language and fear of misunderstanding and feelings of inadequacy may arise. This is particularly true for therapists who have not experienced a substantial level of cultural socialisation. However, Kissil and colleagues (2013) explain that only through accepting the experience of otherness can immigrant therapists use it to their advantage in therapeutic work.

As Akhtar (2006) points out, it is worth bearing in mind that embracing otherness as a means to develop empathy should be done with clinical sensitivity as there is a possibility of developing an affiliation with marginalised clients in opposition to the mainstream culture. This could consequently lead to emotions of anger and frustration for therapist and client which are then transferred onto the host country. When this affiliation occurs, the therapist may become protective, which could then prevent them from challenging their clients when working therapeutically (Gardner & Tang, 2014).

It is also possible during therapy that clients might wonder if an immigrant therapist is able to connect with them and offer successful treatment (Kissil et al., 2013). It could be that the outsider status of the therapist means they are viewed as less capable from the client's perspective; clients may have stereotypes, be racist, or hold prejudice towards foreign born therapists (Akhtar, 2006; Mittal & Weiling, 2006). Consequently, as mentioned, this may cause immigrant therapists to doubt themselves, and create feelings of anger or sadness (Isaacson, 2001). This, however, can be turned into an advantage by therapists managing cultural differences between themselves and their clients (Kissil et al, 2013). As immigrant therapists are seen as outsiders, they can display more curiosity, ask more questions and challenge assumptions that clients have (Isaacson, 2001; S. Sue, 2006). Once again, however, this curiosity should be expressed with clinical judgment to ensure that the

attention is not taken away from the client's problems, and it becomes a conversation whereby the therapist's interest is the focus (Akhtar, 2006).

In a set of guidelines for counsellors, Chung and Bernak (2002), researchers in cross-cultural and multicultural psychological practice, explore the widely debated components of empathy and propose some suggestions for building cross-cultural empathy in counselling. They describe building empathy as the therapist not only positioning themselves alongside the client, but also having the skills to communicate emphatic understanding. This involves the client perceiving the therapist as empathetic, as pointed out earlier by Rogers (1951). In view of the complexities of culture, an important matter for therapists to consider is how one shows empathy in an effective manner across cultures.

One problem in cross-cultural therapeutic work, as indicated in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2015), occurs when a lack of awareness of cultural factors potentially leads to a misdiagnosis as the therapist may misunderstand cultural elements of client reports. This is often the case when the therapist and client have different worldviews, and can also lead to possible conflict and premature termination of therapy (Sue & Sue, 2013). Chung and Bernak (2002) note that therapists should be aware of not only the client's worldview, but also their own perspectives. Therapists can then compare these perspectives and evaluate any misinterpretations that might occur in therapeutic work when the client and therapist have different cultural backgrounds.

In an overview and intervention model to assist refugees with acculturation and adaptation processes, Bernak, Chung, and Pedersen (2003) discuss the importance of understanding and accepting the family and community context of clients from different cultures, particularly in terms of acknowledging collectivist cultural worldviews. They also suggest incorporating indigenous healing practices pertaining to the client's culture whenever possible. These approaches indicate an understanding on the part of the therapist

of the different values and views that the client may hold, and also involve having knowledge of different conceptualisations of health according to clients' cultural views. Their suggestions highlight that this incorporation does not necessarily require the therapist to actually perform rituals specific to different cultures, but rather work cooperatively with healers in partnerships that promote respect for culturally specific methodologies (Bemak et al., 2003). Other guidelines proposed by Chung and Bemak (2002) include the importance of counsellors equipping themselves with knowledge concerning historical and sociopolitical factors pertaining to clients, considering transgenerational trauma, recognising psychosocial adjustment factors when clients change environments, and being acutely sensitive to the daily challenges of oppression, discrimination, and racism that clients may face.

Chung and Bemak's (2002) guidelines and Bemak, Chung and Pedersen's (2003) overview of cross-cultural therapy have direct implications for both native and immigrant therapists in Aotearoa New Zealand working in a bicultural/multicultural context. In addition, there are New Zealand specific guidelines on including indigenous practices in the code of ethics for psychologists, with culturally appropriate models and frameworks incorporating the principles of the Treaty of Waitangi (NZPB, 2010). The following section discusses the cultural context of Aotearoa New Zealand, and the importance of cultural competence and cross-cultural work for therapists. It also considers some important aspects of therapeutic practice that immigrant therapists may encounter in Aotearoa New Zealand.

Immigrant Therapists and the Cultural Context of Aotearoa New Zealand

Immigrant therapists working in New Zealand's mental health services will experience a unique bicultural and multicultural context where the therapist's cultural identity, awareness and competence are highly important to client health outcomes (NZPB, 2012.) They will be working with Māori, Pacific Islanders, Asians, and other cultural minority groups. According to Statistics New Zealand (Stats NZ, 2013), Māori make up 15% of New

Zealand's inhabitants and experience, by and large, the poorest mental health of all cultural groups (Ministry of Health, 2005, 2010). Given the high rate of Māori presenting to mental health services, and an increasing number of Māori suicides (Beautrais & Fergusson, 2006), the capacity for mental health professionals to work successfully with Māori is a topic of considerable importance (Ellison-Loschmann & Pearce, 2006). Being culturally sensitive, competent and skilled in a bicultural and multicultural context is an integral part of and priority in professional training practice in Aotearoa New Zealand, including for psychologists (Johnstone & Read, 2000).

In her paper, *The Treaty Framework for a Sustainable Future for Psychology: Cultural Competencies in Context*, Averil Herbert (2010) considers the notion of developing the discipline of psychology so that it is meaningful and relates to the diverse cultural groups in Aotearoa New Zealand. She notes that the four principles within the NZPB's ethical code: Respect for the dignity of persons and peoples; Responsible caring; Integrity in relationships; and Social justice and responsibility, are all meaningful, and particularly the last principle. The principle of social justice is not a feature of other codes in Western countries, and uniquely the principles of the Treaty of Waitangi are included within the guidelines of the New Zealand Psychological Society (NZPsS) (Herbert, 2010).

As part of the cultural competence requirements of the NZPB, psychologists in Aotearoa New Zealand are legally and ethically bound to consider the Treaty of Waitangi (and the three principles of participation, protection, and partnership) for Māori health (Macfarlane, Blampied & Macfarlane, 2011). The Treaty, signed in 1840, is an agreement between the Crown and iwi and hapū (tribes and subtribes) in Aotearoa New Zealand and considers governance, land rights, and sovereignty (Herbert, 2010). The Treaty provides a relational framework for cultural competence, improved understanding, better communication, and ultimately, challenging inequalities.

Despite the guarantees of the Treaty in terms of Māori rights, history illustrates the negative impacts and suffering faced by Māori due to colonisation (Bennett & Liu, 2018). Problems such as disease, land confiscation, warfare, and loss of Te Reo (Māori language) were the precursors to the contemporary problems of poverty, educational underachievement, and mental health (Macfarlane, et al., 2011). In terms of the clinical context when working in Aotearoa New Zealand, the whakapapa (genealogy) of the Māori client will contain a set of cultural patterns (Bennett & Liu, 2018). It is helpful for therapists to reflect on the historical developments that have led to the presenting problem rather than assuming one particular event caused the problem (Macfarlane et al., 2011).

However, this does not mean that therapeutic work should only focus on the past, but an appreciation of the "historical trajectory" is necessary when working with Māori (Macfarlane et al., 2011). Similarly, a better understanding of diversity and Māori in Aotearoa New Zealand requires an understanding of cultural differences, and an appreciation of the power dynamics within relationships and moving towards reducing imbalances in power resulting from oppression are also important (Herbert, 2010). Knowledge, skill and awareness will also, as noted in the literature, enhance the working alliance and ultimately increase the likelihood of positive therapeutic outcomes (Norcross & Wampold, 2011).

The first principle of participation within the Treaty concerns the participation of tangata whenua (Māori) and provides Māori the right to access culturally suitable services. Each individual should be given a choice of services that meet their needs and these choices should be easy to make (Bennett & Liu, 2018). The second principle of protection illustrates the government's obligation to protect Māori customs, culture and language. In order for this to happen, Māori must have the right to define what health and wellbeing mean to them and decide how to protect their health themselves (Bennett & Liu, 2018). Models appropriate for Māori that incorporate holistic and spiritual aspects of Māori culture have been published

and utilised in clinical settings (Durie, 1994, 2001; Macfarlane et al., 2011; Te Puni Kokiri, 1993). The implications of this principle for clinical practice are services ideally delivered by Māori for Māori clients with a Māori approach that is distinct from Western paradigms (Macfarlane et al., 2011).

As there are fewer Māori psychologists and clinicians than therapists from other cultural groups, it is not always possible for services to be provided by Māori for Māori, making it important for therapists to consider the implications of the Treaty in therapeutic work. This raises the question of whether immigrant therapists working with Māori can adequately meet the needs of Māori from a bicultural perspective. There has been considerable debate on bicultural versus multicultural approaches, raising issues which remain unanswered and continue to be problematic (DeSouza, 2006). However, rather than considering biculturalism as a hurdle to multiculturalism, DeSouza argues that it has paved the way for the mainstream culture to think about cultural issues less restrictively. DeSouza highlights the need to attend to the place of the Treaty against the milieu of making room for multiculturalism. She indicates that some have seen biculturalism as an obstacle to the realisation of a more diverse Aotearoa New Zealand, suggesting that multiculturalism within biculturalism could be a potential solution, but one that requires more exploration and operationalisation.

In terms of the third principle of partnership as it applies to the discipline of psychology, this means working collaboratively with the client within a balanced relationship to reduce disparities (Macfarlane et al., 2011). This third principle of the Treaty indicates that Māori should be granted the same privileges and rights as non-Māori (Johnstone & Read, 2000). Psychological services are therefore required to guarantee that Māori have equal rights to the use of services, as well as to experience the same outcomes (Bennett & Liu, 2018).

Another application of practice for working in partnership may be addressing the similarities between therapists and clients before addressing any differences (Macfarlane et al., 2011). This is seen as culturally competent because it is a collaborative approach. It

adheres to ethical principles for psychologists and is, in a sense, reciprocal as the psychologist assesses the client but the client can also assess the psychologist (Macfarlane et al., 2011).

Immigrant therapists will not only be working with Māori, but also other ethnicities in Aotearoa New Zealand. The number of Asians, for example, had increased by around 140% in the last decade at the time of the 2001 Census, and was expected to increase by 122% by 2021 (DeSouza, 2006). In contrast, the number of Pākehā (European New Zealanders) will only increase by 1%, whereas Māori are projected to increase by 28%, and Pacific People by 58%. DeSouza points out that new migrants and services can learn a substantial amount from Pacific peoples, who represent over 20 diverse cultures. At the 2001 Census, six percent of the New Zealand population was made up of Pacific peoples and this will rise by 2051 to 12%. As immigrant therapists in Aotearoa New Zealand may well be working with other ethnicities in clinical settings, gaining information about experiences with the various cultural groups in Aotearoa New Zealand may provide better insight into ways of increasing the chances of positive therapeutic outcomes in cross-cultural therapy. Several culturally appropriate models have been studied in the research and used recently in clinical settings in Aotearoa New Zealand (Durie, 1994, 2001; Macfarlane et al., 2011; Pitama et al., 2007). It would therefore be valuable to know to what extent immigrant therapists feel comfortable in utilising these frameworks in therapy.

Using the three principles of the Treaty as a framework for clinical practice helps therapists to understand where Māori and other cultural groups in Aotearoa New Zealand are placed in terms of presenting negatively on many social indicators (Macfarlane et al., 2011). An appreciation of the historical context shifts the therapist's thinking and builds empathy by moving away from a deficit model and toward a sociological understanding (Bennett & Liu, 2018). Thus, a better understanding of immigrant therapists' experiences in Aotearoa New Zealand may provide insight into the challenges and positive experiences of working in

a bicultural/multicultural setting, which will ultimately assist with future training, clinical practice, and supervision. In particular, exploring the ways immigrant therapists navigate areas where they may have less historical knowledge or understanding of other cultures may provide useful information about areas to consider in training and future practice.

Although there have been no studies of immigrant therapists' experiences in Aotearoa New Zealand, there has been some discussion on the topic. Thorpe and Thorpe (2008) highlight some specific difficulties they have noted for immigrant psychotherapists in Aotearoa New Zealand. Some of the challenges discussed concern the "bewildering" processes of professional re-registration, the differentiation between psychotherapy and counselling, and the lower status of psychotherapy in comparison to other countries. Other challenges relate to different cultural beliefs such as the "tall poppy" syndrome and developing professional networks (Thorpe & Thorpe, 2008). As discussed earlier, challenges with building support networks may lead to social isolation, health problems, and adjustment difficulties for immigrants (Sluzki, 2008). Gaining a better understanding of how immigrant therapists perceive their professional environment in their new country, and integrate their old professional culture, can provide valuable information on the continuity of their professional identities (Basker & Dominguez, 1984; Isaacson, 2001; Kissil et al., 2013). More research in this area to address questions regarding these aspects would be useful to understand how immigrant therapists perceive these notions and explore what is relevant to immigrant therapists working in Aotearoa New Zealand.

Aotearoa New Zealand is a culturally diverse country and immigrant therapists have a high likelihood of working cross-culturally with clients from other cultural groups including Māori, Pacific Islanders, Asians, and other cultural minority groups. Developing a better understanding of the experiences of immigrant therapists in Aotearoa New Zealand is salient to the current requirement within the field of mental health to work cross-culturally. The findings from this study into some of the challenges faced by immigrant therapists will

provide a knowledge base that may inform appropriate services with a bicultural/multicultural approach for a diverse New Zealand population (Herbert, 2002). In addition, their positive therapeutic experiences may provide further insight and support for future immigrant therapists and supervisors.

Purpose of this Study

The existing research and clinical literature provide some insights into the experience of working cross-culturally. Little is known, however, about the experiences of immigrant therapists and how being an immigrant may play an important part in their therapeutic work. No studies have been conducted in Aotearoa New Zealand in relation to working within the cultural context of Aotearoa. In addition, the few studies that have been carried out describe the immigrant therapists' experiences as problematic and overlook the possible assets of being an immigrant engaged in therapeutic work. Virtually no studies have viewed how identity or sense of self as professional and acculturation processes may change over time and impact therapists' therapeutic work. Given that the processing of cultural identity is viewed as central to immigrants' acculturation experience, along with the increasing number of skilled migrants in Aotearoa New Zealand and the importance of cultural awareness and competence within the field of mental health, there is a definite need to gain further understanding of immigrant therapists' experiences, both for clinical and research purposes. This study attempts to address this gap and add to the international literature.

Consequently, this study sought to explore the experiences of immigrant therapists working in Aotearoa New Zealand. The research had three aims: first, to examine the cultural differences immigrant therapists experience working professionally and therapeutically in Aotearoa New Zealand; second, to explore how the experiences of migration can influence therapists' views of themselves and their work; and lastly, to

consider what impact, if any, being an immigrant has on working therapeutically and the therapeutic relationship. The research questions guiding the study are:

1. *What are the cultural differences therapists experience when working professionally and therapeutically in Aoteorea New Zealand compared to their country of origin?*
2. *How does the experience of being an immigrant therapist impact on the sense of self as a professional and how does this change over time?*
3. *What impact, if any, does being an immigrant therapist have on working therapeutically and on the therapeutic relationship?*

The results of this study will contribute to the international literature regarding immigrant therapists and be considered in terms of implications for the support of immigrant therapists, for client experiences, and for training purposes. There are several other important areas where this study can also make a contribution. It may aid policy development, health outcomes in mental health practice, and add to the establishment of more positive attitudes towards immigrant therapists (Trlin, 2012). Immigration is a vital element in the economic growth of Aotearoa New Zealand, and the successful transition of migrants, particularly their mental health and wellbeing, is an important and relevant issue (Pernice, Trlin, Henderson, & North, 2000). The information gathered may provide insight into building a sustainable future for immigrant therapists and services in Aotearoa New Zealand, effective cross-cultural encounters, strengthening support networks for immigrant clinicians, and enhancing supervision practice.

Chapter Two: Methodology

This chapter provides an overview of the methodology used in this study. It briefly reviews the aims of this research along with the reasoning for using a qualitative approach and how this influenced the research design. It evaluates potential concerns about quality, rigour, and ethics. This is followed by an overview of the methods used in the study. This research had three aims: first, to examine the cultural differences immigrant therapists experience working professionally and therapeutically in Aotearoa New Zealand; second, to explore how the experiences of migration can influence therapists' views of themselves and their work; and third, to consider what impact, if any, being an immigrant has on working therapeutically and on the therapeutic relationship. The results of this study will be considered in view of the implications for the support of migrant therapists, for client experiences, and for training purposes.

Qualitative Design

The overall aim of the thesis study was to examine immigrant therapists' experiences of working professionally and therapeutically in Aotearoa New Zealand. Accordingly, applying a qualitative methodology was considered to be the most suitable approach. One purpose of using qualitative research is to answer research questions by collecting people's accounts of their experiences within their own individual contexts. Qualitative methodologies are orientated towards the importance of meaning and process over cause and effect (Braun & Clarke, 2013). Qualitative research typically focuses on gaining an in-depth understanding of human experiences rather than emphasising generalisable findings (Denzin & Lincoln, 2003; Merriam, 2002).

A qualitative approach was deemed relevant to the kind of understanding sought in this research: that of immigrant therapists' experiences of working professionally and

therapeutically, as well as their perceptions of their sense of self as professionals and how this developed and changed over time. A qualitative design is applicable to the research question as it provides an understanding of the meanings participants' give to their experiences while upholding each individual's description of their stories (Denzin & Lincoln, 2003). This research is influenced by narrative (Murray, 2003; Murray & Ziegler, 2015) and phenomenological (Crossley, 2000) qualitative approaches. Phenomenological approaches emphasise the idiosyncratic, lived experiences of individuals and their views and reflections on these (Crossley, 2000). Interpretative approaches view an individual's self-reflections on their experiences as important, along with the meaning constructed from such experiences (Crossley, 2000; Smith & Osborn, 2008). Narrative approaches also place emphasis on understanding individuals' subjective experiences (Murray, 2003; Murray & Ziegler, 2015). Narrative psychology focuses on the content, structure and function of stories that people tell themselves and discuss together in social interactions (Murray, 2003). Narrative psychology accepts that people come to understand their world through stories and interpretations of their own and other people's experiences or behaviours and are created within the stories they exchange. Narrative research observes individuals' stories to gain an understanding of the interpretations and meanings that individuals give to their experiences (McAdams, 1993).

In this approach, an individual's language is seen as reflecting and enabling expression of meaning and understanding, which is particularly pertinent to a qualitative design (Potter & Wetherell, 1987). By using a narrative approach, this research also aimed to achieve a deep and insightful understanding of therapists' experiences of working professionally and therapeutically, and to discover the real essence or core of immigrant therapists' experiences (Murray, 2003; van Manen, 1997). Consequently, my aim was to ensure that the data collection, analysis and interpretation of the data would validly represent immigrant therapists' experiences of working professionally and therapeutically, as delineated in their stories and the ways in which they understood and gave meaning to these experiences.

Narrative interviews. Within narrative approaches, researchers gather participants' stories on the topic of interest to develop an understanding of their subjective experiences, and how those experiences develop and change over time (McAdams, 1993; Murray, 2003). Narrative approaches consider the context and timing of events, their meaning, importance and effect on the individual, as well as how the individual interprets events (Lieblich, Tuval-Mashiach, & Zilber, 1998; Merriam, 2002; Murray, 2003).

Narrative research approaches often use semi-structured interviews to obtain an in-depth account of participant stories (Lieblich et al., 1998; McAdams, 1993; Murray, 2003). Interviews within narrative research facilitate participant storytelling and descriptions of experiences that are related to the topic of the study (Wengraf, 2001). Narrative structure gives participants the opportunity to determine how the interview unfolds and encourages them to describe their story from their own perspective. Consequently, this enables the researcher to gain a better understanding of the interviewees' experiences with minimal effect potentially arising from the researcher's own assumptions (Smith & Osborn, 2008).

Some narrative approaches (e.g., Lieblich et al., 1998; McAdams, 1993) have participants divide their accounts into stages or phases. Participants divide their stories into sections based on turning points or transitions in the narrative, or more traditionally a beginning, middle and end of their story (Gergen & Gergen, 1986; McAdams, 1993). When participants divide their stories in this way, the researcher can also consider a "plot analysis", a method used in narrative research to consider the shape or structure of narratives as they change over time (Gergen & Gergen, 1986; Lieblich et al., 1998). This form of analysis can examine the core themes that conceptualise a story, as well as the developmental path of the account (Gilgun, 2005; Lieblich et al., 1998).

Gergen and Gergen (1986) propose three main patterns of progression in a narrative, described as "progressive", "regressive", and "stable", which are further discussed by

Lieblich et al. (1998) and Murray (2003). In the progressive pattern, the story gradually rises and advances. This pattern may be linked to an effort towards an objective, or a series of challenges that have been dealt with successfully (Gergen & Gergen, 1986; Lieblich et al., 1998; Murray, 2003). The regressive pattern of narrative portrays a decline or deterioration in a direction away from a goal (Gergen & Gergen, 1986; Lieblich et al., 1998; Murray, 2003). In the stable narrative pattern there is often little or no change in the graph and the plot is steady (Gergen & Gergen, 1986; Lieblich et al., 1998; Murray, 2003). It is also possible, as Lieblich et al. (1998) note, that an individual's story includes a mixture of the three patterns.

Murray (2003) states that participants in narrative research commonly describe positive feelings about taking part in research interviews as it provides them with an opportunity to tell their story. Participants believe that their involvement may prompt them to consider their experiences more closely, provide them with a new perspective, and that contributing to research can be rewarding as the topic is familiar to their own encounters whilst benefiting others (McAdams, 1993). The narrative approach described above was used in the interviews and analyses, and will be discussed in the methods section.

Thematic analysis of the participant narratives. Thematic analysis was also utilised in this thesis study as it supports a qualitative approach, and is flexible and accessible to the analytic process (Braun & Clarke, 2006). Thematic analysis is not bound to any epistemology and consequently can be utilised in different theoretical frameworks (Braun & Clarke, 2006). In this research, thematic analysis was used to examine the research questions, such as the cultural differences immigrant therapists experience in working professionally and therapeutically, and how the experiences of migration can influence therapists' views of themselves and their work. At the heart of thematic analysis is the procedure of identifying patterns and themes from the data (Boyatzis, 1998). Thematic analysis not only consists of simply giving voice to the participants, but also involves a level of interpretation.

The significance of qualitative research lies in whether an identified theme encapsulates

something important that relates to the main research question (Braun & Clarke, 2006). This research has endeavoured to understand immigrant therapists' experiences of working professionally and therapeutically in Aotearoa New Zealand, examine how the experiences of migration can influence therapists' views of themselves and their work, and to consider the implications for the support of migrant therapists. Meanings, motivations, and experiences were conceptualised in a simple and uncomplicated manner, allowing participants' language to reflect and express meaning as well as experience (Braun & Clarke, 2006). Braun and Clarke have created a structured step-by-step procedure for conducting thematic analysis, which is described below in the data collection section. The thematic analysis of the participant narratives and plot analysis are discussed in the methods section.

Quality and rigour. In qualitative research, it is essential to conduct tests of rigour. My aim was to follow the practices of credibility, transferability, dependability and confirmability, as advocated by Denzin and Lincoln (2003). These concepts replace the concepts of "reliability" and "validity" associated with quantitative research. Firstly, to ensure credibility, it is fundamental to portray an accurate and faithful account of the participant's experiences in order for them to be able to recognise it as their own (Sandelowski & Leeman, 2012). One way of ensuring credibility, as Koch (2006) advises, is by consulting with participants and discussing observations or conducting "member checks". This was achieved by checking transcript accuracy with participants and giving them the opportunity to remove any information they felt uncomfortable with. Some participants also emailed with further additions, reflections and changes they wanted to make. It is also important for researchers to develop self-awareness for credibility. Accordingly, I applied Koch's recommendation of noting themes and interactions with participants in a journal.

Working with narrative approaches requires dialogical listening to at least three voices: that of the narrator, the theoretical framework (the source and ideas for interpretation), and the researcher's reflexive monitoring through the process of reading and interpreting

(Lieblich et al., 1998). Koch (2006) suggests that the researcher may also reflect on reactions to specific events in their note-taking as this offers material for later consideration. Koch's discussion of the self-awareness process helped me to observe the biases I carried in the study (Babbie, 2008). One clear example is that I am also a migrant in Aotearoa New Zealand and training to be a psychologist, which I revealed to participants. During the research, I constantly aimed to be reflexive and consider the three voices (participants' narratives, theoretical sources and my own reflections) proposed by Lieblich and colleagues as much as possible in order to avoid biased analyses. This also involved having self-awareness about my own processes when drawing conclusions from the data (Lieblich et al., 1998).

Transferability is also a fundamental component of determining rigour and enables a study's findings to fit settings outside the study. As Sandelowski and Leeman (2012) point out, those reading the study's findings should see them as meaningful and relevant to their own circumstances. I considered transferability throughout the design, analysis, and writing of the research. For example, suggestions are made in Chapter Five about the implications of the findings for migrant therapists.

Lastly, the research process needs to show dependability by being auditable. For another researcher studying this topic, the decision-making trail must be clear and obvious. Other researchers should be able to draw the same or comparable conclusions (Koch, 2006; Sandelowski & Leeman, 2012). I intentionally followed a clear decision-making path by noting decisions, thoughts, and reflections that I organised systematically. These documents, notes and other relevant information were kept in a categorised folder. By observing Koch's processes of rigour, I have also ensured the results' confirmability. Accordingly, I have aimed to display signposts in the study (principally in Chapters Two to Five) that plainly and explicitly show why choices were made and precisely what influenced these choices. Peer review, supervisor and cultural checks were also conducted to ensure rigour, as discussed in the methods section below.

Method

The following section presents the method used in this study. Ethical approval was granted by the University of Auckland Human Participants Ethics Committee (Reference number: 017660; see Appendix G for the ethics approval). An important consideration was protecting the privacy and confidentiality of participants. Participants' rights were addressed in several ways. The transcripts and consent forms were kept in a secure, locked cabinet and voice recordings were only accessible to myself in a personal password-protected computer. Each participant was asked if they wanted to choose their own pseudonyms; some were content to be given a name. As well as using pseudonyms and numbers, I have striven to make sure that no identifying information is exposed in the results section.

Participants and recruitment. The criteria for participating in the study were: being an immigrant from another country, having trained overseas, and being a registered psychologist, clinical psychologist, or registered psychotherapist currently working therapeutically in Aotearoa New Zealand. Recruitment was conducted through advertisements distributed via the New Zealand Psychological Society (NZPsS), the New Zealand Association of Psychotherapists (NZAP), and the New Zealand College of Clinical Psychologists (NZCCP). The study was also advertised through the networks of supervisors and advisors from the clinical psychology programme at the University of Auckland.

People who expressed interest in the study were sent an email with a Participant Information Sheet providing details of the study (Appendix B) and a Consent Form (Appendix C). Once they received the Information Sheet, prospective participants were encouraged to ask questions or raise concerns regarding the research.

Twenty psychologists and psychotherapists inquired about the study. Fifteen of these participants met the criteria and all of these participants took part in the study. As the data analysis proceeded, it was observed that similar themes were emerging across the interviews and 15 interviews were sufficient to reach data saturation.

The fifteen participants included two males and 13 females (see Table 1 for participant demographics).

Table 1. *Participant demographics*

Gender	Age	Relationship *	Years **	Nationality	Occupation
M	42	married	8	South African	Clinical psychologist
F	53	married	5	British	Child psychotherapist
F	33	married	2.5	Indian	Clinical psychologist
F	54	married	9	Sri Lankan	Clinical psychologist
F	32	single	2	British	Clinical psychologist
M	60+	with son	7	NZ/South African	Clinical psychologist
F	42	married	13	Indian	Clinical psychologist
F	39	single	7	South African	Clinical psychologist
F	40s	family	11	Indian	Clinical psychologist
F	48	separated	8	South African	Psychologist
F	43	family	10	South African	Clinical psychologist
F	32	partner	3.5	Asian/American	Clinical psychologist
F	46	partner	3.5	Italian	Clinical psychologist
F	46	family	5.5	Australian	Clinical psychologist
F	52	family	8	South African	Clinical psychologist

Note. * Relationship status now or arrived in New Zealand with family, ** Years in New Zealand as registered psychologist/psychotherapist

Data collection. For convenience related to time constraints, eight interviews took place at the therapists' places of work in two cities in Aotearoa New Zealand. One interview took place at a participant's home. Two interviews took place at the University of Auckland as this was a mutually convenient location, and five interviews were conducted online with participants using Skype from their homes at various locations in Aotearoa New Zealand.

Interviews lasted approximately one hour and were recorded using a digital voice recorder.

Interviews. Participants in the study were experienced registered psychologists and one registered psychotherapist, all of whom had regular professional supervision and non-professional support structures. Consequently, they were not thought to be a vulnerable population. Nevertheless, there was a small chance that in considering their experiences of migration and working therapeutically, difficult matters could surface. Participants were advised at the beginning of the interviews and throughout that they could terminate the interviews at any time, and have parts of the interviews removed if they wanted to.

At the start of the interviews, participants were asked a list of questions regarding their demographic details (see Appendix D). After the demographic data had been collected, participants were asked to consider their years of working professionally in Aotearoa New Zealand. They were then asked to divide their accounts into stages, as Lieblich et al. (1998) and McAdams (1993) propose. The participants were told these stages could be based on turning points or transitions in their experience and asked about their memories of starting work in Aotearoa New Zealand (Appendix D). The accounts often began from the point of registration and beginning work in Aotearoa New Zealand, followed by a middle period and finishing with the present moment, as highlighted by Gergen and Gergen (1986) and McAdams (1993).

Questions were intentionally open-ended and broad enough to encourage participants to fully express themselves. Questions such as "Can you think back and tell me about your first memories of working with clients in the first stage?" were asked. Prompts on the challenges and positive aspects of working professionally and therapeutically in a new culture were given to facilitate discussion, but in general participants were encouraged to lead the interview and determine the relevant content. I guided them to develop the stages and talk through each stage with questions such as "How did you feel about your experience as an

immigrant psychologist during this time?" This generated further discussion and more questions based on what was salient to participants and their responses. Interviews were completed with a set of structured concluding questions on any further thoughts about being a migrant therapist, bicultural Aotearoa New Zealand, advice for future training and advice for other migrant therapists (see Appendix D).

For some participants, speaking about working professionally and therapeutically as a migrant psychologist/psychotherapist was an emotional experience. Some participants described feeling emotional when discussing challenges and expressed surprise they had not previously reflected formally on their experiences as a migrant in the professional context. One participant became tearful when reflecting back on the initial stage. If needed, participants were offered the opportunity to pause and break. Participants were also prompted to talk about any positive experiences of working as a migrant therapist, thereby not just highlighting the difficult challenges. I also asked participants towards the end of the interview how they felt discussing these experiences and reminded them they could add or remove any sections of the interview when they reviewed it.

They were then asked to provide a name for the different stages that they felt conceptualised each time period for them. Some participants chose to reflect further and emailed the titles of the stages after their interview. At least five participants expressed feeling positive about the research and the opportunity to reflect on their experiences as a migrant therapist. This was sometimes expressed verbally at the end of their interview, for example "It was a good opportunity to reflect on my journey in Aotearoa New Zealand as a psychologist", or "It's a really worthwhile thing to do". It was also noted during the member checking phase and follow up correspondence, for example "I found participating in your research interview a beneficial experience for the scent of the rose lingers on the hand that offers it. So I need to thank you.", or "Thank you for your email, I enjoyed the interview!" (in response to an email to thank the participant for taking part in the study).

Data analysis. Following the interviews, each recording was transcribed verbatim by a university approved transcriber for analysis. After the transcribing was completed, I read and re-read the transcriptions and repeatedly played the audio recordings to ensure the transcripts matched the accounts of the participants. Transcripts were then returned to each participant for verification of their accuracy. This member-checking occurred to ensure the rigour and credibility of the research (Koch, 2006). An appropriate amount of time of approximately three months was given to the participants to review transcripts.

Thematic narrative analysis. A thematic narrative analysis was conducted on the data from each of the stages defined by the participants. The data was divided into three sets, one for each of the stages. In thematic analysis, themes are identified in the data and described in detail (Braun & Clarke, 2006). I conducted the six phases of thematic analysis as discussed in depth below.

Phase 1: Becoming familiar with the data. The first phase entailed familiarising myself with the transcripts. This familiarisation was conducted prior to the data analysis phase. All transcripts were read several times. This phase also involved familiarising myself with each set of data for the different stages identified by the participants. I became more familiar with the data for each stage with the first reading. The next reading provided information to start identifying ideas for codes based on the narratives within each stage, and these were noted separately in summaries. Consequent readings strengthened this procedure and this process was repeated for each set of data from the different stages. Data from each of the different stages were then categorised and placed within the data set for each stage.

Phase 2 and 3: Generating initial codes and searching for themes. In phase two and three, the data for each of the stages were coded, initial codes generated, and a search for themes carried out within each of the stages. These were then condensed into summary points which captured similar meanings. Lists of positive concepts and negative concepts were

created and instances of similar pieces of data were gathered and clustered. At this point, I was conscious of the possibility of extracting themes that resonated with the literature. I then re-read the data sets of the three stages to ensure the codes matched participants' own words rather than my expectations based on previous literature.

Phase 4: Reviewing themes. In phase four, initial themes were reviewed and refined. All extracts that were coded and covered by a theme were re-read to confirm they were coherent and clear. As some themes were seen to be closely related at this stage, they were grouped together. The relevance of the initial themes was considered in relation to the whole data set for each stage to determine whether they correctly characterised the meaning of each data set. My supervisor also provided frequent checks, suggestions and review during the thematic analysis and interpretation of the data and revision of themes. My secondary supervisor provided cultural input and feedback on interpretation of data.

Phase 5: Defining and naming themes. In phase five, themes were outlined and named. The themes identified in phase four were further refined with the goal of embodying the core of each theme. Each theme was then re-read along with the data extracts for each of the stages, with the aim of developing a deep understanding of the theme's representation of the data for each stage. By concentrating on this wider level of meaning, the initial themes proposed were then collapsed into main themes. This process is illustrated in Chapter 3, Figures 1, 2, and 3.

Aspects of the data that embodied something important concerning the research questions were coded and grouped together accordingly. The text was then dissected according to a colour-coded framework and regrouped in a Microsoft Word document. As the coding developed, I identified broader level themes. Codes that were perceived as grouping under a particular theme were then identified and placed together in another document. The coded extracts were also cut and clustered together into approximately four groups for each of the

stages. Codes with the same extracts (duplicates) were removed to avoid repetition. To ensure each code was associated with a broader theme, I frequently checked back to the overarching theme the code appeared to fall under. Collection was carried out by physically copying data extracts and matching them to a preliminary theme every time it was identified in a transcript.

Phase 6: Producing the report. In phase six, the results of the thematic narrative analysis were written up. Chapter Three presents these findings. My objective was to adhere to Braun and Clarke's (2006) guidelines on producing the report by using vivid and compelling extract examples. This aim involved analysing beyond simple explanations of the data and creating an argument that was relevant to the research questions.

Plot analysis. As discussed earlier in the narrative interviews section, a plot analysis (Gergen & Gergen, 1986; Lieblich et al., 1998) was conducted on the participants' narratives as they developed over time. A graph was developed for each participant that represented the development of the narrative across the three stages. This allowed for a visual depiction of the development of the narratives across time. To complete the plot analysis, a summary was developed for each participant's data in each stage of their narratives. These summaries included an overview of the main experiences described in each stage. As proposed by Gergen and Gergen (1986) and Lieblich et al. (1998), preliminary graphs were then developed to represent the progress of the narratives across the three stages for each of the therapists. Gergen and Gergen (1986) and Lieblich et al. (1998) describe three main patterns of progression in narratives, namely progressive, regressive, and stable. Narratives can include all of these patterns at different stages.

As outlined by Gergen and Gergen, (1986) and Lieblich et al. (1998), positive inclines in graphs were used to represent a progressive pattern within participants' stories of working professionally. These positive progressions were linked to therapists' efforts towards objectives or a series of challenges that were dealt with successfully, or a feeling of progress

or increase in wellbeing. The regressive pattern of narrative was portrayed by declines in the graphs, representing a deterioration in the narratives of the participants' experiences, with movements away from original goals and an increase in negative or problematic experiences described in the interviews. Lastly, in the stable narrative pattern, the graphs represented little or no change with a steady plot. Some of participants' stories included a mixture of the three patterns, as noted in Lieblich et al. (1998). I met frequently with my supervisor to compare interview summaries and plot graphs of participants' experiences. All interview transcripts were also given to another researcher familiar with this area of the research who examined the data and independently plotted graphs. These were crosschecked with my graphs to ensure a good fit and rigour in interpretation. My supervisor also provided frequent checks and feedback during the plot analysis of the data. During this review, we expressed any disagreements about the graphs and discussed our rationales for any differences until reaching an agreement for each graph and summary. Consequently, some revisions were made to the graphs.

Once the plot analysis was completed, all graphs were examined for similarities and differences. Graphs that shared similar developmental trajectories were grouped based on patterns of progression and ascent (for example, improvement in sense of self as professional), stability, or decline (for example, a decline in their perceived sense of self as professional or an increase in difficulties or struggles) (Lieblich et al., 1998). This resulted in four different types of narratives. Once these narrative types were defined, the narratives in each type or group were examined for common themes using a process similar to that described in the thematic analysis. The next chapter (Chapter Three) presents the findings of the thematic narrative analysis, and Chapter Four presents the results of the plot analyses. The refined graphs are included as Appendices E and F.

Chapter Three: Thematic Narrative Analysis

This chapter presents the results of the thematic analysis of immigrant therapists' narratives of working professionally and therapeutically in the cultural context of Aotearoa New Zealand. It discusses the three stages, the themes within each stage and associated subthemes. Participant quotes provide an illustration of the themes and a sense of the participants' perspectives and experiences. Thematic maps were developed, as recommended by Braun and Clarke (2006), to consider the relationships between the themes and associated subthemes within the data set. The themes and subthemes for each stage are shown in Figures 1, 2 and 3. Table 2 provides an overview of the four themes that emerged from analysis of the data in the first stage of each narrative, the three themes from the second stage, and the three themes from the last stage. Several of the themes in each stage contain at least two subthemes.Table 3, in Chapter Four shows the names given by participants to the stages.

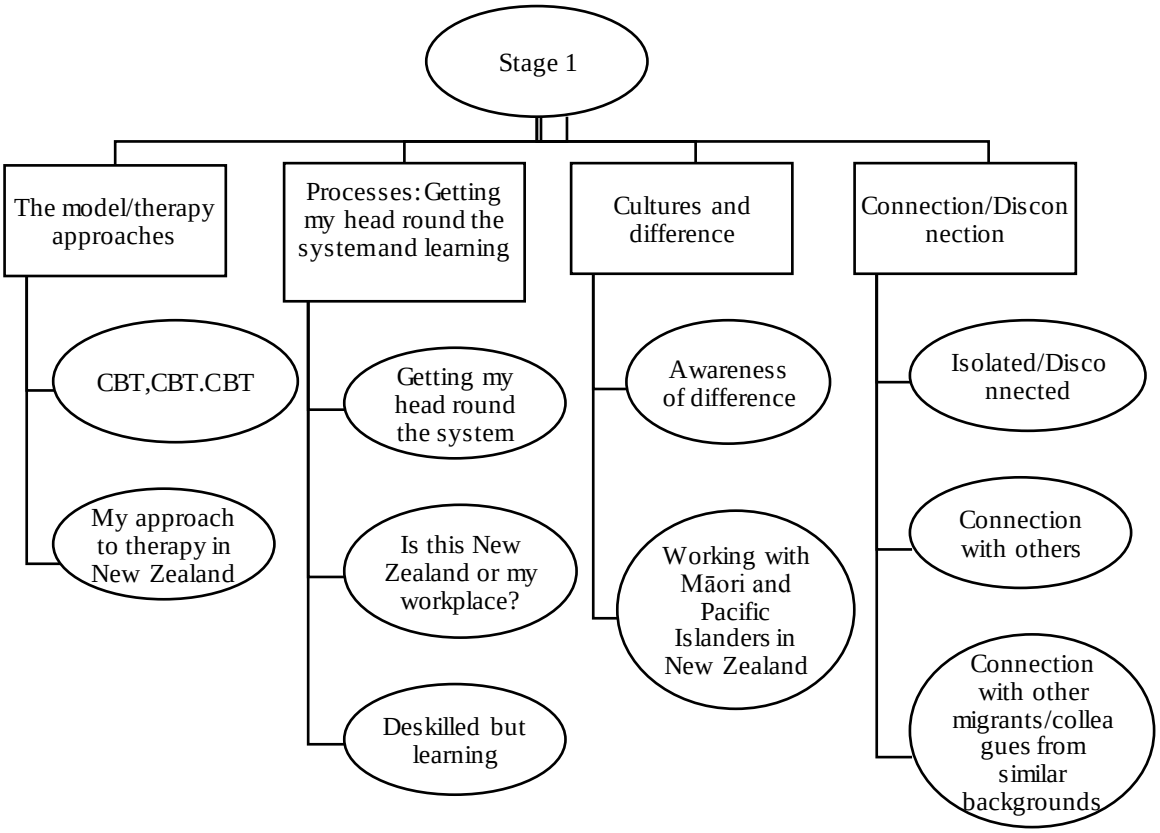


Figure 1. Themes and subthemes of Stage 1

Table 2. *Overview of Stages, Themes and Related Subthemes*

The first stage

- The model/therapy approaches
  - CBT, CBT, CBT
  - My approach to therapy in New Zealand
- Processes: Getting my head round the system and learning new ideas
  - Getting my head round the system
  - Is this New Zealand or my workplace?
  - Deskilled but learning
- Cultures and difference
  - Awareness of difference
  - Working with Māori and Pasifika clients
- Connection/Disconnection
  - Isolated/Disconnected
  - Connection with others
  - Connection with other migrants and colleagues from similar backgrounds

The second stage

- Bringing back my own style… but still adapting
  - Reclaiming my identity
  - Changes and ongoing adapting
- Experiencing Growth
  - Continuous learning
- Reflections on Migration

The third stage

- New beginnings and learning
  - New Opportunities
  - Ongoing Learning
- Competent, comfortable and confident
- Am I still a migrant; is it helpful?
  - Migrant or not?
  - Migrant as a therapeutic tool
  - Reflections on challenges and loss

The First Stage

The model/therapy approaches. When reflecting back on their early period of working in Aotearoa New Zealand, the majority of participants discussed the models used in their work settings, as well as their own training and approaches. Most participants described feeling comfortable working with clients and experienced few or almost no challenges when working therapeutically. Several participants discussed having some difficulty adapting to different frameworks in Aotearoa New Zealand. It appears that the therapists' work settings played a role in their positive and challenging experiences of practising therapy. Below are the subthemes within this first theme: *CBT, CBT, CBT* and *My approach to therapy in New Zealand.*

CBT, CBT, CBT. In this early stage, most participants described their thoughts and reflections on initially encountering the dominance of the Cognitive Behavioural Therapy (CBT) model in their workplaces. They recalled feeling "surprised", "uncomfortable" "frustrated" or experiencing "disbelief" about the prevalence of CBT practice. These experiences occurred in various settings, such as in private therapy where "the tension" of adopting this new approach was part of one participant's first memory:

> *I think the earliest memory is the experience of not having trained in Cognitive Behavioural Therapy. As part of my training we trained in psychodynamic and systemic and interpersonal approaches, and being really aware that the practice I worked for was advertising CBT (Participant 10).*

Another participant, working in the public health system talked about his initial surprise when asked to use CBT:

> *The proliferation of CBT I think would be an example, like everyone trying to do the same thing. I thought that's strange, all dealing with completely different people, how can you possibly be doing the same thing with everyone. That makes no sense (Participant 1).*

Several participants expressed frustration at having to use CBT, and a few spoke of their discomfort in having to change their approach:

Initially I was like oh my gosh I have to learn how to do CBT, got a CBT supervisor and did the stuff to become CBT proficient. And that was difficult for me. It was incredibly weird for me to walk into a cult where everybody did the same thing. Everyone was trained in this one thing and that was kind of the only thing that was acceptable in a way. And so I think in those first few years I tried hard to do CBT and to be CBT (Participant 11).

However, over time, some participants described benefiting from having a different approach and integrating the newly learned model into their work with clients. For example, Participant 10, who initially felt the tension of adopting CBT, spoke about how she addressed this in therapy with her clients:

I was really clear that I wasn't trained in CBT but that I understood the model …but I am a trained family therapist …and then give them an opportunity to decide whether they wanted to continue with therapy or not and those first sessions were treated like information sessions for clients. And that worked well (Participant 10).

Other participants continued to work as they had previously, but incorporated CBT techniques into therapy:

Therapeutically there was really no issue regarding that because I basically just continued as I used to work. I gradually however in my therapeutic practice…introduced more CBT… and mindfulness concepts (Participant 6).

My approach to therapy in New Zealand. In the second subtheme, most of the participants described positive experiences with regard to using their own therapeutic approaches and models they had trained in, or learning from new paradigms they came across in Aotearoa New Zealand. Positive experiences were often linked to having a workplace or supervisor using the same model or approach:

I work much more psycho-dynamically. I was in a place that actually worked psycho-dynamically and long term therapy so I think that was a good match… I'd like to say that it was all planned but I think it was just very fortunate… so that was really helpful (Participant 7).

… my supervisor played an important part in just helping giving me a bit of confidence … and the fact that she is using ACT (Acceptance and Commitment therapy) as her main modality of therapy and supervision was a really helpful way of me continuing to invent my own therapeutic skills and knowledge in ACT (Participant 5).

Participants described positive experiences with seeing changes resulting from their approach, and being sought out by motivated clients and valued:

> *Well, I think that is possibly one of the things that keeps one going in psychology is the fact that you do observe the results of your contribution with some people quicker, with other people it takes longer. It's very variable. But one sees change, one sees improvement, you see healing setting in (Participant 6).*

Processes: getting my head round the system and learning new ideas. During their reflections on working in Aotearoa New Zealand, all participants discussed "processes" they experienced in adapting to their new environment. For a few participants, the process of registration as a psychologist or psychotherapist was "stressful" and shaped their experience of this first stage. Most of the participants spoke about the process of "getting their head round" their new role, "the system" and new legislation. As for the first theme, several participants reflected in hindsight on whether their experiences were impacted by their work setting during the first stage. Lastly, several participants described a sense of feeling de-skilled, as well as learning opportunities in this early stage.

Getting my head round the system. Most participants expressed a sense of "processing" a number of factors during this early stage. Some reflected on the registration process and others described trying to understand systemic issues in their workplace. Many participants described feeling frustrated or experiencing challenges in coming to terms with new processes, and spoke of how they managed to understand new systems, laws, and policies. Some participants reflected on the process of becoming registered prior to working as a big hurdle which cost time, money and caused significant stress during their first stage:

> *It was really hard. It was worrying. It was tiring. It was worrying because you can't legally call yourself a psychotherapist in New Zealand without getting the registration so it's like what if I don't get it? …And time. It was tiring. I'd just finished my training and I kind of didn't want to go through hoops and a huge process again. It's almost like going back onto another course 'cause it was having to do pages and pages of matching my experience to masses and masses of requirements (Participant 2).*

One participant was "unhappy" with the number of requirements for registration, which she felt "discriminated" against therapists from countries such as her home country. She felt undermined and "inadequate" as a result of this process:

> *Yeah because I had my private practice over there and so to get registered …I had to do some assignments and have a supervisor… which I wasn't really happy about doing that because over the years later on I realised that if you are from let's say Europe or you are from some African countries, you don't have to do supervisory practice. Just because you are from America you just get accepted. It still hurts me. It doesn't hurt me hurt me but I feel unhappy about that (Participant 9).*

Several participants spoke about getting their head around systemic factors in the first stage. Some of them referred to this process as taking approximately two years, which they found "frustrating", "shocking" and "exhausting":

> *I think that the first probably two years or so for me was very much around, getting my head around things professionally…you have to get your head around the literature… how to use the instruments and you have to get your head around how to format a Court report or a parole board…(Participant 11*).

> *There were a number of differences that I was trying to get my head around like the way that the service was kind of set up or the wider service and the political issues … I was also making lots of comparisons to how the politics in the organisation and the system was within the UK at that time (Participant 5).*

Others discussed the challenges and frustrations of learning new laws, legislations and features unique to the New Zealand context:

> *I think as a foreigner the problem is you don't know what you don't know and comparatively speaking New Zealand initially felt very over-regulated as far as health professions are concerned. Even if you were to look at the competencies as outlined for us as psychologists, they go into so much detail compared to what they do in other countries that one continuously gets the impression that they are trying to catch you out (Participant 6).*

Participants described how they managed these challenges and "getting their head around" several systemic factors in Aotearoa New Zealand in this initial stage in a numbers of ways, for example by listening and processing internally:

> *Yes, yeah I think it was also all new to me, so I was more listening than talking about my experience. I was trying to absorb and to understand… I was also trying to cope I think and just to do my job, which I think I have done reasonably well… But it was more internally what I was going through (Participant 13).*

One participant who worked in an inpatient setting and struggled considerably during this this stage, recalled:

> *I remember sort of being at work the whole day, you know you just absorbing, absorbing, absorbing. I was going through the orientation process because they really gave me about a six weeks orientation…so they really tried to be accommodating in that way. But coming home exhausted. My kids were young and just feeling I've got nothing more to give (Participant 15).*

For Participant 9 who struggled with registration challenges, speaking to others whom she could relate to was more effective than supervision:

> *I don't think I would have spoken about that in supervision because my supervisor was a Kiwi clinician. But I would have spoken it to other professionals…You meet people from other kinds of professions who have similar kinds of experiences (Participant 9).*

Another participant spoke with hindsight about the benefits of discussing her experience in supervision:

> *I think for me what now feels like was important was to not shy away from seeing, noticing and talking about those experiences, to not belittle myself for having felt that way and finding I guess courage to say this is what's going on, because I never left South Africa. I didn't even know that was part of the migration process….And so I feel like it's important that people know that you can talk about these things, these processes (Participant 8).*

Is this New Zealand or my workplace? Most participants described unique challenges they faced in these early stages, which many, on reflection, thought related to their work setting at that time. These included "feeling vulnerable and financially dependent" as a new practitioner in Aotearoa New Zealand (Participant 10), and "feeling pressured" with private paying clients or "having to charge clients" which was "foreign" (Participant 12). Several participants described feeling shocked about the setting, client load or the type of work in this initial stage:

> *But what was also different is the type of trauma that people have here in New Zealand is almost a few steps higher than the type of trauma that I had previously been exposed to. It is as though in the Kiwi background there has been a great deal of family violence, alcohol and drug abuse as well as sexual abuse (Participant 6).*

Other unique challenges with the work setting related to fitting in. One participant described their first work setting as quite formal:

> *I remember everyone dressing like they were going to a funeral and psychologists being very serious. I remember that striking me. And I probably still feel that. I don't feel a strong fit with the profession necessarily on the whole... it's a very sedate profession here I think. Often I think psychologists take themselves very seriously. I battled with that a little bit…wanting to fit into this new role… (Participant 11).*

In an inpatient setting, another participant described the pressure and unspoken expectations from others in the workplace:

> *I think people had been there for quite a long time, so I was really the new kid on the block. When I say I wasn't feeling pressurised but there was a sense of pressure as well because everyone is saying oh we haven't had a psychologist for so long and I'm thinking I don't know actually what you are expecting of me. So I suppose I felt like I was floundering for a large part of that time in that inpatient setting (Participant 15).*

Feeling deskilled whilst learning. Whilst they were going through new "processes" during this initial stage, some participants described feeling "deskilled", "undervalued" or "insignificant". For instance, in addition to feeling the difference between her training and CBT, one participant described how "deskilled" she felt:

> *Not knowing the processes, having been trained psychodynamically and coming to where psychology is very CBT orientated, feeling like a square peg in a round hole and I suppose feeling very, very deskilled (Participant 15).*

This participant felt "stripped" professionally when attending a training session:

> *I remember getting there and thinking I don't know a solitary person here and I could be a fly on the wall, because that's how significant I felt. I felt very stripped I suppose, professionally. I was no one…. So that was really difficult, yeah (Participant 15).*

There was a sense of feeling lost for this participant which was "really tough, feeling like I don't know my relevance professionally on many levels" (Participant 15). Several participants described feeling frustrated and undervalued in this early stage as they were the new employees, or facing barriers when attempting to implement their new ideas. For example, one participant felt she could not speak out:

You find yourself in situations where you don't feel that you can actually say something or challenge, because you are new and you are dependent on other people's good will and kind of extending trust, that you are not going to do the practice name harm. And I remember that feeling of I was a senior psychologist coming in and I was being treated like a junior. But I also understood that role, but it was quite frustrating at times (Participant 10).

Another participant described her experience as a "double-edged sword", as she was recruited for her expertise in a specialist area but felt she was met with "barrier after barrier" when presenting her new ideas to an already established team (Participant 5). Challenges appeared to differ for those with fewer years of practice: these participants spoke of lacking skills or confidence in this early stage. They reflected on their skills or how they navigated the new environment:

It was the first time I was working post-qualifying. Many people feel initially, it's like first time you pass your driving test and go out in a car on your own, it's like wow, what do I do now? So, it's probably as much to do with building my own confidence and experience (Participant 2).

Despite the initial challenges of feeling deskilled or underskilled, over time many of the participants also described their initial stage as full of learning opportunities:

There was definitely lots of opportunities there which I could have and I think it took some time to get used to it and then once I was used to I thought it's going to take some time to actually get the value from it (Participant 14).

I worked in that acute unit. I worked in the woman's prison. It was a whole lot of learning. I think I saw the extreme of the New Zealand downsides as well. It was a great learning opportunity (Participant 3).

Participants reflected on their own personal attributes and skills as contributing to their experiences of new processes:

It was my first time working in a foreign setup. I was very excited. I was so confident. I did very well in the job. I was well liked… (Participant 3).

I think the fact that I was a little older when I studied, the fact that I did my internship where I did it …getting back to New Zealand in an inpatient unit, was not problematic to me (Participant 6).

In summary, the second theme within the first stage relates to processes participants experienced, such as the registration process, or understanding new policies and procedures within their workplace. Whilst some described feeling deskilled as a result, others spoke of different learning opportunities.

Cultures and difference. When discussing the earlier stage of working in Aotearoa New Zealand, the majority of participants spoke about awareness of their own cultural difference and other cultural groups in Aotearoa New Zealand. Some participants described the impact this awareness had on their experiences and discussed ways they adapted to the new environment, or experienced a sense of cultural shock and adjustment to the new setting. Most participants reflected on working with specific cultural groups in Aotearoa New Zealand, such as Māori and Pacific Island populations. They described their experiences of working in a bicultural setting, including the challenges they faced and also the positive experiences.

Awareness of own difference. Several participants spoke of being aware of their difference in this early stage of their work. This included awareness of their accent, skin colour and differences in their home country's "customs". Many participants discussed being conscious of a difference in their accent, or their accent being demonstrated as different by others:

> *But those first few years, I don't know if my accent was stronger… maybe I was more conscious of it or made more of a thing of it (Participant 11).*

> *I was struggling sometimes and trying to do my job and trying to adapt and of course I think also my accent and every time I met a new client I had to introduce myself (Participant 13).*

Over time Participant 13 used her accent as a "point of entry" to introduce herself to clients. This was suggested to her by her supervisor and she found it "useful" in relationship building.

Others remarked on using their different accent in a humorous way to build the relationship with their clients:

> *I didn't feel discriminated or anything like that because of that or put down... I mean it was kind of more like oh you talk funny, yeah I know, I talk funny…and we could use it to both our advantage, yeah can you slow down, can you explain what you mean (Participant 4).*

Whilst most described having a different accent, participants generally felt it did not have much of an impact on their experience. One participant, for example commented that having a "slightly different accent is sometimes picked up by people but it does not bother them really" (Participant 6). For a minority, having a different accent was described as being another feature that marked their difference from others:

> *But it was and I was just freaking out. Firstly because it felt like everybody was just talking and it was just different. It was a different accent. … like God I speak so differently, my accent is so strong and just constantly worried about that which I never even considered when I was coming to New Zealand (Participant 8).*

Other differences were described and comparisons made between participants' host countries and working in Aotearoa New Zealand, including different traditions and customs. Participants spoke of being "mindful" of being different (Participant 2), and noticing different customs:

> *I was very aware of the cultural differences... probably just a sense of less rules and…less conservatism... less formal kind of way of doing therapy…we were making cups of tea for clients beforehand…and the way we were trained that wasn't okay. … So I had to get used to all of those things and realise that it didn't matter here. It was actually required and necessary to build a relationship (Participant 10).*

Participants who described experiencing culture shock in this first stage, spoke of significant cultural differences in their encounters with other staff or clients. A few experienced a strong sense of difference and recounted situations where they experienced racism from clients and "prejudice" from others. More distressing experiences were marked by a significant sense of difference, such as one participant's experience of racist comments

from a young client (Participant 8). She described a feeling of uncertainty and evaluation of her behaviour, and a major process of adjustment. Her experience of "looking different" was "internalised" and she described a strong sense of "feeling inadequate" during this time:

> *I think I became very, very conscious of obviously I am different, a different country, different culture. I say I am South African and some of the kids seriously they had never ever had any interaction with a black person before. So I was their first contact… (Participant 8).*

She discussed some of the content of a particular session and the emotional impact of her client's reflections on her:

> *We would have a session and he would say to me did you wash today, you know, the stuff that was happening to you in Africa is it not going to affect me in this room…And that's when I took stuff to supervision because that felt very personal. And it was hard working with that young person (Participant 8).*

Although the client was a "lovely" child, the experience of difference was profoundly acute for this participant who benefited from supervision discussions on her experiences of racism. This encounter and other interactions heightened her experience of being different to others in Aotearoa New Zealand. However, over time and through discussions, this experience of difference became "a healing" process for this participant.

Working with Māori and Pasifika clients. In the second subtheme related to culture and difference, the majority of participants described their experiences of working with different cultural groups in Aotearoa New Zealand, highlighting the challenges they faced in this initial phase as well as positive experiences. Although most participants described many learning opportunities, some also described cross-cultural challenges in these initial stages. Participants spoke about "bringing projections and expectations of British culture" (Participant 2), or struggles with "mastering the cultural stuff in terms of getting the very basics right, not offending Māori" (Participant 11), and learning unfamiliar cultural practices.

One participant working for a Kaupapa Māori service described "possibly" feeling that it was harder to "gain trust" as a migrant and how terrified she felt in the initial phase:

> *It was foreign in so many ways. The first day on the job and every single thing was named in Māori, so every team, every service, every person's title in the team. I basically walked in on day one and thought okay now I have to learn a new language. That was a challenge (Participant 14).*

Following cultural training, she would often have questions and felt that the answers given were not direct, and that they "may have been withholding information to test you to see what you would do without the right guidance". She discussed her relief in hindsight when receiving positive feedback on her job position:

> *There wasn't like a formal three month review process, it was just being absolutely terrified every day that you were going to put a foot wrong and eventually being told no you're doing okay, you're still here (Participant 14).*

Others described processes such as whakapapa (the Māori cultural practice of discussing genealogy in introductions) as "unfamiliar" and "different" to their training of not disclosing too much:

> *Oh, my God, it's massively different culturally and I'm like, hang on a minute. And also, therapy wise you're meant to keep your professional, as psychotherapists; self-separate, you don't disclose. But here people talk about a part of their personal lives in public arenas because the Māori way is to do that and Pacific maybe too. I'm like, why? I don't want to share aspects of my personal life. I'm at work here. I keep my personal and professional life separate. This is very different culturally (Participant 2).*

One participant described trying to find a way to disclose that felt "comfortable":

> *I found that was kind of something very kind of Kiwi. It comes from the Māori idea that you introduce yourself, you tell something about who you are, where you come from, which I wasn't really familiar with and being a psychologist as a professional you don't really disclose much about yourself usually. So I was again trying to find my own way to do this in a way that I could feel comfortable... I don't know, saying too much is not what I would feel comfortable about (Participant 13).*

A small number of participants described challenges in this initial stage associated with negative experiences with clients from other cultures, such as experiencing prejudice. Facing

such challenges had an emotional impact on reflections on their own cultural identity and sense of self:

> *I had a few encounters where Māori clients … commented negatively on my being South African and bringing up our political history and talking about apartheid and talking about the role of white South Africans. … But I remember having a few difficult conversations with people around my own cultural background and their perception that I had no right to be there… (Participant 11).*

Another participant expressed the cultural difference between herself and her client as potentially contributing to her sense of disconnection:

> *I suppose he was Pacific Islander. … It was eight years ago. But just in terms of just really having a sense of I don't understand you and I'm sure his psychosis, retrospectively would have contributed to some of that, but it was more than that. So just getting a sense of not getting, not connecting (Participant 15).*

Despite these initial challenges, the majority of participants spoke of positive experiences and having considerable exposure to cultural training and supervision in working with Māori, from learning protocols (Participant 6) to "being exposed to cultural cues, Māori practices, karakia (prayer) and pōwhiri" (a Māori welcoming ceremony including speeches, dancing and singing) (Participant 1). Participant 1 spoke of being interested in and choosing Aotearoa New Zealand because of its reputation for "having a strong connection to its cultural context". Even for those who experienced cross-cultural challenges in the initial phase, there was a sense of positive reflection about cultural learning and training, such as Participant 11's reflection about her workplace having a strong focus on working with Māori. During these positive reflections, participants spoke about what they gained. Many felt they learned from training such as studying the Treaty, regular team supervision, or from training workshop discussions. Others described gaining a good understanding of culturally appropriate practice for Māori and Pasifika clients through being a university student (Participant 7), working as university teachers and speaking with Pacific students, and meaningful experiences with clients:

I had a really positive experience with that family and their feedback was really positive around they felt it was a welcoming space, that I had no preconceived ideas about how white people do therapy and imposing my views. But I think if I didn't have the opportunity through work to do a lot of reading and talking to students, Pasifika students around what would be helpful and what can I do and what can't I do, I would have been in trouble I think as a migrant psychologist. I was able to use metaphors of weaving a space between us where we can sit and talk about things, which I wouldn't have known (Participant 10).

Participants also discussed advantages of their migrant status in working with different cultural groups. Participant 10 mentioned that she was told in her interview that her South African experience of culture was not relevant to the New Zealand context. However, she also described feeling that her past experience, such as working in black townships, was helpful in developing culturally appropriate ways of being with other people.

Another participant described positive experiences of feeling "at ease working with Māori being multilingual" (Participant 6). As a migrant who struggled with feeling different to others because of her skin colour, Participant 8 described working with Māori as a largely positive experience, both personally and as a clinician. She felt the Māori worldview resonated with her own culture. Working therapeutically involved discussing what it means to be *Māori:*

And now this is a Māori family and this boy that is coming is way darker than you and he is Māori, he is not African. He is Māori and he is a New Zealander. And we started talking and you do the cultural Māori thing. I think that is the thing that actually made the connection for me that the appreciation of the fact that there is a model of understanding, a model of health for the Māori people and if you stuck with that the connection is built (Participant 8).

Overall, participants discussed an awareness of cultural differences in their encounters in the initial stage, but most participants also discussed positive learning experiences when working with other cultural groups.

Connection and disconnection. For a few participants, the early stages or working in Aotearoa New Zealand felt "isolating". They spoke about challenging experiences of feeling

isolated professionally or disconnected from others at times, and struggled with having to connect and network. Most participants, on the other hand, spoke about positive experiences of feeling connected to others: these connections were formed with their clients, co-workers, Aotearoa New Zealand and other migrants.

Isolated/disconnected. In this first subtheme, a few participants spoke of isolation and disconnection from others. One participant recalled her personal experience in the very early stages of looking for work and how stressful it was:

> *It was stressful. I think the stressful part was sitting at home having to be dependent on someone, not knowing how to drive and the winter and all of that put together (Participant 3).*

There were a range of experiences that led some participants to feel isolated or disconnected from other professionals. Another participant talked about how difficult it was sharing her previous work experiences "without being seen as a maverick or disregarding best practice". This aspect of her experience made it professionally "isolating":

> *There is very much well you are here and you assimilate. And very little probably the other way around, which is fair enough, you don't necessarily have an expectation of that. It made it a little bit isolated I think initially (Participant 11).*

The participant who experienced racism and a strong sense of difference from others also talked about a feeling of disconnect and isolation at times:

> *I look different but now I kind of feel like oh my God, that's what exacerbated my sense of, I don't know, disconnection, yeah disconnection. It would be it's time to allocate clients and they would go oh we have a seven year old who has serious anxiety. You are the most experienced clinician. I am starting to think have they even seen a black person in their life before? (Participant 8)*

Others spoke about "missing" the support systems they had before as they now had less contact with other psychologists: "It was really not having the colleagues to kind of sound something off…more independent and felt a bit more isolated here than I did in the States" (Participant 4). Participant 5 also described "adjusting to not having other psychologists", as

well as a "disconnect" from her team which left her feeling "deflated". Another participant described feeling "isolated" as they "had no supervisor", and said that when he "finally got one, it meant so much" to him in this early stage (Participant 6).

Connection with others. Despite the sense of disconnection that some participants described, many also experienced a strong connection with others such as their work colleagues and other migrants, or spoke of a good connection in their therapeutic relationships. When discussing a positive experience of therapy with a client from a minority group in Aotearoa New Zealand, one participant reflected:

> *But for whatever reason I almost felt as much like an outsider as they did. So there seemed to be a sense of affiliation really. I think that was probably the most striking experience. That I didn't have any pre-existing assumptions of the conservative nature of their life. It didn't mean anything to me cause' I'm new (Participant 1).*

The same participant, whose first stage was generally a positive experience, not only reflected on this individual therapeutic connection with a client, but also discussed a sense of connection to the country as a whole and how this impacted on his staying:

> *So, it was almost like a personal experience of a connection to a new culture rather than the collective experience that we all get through training… New Zealand has a very curious quality where everybody's actually relatively new and that creates some kind of level playing field which I think makes a big difference (Participant 1).*

Several participants described therapeutic connections when working with various cultural groups. Although she experienced disconnection from others because of her strong sense of difference, Participant 8 said that her "connections were always positive" when working with Māori in the public health system. She explained that she loved working with "Māori people because it felt like their way of looking at the world was just like how we do things". She also noted:

> *I probably only worked with like five Māori clients, but when I did it was one of the most fulfilling things I've done as a psychologist. I felt the connection, you know, how it makes sense not just from theories but from your life experience, you are connecting with the ocean and the mountain and you are connecting with your ancestors, you are connecting*

with your spirit. And I seriously felt like for the first time I was in New Zealand and I was feeling like I can be spiritual and do therapy from that perspective (Participant 8).

Several other participants discussed the importance of building other types of connections, including the struggle of "having to network" (Participant 7) which was then later viewed as a supportive factor in their experience within this first stage. One participant highlighted that it was "definitely the people" and "making friends" that contributed to her positive experience (Participant 2). Another spoke about "positive relations with the team" and "integrating into the community" and "churches" (Participant 6). Participant 7 emphasised that meeting people through university as a migrant was "really helpful", as well as having the support of her husband who is also a psychologist. Similarly, another participant discussed that she was able to process any challenges and discuss them with her partner, also a psychologist, who explained that the client population she was working with "wasn't the norm" when she experienced "culture shock". She noted that by "listening more than talking about her experience" and "talking to her partner", she was able to "absorb and understand more" (Participant 13).

Connection with other migrants and colleagues from similar backgrounds. Many participants who faced challenges in the initial stages talked about the benefits of connecting and meeting other migrants or colleagues from similar backgrounds. As one participant said, "I liked the team there supporting the psychology team … the people I worked with throughout were quite supportive. I never felt out of place" (Participant 3). Others also found that connecting with other migrants was helpful initially: ... "a third of the office was from South Africa and I think that really helped normalise things" (Participant 11). Some commented on "supportive staff" as contributing to their positive experience and noted that many of them were migrants (Participant 4). Participant 8 described the connection she made with others who also felt displaced:

I probably processed that a lot with known clinicians, other people who were migrants that I became friends with and we became friends because we were feeling this sense of disconnect, like we are different. It doesn't feel like we fit. I felt like I didn't fit because I was a different race, but I had a friend who was Canadian and she felt she didn't fit, even though to me she looked very New Zealander. … It was really helpful (Participant 8).

Another participant facing challenges at work described wanting to develop connections outside work: "I had so much else I guess going on outside that I wanted to settle in and explore and develop my connections in my life outside of work" (Participants 5). During this period, she also met another migrant worker. They began to process some of the work issues they faced which was helpful and "reignited" her motivation*:* "I think she came with that same view of what are we doing here… in the UK we'd be doing this" (Participant 5).

Themes in the first stage illustrate that participants experienced some challenges initially, such as adapting to new models of therapy, new processes, and an awareness of differences. However, participants also described opportunities, connections and cultural learning.

The Second Stage

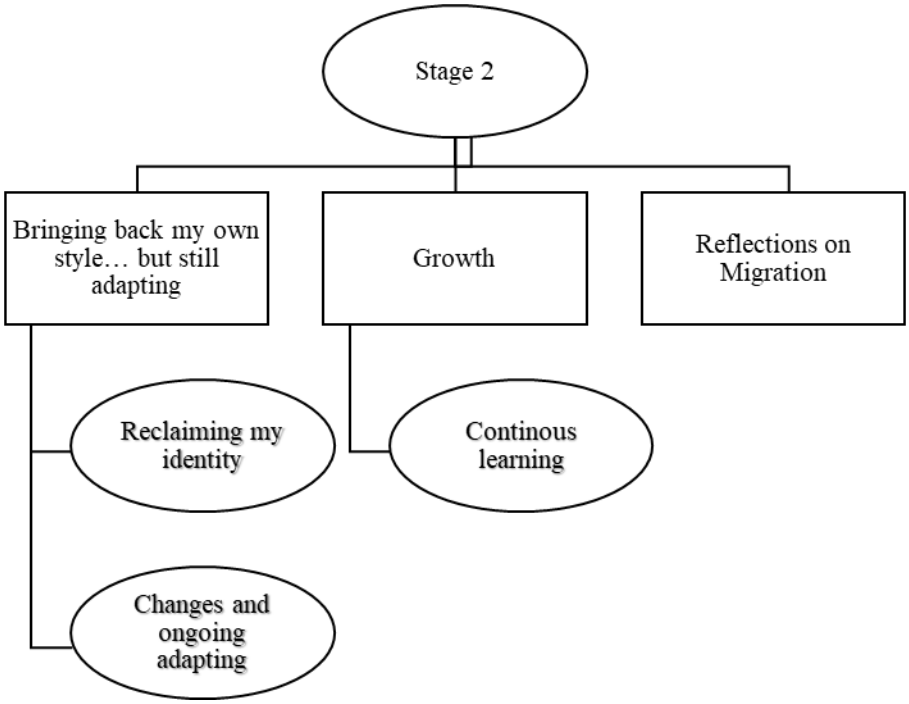


Figure 2. Themes and subthemes of Stage 2

Bringing back my own style but still adapting. The second stage was characterised by ongoing adaptations to the new country and new circumstances, but in contrast to the first stage there was an overall sense of "relief" in overcoming a number of challenges. Many participants spoke of being able to work in "familiar" ways. Several participants reflected on their identity and sense of self, whether "reclaiming" it, feeling less "other", or "taking on a new identity". For some, this stage was described as more challenging than the first or equally as difficult, but for most changes and adaptations that occurred made this next stage easier than the initial period. Similarly to the first stage, which ranged from a period of a few months for more recent migrants to several years for others, this second stage varied in length.

Reclaiming my identity. Several participants discussed a feeling of ease that occurred in this stage in contrast to the previous stage. For instance, Participant 11 talked about a change in "thinking" and "relaxing", as well as moving back to her "own style" more in this stage:

> *And at the same time therapeutically loosening that expectation of I should come to New Zealand and be like people here. So probably starting to kind of bring back my own style of working more so than what I did initially (Participant 11).*

Participant 15 discussed moving from being "hypervigilant" in the first stage "to more relaxed" during the first few months, which she described as "quite typical for your average South African". Along with the feeling that they could "relax" more, many participants spoke of working in a more relaxed manner, and feeling able to work in the way they were trained. Participant 11 talked about moving away from CBT and becoming more "eclectic", "open" and "playful":

> *...more playful work with clients, did more narrative work around, you know, did genograms and did tracing and did story-telling, which is a big thing in Africa (Participant 11).*

These participants described a sense of "familiarity" in this second stage, whether with old ways of working or new ways: "I felt a sense of familiarity in the role of being a psychologist here and working in the system here" (Participant 11). When reflecting on their professional identity and sense of self, participants spoke of relief, and feeling more settled and "secure with self" (Participant 2). For this participant and others who spoke of feeling isolated at times in the first stage, feeling connected, related to others, or "understood" helped them relax more in this stage, and feel "more immersed" and less "other":

> *I think initially you have that sort of imposter syndrome where you think here I am and they have let me loose and I shouldn't be here. And I think especially doubly counts in an indigenous population where you think I really shouldn't be here, this is crazy. But once you got over that and you had the endorsement of the Kaumatua (Māori elder) and you have the endorsement of the CEO and everyone said no you're great, we love you, keep doing what you are doing... (Participant 14).*

Other participants described therapeutic gains in this stage which added to their sense of professional evolution and achievement:

So I think the second part of the phase is I did the hard work, I earned the trust and now they were able to open up …And so we were able to make a lot of therapeutic gain, so a sense of achievement (Participant 4).

Some participants described working in areas that were more linked to their personal interests such as "social policy" (Participant 2), or remarked "this is my normal" (Participant 15). Participants described feeling "aligned with" and "reclaiming their identity" in this stage:

Some of the benefits I think was that I could now completely step away from this pseudo CBT identity and not put it on the website…So I felt much more aligned with my own identity when I was on my own (Participant 10).

When I moved from the inpatient setting to my current setting I think that was more in keeping with where I wanted to be…it was something I was very interested in and felt I had to give up... And so when I moved to this new job it was like reclaiming that (Participant 15).

Having family with her helped this participant feel grounded and put her "cloak of identity" back on:

It helped ground me a bit…my description of feeling quite floundering and I suppose in that way it was a bit of an anchor.... this was into the second stage…at the end of that year I had my in-laws came to visit us and it was almost as though I could put the cloak of my identity back on … that was actually quite important in my journey (Participant 15).

For Participant 8, who struggled in the initial stages with experiences of difference, over time she perceived her evolving identity as a healing process of transformation:

I felt like the first parts of being in New Zealand nobody referred to me as a black person, no one. They called me African which was just so weird at first. But it was part of the healing process, you're not just a black girl. You are representing a continent. You are representing a people. You are African. You are African. I felt like I was taking on a new identity (Participant 8).

Changes and ongoing adaptations. A small number of participants found that their second stage was just as challenging or more challenging than the first stage. This could be due to changes occurring, such as adapting to a new leadership role (Participant 1) or a new position (Participant 3). For others who continued to struggle as they had done initially, challenges related to adapting to accepting work as a general psychologist rather than a clinical psychologist (Participant 9), or still "hitting barriers" after trying to implement changes (Participant 5). Participant 1 described being in an "adversarial situation" because of having a new role and facing a well-established team who was older, rather than anything to do with migration:

> *And I inherited a team with a lot of people who had been doing this for a very long and a way that they liked doing it. They were considerably older than me. I was the younger person in the team by a good 10 or 15 years. So much senior people to me embedded in their old ways (Participant 1).*

During this stage Participant 1 explained that his wife said he had a "shell of toughness and unavailability" and "others knew nothing about his personal life". He described being "highly" vigilant of his own behaviour in this phase, and "being a bit cautious…not wanting to be boorish or intrusive or arrogant". For Participant 3, who had been in Aotearoa New Zealand for just over two years, this stage was also more challenging than the first. She expressed wanting to "hide under the table to not face any of this". This participant had a largely positive experience in her first stage, but explained that the change of jobs in the second stage was "isolating":

> *So after (name deleted), which was such a nicely coloured experience for me, I was so confident, I came here… the team was a little difficult to work in. People can be quite isolating. There are a few people, even now, who tend to put each other down a lot and can be nasty at times…I had clients saying that I refuse to work with her…I was like what the hell. It was not nice (Participant 3).*

Although he spoke about enjoying this new period, Participant 1 reflected that for others a change in role could potentially be a "lonely" situation:

A clinical leader in a new environment, to feel fairly like you have to keep a bit of distance between yourself because you're provoking people too much is quite in theory a lonely situation to be in. Didn't feel that way; I quite enjoyed it…(Participant 1).

Participant 5, who had been in Aotearoa New Zealand for just over a year by this point, was still "hitting barriers" in this stage. She spoke about receiving "a negative reaction from the team" to her proposed changes, which resulted in her feeling "incredibly dismissed, frustrated, angry and unsure what to do":

I was just really kind of angry which my own bias was because I was seeing what they're doing through my lens back in the UK (Participant 5).

In summary, participants who described more challenges in the middle stage appeared to have experienced significant changes involving adapting to already established teams or a new position, or ongoing struggles with processes that occurred in the initial period.

Experiencing growth. During the middle stage, several participants spoke of a feeling of professional growth in their role as a therapist and feeling more "settled". They spoke of taking more chances, trusting their own clinical judgement, and feeling more confident. Various participants discussed continuing to learn during this stage. In contrast, some participants who faced challenges in this stage discussed experiencing conflict with their team and feeling lost or "complacent" during this time.

As can be seen in the titles chosen for the stages (Table 3, Chapter Four), many participants referred to this stage as a time of growth with remarks such as "I can start to really grow into this" (Participant 2). They spoke of understanding the culture more and feeling able to apply their understandings in practice (Participant 12), or described feeling generally positive and "comfortable" (Participant 14). One participant used the metaphor of a growing seed to characterise her potential in this period:

I don't know that I have a word but it's more an image of almost as a kid I used to like growing seeds, where that first radical comes out and it's not necessarily rooted in the ground because you've still got it between the two, that's it. It's I suppose potential (Participant 15).

Others discussed positive experiences and "professional growth" (Participant 12) in this second stage related to career opportunities and new jobs:

> *The good thing about New Zealand is you can change job… in Europe generally because there are few jobs and lots of people and lots of psychologists…so once you have a job you just hold onto that for the rest of your life… (Participant 13).*

> *So, in some ways because it's a smaller society and there is more scope to accept people on merit, it gave me career opportunities I might not have got anywhere else... In South Africa, there would be all kinds of cultural hindrances and complications around who's got the right to lead and who doesn't. Whereas here it was a straightforward matter of, you look like you can do it well… (Participant 1).*

Several participants not only described more opportunities to take on new positions compared to their home countries, but also of progressing professionally within their job and transitioning to more senior roles:

> *That was probably a really good time for me career wise. I was climbing the ladder …. I was kind of confident professionally and collegially I was slowly making that shift towards becoming the person who would advise rather than seek advice (Participant 11).*

One participant spoke about having "outgrown" a position and "wanting a new challenge" (Participant 7). Participants described the professional growth and success they experienced in contrast to their first stage:

> *… and I think that gave me a sense of independence and a kind of a sense of achievement of I have arrived, it's alright, I am going to survive, and I think at that point as well I was fully booked (Participant 10).*

> *…feeling more like I was starting to give support and give advice rather than being the one who was constantly clueless and going what is going on or what do I need to do or what does this mean (Participant 11).*

Some participants spoke of "getting better" (Participant 2, Participant 11) and several discussed being more "competent" (Participants 2, 10, 11, 14) and confident in this stage. They talked about "taking challenges" (Participant 8) or chances:

> *Far more established. It felt that I kind of knew things, I knew my feet, I knew where I was going, I knew the systems, I understood what was going on. It felt that I could actually take some chances (Participant 7).*

And addressing wider systemic issues with confidence:

So the second part of my phase was actually having the opportunity to sit …in restraint meetings and to be able to say look this is happening because staff are getting burnt out. …If we don't look after our staff we can't look after the patients (Participant 4).

Most participants spoke of gaining more confidence over time in the second stage:

I think just the stuff around me being timid and are you even sure you should be here, those feelings just seemed to precipitate (Participant 8)

I guess your confidence grows and you can offer support to others, you're seeing something different where you're not the newbie now, you're kind of the I've got a bit of experience of this (Participant 2).

Continuous learning. More than half the participants referred to many positive experiences of learning in this stage, including "learning more about Kiwi culture" (Participant 12), implementing learning from conferences (Participant 5), learning about "diagnoses", "sensory assessments" and "learning on the cuff" (Participant 4). Some participants discussed ongoing learning about processes, such as ACC processes, and feeling positive about discovering opportunities for funding. Learning in this middle stage was often described as a positive experience:

But one of the things that I have just gone ahead and done is whenever I wanted to know more about something I went ahead and I bought myself the most up to date textbooks on it and I just by way of self-study continued to equip myself. But I have accepted all along that working in the profession…one needs to come to terms that you will be a lifelong student and I find it very stimulating (Participant 6).

Even though the middle stage was characterised by more struggles in her new job position, Participant 3 reflected on the learning that began to occur and still continued:

Through all this I have been learning a lot as well. I got to learn a lot of technical skills… I have learnt much more about the system, how things work (Participant 3).

During this time, some participants spoke about starting to question things, such as in supervision conversations (Participant 12), or "grappling with social and ethical issues" (Participant 14). For instance, participants questioned and discussed "feeling frustrated with

lack of funding" in their areas. Throughout this continuous learning, participants discussed becoming more aware of aspects of their work which were "frustrating":

> *But here as a psychotherapist working in New Zealand it's been the biggest wake up call for me really because of the lack of funding for child services. The lack of legislative- the lack of or social, political legislative support for children in care (Participant 2).*

> *The acquisition of new knowledge, I have enjoyed it, I have found it very stimulating and I have always grabbed the opportunity when it came up. One of the frustrations had been that there was not always funding available and that really was often a frustration (Participant 6).*

Participant 11 described feeling more confident about explicitly questioning aspects of her work and secure with her own knowledge and learning:

> *So yeah and in those years I suppose I started questioning things more rather than having this complete one way system of tell me how to do this. I started going I know how to do this and I can competently do it and I can show other people how to do it, and now I can question (Participant 11).*

During this questioning period, she spoke of becoming aware of areas of improvement and acquired knowledge:

> *I went through a period where I could write a really good parole board report, one that would tick all the boxes and read very easily...so I was doing it a little bit better, doing it a little bit faster, doing it a little bit more complex…(Participant 11).*

Participants also discussed "upskilling" and consciously developing professionally:

> *So I started researching around homework, tasks for clients, daily practices, apps, do I open up the possibility that they can email me once a week? So that was an interesting phase in my practice of kind of adjusting to the changing landscape of therapy and adjusting to the new space, putting up my fees, registering for GST...(Participant 10).*

> *I think the bigger my basket of skills has become I think the easier it has become within the Kiwi context… (Participant 6*).

For other participants, despite ongoing learning and progression in their careers, this second stage was still marked with struggle and difficulties in terms of professional growth. Some participants reflected on challenges with colleagues, clients and their role impacting on their confidence (Participants 1, 3, 9), challenges with supervision (Participant 3, Participant

9), or feeling "complacent" after trying to progress (Participant 5). Although Participant 3 described learning about the system and new skills during this period, the struggles she experienced in her new job as a clinician were more at the forefront. This period was challenging partly because of conflict with other staff:

> *There is this lady, she is a social worker. She hates psychologists. She is viscious with us and I am not exaggerating... so initially I would be like, oh let this person bark for all of the reasons that she wants to, I don't care, but sometimes it still gets to you (Participant 3).*

She also described challenges experienced with clients during this period, such as an incident of "going into shock mode" after a "borderline client went off in my room" and the lack of support available at the time:

> *I hit the panic alarm, I came out looking dazed out of the room and it was a Friday 2.30 appointment so I didn't have anyone to debrief with. It was a long weekend also after that. I still remember coming home. I didn't talk much for the next three days and I didn't realise that means you are in shock and your brain is constantly processing what has happened…(Participant 3).*

Despite receiving some support, this participant described the lack of confidence she felt during this time:

> *There are a few more unpleasant experiences. My confidence had taken such a big hit as well. I was like oh I think I am so not suited. I can't do this job. Why is this happening? I would get so personally upset with clients refusing to see me and all of that (Participant 3).*

Another participant reflected on his lack of confidence during this time after taking on a new position, even though he experienced a sense of professional growth in the more senior role:

> *But I distinctly remember feeling then far more sensitive to feeling like I'd failed or I wasn't good enough or I wasn't doing enough. And part of it was maybe the new job, so it's already a newish role so you're really not quite confident (Participant 1).*

In addition to being new in the job, experiencing conflict with colleagues, being in the second year of working post qualification, Participant 3 also described the impact of a racist

encounter with a client because of her Asian origin. Over time, she was able to distinguish the client factors and transferences that were contributing to her experience:

> *And over time I realised no it's not, you can't take responsibility for them. Like I said there is a thin line between being unwell and between misbehaving…(Participant 3).*

As in the first stage following issues with the registration process, Participant 9 faced ongoing challenges with professional growth during this period. She had been able to register under the general scope of psychology by this stage but wanted to change jobs and work as a clinical psychologist, as she had in her home country. However she was unable to, and hence felt frustration, anger and resentment:

> *So because of not being registered, not being a clinical psychologist you are underpaid. So you are taken advantage of because you are working as a clinical psychologist but you are not a clinical psychologist and that was a big thing… (Participant 9*).

She also described the challenges of working with clients in her setting who had experienced significant trauma. She recounted her experience of "secondary traumatisation" from a client, despite self-care:

> *I came across a horrifying story of a client who was in prison for years… I realised after a long time I was having secondary traumatisation. Even reading a book I was like blah, blah, blah, and watching television and seeing people taking the guns and then I stopped watching Aljazeera… (Participant 9).*

Amongst participants who described professional challenges in this stage, there appeared to be some dissatisfaction with the support available at this time. For instance, whilst Participant 3 received support for her experience, it did not appear to meet her needs:

> *Yes I did get support but I still didn't feel satisfied with the answers very often. Maybe I think it was time and my need to find those own answers (Participant 3).*

For Participant 9, who discussed earlier perceptions of discrimination during the registration process and secondary traumatisation, supervision did not seem to fit her needs either. This was explained as due to the different background of her supervisor, and hence she looked to her colleagues for support:

To be honest supervision doesn't help. We have an environment over here which…If we have a very difficult client we just talk among ourselves. That is more effective. Because the supervisor may not be from your background. They might not have your kind of experience. For them it's fun to listen to those stories but their understanding is different. But over here it's your colleagues who are seeing clients of a similar nature and they can relate to that (Participant 9).

Participant 5 described her dissatisfaction with support and learning and spoke about feeling that clinicians "were not very holistic in the way they think about things" and "felt there was a lot missing" (Participant 5). She discussed feeling "complacent" during this stage rather than growing professionally:

So I kind of realised well this isn't working I need to kind of step back and just settle in and see how things go and kind of took the foot off the gas but then I kind of got to the stage…where I then just felt like I'd almost got too complacent settling in and not doing things that I wanted to do (Participant 5).

Interestingly, as Participant 5 had recently moved to Aotearoa New Zealand, her second stage began a few months into working professionally. It is also worth noting that Participant 2 and Participant 3 had only worked professionally in Aotearoa New Zealand for just over two years at the time of the interviews, so their three stages are shorter than those of the other participants.

Reflections on migration. Several participants reflected on their migrant status in this stage. For some, being a migrant was not perceived as "an issue" by this point. Some participants spoke of ongoing positive connections with other migrants, whilst others described incidents of racism and other challenges.

I don't think the issue of whether I was an immigrant or not was relevant in that sense. People did ask, clients do ask, were you born in New Zealand? Where did you study? …and in that sense there is you do share more of yourself I think as an immigrant psychologist… (*Participant* 7).

I think for myself and possibly others, my being a migrant psychologist probably became something that wasn't necessarily thought of an awful lot and in my professional work (Participant 11).

Participant 7 spoke of her migrant status in a bicultural context:

I fit neither one category, in some ways, and you know now we do live in a multicultural New Zealand but it has got a bicultural aspect to it so …as an immigrant psychologist, how do I fit into a bicultural society being neither Māori nor Pakeha, you know? That's quite interesting (*Participant* 7).

Whereas Participant 1 who faced more challenges in his new role, but felt this was not due to being foreign, described being more aware of his status in this second stage:

Being South African or being a migrant mattered more to me than perhaps I necessarily conveyed to people. So, I think that was really quite crucial. I was more aware of the fact that I have to be careful with how I do things than other people would necessarily have been to the point where I would have been monitoring my own behaviour almost too carefully (Participant 1).

Others described changes that occurred in the second stage which "mirrored" their own initial migration to Aotearoa New Zealand. For instance, when moving to a new clinical setting, one participant "could see the uncertainty play out" in her clients and "it took a long time to settle" for both them and herself. She described "working harder to hold clients" during this change and called this experience "a mini immigration":

The shift there was actually just that I had to move physical location of the practice and funny how that can unsettle you, if you suddenly do therapy in a different space. … to find new practice rooms and renegotiate rent and contract and time and communicate that to clients felt a little bit like a mini immigration, which is an odd thing, because both me and the clients were unsettled for the first month (Participant 10).

Similarly, another participant explained that changes in this stage in her work "mirrored" her own process of immigration:

Yeah. And ironically we knew where our service was physically located was temporary which sort of mirrored my own process. We were looking for premises when we were going to start… (Participant 15).

Some participants discussed migrants supporting each other, whether it was their migrant clients in group work (Participant 12), or support they themselves received from other co-workers who were also migrants. Participant 5, who struggled with her team during this time, explained that she and her colleague "bonded over what it was like to be a migrant practitioner", and described her colleague as "a helpful ally within the team":

I think having my colleague … from overseas … was that more vocal positive support … helped give me that motivation to keep chipping away and keep drip feeding because without that, I was really struggling to kind of keep that going (Participant 5).

Similarly Participant 9, who experienced ongoing struggles with her professional status, spoke of the support she received from her team, who were also migrants working with migrants:

… A migrant psychologist understands things, picks up things much better than the Kiwi psychologist because the population in which we are working is completely different. So this job there is no problem. The clients feel comfortable with you (Participant 9).

She also spoke of "gelling" with migrant clients by being the same colour:

The moment someone saw me they just felt empowered … because I am the same colour…I am not white. It just didn't create a problem. In my country we have Muslims, we have Hindus, Christians. So I've been raised in a multicultural environment. These people don't have an issue. I gel very well with them (Participant 9).

Others commented that talking to other migrants helped the experience of migration feel "normal": "I came from a different country. She came from a different town and she is experiencing this, so this is genuine, this is real and this is okay in some form" (Participant 8). Some participants reflected on their migrant status and whether this impacted on therapeutic work. For instance, for Participant 3 racism from clients towards her origin was "hard and upsetting":

I knew she had a chip on her shoulder, she kept asking me do I own my own house or do I pay rent … all the houses have been bought by Asians and stuff like that. So basically the relationship broke down. I perceived that as racism. The fact that they don't want to meet me because I was Indian. She kind of was blunt in my face and told me that. Later on she changed her story and told people it was not me (Participant 3).

Another participant felt apprehension at being a migrant despite the number of migrants in Aotearoa New Zealand:

..My apprehensions perhaps as an immigrant psychologist would be, would they look at my name and think oh you know maybe I shouldn't send this person to this person because this person may not understand … (Participant 7).

The idea of possible prejudice was sometimes at the back of her mind:

I think that one has to hold that in mind, that perhaps that a prejudice could exist if somebody saw my last name and what that looked like and may have had issues with that… (Participant 7).

The second stage themes highlight a shift or change for many participants, who described gaining confidence, becoming more familiar and being aligned with their identity. Most described this period as a time of growth, whilst a few experienced more challenges. Most participants reflected on their migrant status.

The Third Stage

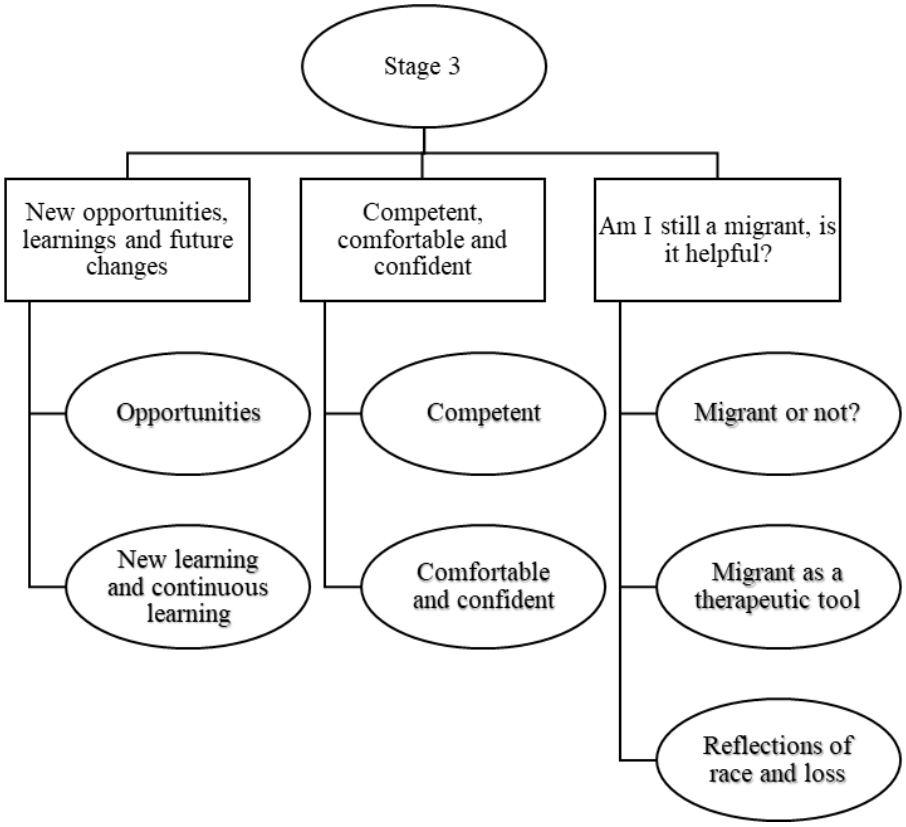


Figure 3. Themes and subthemes of Stage 3

New beginnings and learning. Most participants described new career opportunities, new beginnings or ongoing learning in their third and most recent stage. Some talked about changing positions, becoming a clinical leader and career shifts, while a few participants discussed new changes that characterised this stage, such as making new decisions or setting up for the future. Others described new opportunities to learn and develop professionally.

New opportunities. Several participants discussed a positive transition to this most recent stage through having a new role or new opportunities. Participants discussed new roles and career advancements:

> *So in terms of my practice here I've taken on a lot more ..., my role here is as a psychologist but I've also got…the role of the lead clinician at (name deleted) which means I have clinical oversight… (Participant 7).*

This opportunity involved taking more risks and aligned with the work she enjoyed: "This is my kind of choice of where to work, next phase, taking more risks etc." (Participant 7). Participant 14 also described a new opportunity in this third stage, in this case moving away from a leadership role to work that resonated more with her interests:

> *As much as I was enjoying the leadership work and as much as I do enjoy supervision, the management of people and issues and other things that came with it was not very enjoyable and I was finding it quite tedious. I really wanted to get back into actually doing something that I was really passionate about which was more neuropsychological work…so I thought no I'll look for a new role…(Participant 14).*

For Participant 1, who commenced a new role in the second stage and faced some minor challenges, the third stage involved a welcome expansion of his role as a clinical leader with added responsibilities:

> *Then the last three or four years depending how you cut it up, the clinical leader of a much larger portion of the service …. So, it goes from being a small- me and six people to me being more involved in the whole of child psychology… (Participant 1).*

For Participant 9, who struggled continually in the earlier stages, in this stage there was a sense of recognition of her work and an opportunity to advance in her career: "The biggest difference between the past two stages is…getting a pat on my back that now you can be a team leader over here". Similarly, another participant described the sense of achievement she felt following being appointed to a new position:

> *Then after three months…I got a permanent position, so I started to feel more settled in the job … I guess the manager and the people really wanted to have me there, so I felt good about that (Participant 13).*

She spoke about how much easier obtaining a position was in Aotearoa New Zealand:

> *You can apply for jobs and have the opportunity to get the job, which is something I wasn't really used to…In the workplace people are so relaxed…colleagues and professionals, always smiling and very welcome… in (European country) there is a lot of competition and a lot of people are angry at work and you can feel it…And you have to be, you have to be a little bit like that otherwise everybody is going to get the job instead of you...(Participant 13).*

Other participants spoke about new beginnings and setting up for the future:

And this last phase is about thinking about setting up a practice at my own house, buying a property that I can practice from…if I can manage that then I am kind of set until I am 70, right. Then I don't have to move anywhere. And this is kind of what I am busy with at the moment, thinking about how to achieve that… (Participant 10).

Ongoing learning. Several participants described new learning opportunities in this most recent stage. Comments included "being able to increase my repertoire of cultural diversity" as intended and "deepening learning" (Participant 6), or "immersing myself" in learning (Participant 14). Many participants spoke about continuing learning and ongoing professional development:

I believe that as psychologists we will never get into a space where we know everything, so my approach throughout has been I continue to learn until the end of my days (Participant 6).

I am always wanting to challenge myself and learn something new and do something new, as long as it's safe. To get quality training first and get supervised in it and do it safely and then do it on my own…. I am going to continue to have those periods where I will want to do something new (Participant 14).

For this participant and others, this stage was characterised by enriching experiences:

There was a long period of time where I thought what am I doing here, I am such an imposter, my God this is so foreign. But having gotten through that two years of that feeling, it seemed like a long time to me, then followed three years of just enriching experiences. It was worth persevering (Participant 14).

I suppose sort of the capacity to learn and what's available here to help me develop as a clinician and I suppose the thing that I value the most … (Participant 15).

By this stage there was a sense of achievement, having worked through obstacles and changes over time. Several participants seemed pleased with this phase of deepening their learning:

I've had the opportunity to do training. DBT (Dialectical Behavioural Therapy) in particular is so intensive that there are probably a handful of countries in the world where you can pull off that label of intensive intervention…So to be able to be part of a consult group is something that would never have had the opportunity to do back home…whereas

here you have that as a matter of course and that has been incredibly valuable I think for me in my growth as a therapist (Participant 11).

Small challenges in this last stage were linked to changes such as having a private practice:

But in private practice it's different because I am by myself so it's not like that you discuss this thing, of course I can discuss with my supervisor but not with a team. It's kind of different (Participant 13).

For Participant 9, however, the ongoing challenge of not having her original training in clinical psychology recognised was still something she currently faced. She described this as major obstacle to developing professionally and having further opportunities:

I don't think I can get a job as a clinical psychologist in a community mental health centre. That would be a regret for me but there is nothing I can do about it unless I want to take the big plunge and going and studying for five years which I am not going to do…The issue of the word registered and clinical psychologist has been my most down part of it. Meeting somebody who says I am clinical and not being a clinical psychologist or feeling that the person is paid more than you when you are doing the same kind of job, that has been my glitch in my life in New Zealand…(Participant 9).

Some minor challenges still faced during this last phase included disagreement with how services operate:

My sense is as a larger service people are pushed through the system, assessed, but there's not really much follow-up and I don't want to work in that way (Participant 15).

Along with the learning and development that was occurring, participants expressed feeling "frustrated" (Participant 12) or "aggrieved" with the reality of service providers:

Now that I know how you should work with Māori, I do at times feel very aggrieved that the public service doesn't deliver the kind of care to the Māori population that they really should and that can be grating now that I know what it should be and then I see what's happening ... undignified…I'm surprised they engage at all... (Participant 14).

Competent, comfortable and confident. Several participants discussed a sense of competence by this stage in various areas of their work. They spoke about their skills being valued (Participant 6, Participant 12), "knowing more about processes" (Participant 12), "bringing a different repertoire of skills rather than CBT" (Participant 8), or "acting as a

support/shoulder to cry on" for others (Participant 6). Others talked about "feeling in the swing of things", "feeling strong in themselves" having met "Maslow's hierarchy" of needs (Participant 2), or "doing all the cultural training possible and trying to make cultural learning present" (Participant 14). They spoke of "updating and asking" in order to continue to work competently (Participant 4), or commented, "I think I will just keep getting better" (Participant 3). Several participants spoke of the value brought by their professional skills in this most recent stage of their experience, such as the specialised "courses" (Participant 12) they had done overseas, "being approached for specialist skills to deal with patients" (Participant 6), or that their overseas training was helpful:

> *So, to me it feels like training as a South African psychologist really does equip you to be quite an effective social change agent whether you're in a leadership role or not. So, it's a very, very good grounding for the kind of work I do now and I think it's given me a significant head's up over my colleagues (Participant 1).*

Even for those who discussed challenges they had faced in earlier stages, there was an overall sense of achievement in their professional work by the third stage for most participants. Despite the "issue of not being registered as a clinical psychologist", Participant 9 spoke of others "asking you for support, not the other way around", and being approached for her "expertise" and feeling "empowered". Similarly, despite the constant barriers she faced, Participant 5 began "realising" she had "skills and experience as a migrant" that she "brought from her country" which were "helpful", "well received", and a "positive experience". Participant 15, who had also faced many challenges in earlier stages, noted in this last stage: "I feel like I do actually have a professional identity where I suppose I feel like I am good at my job now". Another participant spoke of feeling self-assured:

> *I think therapeutically what it has meant and established for me is it's, I'm much more self-assured in knowing that this is how I want to work… it's not that I've ever questioned the long term work but…when as you come in as an immigrant psychologist and you realise people work quite differently it's just like wow…would I be able to work long term…from that point of view therapeutically to be able to feel assured that actually I can…that's been really positive (Participant 7).*

Along with a sense of competence, many participants also described a feeling of comfort in this stage, or confidence about how they were working by this point. They spoke of one of their "highlights" as feeling "proud to deliver really quality reports that the courts commend us on", and which were described as "really helpful" and used to get "much better outcomes for some of the clients" (Participant 14). Others spoke of feeling "established":

> *I think feeling well established now within the psychology community… you get to know a lot of them and so it's always been quite positive being in the DHB (Participant 7).*

A few participants spoke of some small challenges faced in more recent years in terms of their confidence as migrant therapists. Participant 14, who discussed feeling competent by this stage, nevertheless recounted the struggle of "re-experiencing the initial feeling of imposter and being of other" when applying for a new job, suggesting changes could reignite earlier apprehensions:

> *I had to go back into a work market where it wasn't necessarily known, wasn't necessarily local, I didn't train here, I wasn't a known quantity and I had to sort of prove myself again. And so I went through a phase of probably being a bit less confident in myself and my ability to sort of compete for another high level job against other psychologists who worked here for many years (Participant14).*

Another remarked on the length of time it had taken to develop confidence:

> *No, just it takes a long time. It really takes a long time. It took me about seven years I think to have a sense of belonging, to have a sense of confidence, of I know I've got a roadmap…. I had a very challenging experience two or three years ago professionally and it was a very public experience that a lot of people knew about and I suddenly realised how many people knew me, were supportive of me and how well connected I had become, which was great. But I also realised how if that happened to me two years in it would have been disastrous. It takes a long time (Participant 10).*

For Participant 5, who had been here for the least amount of time amongst the participants, her confidence in some areas was still a work in progress:

> *Definitely another one I guess is my own confidence, so I had some confidence in terms of working in EI (Early Intervention) that was fine but in terms of my cultural competencies and confidence in working with particularly Māori and Pacific cultures. That's been a challenge, yeah my competence and confidence I would say although I'm used to working*

in a very diverse, multicultural area in (name deleted), hugely diverse but no experience of working with Pacific cultures or the Māori culture (Participant 5).

Am I still a migrant; is it helpful? More than half the participants spoke about no longer feeling like a migrant in this last stage. At the same time, some of these participants also discussed using their "migrant" status as a helpful aspect when working therapeutically. Some challenges to do with being a migrant were reflected on in this stage.

Migrant or not? Most participants spoke of no longer noticing their migrant status in this stage, and this included participants who had been here for fewer years. For instance Participant 5, who had been in Aotearoa New Zealand for just over two years, noted that her therapeutic work using ACT interventions was "probably less about being a migrant and more about just where I am in terms of my ongoing therapeutic allegiance". On the other hand, Participant 1 reflected that "after all these years my experience in my professional life has almost got nothing to do with being an immigrant psychologist. It really doesn't have any bearing on it at this stage". Similarly, Participant 4 reflected: "I think now the fact that I am a migrant is not really an issue any longer". Several others wondered about whether their migrant status related to their work experience in this stage, for example:

I wonder now actually where my migrant status fits into this, you know, what my kind of professional choices would have looked like if I weren't here. I think the shift for me was, again it's always a bit of a gradual shift I suppose (Participant 11).

Another participant spoke of letting go of her migrant identity by the last stage:

I don't think of myself as a migrant psychologist which is the interesting thing, as I probably thought of myself as a migrant psychologist up until stage three, up until year seven more or less, and then I forgot about the fact that I am a migrant psychologist. But I don't carry that identity anymore. It's a funny thing (Participant 10).

Some participants reflected on reasons why their migrant status was no longer a large part of their experience. They considered whether it was the length of time they had been here:

Yeah after this amount of period of time, I'm at 13 years, I'm just a psychologist you know, I'm just I don't see myself as an immigrant, migrant psychologist now. If you ask me

when that changed, I don't actually have an answer to that. But I would say in the last five, four, five years (Participant 7).

Another participant felt that the reason for this was partly to do with working amongst other migrants, and noted they were "just one of a whole range of migrant clinicians working in the big organisation" which made it feel "quite normal" (Participant 14). Similarly, Participant 8 was feeling less "different" because of the "cultural diversity" of her new workplace:

The excuse of going am I going to be the only black person in the training today is zero. For so many years I would go to a workshop…and I stood out (Participant 8).

On the other hand, another described a less diverse team making her migrant status less prominent:

I probably didn't feel my migrant status very acutely. I probably stepped into a team where…culturally it was a much more homogenous team. It was a much larger team and probably the vast majority of them were Kiwi. And so a less diverse team than perhaps what I had been used to and yet it didn't feel ... I think the migrant status was in a way rarely in there (*Participant 11).*

One participant reflected that once others validated her New Zealand status, she felt less of a migrant in the third phase. She spoke of having "all the systems around me, the IRD and the government and everybody else thought that I was a New Zealander" which "helped to some extent" (Participant 10).

Migrant as a therapeutic tool. Several participants talked about the benefits they perceived of being a migrant in general and when working therapeutically in this stage. They discussed enjoying being a migrant as it made them more "aware and more open to what is going on around the world", in addition to knowing "what is happening, what experiences people can bring" (Participant 4). This participant spoke of the advantages of being a migrant for understanding other migrants:

I'm quite comfortable really. I actually feel I have the best of both worlds because as a migrant I understand new migrants who are coming through, especially I mean we've had a few refugees come in as well so I can understand their plight much better than I think a New Zealander does (Participant 4).

Similarly, Participant 10 reflected on the benefits of migration for understanding change in the lives of others. She noted the experience of migration helped her "reshuffle the pieces", bringing an increased understanding of what brings about change for others:

The experience of immigrating I think is a very useful one to have as a person because it helps you understand a lot about change and what needs to happen for people to change and what happens for people when things change.... maybe at the end of the ten years or practicing in South Africa I was at a positon where I felt well I am quite a competent therapist and I might not need to know much more. But of course immigration undoes everything that you think you know and I think that is a really positive experience actually. It kind of reshuffles the pieces (Participant 10).

One participant spoke about a "space" being available to address differences with clients in therapy (Participant 11). Participant 4 noted that she could be honest and genuine about her difference, and how that strengthened relationships with clients through checking with them and requesting feedback:

If I make a mistake I am quite happy to say look I am really sorry, I don't know. Tell me what I did wrong and so I can do it right and usually they are okay with it. I think the patients get quite a kick out of seeing us making blunders. They're like oh no one's perfect (Participant 4).

Another participant spoke of accentuating her difference when working with clients, also checking in with them and working collaboratively around differences:

I think I am more comfortable using the fact of my point of difference, because I know I still sound different…I look different very often. So sort of these days sometimes I will even accentuate the difference. I will say I know I sound different and if you are not sure just ask me but if I am not sure I hope you don't mind if I inquire. So using the difference as opposed to feeling like it's this brick wall (Participant 15).

One participant suggested that using "difference" allows migrant therapists to use a curious naïve inquirer stance as a helpful tool in therapy:

I think being a migrant allows you to not have, you know it forces your client not to have those implicit assumptions…they can't assume that there is a shared understanding about

stuff and so you can, you know, that naïve inquirer role where you can simply curiously question things that perhaps people take for granted or wouldn't have needed to articulate with someone else but need to articulate with you because you don't have that shared understanding and they know that. I think that can be a helpful thing for clients (Participant 11).

Another participant noted that it is easier to establish a relationship with clients when the language is different. She spoke of the possibility of "feeling too familiar" with clients from her own culture when in Aotearoa New Zealand (Participant 13). Others spoke of drawing on commonalities with their migrant clients as a therapeutic tool, which is something one participant described as "bringing herself back into therapy":

I was drawing on my own history in terms of relationships, what it felt like to be a woman, what it felt like to be in my 40s, a professional woman who had been divorced or through a separation (Participant 10).

Some described commonalities to draw on with clients, such as not having a sense of home or belonging:

It becomes a focal point when you know when I can relate to a client who has no extended family… clients often talk about not having a sense of home and not belonging anywhere and those are probably the times when I feel my immigrant status as a therapeutic tool of I get this. We don't have roots here and after ten years I am not from here, I don't belong here, I don't belong there, and I get that and it's a weird space. I think probably a migrant psychologist is the only one who would get that (Participant 11).

Another participant described being 'brown skinned' as really helpful when working with Māori:

I think the fact that I'm brown, the fact that I come from a country that was ruled by the British for 200 years, I come from a country where it's not individualistic, it's community based and family based, means I have a much smoother ride and much smoother, it just feels easier in establishing a relationship, a therapeutic relationship with that you know it just feels easier (Participant 7).

In her reflections, she discussed how her worldview as a migrant and her culture facilitated rapport and the therapeutic relationship with clients in Aotearoa New Zealand, and that she was able to draw from her own experiences for therapeutic purposes:

..my own self having an understanding of the complexities of what Māori have been through, my own cultural background, ethnic background, being Indian but also having mixed blood you know so that's an interesting thing for Māori also who have mixed blood and what that means so I feel for a personal level but also as a therapist and as a psychologist feeling that it, if anything it is in this particular phase being an immigrant psychologist has felt it's been the most useful you know to draw on personal experiences and to be able to use that in the work…(Participant 7).

Reflections on challenges and loss. Despite the majority of participants commenting that their migrant status was no longer an "issue", with most recounting positive experiences of using their migrant status in therapeutic work, these participants had still experienced some challenges in more recent years. They reflected on experiences of racism, working biculturally, and an ongoing sense of change and loss.

Some participants were still occasionally experiencing racism and discussed challenges to do with reflections on their sense of self in this stage. For one participant who had been here for over ten years and had "little if at all any experiences of prejudice or racial issues in terms of being of Asian descent" (Participant 7), communication with colleagues and in supervision had helped "make sense" of a recent challenging experience. She had preferred not to discuss this with the client but the experience had stayed in her mind:

I didn't think it was appropriate to address it directly with them but it's something that's stayed in my head you know as to not having had much experiences at all of anybody being racist you know in some ways my first experiences is long down the track and was really odd and so that's just something that's stayed yeah (Participant 7).

For another, the challenge of working with a client from the same culture with racist views was particularly problematic as the client assumed this participant would share their views:

I could quite easily say one of my South African clients has been the most difficult client to work with because with South Africa you've got all the segregation stuff and she was a client who was still holding on. She was very racist and she thought that I shared that with her because I was South African and it was really, really difficult. So though we shared certain cultural aspects, we didn't share the same worldview. So though we came from the same country we didn't share the same culture (Participant 15).

On the other hand, another participant, who had been working in Aotearoa New Zealand for just over two years, discussed the sense of discomfort she experienced at times when

working with Māori as she reflected on the history of colonisation and its impact. As a result, she wanted to be thoughtful and sensitive in her work:

> *And I guess there's also that sense for me coming from the UK ... Just having to sit with some discomfort around that and being sensitive to the fact that I don't know how much day to day that is going to influence the way that our Māori clients would receive having a UK psychologist but in terms of it being a kind of an undercurrent to some of the qualities and some of the challenges that our Māori would face in their life, that history of colonisation and my own ancestors ... it's certainly something that I'm aware of and want to be just thoughtful about and sensitive about (Participant 5).*

Despite these experiences, conversations in therapy addressing race and identity have been rewarding and positive for both participants and clients. One participant who discussed her therapeutic work with a Māori psychologist who was her client, recalled how nervous she felt at first. She described speaking to her client and asking them to tell her if she did anything that appeared "offensive". However, the process of whakapapa (Māori cultural practise of discussing genealogy in introductions) strengthened their relationship and she "immediately felt this was going to be a good process". She described learning from her client about Māori:

> *Because I could say, suddenly had permission to actually disclose my family history, the place I come from, the mountains that I was climbing as a child. And she has taught me a lot around what it is like to not look Māori but be Māori, which is something I would never comment on because I would be so scared that I would offend someone (Participant 10).*

She spoke of the "amazing experience for her to talk about that tension of being with people who are racist", and the therapeutic effect of being able to express these views for both of them. She also spoke of her own discomfort as a helpful reflection to hold on to:

> *So that has been a really good positive experience but not easy, because there is discomfort in me as well around which racist attitudes do I still hold, which I might not think I do, but of course we all have our biases that can be uncovered I think in certain conversations. So that has been good (Participant 10).*

There were reflections on working biculturally and most participants felt it was a necessary part of working in Aotearoa New Zealand. Participant 10 spoke of how it has become an automatic aspect of her work:

I don't think it's an option. I mean it's not an option that we get of, do you want to work bi-culturally or not, you do have to. That is the way it is here. It's interesting, I was asked that question in South Africa when I went back… tell me about what that's like and I said in the beginning it feels like something you put on, of I am now going to work bi-culturally, but now it's not anymore, it is just what I do. It's an automatic part of how I engage with people (Participant 10).

She described how learning to work with a bicultural framework has been a positive experience and reflected on her status as a migrant and white guest in the country:

I don't assume that they are Māori or not Māori because you don't know. And I think that has been a really positive experience for me, to grow in my confidence and competence around I am actually a guest, not only because I immigrated, but because I am white. This country doesn't belong to us initially, hasn't, didn't and that has been a really good experience (Participant 10).

For Participant 8, who struggled with a strong sense of difference in her earlier stages of working in Aotearoa New Zealand, the bicultural framework and model resonated with her understanding of wellbeing. She spoke of wanting to bring back the concepts to her home country:

... I was taught psychology from a Western point of view. Nobody ever made it easy to understand the fact that your family or your parents or your people still considered the ancestors important as part of the therapeutic intervention and you can use that. Instead yeah the Western model doesn't include that... So I am all for working with cultures from their own perspective of what it means to be mentally healthy or wellness from their own cultures. I think it would be so awesome if I was at home and we had like people's understanding of what wellness looks like. That just because they would go to a traditional healer, to try and figure out what is going on emotionally, it's not wrong, but it's equally as valued, which it's shied upon at home (Participant 8).

On the other hand, Participant 11 described the benefits of learning to work with and learn the framework but felt that as a migrant clinician, there are limits to the therapeutic gains. She discussed the models as helpful initially, however only to a certain extent:

I don't know. I think there is definitely a space for those formal mechanisms of learning to introduce yourself, learning to do those things, learning how to behave at various kind of formal function and whatnot. But I wonder if we place emphasis on that as the, you know, if you can do that, then you can do Te whare tapa wha (Māori model of intervention) then you are kind of done. And those things are easily accessible and after that it becomes a heck of a lot harder to access anything (Participant 11).

This participant noted the importance of respecting power discrepancies and the lack of shared history as a migrant working with Māori. She spoke of the need for clinicians to accept struggles and challenges when working cross-culturally and recognise the limits of competence:

> *I do a lot of trauma work and I see clients that have had abusive experiences that are very clear that I hate Māori, I struggle with my own heritage, I don't want a Māori practitioner. And interestingly they end up with a migrant psychologist which generally I suppose would be coincidence. But I see people that struggle with their cultural stuff and I know there will be a point where I can't do that and I think part of the reality for us is also accepting that at some point, not just as a migrant, but as a non-Māori, you are going to have to step back and say I can't do this with you. I can walk with you up to a point and then after that, it is a world that I cannot enter in some respects (Participant 11).*

Participant 11 expressed that her understanding about learning to work biculturally was due to personal connections outside of the workplace:

> *I kind of think our best learning around working bi-culturally comes in living bi-culturally, in actually meeting Māori and socialising and visiting and having your kids sleep over, you know, building those connections where you get to be ... because you don't get to see someone's life by doing therapy with them. Building those bi-cultural ties outside therapy is what gives us an understanding in therapy (Participant 11).*

Some participants reflected on losses as a migrant during this time. They spoke of "severing ties with their roots" and getting to "a point where your professional life is so different to where you began that the origin of your ideas is just too different" (Participant 1). Another participant spoke of still "missing home" and the loss of her native language:

> *... you start dreaming in English, it's a sign of being very fluent, verbal fluency in a language that you are learning and that was encouraging for me to go okay, but very sad as well because it meant that's how far away I am from my own culture and my own language, my own people, how I make sense of the world. So there was a loss. I experienced a sense of loss. So I am not sure how I feel about that (Participant 8).*

One participant, as noted by others in earlier stages, likened recent changes in her work to another immigration:

> *We are going through a lot of transition right now and that is difficult in and of itself. It feels like another immigration in some ways but not quite as bad. I feel like this is something worth fighting for, what I do (Participant 15).*

Another participant described not having networks as a migrant as the only challenge she still faced. She discussed feeling "quite isolated" professionally as others had been trained locally:

> *They all know each other. Even though they are in different departments, it's easy for them …I don't know anybody. I am sitting there by myself going I don't know much… I think that is the only downside I have had… I feel it would have been nice if I had gone through university here, then I would have had that network of psychologists (Participant 4).*

Despite discussing loss and evolving identity, Participant 1 felt they are a necessary part of his narrative as a migrant psychologist:

> *… I'm far more informed by a narrative view of things that your life is a story that unfolds and that's just you can't have chapter three without chapter one. They're all connected to each other. So, I think there's something about the ideals and the perspectives of my life in South Africa that are still part of who I am but I don't think there's anything that you will see in my life on an everyday basis that tells me I'm connected to somewhere else…In that sense, you've severed your ties 'cause it wouldn't be like that if I'd stayed in South Africa. But in another sense your personal growth and your own identity I think is still connected to where you come from (Participant 1).*

Summary

The results of the thematic analysis show that therapists' experiences of working professionally in Aotearoa New Zealand are influenced by a range of experiences. For the participants, these included experiences of working therapeutically with new models and approaches in the earlier stages, adaptations to processes in their workplaces, and cultural experiences of self and others in Aotearoa New Zealand. The middle stages included the impact of these early encounters on experiences of self as professional, and how this changed over time. Participants' experiences of working professionally in Aotearoa New Zealand were characterised by a sense of professional growth over time, a "realignment" with "familiar ways" of working therapeutically, and further reflections on sense of self as a migrant therapist. For the most recent stage, several participants discussed new opportunities,

learning, feeling competent and seeing their migrant status as part of their therapeutic work. There were some common descriptions within themes, including using their migrant status as a "tool" for the therapeutic relationship. A minority experienced a sense of ongoing struggle working professionally with others. The following chapter considers the narrative trajectories of the findings and the therapists' sense of self as professional over time.

Chapter Four: The Results of the Analysis of Narrative Plots

This section presents the results of a holistic analysis of the plots or progress of participants' narratives of working as professionals in Aotearoa New Zealand. The method of analysis was described earlier in Chapter Two. As noted earlier, four different types of narratives were defined (See Figure 4 for a visual representation of these). First, some participants' narratives began positively and remained stable and positive throughout. This narrative type was titled Positive and Stable. Second, some participants' narratives began positively, declined somewhat during the middle stage, but then recovered again over time. This type of narrative was titled Decline and Recovery. Third, two participants' narratives were of difficulties and challenges that continued through to the current time. These narratives were characterised by ongoing declines or deteriorations, movements away from original goals and an increase in negative or problematic experiences as described in their interviews. This type of narrative was titled Ongoing Struggles. Lastly, some participants' narratives showed a positive incline representing a progressive pattern of participants' stories gradually rising. Named Steady and Gradual Progress, this type of narrative was linked to efforts towards objectives or a series of challenges that were dealt with successfully.

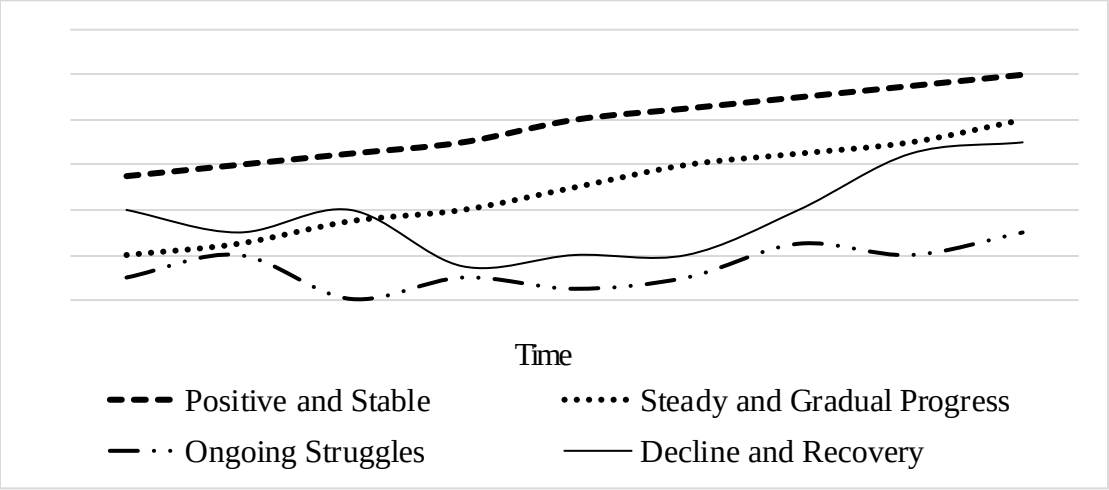


Figure 4. Narrative types.

Table 3. *Names Participants Chose for Stages*

P	Stage 1	Stage 2	Stage 3	Years	Narrative
5	Not named	Not named	Not named	2	Ongoing Struggles
3	Honeymoon	Reality hits	I settle	2.5	Decline and Recovery
13	Settling in	Transition	Familiarising	3.5	Steady and Gradual
12	Ad-hoc	Exploration	Growth	3.5	Positive and Stable
2	Change	Growth	Integration	5	Steady and Gradual
14	Imposter	Competent	Expert	5.5	Steady and Gradual
8	What have I done?	Should-a? Would-a? Could-a?	Maybe… just maybe...this will be ok.	7	Decline and Recovery
6	Feeling lost – I had no idea what I did not know about Kiwi best practice, NZ Law and expectations	At last a Kiwi mentor and starting to find my feet	Standing firm again after trials and tribulations.	7	Steady and Gradual
1	Settling in phase	Exploring new professional options	Consolidation phase	8	Decline and Recovery
10	Lost ground	Finding my feet again/ Growth	Independence	8	Steady and Gradual
15	Maelstrom	Potential: growing seeds, where that first radical comes out and it's not necessarily rooted in the ground because you've still got it between the two	Comfortable	8	Decline and Recovery
4	Early spring- finding my way, beginning to grow…	Late spring- as I find my way and having a core network/resource group	Summer- where my knowledge and networking grows…	9	Positive and Stable
11	Not named	Not named	Not named	10	Steady and Gradual
9	Bad	Better	Good	11	Ongoing Struggles
7	Embarking on the journey	Finding my place	Established and settled in	13	Positive and Stable

Narrative Types

Positive and stable. Three female participants provided narratives of positive experiences of working professionally and therapeutically as immigrant therapists. These participants had worked in Aotearoa New Zealand between three to 13 years. The narratives in this group highlight consistently positive experiences professionally, which contributed to an overall positive sense of themselves as professionals. One participant discussed her initial experience: "My experience by and large was positive in that first sort of phase working with people". This continued 13 years later:

> *I think professionally what's rewarding now is I can see all my hard work and how it's paid off now…after all that time… I've had lots of support from people... I think therapeutically what it has meant and established for me is it's, I'm much more self-assured in knowing that this is how I want to work (Participant 7).*

She described an overall positive and supportive environment, both professionally and personally. Similarly, another participant felt supported by other staff members throughout despite initial minor challenges. She noted in the first stage that even though there was "a lot of paperwork", it was a supportive environment:

> *I think all of it other than just getting my head around notations and the case management…other than that it was positive. All the colleagues were very supportive. Actually even the patients were quite supportive (Participant 4).*

She also described her experience of working therapeutically as positive throughout:

> *In terms of therapeutic work I think it's really the fact that the time spent with the patients, getting to know them and seeing them doing better. I think that is the most rewarding part for any therapist I suppose (Participant 4).*

In addition to support from others and professional opportunities, participants in this group described a positive sense of self throughout. The third participant in this group described her "genuinely motivated" clients in the first stage, being sought out for her expertise, and positive outcomes as contributing to her sense of self as a professional: "People who were coming for a specific issue and they…worked pretty hard to seek me out" (Participant 12).

Even though she discussed not working as much clinically as she had in her country of origin, she described the second stage as generally positive and she continued to develop professionally:

> *It's been generally positive. I was in a really supportive environment and I think ... I was doing a lot of practice, like doing some group therapy with another psychologist, so that was great (Participant 12).*

It appears that experiences of support from others, enjoyment of the work and positive experiences of working professionally and therapeutically contributed to the development of the positive and stable narratives. These participants described positive experiences throughout the stages.

Decline and recovery. The narrartives of four participants (three female and one male) described initial decline and then recovery. They had been working in Aotearoa New Zealand between two and eight years. Two of these participants described their initial excitement and positive experiences (Participant 3 and Participant 8; see graphs in Appendix F), however, as can be seen, Participant 8 questioned her decision. She described herself as very excited in the first stage, but the reality of her difference to others was frightening and impacted on her sense of self as professional:

> *So I was very excited. I enjoyed my interview. It was over Skype but the reality of oh my God, nobody looks like me. I went into a small town…and I never saw any black people for at least three months of my first three months in New Zealand. It was a scary experience (Participant 8).*

Participant 15's graph also shows the effects of "the maelstrom" of the first stage: "It was just chaotic. It was so chaotic. That's how it felt internally". To some extent, these two participants reflected that the decline was due to their experiences of being different. Earlier personal challenges that impacted on these participants' sense of self professionally went unspoken. For Participant 15, who discussed "feeling like a square peg in a round hole" and

"deskilled" in the first stage, the decline in her narrative trajectory was also linked to her sense of difference to others:

> *And though I didn't speak about how sort of my struggle, because I think it was only retrospectively I realised that probably for about the first year I was quite depressed but not admitting it to myself (Participant 15).*

For the other two, decline in the narratives appeared to be associated with challenges of working professionally in a new clinical role with further responsibility (Participant 1), or a new position in the middle stage and a lack of confidence in self (Participant 3).

For Participant 1, the decline in the narrative trajectory could be attributed to gaining a more senior position as a younger psychologist in the team. It also seemed to reflect his sense of difference to his colleagues, which led to more challenges to working professionally and his experience of self as a professional. He described the second stage as "fraught with a lot of conflict and a lot of sense of difference", and he recalled his wife's observations of him as "being not quite paranoid but constantly under siege". He noted that during this period of decline he was "very, very insular" and held a "protected position of myself".

The recovery period was characterised by increased positive experiences, new learnings, and a stronger sense of self as professional. In the last stage, when the narratives reflected positive progression, participants discussed feeling more suited to the ways in which they were working therapeutically (Participant 15), an improvement in their professional development (Participant 1), or gaining confidence and having a change of environment (Participant 8).

Over time, Participant 8 experienced a recovery and began to gain confidence in her work. She felt less "timid" and her sense of self as professional improved as "feelings precipitated". By the most recent stage, with a change of city and a more culturally diverse work environment, she described being excited again:

Exciting for me and I think …it feels like that was the reason I came to New Zealand, just to increase my repertoire of cultural diversity working with different cultures, learning a bit more about that…(Participant 8).

The narratives of these participants demonstrated that over time, a change in work circumstances, increased confidence in themselves in the new cultural context, and the theme of "reclaiming" identities led to recovery and positive progression. For instance, Participant 3 described the initial challenges and then the recovery period:

The initial four months, I had arrived in the middle of winter...I was trying to get my registration sorted. It was like a culture shock. I was depressed and all of that. …Then from there…I really struggled for a good year I think I was like why am I in this job, but gradually I have kind of become more comfortable in the team and I am coping much better there now with both the team and the clients and everything…(Participant 3).

As noted in Chapter 3, Participant 15 also described an increase in her own confidence and ability over time:

I think this last stage now is where I am starting to feel like I do actually have a professional identity where I suppose I feel like I am good at my job now (Participant 15).

In summary, for those whose narratives depicted decline and recovery, the declines appeared to be associated with personal sense of difference, challenges in working professionally with others, and a lack of confidence in themselves as professionals. These aspects appear to have recovered over time due to changes in work environment, working in ways that were more aligned with their sense of self as professional, and an increase in confidence. This is also demonstrated by the titles participants chose for stages and the plot analysis graphs (Table 3 and Appendix F).

Ongoing struggles. Two female participants' narratives were of ongoing challenges and difficulties. One had only been in Aotearoa New Zealand for 2 years at the time of the interview, so this could represent an initial stage in relation to other participants. It is likely that with time, this participant's narrative may show further positive development and progression. The other participant had worked in Aotearoa New Zealand for 11 years. Their

narrative trajectory was titled Ongoing Struggles. Both narratives described challenging initial experiences, which negatively impacted their sense of self as a professional and this effect remained steady throughout. Their stories during the interviews were primarily characterised by conflict with co-workers and the two participants' initial memories consisted of feeling a sense of injustice or "unfairness" about the responses of others. Both participants gave several examples of problematic encounters which then continued to affect their sense of self as professionals. For Participant 9, who had been here for 11 years, the process of registration as a general psychologist rather than a clinical psychologist as in her home country, and the impact of this on her professional identity had been an ongoing challenge. As noted in Chapter 3, her early stages were marked by struggles:

> *So because of not being registered, not being a clinical psychologist you are underpaid. So you are taken advantage of because you are working as a clinical psychologist but you are not a clinical psychologist and that was a big thing...At that point in time I thought I probably want to go somewhere else, change my job and get a better salary, but you can't. You are not a clinical psychologist (Participant 9).*

This initial experience and its lasting impact were associated with a narrative of continuous struggle:

> *The issue of the word registered and clinical psychologist has been my most down part of it. Meeting somebody who says I am clinical and not being a clinical psychologist or feeling that the person is paid more than you when you are doing the same kind of job, that has been my glitch in my life in New Zealand, but there is nothing I can do about it. So just accept and move on. That's why I want to talk about it (Participant 9).*

The other participant had only been in Aotearoa New Zealand for just over two years, hence her continuous struggle narrative may progress and develop positively in the future. At the time of the interview, her narrative was similar to those of the other therapists in their initial stages. Her experience was characterised by ongoing conflict with colleagues, which at times negatively impacted her sense of self as professional. She recalled her early motivation to change the system she worked in during the first stage and utilise her overseas experience, but was met with barriers:

So that sense of someone new coming in and trying to do things differently is not so kind of well received in that sense of don't come here and tell us what to do (Participant 5).

This led her to push further in the later stages of her experience. Towards the end of her narrative, she described using her supports to manage her frustration of not feeling valued professionally.

Steady and gradual progress. Six participants' (five female) narrative trajectories were of gradual development and progression. They had been working between three and a half years to 10 years in New Zealand. Participants described working professionally with some initial challenges that appeared to impact negatively on them, however their experiences appeared to gradually improve over time. This narrative trajectory was titled Steady and Gradual Progress.

Initial challenges related to the registration process, experiencing a lack of support or supervision, a sense of difference, adapting to new models and frameworks, and/or working in an unfamiliar environment. With no supervisor and being trained overseas as the only psychologist, the initial phase for one participant was very challenging: "I had to literally step into an environment that had functioned without a psychologist" (Participant 6). He reflected: "I had no psychologist to supervise me, to orientate me, to guide me and that initially was not a nice part of my initial journey."

Whilst participants in this group also described several positive experiences of working professionally over time, in contrast to the positive narrative type, their initial stages were marked by more challenges. For instance, one participant described below her early experiences of feeling different and later gave a more positive account of her sense of self as professional once her confidence grew: "I think it was all a bit of a challenge in the first stage because I was very mindful of being different I suppose" (Participant 2).

As these narratives continued, participants spoke of gradually adapting to the new environment, or an improvement in the quality of work relationships and their sense of self as

professional having renewed confidence in themselves. Participants spoke of a feeling of "ease", being "more relaxed" and more "familiar" with work (Participant 11), or feeling more "secure with self" and settled" (Participant 2) by this stage.

Over time and with ongoing learning, Participant 6 developed a positive sense of self as professional: "I got an external supervisor … and I started to find my way" (Participant 6). Participants spoke of a lack of confidence in themselves initially, but over time they developed more confidence in their overall experience of working professionally and therapeutically. For instance, Participant 10, who had been in Aotearoa New Zealand for eight years, described the changes that occurred in bringing more of herself into therapy:

> *It's interesting, it feels as if when I first immigrated as a psychologist, I was mostly in my head, thinking about theories, skills, formulation, techniques, but I wasn't really bringing me into the room because I wasn't sure. I think I had confidence that's how people felt about an immigrant…And slowly over time I think I just talked myself back into therapy. And so once I started doing that of course there was lots of common ground just being human (Participant 10).*

For another participant, the learning experiences and initial challenges were ultimately positive and shaped her subsequent progressive trajectory. By the most recent stage she felt she was utilising the knowledge learned in her work, and that the initial supportive environment had positively contributed to her sense of self as a professional over time. She noted it "was incredibly positive to come into a psychological role in Aotearoa New Zealand and work in a kaupapa Māori (Māori service) first off" (Participant 14). Despite the challenges of navigating this new environment, learning and feeling "comfortable" applying the work, the experience and "immersion" in the initial stages "afforded me insights that I wouldn't have had". She described taking on the learning "in an organic way that you can't get from a textbook", and the process as a "holistic way of working" (Participant 14). These aspects largely shaped her gradual sense of progression.

Despite some minor initial setbacks in the first stages, such as experiencing a sense of difference, lack of confidence in self or lack of resources such as supervision, over time

participants with this narrative gradually gained more confidence, increased support systems, were able to utilise their knowledge, and learned to develop their sense of self professionally and bring this sense of self into their therapeutic work.

Summary

Four narrative types were identified and titled Positive and Stable, Decline and Recovery, Ongoing Struggles, and Steady and Gradual Progress. This analysis provides further insight into the experiences that can impact immigrant therapists and any developments over time. The results suggest the significance of the potential impact of the registration process, and the importance of professional support.

The next chapter presents the discussion of results from the two narrative analyses with reference to relevant literature. It also discusses the implications of the study for clinical practice, supervision, support and training for immigrant therapists, along with the limitations of the research and future research directions.

Chapter 5: Discussion

This study aimed to understand the cultural differences therapists experience when working professionally and therapeutically in Aoteorea New Zealand compared to their country of origin. The study examined the experience of being an immigrant therapist, the impact on sense of self as a professional, and changes in therapists' experiences over time. It also aimed to understand the impact of being an immigrant therapist on working therapeutically and on the therapeutic relationship. This chapter examines the results of this thesis study in light of the relevant research and clinical literature, and considers the implications of the study, its limitations, and directions for future research.

Immigrant Therapists' Experiences and Perceptions of Cultural Differences

Despite the variation in their experiences, most therapists described encountering some cultural differences whilst working in Aotearoa New Zealand compared to their country of origin. Many therapists discussed cultural differences experienced in the early stages, such as adapting to different processes and approaches in their workplaces. Some therapists spoke about a perceived sense of difference from others, whilst others talked about experiences of discrimination. Several therapists commented on the similarities and differences between cross-cultural encounters in Aotearoa New Zealand compared to their home countries.

Different models, processes, and systems. As seen in the literature on the processes of acculturation (Berry, 2017), several therapists commented on their initial experiences of cultural differences, describing feelings of "shock", "frustration", and "worry" that often related to cultural "integration" and "adaptation" to the work environment. When talking about the models of therapy used in Aotearoa New Zealand, therapists reported they felt more inclined towards their own cultural and professional practices, as well as a "separation"

(Berry, 2017) from their original ways of working as they parted with or let go of their therapeutic approaches. Experiences of acculturation in this early stage appeared to impact on some therapists' sense of self as a professional as they mourned losses and integrated with the new work culture, such as by adopting the CBT model of therapy. This was also relevant to learning new ways of working, such as case management and bicultural training.

Ward's (2001) theoretical framework on the affective, behavioural and cognitive (ABC) aspects of adaptation and shock summarises the different aspects of acculturation. In this thesis study, as in Ward's framework, affective experiences of acculturation included therapists' feelings of loss and mourning of the old and familiar ways of being a therapist, as well as adaptions to different and unfamiliar cultural work environments. Many therapists discussed in hindsight whether their work setting played a part in adapting to the differences and new processes. During this initial period, several migrant therapists spoke of feeling "de-skilled" in their new work environment whilst learning new ways of working.

As highlighted previously by Berry (2001) and Ward (2001), many of the therapists described behavioural shifts in their actions as a result of acculturation and the cultural differences they experienced. This included the processes of "cultural shedding", in terms of previous ways of working, and "cultural learning", whereby therapists discussed changing how they worked with clients, the models they used, and their greeting processes (Berry, 2001, p. 621).

Cognitive aspects of acculturation included therapists changing their perceptions and ways of processing stressors under the theme of connecting with other migrants and colleagues. Cognitive coping strategies occurred, such as migrant therapists reframing the way they approached and interacted with clients from different cultures and adopting different cultural values according to the New Zealand context.

Being different and being "other". In the initial period, many therapists discussed having an awareness of their own difference. This included having a different language or accent, different skin colour, or an awareness of a different way of working culturally. The experiences of difference and associated challenges appeared to impact some therapists' sense of self as a professional and they appeared to employ strategies of acculturation to provide a sense of continuity to their professional identity. This involved integrating new models of work into practice, assimilating to new processes and systems through learning, speaking about the cultural differences in supervision, or changing their work environment. Acculturation experiences also included connecting with other migrants or co-workers, with clients, and friendships outside of work.

Experiencing discrimination. Many therapists discussed being discriminated against or concerns about prejudice at different points in their work experience due to their different name, skin colour, their country's political history, or different culture. Consistent with the immigration literature, therapists who described incidents of discrimination in the earlier stages, or perceived greater cultural differences in work or in the registration process, described more challenges (Sam & Berry, 2010; Stening, 2002). This occurred for one therapist in particular, who felt marginalised and discriminated against during the registration process and subsequently lacked the desire to interact with New Zealand clinicians. As discussed in the literature on immigration, perceived discrimination played an important role in some therapists' processes of acculturation and subsequent adaptation. In the case above, the perceived discrimination may have contributed to the therapist adopting the separation strategy of acculturation (Sam & Berry, 2006), and subsequent affiliation with their own migrant clients and co-workers. No significant behavioural shifts were discussed by any of the therapists in order to avoid discrimination, as also highlighted in the literature (Sam & Berry, 2010). This may have been because other support systems in their environments were

in place, such as supervision or connections built outside of work.

In their web based study of clinicians, Kissil et al. (2013) found that level of perceived prejudice, rather than acculturation, was significantly linked to levels of clinical self-efficacy and highlighted the role of the host community's attitudes in immigrant therapists' experiences. Similarly, therapists in this study who described experiences of racism from their clients discussed subsequently feeling inadequate, angry, and less confident in themselves. This supports Kissil and colleagues' (2013) finding that the attitudes of clients towards migrant therapists to some extent impacted on some of their doubts and worries about their work. One therapist discussed an incident of perceived discrimination much later in her work experience, which left her feeling surprised and the experience "stayed" in her mind.

The Aotearoa New Zealand context. This thesis study reinforces previous discussion on cultural competence, for example Sue (2006), and the importance of therapists equipping themselves with knowledge of historical and sociopolitical problems relating to clients, taking into consideration transgenerational trauma and challenges of oppression that clients may be facing. Similarly, an understanding of cultural differences is important to better understanding diversity and Māori in Aotearoa New Zealand, as is an appreciation of the power dynamics within relationships and moving towards reducing imbalances in power due to oppression (Herbert, 2010). Some therapists discussed the biases they may have had when working therapeutically, and several reflected on their status as migrants, gender, ethnicity, and the power discrepancies within their relationship with others. For one, this included recognising their status as a "white guest" (Participant 10) in Aotearoa New Zealand. Other therapists discussed acknowledging the impact of colonisation and reflecting on history with sensitivity in cross-cultural encounters with Māori. The majority of therapists discussed having many cultural learning opportunities and agreed with the appropriateness of using

alternative models of practice to Western models of psychological wellbeing.

Some therapists described cultural differences related to working with Māori as challenging initially. They talked about feeling "terrified" and being worried about "getting it wrong" or not wanting to "offend" clients. For two participants, there was an initial "discomfort" during the process of whakapapa (Māori cultural practice of discussing genealogy in introductions; Bennett & Liu, 2018). They felt uncomfortable disclosing personal information during whakapapa, having been trained as therapists to not disclose personal information to clients. Another participant reported feeling disconnected with a client whose culture was different to their own. These reactions of immigrant therapists in Aotearoa New Zealand are similar to those described by Akyil (2011) in her clinical discussion of working cross-culturally.

These findings suggest that an individualistic and collectivistic dimension could be helpful to understanding therapists' awareness, as proposed by Akyil (2011), and may provide opportunities to discuss how various worldviews and cultural differences are brought to therapy. This in turn may then potentially lead to the recognition of different viewpoints, and consequently change client health outcomes during work with different cultures.

On the other hand, most therapists spoke positively about working cross-culturally with Māori and Pasifika and their affiliations with other cultural groups in Aotearoa New Zealand, including other migrants and community groups. When working with other cultures, many therapists felt a strong connection with minority groups in Aotearoa New Zealand such as Māori, due to similarities in cultural worldviews or sharing similarities such as the same skin colour or a history of colonisation. Most therapists commented on the benefits of working biculturally and saw this as a necessary aspect of their work. These findings reflect DeSouza's (2006) observation that working cross-culturally may not necessarily be an obstacle to working biculturally. The findings also suggest that from the therapists'

perspective, there may be some advantages to being foreign-born when working with Māori and other cultural groups in Aotearoa New Zealand. As noted in the literature, there are fewer Māori therapists in Aotearoa New Zealand and it is not always possible for services to be provided by Māori for Māori, which is why it is important for all therapists to consider the implications of the Treaty of Waitangi in therapeutic encounters (Bennett & Liu, 2018).

Although there were initial challenges, many therapists spoke of adapting to cultural differences in their workplaces quite easily over time. The findings indicate, as also noted in the literature, that the processing of cultural identity is more pronounced for migrants when coming into contact with a new culture, particularly in the early years (Berry & Sam, 2016). Furthermore, as discussed in previous research, the processing of professional and cultural identity appeared more pronounced for therapists whose culture was perceived as markedly different from the culture of Aotearoa New Zealand. As English was the first language of most of the therapists, and research has shown that a good level of language proficiency is linked to more interactions with the host country as well as a reduction in sociocultural instabilities (Ward & Masgoret, 2004), this may have contributed to the therapists' overall positive adaptations over time.

Changes in Overall Experiences and Sense of Self as Professional over Time.

This research examined changes in the overall experience of being an immigrant therapist and sense of self as professional over time. As found in the literature relating to individuals' experiences of immigration (Berry, 2001), there was substantial variation in the quality and developmental trajectories of migrant therapists' experiences. Most therapists' narratives (Positive and Stable, Decline and Recovery, Ongoing Struggles, and Gradual and Steady) suggest they were experiencing a more positive sense of self as professional by the time of the interviews, and in general the migrant therapists' experiences showed positive progress over time. Experiences identified as contributing to a positive sense of self as professional

included a supportive personal and professional environment in addition to new opportunities, experiences, and professional development.

Narrative types. Migrant therapists in the Decline and Recovery group recollected professional and personal experiences that led to a decline in their sense of self as professional during the middle stage. However, with time many therapists' sense of self as professional appeared to recover due to an improvement in their professional development, gaining confidence and having a change of environment in the last stage. Therapists in the Gradual and Steady narrative type often spoke of initial challenges in the early stages; however, their sense of self as professional gradually improved over time. The two therapists in the Ongoing Struggles narrative group discussed continuous challenges faced in their professional experiences, with both feeling frustrated despite their efforts. It appears that both therapists felt undervalued in their cultural context and de-skilled throughout, which impacted in an ongoing way on their sense of self as professional. However, only two therapists fell into this narrative type and one had been in Aotearoa New Zealand for just over two years. As noted in the literature, earlier acculturation experiences for immigrants can be more challenging, thus the findings might be different for this therapist at another point in time (Berry, 2017). In addition, it has been noted in the literature that acculturation strategies are neither outcomes nor static factors, and they can often change based on contextual factors (Berry, 2017). Several participants noted the importance of having support, which is discussed below as a contributing factor to their overall experience and development over time.

The importance of support. Similarly to Sluzki's (2008) clinical practice findings, several therapists discussed obstacles they encountered when changing their environment, and the disruption of their social networks was often experienced as a contributing challenge and stressor. Many therapists discussed their initial feelings of loss and spoke about the

importance of support to their wellbeing. The losses associated with therapists leaving their countries, coupled with challenges in building support networks in Aotearoa New Zealand, potentially caused some social isolation, health issues, and adjustment issues in the early stages, as noted by Sluzki (2008). In this research, as in the immigration literature, social support was often a major factor contributing to how therapists experienced acculturating to their new work environments (e.g., Berry, 2017), as well as their ensuing adaptation.

Positive developments. Despite some minor initial setbacks in the first stages, including experiencing a sense of difference, lack of confidence in self, or lack of resources such as supervision, over time most therapists gradually gained more confidence, They developed support systems, were able to utilise their knowledge, developed a stronger sense of themselves as professional and brought their sense of self into therapeutic work. This is in line with Marín and Gamba (1996) who proposed that healthy acculturation involves balancing and combining elements of the original culture and the host culture. For most therapists, over time integration of their home culture and new professional culture facilitated some continuity in their sense of self as professional, despite the various changes that occurred in their surroundings. Similarly, in their discussion on the renegotiation of identity, Sam and Berry (2010) describe it as an on-going process for an immigrant experiencing acculturation and adaptation, with the restructuring of identity likely to develop and change over time.

The results are also similar to Akhtar's (2010) descriptions of the psychological outcomes of immigration. With regard to clinical guidelines, Akhtar argues that during the process of immigration, a restructuring of identity can threaten the strength of an individual's internal structure but also provide an opportunity for development. The progressive and positive narratives illustrate the processes therapists discussed for building a new concept of familiarity and consistency in Aotearoa New Zealand. For instance, therapists who spoke of

positive experiences throughout, discussed ongoing connections, learning, and support from others in their workplaces. The literature on this topic (e.g., Akhtar, 2010; Berry et al., 2006; Sam & Berry, 2010) is further supported by the finding that therapists with negative encounters of perceived discrimination and cultural shock struggled with their sense of self as professional at times. In this study, the Ongoing Struggles narrative and regressive accounts include reports on the negative impact of the loss and mourning of old ways on therapists' sense of certainty and self as professional.

By the second stage, many therapists spoke of a sense of "growth" in their professional work, a "realignment with their identity", and "bringing back" their own ways of working in therapy. Major changes to therapists' environments such as changes at work, described as "mini immigrations" (Participant 10), seemed to be mirrored by experiences of disruption in the therapists' sense of self as professional, as discussed in previous literature on cultural identity (Garza-Guerrero, 1974). This may have contributed to challenges experienced with new processes and learning, and the subsequent adoption of the acculturation strategies of integration or separation.

As Berry (2001) suggests with regard to the psychology of immigration, therapists who spoke of integration tended to speak of positive adaptations such as adopting and learning new ways of working with clients and colleagues. Most therapists appeared to have adopted the integration strategy of acculturation as they reflected on their migrant status, and the challenges and contributions of their migrant status to therapy. By the most recent stage, several therapists discussed having new opportunities to learn, develop professionally and advance in their careers. Some expressed a renewed sense of competence, confidence, and feeling more settled in their positions. Examples over time included integrating with other migrants, changing positions to work in a more "familiar" environment, and learning new ways of working such as incorporating whakapapa and Kaupapa Māori. These findings also

support previous research highlighting that over time, situational factors can change the process of acculturation and lead to different outcomes for therapists when considering their changing experiences (e.g., Berry, 2017).

Working Therapeutically and the Therapeutic Relationship

This study identifies a range of experiences from the therapists' perspective that may have supported or hindered their therapeutic work in Aotearoa New Zealand. The majority of therapists in this study discussed several positive experiences of working with diverse cultures and gaining cultural awareness in their workplaces. Many therapists expressed that in general they did not experience challenges to working therapeutically, and discussed the therapeutic relationship less in comparison to the professional challenges they faced. There were some minor obstacles that a few therapists observed and reflected on, however, overall, therapeutic encounters were often perceived as a positive aspect of therapists' work.

Therapists' experiences and observations of what supported therapeutic work. As mentioned earlier, some therapists reflected on the different ways they believed they were able to use their migrant status to improve their relationships with clients. Therapist observations about the perceived advantages of their migrant status included using their language difficulties to decrease power discrepancies in the therapeutic relationship and discuss difference. Some therapists spoke of using their "otherness", such as being displaced, not having an extended family, or being "black", "brown" or part of a minority group, as a facilitator in relationships with their clients. Many therapists adopted strategies to strengthen their relationships, such as introducing their culture and language to build rapport and taking on a naïve inquirer stance in order to express empathy and curiosity about their client's world. This finding supports previous research, such as Kissil and colleagues' (2013) study which suggests the ability to be genuinely curious is an advantage for immigrant therapists.

Therapists' views that their migrant status, sensitivity, and curiosity facilitated positive development in the therapeutic relationships confirm the findings of other research which highlights that similarities in ethnicity are not a prerequisite for cultural empathy. As found in Niño and colleagues' (2016) study of immigrant therapists, rather than matching client-therapist backgrounds having a positive association with the quality of the therapeutic relationship and therapy outcomes, it is the therapist's empathy and warmth, their competence and cultural sensitivity, in addition to similar values between therapist and client that are more strongly related to perceived improvements in the therapeutic relationship. In this study, as in previous clinical discussions (e.g., Sue & Sue, 2013), culturally sensitive responses and approaches were seen as important, thus highlighting the necessity of learning cultural empathy to enhance cross-cultural work. One of the strongest themes associated with positive experiences of working therapeutically was therapists' reports of connection with their clients. This supports previous clinical and research findings (Norcross & Wampold, 2011) that building a strong therapeutic connection and engagement are essential for optimal cross-cultural therapy. The results also add to prior research illustrating that despite migrant therapists having different backgrounds to their clients, they are able to transform their cultural differences into assets when working therapeutically (Niño et al., 2016).

In line with clinical guidance (e.g., Akyil, 2011) and research (e.g., Chung & Bernak, 2002), the therapists in this study believed it is important to understand and respect clients' cultures, such as their collectivist worldview, and accept contextual aspects including the families and communities of clients from different cultures. Some therapists spoke of therapeutic gains and connecting with their clients whose culture resonated with their own worldview. Others spoke of drawing on their own personal experiences as seemingly helpful in their therapeutic work. The findings support previous discussion on the topic (Chung & Bernak, 2002) which notes that effective cross-cultural work involves the therapist having

knowledge of different conceptualisations of health according to clients' cultural views, and an understanding of the different values they themselves and clients may have.

Perceived obstacles to working therapeutically. Another aspect that emerged from the analyses were the perceived minor obstacles a few therapists faced as migrants, and how at times (particularly initially) they felt they needed to work harder to strengthen the therapeutic relationship with their clients. Some therapists mentioned adapting to the "kiwi culture" rather than wanting to impose their own culture, which is in line with Akyil's (2011) reflections as a migrant therapist. Akyil discussed her initial doubts about imposing her own culture as she saw this as potentially damaging or unhelpful. The finding that some therapists perceived they had to work harder initially is consistent with Gelso and Mohr's (2001) observation that when individuals in dyads are different (particularly in terms of race and sexual orientation), this can impact the working alliance which may then require more effort to cultivate. This is particularly relevant when the therapist in the dyad is from a minority group and the client belongs to a dominant cultural group, resulting in cultural transference.

None of the therapists talked about experiencing transference. However, the challenges some therapists experienced with client transference may have been linked to their outsider status and being perceived as less capable or markedly different from their client's perspective. For instance, one therapist discussed her experience of perceived racism when told by her client that her cultural group had taken all of housing in Aotearoa New Zealand. Similarly, other therapists described the assumptions clients held about their cultural background, such as assuming they were racist due to their country's historical past or because of their origins. These findings are in line with previous discussion of potential client factors such as stereotyping, racism, and prejudice towards foreign-born therapists (Akhtar, 2006; Mittal & Weiling, 2006). Several therapists commented that they may have doubted

themselves and experienced feelings of sadness or anger as a result of these experiences, as similarly discussed by Isaacson (2001).

It is also possible that some cultural countertransference was neglected by therapists, as Foster (1998) has suggested, which may have impacted on working therapeutically and although not verbalised, was perceived by their clients. A possible example of this is therapists who discussed their discomfort with self-disclosure during the practice of whakapapa, or different cultural practices to their country of origin, which may have been noted by clients. Therapists' own cultural biases may have shaped their viewpoints when working with clients of a different culture to their own. Some therapists, however, reflected on their own culture and biases as migrants, which supports research noting the importance of considering countertransference in therapist reflections and in supervision (Cartwright, 2011). Most therapists felt their initial challenges and experiences did not affect their therapeutic work and it is unknown whether they had conversations with their clients as to how they perceived the therapy. As previous research highlights the importance of requesting feedback to enhance the therapeutic alliance and therapeutic outcomes, this is an important consideration for clinical practice (Norcross & Wampold, 2011).

As the quality of the working alliance and relationship are seen as pivotal factors linked to health outcomes (Norcross & Wampold, 2011), gaining a better understanding of immigrant therapists' experiences when working therapeutically in Aotearoa New Zealand is likely to provide further insight into successful cross-cultural therapy. As migrant clinicians in the New Zealand context may have different worldviews from their clients, this could potentially lead to conflict, less exploration of client dynamics, ruptures in the therapeutic relationship, and early termination of therapy (Sue & Sue, 2013). It could be that the challenges faced by these therapists when working cross-culturally were similar to those observed by Foster (1998) and Gelso and Mohr (2001), who suggest cultural countertransference can be ignored,

not noticed, or even downplayed, leading to client dropout. It is possible that the absence of discussion on countertransference in the findings supports previous supposition that the neglect of cultural countertransference can have negative implications for working therapeutically. However, it is not possible to infer this from the data of this study and thus further research focused specifically on cross-cultural countertransference is necessary to explore this possibility in the New Zealand context.

In addition, over time and in the later stages, therapists discussed using their own cultural beliefs and personal information as tools in the therapeutic relationship. For instance, despite discomfort related to their original ways of working professionally, therapists were able to "culturally shed" (Berry, 2001, p. 621) their psychotherapeutic framework of non-disclosure and adopt the process of whakapapa (explaining genealogy). As they adjusted to their new setting and experienced an improvement in their sense of self as professional, they were also able to work in familiar ways, which may have had a perceived positive impact on their therapeutic work.

Furthermore, as seen in a previous study on migrant clinicians (Niño et al., 2016), despite initial challenges when working therapeutically, once relationships with clients were established, therapists' sense of "foreignness" became less important and secondary to their work experience. Further, some therapists reported a change in their perceptions of their status as being foreign. While they described feeling initially that their "foreignness" was an obstacle and wondering about their migrant status affecting therapeutic work, over time they reframed these anticipated problems (worries of language difficulties and not understanding the culture) and reported feeling more comfortable and effective as therapists.

Clinical Implications

This study adds to the research on the role of support as a significant contributing factor to successful acculturation, with implications for therapists working in Aotearoa New Zealand. In line with previous research (Berry, 2017; Sluzki, 2008), support was often a major factor contributing to how therapists experienced acculturating to their new work environment. The findings suggest possible support strategies for migrant therapists in Aotearoa New Zealand, such as mentoring processes or discussing the impact of immigration in supervision. Further support for migrant therapists could include regular professional supervision and peer support groups to discuss the impact of immigration to Aotearoa New Zealand on their sense of self as professional and their therapeutic work. Cultural support toward gaining further understanding of working biculturally, and discussion about worldviews, therapist cultural values, and cross-cultural countertransference, may provide further support in relation to challenging experiences migrant therapists encounter, particularly in the earlier stages of working in Aotearoa New Zealand. This study provides some suggestions to reduce the potential for client disengagement from therapy, as well as strengthen cross-cultural therapy. Firstly, it supports therapists addressing cultural differences and worldviews with clients in therapy. Secondly, it highlights the importance of discussing any challenges encountered in practice with co-workers and supervisors.

This thesis study also has implications for therapist training programmes and mental health workplaces. The findings of the study suggest the potential usefulness of educating future trainees in various models of practice, working cross-culturally, and diversity in therapy approaches. The importance of developing ways of working cross-culturally has also been raised by other clinicians and researchers (Bennet & Lui, 2018; Chung & Bernak, 2002; Niño et. al., 2016). In addition, this study raises awareness of the challenges and frustrations

many migrant therapists appear to experience when working in a predominately CBT-orientated workplace.

Some therapists noted in their concluding remarks that New Zealand universities can learn from other countries in adopting different modalities in their training programmes in addition to CBT, with more exposure to systemic understanding and attachment as a core part of training. Several therapists emphasised that New Zealand workplaces are CBT orientated and commented on the value of other available therapeutic approaches. The findings highlight the advantages of more varied training programmes teaching therapy approaches that prepare students for different ways of working therapeutically.

Lastly the study highlights potential implications for diversity training and more mindful understanding of the immigrant population in Aotearoa New Zealand. This could include support systems for migrant groups, as well as training in various therapeutic approaches in addition to Western models of working with clients to adapt to the changing population of Aotearoa New Zealand. Training could also include information on migrant therapists' perceptions of themselves as "other" and the impact this may have on therapy, as well as the impact immigration may have on staff in workplaces.

Limitations

This study offers a new and unique perspective on immigrant therapists' experiences of working in Aotearoa New Zealand. Although a range of therapists was sought to represent migrant therapists in Aotearoa New Zealand (e.g., by gender), the small sample of self-selected therapists were mainly female and the majority native speakers of English. As a result, the sample is not representative of migrants who may struggle with language, cultural, or socioeconomic differences. Further, because of the relatively small sample size, it cannot be assumed that these migrant therapists' views represent those of all migrant therapists. In

addition this thesis study was of therapists' views of working therapeutically and is not representative of client perspectives.

Several other migrant therapists expressed interest in the research, however they were not able to take part for various reasons. These included not meeting the criteria of working in Aotearoa New Zealand, such as not having lived in Aotearoa New Zealand for more than two years, or not being registered. Others decided they were no longer able to take part in the research. It is possible that limiting the sample to registered practitioners overly narrowed the research. During this study, I was informed there are a number of professional migrants who practise psychotherapy for instance who are not registered, and also several migrants who were psychologists or psychotherapists in their country of origin. It could be argued that this change in professional identity plays a large part of their experience as migrants in Aotearoa New Zealand. Therefore by excluding those not registered as practitioners, this study could potentially have missed important aspects of the migrant experience with regard to the regulation and registration of therapists. Further, other individuals may be working as counsellors or other types of mental health worker.

This study investigated migrant therapists' experiences of working professionally in Aotearoa New Zealand and examined the changes they experienced over time. Given that an individual's narrative of life experiences can change as time goes on (Lieblich et al., 1998), it is possible that interviewing therapists at different stages of their lives may have resulted in different narratives. Therapists' narratives may also have been influenced by the quality of their experience at the time of the interview. That is, if a therapist's experience of working professionally was currently positive, it may be likely that the therapist would focus more on the positive experiences, as opposed to therapists whose experiences were currently difficult, and vice versa. It is therefore possible that the current quality of their work and professional

relationships influenced the therapists' recollection of earlier encounters and therefore their narratives.

The therapists also varied in the amount of time they had worked in Aotearoa New Zealand, from between two years and thirteen years. Accordingly, the experiences and stages described are different for those who had been in Aotearoa New Zealand for less time. In addition, the findings were narrated and analysed in a linear manner, although it is possible for narratives to be circular in form and reflections on early stages can overlap with later or more recent experiences.

There is also the possibility of overgeneralising information in the findings when the number of experiences that may contribute to therapists' experience of working professionally are considered. However, in line with previous discussion (e.g., Kissil et al., 2013), the choice was made to study the experience of migration in relation to working professionally as the concept of being "not from here" is not currently discussed in research on ethnicity, race, and minorities. In addition, amongst the diverse experiences of immigrants, there are commonalities in the changes associated with living in another country when one has been raised in a different cultural environment.

Directions for Future Research

Qualitative and quantitative research both have an important role in helping clinicians and researchers understand immigration, cultural competence, and migrant clinicians' experiences of working professionally. Further qualitative studies are needed to build on the results of this study and previous research in order to broaden the focus on the experiences of migrant clinicians. Gathering qualitative and quantitative information from other countries and clinicians in Aotearoa New Zealand would deepen our understanding of these cross-cultural experiences. Gaining the perspective of other migrant clinicians would also help to broaden

understanding of what may help or hinder them in engaging in experiences that enhance client relations, and what may help to reduce adverse experiences.

Future studies examining mediating and moderating factors before and throughout acculturation, such as personal characteristics, age and gender, may provide further information on contributing factors in acculturative stress as females, older migrants, and those lacking social support are more likely to experience this stress (Berry, 2006, 2017). Further research in cross-cultural psychology that is longitudinal could potentially examine the psychological and cultural changes occurring over time during the processes of acculturation, and how these may impact on professionals' sense of self and ensuing methods of adaptation to the work environment.

As this thesis study investigated migrant therapists' experiences, it is important that future research in Aotearoa New Zealand investigates Māori, Pacific Island and other clients' cultural experiences of therapy with migrant therapists as their perspectives may differ to those of migrant clinicians. Future research in this area would likely add to the existing literature on appropriate ways of working cross-culturally and inform therapeutic practice in Aotearoa New Zealand toward positive therapy outcomes (Bennett & Liu, 2018). This would also add to the international research literature on cross-cultural dyads in therapy.

Qualitative studies using longitudinal designs would allow for the investigation of migrant and client experiences across time, assessing how time affects their perceptions of experiences. The findings from this study support the notion that cultural competence can improve the therapeutic relationship and be a key tool in repairing intercultural misunderstanding. Further research in this area should be undertaken to examine barriers to adopting cultural frameworks in migrant therapists' workplaces.

The findings raise suggestions for future research regarding the nature of narrative research. A common feature of narrative research, as Murray (2003) notes, is that participants

enjoy telling their stories. Several therapists in this study expressed enjoying the interview process and stated they were pleased to have the opportunity to reflect on and discuss their experiences as migrant clinicians, suggesting the importance for migrant clinicians of having opportunities to consider their migration as a contextual aspect of their professional work. It also indicates the potential value of discussing experiences in a supportive network, and the implications for their work and ultimately, client health outcomes.

Future research in the New Zealand context is also needed to develop and investigate the efficacy of training programmes utilising the information gained from this research, such as varying the approaches taught in different institutions. Finally, immigration research has shown that processes of acculturation that occur in the early stages can impact on individuals' sense of self and psychological wellbeing over time. Despite being trained to work cross-culturally, many migrant therapists in this study appeared to initially face challenges with their own adaptation to the new work environment. Given the findings of this study, future research that aims to investigate these areas would be useful.

Conclusion

The results from this study, along with previous research, emphasise the challenges and positive experiences of working as a migrant clinician. Challenges in the early stages include adapting to new models, approaches and processes, with positive cross-cultural encounters and professional development occurring over time. Therapists' sense of self as professional in this study varied in degree and developmental trajectory, however, over time, the majority of migrant therapists had positive experiences such as forming new connections, learning new ways of working, and having new opportunities. Most therapists also experienced a positive sense of self as professional in Aotearoa New Zealand. Some minor challenges were identified such as new changes that occurred and reflections of loss, however therapists identified several positive experiences that affected the quality of their work experience in

Aotearoa New Zealand. Many appreciated support from other migrants, co-workers, friends, and the learning opportunities in Aotearoa New Zealand. On the whole, they described the New Zealand work environment as a positive learning experience and felt a sense of professional development over time. Several participants described many cultural learning opportunities and professional development in their workplaces, as well as a renewed sense of confidence and growth as a therapist over time.

References

Akhtar, S. (2006). Technical challenges faced by the immigrant psychoanalyst. *The Psychoanalytic Quarterly, 75*, 21-43.

Akhtar, S. (2010). *Immigration and acculturation: Mourning, adaptation, and the next generation*. Jason Aronson.

Akyil, Y. (2011). Being a family therapist in the United States: Multicultural competency through the lenses of an immigrant therapist. *Journal of Family Psychotherapy, 22*, 157-171. doi:10.1080/08975353.2011.578047

American Psychiatric Association. (2015). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author. doi:10.1176/appi.books.9780890425596.323864

Babbie, E. (2008). *The basics of social research* (4th ed.). Belmont, CA: Thomson Wadsworth.

Basker, E. and Dominguez, V. R. (1984). Limits of cultural awareness: The immigrant as therapist. *Human Relations*, 37, 693–719.

Beautrais, A. L., & Fergusson, D. M. (2006). Indigenous suicide in New Zealand. *Archives of Suicide Research, 10*, 159-168.

Bemak, F., Chung, R. C., & Pedersen, P. (2003). *Counseling refugees: A psychosocial approach to innovative multicultural interventions*. Westport, CT: Greenwood Press.

Bennett, S. T., & Liu, J. H. (2018). Historical trajectories for reclaiming an indigenous identity in mental health interventions for Aotearoa/New Zealand – Māori values, biculturalism, and multiculturalism. *International Journal of Intercultural Relations, 62*, 93-102.

Berry, J. W. (2001). A psychology of immigration. *Journal of Social Issues, 57*, 615-631.

Berry, J. W. (2017). Theories and models of acculturation. In S. J. Schwartz & J. B. Unger (Eds.), Oxford library of psychology. The Oxford handbook of acculturation and health (pp. 15-28). New York, NY, US: Oxford University Press.

Berry, J. W., Phinney, J., Sam, D. L., & Vedder, P. (Eds.). (2006). *Immigrant youth in cultural transition: Acculturation, identity and adaptation across national contexts*. Mahwah, NJ: Erlbaum.

Berry, J. W., & Sam, D. L. (2016). Conceptual approaches to acculturation. In. D. L. Sam & J. W. Berry (Eds.), *Cambridge handbook of acculturation psychology* (pp. 11–29). Cambridge, UK: Cambridge University Press.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O., II. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*, 293-302.

Bhawuk, D. P., Landis, D., & Lo, K. D. (2006). Intercultural training. In D. L. Sam, & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 504-524). Cambridge, UK: Cambridge University Press.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Boyd-Franklin, N. (2013). *Black families in therapy: Understanding the African American experience* (2nd ed.). New York, NY: Guilford Publications.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology *Qualitative Researh in Psychology, 3*, 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London, UK: Sage.

Cartwright, C. (2011). Transference, countertransference, and reflective practice in cognitive therapy. *Clinical Psychologist, 15*, 112-120. doi:10.1111/j.1742-9552.2011.00030.x

Chung, R. C., & Bemak, F. (2002). The relationship of culture and empathy in cross-cultural counseling. *Journal of Counseling & Development, 80*, 154-159.

Crossley, M. L. (2000). *Introducing narrative psychology*. Buckingham, UK: Open University Press.

Deaux, K. (2006). *To be an immigrant*. New York, NY: Russell Sage Foundation.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *The handbook of qualitative research*. Thousand Oaks, CA: Sage.

DeSouza, R. (2006). Sailing in a new direction: Multicultural mental health in New Zealand. *Australian e-Journal for the Advancement of Mental Health, 5*, 155-165. doi:10.5172/jamh.5.2.155

Durie, M. (1994). Māori perspectives on health and illness. In J. Spicer, A. Trlin, & J. L. Walton (Eds.), *Social Dimensions of Health and Disease: New Zealand Perspectives* (pp. 194-203) Palmerston North, New Zealand: Dunmore Press.

Durie, M. (2001). *Mauri ora: The dynamics of Māori health*. Auckland, New Zealand: Oxford University Press.

Ehrensaft, E., & Tousignant, M. (2006). Immigration and resilience. In D. L. Sam & S. W. Berry (Eds.), *The Cambridge handbook of acculturation psychology* (pp. 469-483) Cambridge, UK: Cambridge University Press.

Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Māori population. *American Journal of Public Health, 96*, 612-617.

Foster, R. P. (1998). The clinician's cultural countertransference: The psychodynamics of culturally competent practice. *Clinical Social Work Journal, 26*, 253-270.

Gabbard, G. (2004). *Long-term psychodynamic psychotherapy: A basic text*. Arlington, VA: American Psychiatric Association.

Gardner, J., & Tang, N. M. (2014). Interpretation of race in the transference: Perspectives of similarity and difference in the patient/therapist dyad. *In Race, Culture and Psychotherapy* (pp. 107-117). Routledge.

Garza-Guerrero, A. C. (1974). Culture shock: Its mourning and the vicissitudes of identity. *Journal of the American Psychoanalytic Association, 22*, 408-429. doi:10.1177/000306517402200213

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

Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy Research, 24*, 117-131. doi:10.1080/10503307.2013.845920

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 296-306. doi:10.1037/0022-0167.41.3.296

Gelso, C. J., & Mohr, J. J. (2001). The working alliance and the transference/countertransference relationship: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists. Applied and Preventive Psychology, 10, 51-68.

Gergen, K. J., & Gergen, M. M. (1986). Narrative form and the construction of psychological science. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 22-44). New York, NY: Praeger.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy, 48*, 88-97.

Herbert, A. M. (2002). Bicultural partnerships in clinical training and practice in Aotearoa/New Zealand. *New Zealand Journal of Psychology, 31*, 110-116.

Herbert, A. M. (2010). Treaty framework for a sustainable future for psychology: Cultural competencies in context. *Psychology Aotearoa*, *2*, 106-111.

Immigration New Zealand. (2016). *New Zealand Residence Programme policy changes*. Retrieved from https://www.immigration.govt.nz/about-us/media-centre/news-notifications/new-zealand-residence-programme-changes

Isaacson, E. (2001). *The effect of evolving cultural identities on the experience of immigrant psychotherapists*. (Unpublished doctoral dissertation). Massachusetts School of Professional Psychology, Boston, MA.

Jasinskaja-Lahti, I., Liebkind, K., Jaakkola, M., & Reuter, A. (2006). Perceived discrimination, social support networks, and psychological well-being among three immigrant groups. *Journal of Cross-Cultural Psychology, 37*, 293-311.

Johnson, L. A., & Caldwell, B. E. (2011). Race, gender, and therapist confidence: Effects on satisfaction with the therapeutic relationship in MFT. The American Journal of Family Therapy, 39, 307-324.

Johnstone, K., & Read, J. (2000). Psychiatrists? Recommendations for improving bicultural training and Māori mental health services: a New Zealand survey. *Australian and New Zealand Journal of Psychiatry*, *34*, 135-145. doi:10.1046/j.1440-1614.2000.00683.x

Kissil, K., Davey, M., & Davey, A. (2012). Therapists in a foreign land: Acculturation, language proficiency and counseling self-efficacy among foreign-born therapists practicing in the United States. *International Journal for the Advancement of Counselling*, *35*, 216-233.

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

Koch, T. (2006). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing, 53,* 91-100. doi:10.1111/j.1365-2648.2006.03681.x

Kosic, A. (2006). Personality and individual factors in acculturation. In D. L. Sam & J. W. Berry (Ed.), *The Cambridge handbook of acculturation psychology* (pp. 113-128). Cambridge, UK: Cambridge University Press.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38,* 357-361.

Lee, E. (2011). Clinical significance of cross-cultural competencies (CCC) in social work practice. *Journal of Social Work Practice, 25,* 185-203. doi:10.1080/02650533.2011.573654

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. Thousand Oaks, CA: Sage.

Macfarlane, A., Blampied, N., & Macfarlane, S. (2011). Blending the clinical and the cultural: A framework for conducting formal psychological assessment in bicultural settings. New Zealand Journal of Psychology, 40, 5-15.

Marín, G., & Gamba, R. J. (1996). A new measurement of acculturation for Hispanics: The Bidimensional Acculturation Scale for Hispanics (BAS). *Hispanic Journal of Behavioral Sciences, 18,* 297-316. doi:10.1177/07399863960183002

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. Journal of consulting and clinical psychology, 68, 438.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York, NY: Guilford Press.

Merriam, S. B. (2002). Introduction to qualitative research. In S. B. Merriam & Associates (Eds.), *Qualitative research in practice: Examples for discussion and analysis* (pp. 1-17). San Francisco, CA: Jossey-Bass.

Ministry of Health. (2005). *Te Orau Ora – Pacific Mental Health Profile*. Wellington, New Zealand: Author.

Ministry of Health. (2010). *Tatau kahukura: Māori health chart book 2010* (2nd ed.). Wellington, New Zealand: Author.

Mittal, M., & Wieling, E. (2006). Training experiences of international doctoral students in marriage and family therapy. *Journal of Marital and Family Therapy, 32*, 369-383. doi:10.1111/j.1752-0606.2006.tb01613.x

Murray, M. (2003). Narrative psychology. In J. A. Smith, & J. Smith (Eds.), *Qualitative research: A practical guide to research methods* (pp. 111-132) London, UK: Sage.

Murray, M., & Ziegler, F. (2015). The narrative psychology of community health workers. *Journal of Health Psychology, 20*, 338-349. doi:10.1177/1359105314566615

Nauck, B. (2008). Acculturation. In F. J. Van de Vijver, D. A. van Hemert, & Y. H. Poortinga (Eds.), *Multilevel analysis of individuals and cultures* (pp. 379-410). Mahwah, NJ: Erlbaum.

New Zealand Psychologists Board. (2010). *The continuing competence programme for psychologists practising in Aotearoa, New Zealand: A guide for participants*. Wellington, New Zealand: Author.

New Zealand Psychologists Board. (2012). *Scopes of practice and qualifications: For psychologists registered in New Zealand under the HPCA Act 2003*. Wellington, New Zealand: Author.

New Zealand Psychotherapists Board of Aotearoa New Zealand. (2013). *Pathways to registration*. Retrieved fromhttp://www.pbanz.org.nz/index.php?PathwaystoRegistration.

Niño, A., Kissil, K., & Davey, M. P. (2016). Strategies used by foreign-born family therapists to connect across cultural differences: A thematic analysis. *Journal of Marital and Family Therapy, 42*, 123-138. doi:10.1111/jmft.12115

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*, 98.

Pavagada, R., & DeSouza, R. (2012). Culture and mental health care in New Zealand: Indigenous and non-indigenous people. In K. Bhui, & D. Bhugra (Eds.), *Culture and mental health* (pp. 245-260). London, UK: Hodder Arnold.

Pedersen, P. B., Crethar, H. C., & Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy*. Washington, DC: American Psychological Association.

Pernice, R., Trlin, A., Henderson, A., & North, N. (2000). Employment and mental health of three groups of immigrants to New Zealand. *New Zealand Journal of Psychology, 29*, 24.

Phinney, J. S. (2013). Ethnic identity exploration in emerging adulthood. In D. L. Browning (Ed.), *Adolescent identities* (pp. 65-84). New York, NY: Routledge.

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology, 36*, 118.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Newbury Park, CA: Sage.

Poulsen, S., Karuppaswamy, N., & Natrajan, R. (2005). Immigration as a dynamic experience: Personal narratives and clinical implications for family therapists. Contemporary Family Therapy, 27, 403-414.

Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods*. South Melbourne, Australia: Oxford University Press.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston, MA: Houghton Mifflin.

Rumbaut, R. G. (2004). Ages, life stages, and generational cohorts: Decomposing the immigrant first and second generations in the United States. *International Migration Review, 38*, 1160-1205. doi:0197-9183/04/3803.0147

Sam, D. L., & Berry, J. W. (Eds.). (2006). *The Cambridge handbook of acculturation psychology*. Cambridge, UK: Cambridge University Press.

Sam, D. L., & Berry, J. W. (2010). Acculturation: When Individuals and Groups of Different Cultural Backgrounds Meet. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science, 5*, 472-481. doi:10.1177/1745691610373075 [doi]

Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research, 22*, 1404-1413. Retrieved from https://journals.sagepub.com/doi/abs/10.1177/1049732312450368

Sluzki, C. E. (2008). Migration and the disruption of the social network. In M. McGoldrick, & K. V. Hardy (Eds.), *Re-visioning family therapy. Race, culture and gender in clinical practice* (pp. 39-47). New York, NY: Guildford Press.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 53-80). Los Angeles, CA: Sage

Sobrun-Maharaj, A., Tse, S., Hoque, E., & Rossen, F. (2008). Survey of key informants for a study of migrant and refugee youth settlement and social inclusion in New Zealand. Prepared for the Department of Labour. Centre for Asian Health Research and Evaluation, Auckland UniServices Limited, University of Auckland.

Sparks, J. A., & Duncan, B. L. (2010). Common factors in couple and family therapy: Must all have prizes? In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (pp. 257-391). Washington, DC: American Psychological Association.

Stats NZ. (2013). *2013 Census Quickstats about culture and identity. Ethnic groups in New Zealand*. Retrieved from http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/ethnic-groups-NZ.aspx

Stats NZ. (2017). *International travel and migration: July 2017 – Media release*. Retrieved from http://archive.stats.govt.nz/browse_for_stats/population/Migration/IntTravelAndMigration_MRJul17.aspx

Stening, B. W. (2002). Problems in cross-cultural contact: A literature review. *International Journal of Intercultural Relations, 3*, 269-313. doi:10.1016/0147-1767 (79)90016-6

Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology, 34*(2), 237-245. doi:10.1002/jcop.20095

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: John Wiley & Sons.

Te Puni Kokiri. (1993). *Nga Ia O Te Oranga Hinengaro Māori. Trends in Māori mental 22 health: A discussion document*. Wellington, New Zealand: Author.

Thorpe, M. R., & Thorpe, M. A. (2008). Immigrant psychotherapists and New Zealand clients: Forum. *The Journal of the New Zealand Association of Psychotherapists*, *14*, 30-45.

Trlin, A. (2012). "It's all so different here…": Initial employment and social engagement experiences of South Africans in New Zealand. *Asian and Pacific Migration Journal, 21*, 57-81.

van Manen, M. (1997). *Researching lived experience* (2nd ed.). Ontario, CA: Althouse Press.

Ward, C. (2001). *The A, B, Cs of acculturation*. In D. Matsumoto (Ed.), (pp. 411-445). Oxford, UK: Oxford University Press.

Ward, C., & Masgoret, A. (2004). *The experiences of international students in New Zealand.* (Report on the Results of a National Survey). Wellington, New Zealand: Ministry of Education.

Ward, C., & Masgoret, A. (2008). Attitudes toward immigrants, immigration, and multiculturalism in New Zealand: A social psychological analysis. *International Migration Review, 42*, 227-248.

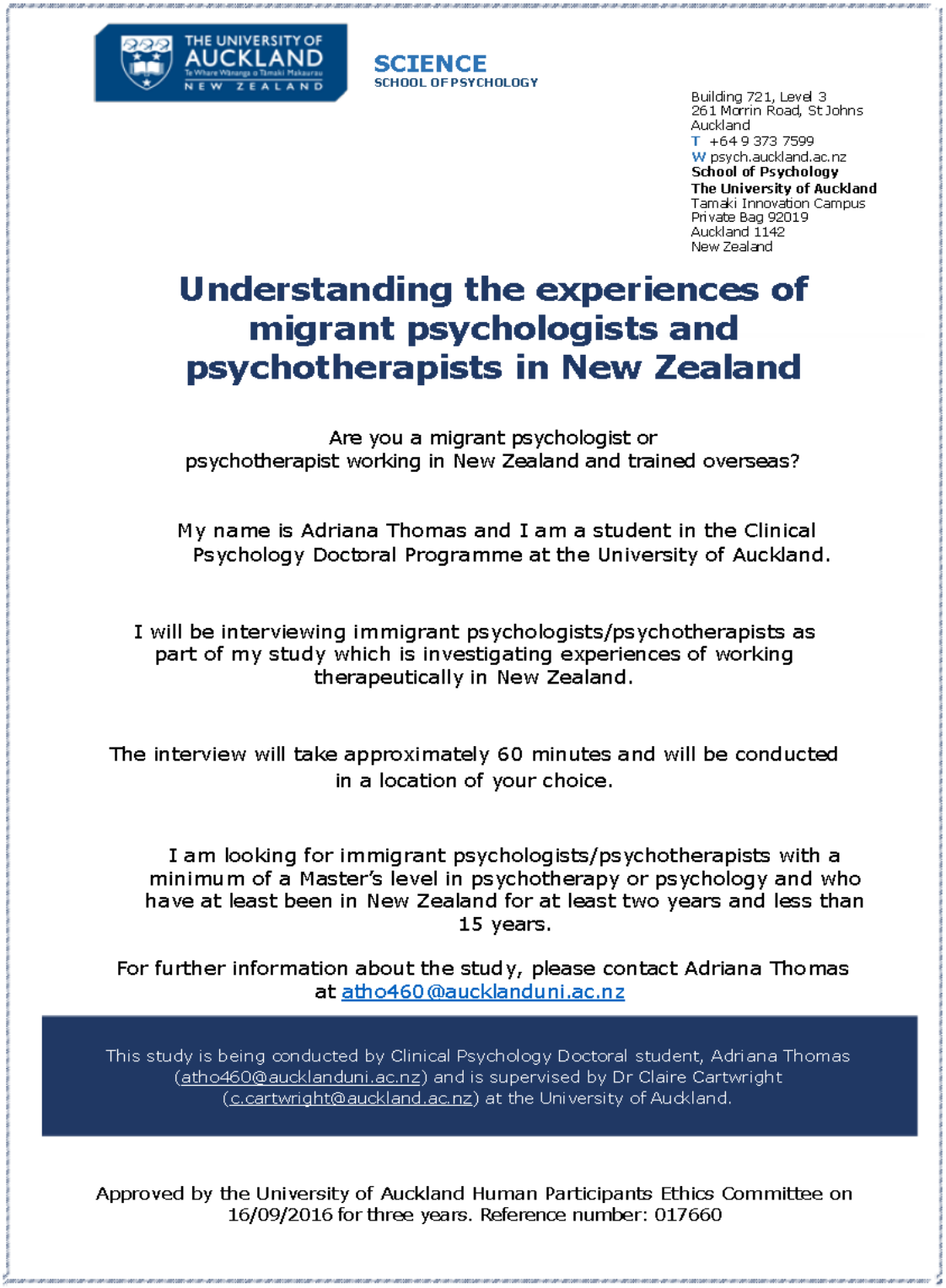
Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. London, UK: Sage

Yedidia, T. (2005). Immigrant therapists' unresolved identity problems and countertransference. *Clinical Social Work Journal, 33*, 159-171. doi:10.1007/s10615-005-3530-3

Zane, N., Hall, G. N., Sue, S., & Young, K. Nuñez (2004). Research on psychotherapy with culturally diverse populations. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavioral change* (pp. 767-804). New York, NY: John Wiley & Sons.

Appendices

Appendix A: Advertisement



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

SCIENCE
SCHOOL OF PSYCHOLOGY

Building 721, Level 3
261 Morrin Road, St Johns
Auckland
T +64 9 373 7599
W psych.auckland.ac.nz
School of Psychology
The University of Auckland
Tamaki Innovation Campus
Private Bag 92019
Auckland 1142
New Zealand

Understanding the experiences of migrant psychologists and psychotherapists in New Zealand

Are you a migrant psychologist or psychotherapist working in New Zealand and trained overseas?

My name is Adriana Thomas and I am a student in the Clinical Psychology Doctoral Programme at the University of Auckland.

I will be interviewing immigrant psychologists/psychotherapists as part of my study which is investigating experiences of working therapeutically in New Zealand.

The interview will take approximately 60 minutes and will be conducted in a location of your choice.

I am looking for immigrant psychologists/psychotherapists with a minimum of a Master's level in psychotherapy or psychology and who have at least been in New Zealand for at least two years and less than 15 years.

For further information about the study, please contact Adriana Thomas at atho460@aucklanduni.ac.nz

This study is being conducted by Clinical Psychology Doctoral student, Adriana Thomas (atho460@aucklanduni.ac.nz) and is supervised by Dr Claire Cartwright (c.cartwright@auckland.ac.nz) at the University of Auckland.

Approved by the University of Auckland Human Participants Ethics Committee on 16/09/2016 for three years. Reference number: 017660

Appendix B: Participant Information Sheet

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

SCHOOL OF PSYCHOLOGY
Faculty of Science
Tāmaki Innovation Campus
Level 3 Building 721
261 Morrin Road, St Johns
Auckland 1072, New Zealand
Telephone 64 9 373 7599
Facsimile 64 9 373 7902
The University of Auckland
Private Bag 92019
Auckland 1142, New Zealand

A Qualitative narrative study of Immigrant psychologists' experiences of working professionally in the cultural context of Aotearoa, New Zealand

PARTICIPANT INFORMATION SHEET

Researcher:
Adriana Thomas

Supervisors:
Dr Claire Cartwright
Dr Margaret Dudley

My name is Adriana Thomas and I am currently completing a doctorate in clinical psychology at the University of Auckland.

Immigrant Psychologists

This study focuses on understanding more about the experiences of immigrant psychologists when working therapeutically in New Zealand. This study is interested in understanding more about psychologists who have trained overseas and any challenges that immigrant psychologists face when working therapeutically in Aotearoa. Participants in the study will be immigrant psychologists or psychotherapists, who have lived in New Zealand for less than fifteen years.

We believe it is important to understand more about immigrant psychologists' experiences of working therapeutically in New Zealand. Previous research has focused on psychologists working therapeutically when the client is part of a minority group, however, there is a paucity of research which discusses the experience of the therapist as 'other' in the therapeutic dyad. Despite this, the number of foreign-born psychologists and psychotherapists in New Zealand and internationally continues to rise.

Invitation to Participate

You have been sent this Information Sheet as you have shown interest in the study. If you are a psychologist or psychotherapist with experience of working in New Zealand for less than 15 years and have trained overseas, we invite you to take part in this study, although you are under no pressure to do so. If you do take part you will be asked to complete an interview in a location of your choice or at the University of Auckland. Interviews will last approximately 60

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

SCHOOL OF PSYCHOLOGY
Faculty of Science
Tāmaki Innovation Campus
Level 3 Building 721
261 Morrin Road, St Johns
Auckland 1072, New Zealand
Telephone 64 9 373 7599
Facsimile 64 9 373 7902
The University of Auckland
Private Bag 92019
Auckland 1142, New Zealand

minutes. Fifteen to 20 psychologists will be interviewed. The consent form attached along with this information can be signed and returned to Adriana Thomas if you wish to participate (see contact details below). If this is not possible, you can sign the consent form on the day of the interview.

During the interview, you will be encouraged to talk about your experiences of working therapeutically in New Zealand in a bicultural and multicultural context. I am interested in your views on being an immigrant psychologist and if your experiences have changed over time. I am also interested in any experiences of cultural differences you may have encountered when working therapeutically in New Zealand compared to your country of origin or training; and what experiences supported or hindered therapeutic encounters here. If you discuss experiences of working with clients, care will be taken to make sure that no clients are named or identities revealed. The emphasis will be on your views of your experience of being an immigrant psychologist here, and in what circumstances that has played a role in working therapeutically.

Anonymity and Confidentiality

The interviews will be digitally recorded and transcribed by a professional transcriber who will sign a confidentiality agreement. Your name will not be used on the recording and your identity will be protected. Each recording will be assigned a number and the identity of the numbers will be stored in a separate location so that individual recordings cannot be identified. If you decide you wish to withdraw from the interview, you can do that. You can withdraw data up to a month after the interview. You will also be given the opportunity to read and edit transcripts if requested within a month of the interview.

Data Storage, Retention, Destruction and Future Use

If you do take part in the study, the recordings will be stored on a locked University of Auckland computer that is password protected, electronic data will be backed up and stored on the University of Auckland server and the transcripts will be stored in a locked cabinet at the University of Auckland by Adriana Thomas. The data and consent form will be kept for ten years for the purpose of publication. All data will then be destroyed when ten years has elapsed. The results from this study will be published in New Zealand and in International Research Journals. However, no individuals will be identifiable in any publications. If you take part in the study, you can request a report on the results of the study and this will be sent to the contact address that you provide. This data will be destroyed if you request it.

Appendix C: Consent Form

SCHOOL OF PSYCHOLOGY
Faculty of Science
Tāmaki Innovation Campus
Level 3 Building 721
261 Morrin Road
St Johns
Auckland 1072, New Zealand
Telephone 64 9 373 7599
Facsimile 64 9 373 7902

The University of Auckland
Private Bag 92019
Auckland 1142, New Zealand

A Qualitative narrative study of Immigrant psychologists' experiences of working professionally in the cultural context of Aotearoa, New Zealand

CONSENT FORM

THIS FORM WILL BE HELD FOR A PERIOD OF 10 YEARS

Researcher:
Adriana Thomas

Supervisors:
Dr Claire Cartwright
c.cartwright@auckland.ac.nz
Dr Margaret Dudley
m.dudley@auckland.ac.nz

- I have read the Participant Information Sheet and I have understood the nature of the research. I have had the opportunity to ask questions and have them answered to my satisfaction.
- I agree to take part in this research.
- I understand that my participation is voluntary and that I am free to withdraw at any time, and to withdraw any data traceable to me up to a month after the interview.
- I agree to be digitally recorded. I would like to receive a copy of the interview transcript and can choose to edit the transcript (this will be provided within one month of the interview date). Please select: Yes ◯ No ◯
- I understand that a third party who has signed a confidentiality agreement will transcribe the recordings.

SCHOOL OF PSYCHOLOGY
Faculty of Science
Tāmaki Innovation Campus
Level 3 Building 721
261 Morrin Road
St Johns
Auckland 1072, New Zealand
Telephone 64 9 373 7599
Facsimile 64 9 373 7902

The University of Auckland
Private Bag 92019
Auckland 1142, New Zealand

- I understand that data will be stored in a secure location and electronic data will be password protected, backed up and stored on the University of Auckland server by Adriana Thomas.

- I understand that all data will be kept for ten years for the purposes of publication, after which they will be destroyed.

- I understand that my identity will be treated confidentially and that my anonymity will be protected if the results from this study are published in New Zealand and in International Research Journals. If the information you provide is reported/published, this will be done in such a way that its source cannot be identified.

- **I wish to receive a summary of findings, which can be emailed to me at this email address:** _____.

Name _____

Contact address_____

_____

Signature _____ Date _____

Approved by the University of Auckland Human Participants Ethics Committee on 16/09/2016 for three years. Reference number: 017660

Appendix D: Interview Guide

Background

- How did you hear about the research?

- Confidentiality

Introduction

I'm interested in hearing about your impressions and experiences as an immigrant psychologist working in New Zealand, and how this might change and develop over time. This might include understanding the positive experiences and also any difficult experiences that you might have encountered

I have some questions to guide this, but as we go please feel free to talk about other areas that I haven't asked about. Also, throughout the interview I'll ask you to speak generally about your experience, however I'll also ask whether you can think of some specific examples of therapy and clients, without giving names, to illustrate what you're saying.

Demographics

First I would like to gather some background information such as your age now, and your nationality/ethnicity; your training; number of years practicing overseas and in New Zealand

Stages – Early, middle, latter

I would like you to divide your story into three stages. This can either be beginning, middle and now or you can identify definite turning points or changes in your experience as an immigrant psychologist in New Zealand which signify a new stage for you. Which years make up the early, middle and latter stages?

Stage 1 – Early years

Can you tell me about your memories of starting work as a psychologist in NZ and how that was for you? Start wherever you like and talk about what is important to you.

Prompts:

- How did you feel about working therapeutically?

-What positive experiences did you encounter? What challenges?

-Can you tell me about a specific client in therapy that you found challenging, being an immigrant psychologist? What was it like for you working within the psychology community/ or in teams (the challenges and the positive experiences)

Stage 2 – Middle years

- How did you feel about your experience as an immigrant psychologist during this time?

- How did you feel about working therapeutically?

- What positive experiences did you encounter? Any challenges?

- Can you tell me about a specific time you found challenging being an immigrant psychologist?

Stage 3 – Recent years

- How do you feel about being an immigrant psychologist in New Zealand now?

- Does that have any effect on your therapeutic work now?

Concluding questions

1. What do you think have been the main difficulties for you in working therapeutically in New Zealand?
2. What have been the best times/positive aspects of your therapeutic work here?
3. What were the most important ups and downs?
4. What has worked?
5. What has not? (Can delete these if answered previously)
6. Drawing on your experience what advice would you give to other immigrant psychologists working in New Zealand?
7. What advice would you give to training programmes in New Zealand?
8. What are your thoughts about working bi-culturally?

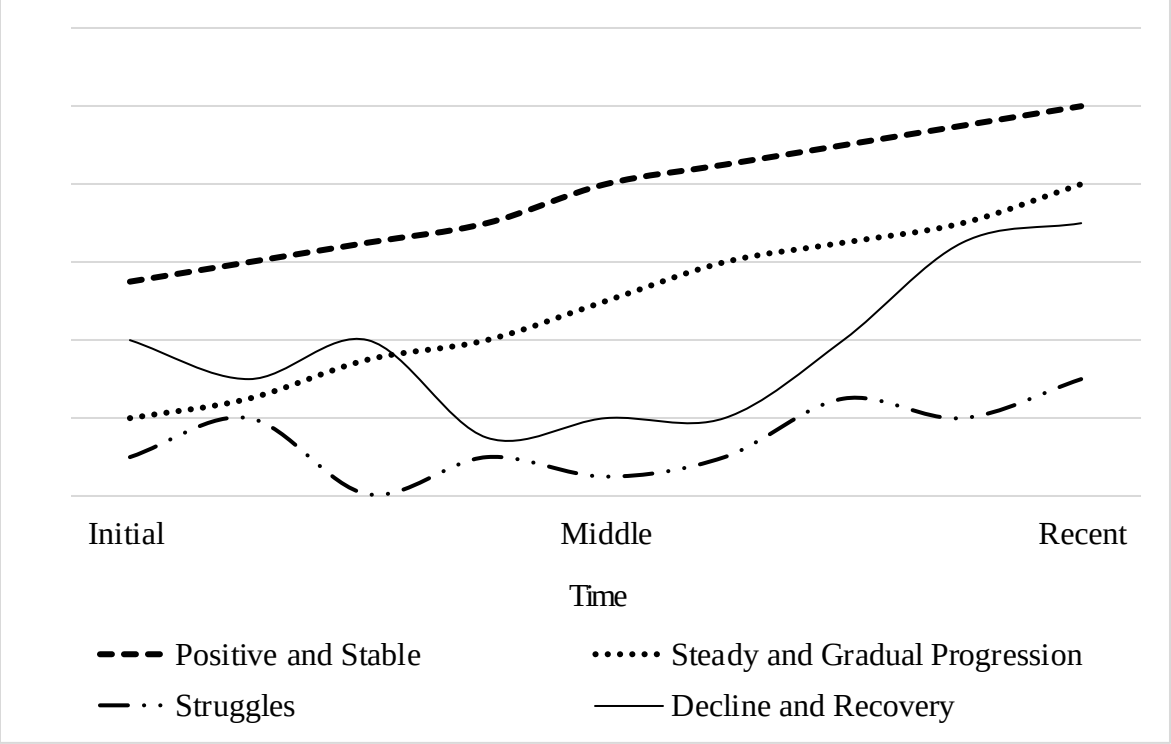
More Prompt Questions

- How were you feeling about yourself as a psychologist at this time? How did you make sense of that?

- Do you remember what was happening at this time?

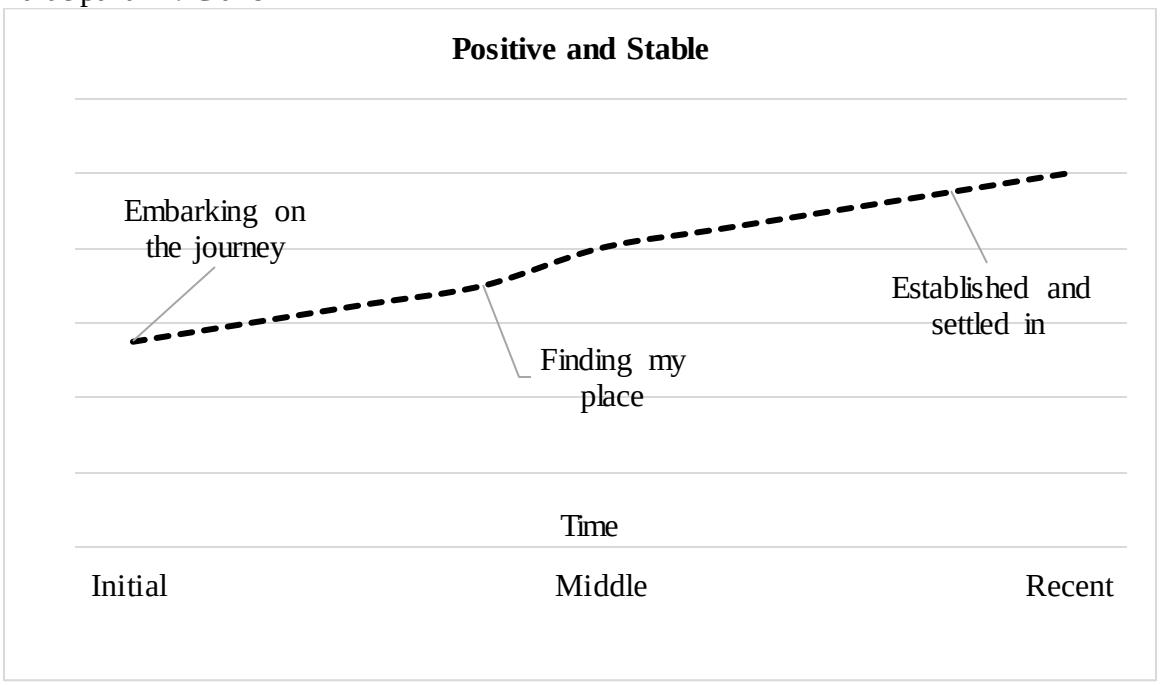
- What did you think about what was happening?

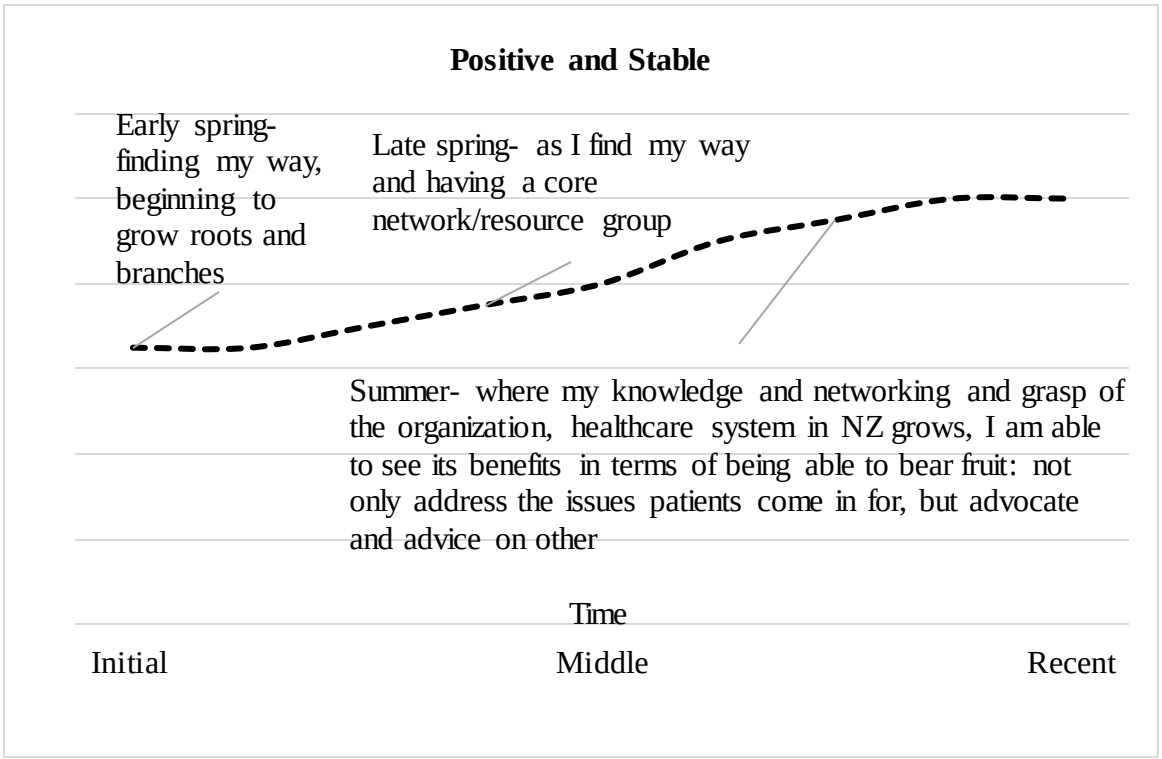
Appendix E: Graph – Narrative Types



Appendix F: Participant Graphs

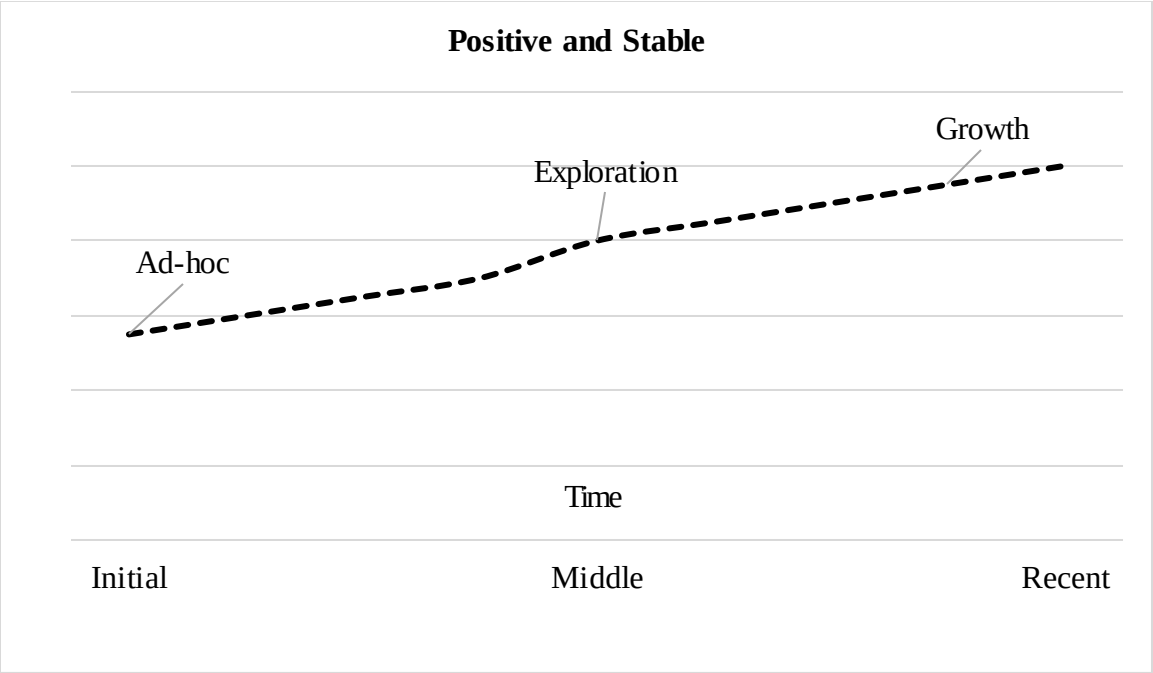
Participant 7 : Claire



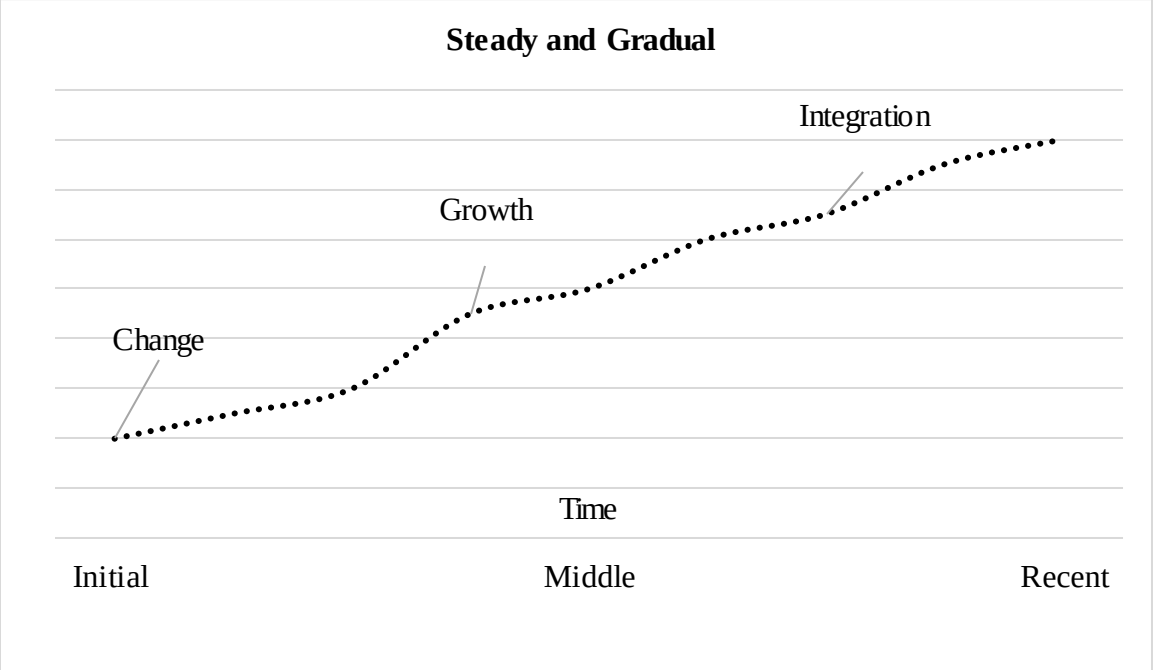


Participant 4: Celine

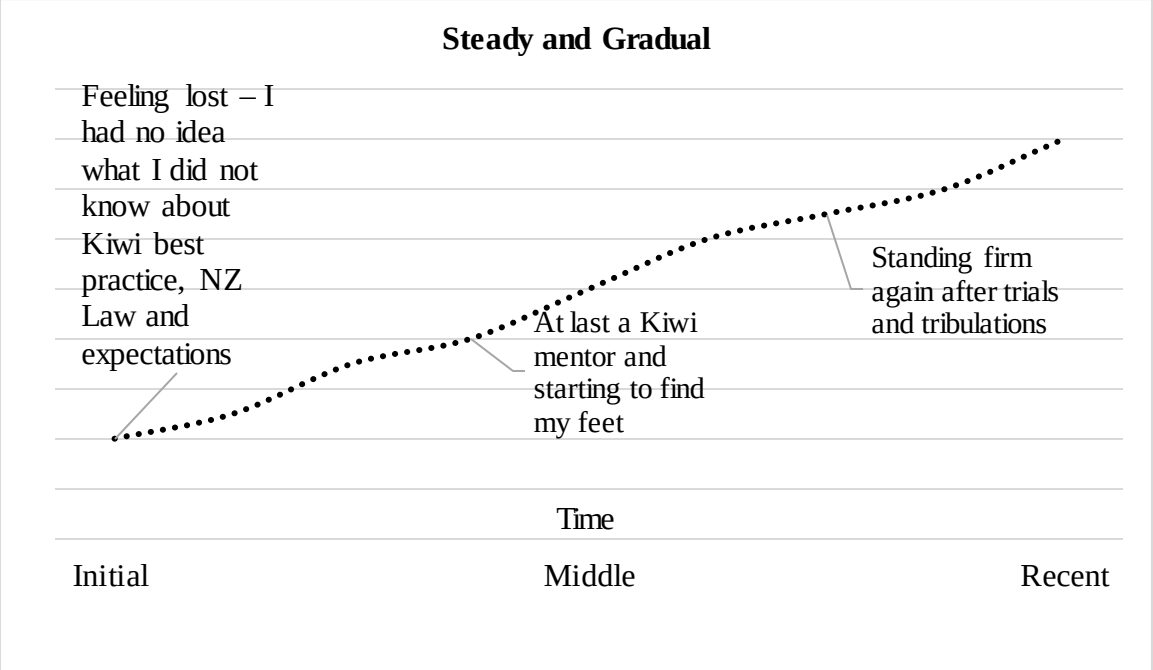
Participant 12: Maya



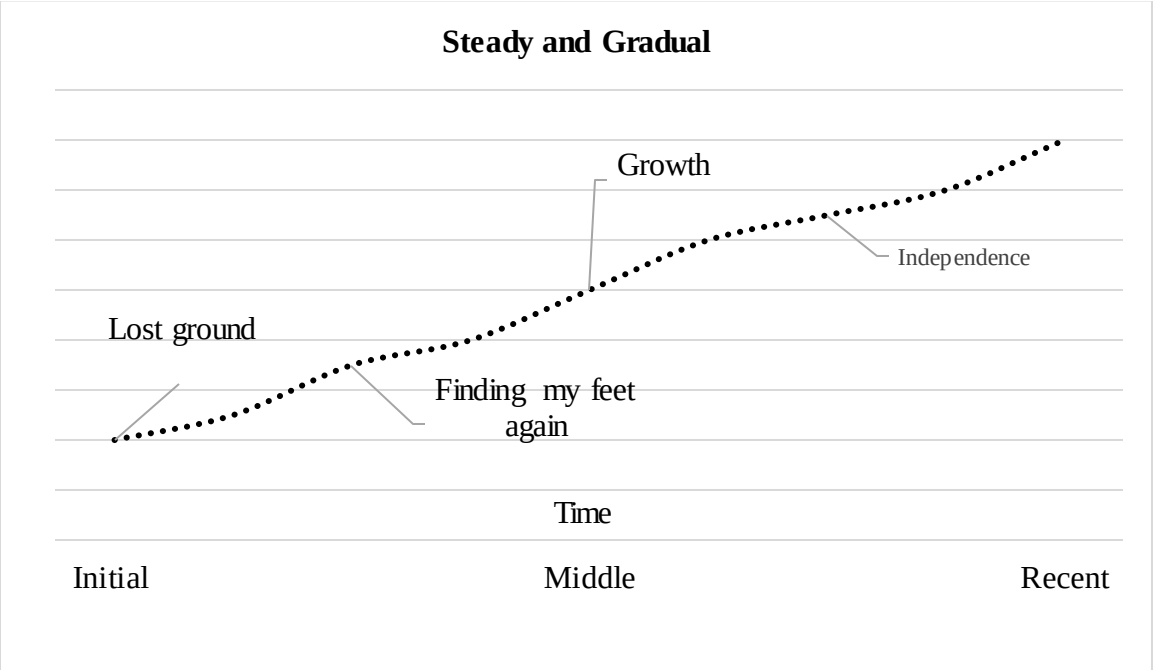
Participant 2: Jen



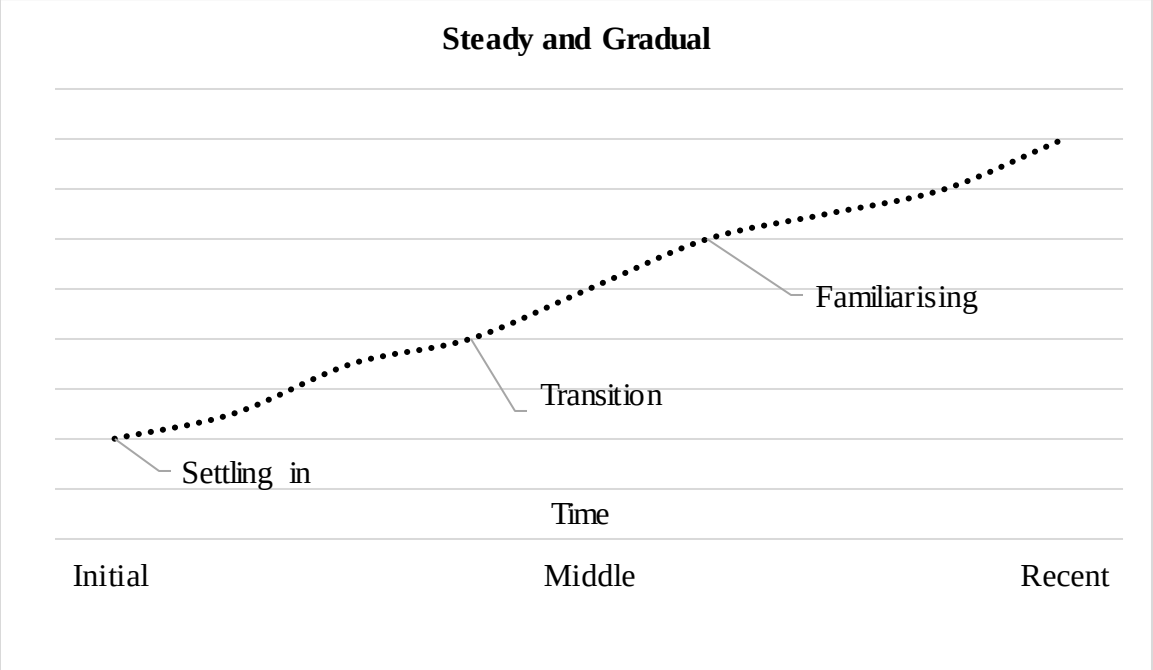
Participant 6: Ethan



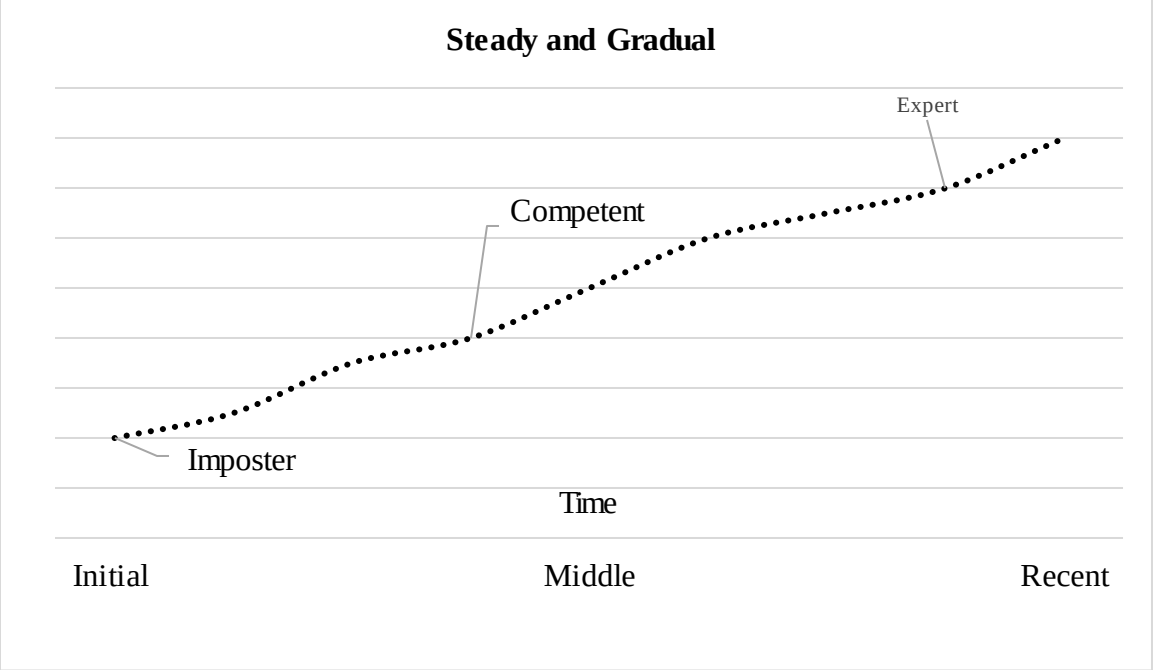
Participant 9: Christine



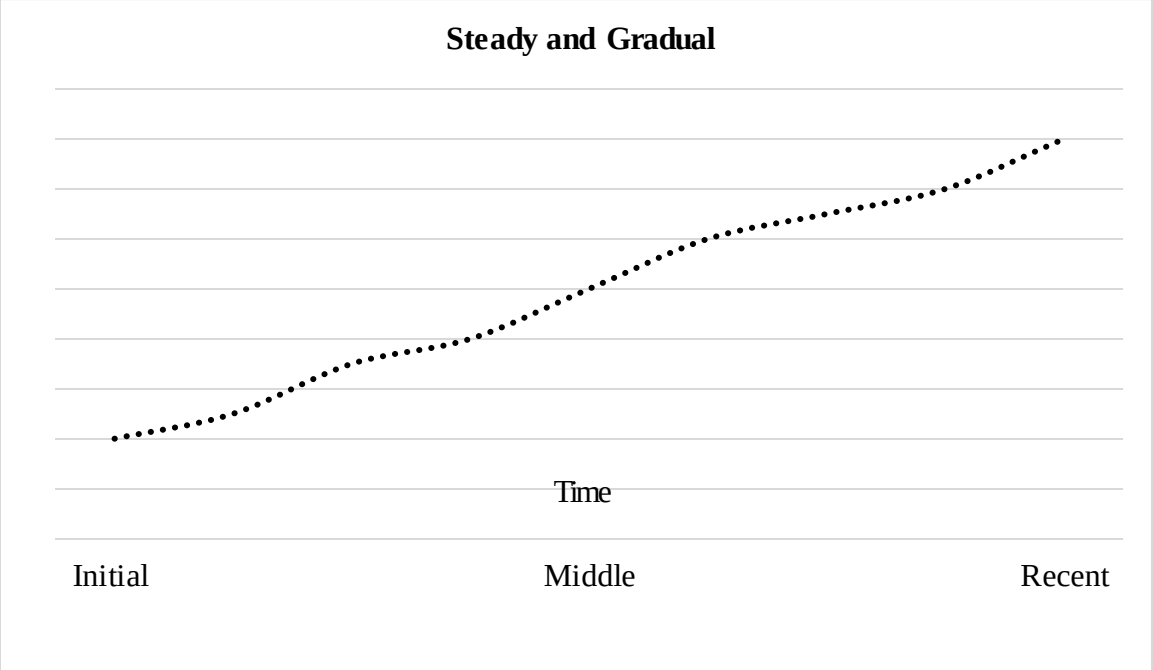
Participant 13: Clarissa



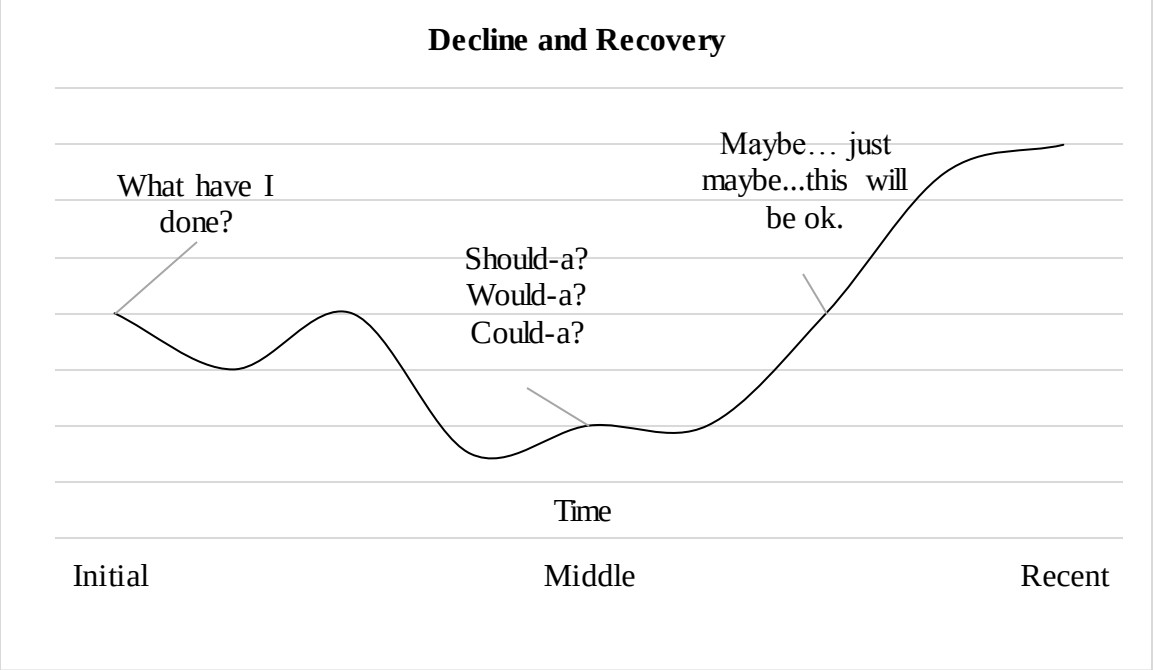
Participant 14: Angie



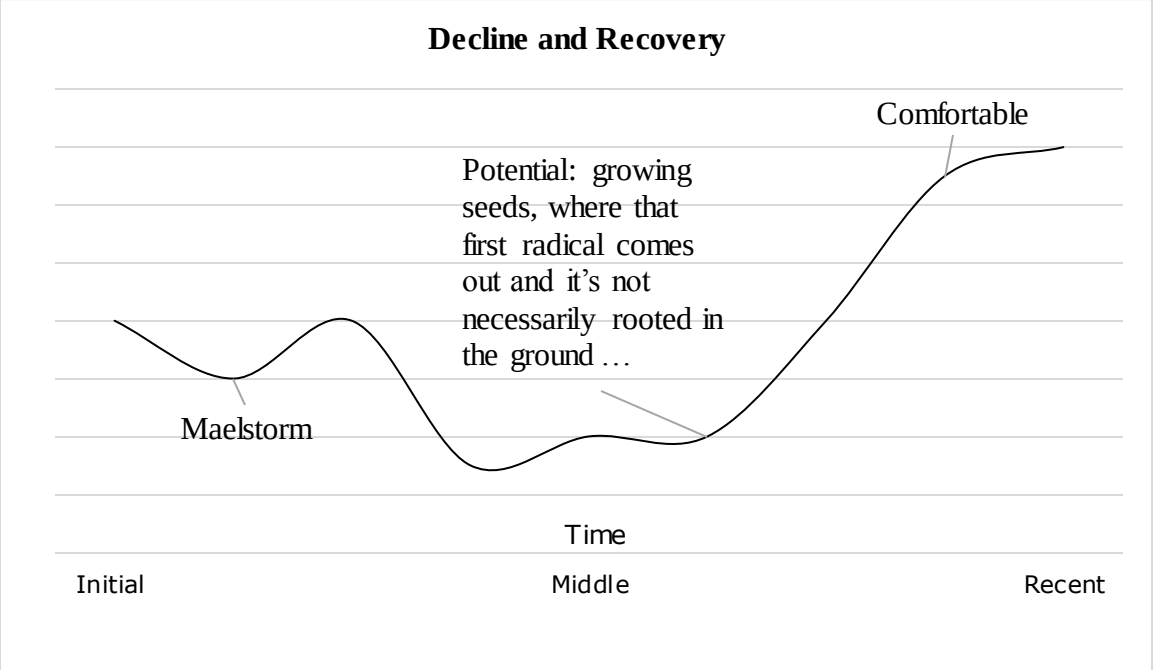
Participant 11: Mary



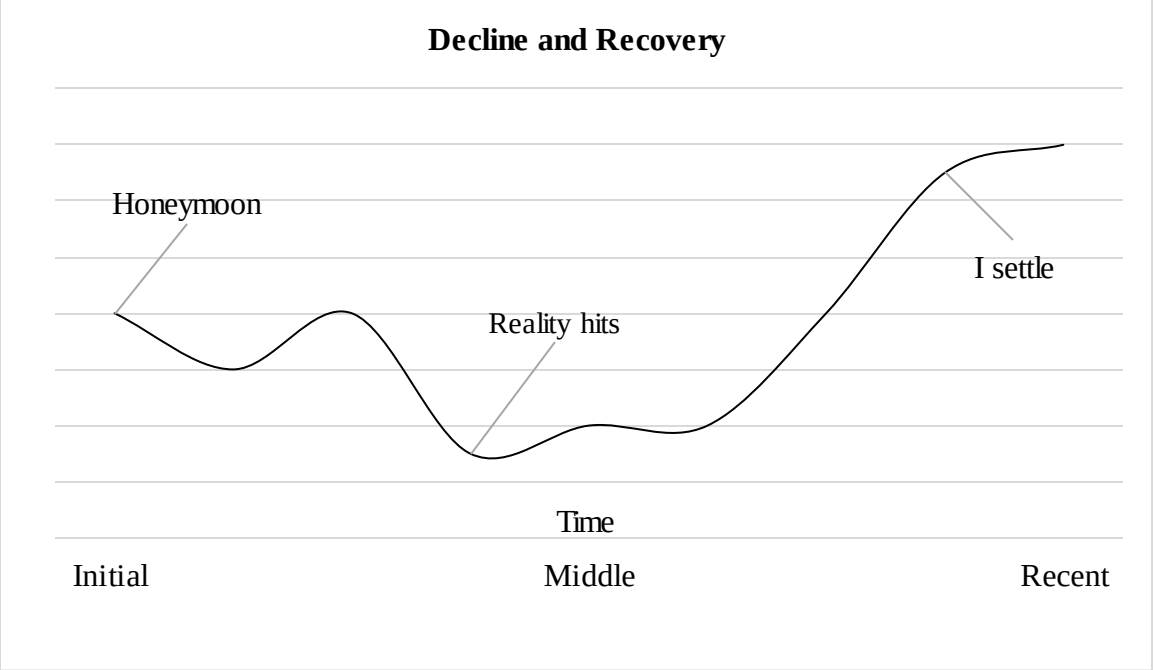
Participant 8: Lara



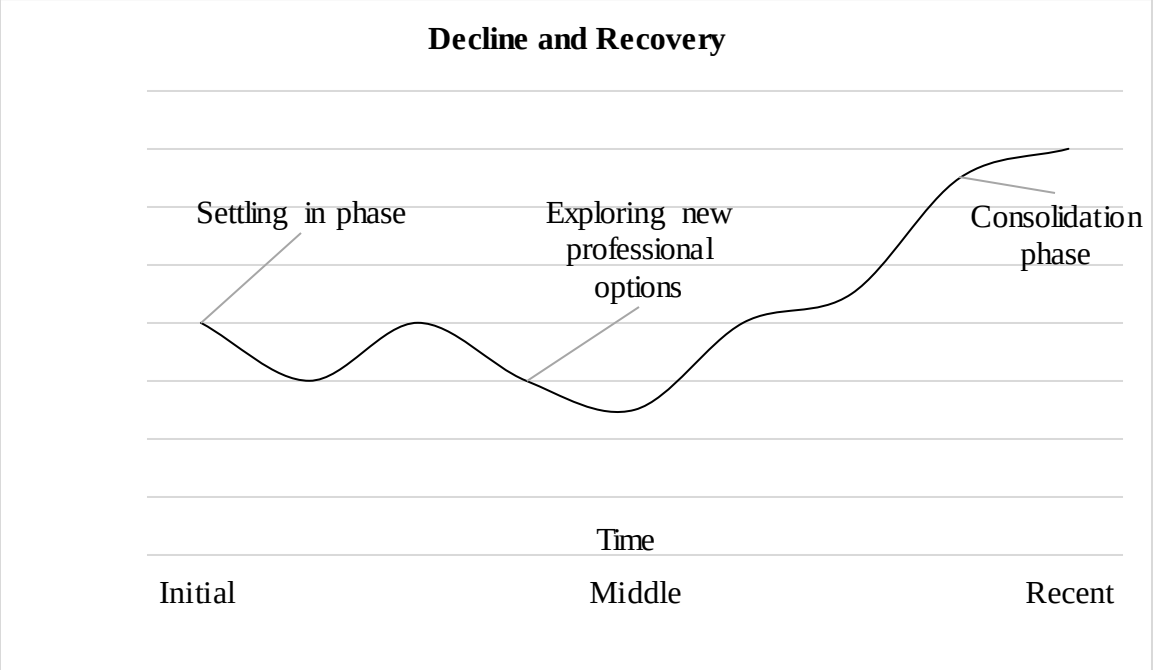
Participant 15: Miriam



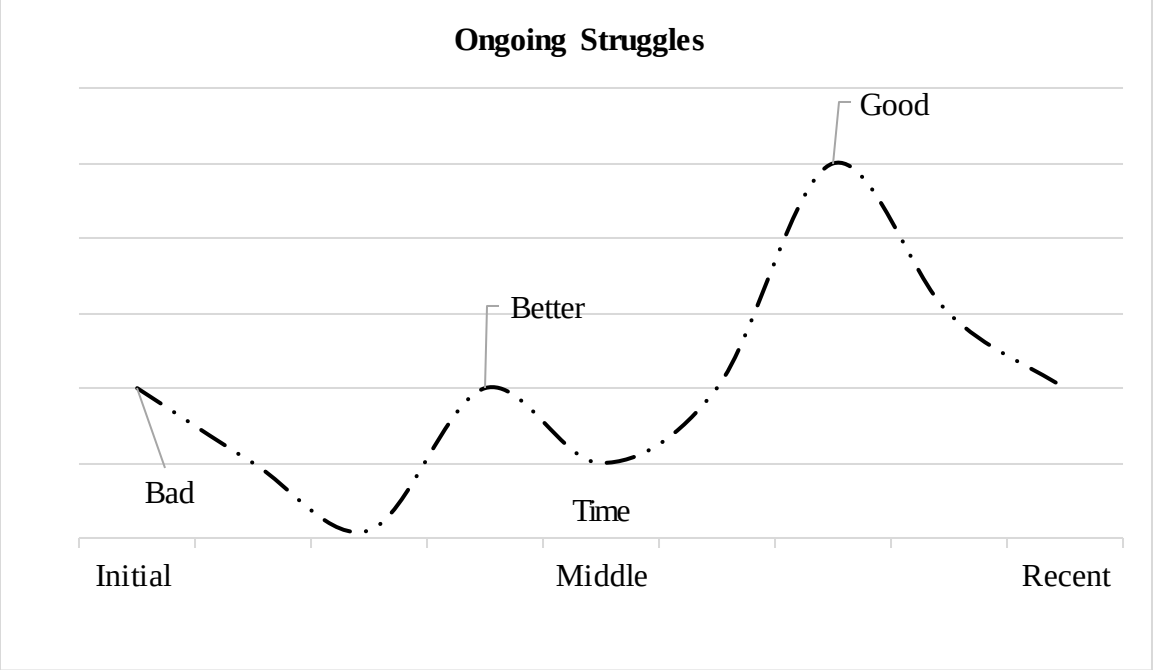
Participant 2: Melina



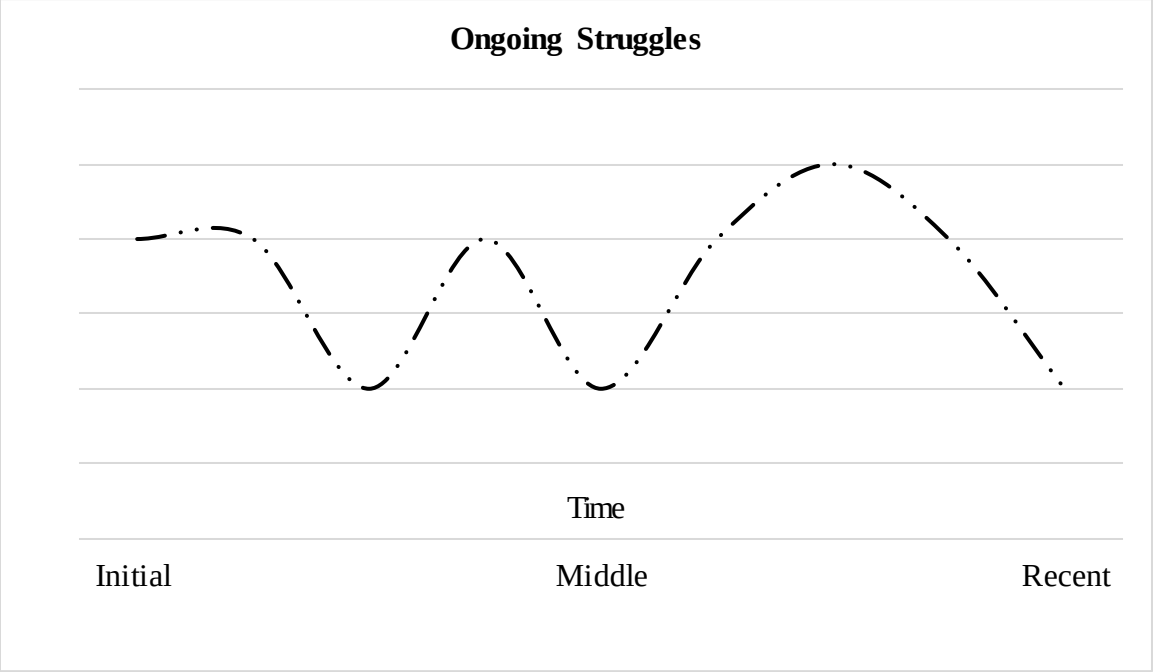
Participant 1: Leonard



Participant 10: Sarah



Participant 5: Emily



Appendix G: Ethics Approval

Office of the Vice-Chancellor
Finance, Ethics and Compliance

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Level 10, 49 Symonds Street
Telephone: 64 9 373 7599
Extension: 87810 / 83761
Facsimile: 64 9 373 7432

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

16-Sep-2016

MEMORANDUM TO:

Dr Patricia Cartwright
DELNA

Re: Application for Ethics Approval (Our Ref. 017660): Approved

The Committee considered your application for ethics approval for your project entitled **A narrative study of Immigrant psychologists' experiences of working professionally in the cultural context of Aotearoa, New Zealand**.

We are pleased to inform you that ethics approval is granted for a period of three years.

The expiry date for this approval is 16-Sep-2019.

If the project changes significantly, you are required to submit a new application to UAHPEC for further consideration.

If you have obtained funding other than from UniServices, send a copy of this approval letter to the Research Office, at ro-awards@auckland.ac.nz. For UniServices contracts, send a copy of the approval letter to the Contract Manager, UniServices.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

Please quote reference number: **017660** on all communication with the UAHPEC regarding this application.

(This is a computer generated letter. No signature required.)

UAHPEC Administrators
University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, DELNA
Dr Margaret Dudley
Miss Adriana Thomas

Additional information:

1. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

2. Should you need to make any changes to the project,please complete the online proposed changes and include any revised documentation.

3. At the end of three years, or if the project is completed before the expiry, please advise UAHPEC of its completion.

4. Should you require an extension, please complete the online Amendment Request form associated with this approval number giving full details along with revised documentation. An extension can be granted for up to three years, after which a new application must be submitted.

5. Please note that UAHPEC may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.